Evaluation Report

The Youth Primary Mental Health Service

January 2016

Acknowledgements

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Acronyms

AOD	Alcohol and other drugs
BI and BIC	Brief intervention and brief intervention counselling
CAFS	Child and Family Services
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CEP	Co-Existing Problems
CFA	Crown Funding Agreement
COPMIA	Children of parents with mental illness and/or addiction
DHB	District Health Board
DNA	Did Not Attend
ED	Emergency Department
FTE	Full-Time Equivalent
GP	General Practitioner (i.e. family doctor)
HEEADSSS	Home, Education/ Employment, Eating, Activities, Drug and Alcohol, Sexuality, Suicide and Depression, Safety (Wellness Checks)
LGBT	Lesbian, Gay, Bisexual, Transgender
NGO	Non-Governmental Organisation
OECD	Organisation for Economic Co-operation and Development
PBFF	Population-Based Funding Formula
PHO	Primary Health Organisation
PMHS	Primary mental health service
POC	Packages of care
SBHS	School-Based Health Services
YSLAT	Youth Service Level Alliance Team
YMHP	Youth Mental Health Project
YPMHS	Youth Primary Mental Health Service
YOSS	Youth One Stop Shop

1.   Executive summary

New Zealand youth have relatively high rates of mental health issues and the youth suicide rate is one of the highest in the OECD. As well as the consequences for individuals, poor youth mental health has substantial social and economic impacts. It is associated with increases in risky behaviours, and decreased participation and achievement at school which flows through to lower rates of workforce participation in future years.

The Prime Minister's Youth Mental Health Project (YMHP) was launched in 2012 to help prevent youth developing mental health issues and to improve access to mental health services for young people aged 12 to 19 years with mild to moderate mental health issues.

The YMHP includes 26 initiatives. The Youth Primary Mental Health Service (YPMHS) evaluated in this report is Initiative Three. The aim of the YPMHS is to extend existing primary mental health services (PMHS)[1] to increase access for all youth aged 12 to 19 years who require such a service. The expected outcomes are to enable early identification of youth developing mental health and/or addiction issues and better access to timely and appropriate treatment and follow-up for those who need it.

1.1   The evaluation

The Ministry of Health has funded this evaluation of the YPMHS to contribute to building the body of knowledge about what works for youth mental health. The objectives for the evaluation are to assess whether:

- Funding has gone where it was intended and whether it has demonstrated the best value for public health system resources
- The service has contributed to improved health and equity for New Zealand youth
- The service reached the target group and improved the quality, safety and experience of care.

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[1] As part of the Primary Healthcare Strategy, DHBs (through PHOs) provide a general primary care response to the needs of people of any age with mild to moderate mental health issues. In addition to this, access to primary mental health interventions are funded for specific population groups (Māori, Pacific and/or low income). After a development phase, the primary health initiative is now embedded in primary care and referred to as the primary mental health services (PMHS).

The evaluation covered the period from 2012, when the YPMHS implementation began, to late 2015. The information came from:

- A review of literature and reports relevant to youth primary mental health
- Interviews with key stakeholders in each District Health Board (DHB) district including DHB portfolio managers, managers of provider organisations, and frontline providers
- Interviews with youth who used the youth mental health services provided through the YPMHS
- In-depth profiles of examples of different ways services are being delivered to youth
- A survey of providers involved in youth healthcare
- Analysis of data provided by the Ministry of Health and by individual provider organisations, about youth engagement with primary mental health services.

1.2   How DHBs used the YPMHS funding

Youth primary mental health funding consists of $11.3 million allocated over four years from 2012/13 to 2015/16. Of this $11.3 million, $8.9 million comes from within DHB baselines and a further $1.9 million was allocated across the 20 DHBs from 1 July 2015.

DHBs were able to decide how to use the additional funding, responding to local needs and opportunities. There were four broad approaches:

- Expansion of the age range of existing primary mental health services e.g. by increasing funding available to PHOs and other providers for packages of care and brief interventions
- Adapting existing primary mental health services for youth e.g. by creating a new youth mental health co-ordinator role
- Expanding existing NGO or community-based initiatives e.g. funding new roles or programmes
- Developing new initiatives to meet local needs e.g. youth psychologists co-located in schools and NGO youth services, and/or funding youth specific services ranging from resilience building to treatment.

DHB portfolio managers were mostly able to describe how the Ministry of Health share of the funding had been allocated but many were not able to link the redirected pharmaceutical savings to specific YPMHS activities. Redirected pharmaceutical savings may be part of the overall pool of money for mental health used for DHB services or allocated to PHO and NGO services. Where redirected

savings was used to adapt or expand existing services it may not be possible, or useful, for DHBs to report about what different funding streams have achieved in service delivery.

1.3   Evidence about what works

The knowledge base about what works in improving youth mental health and wellbeing continues to grow. There is evidence about the effectiveness of talking therapies such as cognitive behavioural therapy and medication provided through primary care. There is less information about the effectiveness of different primary care service models and initiatives.

A lack of consistent measures limits conclusions about effectiveness and the extent services have improved outcomes for youth. This is a problem across the spectrum of youth health services. Youth often participate in multiple, overlapping interventions. Their outcomes are also closely linked to those of their families, who may also receive a range of services concurrently.

Where services and interventions are evidence-based it is reasonable to assume that at least some of the youth who have used them have benefitted. However, the absence of evidence does not mean that some of the service models described in this evaluation are not effective as many have not been evaluated. Evaluation of different youth mental health services would help DHBs decide where to invest their youth primary mental health budgets.

> **Recommendation: Develop a consistent way of measuring the effectiveness of different service models and interventions in improving youth mental health and wellbeing**
>
> More information about what works would inform decisions about the cost and effectiveness of different primary mental health systems and services for youth. Potential next steps are reviewing the data collected by the Ministry of Health and adopting a simple outcomes measurement tool (aligned with the National Populations Outcomes Framework). An ideal tool would link to an established outcomes measurement system, align with specialist service outcomes, provide consistent outcomes across providers, and could be set up in patient management systems or work as 'stand-alone' modules in software such as Excel.

1.4   Differences the YPMHS has made for youth

As a result of the YPMHS, more youth have accessed services to support wellbeing and mental health. The YPMHS has:

- Increased the capacity of services to support youth mental health and wellbeing. Primary mental health services are reaching between 3,300 and 4,200 youth each quarter. These numbers are an increase in the totals seen by primary mental health services, as the numbers of adults seen has also increased since the YPMHS was introduced.
- Increased the range of provider and service options for youth including more youth-friendly services.

Providers funded by the YPMHS most commonly delivered brief interventions (counselling) and packages of care to youth. Group therapy was infrequently used but some youth specific services were starting to use group therapy and reporting its effectiveness for youth with anxiety issues.

Māori and Pacific youth, and youth living in lower socio-economic localities have higher rates of mental health issues. These contribute to disparities between Māori and Pacific peoples and people from European ethnic groups in a broad range of life outcomes. The YPMHS is likely to be contributing to reducing disparities between ethnic groups as services are reaching Māori youth at higher rates than their proportion in the population.

Although more youth are using primary mental health services, the evaluation identified some gaps:

- Many providers reported unmet need for services, either because of barriers to accessing services, services at capacity or a lack of appropriate services for youth.
- With the exception of one district, services are not reaching young males to the same extent as they are reaching young females.
- Many providers who responded to a survey found it difficult to find services for Māori and Pacific youth. Providers in districts with a high Māori population noted difficulty reaching young Māori males.
- Many providers noted a need for youth primary mental health services for youth younger and older than the 12 to 19 year age range.

Recommendation: Continue to develop the YPMHS

Continue to develop the YPMHS because it has increased awareness of youth mental health, improved access to primary mental health and is improving outcomes for youth (largely based on qualitative data). Feedback from providers suggests an ongoing need for the YPMHS and for further development of services to increase capacity and focus on the identified gaps.

1.5   Differences the YPMHS has made to the way primary services are provided for youth

The interviewed providers talked about the differences they had seen in primary mental health services for youth in their districts. However, funding from other YMHP initiatives, one-off money for YOSS development and other initiatives such as alcohol and drug exemplar programmes, social sector trials and children's teams have been put in place over the same time period as the YPMHS and have confused the ability to attribute any differences to YPMHS funding.

The differences the YPMHS funding has made to primary service provision for youth can be summarised as:

- Raising the profile of youth mental health.
- Increasing the cohesion of youth services through the development of governance groups or new roles to bring together local services for youth.
- Adapting existing primary mental health services for youth e.g. by creating new youth mental health co-ordinator roles and/or improving the youth-friendliness of services.
- Supporting the development of new initiatives to meet local needs e.g. through the development of youth-specific services, co-location of specialist youth mental health services such as youth psychologists in primary care settings.
- Supporting new workforce roles for youth mental health co-ordinators to provide brief interventions and referral pathways for youth who need more intensive support

There was variation between districts in the way the YPMHS funding had been used. Some districts were innovative in the ways they used the new funding, even relatively small amounts of funding. Some districts that received relatively small amounts of new funding were not able to contract with a provider to do anything more than expand existing services such as packages of care.

Service delivery for youth seemed to be most effective in districts where:

- DHBs and PHOs prioritised youth compared to other population groups
- Governance was effective and included representation across the range of youth service providers
- There was a local leader who worked to link the different service providers together
- There was the ability to be innovative and set up and trial new initiatives.

Recommendation: Funding for innovation

The evaluation identified many examples of innovation in reaching youth who need support. Traditional ways of providing primary care services could be made more accessible for youth with an increased focus on youth-friendly services and new service models such as co-located and integrated services. Service efficiency could be improved through strengthening links between providers.

Enhancing the efficiency and effectiveness of youth services could be achieved through:

Sharing information between districts about what works is likely to help districts develop innovative ways of supporting youth. Although there are differences in the youth context between districts there are common elements of a youth primary mental health service that could be shared across districts. For example, the costs and effectiveness of different youth primary mental health services, what to consider when developing services especially integrated and/or co-located services, how to reach Māori and Pacific youth and other vulnerable groups, and how to measure outcomes.

Funding for innovation by setting expectations and acknowledging the costs of developing new and innovative approaches to bring together an effective youth primary mental health service in each district. Criteria for funding youth primary mental health services might include requirements for:

- A lead agency that can demonstrate strong links with other stakeholders
- An appropriate infrastructure, governance and management
- Youth participation in leadership and service development
- A plan that is innovative and a justification for any additional funding
- A commitment to measuring outcomes and to evaluation.

Establishing an effective youth primary mental health service takes time to develop governance, design systems and services, build relationships with local providers and promote the service. Some districts may need additional funding to take a system-wide approach and fill existing gaps in their youth services. An approach that has been successfully used in the past is to establish a contestable pool of money for innovation.

1.6 The youth health workforce

Workforce development is an essential component of expanding youth primary mental health services. New workforce initiatives and new roles are developing the capability of the youth health workforce to identify and intervene where youth need support for mental health issues.

General practice teams are an important part of the youth health workforce. General practices have an established infrastructure and a regulated workforce. However, many are not confident in aspects of youth mental health. The majority of surveyed general practice providers and other youth providers wanted more training about how to support youth with mental health issues. Exploring how to build specialist support for youth into general practices (for example, youth workers and psychologists) and removing barriers such as cost and time in the consultation are also likely to increase access for youth.

New roles such as youth psychologists either co-located or able to provide advice when needed are contributing to upskilling the primary care workforce.

The non-clinical workforce provides services ranging from resilience building programmes to facilitating group therapy sessions. Many of the youth primary health workforce, especially the non-clinical workforce is employed by NGOs. Many are employed on short-term contracts and do not have the same opportunities for professional development as their peers employed by agencies and DHBs. Differences in employment conditions and salaries contributed to difficulties for NGOs in employing a skilled workforce.

> **Recommendation: Invest in the development of a youth primary mental health workforce**
>
> - The findings from this evaluation support the following recommendations from the report on New Zealand's youth health workforce[2]:
>   - The workforce for youth should be trained so it is competent – including undergraduate youth-specific training for doctors and nurses and specific career paths and recognition for those who wish to specialise in youth health
>   - Future clinical leaders and researchers should be developed to support the workforce and inform service development.
> - NGO providers included in the YPMHS evaluation identified the importance of secure funding as a foundation for workforce retention and development. As good information becomes available about what systems work to support youth, approaches to contracting NGOs could be reviewed to:
>   - Enable workforce development and security

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[2] Kerkus M et al (2011). Report of the youth health workforce service review. https://www.health.govt.nz/system/files/documents/pages/youth-health-workforce-service-review.pdf

> o Encourage innovation, for example, high-trust contracts use simple but effective contracting processes to support and capitalise on the strengths and benefits of high trust relationships. They provide upfront funding, minimise reporting requirements and allow flexibility because they focus on reporting agreed outcomes rather than processes.

1.7 The value of investing in youth mental health

Many youth with mild to moderate mental health issues may go on to achieve positive outcomes. However, there is a greater risk for some of significant negative impacts on future health, employment and wellbeing. Intervention, especially early intervention has the potential to divert a proportion of youth from long-term negative outcomes such as benefit dependence and can result in significant social and economic benefits that can offset programme costs. Numerous studies have demonstrated that net positive financial returns can result from investing in mental health treatment for young people.

There is not sufficient consistent measurement of outcomes for youth receiving youth primary mental health services to allow a robust cost-benefit analysis as part of this evaluation. However, information from this evaluation demonstrates that services are achieving outcomes that are associated with positive returns on investment such as:

- Improved mental health outcomes following intervention
- Improved resilience
- Youth staying in school for longer
- Youth being helped to get jobs.

One of the challenges for funders is balancing targeted services – to reach the districts with the highest proportions of vulnerable youth (often youth who are difficult to reach) - against funding districts with the largest number of vulnerable youth.

1.8 Conclusions

The YPMHS has contributed to improvements in the quality, safety and experience of primary youth mental health services through:

- Enhanced youth-friendliness of general services and development of youth-specific services

- Workforce upskilling and co-location of youth-specific services with primary healthcare providers
- New and innovative ways of supporting youth that are breaking down some of the access barriers.

The YPMHS funding is contributing to improved health and equity for New Zealand youth because Māori youth are accessing services at higher rates than Pākeha.

There are opportunities to continue the development of primary mental health services by:

- Continuing to reduce access barriers for youth seeking help, for example the stigma attached to mental health issues
- Improving access for Māori and Pacific youth and young males
- Increasing the capacity of services to see youth, especially youth-specific services
- Improving the effectiveness of the services by sharing information about what works
- Supporting innovation to contribute to the development of efficient and cohesive services
- Developing the youth workforce including continuing to develop the youth worker role and co-located primary and specialist youth services.

The extent conclusions can be drawn about whether the YPMHS has demonstrated the **best** value for public health system resources is limited by a lack of consistent measures of outcomes for youth using the services.

2.   Introduction

2.1   The Prime Minister's Youth Mental Health Project (YMHP)

The Prime Minister's Youth Mental Health Project (YMHP) was launched in 2012 to help prevent youth developing mental health issues and to improve access to mental health services for young people aged 12 to 19 years with mild to moderate mental health issues. The YMHP includes 26 initiatives. The Youth Primary Mental Health Service (YPMHS) evaluated in this report is Initiative Three.

2.2   The Primary Mental Health Initiative

In most instances primary care is the first point of contact to health services. As part of the Primary Healthcare Strategy, DHBs (through PHOs) provide a general primary care response to the needs of people of any age with mild to moderate mental health issues. In addition to this, access to primary mental health interventions are funded for specific population groups (Māori, Pacific and/or people with low incomes). After a development phase, the primary health initiative is now embedded in primary care and referred to as the primary mental health services (PMHS).

2.3   The Youth Primary Mental Health Service (YPMHS)

The YPMHS builds on the existing PMHS to support mental health and AOD responses in primary care settings for people with high prevalence conditions (mild to moderate anxiety, depression, alcohol and drug issues or co-existing conditions and medically unexplained symptoms).

Appropriate primary care services have the potential to link young people to care earlier. The YPMHS contributes to achieving the goals of *Rising to the Challenge: The Mental Health and Service Development Plan 2012-2017*[3].

Funding for the YPMHS was provided to DHBs to enable them to contract local PHOs and NGOs to increase access for youth aged 12 to 19 years (regardless of PHO enrolment) who require psychological therapies, other psychosocial interventions and packages of care and/or mental health and AOD interventions in a primary care

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[3] Ministry of Health. (2012). *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017.* http://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017

setting[4]. The 12 to 19 age group was selected to include transitions into and from secondary school.

2.4   The evaluation of the Youth Primary Mental Health Service (YPMHS)

The YMHP has emphasised the role of evaluation and one of the aims of the project is to learn more about what works and what does not work for youth mental health. The Ministry of Health has commissioned an evaluation of the YPMHS to provide information about:

- Whether the YPMHS funding has gone where it was intended and whether it has demonstrated the best value for public health system resources
- The effectiveness of the services delivered and whether the service has contributed to improved health and equity for New Zealand youth
- Whether the services reached the target group and have improved quality, safety and experience of care.

There is frequently no clear delineation of funding or service delivery across different initiatives for youth. The evaluation therefore includes DHB initiatives that fit into the broad interpretation of improving access to primary mental health care.

One of the longstanding problems with delivering services to young people – they tend to be 'messy' – often standard 'medical' models / problem focussed approaches don't work – need holistic models of care. (Provider)

2.5   Youth mental health issues

Adolescence is a period of extensive psychological and biological development[5] [6] and coincides with other social and education life-stage changes (e.g. leaving school, developing an identity separate to the family)[7]. Experiencing poor mental health at this stage can have life-long negative consequences, including diminished

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[4] Ministry of Health (2015). Schedule D6: Youth Primary Mental Health Service

[5] Fox, S., Southwell, A., Stafford, N., Goodhue, R., Jackson, D. and Smith, C. (2015). *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention*. Canberra: Australian Research Alliance for Children and Youth (ARACY).

[6] Gluckman, P. (May 2011). *Improving the Transition: Reducing social and psychological morbidity during adolescence - A report from the Prime Minister's Chief Science Advisor*. http://www.pmcsa.org.nz/wp-content/uploads/Improving-the-Transition-report.pdf

[7] Ibid.

participation in the future workforce[8] as well as enduring disability and/or poor family and social functioning[9].

Wellbeing is not simply a lack of mental health issues[10] and instead involves positive factors that actively contribute to positive wellbeing. It is well established that social, economic, cultural and ethnic contexts and the wider context in which youth live, go to school, work and socialise influences their wellbeing[11].

Using information from New Zealand's Integrated Administrative Data, and noting that it is likely to not include mild conditions, around one-tenth of young people were identified as having a history of substance abuse and one-quarter of having mental health issues[12]. Mental health issues were more common in females and older youth.

Findings from the New Zealand Health Survey show mood disorders, depression and anxiety are the most common diagnosed disorders[13]. Self-harm is also increasing among New Zealand youth and one New Zealand study found 21% of students had engaged in self-injury at some point[14].

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[8] Holt, H. (2010, 16 Nov). *Health and Labour Force Participation. New Zealand Treasury Working Paper 10/03*.

[9] McGorry, P.D., Purcell, R., Hickie, I.B., and A. F. Jorm. (2007, 1 October). Investing in youth mental health is a best buy: The logic and plan for achieving early intervention in youth mental health in Australia (Editorial). *Medical Journal of Australia, 187* (7) S5-S7.

[10] Ball, J. (2010). Review of evidence about the effectiveness of mental health promotion programmes targeting youth/rangatahi. *Mental Health Foundation of New Zealand*. http://www.mentalhealth.org.nz/assets/ResourceFinder/Review-of-evidence-about-effectiveness-of-mental-health-promotion-programmes-targeting-youth.pdf

[11] Ministry of Youth Affairs. (2002). *Youth Development Strategy Aotearoa: Action for Child and Youth Development.* http://www.myd.govt.nz/documents/resources-and-reports/publications/youth-development-strategy-aotearoa/ydsa.pdf

[12] Indicators of substance abuse and other mental health issues were derived from a broad set of measures including health data and prescriptions for mental health-related pharmaceuticals. McLeod, K., R. Templeton, C. Ball, S. Tumen, S. Crichton & S. Dixon. (2015, December). *Analytical Paper 15/02 Using Integrated Administrative Data to Identify Youth Who are at Risk of Poor Outcomes as Adults*. http://www.treasury.govt.nz/publications/research-policy/ap/2015/15-02/ap15-02.pdf

[13] Ministry of Health. (2015). *New Zealand Health Survey.* http://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/current-recent-surveys/new-zealand-health-survey

[14] Wilson, M., J. Garisch, R. Langlands, L. Russell, A. O'Connell, T. Kingi, E. Brown, M. Judge, K. Robinson & W. Ashby. (2014). *Youth Wellbeing Study Longitudinal Survey: Summary of second wave of results*. http://www.victoria.ac.nz/psyc/research/youth-and-wellbeing-study/resources/Wave-2-Feedback-for-Parents-and-Whanau.pdf

Youth mental health issues have been associated with a range of risky behaviours including risky sexual behaviour[15][16], early sexual behaviour[17], smoking[18] and alcohol and/or drug use[19][20][21]. Early unsafe sex is reflected in New Zealand's teenage birth rate: the second highest amongst developed countries (after the United States) although this is declining[22].

Lesbian, gay, bisexual, transgender (LGBT) youth have higher rates of depression[23], suicide, substance use, homelessness and school drop-out rates than heterosexual youth[24].

[15] Shrier, L. A., S. K. Harris & W. R. Beardslee. (2001). Associations of depression, self-esteem, and substance use with sexual risk among adolescents. *Preventive Medicine, 33*(3), 179-189.

[16] Rubin, A. G., M. A. Gold & B. A. Primack. (2009). Associations between depressive symptoms and sexual risk behaviour in a diverse sample of female adolescents. *Journal of Pediatric and Adolescent Gynecology, 22*(5), 306-312.

[17] Ethier, K. A., T. S. Kershaw, J. B. Lewis, S. Milan, L. M. Noccolai & J. R. Ickovics. (2006). Self-esteem, emotional distress and sexual behaviour among adolescent females: Inter-relationships and temporal effects. *Journal of Adolescent Health, 38*(2), 268-274.

[18] Glendinning, A. & D. Inglis. (1999). Smoking behaviour in youth: The problem of low self-esteem? *Journal of Adolescence, 22*, 673-682.

[19] Comeau, N., S. H. Stewart & P. Loba. (2001). The relations of trait anxiety, anxiety sensitivity, and sensation seeking to adolescents' motivations for alcohol, cigarette and marijuana use. *Addictive Behaviors, 26*, 803-825.

[20] Kaplow, J. B., P. J. Curran, A. Angold & E. J. Costello. (2001). The prospective relation between dimensions of anxiety and the initiation of adolescent alcohol use. *Journal of Clinical Child and Adolescent Psychology, 30*(3), 316-326.

[21] Zimmerman, P., H. U. Wittchen, M. Höfler, H. Pfister, R. C. Kessler & R. Lieb. (2003). Primary anxiety disorders and the development of subsequent alcohol use disorders: A 4-year community study of adolescents and young adults. *Psychological Medicine, 33*, 1211-1222.

[22] Families Commission. (2014). *Current trends for teenage births in New Zealand* http://www.superu.govt.nz/sites/default/files/Teen_Births_Report_0.pdf

[23] Lucassen MF, Clark TC, Denny SJ, Fleming TM, Rossen FV, Sheridan J, Bullen P, Robinson EM. (2015). What has changed from 2001 to 2012 for sexual minority youth in New Zealand? *Journal of Paediatric Child Health, 51*(4), 410-418.

[24] Lock, J. & H. Steiner. (1999). Gay, lesbian and bisexual youth risks for emotional, physical and social problems: Results from a community-based survey. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(3), 297-304.

New Zealand has one of the highest youth suicide rates in the OECD[25] although this rate is decreasing[26]. Despite lower rates of diagnosed disorders, males have a higher suicide rate than females, although females have higher rates of suicide attempts.

Disadvantage, poverty and inequality are contributors to poorer outcomes for youth health and wellbeing[27] . Young Māori are disproportionately affected by mental health issues and have higher rates of suicide than non-Māori[28]. The teenage birth rate for Māori is higher than average although this is also declining[29]. Higher rates of mental health issues amongst Māori youth contribute to disparities in outcomes between Māori and Pakeha ethnic groups.

2.6   Guide to the evaluation report

The focus of the evaluation report is on youth aged 12 to 19 years, although in some cases data are only available for a wider age range. In response to feedback from providers, the evaluation report takes a holistic approach and considers youth mental health as part of overall health and wellbeing.

The report is set out as follows:

Section 3: summarises the evaluation methods and sources of information.

Section 4: sets out the ways DHBs have used the YPMHS funding.

Section 5: provides an overview of the evidence from the literature about different service models and interventions. It summarises the evidence that has informed the different ways the YPMHS funding has been used.

Section 6: analyses the YPMHS data about youth seen to demonstrate the differences the YPMHS has made for youth.

Section 7: describes the differences the YPMHS has made to the ways primary mental health services are being provided to youth.

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[25] Ministry of Health. (2015). Understanding suicide in New Zealand. http://www.health.govt.nz/our-work/mental-health-and-addictions/working-prevent-suicide/understanding-suicide-new-zealand#suiciderates

[26] Mental Health Foundation. (2014). *Quick Facts and Stats 2014.* http://www.mentalhealth.org.nz/assets/Uploads/MHF-Quick-facts-and-stats-FINAL.pdf

[27] Fox, S., Southwell, A., Stafford, N., Goodhue, R., Jackson, D. and Smith, C. (2015). *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention*. Canberra: Australian Research Alliance for Children and Youth (ARACY).

[28] Ministry of Health. (2015). *Suicide Facts: Deaths and intentional self-harm hospitalisations 2012*. Wellington: Ministry of Health.

[29] Families Commission. (2014). *Current trends for teenage births in New Zealand* http://www.superu.govt.nz/sites/default/files/Teen_Births_Report_0.pdf

Section 8: discusses the youth workforce.

Section 9: summarises information about the costs of poor mental health and the costs and benefits of improving mental health outcomes for youth.

3.   Evaluation methods

This section provides an overview of the evaluation methods. The evaluation covered the period from 2012, when the YPMHS implementation began, to late 2015. The focus of this report is on the age group included in the YPMHS, the 12 to 19 age group. However, some information included in the evaluation is for a wider age range because of different age criteria used by service providers.

3.1   Theoretical foundation for the evaluation

Information from a review of the literature, key project documents and interviews with the Ministry of Health were used to develop a logic model and an evaluation framework (Appendix 1). These provided a theoretical foundation for the evaluation.

