Improving youth mental health:
What has worked, what else could be done

SUMMARY OF FINDINGS FROM THE PHASE 2 EVALUATION OF THE PRIME MINISTER'S YOUTH MENTAL HEALTH PROJECT

MAY 2017

Adolescence can be a period of high vulnerability for young people. To support their resilience and wellbeing, the Prime Minister's Youth Mental Health Project (YMHP) was launched in 2012 as a package of initiatives to complement existing services. Focus was placed on youth aged 12 to 19 with, or at risk of developing, mild to moderate mental health issues.

This research summary presents insights from the evaluation which reports on the progress, achievements and effectiveness of the YMHP to June 2016. It focuses on what we can learn from this assessment of the YMHP: What has worked to improve youth mental health and where could further efforts be directed?

Along with high-level findings, we flag potential ways to improve services and overcome barriers that were experienced by youth and providers involved in the YMHP.

This overview will have implications for a wide range of stakeholders, including policymakers; education, health and social service providers; workforce and professional bodies as well as programme funders and developers.

See page 14 for more information on the YMHP evaluations and reports.

The YMHP has been effective...

- More youth mental health services were made available to youth in places where they live, study, work and play
- YMHP has been a worthwhile financial investment, returning social and economic benefits as well as potential gains in quality of life
- More youth were identified, supported and treated for mental health concerns – early identification and support activities were found to be particularly effective

...but there are key areas to look at for making a bigger impact on youth wellbeing:

- Improving connectedness and integration at local service delivery level
- Encouraging more youth-friendly and co-located services, particularly in schools
- Sorting out bottlenecks at the points of transition for youth referred to other services
- Expanding YMHP initiatives to all youth aged 12-19, given that everyone in this group is potentially vulnerable to mental health issues
- Targeting specific youth populations that could be better served, including youth in Canterbury, youth identifying as lesbian, gay, bisexual, transgender or inter-sex (LGBTI), youth with disabilities, youth experiencing unexpected transitions or potentially traumatic events, and youth not in school, particularly those not in employment, education or training (NEET)
- Further promoting existing resources and support services to youth, their families, whānau and communities
- Addressing ongoing stigma around mental health

More youth mental health services were made available to youth in places where they live, study, work and play

As outlined below, the 26 YMHP initiatives took a range of forms, variously focusing on prevention (promotion of wellbeing), support and treatment, with some targeting specific sub-groups.

Falling into five system 'components' or focus areas, these initiatives expanded or improved existing services, provided new services and piloted services used overseas. Reviews of systems and processes were also conducted.

An overarching youth engagement initiative saw youth involved in the design and/or development of most YMHP initiatives through participation in surveys, focus groups, interviews and decision-making panels.

Initiatives were adopted at different stages over the four-year period (2012-2016) and in different settings, with implementation also varying in quality and from one place to another.

What was implemented and where?

Health services – including primary care (general practice doctors, "GPs", and nurses)

Schools

Communities

Online

FOCUS AREA #1: Better access to timely treatment and follow-up

Expanded primary mental health services for youth nationwide – since 2013/14, about 13,000 youth per year have been assessed, treated and/or managed for mental health issues in primary care settings

Refined and implemented SPARX, an e-therapy tool – specifically designed for adolescents with mild to moderate depression and/or anxiety – by December 2015, about 400 youth (of the 4,100 registered) had completed enough SPARX modules for some to have experienced a positive change in their mental health

Improved access to and follow-up from Child and Adolescent Mental Health Services (CAMHS) & Alcohol and Other Drugs (AOD) – waiting times reduced for youth referred for initial assessment, with 990 extra youth accessing CAMHS/AOD services by December 2015; 16 District Health Boards (DHBs) strengthened planning and follow-up care for youth discharged from these services

Set up a school-based mental health team following the Canterbury earthquakes – 102 primary and secondary schools engaged with this team which worked with students, parents, teachers, and pastoral care staff from mid-2013

FOCUS AREA #2: Early identification of mild to moderate mental health issues

Extended School-Based Health Services (SBHS) to 44 decile 3 schools and maintained SBHS in decile 1-2 schools, with about 110,000 student visits to SBHS in 2015/16

