Social Policy Evaluation and Research Unit

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Youth Mental Health Project

FORMATIVE EVALUATION REPORT

MAY 2015

Our purpose

The purpose of the Social Policy Evaluation and Research Unit (Superu) is to increase the use of evidence by people across the social sector so that they can make better decisions – about funding, policies or services – to improve the lives of New Zealanders, New Zealand communities, families and whānau.

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Executive summary

The Youth Mental Health Project

Youth mental health is a complex issue and of significant concern to families, communities, policymakers and practitioners. In 2009 the Prime Minister requested a report from the Chief Science Advisor, Peter Gluckman, on how outcomes for young people in their transition from childhood to adulthood could be improved. Gluckman's 2011 report *Improving the Transition: Reducing social and psychological morbidity during adolescence* raised concerns about the relative high morbidity among young New Zealanders compared with other similar countries.

In 2012 the Prime Minister's Youth Mental Health Project (YMHP) was established as a response to the concerns about mental health vulnerability among young people. The YMHP is intended to promote the mental health and wellbeing of young people (aged 12-19 years) with, or at risk of developing, mild to moderate mental health issues.

The project consists of 26 initiatives designed to operate in a variety of settings in which young people live their lives, such as families, schools, communities, health services and online environments.

The YMHP is an example of government trialling different models of integration to provide services to those with complex needs and those who are hard to reach.

The four-year expected outcomes of the YMHP are:

- improved knowledge of what works to improve youth mental health
- increased resilience among youth
- more supportive schools, communities and health services
- better access to appropriate information for youth and their families/whānau
- early identification of mild to moderate mental health issues in youth
- better access to timely and appropriate treatment and follow-up.

Key points

- This report focuses largely on the governance, leadership and implementation of the YMHP.
- Overall, the YMHP initiatives are on track to deliver their intended outcomes and the YMHP has generally strong oversight and governance.
- The YMHP is a new way of working across government and a greater understanding of what is expected to change is required.
- There is a need for consistent metrics for measuring outcomes.
- Lessons are being drawn on what interventions work and how to evaluate complex systems for addressing complex problems.
- **Recommendations** for improvement include: establishing stronger monitoring, reporting and tracking of resources; and ensuring the adequate targeting of, and uptake by, vulnerable groups such as Māori and Pacific youth.

The evaluation

The Social Policy Evaluation and Research Unit (Superu) was contracted by the Ministry of Health to undertake a strategic evaluation of the overall YMHP to assess **whether, how well,** and **why** the YMHP is progressing towards its expected outcomes. The evaluation of the YMHP is a significant systems evaluation that will generate lessons about how to undertake evaluations on complex systems that have been set up to address complex problems at a population level.

This report presents the findings of the first phase of the evaluation, which has focused on understanding the extent to which the YMHP is a comprehensive and coherent programme, and how well it has been implemented.

This stage of the evaluation has been informed by:

- a research review to highlight protective factors and settings, and good-practice implementation (completed)
- an analysis of the evaluation and monitoring reports of the YMHP initiatives (which is an ongoing activity throughout the evaluation)
- a range of key informant and stakeholder interviews about the YMHP (which will be followed up at future points in the course of the evaluation)
- a value for money (VfM) analysis for selected YMHP initiatives.

Key findings

The YMHP is moderately comprehensive in its coverage and settings

To be considered comprehensive and coherent, YMHP initiatives need to be aligned to deliver YMHP outcomes and meet the needs of young people. The evaluation has found that the YMHP aims to support all the YMHP outcomes, to varying degrees. The nationwide distribution of the initiatives broadly reflects the distribution and concentrations of deprivation as measured by the New Zealand Deprivation Index.

The YMHP is comprised of initiatives that address the promotion, prevention and treatment continuum, recognising the multifaceted nature of youth mental health and the need to take an approach that is centred on and around the young person. It is moderately comprehensive in its coverage of settings in which young people congregate and access services. The family setting is less obviously targeted than school, health service, community and online environments. The project places a greater emphasis on prevention as opposed to promotion or treatment, which is in line with the taskforce research underpinning the intention of the programme.