The logic model sets out:

- The YPMHS activities
- How the different activities work together
- What will be produced (the outputs)
- The difference the programme is expected to make (the outcomes).

The evaluation framework aligned with the logic model and set out the evaluation questions and sub-questions, measurable indicators and data sources for each evaluation question. Measuring what is in place at each level in the logic model means it is possible to identify any problems that may be limiting the results achieved by a programme.

3.2   Evidence review

A review of relevant published literature was conducted around youth primary mental health and youth mental health and wellbeing more broadly, including suggestions for evidence-based best practice. Relevant reports relating to youth mental health (both New Zealand and international) were also reviewed.

3.3   Ethics

The Health and Disability Ethics Committee summary flowchart[30] was used to determine whether the evaluation fell within the scope of the Health and Disability Ethics Review Guidelines. Based on the flowchart formal ethics review was not

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[30] Health and Disability Ethics Committee. *Does your study require HDEC review?* http://ethics.health.govt.nz/system/files/documents/pages/HDEC%20scope%20summary.pdf

required. The evaluation data collection, analysis and reporting adheres to the underlying ethical principles outlined in the Health and Disability Ethics Committee's Ethical Guidelines for Observational Studies 2012.

Some information in the evaluation was drawn from individual and focus group interviews with youth completed as part of in-depth locality studies for the overall evaluation of the YMHP. The approach to these youth interviews was approved by the Social Policy Evaluation and Research Unit (Superu) ethics committee.

3.4 Data collection

Data collection included in-person and telephone interviews, a survey of providers and analysis of primary and secondary data. Details of the different aspects of the evaluation are appended (Appendix 2).

3.4.1. Interviews

Information for the evaluation was gathered through a series of interviews. All interviews were semi-structured and a generic set of questions was adapted to fit the role and responsibilities of the person being interviewed. Details of who was interviewed are provided in Appendix 2.

- Initial interviews with the DHB portfolio managers responsible for the YPMHS explored how youth primary mental health services were provided in the DHB and how the YPMHS funding had been allocated. During the interview we asked the portfolio managers for an introduction and/or the contact details of key people involved in delivering the YPMHS in their district. We also asked for copies of relevant needs assessments, planning or evaluation reports held by the DHB.

- Interviews with key people involved in delivering the YPMHS were undertaken to understand what was being delivered and to collect any information on what was being achieved.

- Interviews identified detailed examples of different ways the YPMHS was being delivered in each DHB. The aim of the examples was to learn from youth primary mental health approaches or initiatives that are believed to be producing positive results to understand to what extent that might be true and what lessons can be learnt and shared across all sites. The examples were agreed with the DHB and/or organisation responsible for the service. In most cases the examples included a site visit to observe the service and complete additional interviews.

- In some districts, youth who used services were3 interviewed. Additional information about youth views was drawn from the overall evaluation of the YMHP.

3.4.2. Survey of providers

An online survey of providers was developed to explore: the types of services provided; workforce confidence and the strengths and challenges of providing primary mental health care to youth; provider training needs; and examples of innovative practice.

Responses were received from 317 people involved in youth primary mental health services (Figure 1)[31].
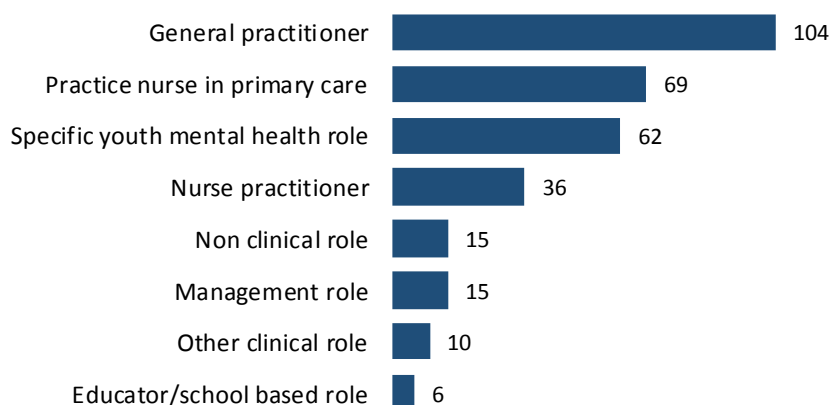
Figure 1. Professional group (Source: Provider survey)

Survey data were analysed in the Statistical Package for the Social Sciences (SPSS) to provide descriptive statistics of the experiences of service providers.

3.5   Data analysis

Information about volumes of youth accessing services, costs of services and outcomes for youth came from analysis of data that included:

- DHB profiles and populations gathered from DHB websites and the New Zealand Census of Populations and Dwellings.

- Youth engagement with primary mental health services provided to the Ministry of Health by each DHB using the Ministry data collection template. Data are available for the full 2014/15 financial year and the first quarter of the 2015/16 financial year.

- Specific services provided by the service provider organisation including numbers of youth seen, types of services provided and the costs of services. This information was not available from all services.

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[31] The survey was distributed by PHO and other organisations. Therefore, it is not possible to calculate a response rate and to determine the extent responses reflect youth service providers nationally.

- Outcomes collected by some services.

3.6 Strengths and limitations of the evaluation

The strengths of the approach included:

- Consultation during a planning phase.

- The development of a logic model and evaluation framework provided a theoretical foundation for the evaluation.

- A mixed methods approach to data collection that included in-depth feedback from a range of stakeholders, analysis of administrative data as well as a survey to collect information from a breadth of participants. Information from different sources enabled triangulation of findings.

- Support and interest from providers in the evaluation that resulted in feedback from a wider range of people involved with youth primary mental health. Stakeholders reported on the complexity of youth primary mental health care and we were able to collect rich information about how services were provided and the differences they made for youth.

The limitations of the approach included:

- The literature review was limited to publically available literature. These include well-established studies but exclude emerging work.

- We were dependent on PHO and other organisations to distribute the provider survey. The responses while providing useful information about a group of providers who work with youth, cannot be considered representative of all providers.

- Ministry of Health data was the source of data about how youth have used YPMHS services. There are a number of limitations to the data that are detailed in Section 6.

4. How DHBs have used the YPMHS funding

Key messages

Youth primary mental health funding consists of $11.3 million allocated over four years from 2012/13 to 2015/16. Of this $11.3 million, $8.9 million comes from within DHB baselines and a further $1.9 million was allocated across the 20 DHBs from 1 July 2015.

DHB portfolio managers were mostly able to describe how the new funding had been allocated but many were not able to link the redirected pharmaceutical savings to specific YPMHS activities. Redirected pharmaceutical savings may be part of the overall pool of money for mental health used for DHB services or allocated to PHO and NGO services. Where redirected savings was used to adapt or expand existing services it may not be possible, or useful, for DHBs to report about what different funding streams have achieved in service delivery.

4.1 Funding for the YPMHS

As part of the Primary Healthcare Strategy, District Health Boards (usually through Primary Health Organisations) provide a general primary care response to the needs of people with mental health and addiction issues. In addition to this, access to primary mental health interventions were funded for specific population groups, initially for Māori, Pacific and low income and from 2012 this was extended to all youth (12-19 years) as part of the Prime Minister's Youth Mental Health Project.

Primary mental health funding consists of two components:

- $24.3 million devolved from 1 July 2015 to DHBs to fund free primary mental health interventions for the Māori, Pacific and low income population groups.
- $11.3 million allocated for youth primary mental health over four years from 2012/13 to 2015/16. Of this $11.3 million, $8.9 million comes from within DHB baselines and a further $1.9 million was allocated across the 20 DHBs from 1 July 2015.

The 2015/16 funding is allocated to YPMH services based on its Population-Based Funding Formula (PBFF) [32]. Nationally $3.1 million per annum has come from DHB baselines, and $1.9 million from the Ministry as additional funding (Table 1).

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[32] The formula takes into account the number of people who live in each DHB catchment, their age, socio-economic status, ethnicity, and sex. It also has mechanisms to compensate DHBs who service rural communities and areas of high deprivation.

Table 1: YPMHS proportion of funding for each DHB 2015/16 financial year

DHB	% of total YPMHS funding	% of NZ youth aged 12-19 in the district	Total population aged 12-19 in the district
Northland	4.50%	3.71%	18,340
Waitematā	11.25%	12.45%	61,600
Auckland	9.31%	9.50%	46,990
Counties Manukau	10.81%	12.87%	63,640
Waikato	8.91%	8.86%	43,800
Bay of Plenty	5.55%	4.75%	23,500
Tairāwhiti	1.26%	1.17%	5,770
Lakes	2.48%	2.39%	11,840
Hawke's Bay	3.96%	3.64%	17,990
Taranaki	2.79%	2.44%	12,070
Whanganui	1.69%	1.37%	6,800
MidCentral	4.05%	3.93%	19,430
Wairarapa	1.12%	0.89%	4,420
Capital and Coast	5.76%	6.34%	31,360
Hutt Valley	3.09%	3.17%	15,680
Nelson Marlborough	3.42%	2.87%	14,190
West Coast	0.89%	0.62%	3,090
Canterbury	10.94%	10.90%	53,890
South Canterbury	1.46%	1.19%	5,910
Southern	6.78%	6.93%	34,290
TOTALS	**100%**	**100%**	**494,600**

4.2   How the funding has been used

Interviews with DHB portfolio managers explored how the YPMHS funding has been used (Table 2). While most DHB portfolio managers could explain how the Ministry of Health share of the funding had been allocated many were unclear about the DHB contribution (redirected pharmaceutical savings). In some DHBs the YPMHS dollars were added to a general pool of money allocated to youth primary mental health

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Ministry of Health. (2015). *Population-based funding formula.*
http://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards/accountability-and-funding/population-based-funding-formula

and it was therefore not possible to attribute particular services or outcomes to those dollars.

Funding from other YMHP initiatives, one-off money for YOSS development and other initiatives such as alcohol and drug exemplar programmes, social sector trials (SST) and children's teams have been put in place over the same time period as the YPMHS and have confused the ability to track YPMHS funding.

Table 2: How YPMHS funding has been used

DHB	How the funding was used	Other major locality initiatives
Northland	Manaia PHO Funded a new primary mental health clinical role that has developed new services and coordinated service provision Packages of care	Kaikohe SST[33] Youth One Stop Shop (YOSS) – Whangarei YOSS - Youth Space
	Te Tai Tokerau PHO Developed a model for youth mental health Contributed to the work provided in assessment by the adolescent health nurse and by the primary mental health co-ordinator Packages of care	
Waitematā	Increased packages of care to HealthWest	Ranui SST
Auckland	Enhanced youth mental health packages of care delivered through Auckland Youth Health Services Alliance YSLAT.	
Counties Manukau	Manurewa Youth Mental Health Pilot Project 2013 (Unsuccessful and not continued)	
	19 / 33 high schools in DHB area have School Based Health Services (SBHS-	
	A 'youth-friendly' primary-care based quality improvement initiative and recruitment of a Primary Care Youth Health Quality Advisor (1 year, 1 FTE	
	18+ Clinical Care Model depression programme	

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[33] SST – Social Sector Trials

Waikato	The majority of funding went to the three PHOs for additional primary mental health FTEs and additional packages of care	SST in Waikato District, South Waikato, Waitomo and Taumarunui
	DHB to consult with PHOs around new youth AOD model of care	
	DHB time to support SST in district	
Bay of Plenty	Each of four providers received funding equivalent to 0.5FTE but funding was not tagged to a particular position	Whakatāne SST Kawerau SST
Tairāwhiti	PHOs have a district wide contract to provide youth primary mental health services through general practice. Funding used for a youth mental health nurse role	Gisborne SST
Lakes	Specialist mental health clinicians in primary care	Rotorua SST YOSS – Rotovegas YOSS – Anamata CAFE Children's Teams
	REAL (living life and loving it) – an NGO service providing youth workers and psychologists on site and in five schools	
	Youth psychologist roles 0.2 FTE at Anamata CAFE Taupō and 0.2 in schools	
Hawke's Bay	YOSS (to support development of Pasifika and LGBT youth groups)	YOSS - Directions
	Additional support for PHO primary mental health services	
Taranaki	Brief Intervention Packages of care known as Vouchers	South Taranaki SST
	Group Therapy - Sweet Programme. Part of the SST.	
Whanganui	Iwi provider Te Oranganui to employ one FTE as male Māori role model	YOSS - Youth Services Trust
MidCentral	PHO for various youth development programmes including: Combined Alliance Challenge Training Unit Support (CACTUS) – programmes in three schools Stand Tall – Youthline Hip Hop success	Horowhenua SST YOSS -Palmerston North

	Tararua Youth Community Group Highbury Youth Programmes (health, nutrition and AOD)		
Wairarapa	Two primary mental health nurses working alongside practice clinicians in GP clinics to provide triage and referral to 'To Be Heard', an integrated counselling model	Wairarapa SST	
Capital and Coast	PHO are contracted to provide youth primary mental health care	YOSS - Kāpiti Youth Support YOSS – Evolve Porirua SST	
Hutt Valley	YOSS	YOSS - Vibe	
Nelson Marlborough	Increased packages of care for PHOs and Te Piki Oranga (Māori provider) Single point of entry	Children's teams in Blenheim	
West Coast	Expanded PHO capacity for brief intervention counselling		
Canterbury	Strengthen youth mental health and AOD responsiveness	YOSS - 298	
	Expanded PHO capacity for PHO brief interventions Youth-specific Brief Interventions (BI)		
	BRAVE (Tool) – online therapy for anxiety		
	Child and adolescent psychiatrist		
South Canterbury	Adventure Development Trust - multiple services		
	Arowhenua Whanau Services - mental health support mainly AOD for people aged 12 +		
Southern District	PHO providing BI services for youth (including development of a new FTE in Otago) Small amount of funding to PHO for extended consultations and packages of care.	South Dunedin SST Gore SST YOSS - Number 10	

4.3 Factors contributing to variation in DHB service models

Some variation is a result of service development to meet the needs of the local population. However, variation has also been driven by other factors (Table 2).

Table 3: Factors contributing to variation in the ways DHBs provide youth primary mental health services

DHB and PHO priorities	The priority given to youth mental health by the DHB and PHOs depended to some extent on the proportion of youth in the district and the extent to which youth mental health was perceived as an issue within the district.
Leadership	Effective governance and leadership was linked with building a well-functioning youth system. In some districts, cross-sector alliance groups and strategic plans pre-dated the YPMHS and the YPMHS funding provided opportunities to trial new initiatives or to expand existing initiatives. Cross-sector alliance/ governance/ planning groups contributed to increasing provider awareness of each other's services. The DHBs that seemed to have effective systems in place for youth mental health had a person or group in a leadership role and the governance/alliance groups included people who could make funding decisions. The person in the leadership role connected different people and services and brought together a support system for youth. Examples of effective leadership were seen from people in different roles from DHB managers to frontline staff. This suggests the specific placement of the role is less important than assigning responsibility and authority to an individual focused on youth.
Integration of services in the district	The number of PHOs in a DHB can affect how well services are integrated and this can also affect how funding was spent. For example, in some districts all GP clinics are part of the same PHO, while in other districts there may be three or more PHOs providing similar services across the same locality. Mental health workers employed by PHOs in districts with multiple PHOs said it was *"not really an efficient use of practitioners"* since they spend time driving past other practices that are part of a different PHO. In some districts providers all know each other and work together well – this was particularly the case in rural/regional DHBs rather than the larger cities.

	Everybody knows everybody and works well together. (Provider)
Geography	The physical size and population density of a district can also affect how funding is spent. For example, in many districts services are largely concentrated in the main centres.
	Depending on the population density it may be more practical to have mental health workers divided by geography to reduce travel time.
	Our geography, we have to think about spending our money really carefully to make sure we are getting good coverage and promoting good access right across the coast. (Agency)
Amount of funding to support innovation	Some DHBs found it difficult to use smaller amounts of money to set up a new service and instead used the YPMHS funding to expand the age range of existing services or increase the numbers of packages of care.

5.   What works for youth

Key messages

The knowledge base about what works in improving youth mental health and wellbeing continues to grow.

Cognitive behavioural therapy (CBT) remains a cornerstone of the evidence base of effective therapy and can be delivered through primary care. However, evidence of efficacy depends on the delivery context (individual, group, with or without parent support) and the underlying condition (depression, anxiety, substance use, etc.).

There is evidence about the effectiveness of medication for youth with moderate to severe depressive and anxiety disorders. Medication can be effectively provided in primary care settings but this should be in conjunction with social and/or psychological support.

There is less information about the effectiveness of different primary care service models and initiatives.

A lack of consistent measures limits conclusions about effectiveness and the extent services have improved outcomes for youth. This is a problem across the spectrum of youth health services. Where services and interventions are evidence-based it is reasonable to assume that youth who have used the services have benefitted. However, the absence of evidence does not mean that some of the service models described in this evaluation are not effective as many have not been evaluated. Evaluation of different youth mental health services would help DHBs decide where to invest their youth primary mental health budgets.

An Australian review of research and practice for prevention and early intervention identified priority intervention pathways for different age groups[34]:

- The middle years - parenting skill development, promoting engagement with school and preventing disengagement, learning support, behavioural issues, school-based health and wellbeing, preventing substance misuse, transition to high school

- Adolescence and youth - preventing disengagement from school, mental health promotion, access to health services, sexual health promotion, preventing risky behaviours, young parenthood, preventing substance

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[34] Fox, S., Southwell, A., Stafford, N., Goodhue, R., Jackson, D. and Smith, C. (2015). *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention*. Canberra: Australian Research Alliance for Children and Youth (ARACY).

misuse, community connectedness and participation, crime prevention, restorative justice, suicide prevention, career pathways and transitions.

The priority intervention pathways sit across the domains of health, education and justice, highlighting the importance of cross-sector collaboration.

5.1   The stepped care model

YPMHS interventions are intended to be based on a stepped care model with the intensity of interventions matched to service user needs (Figure 2). 'Stepped care' is a term used to describe service systems in which the primary care team is central, but where other levels of professional service are then added proportionately to the severity and complexity of the clinical scenario. Thus, effective primary medical care is linked with the appropriate and timely use of specialist resources. Internationally, such models have proved to be cost-effective[35].

Types of services include:

- **Extended consultation:** with a GP or practice nurse.

- **Brief intervention (counselling):** Includes assessments, reviews and problem solving support or counselling provided by primary mental health clinicians or counsellors. Usually one to two sessions are provided and sessions can be planned or unplanned.

- **Brief intervention (AOD):** Structured assessment and screening, advice, ABC style brief intervention and/or referral to appropriate counselling or specialist AOD service, this may involve extended consultation. For example, the ABC approach has three steps: ask about the person's alcohol consumption; offer brief advice if there are concerns; refer for counselling if needed[36].

- **Group therapy:** A psychotherapy/skill development or education programme designed for more than two individuals which lasts between one and three hours. Group therapy usually involves a series of sessions that are part of a programme with a particular focus.

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[35] Hickie IB1, Groom GL, McGorry PD, Davenport TA, Luscombe GM. (2005). Australian mental health reform: time for real outcomes. *Medical Journal of Australia, 18*;182(8):401-406. http://www.ncbi.nlm.nih.gov/pubmed/15850437

[36] The Royal New Zealand College of General Practitioners. *Implementing the ABC Alcohol Approach in Primary Care*. https://www.rnzcgp.org.nz/assets/documents/News--Events/CGP4044-Clinical-Effectiveness-Modules-Template-v2-LR.pdf

[36] Cheung et al. (2007). Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management. *Pediatrics, 120*(5): e1313

- **Package of care:** Involves development of a care plan (i.e. an assessment is done to identify needs and a plan is developed with the client/patient that includes a timeframe for review and completion of the plan). The plan involves a series of interventions such as CBT, medication reviews, counselling and other psychosocial interventions.

Levels and types of therapy
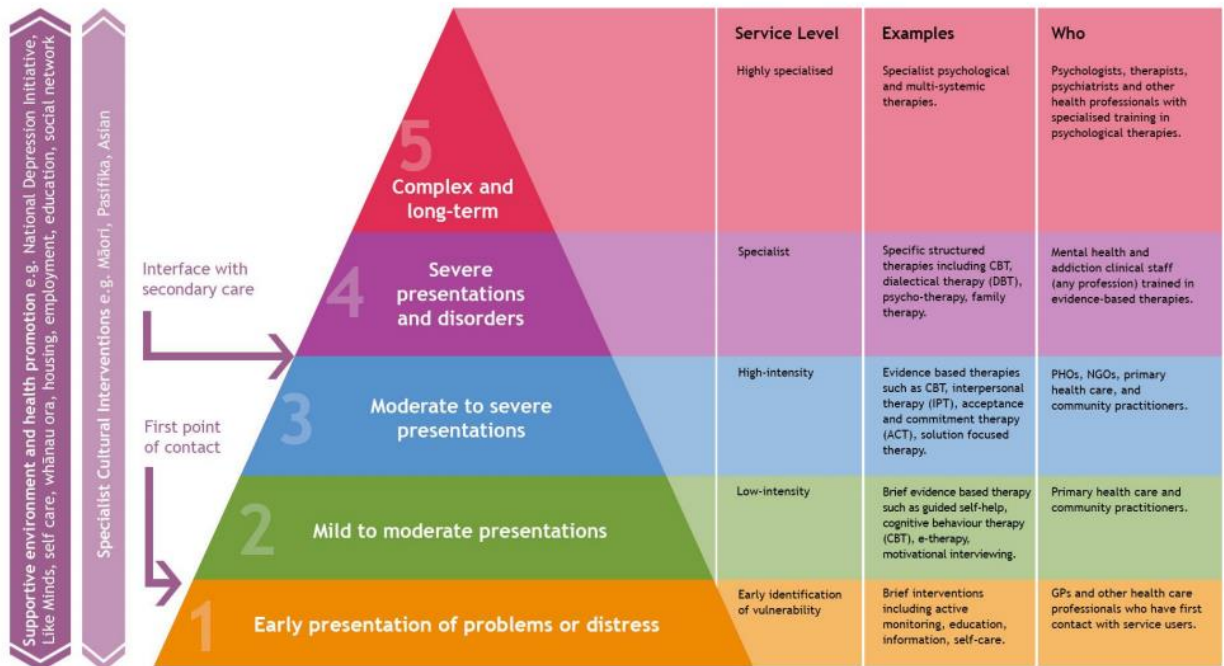
Figure 2: Levels of intervention in a stepped care model[37]

In practice, the transition between steps in the model may take place at different points and could transition 'up' or 'down' the stepped model of care. The Guidelines for Adolescent Depression in Primary Care (GLAD-PC) provide an illustration of step transitioning[38].

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[37] Te Pou. *Introduction: A stepped care approach to talking therapies*. http://www.tepou.co.nz/uploads/files/resource-assets/lets-get-talking-introduction-factsheet.pdf

5.2   Evidence summary

The knowledge base about how to support youth and what works in treating youth with mental health issues continues to grow[39].

We still need more information about what is effective for youth aged 16 to 24. Family therapy becomes less effective for this age group. They need a variety of social and psychological support and cultural options. (Specialist)

Where services and interventions are evidence-based it is reasonable to assume that youth who have used the services have benefitted. An overview of the evidence that has informed the different services funded from the YPMHS is provided in Table 4. However, the absence of evidence does not mean that some of the service models described in this evaluation are not effective as many have not been evaluated.

Table 4: Evidence for youth primary mental health interventions

	Evidence
Building resilience	• Resilience building programmes can teach skills that have been shown to have a protective factor against developing mental health issues[40]. • There is little evidence as to what components of a programme work when educating young people or adults about mental health[41]. • Examples: Tuwharetoa Ki Kawerau (Bay of Plenty); Te Manu Toroa – Oncore Drop In Clinic (Bay of Plenty); Emerge Whakatāne (Bay of Plenty); CACTUS programme (MidCentral).

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[39] Dunnachie, B. (2007). *Evidence-Based Age-Appropriate Interventions – A Guide for Child and Adolescent Mental Health Services (CAMHS).* Auckland: The Werry Centre for Child and Adolescent Mental Health Workforce Development. http://www.werrycentre.org.nz/sites/default/files/Evidence_Based_Intervention_Final_Doc.pdf

[40] Fox, S., Southwell, A., Stafford, N., Goodhue, R., Jackson, D. and Smith, C. (2015). *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention*. Canberra: Australian Research Alliance for Children and Youth (ARACY).

[41] Kelly, C. M., Jorm, A. F. and A. Wright. (2007, Oct 1) Improving mental health literacy as a strategy to facilitate early intervention for mental disorders. *Medical Journal of Australia, 187*(7 Suppl) S26-30. http://www.researchgate.net/profile/Annemarie_Wright/publication/5937053_Improving_mental_health_literacy_as_a_strategy_to_facilitate_early_intervention_for_mental_disorders/links/00b4952af9b0d2e095000000.pdf

	Evidence
Early identification and intervention	• Early intervention is more effective than responding to established mental health issues[42] [43]. • Brief, primary-care alcohol and other drug interventions (15 minutes to 1 hour) targeting high risk use of alcohol for both youth and adults were shown to have a positive financial net benefit[44]. Brief interventions in hospital and emergency rooms for youth and adults targeting high-risk alcohol use were also shown to have positive benefits for youth and positive financial net benefits. • Every interaction with a young person should be regarded as an opportunity to enquire after their psychosocial wellbeing, regardless of the presenting complaint[45]. • School-based health services can improve utilisation of mental health services by hard to reach populations[46] (i.e. males, ethnic minorities) and lead to a decrease in emergency department utilisation[47]. • Examples: Wellington Emergency Department triage model (Capital and Coast); HEEADSSS Wellness Checks.

[42] Fox, S., Southwell, A., Stafford, N., Goodhue, R., Jackson, D. and Smith, C. (2015). *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention*. Canberra: Australian Research Alliance for Children and Youth (ARACY).

[43] Ministry of Health. (2011). *Report on the Youth Health Workforce Service Review – April 2011*. https://www.health.govt.nz/system/files/documents/pages/youth-health-workforce-service-review.pdf

[44] http://www.wsipp.wa.gov/BenefitCost?topicId=5 provides a summary of meta-analyses, as of December, 2015. Note that the research is being updated on a cyclical basis as new publications are made available, which can alter findings.