Developed an online training course for health professionals for the wellness assessment tool HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety) – a series of workshops was also run across the country to train health care professionals who used the tool in communities as well as in schools where over 9,000 assessments of Year 9 students were completed in 2015/16

Developed the MH101 training programme to help frontline service staff and others recognise signs and respond when youth present with mental health issues – training was initially provided to 246 frontline Child, Youth and Family staff, with other agencies then picking it up

Used a one-off funding boost for 12 Youth One Stop Shops (YOSS) to support training, staff availability, youth advisory groups and existing programmes in 2012; agencies worked together to support YOSS sustainability through ongoing funding to 2018

Expanded primary care responsiveness to youth through new governance and management groups known as Youth Service Level Alliance Teams (or equivalents) set up in 19 DHBs to coordinate service provision and funding based on local needs and priorities

Piloted a whānau-centred approach to youth mental health, two providers worked with 40 youth and their whānau/aiga over a two-year period

FOCUS AREA #3: More supportive schools

Rolled out the Positive Behaviour for Learning (PB4L) School-Wide programme promoting student resilience and wellbeing to low-decile schools with high Māori and Pacific populations and larger schools – an early evaluation indicates improved school cultures and more inclusive school environments

Piloted PB4L My FRIENDS Youth, a cognitive behavioural therapy programme, with about 14,000 Year 9 students in 26 schools over a two-year period – students reported changes in how they managed their own feelings as well as thinking about the feelings of others

Piloted the Youth Workers in Low-Decile Secondary Schools (YWiSS) initiative which expanded on other support service models to include a focus on youth with mental health issues. In 18 of the 20 schools, these youth workers delivered the **PB4L Check & Connect** mentoring programme to work with disengaged or at-risk youth for a two-year period – students reported improved self-management and better school results

FOCUS AREA #4: Better access to appropriate information

Creative ventures were established under the Social Media Innovation Fund, with over 500 youth participating in Lifehack workshops and other events to develop mobile device applications (apps) and other innovative tools to support youth wellbeing

Improved the youth friendliness of mental health resources, with guidelines completed and shared with the wider youth mental health sector

Established the Common Ground hub to provide information for parents, families and friends through various channels (a website, free phone line, social media, links to relevant services, ability to order printed resources) – by early 2016, more than 28,000 people had accessed the website

Published guidance for anyone wanting to support youth with stress, anxiety and/or depression

FOCUS AREA #5: Improved knowledge of what works to strengthen systems and processes

Review of wellbeing in schools – the Education Review Office (ERO) developed wellbeing indicators against which it evaluated 68 schools; ERO then produced effective practice guidelines to support primary and secondary schools to improve their students' wellbeing

A review on improving the school guidance system was completed by ERO, and the Ministry of Education is implementing work in response to the findings

Alcohol and Other Drugs (AOD) education programmes were reviewed and a guide for schools on programme selection was published

Other reviews looked at **youth referrals pathways** and **co-locating additional social services in schools** – implementation of recommendations is ongoing

For more information on the initiatives, see the full reports at **superu.govt.nz/ymh**

$1–$1.60
worth of social benefits for every $1 spent

$21,000–$30,000
– the gross economic benefit for every young person no longer having mild to moderate mental health issues

Early identification and support initiatives
delivered the greatest economic value

For every $1 million spent, YMHP will generate **31–35 extra years of life** free from mental health issues

Overall YMHP has been a worthwhile financial investment, returning social and economic benefits as well as gains in quality of life

Between 2012 and 2016, government allocated a total of $64 million to the YMHP. PwC's economic evaluation of the YMHP tells us that this has generally been money well spent.

$1–$1.60 worth of social benefits for every $1 spent – this is considered a **positive return on investment**, with the estimated value of the benefits to youth, society and government over 10 years **outweighing the shorter-term costs** of providing YMHP.[1]

$21,000–$30,000 – the gross economic benefit for every young person no longer having mild to moderate mental health issues. These dollar amounts partly reflect **savings to government** in healthcare and welfare costs.

These figures provide a **benchmark for future investment decisions:** initiatives that cost more per youth may not be worth it in dollar terms, although there can be **compelling non-financial reasons to invest** in initiatives that are unlikely to show economic benefit.

Following the Canterbury earthquakes, for example, the New Zealand government supported those who were negatively impacted, regardless of any potential economic benefit or loss linked with the cost involved.