[45] New Zealand Guidelines Group. (2008). *Identification of Common Mental Disorders and Management of Depression in Primary Care*. New Zealand Guidelines Group, Wellington. http://www.mentalhealth.org.nz/assets/ResourceFinder/Identification-of-common-mental-disorders-and-management-of-depression-in-primary-care.pdf

[46] Juszczak, L., P. Melinkovich., & D. Kaplan. (2003). Use of health and mental health services by adolescents across multiple delivery sites. *Journal of Adolescent Health, 32* (6), S 108-118. http://www.jahonline.org/article/S1054-139X(03)00073-9/abstract

[47] Key, J. D., E. C. Washington. & T. C. Hulsey. (2002). Reduced emergency department utilization associated with school-based clinic enrolment. *Journal of Adolescent Health, 30* (4), 273-278. http://www.ncbi.nlm.nih.gov/pubmed/11927239

	Evidence
Linking youth to the right services	• Guidelines suggest that: a young person with severe depression should be referred urgently to secondary care mental health services… [while] a young person with mild or moderate depression can typically be managed within primary care services[48]. • Examples: AOD model of care (Waikato); FlaxAID (Hawkes Bay); Single point of entry services (Nelson Marlborough); Co-located services (Northland).
Tikanga Māori	• Evidence suggests that for some Māori service users it is important to be able to access a service provider who shares their Māori understanding of health and wellbeing[49]. • Examples: Male Māori role model (Whanganui).
General practice	• Evidence links access to regular primary health care with improvements in health status (irrespective of income)[50]. • Examples: PHO primary mental health services and general practice care.
Treatments	• Cognitive Behavioural Therapy (CBT) remains a cornerstone of the evidence base of effective therapy and has been found to be effective (whether as an individual or in a group setting) for depression, anxiety[51], disruptive behaviour disorders, substance abuse, self-harm, and PTSD.

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[48] New Zealand Guidelines Group. (2008). *Identification of Common Mental Disorders and Management of Depression in Primary Care*. New Zealand Guidelines Group, Wellington. http://www.mentalhealth.org.nz/assets/ResourceFinder/Identification-of-common-mental-disorders-and-management-of-depression-in-primary-care.pdf

[49] Dowell AC. Garrett S. Collings S. McBain L. McKinlay E. Stanley J. (2009). *Evaluation of the primary mental health initiatives: Summary report*. University of Otago and Ministry of Health. http://www.mentalhealth.org.nz/assets/ResourceFinder/evaluation-primary-mental-health-initiatives-summary-report-jul09.pdf

[50] Politzer and Yoon 2001 – cited in Mathias. K. (2002). Youth-specific primary health care - access, utilisation and health outcomes: A critical appraisal of the literature. *New Zealand Health Technology Assessment Report*, 5 (1). http://nzhta.chmeds.ac.nz/publications/youth.pdf

[51] Seligman, L. D., & T. H. Ollendick. (2011). Cognitive Behavioral Therapy for Anxiety Disorders in Youth. *Child and Adolescent Psychiatric Clinics of North America, 20* (2), 217-238. http://www.sciencedirect.com/science/article/pii/S1056499311000046

	Evidence
	• The established efficacy of CBT depends on the delivery context (individual, group, with or without parent support) and the underlying condition (depression, anxiety, substance use, etc.)[52].
	• Interpersonal Psychotherapy (IPT) and other forms of therapy have been shown to be effective in treating particular mental health conditions[53].
	• Brief interventions incorporating motivational interviewing and CBT are an established therapy for harmful AOD use and can minimise harm and help with engagement into tertiary services if necessary[54].
	• Brief interventions for mild to moderate mental health disorders are less well established. However, they have applicability to the primary care system and need further evaluation[55].
	• Medication, in particular SSRI's[56] can be prescribed in primary care for moderate to severe depressive and anxiety disorders but this should be in conjunction with social and/or psychological support[57].
	• Examples: Brief interventions (counselling); Brief interventions (AOD); Group therapy e.g. "Sweet Youth Group Therapy" (Taranaki); "To Be Heard" packages of care (Wairarapa); Mental

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[52] Effective Child Therapy. *The Society of Clinical Child and Adolescent Psychology and the Association for Behavioural and Cognitive Therapies clearinghouse*. http://effectivechildtherapy.org/

[53] Dunnachie, B. (2007). *Evidence-Based Age-Appropriate Interventions – A Guide for Child and Adolescent Mental Health Services (CAMHS)*. Auckland: The Werry Centre for Child and Adolescent Mental Health Workforce Development. http://www.werrycentre.org.nz/sites/default/files/Evidence_Based_Intervention_Final_Doc.pdf

[54] Mitchell, S. G., et al. (2013). SBIRT for adolescent drug and alcohol use: Current status and future directions. *Journal of Substance Abuse Treatment* 44(5): 463-472.

[55] The Werry Centre (2013). Co-Existing problems (CEP) and youth: A resource for enhancing practice and service delivery. Auckland, The Werry Centre for Child and Adolescent Mental Health Workforce Development, University of Auckland. See also Duvall, et al. (2012) *No More, No Less: Brief mental health services for children and youth.* Ontario Centre of Excellence for Child and Youth Mental Health.

[56] Selective serotonin reuptake inhibitors.

[57] Asarnew et al. (2005). Effectiveness of a Quality Improvement Intervention for Adolescent Depression in Primary Care Clinic: A Randomized Controlled Trial *JAMA* 293 (3): 311-319. Cheung et al. (2007). Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management *Pediatrics* 120(5): e1313

	Evidence
	health co-ordinator (Southern); Adventure Development Counselling (South Canterbury).
Youth One Stop Shops (YOSS) and youth-specific services	• Youth respond better to services that are youth-specific rather than being an 'add-on' to an existing child or adult service[58]. • Meta-analysis of current evidence strongly supports enhanced access and utilisation of youth-specific primary care and suggests youth-specific primary care can reduce emergency department use[59]. • Socio-economically disadvantaged youth, female and at-risk youth particularly benefit from these services. • An evaluation of Kapiti Youth Support in 2013 found most young people using Kapiti Youth Support services are reporting positive changes. In particular, the young people who have the greatest need for positive health and wellbeing changes reported the best outcomes[60]. • Examples: Whangarei Youth Space (Northern); HealthWest Youth Health Hub (Waitematā); Anamata CAFE (Lakes); Rotovegas (Lakes); Youth Services Trust (Whanganui); 298 (Canterbury); Directions Youth Health Centre (Hawke's Bay); Youth One Stop Shop (MidCentral); Kapiti Youth Support (Capital and Coast); Vibe (Hutt); Evolve (Capital and Coast); Number 10 (Southern).

[58] Mathias. K. (2002). Youth-specific primary health care - access, utilisation and health outcomes: A critical appraisal of the literature. *New Zealand Health Technology Assessment Report*, 5 (1). http://nzhta.chmeds.ac.nz/publications/youth.pdf

[59] Mathias. K. (2002). Youth-specific primary health care - access, utilisation and health outcomes: A critical appraisal of the literature. *New Zealand Health Technology Assessment Report*, 5 (1). http://nzhta.chmeds.ac.nz/publications/youth.pdf

[60] Bailey, R., Torrie, R., & Osborne, R. with Bagshaw, S., Blyth, S., Davidson, J., Merry, S., Munford, R., Pipi, K., Porima, L., Sanders, J., Stasiak, K., Wehipeihana, N., Wilde, V. (2013). *How we know what we're doing works: Measuring youth outcomes at Kapiti Youth Support*. Impact Evaluation - Summary Report 2013

School and community-based health services	• Evidence shows school-based health services can improve youth access to primary care which can result in higher educational outcomes[61]. • The YMHP funds HEEADSSS assessments for all year 9 youth in decile 1 to 3 schools as an early identification programme. • School-based health services can also encourage the establishment of healthy behaviours in adolescence (e.g. not smoking)[62]. • Youth with access to school-based health services are less likely to use emergency departments which suggests they are able to access earlier intervention[63]. • Examples: School-based health services (including HEEADSSS Wellness Checks and nurses at decile one to three schools as funded by the YMHP): GP clinic in schools (Tairāwhiti DHB).
Increasing access to specialist services	• Moving from specialist, office based services towards flexibly sited services that relate to the wider community can result in better, sooner, more convenient and timely services[64]. • Examples: PHO Youth Mental Health Coordinator (Tairāwhiti DHB); Enhanced School Based Health Services: Psychologists in low decile high schools (Auckland DHB); Adolescent Clinical Role (Northland DHB); REAL providing youth workers and psychologists on site and in five schools (Lakes DHB).

[61] Winnard, D., S. Denny & T. Fleming. (2005, May). *Successful School Health Services for Adolescents: Best Practice Review*. Manukau: Kidz First Community Health – Centre for Youth Health.

[62] Winnard, D., S. Denny & T. Fleming. (2005, May). *Successful School Health Services for Adolescents: Best Practice Review*. Manukau: Kidz First Community Health – Centre for Youth Health.

[63] Mathias. K. (2002). Youth-specific primary health care - access, utilisation and health outcomes: A critical appraisal of the literature. *New Zealand Health Technology Assessment Report*, 5 (1). http://nzhta.chmeds.ac.nz/publications/youth.pdf

[64] Ministry of Health. (2011). *Report on the Youth Health Workforce Service Review – April 2011*. https://www.health.govt.nz/system/files/documents/pages/youth-health-workforce-service-review.pdf

6.   Differences the YPMHS has made for youth

Key messages

As a result of the YPMHS, more youth have access to services to support wellbeing and mental health. The YPMHS has:

- Increased the capacity of services to support youth wellbeing and mental health. Youth primary mental health services are reaching between 3,300 and 4,200 youth each quarter.

- Increased the range of provider and service options for youth including more youth-friendly services.

Providers funded by the YPMHS most commonly delivered brief interventions (counselling) and packages of care to youth. They used group therapy less often but some reported that the use of group therapy is increasing.

Māori and Pacific youth, and youth living in lower socio-economic areas have higher rates of mental health issues. These contribute to disparities between Māori and Pacific peoples and people from European ethnic groups in a broad range of life outcomes. The YPMHS is likely to be contributing to reducing disparities between ethnic groups as services are reaching Māori youth at higher rates than their proportion in the population.

Although more youth are using primary mental health services, the evaluation identified some gaps:

- Many providers reported unmet need, either because of barriers to accessing services, services at capacity or a lack of appropriate services for youth.

- With the exception of one district, services are not reaching young males to the same extent as they are reaching young females.

- Many providers who responded to a survey found it difficult to find services for Māori and Pacific youth. Providers in districts with a high Māori population noted difficulty reaching young Māori males.

- Many providers noted a need for youth primary mental health services for youth younger and older than the 12 to 19 year age range.

Information about the numbers of youth the YPMHS is reaching has been sourced from data collected by the Ministry of Health using a form developed for DHBs to enter information about the number of youth, their demographic profile and the services they received. The original form was updated in mid-2014 so data are available for the complete 2014/15 financial year and the first quarter of the

2015/16 financial year[65]. Data about adult clients collected using the same process were used for comparative analyses.

As is commonly found in administrative data, there are limitations to the data collected including:

- Data do not accurately capture the first quarters of the YPMHS (prior to 2014/15)
- Difficulty in differentiating between individuals receiving interventions and treatment episodes
- Difficulty in differentiating clients and sessions - because client numbers are recorded per quarter for each DHB we can only estimate the total clients seen per year and for New Zealand. For example, clients may appear in more than one quarter
- Data limitations – lack of information about referral rates, number of sessions per package of care may differ or not be recorded, 'did not attend' (DNA) rates and in rural and remote localities travel time may limit the numbers of youth seen
- Data gaps and errors include - missing data, particularly in measuring the number of interventions delivered to youth aged 12-19 and apparent data errors.

In recognition of data limitations, the numbers of youth reported as seen by YPMHS have been rounded. The numbers of youth reported aligned with data held by the Ministry of Health in January 2016. However, providers may update data from preceding quarters when they submit data for subsequent quarters. Changes may reflect delays in information flowing through from services to the DHBs and errors identified in previous quarters that are corrected in subsequent quarters.

6.1 Number of youth clients

Youth primary mental health services are reaching between 3,300 and 4,200 youth each quarter.

It is important to note that although the number of youth clients recorded in each quarter are presumed to be 'unique' cases, the number of cases is not recorded for the full year as interventions may occur in more than one quarter and youth may re-

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[65] The Ministry of Health financial year runs from 1 July to 30 June.

present in subsequent quarters[66]. As a result, summing the quarterly totals will overestimate the total number of individuals seen.

We also heard from some DHBs that not all the services they provide to youth are reported to the Ministry of Health and this contributes to an underestimate of the total youth using the YPMHS. The reach of the service and the indirect benefits for youth through, for example, new roles and mentorship of providers is also not captured through the current data reporting process.

Numbers reported to the Ministry of Health may also reflect activities funded from other DHB, Ministry of Health and agency sources where funding for a service is combined into a common pool.

The number of youth clients seen in each quarter decreases slightly from the first quarter to quarter three of 2014/15, then increases in the final quarter of 2014/15 and again in the first quarter of 2015/16 (Figure 3). Based on actual numbers[67], the number of youth clients seen increased by approximately 24%, from the first quarter of 2014/15 to the first quarter of 2015/16.

While the pattern and extent of change in the number of adult clients differs slightly from that of youth clients, there is a similar percentage increase, with the total number of adult clients increasing by approximately 5,200 (26%[68]) from the first quarter of 2014/15 to the first quarter of 2015/16.

▲ 3%	▼ -9%	▲ 19%	▲ 14%
Q1 2014/15 3,300	Q2 2014/15 3,400	Q3 2014/15 3,100	Q4 2014/15 3,700	Q1 2015/16 4,200
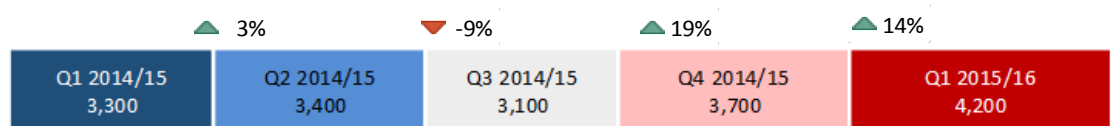
Figure 3: Total number of youth clients seen in each quarter. Arrow bars show change (%) from one quarter to the next

The total numbers of clients seen in each quarter may also be limited by caps on access to packages of care. Some GPs reported they were unable to access packages of care past a certain point in the year. This means that the volume of care provided for these services may not reflect total demand or need for the service.

We could triple our access to packages of care... There is always more demand than funding. (DHB)

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[66] The NHI numbers are not recorded for youth seen by YPMHS therefore it is not possible to identify 'unique' cases over longer periods than the quarterly reporting periods.

[67] Based on actual numbers recorded by 20 January 2016. Noting that as providers submit numbers for subsequent quarters changes may be made to update previous quarters. For example to include data not received prior to the cut-off date for the quarterly reporting.

[68] Based on actual rather than rounded numbers recorded by 20 January 2016.

The totals for each quarter mask substantial variation in the number of youth and adult clients seen in each district in each quarter. In DHBs where school based youth mental health services have been funded as part of the YPMHS, reported numbers will fluctuate by school term.

Table 5 shows the percentage increase or decrease in youth clients from one quarter to the next for all DHBs and all quarters. The number of DHBs reporting an increased number of youth clients (as compared to the previous quarter) increases from Q3 2014/15.

Table 5: Proportional change in youth clients from Q1 2014/15 to Q1 2015/16 by DHB area. Green shading indicates an increase from the previous quarter (Source: MOH data)

DHB	Q1 to Q2 2014/15	Q2 to Q3 2014/15	Q3 to Q4 2014/15	Q4 to Q1 2015/16
Northland	4%	-8%	10%	21%
Waitematā	-13%	1%	-9%	15%
Auckland	4%	-19%	27%	-45%
Counties Manukau	-8%	13%	-1%	119%
Waikato	98%	-72%	86%	35%
Bay of Plenty	32%	-2%	34%	15%
Tairawhiti	50%	-22%	57%	82%
Lakes	-39%	10%	59%	-41%
Hawke's Bay	15%	-23%	-17%	10%
Taranaki	30%	-33%	47%	24%
Whanganui	-54%	194%	15%	30%
MidCentral	-26%	-23%	23%	7%
Wairarapa	-40%	-8%	9%	51%
Capital and Coast	343%	17%	-2%	65%
Hutt Valley	5%	-2%	18%	-2%
Nelson Marlborough	-53%	41%	33%	12%
West Coast	-16%	-20%	77%	46%
Canterbury	-6%	-2%	8%	-26%
South Canterbury	-3%	-8%	3%	-5%
Southern	-41%	45%	19%	40%
All DHBs (rounded figures)	*3%*	*-9%*	*19%*	*14%*

Note: Variation between quarters for a DHB is likely to reflect data recording errors or the timing of data entry

6.2 Client counts relative to population

In 2014, the total youth population aged 12 to 19 across the DHBs was 494,600[69]. The average number of youth clients seen as part of the YPMHS in each quarter (3,500) represents 0.7% of New Zealand youth aged 12 to 19 years.

As expected from the different approaches DHBs took to developing the YPMHS, there are differences between districts in the levels of youth engagement with services, the ratio of adult to youth clients and the types of services provided.

Table 6 shows the number of youth seen in each quarter as a proportion of the youth population in each DHB area. By Q1 2015/16, this ranges from 0.3% for Lakes DHB to 3.3% (West Coast DHB).

Table 6: Youth seen in each quarter as a proportion of total youth population in each DHB area (Source: MOH data)

DHB	Q1 2014/15	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16
Northland	0.5%	0.5%	0.4%	0.5%	0.6%
Waitematā	0.9%	0.8%	0.8%	0.7%	0.9%
Auckland	1.2%	1.3%	1.0%	1.3%	0.7%
Counties Manukau	0.4%	0.4%	0.4%	0.4%	0.9%
Waikato	0.3%	0.6%	0.2%	0.3%	0.4%
Bay of Plenty	1.4%	1.8%	1.8%	2.4%	2.7%
Tairawhiti	0.3%	0.5%	0.4%	0.6%	1.0%
Lakes	0.4%	0.3%	0.3%	0.5%	0.3%
Hawke's Bay	0.5%	0.5%	0.4%	0.3%	0.4%
Taranaki	0.5%	0.7%	0.5%	0.7%	0.9%
Whanganui	1.5%	0.7%	2.1%	2.4%	3.1%
MidCentral	1.3%	1.0%	0.7%	0.9%	1.0%
Wairarapa	1.4%	0.8%	0.8%	0.8%	1.3%
Capital and Coast	0.1%	0.5%	0.6%	0.6%	0.9%
Hutt Valley	0.7%	0.7%	0.7%	0.8%	0.8%
Nelson Marlborough	0.9%	0.4%	0.6%	0.8%	0.9%
West Coast	1.9%	1.6%	1.3%	2.2%	3.3%
Canterbury	0.5%	0.5%	0.4%	0.5%	0.4%
South Canterbury	1.1%	1.1%	1.0%	1.0%	1.0%
Southern	0.3%	0.2%	0.3%	0.3%	0.5%
All DHBs	*0.7%*	*0.7%*	*0.6%*	*0.7%*	*0.8%*

6.3 Youth clients as a proportion of all clients

On average, a total of approximately 24,900 youth and adult clients were seen in each quarter. The average ratio of adult to youth clients seen in each quarter is 6.1

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[69] Statistics New Zealand data provided by Ministry of Health.

to 1 (six adults seen for every one youth client). This changes slightly over time, falling to 5.6 to 1 in Q2 of 2014/15 and peaking at 6.5 to 1 in Q4 of 2014/15 (Figure 4).

Q1 2014/15 6.0	Q2 2014/15 5.6	Q3 2014/15 6.1	Q4 2014/15 6.5	Q1 2015/16 6.1

Figure 4. Ratio of total adult to total youth clients in each quarter (Source: MOH data)

As the number of both youth and adult clients seen increases over time, the relatively consistent ratio of adult to youth from Q1 2014/15 to Q1 2015/16 confirms an expansion of the YPMHS rather than a shift of resources from adults to youth. If the latter was true, we would expect to see the ratio of adult to youth fall (fewer adults seen to every one youth) from one quarter to the next.

There is variation between districts in the proportion of clients that are youth. By Q1 2015/16, the youth proportion of total clients reported in each quarter ranges from 4% (Counties Manukau DHB) to 53% (Bay of Plenty DHB) (Table 7).

Table 7: Youth clients as a proportion of total (adult plus youth) clients in each DHB and quarter (Source: MOH data)

DHB	Q1 2014/15	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16
Northland	14%	16%	14%	13%	18%
Waitematā	30%	27%	26%	19%	20%
Auckland	16%	24%	17%	13%	9%
Counties Manukau	4%	4%	5%	4%	6%
Waikato	13%	15%	8%	9%	10%
Bay of Plenty	40%	48%	42%	52%	53%
Tairawhiti	7%	14%	7%	9%	16%
Lakes	9%	10%	7%	11%	13%
Hawke's Bay	14%	15%	13%	13%	11%
Taranaki	23%	20%	14%	20%	18%
Whanganui	26%	15%	34%	36%	40%
MidCentral	20%	19%	21%	21%	25%
Wairarapa	19%	16%	15%	15%	20%
Capital and Coast	13%	21%	20%	24%	29%
Hutt Valley	14%	16%	15%	17%	16%
Nelson Marlborough	16%	10%	13%	16%	18%
West Coast	18%	21%	14%	22%	27%
Canterbury	12%	11%	11%	12%	9%
South Canterbury	21%	21%	18%	19%	18%
Southern	10%	6%	9%	10%	13%
All DHBs	*14%*	*15%*	*14%*	*13%*	*14%*

6.4 Demographic profile of youth receiving services

A consistently higher proportion of females than males have used YPMHS across all quarters and across all DHBs (Figure 5) and this reflects the higher prevalence of mental health issues reported in females. However, it is also important to note the higher suicide rates among males compared with female youth. In several districts we were told about the difficulties in connecting young Māori males with mental health services.
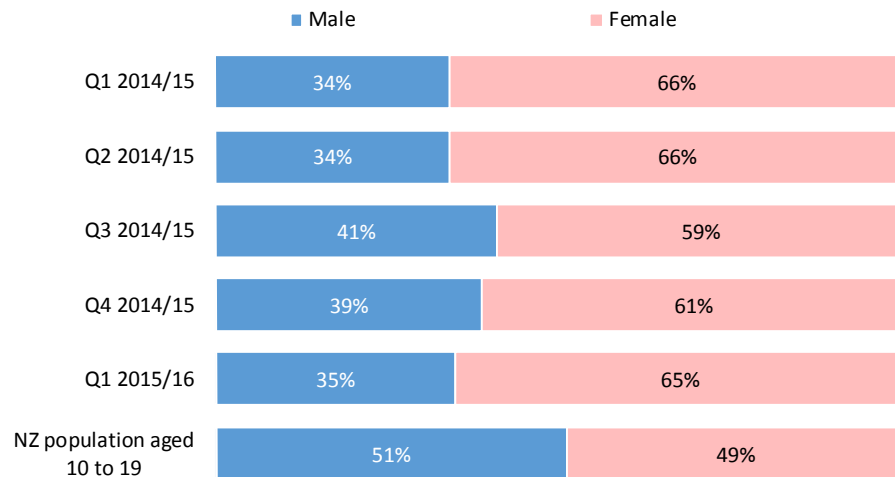
Figure 5: Gender profiles of youth using primary mental health services (Source: MOH data)

Māori make up nearly one-third of all youth clients and are 'over-represented' relative to the youth population profile as a whole (21% Māori) (Figure 6). This aligns with the intended focus of services to target Māori because of higher need. Pacific youth receiving YPMHS also represent approximately the same proportion as in the youth population as a whole. The high rates of 'other ethnic' group in Q1 2014/15 suggests ethnicity data were incompletely recorded in that quarter.
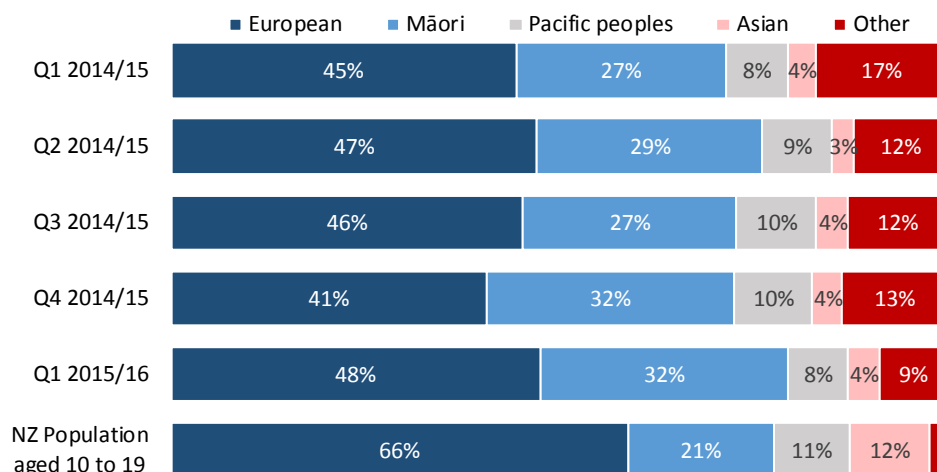
Figure 6: Ethnic profiles of youth receiving primary mental health services (Source: MOH data template)

The ethnic profile of the population varies substantially between DHBs and so too does the ethnicity of youth clients. In most DHBs the average proportion[70] of Māori youth clients seen in any one quarter approximately equals or exceeds that of the Māori proportion of the area population (Table 8). Pacific peoples account for a substantially higher proportion of service users than their representation in the population in only Auckland DHB.

Table 8. Proportion of Māori and Pacific youth clients relative to the population in each DHB area (Source: MOH data)

	Māori		Pacific peoples	
	Youth clients (average)	Population aged 10 to 19	Youth clients (average)	Population aged 10 to 19
Northland	41%	44%	1%	6%
Waitematā	31%	13%	10%	12%
Auckland	16%	10%	32%	19%
Counties Manukau	16%	19%	15%	31%
Waikato	20%	30%	1%	6%
Bay of Plenty	67%	35%	2%	4%
Tairawhiti	53%	58%	0%	5%
Lakes	31%	46%	0%	7%
Hawke's Bay	38%	34%	1%	7%
Taranaki	30%	26%	0%	3%
Whanganui	60%	35%	3%	5%
MidCentral	31%	27%	2%	6%
Wairarapa	23%	26%	1%	4%
Capital and Coast	20%	15%	4%	13%
Hutt Valley	27%	22%	7%	14%
Nelson Marlborough	12%	16%	2%	3%
West Coast	21%	17%	1%	1%
Canterbury	9%	12%	1%	4%
South Canterbury	13%	12%	1%	2%
Southern	6%	14%	2%	3%
All DHBs	30%	21%	9%	11%

One DHB that collected and analysed data from 380 service users by quintile found a relatively even spread of users across deprivation quintiles and that the highest proportion of YPMHS users were in quintiles 3 and 4. Proportions of users were quintile (least deprived): 17%; quintile 2:13%; quintile 3: 27%; quintile 4: 23% and quintile 5 (most deprived):19%.

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[70] As it is not possible to sum the number of youth clients over all quarters the average proportion of each ethnic group over all quarters is used here. The proportions vary little over time hence this average is a reasonable representation of the ethnic make-up of the youth client base.

Example: How one DHB has increased use of services by young men

One DHB, Bay of Plenty, has provided care for approximately equal numbers of male and female youth. Aspects of the district's service models that may have enhanced access for young men are:

- Collaboration between agencies - Police, DHB, MSD, Employment New Zealand, Justice, schools
- Access to strong male role models although not all providers were male
- Group therapy through activity based programmes that had components of theory as well as practical, and linked skills learnt into mental resilience. The programmes especially appealed to males were:
  - Music therapy, Brazilian Jujitsu, visiting their marae, visiting the urupā of their tūpuna, paint balling, adventure courses, sports teams.
- Service models that are youth-friendly and flexible and include committed time to establish relationships
- A feeling that they belonged.

6.5 The types of services youth have received through the YPMHS

The expectation of the stepped care model in the 2013/14 YPMHS service schedule was that interventions in the primary care environment would be appropriate for 6.6% of youth who would have a mild disorder and 9.4% with a moderate disorder[71].

Counselling (brief intervention) and packages of care are consistently the most frequent interventions recorded in the Ministry of Health data (Figure 7). There is variation between DHBs in the proportions of different services offered due to different approaches and areas of focus; and to some extent gaps in reporting and small sample sizes.

Extended consultations are infrequently used. GPs explained that challenges to providing extended consultations included:

- Practical challenges – lack of flexibility to extend consultations because of other people in the waiting room
- Cost – in some PHOs youth had to pay for the initial consultation and then come back for an extended consultation.

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[71] Ministry of Health (2013, July). *Primary Mental Health Service Specification*.
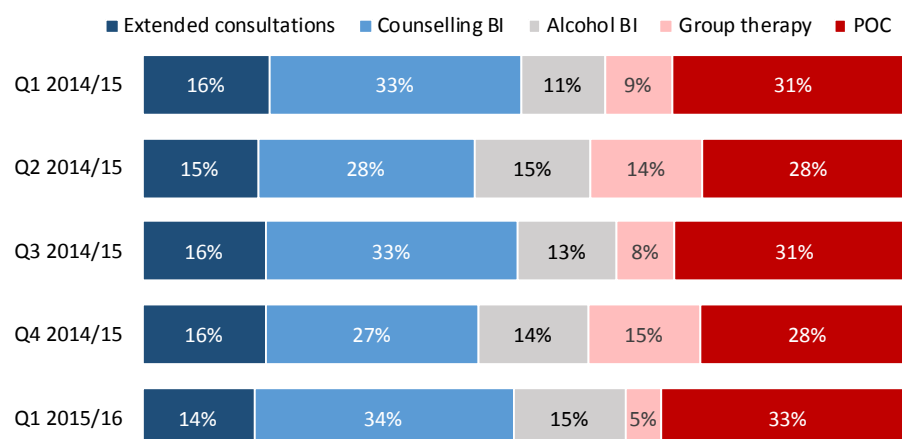
Figure 7. Types of primary mental health service provided in each quarter as a proportion of the quarterly total number of services (Source: MOH data)

The total number of youth clients receiving the different mental health services in each quarter is summarised in Table 9.

Table 9: Total number of youth clients receiving each type of primary mental health service (Source: MOH data)

	Total youth seen	Extended consultations (total)	Counselling BI	Alcohol BI	Group therapy	POC
Q1 2014/15	3,300	*780 (17)*	1,540 (18)	510 (14)	410 (16)	1,490 (17)
Q2 2014/15	3,400	*830 (16)*	1,580 (16)	840 (14)	810 (16)	1,550 (16)
Q3 2014/15	3,100	*650 (16)*	1,330 (17)	520 (14)	310 (14)	1,270 (17)
Q4 2014/15	3,700	*760 (17)*	1,310 (16)	680 (16)	690 (15)	1,330 (17)
Q1 2015/16	4,200	*730 (16)*	1,700 (19)	740 (17)	230 (16)	1,670 (16)

Note: The figure in brackets is the number of DHBs that reported on the intervention in each quarter (a count of less than 20 therefore indicates missing data). Figures rounded to nearest 10 for interventions; to 100 for total youth clients.

Most PHO had a defined number of counselling sessions per package of care ranging from three to six. However, if needed youth could be allocated another package of care. Packages of care were budgeted with different costs for different intensities. Different providers had different approaches to packages of care.

> *The [provider] delivers what we call mental health packages of care… I don't mean in the step-care approach because within that it's quite a defined sort of – we consider a package of care to be anything. (Agency Provider)*

Analysis provided by one PHO demonstrated that average services per referral is 4.5 (based on 380 youth over three years). The average number of consultations for Māori youth was fewer than for Pakeha youth (3.6 compared to 4.9).

Group therapy was infrequently used but some youth specific services were starting to use group therapy and reporting its effectiveness for youth with anxiety issues. Providers also described mentoring youth workers to take over from youth psychologists as group facilitators once groups were established. Initial joint sessions provided mentorship to the youth workers.

We are trying to get the best bang for our buck by putting people into groups. This is proving to be effective and we are getting exciting gains and outcomes, especially for youth with anxiety. In a group they have to practice group work. The ideal group size is six to eight youth. Groups are facilitated by a psychologist but some are also facilitated by a youth worker. (NGO)

Example: HealthWest Youth Health Hub – Your Choice (Packages of Care) Waitematā DHB

The HealthWest Youth Health Hub support youth across the Waitematā DHB using a model of care known as 'Your Choice'. There are multiple entry points for referrals which average 25 to 45 a week and have peaked at 53. Referrals are triaged, processed and the client spoken to within the week referrals are received.

The triage team include team leaders from secondary care, an 18+ primary care liaison nurse, secondary youth mental health, youth hub clinicians, and a senior clinical psychologist or paediatrician/psychiatrist as required. The triage team make a clinically informed decision about whether the youth requires mild-moderate or complex packages of care.

A tiered system of support provides back-up and confidence we are doing the right thing. (HealthWest)

Clients with mild to moderate issues are referred to packages of care known as 'Your Choice'. 'Your Choice' includes talk therapy, mentoring and or group therapy. All clients must be seen by the contractor within two weeks of the first point of contact.

Contractors are teamed with youth after consultation with the youth, and the 'right match' considered, the type of therapy required, whether the youth want care within their own community or outside it, whether gender and ethnicity are important, whether religious beliefs are important and the age the contractor prefers to work with.

There is a monthly review to ensure youth have engaged with the service. A 'Moving Forward' plan is written at the end of the package of care in partnership with the young person. It includes what the youth liked, what helped, and where to from here.

Example: Sweet Youth Group Therapy – Known as 'Sweet' (Taranaki DHB)

Tui Ora, a health and social sector provider governed by a structure representing the eight Taranaki iwi, provides youth primary mental health care across the region for all populations.

Tui Ora are also contracted to provide the South Taranaki Social Sector trial (STSST). The STSST have worked to develop links between MOH/DHB, MSD, Police, MOE and MOJ. Through these partnerships the need for youth talk therapy was identified for at risk youth.

To date three groups have been trialled with half the funding used, more groups will be run next year. One group has been run in an intermediate and two within a high school. The high school does not come within the decile one to three band for School Based nurse support although the need is high. Stakeholders considered the school decile rating does not reflect the school community but rather the wealth in the surrounding farmland. The high school is isolated geographically with no public transport.

'Sweet' has been run by a clinical psychologist, and a primary care youth mental care nurse who has co-ordinated the trial. The need to make the group sustainable has led to another youth co-ordinator being trained to run the programme.

Anecdotal evidence of achievements includes: increased educational achievement and expectations - the high school reported a 100% pass rate at Level 2 NCEA including for Māori males; lower rates of personal harm with students talking openly about the need to talk about issues and not cut, and improved mental health.

The DHB have funded a separate evaluation of the benefits of the programme.

6.6   Outcomes achieved

The report from the Prime Minister's Chief Science Advisor[72] that was the foundation for the development of the YMHP emphasised the importance of evaluating programmes that aim to improve youth wellbeing. The report noted the lack of an evidential approach in deciding what programmes to offer and which to maintain.

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[72] Gluckman, P. (May 2011). *Improving the Transition: Reducing social and psychological morbidity during adolescence - A report from the Prime Minister's Chief Science Advisor*. http://www.pmcsa.org.nz/wp-content/uploads/Improving-the-Transition-report.pdf

A lack of outcomes data across the spectrum of youth services has limited the conclusions that can be drawn about the effectiveness of different approaches.

Many providers recognise the importance of good data about outcomes and the value of data in informing service delivery. However, data collection is inconsistent and different outcomes measures are used by different providers. Many are not sure of the best way to measure outcomes.

We struggle to prove what we do is of value…we can't count a lot of what we do. (GP youth health provider)

One of the challenges for providers who are using tools to measure changes over time is that while scores can be recorded for all or most youth at the start of a programme or treatment, it is more difficult to capture later scores as youth may stop coming before the planned end of sessions.

Tools used include:

- **The Kessler-10** - a 10-item questionnaire intended to yield a global measure of distress based on questions about anxiety and depressive symptoms in the most recent four-week period. The Kessler-10 has been used extensively in New Zealand for people aged 15 years and over as part of the New Zealand Health Survey. Providers who have used the Kessler-10 have demonstrated positive differences pre- and post-intervention.

How confident are you…	■ Not	■ A little	■ Quite	■ Very
Using tools such as Kessler K10 or PHQ-9 (268)	13%	13%	24%	50%
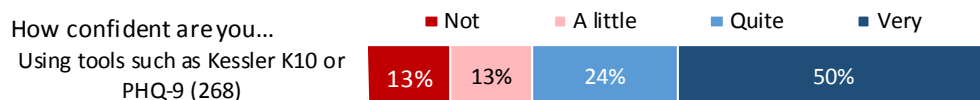
Figure 8: Provider confidence in using tools such as the Kessler-10 (Source: Provider survey)

- **Kapiti Youth Services (KYS) Youth Outcome Measure and Model (YOMM)** - developed to track the changes for youth using KYS services. The model and measures were designed to take account of 'positive choices, markers of resilience and indicators of wellbeing…associated with long-term positive outcomes' for young people. There are plans to use YOMM at all YOSS in New Zealand to begin in 2016 (although there are currently some issues around copyright).

- **The Outcome Rating Scale and the Session Rating Scale (ORS and SRS)[73]** - both four item questionnaires with a self-reporting scale for clients to indicate how they have felt over the last week (for the ORS) and about the therapeutic session (for the SRS). The SRS was designed to help assess the

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[73] Miller, S. D. & S. Bargmann. (2012). The Outcome Rating Scale (ORS) and the Session Rating Scale (SRS). *Integrating Science and Practice, 2*(2), 28-31. https://www.ordrepsy.qc.ca/pdf/2012_11_01_Integrating_SandP_Dossier_06_Miller_Bargmann_En.pdf

"alliance" between the health professional and patient as this has been found to be a strong predictor of outcomes from therapy. The software package costs $5,000 for 33 clinicians ($100 per month per clinician) and can also be used in Excel. The tool can also provide data that can help with service delivery.

- **Patient Health Questionnaire 9 (PHQ9) -** a multi-purpose instrument for screening, diagnosing, monitoring and measuring the severity of depression. The standard PHQ9 has been validated in adolescents aged 13 to 17 and is considered a reliable tool for assessing the level of depression in youth[74].

- **Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) -** designed specifically as a brief measure that was relevant for routine use in child and adolescent mental health services. HoNOSCA includes 15 items that measure symptom severity and social functioning across time on a scale of 0-4. Changes in ratings are known as outcomes and may be attributed to services provided. Te Pou recommend it for use in inpatient and community settings as an outcome tool[75].

Collecting consistent data about a programme is enhanced where managers can see the value of having consistent meaningful comparative data to service management, and frontline staff can see the value in service delivery. The Ministry is developing a National Population Outcomes Framework that will apply across all mental health and addiction services. Defining outcomes and a consistent way of measuring and recording outcomes will provide the information required to understand the costs and benefits of different approaches to improving youth mental health.

Example: Applying data to service delivery

PHOs estimate the number of youth packages of care they can provide based on a standard cost per package. A new approach to data analysis by one PHO identified that the average counselling sessions for youth was less than expected. This information was used to increase the number of packages of care.

Example: Use of ORS to improve service delivery

Analysis of ORS data one service demonstrated Māori and socio-economically disadvantaged youth had decreased contact time and poorer outcomes. A focus on keeping this group in treatment for longer was monitored using ORS data and resulted in the difference disappearing.

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[74] Richardson, L. P., McCauley, E., Grossman, D. C., McCarty, C. A., Richards, J., Russo, J. E., Katon, W. (2010). Evaluation of the Patient Health Questionnaire (PHQ-9) for Detecting Major Depression among Adolescents. Pediatrics, 126(6), 1117–1123.
[75] Te Pou. (2014, June). *HoNOSCA: a New Zealand clinician's guide to ratings and use.* http://www.tepou.co.nz/uploads/files/resource-assets/honosca-ebook-final.pdf

7. Differences the YPMHS has made to the way primary services are provided for youth

> **Key messages**
>
> The differences the YPMHS funding has made to the ways primary services are provided for youth can be summarised as:
>
> - Raising the profile of youth mental health.
> - Increasing the cohesion of youth services through the development of governance groups or new roles to bring together local services for youth.
> - Adapting existing primary mental health services for youth e.g. by creating new youth mental health co-ordinator roles and/or improving the youth-friendliness of services.
> - Supporting the development of new initiatives to meet local needs e.g. through the development of youth-specific services, co-location of specialist youth mental health services such as youth psychologists in primary care settings.
> - Supporting new workforce roles for youth mental health co-ordinators to provide brief interventions and referral pathways for youth who need more intensive support.
>
> There was variation between districts in the way YPMHS funding had been used. Some districts were innovative in the ways they used the new funding, even relatively small amounts of funding. Some districts that received relatively small amounts of new funding were not able to contract with a provider to do anything more than expand existing services such as packages of care.

Youth have different needs to both adults and children. Some existing mainstream primary care services do not necessarily meet the needs of young people and this is demonstrated through the numbers of young people reporting unmet healthcare needs and low uptake of some primary care services[76] [77].

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[76] Ministry of Health, 2002 as cited in Ministry of Health. (2011). *Report on the Youth Health Workforce Service Review – April 2011*. https://www.health.govt.nz/system/files/documents/pages/youth-health-workforce-service-review.pdf

[77] Ministry of Health. (2015). *New Zealand Health Survey.* http://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/current-recent-surveys/new-zealand-health-survey

Elements that contribute to effective, efficient and acceptable health care for youth include[78] [79]:

- A holistic service – the interconnection between mental health and physical health for youth suggests services targeting youth mental health should be holistic[80] and focus on both the environment and the individual.

  You can't separate out youth health and youth mental health. People are entire human beings. (Youth psychologist)

  Whenever I talk about youth I say you can't look at a young person as a mental health problem or a sexual health problem. You're getting a package in front of you and you need to have the services to deal with that young person. (Agency)

- Flexible and comprehensive approach – every door is a right door and an acknowledgement that no one size fits all, the need for multiple interventions in multiple settings and domains.

  Young people do lots of grazing for things. They'll come, get what they want, and then go away and come back another day – as opposed to being in treatment. That tends to be how young people work. (Provider)

- A youth-friendly environment that is culturally appropriate, and tailored to age and gender.

- Continuity of care and robust referral process (e.g. at a YOSS the nurse may physically accompany a youth down the corridor to meet their new counsellor – rather than the youth being given a written referral and having to go to a different location for their appointment).

- A skilled and competent workforce who are comfortable working with youth – this includes medical professionals and counsellors but also receptionists who greet youth on arrival and make them feel comfortable.

- Consent processes that assure youth of confidentiality and are phrased in ways youth can understand.

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[78] Ball, J. (2010). Review of evidence about the effectiveness of mental health promotion programmes targeting youth/rangatahi. *Mental Health Foundation of New Zealand*. http://www.mentalhealth.org.nz/assets/ResourceFinder/Review-of-evidence-about-effectiveness-of-mental-health-promotion-programmes-targeting-youth.pdf

[79] Deane, F. P., V. Biro & J. Ciarrochi. (2003). *Youth barriers to help-seeking and referral from general practitioners*. National Health and Medical Council of Australia. Wollongong, NSW: Illawarra Division of General Practice & the University of Wollongong Illawara Institute for Mental Health

[80] Ministry of Health. (2011). *Report on the Youth Health Workforce Service Review – April 2011.* https://www.health.govt.nz/system/files/documents/pages/youth-health-workforce-service-review.pdf

- An accessible service with no cost or transport barriers (e.g. services are accessible via public transport), appointment times are suitable for youth at school and/or working part-time jobs, drop-in clinics are available.

   I think we've come a long way and we've shown that there's a need for youth and we've done that by saying, "Youth are distinct, here's a youth-friendly service" and stuff like that but youth-friendly is just the appearance and we know for young people it's actually the experience of the service and the personal factors that are biggest barrier rather than the physical ones. (Provider)

7.1   Adapting services to be more youth-friendly

YPMHS funding has been used to develop different ways that services are provided to youth including how to make services more youth-friendly.

   There is a need for more services geared for youth. Not adapted from adult services like the green prescription…There is a need for youth driven services developed for youth. (GP)

There is evidence about the value of consumer-provider partnerships in strengthening governance, leadership, co-design and direct healthcare. One approach to ensuring services meet the needs of youth is to include youth in the governance and development of services.

While many organisations had youth advisory groups, the extent these groups provided effective input into service development varied.

   We should be supporting the young people to be the best that they can be… We ask young people all the time what they want and we never act on it. (DHB)

   There is an obligation on DHBs to have it [youth input], but what they won't have is youth involvement… to the level that we have done. Which I'm really proud of because it's about them, we can't be their voice. (DHB)

   We need to know how to keep inviting youth back to learn from what they know. (NGO)

Example: Youth Wellness Advisory Group (MidCentral DHB)

The purpose of the Youth Wellness Advisory Group (YWAG) is to improve provision of health services for young people through optimised service development and delivery processes. The YWAG is part of the Child Health District Group and includes agency and provider representation from health and social sectors and police.

The group meets once every two months and each group member has an associated young person they bring to meetings (mostly secondary school students in Years 11-13). The current chairperson is a 16-year-old school student.

The YWAG provides a platform for communication and engagement across the district allowing clinicians and others working in youth health to contribute and help develop and implement youth-focussed care. The DHB get useful feedback about what youth think, while the youth develop leadership and governance skills. Youth in this group have a direct say on the annual plan and other strategic measures.

Those kids, they drove our annual plan for youth this year. They told us what they wanted. – DHB

The group's costs are covered from the DHB's "general account". At the beginning some DHB staff members were sceptical about the benefits of the group, however this has decreased as an issue as the group has become established. The major challenge is keeping youth motivated over time.

Example: The Anamata CAFE A-Team

The Anamata CAFE has evolved over 25 years from a small community initiated family planning clinic into a comprehensive holistic youth service.

The A-team are a group of school year 12 and 13 youth recruited by the health promoter/youth worker and board to provide youth advice, leadership and a voice to guide the work CAFE does, both at CAFE and in the community. The A-team focus on and support mental health promotion within their schools and community.

The A-team has made a huge change in the attitude of the youth towards the CAFE. (A-Team youth)

They have run a suicide prevention day, anti-bullying – pink shirt day, the day of silence for LGBT youth - the day of silence resulted in unisex toilets being established in both colleges. Kindness cards were given out to people for them to pass on and make them think about their actions more, start appreciating differences and brighten someone's day.

We go to schools and talk to young people, teachers give out stickers, posters, ribbons and flyers and tell them what we are doing and remind them to be aware of people's mental health. (A-Team youth)

Example: Secret shopper (West Coast DHB)[81]

Members of the West Coast Youth Health Action group completed a 'secret shopper' project. The project was staffed by youth volunteers.

Over the summer of 2014-2015, two groups of local young people (aged 13 to 23) made visits and phone calls to 16 primary care services commonly used by this age group. Half of the services visited were general practices, one-quarter were pharmacies and one-quarter were sexual health, family planning and mental health services.

The 'shoppers' enquired about making an appointment or tried to seek advice about a health concern. They then rated the services on their 'youth-friendliness' (welcome of the staff, feel of the environment, information given, privacy and overall impression).

The results highlighted generally good responses in terms of personal welcome, friendliness and the perception that 'shoppers' had been listened to and taken seriously. However, there was less positive feedback regarding privacy and how comfortable the young people felt in the environments. This was a particular issue for services where the reception desk was situated where other people were waiting for an appointment.

Following the Secret Shopper project the services evaluated were given the *Youth-Friendliness of Health Services in the West Coast Region* report which highlighted recommendations, and were offered the opportunity to discuss their individual feedback. A youth health specialist came to the West Coast to run three sessions to provide services with the skills and information to be more responsive to the needs of young people. These sessions were for clinicians, youth workers and other staff who have interactions with youth such as receptionists and counter staff at general practices, pharmacies and other health services.

Running a secret shopper project was one of the recommendations from a series of youth-friendliness education sessions run around the country through PHOs by a youth health specialist over 2012/2013. There is a plan for another secret shopper project within the next two years.

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[81] Summary drawn from interviews and the West Coast Health System. Youth Friendliness in the West Coast Region. April 2015.

7.2   Service models

The YPMHS has increased the range of services available to youth in many DHBs through direct funding of new systems and ways of providing services for youth.

7.2.1.   Programmes to build resilience

Across the DHBs a number of programmes to help build resilience in youth were funded from the YPMHS as well as from other primary mental health sources. The rationale for the programmes was to provide young people who may be at risk of mental health issues with a contact person and support. Providers in districts such as Northland, MidCentral, Whanganui, and other districts with high proportions of youth living in areas of high deprivation had programmes aiming to build resilience, particularly in young Māori males who might not have a role model.

The primary health contribution is in teaching young people the skills to maintain resilience and to maintain wellbeing (Youth primary provider)

Youth need a variety of social and psychological support and cultural options. (CAMHS)

Example: CACTUS programme (MidCentral DHB)

The Combined Adolescent Challenge Training Unit Support (CACTUS) programme started in MidCentral four years ago and in 2015 was run at four schools in the district. The programme is provided by the Police and focusses on personal development including physical fitness and goal setting. YPMHS funding contributes to the programme costs.

The eight-week programme is held at each school in Term 2. Youth apply to complete the programme. Approximately 20 to 25 youth are accepted at each school to provide an even mix of males and females, and school years 9 to 13. Youth from high, medium and low-risk backgrounds are chosen.

It's not just marginalised kids, they take kids from both ends, so it's that cross-pollination. (DHB)

The programme runs from 5:45am to 8:30am and emphasises uniform drills and physical exercise, as well as goal-setting. All students keep a journal and a guest speaker speaks to the group each day. The last day of the programme involves a full day off-site completing challenging physical activities, followed by a graduation dinner with the mayor, the school principal, parents, and others.

I've heard some of the stories these kids reveal at their graduation which would bring tears to your eyes… They didn't want to go on the dumb programme but by the end they have goals and things. (DHB)

Feedback on the programme has been positive and youth develop self-confidence and goal-setting, as well as basic hygiene and good habits (e.g. eating breakfast, physical activity, getting to school on time).

Just amazing transformation in eight weeks. (School)

While there are no outcome measures available, schools suggest that students who would have otherwise have left (if they had not done the programme) are instead staying and completing Years 12 and 13. The programme also helps foster positive relationships between the Police and students which has benefits within the wider community (e.g. can diffuse a situation if Police go to break up a party and already have a positive relationship with some of the youth there).

From a policing point of view, it's a terrific opportunity to interact with kids in a very positive way. (Police)

Example: Emerge Aotearoa

Emerge Aotearoa are contracted to provide primary mental health initiatives to youth. They are based in Whakatāne with satellite clinics in Ōpōtiki and Kawerau (in conjunction with Tuwharetoa Ki Kawerau), Murupara and within local schools.

The young person can get who they need, we have a lot of people with a lot of different strengths. It's a juggling act. (Emerge provider)

The strengths-based programme provides brief interventions. Group therapy is run at the local Intermediate with groups of up to 10 boys at risk of mild to moderate mental health issues, to help them transition to college. The groups have had a focus on boys with no fathers, youth with drugs, alcohol and bullying issues. Groups are held after school with consent from whānau. The youth who attend are identified through the school pastoral care system, with the school doing the administration involved. Future groups will include a girls' group and a group in Alternative Education settings. Continuity of support was identified by the provider as important in improving outcomes.

The reality is these kids are not super high achieving. They are going to wobble and fall over and there needs to be someone there. A consistent someone or a consistent service. Otherwise they have to tell their story again and then tell it again to someone else. (Emerge provider)

Packages of care are accessed through many referral paths, with a community meeting once a week identifying youth who are at risk. Emerge providers say that many youths prefer counselling through Emerge because of perceived stigma and/or confidentiality issues with school and other providers.

Support gets young people to professionals without going through CAMHS and the stigma attached... As a funder it is hard to justify but the outcome speaks for itself. (Emerge provider)

7.2.2.   Early identification and intervention for youth at risk of mental health issues

Youth are not particularly good at identifying mental illness (although this improves with age)[82] and may not recognise when they need help for mental health issues. Instead, mental unwellness may be demonstrated by risky behaviours that influence physical health (e.g. alcohol and drug use, smoking, unprotected sex).

The use of various screening tools may help identify youth experiencing mental health issues. Examples include the HEEADSSS Wellness Checks (Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and Depression, Safety). HEEADSSS has been promoted as part of the YMHP and is used in schools to assess Year 9 students and by other providers (e.g. GPs, AOD counsellors) to assess young people.