Early identification and support initiatives (focus area #2) delivered the **greatest economic value**. The School-Based Health Services, HEEADSSS wellness checks and Youth One Stop Shop initiatives achieved wide overall coverage and moderate impact for moderate cost.

The **other focus areas remain vital** – for the youth mental health system to work well as a whole, it still needs supportive schools; timely treatment and follow-up; better access to appropriate information; and strengthened systems and processes.

1,300 healthy life years gained
Greater quality of life: for every $1 million spent, YMHP will generate 31–35 extra years of life free from mental health issues – these 'disability-adjusted life years' (DALYS) are a unit of measurement commonly used in the health sector to assess the value and impact of its programmes and other interventions.

Given the long-term nature of outcomes from YMHP, PwC calculated the benefits over a 10-year timeframe. For more detail, see PwC's full cost-benefit analysis report at superu.govt.nz/ymh

1 This result was based on the 10 initiatives able to be quantitatively assessed in 2016, representing 74% of the total YMHP funding.

More youth were identified, supported and treated for mental health issues

More than **180,000 youth** have been reached by the various YMHP initiatives.

As a result, PwC estimated that **1,800 youth** will have long-term improvements in their mental health or wellbeing over a 10-year period.

PwC also found that medium- to long-term outcomes associated with improved youth mental health, and contributions by YMHP initiatives, include:

- Higher overall life satisfaction
- Greater educational gains at secondary school
- Increased employment
- Better income

- Fewer clinically diagnosed mental health conditions
- Reduction in youth suicides
- Less alcohol and substance abuse, including smoking
- Fewer youth receiving welfare benefits
- Reduced bullying at school

Schools are crucial environments for promoting and supporting youth wellbeing, but they varied in how well they did this

11 out of 68 schools were found by ERO to be well-placed to promote and respond to student wellbeing

Differences between schools in terms of student wellbeing and support were also reported in interviews and surveys carried out as part of the evaluation. This case study-based work looked closely at YMHP implementation in six areas: Northland, West Auckland, Hawke's Bay, Lower Hutt, East Christchurch and Invercargill (see Malatest's *Localities and national perspectives* report at superu.govt.nz/ymh)

An online survey was completed by more than 3,000 secondary students in the six study areas.[2] The results provide useful information on what can stress or support student wellbeing, including the following:

'Risk factors' or 'stressors'

On average, 12% of surveyed students had experienced **moderate to severe bullying** and 32% felt **unsafe at school**

In the best case, only 4% of students were affected by bullying and 89% felt safe at school. In one school, however, bullying affected about one-quarter of students and more than half of students felt unsafe.

Across schools, **social media bullying** was identified as a particular problem

On average, 28% of students had experienced 3 **or more traumatic events**

Self-harming was reported by 20% of students

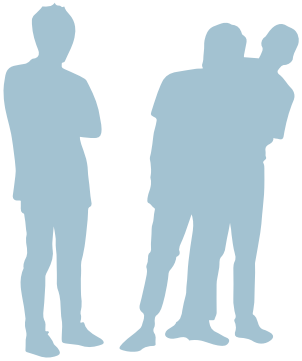
'Protective factors'

On average, 74% of surveyed students reported a **positive sense of belonging** at school, but this varied from 50% to 88% across schools

Positive student-teacher relations were found for 75% of students on average, with results for individual schools ranging from 61% to 89%. An average of 75% of students also reported having a **positive learning climate**

59% of surveyed students reported having **good family support** (e.g. parents or other family members showing interest in how they were going with school work and getting along with other students)

Superu is carrying out more in-depth analysis of this survey data and will report on it in 2017.



2 Survey respondents were from schools that agreed to participate in the evaluation. Because of this, for comparison of localities, deciles, or individual schools, the results can be treated as indicative only. That said, the youth surveyed were both broadly representative of all schools in a given locality in terms of school year group, gender and ethnicity.

- YMHP was effective in targeting decile 1–3 schools to reach more vulnerable groups, including Māori and Pacific youth
- But *all* youth are potentially vulnerable to mental health issues, regardless of their school decile or location
- Focusing YMHP on school decile meant that some students missed out, and other groups were also less well served

Students in **middle decile schools (4–7)** were found to be at greater **risk of 'falling through the cracks'** as these schools could not access most YMHP initiatives and parents could not always pay for services privately.