	■ No	■ Partially	■ Informally	■ Formally	■ Not aware of
Do you use HEEADSSS Wellness Checks with young people?	14%	18%	33%	23%	12%
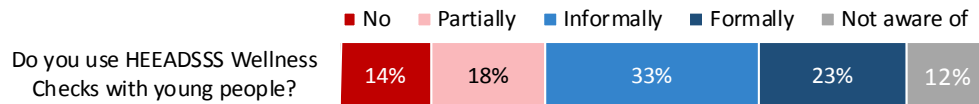
Figure 9. Use of HEEADSSS Wellness Checks with young people (Source: Provider survey)

Screening youth where they present with risk factors associated with mental health issues can also be an effective approach to identifying youth needing additional support.

A number of services have been developed with the aim of identifying youth at risk of mental health issues with some also providing brief interventions or talking therapies at the same time.

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[82] Kelly, C. M., Jorm, A. F. and A. Wright. (2007, Oct 1) Improving mental health literacy as a strategy to facilitate early intervention for mental disorders. *Medical Journal of Australia, 187*(7 Suppl) S26-30.
http://www.researchgate.net/profile/Annemarie_Wright/publication/5937053_Improving_mental_health_literacy_as_a_strategy_to_facilitate_early_intervention_for_mental_disorders/links/00b4952af9b0d2e095000000.pdfhttps://www.researchgate.net/profile/Annemarie_Wright/publication/5937053_Improving_mental_health_literacy_as_a_strategy_to_facilitate_early_intervention_for_mental_disorders/links/00b4952af9b0d2e095000000.pdf

Example: Wellington Emergency Department (ED) triage model[83]

Youth who had an alcohol-related ED presentation between 10pm and 6am on Friday nights and 10pm and 8am on Saturday nights were screened for alcohol and other drugs and mood disorders (specifically depression).

An app was developed for the screening. There are a number of screening tools within the app which are automatically selected after the person has completed the RAPID screening: AUDIT, PHQ, Kessler and CRAFFT. If those screened with the RAPID tool meet the criteria they are screened more fully and a brief intervention provided.

Full screening is conducted by a dedicated screener using an iPad. Once the full screening is completed, the clinical psychologist receives an e-mail notification which highlights the risk and urgency that might be required in dealing with the referral. The clinical psychologist then phones the client for any further clarification on their situation and then makes a referral. If the screening identifies a patient at high risk of suicide, an ED charge nurse or doctor was alerted immediately and the Crisis Assessment and Treatment Team (CATT) called.

The cost of the programme was close to $200,000 per annum. Around half of the cost was for the clinical psychologist while the other half paid for the dedicated screeners for the two nights a week as well as development costs.

A project team member considered that most of the 3,300 youth screened would not have otherwise engaged with services and an estimated 60% were not enrolled with a GP. Youth were not followed-up and therefore outcome measures were not available.

The advantages of the programme were considered to be in prevention and resilience building - providing a brief intervention at a 'teachable moment' resulting in cost savings for police and the DHB.

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[83] Evaluation Consult. (2015). *Process Evaluation: Alcohol screening and brief intervention (SBI), Wellington Hospital Emergency Department*. Wellington: ACC

Example: FlaxAID (Hawke's Bay DHB)

FlaxAID is a free smartphone application ('app') which lists various services in Flaxmere to support youth wellbeing. Flaxmere has experienced a cluster of suicides in recent years and the app was developed with the aim of decreasing the youth suicide rate in the area. Rather than using one-off funding for a one-off event, a conscious effort was made to develop something that would be ongoing. Te Rau Matatini provided funding to Innov8 as part of a suicide prevention contract called Waka Hourua. Innov8 cover the ongoing costs of the freephone service.

In the app, a relevant local worker is introduced (including a photo) followed by general advice, advice for youth, advice for parents/caregivers, support services located in Flaxmere, services located in the DHB district and/or nationally, and finally an on-call freephone service staffed 24/7 by an Innov8 (YOSS) staff member. The app was released in January 2015 and by June 2015 there had been 423 downloads and 536 launches of the app; 25 contacts had been made through the on-call phone number.

FlaxAID links youth to services by bringing information and contact details for all services all together in one place. However, it is an online product and many youth do not have data on their phones (nor is there free publically-available Wi-Fi in Flaxmere) which can making accessing the app difficult. Similarly, not all services wanted to take part in the project. The app developers experienced difficulties with the Apple store and currently the app is only available for android phones. Initial promotion of the app has stopped and download numbers have dropped.

7.2.3. General practices

General practices are the most widely used primary healthcare provider. General practices are located in all of New Zealand's major towns and cities. The general practice team is a skilled, regulated and organised workforce. General practices are organised into primary health organisations (PHOs) that are funded by district health boards (DHBs). A PHO provides primary health services either directly or through its provider members and these organisations provide a point of contact for contracts and for the development of new initiatives [84].

Although many young people express a preference for youth specific services, for most the first point of contact remains the general practitioner. In the New Zealand Health Survey 2014/15, approximately two-thirds of youth aged between 10 and 24 visited a GP at least once in the last twelve months.

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[84] http://www.health.govt.nz/our-work/primary-health-care/about-primary-health-organisations

The extensive general practice infrastructure makes general practice an essential part of any service delivery model for youth mental health. However, there are existing barriers to general practice care for youth. Not all youth can go to a general practice. Levels of unmet need in the New Zealand Health survey were 22.0% overall (29.1% females and 15.6% males). In a survey of over 9,000 New Zealand secondary school students, 17% had not seen a doctor or nurse when needed in the last 12 months[85]. Reasons for not going to a GP when needed include:

- Cost – the consultation fee GPs may charge is cited as a barrier by youth and providers (Figure 10). Cost is the reason for not going to a GP for 12.3% of youth[86]. Consultation fees may be higher for those not enrolled at a practice[87]. Youth can access free sexual health consultations in some areas and from 1 July 2015, most general practices offer free visits to under-13s.

- Access – transport, the reason for not going to a GP for 3.8% of youth[88], inconvenient hours, youth not enrolled with a PHO, lack of documentation required to enrol, difficulty making an appointment.

  …so they're happy to go to counselling, you don't need the parental consent but they don't physically have transport and the teachers who want to take them are not allowed to put them in the car without parental consent so they can't get to the counselling. (Provider)

- Attitudes - confidentiality concerns, embarrassment with the doctor and/or nurse. Concerns about maintaining confidentiality can be an issue for youth in rural areas and small towns with limited health services (e.g. if the family GP is also a friend or GP of the youth's parents)

  Yep I think they're just worried we're going to be like, "What are you here for?" and shout it out. (Practice nurse)

- Service characteristics - judgmental attitudes of staff, whether a service is youth and/or culturally appropriate[89].

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[85] Denney et al., 2011 – as cited in KPMG/University of Otago (2013, Feb 1). *Value for Money review of sexual and reproductive health services*. Wellington: Ministry of Health.

[86] Ministry of Health. (2015). *New Zealand Health Survey.* http://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/current-recent-surveys/new-zealand-health-survey

[87] Ministry of Health. (2015). *Visiting a doctor.* http://www.health.govt.nz/your-health/services-and-support/health-care-services/visiting-doctor

[88] Ibid

[89] Mathias. K. (2002). Youth-specific primary health care - access, utilisation and health outcomes: A critical appraisal of the literature. *New Zealand Health Technology Assessment Report*, 5 (1). http://nzhta.chmeds.ac.nz/publications/youth.pdf

- Awareness – seeing a GP as a place to go for physical health issues and not realising GPs can help with mental health issues[90] [91].

The PMHS was established as an initiative to be primarily delivered through general practices. The different models of care developed are described in the evaluation of the primary mental health initiative. Although youth could be seen as part of the PMHS, services were provided to relatively few youth[92].

As part of the YPMHS, almost all DHBs contracted with local PHOs to deliver services such as extended consultations, brief interventions and packages of care. In some DHBs all the YPMHS funding was contracted to PHOs.

The ways PHOs provide youth primary mental health services include:

- Youth services provided by the practice team as part of usual or extended consultations
- Referral to a PHO mental health co-ordinator who can provide brief interventions or link youth to the most appropriate service
- Direct referrals to an external counsellor from a list approved by the PHO
- Direct referrals to other services.

The importance of general practices as providers of youth (and adult) mental health care highlight the need to explore opportunities to address the challenges for the general practice team in providing mental health care for youth (and adults).

Challenges include:

- Lack of time in the consultation. Funding for extended consultations is available but an extended consultation may not be feasible due to time constraints and the number of people in the waiting room. Funding may limit the number of extended consultations for each youth to as few as one per year.

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[90] Ministry of Health. (2011). *Report on the Youth Health Workforce Service Review – April 2011.* https://www.health.govt.nz/system/files/documents/pages/youth-health-workforce-service-review.pdf

[91] Andrews, G., Henderson, S., and W. Hall. (2001). Prevalence, comorbidity, disability and service utilisation: Overview of the Australian National Mental Health Survey. *British Journal of Psychiatry* (178) pp. 145-153

[92] Dowell AC. Garrett S. Collings S. McBain L. McKinlay E. Stanley J. (2009). *Evaluation of the primary mental health initiatives: Summary report*. University of Otago and Ministry of Health. http://www.mentalhealth.org.nz/assets/ResourceFinder/evaluation-primary-mental-health-initiatives-summary-report-jul09.pdf

Barriers to providing care...	■ Major	■ Substantial	■ Slight	■ Not a barrier
Insufficient time in the consultation	20%	28%	27%	24%
Affordability of care for youth	21%	33%	24%	23%
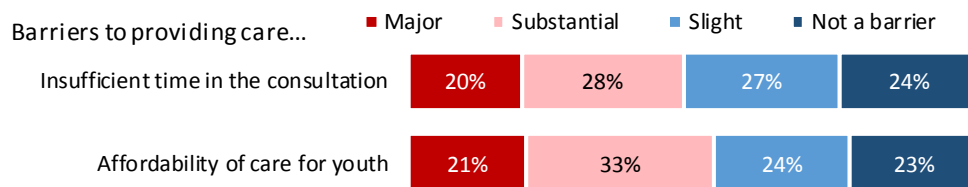
Figure 10. Provider views about access-related barriers to providing care for youth with mental health issues (Source: provider survey)

- Youth may be a relatively small proportion of the practice workload. Much is expected from general practices across all age ranges. Practices in some localities may not see many youth.

- GPs do not necessarily have the skills/experience/inclination to follow-up appropriately[93]; this is a particular issue in rural areas[94]. In the survey of providers, 72% of GPs wanted more training on aspects of youth mental health (Section 8). There is therefore potential to increase general practice staff confidence in engaging with youth and supporting youth with mental health issues.

  GPs may not understand the youth development context… there is a need to upskill general practice and make them more responsive to youth. (GP)

- Lack of access to, or awareness of, other services to refer youth.

Across the DHBs there were examples of ways PHOs and general practices were supporting youth.

- Providing a readily available expert contact point (a youth psychologist or clinical psychiatrist) for general practice teams if they want to discuss appropriate treatment with a specialist.

- Co-location of specialist youth workers.

- Increasing youth-friendliness of practices through training for general practice teams including receptionists. The stakeholders we interviewed frequently commented on the general practices in their locality and were clear about which ones were 'youth-friendly'.

- Outreach services through clinics in schools.

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[93] Wilhelm, K. A., Finch, A. W., Davenport, T. A. and I. B. Hickie. (2008, June 16). What can alert the general practitioner to people whose common mental health problems are unrecognised? *Medical Journal of Australia, 188* (12 Suppl), S114-118

[94] Malcolm P Forbes and David B King. (2015). The need to upskill rural general practitioners in mental health care. *Medical Journal of Australia, 203* (5), 211-214.

Example: A youth-friendly general practice

The practice is a large practice with over 20 clinical staff in a modern building. Within the same building there are counselling, physiotherapy and podiatry services, and a pharmacy, all of which are separate organisations.

The practice employs a social worker who is on-site and can liaise with and follow-up referrals to outside services. There is also a PHO mental health worker (clinical psychologist) on-site for the majority of the time. The mental health worker can see patients from age 16 and up but is predominantly used for adults. The practice does not run a drop-in clinic but will shuffle appointments around to be able to see youth on the same day they request an appointment.

The defining features of the practice are that it has been in the area for a long time, it is large and the only medical centre in the surrounding area. The majority of the staff both work and live in the area and are part of the community and therefore may better understand and relate to the context people are living in. Some of the staff have worked at the practice for 40 years.

There is that generation thing, I think we are a well-established practice and because of that we have children of children of children now. So they are used to the fact we care. (Staff member)

Although the practice did not think they were doing anything differently they did speak about the nurses going to some school hui's and the practice social worker is in contact with the head of pastoral care at one of the local secondary schools. Another example of trying to engage with the community was to advertise a sexual health clinic for youth at one of the local secondary schools. Staff also spoke about knowing the local police team and being part of the community.

I know that some of the nurses attend some of the hui's that the schools have, so the nurses get out and meet people and try to find better ways to engage. (Staff member)

A summary of what may make this general practice more youth-friendly is:

- It is a large practice with a lot of clinical staff which may increase confidentiality
- There are a range of services in one location (GP, nurse, counselling, podiatry, physio-therapy and a pharmacy)
- Flexibility – the practice will see youth who drop in on the same day
- Practice staff are well integrated into the local community
- The practice is well established within the community.

7.2.4. Youth mental health co-ordinators

Different PHOs have different ways of providing primary mental health services for youth. While some PHOs refer youth to external providers, many PHOs employ mental health co-ordinators to provide primary mental health services for youth (and adults) and/or to link youth to appropriate external services.

In some DHBs the additional YPMHS funding was used to extend existing adult primary mental health services into younger age groups (i.e. 12 to 19 years). In other DHBs the additional funding was used to develop a new youth-specific mental health co-ordinator role. In some DHBs the co-ordinators main role is triaging referrals and referring them to various external providers (and/or secondary services).

Which method is used often relates to geography, for example, in Southern DHB it was considered more efficient to have one staff member located in Wanaka to see both adult and youth clients, rather than having two staff members (i.e. one for youth and one for adults) to travel from elsewhere to see Wanaka-based clients.

Example: A youth-specific leadership and co-ordination role

Northland DHB contract youth mental health services to Manaia Health PHO and Te Tai Tokerau PHO. Manaia Health use the funding to employ a youth specialist mental health worker and provide packages of care: 2.5 days of the youth specialist mental health worker's time are prioritised for rural locations.

…so what we do with our service is we take it to the people rather than them having to come into town or wherever. (PHO)

The youth specialist mental health worker takes referrals from general practice, NGOs, families and self-referrals. Referrals are triaged and the youth referred to an appropriate counsellor or therapist who provide packages of care – up to three sessions. Three sessions have proved effective with most young people attending all three and then not wanting / needing the extra sessions which can be offered if required.

Examples of outreach clinics for more isolated communities and for youth-specific services include:

The Bream Bay Trust – Manaia Health PHO have formed a partnership with the Bream Bay Community Trust. Programmes at the Trust include a tutorship carving programme based on attachment theory where male youth learn to carve and then share those skills with their fathers, and a postnatal depression group for young mothers. Manaia PHO use a space at the Trust to provide a half day youth mental health counselling clinic. A youth psychologist travels to the clinic. Some of the financial challenges for outreach services are addressed through a set fee for

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the youth psychologist that is not linked to the number of youth seen or affected by DNAs.

We've got a very good relationship with [the counsellor], she knows our community as well, knows the people – saw them when they were babies and probably actually saw their parents – you know like we've known her a long, long time so she's a perfect... (Trust).

Teen parent unit and Te Ora Hou– a clinic is co-located with the teen parent unit and Te Ora Hou. The youth specialist mental health workers are onsite and get to know the girls at the teen parent unit, and other youth: filling what had been a gap.

Mental health was a real gap for us and counselling was a real gap for us. (Teen parent unit)

With them coming on site they're actually now much more accessible. Like they've always offered that self-referral, "here's my number call me if you need" but now the girls are forming a relationship with them. (Teen parent unit)

Te Whareora o Tikipunga – a general practice co-located clinic has just started. The youth specialist mental health worker sees youth and also provides support and advice to the team about youth. The clinic has just started and at the time interviews were completed was not busy. Youth were not yet aware of the service and the age group criteria for YPMHS funding was a little young for many general practice attendees.

I think there is a need. It comes up sporadically that's the thing, so having the person here one day and then as sure as anything you'll need them the next day and then you can't access it.

I had a young one and I discussed it with [youth specialist] and it was just so helpful to go over a very difficult case with her. In the end we didn't need her for the young woman but just to discuss it with her she was really excellent.

If she could see under 24 she'd be full.

Whangarei Youth Space – a YOSS where the youth specialist mental health worker had offered onsite clinics that had since been stopped.

So I feel like she's really normalised mental health for young people here and she rings them and just has a chat and when she was just wondering around here it was just all normal that you went to see [youth specialist] – she wasn't the counsellor or therapist. (YOSS)

Example: Brief Intervention Co-ordinator (Southern DHB)

Southern DHB used $100,000 of the YPMHS funding to develop an additional FTE youth-specific mental health brief intervention co-ordinator for central Otago. The one FTE is split into two positions: a 0.2 FTE position based at a clinic in Clutha (South Otago), and a 0.8 FTE position who has an office in Cromwell but is mobile and visits various towns in central Otago.

The target group for this intervention is youth aged 12 to 19 years with mild to moderate mental health issues. The brief intervention co-ordinators deliver brief interventions to young people who are referred by guidance counsellors, GPs, NGO providers and other people working with youth (e.g. public health nurses).

The co-ordinators see youth in a variety of settings, including schools, local clinics, their home, or the co-ordinator's office in Cromwell. Generally, youth have four to six sessions although they can access up to eight sessions through this service.

It is important to consider the travel time required to support this very large geographical area. Both Ranfurly and Roxburgh are area schools and do not have access to a school counsellor; instead the brief intervention co-ordinator engages with the principal and associated teachers when required.

In the five months from 1 July to 30 Nov 2015, the two co-ordinators between them saw 21 male and 36 female youth, the vast majority of whom were New Zealand European. One of these youth was transferred to secondary service. Previously there was no primary care service in place and this led to a lack of early intervention (i.e. youth tended to reach crisis point and then get referred to secondary services).

Been a huge addition to supports for young people. (PHO)

7.2.5.   Youth-specific services

Non-governmental organisations (NGOs) are important service providers for youth. DHBs and PHOs have contracted YPMHS activities to NGO providers within their community, with the YPMHS activities often bundled with other contracts to ensure the best use of resource for youth.

The strengths of NGO youth specific services are:

- NGO providers have strong links with their communities and are able to provide services to meet the needs of specific groups of youth

- Their links with their communities means they are trusted

- NGOs are able to develop innovative services in response to identified needs.

YOSS are one of the main youth specific service providers in New Zealand. There are currently 11 YOSS around New Zealand. YOSS received separate one-off-funding from the Ministry of Social Development under the YMHP Initiative 5 and different YOSS have different funding models (from grants, trust, agency funding, DHB funding, PHO funding). Some YOSS deliver packages of care that may be funded as part of the YPMHS.

YOSS are community-based organisations which operate within a holistic model of care to provide wraparound services to youth aged between 10 and 24 years (or 12 to 19 years depending on contracts). The need for a wider age range than 12 to 19 is explained by risky behaviours at the younger end and a spectrum of issues for older youth.

> *There's a lot of children that have a lot of problems. (Provider)*

YOSS offer a range of health and social services including primary healthcare, sexual and reproductive health, family planning, vaccinations, counselling, mental health services, alcohol and other drug services, social work, youth transition services, youth development programmes, mentoring programmes, teen parenting programmes, and advice on accommodation, training and education, budgeting and employment.

> *I think we have some amazing nurses who are empowered to do a lot more than they would in normal general practice. (YOSS staff)*

Youth are encouraged to also register with a general practice.

> *Even though we have doctors and nurses, we don't have patients that enrol. We're not a full-time GP practice. We're the back-up. (Primary care provider)*

Providing multiple services in one location removes transport and other barriers that may prevent youth from going to an external service if referred. YOSS providers report this reduces the risk of youth being lost to follow-up. An evaluation of YOSS could not quantify the effectiveness of YOSS in improving access to services because no pre- and post-YOSS implementation figures were available[95]. However, the evaluation overall was positive regarding YOSS.

Challenges for YOSS:

- Access remains an issue for youth who do not live, go to school or work near to a YOSS.
- Some of the main challenges for YOSS relate to funding.

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[95] Communico. (2009). *Evaluation of Youth One Stop Shops.* Ministry of Health. http://www.health.govt.nz/system/files/documents/publications/youth-one-stop-shop-evaluation-report-v1.1.pdf

- YOSS are often somewhat under-resourced compared to demand which can limit access to services (e.g. if YOSS have to 'close their books' for a period of time).

We don't advertise, we just can't we are already at absolute capacity. It's all word of mouth, it's referral. If we advertised, we'd be swamped. (YOSS staff)

- YOSS typically hold contracts from many funding streams (e.g. MOH and DHBs, MOE, MSD, MOJ, PHO, community trust) and this leads to a high reporting burden.

- Different contracts may specify different age ranges for services.

I think if the funding more represented the 12 to 25 age range it would work much better rather than splitting services in that 18-year-old mark. (YOSS staff)

- Lack of stability and security of funding[96] limits long-term planning and staff professional development.

I would love to see minimum three year contracts so we can actually plan ahead, one big contract for the YOSS would be nice. So we would really like joined up funding for the longer term. (YOSS staff)

So a lot of GPs refer to us. They might have a 16-year-old who said they are self-harming and they say "oh no that's too scary for me I'll refer you to [the YOSS]" and they continue to get the bulk funding for that girl while we are seeing her for free. (YOSS staff)

Not all YOSS are successful. Key considerations when setting up a YOSS include: it takes time to set them up so a lead in period for services and contracts is required; they should be an independent organisation; the need for involvement of youth in the service; familiarity of contracting and invoicing; and a need for support from other local services and the community[97].

Although YOSS can provide wraparound care for youth it is also important for them to be linked with the other providers in the area[98]. YOSS often have a role around capacity development, and support developments to improve mainstream health

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[96] Communico. (2009). *Evaluation of Youth One Stop Shops.* Ministry of Health. http://www.health.govt.nz/system/files/documents/publications/youth-one-stop-shop-evaluation-report-v1.1.pdf

[97] Central Health. (1998). *Formative evaluation of youth one stop shops in the central region*. Central Health, Wellington. http://www.moh.govt.nz/notebook/nbbooks.nsf/0/98CFBD364EDC5B2ECC256AC600097C55/$file/Formative%20evaluation%20of%20the%20youth%20one%20stop%20shops.pdf

[98] Communico. (2009). *Evaluation of Youth One Stop Shops.* Ministry of Health. http://www.health.govt.nz/system/files/documents/publications/youth-one-stop-shop-evaluation-report-v1.1.pdf

services[99]. Doctors at YOSS generally work at the YOSS part-time which means that these clinicians are taking their youth-friendly skills and also using them in their regular general practices.

I think the YOSS have a great role to play in staff training and being a training ground, so we constantly have registrars, nursing students and counselling students social work students and particularly for the registrars and nurses that youth training has been great so then they can go off and take that youth development stuff. (YOSS staff)

Example: What youth say about youth-specific services

The youth we spoke with were very positive about the YOSS they went to. Some of their comments explain what they liked about the YOSS:

I love this place they are very supportive that's why I've always come back to them. Even things that are not really to do with them they are still helpful and they will still welcome you in and try to help. They are just about helping the youth in general.

Here I've gained a trustworthy relationship.

Confidential, here I know my rights.

[YOSS] is a place where you can just hang out and talk to the people about your problems and just have fun.

Some examples of innovative youth specific programmes that have been funded through the YPMHS are summarised in (Table 10).

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[99] Fleming, T. M. & J. M. Elvidge. (2010). *Youth health services literature review: A rapid review of School based health services, Community based youth specific health services & General practice health care for youth people*. Waitemata DHB, Auckland. https://researchspace.auckland.ac.nz/handle/2292/16871

Table 10: Examples of youth-specific YPMHS Initiatives

DHB	What they provide?	Context
Northland - Bream Bay Trust	Provides space for a youth psychologist.	The Trust is located near to the local high school and is a trusted community provider. There is no public transport into Whangarei and outreach service is the only way to reach youth.
Waitematā - *Health*WEST	Offers 'Your Choice' packages of care and group therapy for 11 -13 year olds.	Established as a central point for youth services (a youth health hub).
Counties Manukau - Youthline	Early intervention, text based support, counselling and mentoring	The aim is to improve awareness of services and accessibility for youth.
Bay of Plenty - Tuwharetoa Ki Kawerau	Packages of care Group resilience training Youth Stylze (YOSS)	Established in response to high youth suicide rated and in recognition of the relative isolation of Kawerau.
Lakes - REAL	Youth worker support for youth	Including a youth worker, easy access for youth and youth mental health specialist.
South Canterbury - Adventure Development Ltd	Long-term intensive support programme	Provides accessible, youth-friendly counselling services for local providers to refer youth.
Whanganui - Te Oranganui	Rangatahi Mental Health Team	To provide a positive male Māori role model.

Example: Adventure Development Counselling

Adventure Development Limited are an AOD service operating in South Canterbury, Otago and Southland.

Adventure Development Counselling (ADC) is a long-term programme lasting up to six months that can offer support to young people wanting more intensive support with mental health or alcohol or drug concerns. ADC uses activity and outdoor experiences to help develop new skills to better manage difficult times.

As part of ADC there is one on one counselling, group work, day activities and counsellors can also work with family/whānau. Near the conclusion of the programme, clients may be offered a four to nine day journey. The journey involves activities like mountain biking, caving, tramping and kayaking. ADC also offer a marae-based Journey.

The strengths of this programme include the long-term nature which allows counsellors to provide ongoing support and also to work with not only the youth but also their family/whānau. Having an adventure component to the programme also helps teach youth personal and life skills as well as providing something positive to look forward to (the journey) at the end of the programme.

Example: REAL – Living life and loving it

REAL is a programme provided by Pathways, a national provider. It is a structured youth brand and service. A series of focus groups included young people in planning the service. REAL is accessible by any youth and the service receives referrals from across the sector.

The model includes youth workers and psychologists. The first engagement for youth is with the youth worker and then if needed to the psychologist. Services are also provided through school clinics.

REAL has good relationships with local GPs, the YOSS and secondary services. Referral pathways to secondary services work well. The youth worker goes to secondary care appointments with the young person.

They trust that if we refer [CAMHS] are needed to intervene. (Provider)

Youth workers enable access to CAMHS for kids who wouldn't feel comfortable going there. They can sit in on appointments. (Provider)

The service has flexibility to fund the things youth need to improve their wellbeing. This may be sports equipment, or the cost of driver training and getting a license to make it easier for youth to get a job.

Example: Youth Alcohol and Other Drug Model of Care (Waikato DHB)

Waikato DHB conducted an intensive consultation process which highlighted the need for a redeveloped AOD model for youth. The DHB then spent nine months developing the model and consulting with stakeholders. An AOD model of care will be rolled out in early 2016 (1 April within Hamilton and 1 July throughout the rest of the district).

The focus of the new model is on placing youth at the centre and providing wraparound services. Currently, youth need to prove they have an issue (e.g. AOD addiction) to access services. In the new model of care youth simply need to acknowledge having an AOD problem and they will be able to access appropriate services.

The new approach has involved changes to funding models, for example, historically youth had to be registered as a client before the provider could claim funding. Under the new model the provider can also include other interactions such as providing advice to a parent concerned about their child's alcohol/drug use. The new model also encourages providers to see youth within the community (e.g. at school or at a youth hub) rather than requiring youth to come to the provider.

Challenges associated with NGO service providers include:

- Lack of evidence of effectiveness and lack of outcomes measures and evaluation can make it difficult for funders to assess the effectiveness of the services that are provided by NGOs.

- Youth and providers may have difficulty knowing which NGO providers to go to. Providers may also have changing criteria for the services they provide through different funding contracts.

   I know [colleague] and I do a lot of like foraging around looking for people to refer to and it's like, "They're not Māori or they're not under-18". (Provider)

- Uncertain funding may also lead to challenges with recruiting and retaining a skilled workforce, especially a clinical workforce.

   A lot of the NGO's aren't able to attract the clinical people with clinical experience. So we are getting referrals from the NGO's as well. (PHO Provider)

- Smaller NGO providers may not have the organisational infrastructure to respond to reporting requirements and/or the time investment in compliance activities and obtaining funding can be a large part of a small organisation's budget. The more established infrastructure of larger, national organisations better supports the development of new initiatives.

7.2.6.   Services for Māori

Māori have a high prevalence of mental health problems when compared to Pakeha. As a result of the YPMHS more Māori youth are using primary mental health services than previously and Māori youth are using services at higher rates than their proportion in the population.

However, in interviews providers reported unmet need for Māori youth and in the provider survey 71% of providers considered finding services for Māori and Pacific youth, was somewhat or not at all easy. The need for more services for young Māori males was highlighted in districts with a high Māori population.

Providing effective care for Māori includes acknowledging the unique perspective of Māori culture and recognising the ways that Māori might perceive and deal with mental health problems[100].

Evidence suggests that for some Māori service users it is important to have a service provider who shares their Māori understanding of health and wellbeing[101], for example, a focus on more holistic care and whānau involvement.

For Māori youth seeing a Māori person they can see themselves reflected in is a bonus (GP)

So when she's seen the young people that we may have referred we've made sure that she's also connected with their family. See a lot of services don't do that – we make sure of it. (Māori provider)

Youth felt that they enjoyed the cultural context:

…learning about stuff, like not going on the bad stuff on the computer. The karakia makes me feel good, it makes me feel like a Māori tribe. (Youth)

Strong community connections are important within Te Ao Māori and this can be one of the main strengths of iwi providers as they often have these connections in place and are therefore able to engage with a young person and their whānau.

One of our big strengths is we can get into the homes, almost immediately we can get into the homes with our kaumātua and support. An iwi provider has another level of being able to engage. Most times the youth is going back into the same whānau environment so our influence is washed off unless we can work with the whānau as well. (Iwi provider)

..because of the Trust's ability and their linkages in the community we were able to actually work to keep me in a position where I could still advocate for the young person

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[100] Dowell AC. Garrett S. Collings S. McBain L. McKinlay E. Stanley J. (2009). *Evaluation of the primary mental health initiatives: Summary report*. University of Otago and Ministry of Health. http://www.mentalhealth.org.nz/assets/ResourceFinder/evaluation-primary-mental-health-initiatives-summary-report-jul09.pdf

[101] Ibid.

without having to be involved in the bigger stuff that was going on around there…(Counsellor)

However, workforce issues can be a major challenge (i.e. employing people who are appropriately qualified and have knowledge of working within a Māori health perspective).

Providing services for Māori youth is more than cultural competency. It needs people who are expert in the Māori world - in Te Ao Māori. (GP)

A relatively high proportion of Māori youth live in the highest risk areas for poor youth outcomes including more isolated rural areas where accessing services can be difficult. Travel time for counsellors is expensive and limits capacity (i.e. if counsellors are spending several hours each day travelling this limits the number of youth they can see each day). It is difficult for youth to travel to services where there is no public transport, and roads in some areas are poor.

Example: Manaia PHO

In the Manaia PHO area, use of primary mental health services by Māori has increased from 5% to 40% since the appointment of a specialist youth primary mental health clinician and reshaping of services.

Example: Male Māori mental health worker

In Whanganui the additional YPMHS funding went to an iwi provider to employ a Māori man to work as a positive role model (particularly for young Māori men). The role is funded directly by the DHB which funds one FTE as well as funding towards packages of care.

The person originally employed under this contract then left the organisation and another Māori man was employed; at this point the position was shifted from the health clinic to the mental health team.

This role has been combined with two other contracts (AOD and a child and adolescent worker) to develop the three-person Rangatahi Mental Health Team. While each person has their own caseloads (and specific roles) they also work together as needed (e.g. to match gender with a youth). The three workers receive referrals from GPs, schools, CYFS, Work and Income, various local NGOs and also accept self-referrals.

Each of the three staff members complete around 30 brief interventions with youth each month which take between five and 30 minutes. They also have regular caseloads of around 15 youth at any one time who they meet once or twice every one to two weeks (e.g. twice-weekly to start with which may taper off to once fortnightly once a routine is established). Caseloads are reassessed every

three months. The average length of time youth are on the programme is six months.

Developing this position has led to an improved service since it is a new role (i.e. increased capacity) and also streamlined the referral process since the relevant providers know they can refer to all three services as part of the one team.

Example: Tuwharetoa Ki Kawerau (Bay of Plenty DHB)

Kawerau has a population who are frequently culturally disconnected to the area and community, and ranks as one of the highest areas of social deprivation in the country (e.g. more than 60% of the population are unemployed or on a form of benefit). Youth issues include the sense of disconnection, inter-generational poverty, lack of employment opportunities, the ease of access to drugs, and poor educational outcomes.

The DHB funds the Tuwharetoa Ki Kawerau directly following a significant increase in suicides five years ago. Tuwharetoa Ki Kawerau have strong community connections. They have developed a collaborative approach with external services and many weekly clinics are held in their buildings. They offer a dietician, paediatrician, a health clinic, and a youth centre.

The Kauri Restoration Project (the analogy used is of Māori a once strong proud race cut down by milling – destruction of the environment, disease and urbanisation) aims to:

> *…support people through a multi-disciplinary programme of self-reflection, with the intention of reconnecting each individual with the ancient Spirit of his or her whānau, tīpuna and hapū; building them strong internal whare for their shelter and protection, and stable waka in which to navigate the turbulent waters of life.[102] (Provider)*

Tuwharetoa Ki Kawerau deliver programmes aimed at developing youth resilience and developing a sense of connection to their whanāu and their tūrangawaewae. Tuwharetoa Ki Kawerau focus on the whole youth; inherent in their belief of whakawhānaungatanga is their belief that they cannot make change for the youth without involving whānau. The focus is on the four-quarters of life: spiritual, emotional, mental and physical.

> *The western model has taken a spiritual people and shoved them in a mental setting, they became physically sick and emotionally dyslexic and then spiritually disconnected. (Provider)*

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[102] Lakota, J. (2014) *The Kauri Restoration Project*. Nga Hau e Wha / Four Winds.

The programmes acknowledge the bravery that it takes for whānau to engage with services outside their whānau (He toa taumata rau – Bravery has many resting places). Activities use kaumatua as advisors and centre around principles of self-esteem, a sense of belonging, respect and acknowledgement of aroha.

Our cultural advisor journeys with them and connects with everyone in the classroom, not just learning about it but visiting their marae, visiting the urupā of their tūpuna, actually putting a face to it. (Provider)

7.2.7. Co-location of youth specialists

In a number of districts, service models with youth specialists such as youth psychologists co-located in other services have been trialled (e.g. CAMHS staff visiting youth at YOSS, psychologists based in schools).

Locating different providers together where youth are reduces the risks of losing youth who may be referred from primary to secondary services. One of the benefits of co-location of youth specialists is that it avoids youth having to go to an unfamiliar place such as a hospital to access secondary care services (i.e. stigma, transport issues). Instead, youth can see secondary care services in a setting in which they are already comfortable (e.g. YOSS, youth clinic, school).

When [youth specialist] was here on site it was just an extension of that like I'd see a client, we'd get to a place where they may need some extra support and I'd go, "I've got someone you'd like to meet" and [youth specialist] would come over, "This is [youth specialist] would you like to come and talk to her?" And then what we found they did come back to see me. (Provider)

Having secondary care services in a primary care setting also allows for knowledge sharing between primary and secondary providers. For example, in Whanganui the CAMHS psychiatric registrar comes to the YOSS for one hour per week (mostly to do risk assessments and to give advice on medication). This allows YOSS staff to access specialist services, and allows the psychiatric registrar to learn more about working with youth and about what services are available at the YOSS.

Sometimes when there is a case I need to talk about – if the primary mental health team aren't here, the CAMHS team are here. I can always sit down and talk around issues. I can then talk to the student and say would you like me to refer you to… When they come up here they are used to seeing everybody, they don't always know who they are and what they do but they see their faces and they are comfortable with that. (NGO provider)

Example: SUPP (Whanganui DHB)

The SUPP model in Whanganui DHB is essentially secondary level youth mental health services being provided within the community.

> *SUPP is a nod to the commonly used expression 'What's up', which over time, we hope young people will also identify with 'Sort your Problems', or even 'Support your Peers'. - DHB*[103]

The SUPP team (4.2 FTE) includes five health professionals from various backgrounds and experience including nursing, counselling, alcohol and drug work, and youth work who provide drop-in clinics for young people at schools and community agencies. The programme was developed following feedback from youth who said there was too much stigma around going to CAMHS at the hospital. SUPP runs clinics at schools where there are no guidance counsellors and also provides education programmes at schools with guidance counsellors.

Example: Enhanced School Based Health Services (ESBHS): Psychologists in low decile high schools (Auckland DHB)

School health services identify a significant volume of mental health issues. A long-term gap was identified in the care provided for youth mental health between what the school guidance counsellor was able to provide (i.e. for youth with mild mental health issues), and the eligibility criteria to be referred to secondary services (i.e. severe mental health issues). Additionally, referral to outside agencies requires parental permission for youth under 16 years and this may be a barrier to accessing services.

> *There were also youth who met the requirements of the secondary service but couldn't engage because of parents refusing consent. (School Nurse Educator)*

Instead, psychologists go and see students in schools. Referrals come through school counsellors, nurses, social workers and occasionally through school deans. The referral is discussed with the student. Students receive a package of care in school hours, through the Health Centre appointments system, which ensures anonymity and easy accessibility of the service.

Although the package of care is four to six one hour sessions, (with more available if requested) in reality these sessions are varied to meet the needs of the youth

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[103] Whanganui DHB. (2015, March). *Whanganui's SUPP team prepares for April 2 launch.* http://www.wdhb.org.nz/view/page/media-releases/story/whanganui-s-supp-team-prepares-for-april-2-launch/

and are tailored to the student's needs, their attendance at school and in-class commitments.

I go for as long as it is needed, some only need 15 minutes to do a quick burst of something and some need an hour, the majority are around 30 to 45 minutes. It's not a counselling session where they can come and talk for hours on end. It is very targeted. (School health services)

The ability to be flexible is seen as a strength when working with youth who have chaotic lives, are not always at school and at times cannot be found within the school.

We have to be doing what we can to engage the students and we have to be doing what we can to fit into the school system and not doing it in rigid bits – if you're not at school it's a DNA and it's one off your list of six – that just doesn't work. (School health services)

The school and school based health services have seen benefits and changes in students, in staff, and in attitudes to mental health care.

7.2.8. School-based health services

The YMHP extended Ministry of Health funded school based health services (SBHS) and HEEADSSS assessments for year nine students[104] to decile one to three schools. SBHS are the subject of a separate evaluation. SBHS are briefly described in this section as they are a key element of service provision for youth and some YPMHS funding supported services based in schools.

Having mental health services available in schools can help normalise mental health care and reduce the associated stigma. Nurses indicated that the main reason students use the nursing service is for contraception and/or sexual health and one-third of nurses said students seek help for mental health issues such as depression and/or anxiety[105].

The YPMHS has in some DHBs supported an extension of SBHS to decile four or higher decile schools and other school based initiatives such as the psychologists in schools programme detailed above.

GPs also provide clinics in schools and GPs involved in providing these services report identifying mental health issues for youth and consider that as many of the

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[104] HEEADSSS assessments aim to identify students who need extra support for mental health issues.

[105] Buckley, S., J. McDonald, D. Mason, Z. Gerring, M. Churchward & J. Cumming. (2009). *Report to the Ministry of Health – Nursing Services in New Zealand Secondary Schools.* http://www.victoria.ac.nz/sog/researchcentres/health-services-research-centre/docs/reports/downloads/Nursing-Services-in-Schools-Edited-19-Feb.pdf

youth they see are not enrolled with other services their mental health issues would not have otherwise been identified unless they reached crisis point.

Example: GP Clinic in a high needs areas

GPs were part of school based health services in many localities, often in a supporting role to nurses. In some localities there were GP led clinics in schools. In rural and/or high needs localities the GP clinics provided a link between youth and general practice. Estimates were that as many as 60% of youth attending clinics were not enrolled with GPs (mobile families, lack of documentation for registration) and would not otherwise have been identified as needing support for mental health issues.

[Clinics] get youth used to engaging with health services. (GP)

In one clinic, about half of youth were seen for contraception, one-third for physical conditions (e.g. skin infections) and a small but significant proportion for mental health issues.

The working relationships with schools varied. Some schools prefer to have the guidance counsellor as the main point of contact for youth wellbeing.

Example: General practice Youth Nurse also working as a SBHS Nurse (Wairarapa DHB)

The DHB have funded SBHS in all local high schools regardless of decile. The SBHS are provided by practice nurses who also work in local general practices. This approach has led to youth accessing care in general practices outside of the hours the nurse is in the school, even when it is not their regular GP. Through the general practice they can be easily referred to the primary mental care nurses if needed.

…youth need people who will keep trying and who foster and establish a relationship. …there has been a direct flow on to the number of youth being seen at the GP clinic. (Practice Nurse).

Often with youth if you can get a rapport with them, and you can have the same people seeing them you have a lot more success than you do with multiple different ones seeing them. (Medical Centre)

7.3 Linking youth to the 'right' services

An important aspect of any health system is the linkages and communication between the providers in the system. Providers have an important role in linking youth with the most appropriate service provider and treatment.

In the survey of providers, slightly over half (55%) of those responding considered the health system in their area was working moderately or very well (Figure 11). This proportion was relatively consistent across the DHBs where providers completed the survey.

How well is the health system in your area is working to support youth with mental health issues?

■ Not at all well ■ A little ■ Moderately well ■ Very well

| 13% | 32% | 50% | |
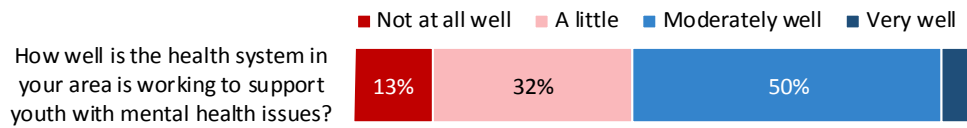
Figure 11. Perceptions of how well the health system is working in their area for youth with mental health issues (Source: Provider survey)

Survey responses demonstrated that providers had access to a number of different options for youth within their own practices (Figure 12).

Referral to mental health or other services — 79%
Brief interventions — 58%
Extended GP consultations — 44%
School-based — 42%
Extended nurse consultations — 34%
Drop-in clinics for youth — 26%
Group therapy — 15%
Non clinical services — 7%
Youth services — 5%
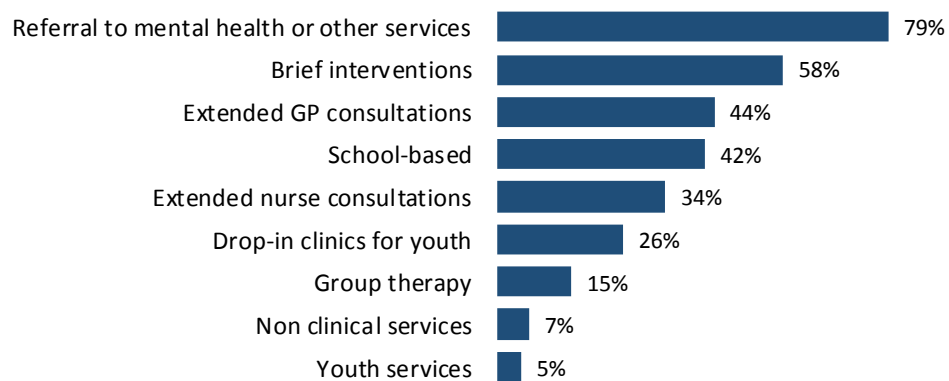
Figure 12. Different services provided for youth aged 12 to 19 within the practices of survey respondents (Source: Provider survey – multiple responses)

Approximately half of the providers who responded to the survey considered that lack of suitable services, waiting times for referrals and other access issues were major or substantial issues in providing care for youth with mental health issues (Figure 13).

Barriers to providing care...

■ Major ■ Substantial ■ Slight ■ Not a barrier

	Major	Substantial	Slight	Not a barrier
Lack of suitable services	20%	31%	33%	15%
Waiting times for referrals to specialists	26%	35%	30%	8%
Other access issues	22%	34%	33%	12%
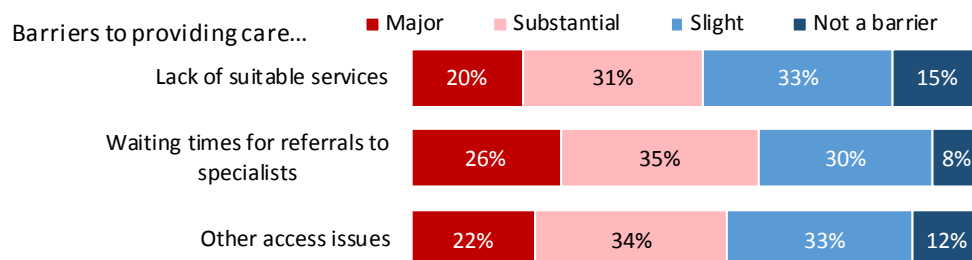
Figure 13: Barriers to providing care for youth (Source: Provider survey)

Accessing particular types of services was a problem for substantial numbers of survey respondents (Figure 14). Finding services for Māori and Pacific youth, was particularly difficult with 71% of providers saying access for Māori youth was somewhat or not at all easy; and 79% of providers for Pacific youth.

Ease of accessing services...	Not at all	Somewhat	Quite	Very
General practice services	11%	28%	34%	27%
NGO services	25%	33%	31%	11%
Services for Maori youth	29%	42%	20%	9%
Services for Pacific youth	38%	41%	15%	6%
Alcohol and drug services	22%	33%	28%	17%
Secondary Mental Health services	31%	33%	29%	7%
Crisis response teams	28%	31%	29%	12%
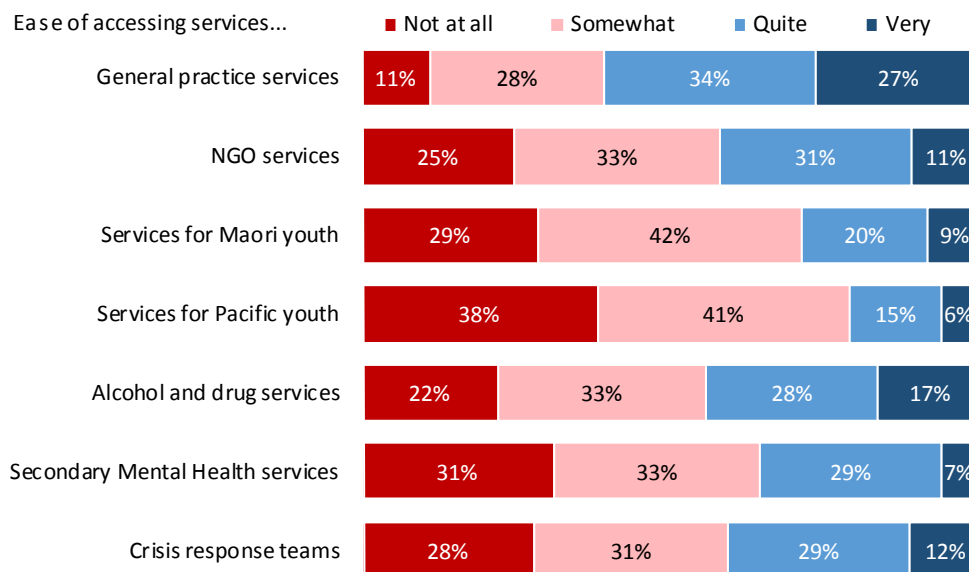
Figure 14. Availability and access-related barriers to providing care for youth with mental health issues (Source: Provider survey)

Information sharing is an important aspect of effective referral pathways. Providers commonly discuss with young people what happens to their information and let them know when they need to share information.

We use a no surprise consent process. (NGO)

We want to use more mobile technology to give young people access to their notes as well. (NGO)

Most providers who responded to the survey considered confidentiality requirements and sharing information about youth with other providers were not barriers to care (Figure 15). However, 54% said that receiving information back about youth they had referred was a major or substantial barrier in supporting youth with mental health issues.

Barriers to providing care...	Major	Substantial	Slight	Not a barrier
Confidentiality requirement		6%	34%	58%
Sharing information with other health professionals		8%	34%	56%
Receiving information about youth you referred	20%	34%	31%	15%
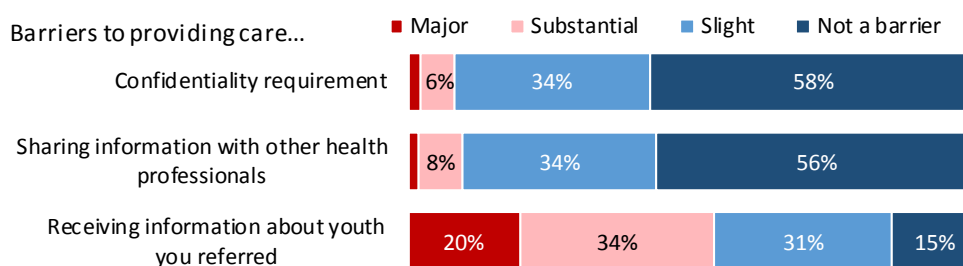
Figure 15. Process-related barriers to providing care for youth with mental health issues (Source: Provider survey)

7.3.1. Access to specialist services

Although secondary services are not part of the youth primary mental health service, the interface between primary and secondary services drives behaviours and service models.

The interface between CAMHS and primary care needs to be effective. Who makes the call on what that is? (Youth clinical specialist)

Access to specialist services was described by one provider as a *'two edged sword'* with issues including:

- Lack of clarity about appropriate referrals – with some specialists not appreciating what primary care could cover and some primary care providers referring youth who may be able to be supported in primary care.

   There is a lack of understanding about what primary care can offer. Primary care interventions are brief and there is a perception that long-term interventions are best. (PHO)

   GPs get frustrated – what can I do with this youth – and refer them to CAMHS (NGO provider)

- Long waiting times for secondary care services resulting in some primary care providers supporting youth with higher levels of acuity than they felt confident in supporting. We heard from GPs that in these cases they may prescribe medication even though they felt may not be the best approach[106].

The mental health workforce review noted that moving from specialist, office based services towards flexibly sited services that relate to the wider community can result in better, sooner, more convenient and timely services. They also noted that advice from secondary mental health specialists directly to those working in the community with youth would be a more effective way of delivering these services to young people. Therefore, moving some resources from the DHB mental health services into supporting those working with youth in the community will decrease costs, result in better health outcomes and help break down the primary-secondary service divide[107].

Feedback about examples of youth mental health specialists in primary care locations as part of the YPMHS describes this way of providing services as effective in bridging the gap between primary and secondary care by reducing the number of referrals and increasing the trust that youth referred need secondary care services.

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[106] Guidelines advise not to prescribe mental health meds to those under 18 years without first consulting with adolescent psychiatrist / mental health specialist

[107] Ministry of Health. (2011). *Report on the Youth Health Workforce Service Review – April 2011*. https://www.health.govt.nz/system/files/documents/pages/youth-health-workforce-service-review.pdf

Example: Specialist services co-located in a youth service

Over a 12-month period a youth psychologist based in a youth service setting had 250 sessions for 61 clients: an average of 4.2 sessions per client.

Measurement of the outcomes of this service model demonstrated effectiveness, the identification of mental health issues in youth who would not otherwise have been seen by a mental health service and efficiency as most youth were managed on-site by the youth psychologist with few referrals to secondary care.

- Level of distress at intake measured using the ORS: 16.6/40 (a score of 18 is the usual threshold for secondary care) and 40/40 is the best possible score.
- Level of distress at discharge: 29/40 (a score of 27 to 40 indicates no further need for services)
- Post effect size[108]: 1.3 (0 is no effect and 0.8 to 1 is considered an effective mental health service).

A co-located youth psychologist can also work in a consultative way to support non-clinical roles such as youth workers.

When surveyed providers were asked what they would like to see changed that would improve the support they could to provide for youth with mental health issues the most frequent responses related to:

- Better referral processes (44)
- More funding, capacity, staff or resources (44)
- Better access to secondary or crisis care (42)
- More joined up providers (39)
- Better access to different types of primary care (30)
- More brief interventions, packages of care or counselling (27)
- More professional development about youth mental health (27)
- Improved school based health and guidance counsellor services (19)
- Providers more embedded in the community (15)
- More youth specific services (14)
- And a range of other comments about specific service types or treatments.

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[108] Magnusson, K. (2014). *Interpreting Cohen's d effect size: An interactive visualization*. http://rpsychologist.com/d3/cohend/

8.   Workforce development

Key messages

There is recognition of the need for youth-friendly and appropriately trained providers, as well as a call for more services across a range of areas. A workforce review concluded that currently the youth mental health workforce is often not appropriately trained, supported or rewarded[109]. The majority of providers would like more training about mental health.

New workforce initiatives are developing the capability of the youth health workforce to identify and intervene where youth need support for mental health issues.