Overall, Māori and Pacific youth seemed reasonably well served by YMHP. However the evaluation found that more work is needed to determine the full value of targeting programme initiatives for these two groups, and to ensure they have access to culturally appropriate and/or mainstream youth mental health services, in line with their needs and preferences.

Despite having a YMHP initiative specifically for youth in Canterbury, the evaluation found they were still experiencing worse emotional health outcomes than youth elsewhere in New Zealand.

Other groups less well served by YMHP, regardless of school decile,[3] were:

- Youth identifying as lesbian, gay, bisexual, transgender or inter-sex (LGBTI)[4]
- Youth with disabilities
- Youth experiencing unexpected transitions or potentially traumatic events (e.g. death, divorce, violence, serious accident) that can lead or be related to mental health issues
- Youth not in school, particularly those not in employment, education or training (NEET).

The evaluation points to other barriers and potential solutions for improving how youth with mental health issues get support

Drawing on the findings of the YMHP evaluation, we can identify other potential areas for service improvements.

We base these on what we learned from the two groups at the heart of the YMHP initiatives: those who need help (youth) and those who provide help (providers). Looking at how each of these groups broadly experienced YMHP, we pull together what was hard and what could make things better or easier.

For each of the themes that follow, we present some problem areas ('barriers') and potential solutions ('enablers') for improving youth mental health, as indicated in the evaluation reports. Being interrelated, these themes naturally have some points of overlap.

Youth getting help

- Theme #1 – Asking for help
- Theme #2 – Accessing help

Providers giving help

- Theme #3 – Delivering help in primary care
- Theme #4 – Referring onwards for help

3 See Superu's *At a Glance* publication (2017) which discusses these groups in more detail.
4 We follow the overall Summative report in including youth identifying as inter-sex, although the survey part of the evaluation did not ask about these youth.

THEME #1

ASKING FOR HELP – youth being willing and feeling supported to reach out

Barriers

94% of surveyed youth said they had someone either inside or outside school to turn to if they were upset, but only 68% said they would ask **friends and/or family for help**

Stigma

- Most commonly, students were **worried about being judged** by their peers, or being bullied and talked about negatively
- **Embarrassment or shyness** was the second most commonly cited barrier:

  1 out of 3 surveyed students said it was **not socially acceptable** to see someone for guidance and counselling

Feeling 'exposed' – students' privacy was not always protected, discouraging their help-seeking

- In some cases, the **physical spaces** used for school guidance and counselling appointments were highly visible to others walking past, e.g. a waiting room with a lot of window glass
- Some processes also made it hard for students to make appointments without others knowing, e.g. different coloured absence slips for students leaving class to see the guidance counsellor

Potential solutions

- Increasing **focus on supportive youth-adult relationships**, particularly between youth and their parents or caregivers – this is known to be critical for **creating resilience** but was not a focus of YMHP
- Placing more emphasis on improving youth self-esteem, possibly by expanding Positive Behaviour for Learning School-Wide and the other piloted 'PB4L' programmes that can contribute to **safer and more supportive school environments**
- Working with the Ministry of Education, schools could do more to **promote the importance of student wellbeing** (which became part of standard ERO reviews in schools from 2016), e.g. by setting goals and approaches for student wellbeing and adopting good practices for school guidance and counselling as outlined by ERO
- Lifting the mental health 'literacy' (education and understanding) of youth and those who support them, as well as further raising awareness about **online and telephone resources** such as Common Ground, The Lowdown, Aunty Dee and the guidelines for supporting youth with stress, anxiety or depression
  - Having access to online or telephone services was found to be particularly important for youth who would not ask anyone for help inside or outside of school; youth who identify as LGBTI; and youth with disabilities

*"Some [youth] had been told to **'suck it up'** or **'be a man'**"*
(Summative/Localities report)

*I think part of it is **de-stigmatising mental health** and getting people to understand that mental health is like physical health, **everybody gets a cold every now and then, and people go up and down**. So it's about **making that more understood in the whole population**.*
– Agency perspective (Christchurch)

THEME #2

ACCESSING HELP – youth and their support networks knowing how and where to get help