Workforce development is an essential component of expanding youth primary mental health services.

We need to put a lot of time into it (PHO)

The YPMHS has supported the development of new workforce roles and the expansion of existing roles within the different initiatives and many initiatives highlight the value of the non-clinical workforce.

Examples of new roles:

Youth mental health professionals: Youth clinical specialists have been appointed into new roles in a number of DHBs. They run youth clinics but also have a key role in supporting other health professionals by discussing 'difficult cases'. People in this role are key in integrating primary providers and bridging the gap between primary and secondary services. A CAMHS background is particularly useful in this respect.

The provider survey gathered feedback about a youth clinical specialist in one DHB: 26 of 31 providers described the role as either very useful (13) or quite useful (6). Of the 16 providers who had referred youth to the service: 10 said the service met their needs, five that it met their needs to some extent and one that the service did not meet their needs.

Male Māori mental health worker – new role in Whanganui funded by YPMHS who has a caseload to work with youth and also does brief interventions.

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[109] Ministry of Health. (2011). *Report on the Youth Health Workforce Service Review – April 2011*. https://www.health.govt.nz/system/files/documents/pages/youth-health-workforce-service-review.pdf

A visiting clinical psychologist into lower decile schools: Clinical psychologists have been added to the SBHS. Having a psychologist within a school has normalised mental health care and has allowed more flexibility with the care given. It has also reduced the stigma of mental health as well as religious beliefs that may stop some Pacific youth from seeking help. The result of moving care into the schools has been an increase in Pacific youth numbers accessing care. The success of this model has seen it also moved into some other identified schools that sit above the decile 3 threshold.

An enrolled nurse with mental health training: Te Manu Toroa use the YPMHS funding to employ the nurse to run Oncore, a youth drop-in clinic which operates within the wider Te Manu Toroa facilities.

A youth support worker: has also been employed 20 hours a week to provide support for an enrolled nurse who can see 20 to 30 youth an afternoon.

Mental health co-ordinator / clinicians and social workers: Tui Ora an NGO have employed two co-ordinator / clinicians and social workers. They can provide packages of care if a referrer doesn't identify the need for a psychologist or counsellor. They are mobile and can go to rural areas. The hope is that this will be well used and reduce the numbers of DNAs.

8.1.1. Confidence in providing care for youth with mental health issues

Providers responding to the survey were asked about their confidence in aspects of supporting youth with mental health issues. Providers were mostly confident about:

- Building rapport with youth
- Initiating a conversation about mental health issues
- Initiating conversations with the young person's family.

Fewer providers were confident in identifying a young person with mental health issues and in knowing what to do once they had identified a youth with mental health issues, and assessing the risk of suicide (Figure 16).

In general practice I wasn't confident about what to do with a suicidal youth or asking about sexual abuse. So I might not ask. (GP)
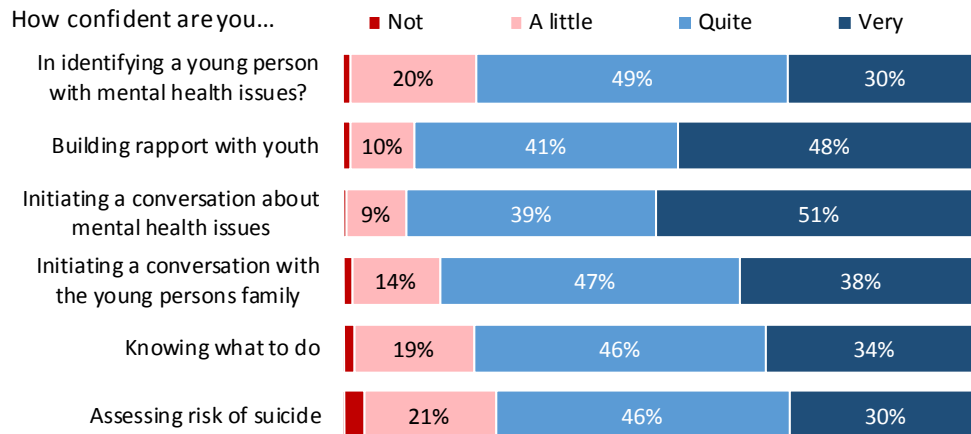
Figure 16. Levels of confidence amongst survey respondents about initial engagement with youth (Source: Provider survey)

With respect to specific interventions between 30% and 52% of providers were a little or not confident about common interventions for youth with mental health issues (Figure 17).
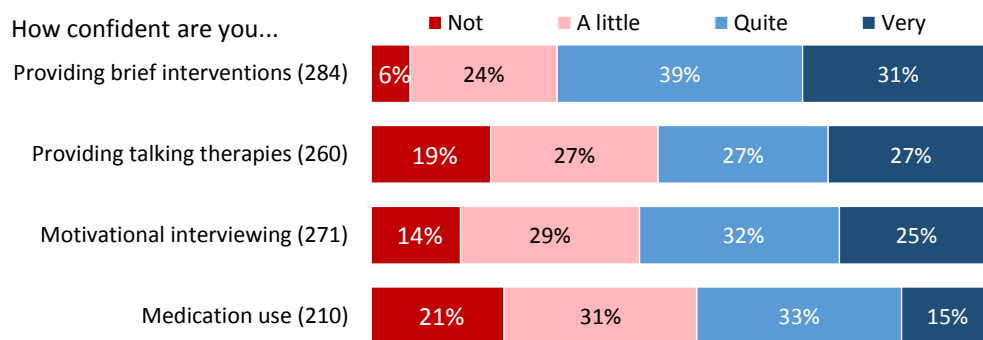
Figure 17. Levels of confidence amongst survey respondents about interventions to support youth with mental health issues (Source: Provider survey – numbers varied for each option and are shown in brackets)

Up to one-quarter of providers were a little or not confident about knowing where to refer youth for specialist services and accessing advice on services (Figure 18).
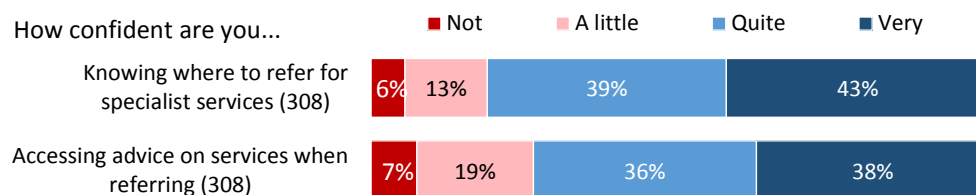
Figure 18. Levels of confidence amongst survey respondents in using tools with youth who need additional support for mental health issues (Source: Provider survey- numbers varied for each option and are shown in brackets)

8.1.2. Training and professional development

Over 80% of providers responding to the survey said youth mental health was a topic where they would like professional development or training (Figure 19).

Role type	Yes	No	Response count
General practitioner	72%	28%	104
Practice nurse in primary care	84%	16%	69
Nurse practitioner	92%	8%	36
Specific youth mental health role	89%	11%	62
Other clinical role	100%	0%	10
Non clinical role	93%	7%	15
Management role	40%	60%	15
Educator/school based role	*100%*	*0%*	6
Total	81%	19%	317

Figure 19: Interest in professional development and training by professional group (Source: Provider survey). Note: Figures in italics denote small numbers

Over two-thirds (69%) of survey respondents had taken part in some professional development or training about youth mental health in the last five years (Figure 20). Slightly more of those who had taken part in professional development or training wanted further training (85%) than those who had not had training in the last five years (72%).
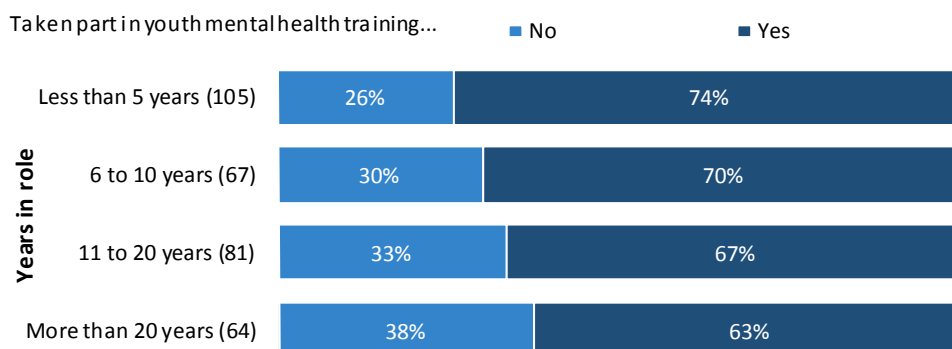
Figure 20. Years in current professional role and whether taken part in any professional development or training about youth mental health in the last five years (Source: Provider survey)

The main topics providers suggested for professional development and training are summarised below (Table 11).

Table 11: Provider suggestions for professional development and training

Topics of interest for professional training	Count
Suicide and self-harm (assessing risk, what to do)	21
Anxiety and depression	18
Accessing services and referral processes (how, knowing what's available)	17
CBT, Mindfulness	15
Assessment / recognition (of mental health issues)	13
Motivational interviewing	12
Drug and alcohol	12
Eating disorders	9
Providing brief interventions	9
Medication (use, prescribing)	9
Acceptance and commitment therapy	7
Families (working with, involving)	7
Online tools	6

National workforce development resources have been developed by the Ministry of Social Development http://www.mh101.co.nz/ but may need further promotion to the youth primary care workforce.

9.   Investing in Youth Mental Health

Key messages

Many youth with mild to moderate mental health issues may go on to achieve positive outcomes. However, there is a greater risk for some of significant negative impacts on future health, employment and wellbeing. Intervention, especially early intervention has the potential to divert a proportion of youth from long-term negative outcomes such as benefit dependence and can result in significant social and economic benefits that can offset programme costs.

Numerous studies have demonstrated that net positive financial returns can result from investing in mental health treatment for young people.

There is not sufficient consistent measurement of outcomes for youth receiving youth primary mental health services to allow a robust cost-benefit analysis as part of this evaluation. However, information from this evaluation demonstrates that services are achieving outcomes that are associated with positive returns on investment such as:

- Improved mental health outcomes following intervention
- Improved resilience
- Staying in school for longer
- Being helped to get jobs.

One of the challenges for funders is balancing targeted services – to reach the districts with the highest *proportions* of vulnerable youth (often youth who are difficult to reach) - against funding districts with the largest *number* of vulnerable youth.

This section summarises information about the costs of poor mental health and the costs and benefits of improving mental health outcomes for youth. An economic evaluation of the YMHP as a whole is being completed. The information in this section complements the wider economic evaluation by focussing on the YPMHS.

9.1   Investing in youth mental health services

In New Zealand, mental health spending has grown to $1.2 billion in 2010/11, representing 9.5% of the Vote Health Budget. Of this, 76% is spent on community

programming (as opposed to inpatient services)[110]. Spending on youth is not calculated separately, but young people (under 25) represent approximately one-third of those receiving mental health treatment in the same time period[111].

Early intervention at key points can alter a life path. Repeated research has shown it is more cost effective to spend money on early interventions for young people rather than on remedial programmes[112] [113]. Early interventions can result in better outcomes[114]. However, it is never too late to intervene and YPMHS funds interventions for older children and youth. Interventions do not need to change outcomes for many to become cost effective[115]. Some have argued that while a programme itself (e.g. CBT) may not have direct long-term impacts, as long as the effect persists long enough to improve educational attainment, it can alter the student's life trajectory[116].

9.2   The cost of poor mental health among young people

Mental health conditions are one element of risk for youth, in that they are associated with future poor outcomes. As well as the consequences for individuals, poor youth mental health has substantial social and economic impacts as it is associated with:

- Lower educational attainment which results in lower earnings. If those with a mental health condition are more likely to leave school early, they forgo the additional earnings that tend to accompany a school qualification and especially tertiary education or qualifications. Leaving school could cost

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[110] Ministry of Health. (2012). *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017.* http://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017

[111] Ministry of Health. (2014). *Mental Health and Addiction: Service use 2010/11*. http://www.health.govt.nz/publication/mental-health-and-addiction-service-use-2010-11

[112] Fox, S., Southwell, A., Stafford, N., Goodhue, R., Jackson, D. and Smith, C. (2015). *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention*. Canberra: Australian Research Alliance for Children and Youth (ARACY).

[113] Ministry of Health. (2011). *Report on the Youth Health Workforce Service Review – April 2011*. https://www.health.govt.nz/system/files/documents/pages/youth-health-workforce-service-review.pdf

[114] Bpac. (2010, January). *Depression in Young People*. Best Practice: Special Edition.

[115] Fox, S., Southwell, A., Stafford, N., Goodhue, R., Jackson, D. and Smith, C. (2015). *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention*. Canberra: Australian Research Alliance for Children and Youth (ARACY).

[116] Behm, A., Drazkowski, A., Matteson, S., Serakos, M. and Wolter, C. (2014). *Increasing Access to Youth Mental Health Services: A Cost-Benefit Analysis of the PATH Program in the Fox Valley*. Madison, Wisconsin: United Way Fox Cities. https://www.lafollette.wisc.edu/images/publications/cba/2014-path.pdf

between $3,500 and $15,000 per year in lower median earnings, compared to graduating or obtaining a tertiary degree[117] [118]. School completion seems to have a smaller quantum of impact on earnings in New Zealand than in some widely published international work, however the principal relationship remains[119].

- Lost earnings – young people with poor mental health are expected to, on average, work less and earn less than others. There is a clearly established link between a mental health condition and both reduced participation in the labour force (6% for women, 13% for men) as well as the number of hours worked[120].

- Benefit payments – longer-term, we know that suffering from poor mental health is associated with an increased likelihood of benefit receipt[121]. A young person entering the social welfare benefit system has an average lifetime liability of $250,000[122]. Those who leave school early are twice as likely to receive a benefit within five years (13%) compared to those with qualifications (6%), and more than six times as likely compared to those with a tertiary degree (2%)[123].

[117] Education Counts. (2015) *Impact of education on outcome.* https://www.educationcounts.govt.nz/indicators/main/education-and-learning-outcomes/1919

[118] Education Counts. (2013). *Tertiary education occasional paper 2013/02. Looking at the employment outcomes of tertiary education: New data on the earnings of young graduates.* https://www.educationcounts.govt.nz/__data/assets/pdf_file/0020/143561/Looking-at-the-employment-outcomes-of-tertiary-education-ii.pdf

[119] Education Counts. (2015) *Impact of education on outcome.* https://www.educationcounts.govt.nz/indicators/main/education-and-learning-outcomes/1919" and "Education Counts. (2013). *Tertiary education occasional paper 2013/02. Looking at the employment outcomes of tertiary education: New data on the earnings of young graduates.* https://www.educationcounts.govt.nz/__data/assets/pdf_file/0020/143561/Looking-at-the-employment-outcomes-of-tertiary-education-ii.pdf"

[120] Holt, H. (2010). *Working paper 10/03 – Health and Labour Force Participation*. The Treasury. http://www.treasury.govt.nz/publications/research-policy/wp/2010/10-03

[121] For example: Fergusson, D. M., J. M. Boden & L. J. Horwood. Recurrence of major depression in adolescence and early adulthood, and later mental health, educational and economic outcomes. *British Journal of Psychiatry, 191*, 335-342. http://www.ncbi.nlm.nih.gov/pubmed/17906244

[122] Ministry of Social Development. (2012). *Investment approach refocuses entire welfare system*. http://www.msd.govt.nz/about-msd-and-our-work/newsroom/media-releases/2012/valuation-report.html

[123] Education Counts. (2013). *Tertiary education occasional paper 2013/02. Looking at the employment outcomes of tertiary education: New data on the earnings of young graduates.* https://www.educationcounts.govt.nz/__data/assets/pdf_file/0020/143561/Looking-at-the-employment-outcomes-of-tertiary-education-ii.pdf

- Additional costs to health, education, justice and other social systems resulting from risky behaviour or poor outcomes. Millions have been invested in youth justice and incarceration for young people[124] which is the least desired outcome for youth at risk[125].

- Ultimately, poor mental health can result in suicide. Suicide has far reaching costs. Apart from the incalculable pain resulting from such a loss, studies in the United States, including a review by the Centre for Disease Control[126], and Australia[127] have calculated considerable economic costs of a suicide to society[128].

A recent New Zealand Treasury paper based on the Integrated Administrative Data set (IDI), which draws information from a number of agencies, has estimated the future costs to society for those born between 1 July 1990 and 30 June 1991, and followed to the age of 21[129]. The paper compares a range of costs associated with groups of people with different levels of risk. Some young people are predicted to incur high future costs - $200,001 or more in welfare and corrections costs. The high risk cohort are five times more likely to incur such high costs, and the most-at-risk cohort is ten times for likely. Poor mental health is associated with higher risk.

9.3   The cost and benefits of primary mental health services

The costs of primary mental health services are driven by the direct costs of providing different types of services, interventions and treatments in different contexts or through different services (e.g., mobile services, YOSS, general practice).

The YPMHS stepped care model is premised on linking youth to the right interventions with some youth benefitting from support from the non-clinical

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[124] Ministry of Justice. (2000). *Budgeted Criminal Justice Expenditure 1999-2000.* http://www.justice.govt.nz/publications/publications-archived/1999/responses-to-crime-annual-review-1999/budgeted-criminal-justice-expenditure-in-1999-2000

[125] Ministry of Justice. (2013). *Youth Crime Action Plan.* http://www.justice.govt.nz/publications/global-publications/y/youth-crime-action-plan-full-report

[126] http://www.cdc.gov/violenceprevention/suicide/consequences.html

[127] file:///C:/Users/Deborah/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/F0OH48OD/KPMG-Economic-cost-of-suicide-in-Australia-Menslink.pdf

[128] O'Dea D, Tucker S. (2005). *The cost of suicide to society.* Wellington: Ministry of Health. http://www.health.govt.nz/publication/cost-suicide-society

[129] McLeod, K., R. Templeton, C. Ball, S. Tumen, S. Crichton & S. Dixon. (2015, December). *Analytical Paper 15/02 Using Integrated Administrative Data to Identify Youth Who are at Risk of Poor Outcomes as Adults.* http://www.treasury.govt.nz/publications/research-policy/ap/2015/15-02/ap15-02.pdf

workforce and some requiring higher intensity and more costly treatments. For example youth workers may cost $40,000 to $50,000 per annum whereas trained counsellors would cost up to $80,000 per year, and clinical professionals would cost $100,000 for psychological services or up to $250,000 for specialised psychiatry services.

The literature cites a range of cost-benefit studies[130], considering both treatment types and specific programmes. This establishes an evidence base of potential positive returns to individuals and wider society from investing in mental health. Evidence informing the different ways YPMHS are provided is summarised in Section 5.

Evidence from a series of meta-analyses include interventions similar to those provided under YPMHS. These do not suggest that YPMHS **will** see the same results, or that all interventions result in a positive net benefit but that **it is possible** for similar intervention in similar contexts to yield similar findings[131]. Note that these studies focus on programme outcomes, not clinical studies of treatments.

- For the treatment of depression in young people, CBT showed positive net benefits of up to **$5,000** for children. Talking therapy is a part of the YPMHS.

- For the treatment of anxiety in young people, all forms of CBT studied (individual, group, family and remote delivery) had positive cost-benefit results. Benefits exceeded costs **by up to $23,000** per youth. The highest returns were found for remote delivery 'E-therapy'[132]. E-therapy is provided by the YMHP through SPARX and YPMHS providers refer youth to SPARX.

- Brief, primary-care interventions (15 minutes to one hour) for adults at high-risk use of alcohol were shown to have a positive net benefit of over **$7,000** per person**.** Brief interventions in hospital and emergency rooms for adults at high-risk alcohol use were also shown to have positive benefits and net benefits **($4,000-$6,000**). These are similar to the interventions introduced by Capital and Coast targeting youth.

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[130] At the highest level, CBA will identify whether there is a net benefit to an intervention. A CBA includes calculation of a comprehensive view of costs (including opportunity costs) and lifetime individual, social and economic benefits. CBA results are often regarded as establishing a threshold; an intervention without a positive net benefit is by definition costing more than it is worth. CBA provides a single number in the form of a ratio (total monetized benefits compared to total monetized costs) or a dollar amount (total monetized benefits less total monetized costs). A ratio greater than one, or a positive dollar amount, indicates benefits exceed costs. However, CBA has stringent data requirements and is not always practical to implement.

[131] http://www.wsipp.wa.gov/BenefitCost?topicId=5 provides a summary of meta-analyses, as of December, 2015. Note that the research is being updated on a cyclical basis as new publications are made available, which can alter findings.

[132] The E-therapy tool SPARX is part of the YMHP.

- Programmes that targeted college (tertiary) students or youth and provided a brief intervention for high risk alcohol or drug use also had positive returns, ranging from **$800 to $1,800**.
- Of programmes specifically targeting youth, primary care interventions and a school-based marijuana programme had positive returns of **$800 to $1,800**.

Not all programme treatments were calculated as cost-effective for all conditions. For example, programmes in the study that provided CBT for children with ADHD had costs exceeding benefits. Programmes providing CBT for depression reported positive net benefits for children and adults, but not always for adolescents.

In summary, there is precedence for therapies and treatments that are broadly consistent with those being provided under the YPMHS to yield greater benefits overall than they cost. Tracking outcomes and more understanding about how and why programmes work is required to maximise returns on investment.

> **Example: Returns on investment – PATH programme (USA)**
>
> The PATH programme is 'a school-based mental health intervention program to address these barriers [to accessing services] by placing mental health professionals in schools and financing treatment when necessary'[133]. The programme is located in Fox Valley, Wisconsin, USA.
>
> The PATH programme showed modest gains in the short term through reduced truancy, behavioural problems and discipline problems, less time required from guidance counsellors, avoiding juvenile crime/delinquency, and avoided suicide. It was through long-term changes in lifetime earnings and avoided crime in adulthood that drove substantial gains – over $9,000,000 in benefits for a $555,000 investment.

9.4   How might YPMHS investment yield returns in New Zealand?

Although not every programme is effective, there is evidence that substantial benefits can arise from programmes that are effective for at least some young people. The pre- and post-intervention data that often underpins an impact study is not available for the YPMHS. However, studies often link evidence together and draw on the literature or knowledge base to model likely future impacts that follow the causal chain of an intervention.

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[133] Behm, A., Drazkowski, A., Matteson, S., Serakos, M. and Wolter, C. (2014). *Increasing Access to Youth Mental Health Services: A Cost-Benefit Analysis of the PATH Program in the Fox Valley*. Madison, Wisconsin: United Way Fox Cities
https://www.lafollette.wisc.edu/images/publications/cba/2014-path.pdf

How many youth have been reached? → What treatments are available? → What impact has been shown on mental health? → How has improved mental health resulted in short-term benefits? → What are known links between short term and long term outcomes? → Therefore, what long term outcomes do we expect from the programme?
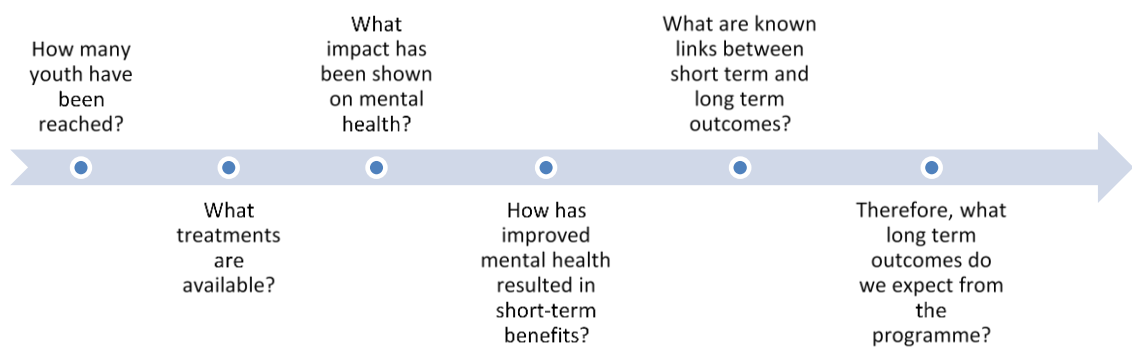
Applying this thinking to the YPMHS, illustrates how investment can yield financial returns.

Treatment success will be highly dependent upon an individual young person and their treatment. However, many treatments show improvement or recovery for a majority of young patients.

- Cognitive Behavioural Therapy for Anxiety Disorders in Youth: 'Cognitive behavioral therapies (CBTs) have been shown to be efficacious for the treatment of anxiety disorders in children and adolescents. Randomized clinical trials indicate that approximately **two-thirds** of children treated with CBT will be free of their primary diagnosis at posttreatment'[134].

- Cognitive-Behavioural Treatment of Adolescent Depression: 'Acute CBT groups yielded higher depression recovery rates (**66.7%**) than the waitlist (48.1%), and greater reduction in self-reported depression'[135].

- Remission and Recovery in the Treatment for Adolescents with Depression Study: 'At week 36, the estimated remission rates for intention-to-treat cases were as follows: combination, 60%; fluoxetine, 55%; cognitive–behavioral therapy, **64**%; and overall, 60%'[136].

[134] Seligman, L. D., & T. H. Ollendick. (2011). Cognitive Behavioral Therapy for Anxiety Disorders in Youth. *Child and Adolescent Psychiatric Clinics of North America, 20* (2), 217-238. http://www.sciencedirect.com/science/article/pii/S1056499311000046

[135] Clarke, G. N., P. Rohde, P. M. Lewinsohn, H. Hops & J. R. Seeley. (1999). Cognitive-behavioral treatment of adolescent depression: Efficacy of acute group treatment and booster sessions. *Journal of the American Academy of Child and Adolescent Psychiatry, 38* (3), 272-279. http://www.sciencedirect.com/science/article/pii/S0890856709629221

[136] Kennard, B. D., S. G. Silva, S. Tonev, P. Rohde, J. L. Hughes, B. Vitiello, C. J. Kratochvil, J. F. Curry, G. J. Emslie, M. Reinecke & J. March. (2009). Remission and recovery in the treatment for adolescents with depression study (TADS): acute and long-term outcomes. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(2), 186-195. http://www.ncbi.nlm.nih.gov/pubmed/19127172

The outcomes data collected by some YPMHS initiatives for some participating youth provides (qualitative or quantitative) information about positive impacts as a result of initiatives. Examples include:

- An evaluation of the Kapiti YOSS reported that 90% of youth receiving support remained steady or improved in wellbeing, and that 35% improved[137].

- An evaluation of the youth brief intervention service provided by Adventure Trust reported 82% of youth with pre- and post-intervention Kessler scores (only some youth had these scores) improved from 'psychological distress' to 'wellness'.

- Providers report that the types of short term benefits described in the literature are occurring in practice:

*We are finding it very effective. The nurses are reporting that the students who initially were not bad enough for secondary services or could only access the school guidance counsellor or were beyond the school guidance counsellor scope or skill level, for those students they used to stall and were in a holding pattern for too long which effected their learning and engagement and achievement **meaning they were leaving school early as a result**. **The nurses are reporting that those who meet the criteria for the psychologists are being shifted from a dark negative space or an anxious space to a more resilience space and engaging in their learning**. (School health services, Auckland Psychologist in Schools Example)*

*… it has made a huge difference, for the students it has been very, very beneficial. Last year I just didn't know what to do with them. They weren't bad enough for exclusion, not quite social worker, not quite counselling. As a dean **the pastoral incidents have dropped with those students**. (School Dean - Psychologist in Schools)*

A significant proportion of the youth I see respond well with treatment and it prevents progression. (Youth psychologist collocated at a youth service)

While there are no outcomes measures available, schools suggest that students who would have otherwise have left (if they had not done the programme) are instead staying and completing Years 12-13. (NGO resilience building programme)

Based on this information, we could estimate that many young people receiving treatment through YPMHS could recover. The magnitude of benefits from supporting even a few young people into improved long-term outcomes can be substantial and are worth studying. Through improved mental health, we expect less likelihood of benefit receipt and we expect fewer to receive a benefit than otherwise. In addition, we know that young people in good health tend to work and

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[137] Bailey, R., Torrie, R., & Osborne, R. with Bagshaw, S., Blyth, S., Davidson, J., Merry, S., Munford, R., Pipi, K., Porima, L., Sanders, J., Stasiak, K., Wehipeihana, N., Wilde, V. (2013). *How we know what we're doing works: Measuring youth outcomes at Kapiti Youth Support. Impact Evaluation - Summary Report 2013*

earn more. As youth progress into adulthood, they are likely to have even higher earnings and contributions.

We know less about the quantum of savings in health care costs, criminal justice costs, and other negative outcomes in New Zealand. Collecting key outcome measures for programmes is a first step towards establishing these returns.

Applying this thinking to the YPMHS, we can illustrate how the investment can yield longer-term gains.
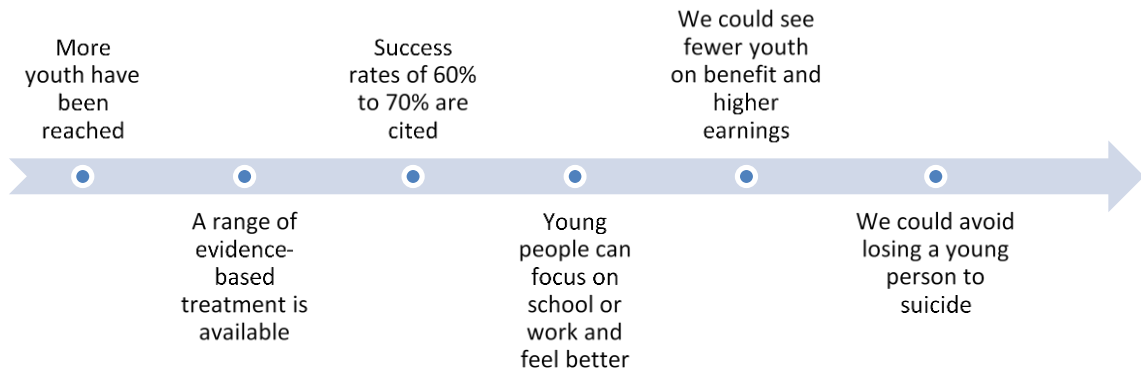
Example: A young male suffering from depression

Reaching young men with mental health conditions is considered a challenge by many health professionals. One innovative approach provided by an NGO costs $8,500 per youth.

Evidence suggests that CBT, including group therapy and interpersonal psychotherapy (IPT) are preferred therapies for adolescent depression[138]. Evidence also suggests that poor mental health is associated with criminal justice involvement, particularly for young men. Once charged the likelihood of additional involvement in the justice system increases. Similarly, education and employment outcomes tend to be poorer than otherwise[139].

- If treatment can avoid a criminal charge and the associated criminal justice outcomes, it could save between $1,100 for diversion response to

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[138] Effective Child Therapy. (2013). *Depression.* http://effectivechildtherapy.org/content/depression

[139] McLeod, K., R. Templeton, C. Ball, S. Tumen, S. Crichton & S. Dixon. (2015, December). *Analytical Paper 15/02 Using Integrated Administrative Data to Identify Youth Who are at Risk of Poor Outcomes as Adults*. http://www.treasury.govt.nz/publications/research-policy/ap/2015/15-02/ap15-02.pdf. Wellington: The Treasury.

> nearly $30,000 for a 90 day CYF residence order, to more than $50,000 per year for incarceration[140].

- If treatment can help a young man continue his education, achieve tertiary qualifications and gain employment, he might be expected to earn more - $15,000 per year more than otherwise, even early in his career[141].

- If treatment could avoid reliance on a benefit, particularly at a young age, it could save up to $250,000 in lifetime benefit costs[142].

9.5   What investment yields the greatest value for money

The UK's National Audit Office (NAO) summarises the value for money of investment in services as '*about spending less (economy); spending well (efficiency); and spending wisely (effectiveness)*'[143]*,* a fourth "E" of **e**quity is often considered.

In youth primary mental health:

- Economy is achieved through minimising spending by matching patients with interventions of the intensity they need, including low-cost, low-intensity services.

- An efficient primary mental health system reaches and treats patients in a cost-effective manner. Using a range of service delivery settings helps reach youth in settings that are relevant to them and helps deliver treatment that is the best match to their needs. In addition, a range of service delivery settings is more likely to reach different types of youth, therefore improving equity in access to services to support youth wellbeing and mental health.

- An effective YPMHS will improve the mental health and wellbeing of young people by treating their mild to moderate mental health conditions.

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[140] Ministry of Justice and Ministry of Social Development. (2002, April). *The Youth Offending Strategy*. https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/archive/2002-youth-strategy.pdf

[141] Note that this example is illustrative and based on median reported incomes.

[142] Ministry of Social Development. (2012). *Investment approach refocuses entire welfare system*. http://www.msd.govt.nz/about-msd-and-our-work/newsroom/media-releases/2012/valuation-report.html

[143] Briefing Note Indicators and VFM in Governance Programming July 2011 p 12-13.

Pursuing objectives of the YPMHS to provide increased access for all young persons who require mental health interventions is consistent with wise public investment. Some young people in need of mental health services will be facing multiple risk factors (including poor mental health) and be at higher risk for negative short and longer term outcomes. It makes sense to support these youth and help improve their outcomes in health, education and employment.

10. Conclusions and recommendations

Key messages

The YPMHS has contributed to improvements in the quality, safety and experience of primary youth mental health services through:

- Enhanced youth-friendliness of general services and development of youth-specific services
- Workforce upskilling and co-location of youth-specific services with primary healthcare providers
- New and innovative ways of supporting youth that are breaking down some of the access barriers.

The YPMHS funding is contributing to improved health and equity for New Zealand youth because Māori youth are accessing services at higher rates than Pākeha.

There are opportunities to continue the development of primary mental health services by:

- Continuing to reduce access barriers for youth seeking help, for example the stigma attached to mental health issues
- Improving access for Māori and Pacific youth and young males
- Increasing the capacity of services to see youth, especially youth-specific services
- Improving the effectiveness of the services by sharing information about what works
- Supporting innovation to contribute to the development of efficient and cohesive services
- Developing the youth workforce including continuing to develop the youth worker role and co-located primary and specialist youth services.

The extent conclusions can be drawn about whether the YPMHS has demonstrated the best value for public health system resources is limited by a lack of consistent measures of outcomes for youth using the services.

The key elements of a healthcare system that are important to consider in developing an economical, efficient and effective system to support youth health and wellbeing are summarised in Figure 21 based on information from the evaluation. Many aspects of the system are in place, although not necessarily in each district.

Positive feedback loop

A range of services for youth	More youth access services	Youth are matched to the 'right' services	Youth receive the 'right' intervention	The system is more efficient	Long-term benefits and reduced costs
Multiple avenues for primary youth mental health services	Services are youth-friendly	Youth general services	Support	Reduced overtreatment	Education
	More equitable access	Non-clinical services	Extended consultations	Improved mental health	Employment
	Youth identified earlier	General practice services	Brief intervention counselling	Improved outcomes	Health services
		Youth-specific medical services	Individual packages of care		Social welfare
		Specialist services	Group therapy		Criminal justice
					Other social outcomes

If demand exceeds supply of treatment, some youth are more likely to miss out. There are different costs associated with reaching youth in different settings.

Remove barriers to access.

There are different costs of providing different interventions in different service delivery models.

Effective referral pathways and links between services.

A more efficient system achieves better results and/or lower costs.

Helping even a few youth avoid long-term negative outcomes and achieve positive outcomes provides individual and social benefits.

Figure 21: An overview of the key elements of an effective healthcare system to support youth

A range of services for youth

There are a range of different services in many but not all districts. Particular challenges are locating youth-specific services where they are most needed, developing services for young males, and for Māori and Pacific youth.

It is more feasible to provide multiple service options for youth in localities where youth are clustered and they represent higher proportions of the population. In these cases, it may make sense to focus on efficiently reaching and linking youth to youth service providers. However, when high risk youth are in rural or isolated areas, there tend to be fewer service options available, and start-up costs and human resource requirements are barriers to innovation. In these cases, it may make sense to focus on better utilising existing primary care infrastructure to reach and treat youth with mental health issues.

GPs are the most frequently seen health professionals and general practices are the only source of primary care in some settings. However, not all general practices will prioritise youth-friendly services and not all youth will want to go to a general practice. There are barriers both to GPs providing primary youth mental health care (for example, knowledge, awareness, time limitations and compensation) and to youth accessing care through general practices (for example, cost, confidentiality, access and not considering general practice as a place to go). Professional development of the general practice teams and adopting new ways to provide

services through practice nurses, nurse practitioners and co-located youth specialist roles can build on the existing general practice infrastructure to address these barriers and improve access for youth.

Youth-specific services are an effective service model but they need to be where youth can easily get to them. Different approaches to youth-specific services are in place across different DHBs. Outreach services are particularly important in rural areas.

The non-clinical workforce (social workers and youth workers) plays an important role in resilience building, early identification, and supporting youth as they engage with specialist services.

More youth access services

The YPMHS has improved access to primary care services for youth and increased capacity. However, providers report unmet need for mental health services for young people, suggesting further increases in capacity are required in some areas and in some services. Youth-specific services in particular report times when they are at capacity and cannot see more youth.

Youth are matched to the right services

Matching youth with the most appropriate and accessible services can reduce pressure, waiting times, and potential over-treatment in other service areas. Achieving this requires providers to be aware of the range of services available in their areas. DHBs have used YPMHS funding for mental health co-ordinators and single point of entry services to increase awareness.

Effective referral pathways require both appropriate referrals and sufficient capacity at specialist providers to accept referrals and treat youth in a timely manner. Improving primary provider skills and confidence in managing youth in primary care will relieve some pressure on secondary services. DHBs are doing this by providing further training for primary providers, access to specialists for advice e.g. youth clinical specialist co-ordination roles, and co-location of youth psychologists in primary care services.

The YPMHS funding provided some districts with opportunities for innovation in service delivery. In others development of services through the YPMHS was limited where:

- Youth were not as high a priority as other population groups
- The amount of YPMHS money was considered to be insufficient to set up new sustainable services or for the DHB to find a provider willing to develop a new service
- There was a lack of leadership and strategic planning around youth primary mental health services.

Youth receive the right intervention

Receiving the 'right' intervention requires providers to be confident in assessing and able to access the type of intervention with the most potential to benefit youth.

Practical issues such as the realities of a crowded general practice waiting room and lack of flexibility limit extended consultations. Extended consultations with a practice nurse were not commonly reported, although in some practices youth nurse practitioners were effective in reaching youth. PHO youth mental health co-ordinators had an important role in providing brief interventions or linking youth with counselling either provided within the PHO or by an external counsellor.

The interface between primary and secondary services was often described as difficult. Primary providers who lacked confidence may refer youth who could be managed in primary care to secondary services. Some specialist providers did not support the management of some youth in primary care settings. New roles such as youth clinical specialists and youth psychologists located in schools and primary care settings are bridging the gap between primary and secondary services and upskilling primary care providers. Continuing to improve integration between primary care and specialist services will help to ensure 'every door is the right door' and the stepped care model works efficiently[144].

The system is more efficient

Efficiency is premised on the stepped care model where the intensity of services is matched to the level of need. Matching youth to the correct 'step' means the most effective, yet least resource intensive, treatment is delivered first. Much of the evidence from the literature is about treatments such as CBT and medication, rather than low cost, low intensity services. However, there is evidence that some youth benefit from these other models of care, reducing the need for higher intensity and higher cost services.

Long-term benefits and reduced costs

Steps toward long-term benefits are being observed. Increased attention on short-term outcomes is essential to provide further evidence about whether value for money is being achieved and about where to invest the YPMHS dollars.

Deciding how to prioritise investment in smaller numbers of high risk groups versus larger numbers of youth at lower risk is a challenge for funders. Analysis of New Zealand's Integrated Administrative Data has demonstrated that in general, geographic location is strongly associated with risk of poor outcomes. Locations and location-based measures such as the New Zealand Deprivation Index (NZDep) and

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[144] Ministry of Health. (2014). Transition Planning Guidelines for Infant, Child and Adolescent Mental Health/Alcohol and Other Drugs Services. Wellington: Ministry of Health.

territorial authority area are important predictors of risk, even controlling for other observed characteristics. Youth at risk of poor outcomes tend to be concentrated in specific areas such as the Far North, Kawerau, Opotiki and Wairoa. However, it is important to note that the largest numbers of at-risk youth still live in larger urban centres such as Manukau, Waitakere, Hamilton and Christchurch[145].Helping to divert even a small proportion from negative outcomes with significant financial cost can result in long-term financial returns.

10.1   Recommendations

Recommendation 1: Continue to develop the YPMHS because it has increased awareness of youth mental health, improved access to primary mental health and is improving outcomes for youth (largely based on qualitative data).

The YPMHS funding has contributed to improved health and equity for New Zealand youth because:

- Between 3,300 and 4,200 youth are accessing primary care services each quarter
- Māori youth are accessing services at higher rates than Pākeha
- New and innovative ways of supporting youth are breaking down some of the access barriers.

However, there is more to do to. Feedback from providers suggests an ongoing need for the YPMHS and for further development to:

- Further remove stigma and access barriers for youth seeking help
- Further improve access for Māori and Pacific youth and young males
- Increase the capacity of services to see youth, especially youth-specific services
- Improve the effectiveness of the services provided by sharing information about what works and supporting innovation to contribute to the development of efficient and cohesive services
- Support and develop the youth workforce and continue to develop the youth worker role and co-located primary and specialist youth services.

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[145] McLeod, K., R. Templeton, C. Ball, S. Tumen, S. Crichton & S. Dixon. (2015, December). *Analytical Paper 15/02 Using Integrated Administrative Data to Identify Youth Who are at Risk of Poor Outcomes as Adults*. http://www.treasury.govt.nz/publications/research-policy/ap/2015/15-02/ap15-02.pdf

Recommendation 2: Develop a consistent way of measuring the effectiveness of different service models and interventions in improving youth mental health and wellbeing

More information about what works would help inform decisions about the costs and effectiveness of different primary mental health systems and services for youth. Potential next steps are reviewing the data collected by the Ministry of Health and adopting a simple outcomes measurement tool. An ideal tool would link to an established outcomes measurement system, align with specialist service outcomes, provide consistent outcomes across providers, and could be set up in patient management systems or work as 'stand-alone' modules in software such as Excel.

Recommendation 3: Provide funding for innovation

The evaluation of the youth primary mental health service has identified many examples of innovation in new ways of reaching youth who need support. Many traditional ways of providing primary care services could become more accessible for youth with an increased focus on youth-friendly services and new service models such as co-located and integrated services. Service efficiency could be improved through better linkages between providers.

Enhancing the efficiency and effectiveness of youth services could be achieved through:

- **Sharing information between districts about what works at the system level and for providers.** Although there are differences in the youth population context between districts, there are common elements in youth primary mental health services that could be shared across districts. For example, the costs and benefits of different youth primary mental health services, what to think about when developing services especially integrated and/or co-located services, how to reach Māori and Pacific youth and other vulnerable groups, and how to measure outcomes. Sharing information about what works is likely to help districts develop innovative ways of supporting youth.

- **Funding for innovation** by setting appropriate expectations and acknowledging the costs of developing new and innovative approaches to bring together an effective youth primary mental health service. Criteria for funding youth primary mental health services might include requirements for:
    o A lead agency that can demonstrate strong links with other stakeholders in the locality
    o An appropriate infrastructure, governance and management
    o Youth participation in leadership and service development

o   A plan that is innovative and a justification for any additional funding required

o   A commitment to adopting an outcomes framework (aligned with the National Population Outcomes Framework currently being developed by the Ministry of Health) and a tool for measuring expected outcomes and to evaluating the pilot.

Establishing an effective youth primary mental health service takes time to develop governance, design systems and services, build relationships with local providers and promote the service. Some districts may need additional funding to take a system-wide approach and fill existing gaps in their youth services. An approach that has been successfully used is to establish a contestable pool of money for innovation.

Recommendation 3: Invest in the development of the youth primary mental health workforce

- The findings from this evaluation support the following recommendations from the report on New Zealand's youth health workforce[146]:

  o   The workforce for youth should be trained so it is competent – including undergraduate youth-specific training for doctors and nurses and specific career paths and recognition for those who wish to specialise in youth health

  o   Future clinical leaders and researchers should be developed to support the workforce and inform service development.

- NGO providers included in the YPMHS evaluation identified the importance of secure funding as a foundation for workforce retention and development. As good information becomes available about what systems work to support youth, approaches to contracting NGOs could be reviewed to:

  o   Enable workforce development and security

  o   Encourage innovation, for example, high-trust contracts use simple but effective contracting processes to support and capitalise on the strengths and benefits of high trust relationships. They provide upfront funding, minimise reporting requirements and allow flexibility because they focus on reporting agreed outcomes rather than processes.

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[146] Kerkus M et al (2011). Report of the youth health workforce service review. https://www.health.govt.nz/system/files/documents/pages/youth-health-workforce-service-review.pdf

11.   Appendix 1: Logic model

Ultimate outcomes

Increased knowledge of 'what works' for youth primary mental health	Better access to timely and appropriate treatment and follow up for youth with mild to moderate mental health issues
	Early identification of mild to moderate mental health issues in youth
	More supportive health services, schools and communities
	Better access to appropriate information

Increased resilience among youth to support mental health

Intermediate outcomes

Reductions in the number of youth requiring secondary care or crisis responses	Reach to target groups increases
	Interventions are effective for youth
	Schools, health and social services provide integrated care and referral pathways are clear
	Improved feedback and communication enhances care for youth

More youth use services

Recommend services and resources to other youth

Outputs

Optimal type and mix of services for each DHB are available to meet local need. Integrated primary and secondary services

Make referrals and work with other providers

Innovative service solutions to meet local needs e.g. integrated service delivery such as youth clinics or youth one-stop-shops

Can access youth friendly services (stigma, cost, travel and opening hours are not barriers)

The workforce is in place to support primary youth mental health care

Existing services modified: opening hours extended youth friendly staff and environment created

Know who to refer to and trust local

Staff know how to identify risk

Recognise when youth need extra support

Activities

Contracts and allocation of funding

NGOs provide primary and specialist services for youth mental health

Stepped care matched to service user need: extended consultations, brief interventions, individual packages of care, group therapy

Schools adopt practices that remove the stigma associated with mental health

Adapt and develop services

Develop a youth mental health care strategy

Development of new youth specific services, programmes orapproaches

School based health services established/ reviewed/ expanded

Governance groups / youth SLAT with representation from health and social sectors and youth

Existing services reviewed and modified to better meet the needs of youth, especially Maori and Pacific

Inputs

Needs assessment and strategic planning

Identify what is needed to make services more accessible and youth friendly

Representation on planning /advisory groups

New funding for 12-19 yrs

Representation on planning/ advisory groups

Reallocated funding

Staff training on youth mental health and identifying risk

Existing funding

Review how well services reach youth

DHBs	NGOs	PHOs	School based primary care	Youth and their families/whānau
			Schools	

Specialist health services for youth   Primary health services for youth

12. Appendix 2: Details of evaluation methods

12.1 Interviews

Interviews were completed in three stages as outlined in Section 3. Initial interviews with portfolio managers were completed by the project manager. Subsequently an evaluation team member was allocated responsibility for a district and completed the remaining interviews in that district. Using this approach, an evaluator gained an in-depth perspective on each district.

Qualitative data from interviews and comments (in response to open-ended questions in the consultation form) were analysed to:

- Identify key themes: Thematic analysis highlighted where similar evidence appeared across groups of individuals. Thematic analysis identified common or similar views, experiences or perceived results.

- Describe particular issues: Descriptive analysis complements thematic analysis. It highlights all evidence pertaining to a particular issue. For example it may be helpful to describe all of the different perceptions of access for different stakeholder groups. It may be that some perceptions, even if not common enough to be themes, provide useful information.

Analysis was completed within each DHB and then the similarities and differences between DHBs were examined by evaluators in a workshop setting.

The number of interviews completed at each DHB and the stakeholder groups interviewed are summarised below.

District	DHB staff	PHO	Site Visit	Stakeholders	Total Interviews	Provider survey response
Northland	1 + 1	3	Yes	In-depth examples: Examples of co-location: Adolescent clinical specialist x 1 Bream Bay Trust – co-located specialist x 3; Te Ora Hou – The Pulse x 2; Whangarei Youth Space (YOSS) x 2; GP FG x 1; Teen parent unit x 1; Other: Youth alt-ed group Focus Group x1 Other: Adolescent health clinics near schools x 1	17	26
Waitematā	1 + 1	-	Yes	In-depth examples: HealthWest - Your Choice x 3 Other: Marinoto West x 1; MOE x 1	7	9
Auckland	1	YSLAT Programme Manager x 1 YSLAT PHO members x 3	Yes	In-depth examples: Enhanced School Based Health Service x 4; Other: Deputy Principal of profile school x 1; Pastoral Care Team of profile school x 1 (Focus Group = 10)	11	17
Counties Manukau	3 + 1	5 x Mental Health Coordinators	No	No example; Other: NGO x 1; MYD x 1	11	22
Waikato	1	3	Yes	In-depth examples: Youth Alcohol and Other Drug Model of Care x 1	5	8

Bay of Plenty	1 + 1	3	Yes	In-depth examples: Emerge Whakatāne x 2 + Focus Group x 1 (=5); Kaupapa Māori service: Te Manu Toroa – Oncore Drop In Clinic x 6; Tuwharetoa Ki Kawerau youth primary health service in Kawerau x 1 + Focus Group x 1 (= 4). Other: Social Sector Trial x 2; Te Puna Hauora (NGO) x 1	19	10
Tairāwhiti	1	2	No	In-depth examples: GP clinic in Schools Other: Youth Mental Health Coordinator; CAMHS x 1; Public health nursing x 1	2	16
Lakes	1+1	-	Yes	In-depth examples: REAL (NGO) x 2; Anamata CAFE (YOSS) x 4; Anamata CAFE Youth x 3 (focus group = 3); Youth psychologist x 1 Other: Public health nursing x 1; Rotovegas (YOSS - GP) x 1; CAMHS x 1	15	16
Hawke's Bay	1	1	Yes	In-depth examples: FlaxAID - a free smartphone application x 1 Other: Te Taiwhenua o Heretaunga x 1; Directions (YOSS) x 1	5	5
Taranaki	1	2	Yes	In-depth examples: Sweet Youth Group Therapy x 5 Other: DHB evaluator x 1; Social Sector Trial x 1; Principal x 1	11	2
Whanganui	1	1	No	In-depth examples: Youth Services Trust (YOSS) x 1; Male Māori mental health worker; focus Group x 1 (=4) Other: CAMHS x 1; SUPP x 1	6	13

MidCentral	1 + 1	1	No	In-depth examples: CACTUS programme x 1; Youth Wellness Advisory Group x 1; Other: GP x 1; Iwi Provider x 1; Mana o te Tangata x 1 ; YOSS Palmerston North (YOSS) x 1; Tararua College Staff x 1 Youth x 1	10	20
Wairarapa	1	2	Yes	In-depth examples: Youth Counselling: To Be Heard x 2 + GP Focus Group x 1 (= 5) Other: Social Sector Trial x 1; Youth Kinex x 1	8	14
Capital and Coast and Hutt Valley	1	- 1	Yes	In-depth examples: Wellington Emergency Department triage model x 3; Vibe (YOSS) x 2; Evolve (YOSS) x 1; Kāpiti Youth Support (YOSS) x 5	13	15
Nelson Marlborough	1	2	Yes	In-depth examples: Single point of entry Other: GP x 1; Youth service provider x1; GP clinics in schools x1	6	19
West Coast	1 + 4	1	No	In-depth examples: Youth Secret Shopper; PHO x 1 Other: NGO x 2	9	16
Canterbury	1 + 1	4	Yes	In-depth examples: YOSS 298 x 2; GP Practice - Example Focus Group x 1 (= 6) Other: NGO x 1; Consultant x 1	11	46
South Canterbury	1 + 1		No	In-depth examples: Adventure Development Counselling x 4; Focus Group x 1 (= 12); Arowhenua x 1 Other: NGO x 1	9	5

Southern District	1 + 3	3	Yes	In-depth examples: Brief Intervention Coordinator (PHO); YOSS – Number 10 x 1 Other: Public health nurse x 1; CYS x 1; NGO x 3; PHM x 1	14	29

12.2 In-depth profiles

Examples of youth mental health services were selected across the districts to provide examples of:

- Innovation
- Services that are working well
- Other mainstream services to profile typical examples of youth service provision

A mixed methods approach was used to collect data for the case studies including:

- Review of evaluations of the service
- In-depth interviews with provider organisations including general practices, NGOs, YOSS
- In-depth interviews with other stakeholders involved in the example initiative
- Analysis of any outcomes data available.

12.3 Survey of providers

The survey was distributed as an 'open-link' survey where answers are confidential but a specific email address is not required. The survey was distributed by DHBs and PHOs to their email lists. Information about the survey and a link to the survey was included in the November GP immunisation fax to all practices.