Barriers

- **Not knowing where** to get help – despite the creation of more resources, some parents, teachers and health professionals **still didn't know what to do or how to help youth** with mental health issues
- Youth not having **access to community-based services** due to transport, cost, safety, school holiday closure and other hurdles

Potential solutions

- Better promoting existing information and services to increase awareness and use by youth as well as by their friends, family and whānau
- Supporting YMHP initiatives that **bring help to places where youth already are** and that provide the **'right services in the right ways'**:
  - having more low-cost or free **youth-friendly services**, such as drop-in centres and YOSS-branded clinics in schools and marae (see also the box on co-location)
  - continuing to support routine HEEADSSS wellness screening of all Year 9 students in schools with School-Based Health Services and extending use of this assessment tool to higher decile schools
  - clarifying, and if necessary simplifying, referral processes for health professionals to enable youth to get further help where needed

*There are probably enough services out there **but you don't know about them,** I didn't know about them. Like it's probably on the internet but I didn't know where I could go. **It's not like it's right there in your face or anything.***

– Youth not at school (Christchurch)

Co-location means having different services in one place – for youth, this can be handy and also less intimidating

For providers, this also makes sense – in one case study, a large well-connected community provider of multiple services had high visibility and was seen as part of the primary care network and not competing with other providers

Other examples include:

- Youth One Stop Shops offering general health care as well as social services and specialist youth mental health services on site, e.g. psychiatric registrars visiting from hospitals, short-term drug and alcohol counselling, packages of care
- Youth psychologists working in GP practices or in schools

THEME #3

DELIVERING HELP IN PRIMARY CARE – service providers knowing how, and being able, to support youth

Barriers

Overload – being stretched to capacity saw some providers not promoting their services, with related concerns of **inadequate resourcing** and **long-term sustainability**

Lack of confidence or comfort in treating youth with moderate mental health issues was a possible factor in potential 'over-referrals' to specialist services by school nurses or GPs

Some services appeared to be treating **youth as a 'problem to be managed'** despite the strengths-based approach intended for YMHP

Potential solutions

- Encouraging **more health professionals to train in and use HEEADSSS** wellness screening
- Providing **further workforce development for GPs, nurses** and the like to improve their skills and confidence in working with youth – this includes raising their awareness of SPARX e-therapy as a way of supporting youth who are on a waiting list or below the threshold for referral
- Continuing support for **School-Based Health Services** – there was significantly **less depression and suicide risk** among youth in schools where health professionals were:
  - **on school grounds**
  - providing 2.5 or more hours per week of nursing time per 100 students
  - **trained in youth health** and supported through professional peer review
  - integrated with the school and local community

Early identification of youth requiring support or treatment was facilitated by wellness screening in selected schools

BUT referring these students onwards was not always easy or efficient, with hold-ups at the transition point to treatment or other services

Disconnected and fragmented local service delivery also led to some gaps and overlaps as well as confusion about where to refer youth

THEME #4

REFERRING ONWARDS FOR HELP – specialist or other secondary services being available and known to referring schools and GPs

Barriers

Referrals can be **complex to complete, with unclear referral pathways and eligibility criteria** too – this meant schools and primary care providers sometimes relied on personal networks when they didn't know who to refer youth to

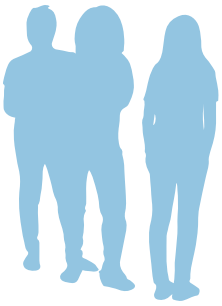
61% of surveyed health professionals saw **waiting times for referrals to specialists** as a major or substantial barrier for providing care, and more than half of respondents also reported **lack of suitable services**

'Communication breakdowns' following referrals: school- and community-based health professionals reported frustration with **not knowing what happened after referring a youth** to another service, including what (if any) treatment the youth was receiving

Potential solutions

- Supporting and strengthening local governance through the Youth Service Level Alliance Teams or their equivalent, especially by ensuring a **wide cross-sector representation**, i.e. including schools and regional-based government agencies as well as youth and community voices
- **Clarifying what causes delays and blockages** in the system is important for increasing connectedness and integration of local delivery
- Encouraging DHBs, schools, and other providers to come together to **share information** about what works, e.g. learning from what some DHBs are doing to address referral pathway issues such as funding mental health **coordinators and 'single point of entry' services**
- Working through **'communities of schools'** to **foster better links** and transitions between schools and community-based support services, e.g. stronger connections between general practices and SBHS

"Continuing to improve referral processes and integration between primary care and specialist or secondary services will help to ensure 'every door is the right door'"
(Summative)



The YMHP evaluation findings and recommendations were shared with key stakeholders, including the Ministries of Health, Social Development, and Education as well as Te Puni Kōkiri and the Education Review Office, for their consideration.

Based on this evidence and advice, government has decided to continue supporting YMHP work.

At a local level, frontline workers and organisations could use the information on barriers and potential solutions to inform what they do to support youth wellbeing, and how they might do it better.

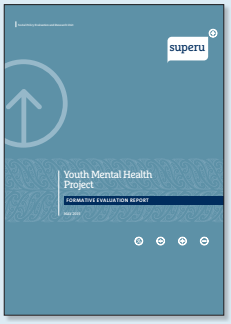
In December 2016 the Ministry of Health announced that government agencies would continue working to strengthen the reach and impact of YMHP. It also proposed that further investment be made in a number of the initiatives.

Superu's findings on what has and hasn't worked so well in the YMHP can also be used by those working in community and clinical settings as they seek to improve the ways they individually and collectively achieve the end goal – better mental health and wellbeing for young people.

ABOUT THE YMHP EVALUATION

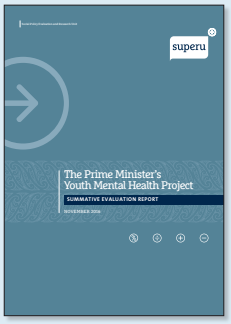
Managed by Superu, the strategic evaluation of the overall YMHP programme focused on its value as a complement to the existing youth mental health system.

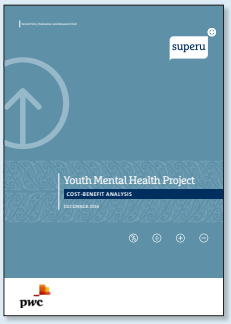
Phase 1 Formative Evaluation (May 2015)



The first phase of the YMHP evaluation looked at the design and early implementation of the initiatives as well as governance. The resulting report provided recommendations which subsequently informed agencies' work.

Phase 2 Summative Evaluation (December 2016)





The second phase assessment focuses on what the YMHP achieved to June 2016, with much of the data collected to the end of March 2016. As a progress report, it notes that many initiatives are *ongoing* and will affect more youth, adding to the potential benefits of YMHP. It also identifies some next steps and future research and evaluation activities.

The Phase 2 Summative Evaluation report, on which this research summary is based, synthesises the findings of two studies commissioned and published by Superu:

- A cost-benefit analysis undertaken by PwC
- A mixed methods evaluation by Malatest International providing locality and national perspectives from in-depth studies of YMHP in different parts of New Zealand

These studies were also supplemented by reviews and evaluations of individual initiatives, plus monitoring reports and other documentation.

A major constraint for evaluators was the overall lack of data which limited the ability to report on medium- and long-term outcomes in particular. Improving and simplifying the collection and reporting of data is one of the recommendations made in Superu's Summative report.

Other recommendations include reviewing the mix of initiatives available within and across the youth mental health system, taking into consideration:

- the strength of evidence that they work (and have valid outcomes)
- the balance between services that are
  - targeted and universal (for everyone)
  - for prevention (including promotion of wellbeing) versus treatment
- the possibility that other initiatives could be more effective than those that are currently funded.

See **superu.govt.nz/ymh** for all published reports on the full strategic evaluation.

About Superu

Superu is a government agency that focuses on what works to improve the lives of families, children and whānau.

What we do:

- We generate evidence that helps decision-makers understand complex social issues and what works to address them.
- We share evidence about what works with the people who make decisions on social services.
- We support decision-makers to use evidence to make better decisions to improve social outcomes.

We also provide independent assurance by:

- developing standards of evidence and good practice guidelines.
- supporting the use of evidence and good evaluation by others in the social sector.

Related Youth Mental Health Project publications:

- Formative evaluation report (May 2015)
- Localities and national perspectives evaluation report (December 2016)
- At a Glance: Spotlight on youth less well served by the existing programme (May 2017)
- Summative evaluation report (December 2016)
- Cost-benefit analysis (December 2016)

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