Overall, the YMHP initiatives are on track to deliver their intended outcomes and there is good governance and project management of the project

The YMHP is governed by an interagency Steering Group led by the Ministry of Health. YMHP initiatives have generally been designed and set up well and the governance and reporting arrangements have been strong. A review of YMHP records provides some confidence that the YMHP initiatives are on track to deliver their intended benefits. There remain some implementation issues to be considered. This includes ensuring alignment and integration of the YMHP initiatives as a coherent programme that sufficiently meet the needs of the target population. In particular, it is not known whether the needs of Māori and Pacific youth are being met by this project and how this is intended to happen. This information will support decision making focused on enhancing the collective impact of the package.

The YMHP is a new way of working across government and a greater understanding of what is expected to change is required

The YMHP is a new way of working across government. It is an integrated planning and decision making model. To understand the value of this approach, the model needs to be clearly described ie how it works in practice to achieve specific outcomes. This work will enable the YMHP to establish measures for assessing how the project is working as a new model and whether it has impacts over and above what would be achieved from a series of stand-alone initiatives.

The YMHP has been designed to deliver value but there is a need for consistent metrics for measuring outcomes

The largest five initiatives, in terms of funding, were assessed for how they had been set up and whether they operated economically, efficiently, effectively and equitably. The analysis drew largely on qualitative judgements due to limitations in the data available, but a more robust analysis will be possible once issues of data availability and quality have been addressed. The analysis concluded that the YMHP initiatives had been designed and set up to deliver value, but that they had been set up quickly without consistent metrics for measuring individual initiative outcomes.

Lessons are being drawn on what interventions work and how to evaluate complex systems for addressing complex problems

The YMHP incorporates a range of approaches for promoting mental health among young people, operating in different settings and through different means. The results of the different initiatives will provide valuable lessons for future policies and practices. Further, the evaluation of the YMHP is also generating lessons about how to evaluate complex systems when a systems approach is sought for addressing population-based problems and issues.

Key recommendations

The following recommendations are made to the Steering Group and agencies implementing the YMHP:

Understanding programme expectations

We recommend the Steering Group review and revise its understanding of expectations from the YMHP so that there is a strong basis for understanding how the different initiatives collectively contribute to the overall YMHP outcomes – the added value of being a programme will then be fully understood. This work will help to describe the expectations the Steering Group have about how the initiatives work together as a package. It will build on developmental work done by the Department of Prime Minister and Cabinet (DPMC) on the high level intention of the project.

Monitoring mechanisms

We recommend that the YMHP agencies establish stronger monitoring and reporting mechanisms to measure progress towards achieving the expected outcomes, consistent with the project's expectations. These mechanisms should provide baseline data prior to the start of the YMHP as well as measures of the YMHP outcomes over four years.

Funding resources

We recommend that agencies provide more comprehensive information on the resources that are being used for the YMHP, how cost effectively the initiatives are being delivered, and where they should be targeted, ensuring adequate uptake and the appropriateness of settings and delivery channels. Superu will give the Steering Group guidance on the level of financial information needed in order to adequately inform these judgements.

Cultural appropriateness – meeting the needs of Māori and Pacific youth

We recommend that agencies place a greater emphasis on ensuring that the needs of Māori and Pacific youth are met. In particular we recommend that the project monitor whether the initiatives are adequately targeting, and being taken up by, vulnerable groups such as Māori and Pacific youth.

Contents

Figures

Tables

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01

Introduction

This report constitutes the first of two significant reports planned for the Youth Mental Health Project (YMHP) evaluation. It draws on the YMHP initiative plans, reports and other documentation, as well as interviews with selected officials from government agencies. It focuses largely on the design and implementation of the YMHP, providing early conclusions that will be tested further once additional research has been carried out. This report provides a snapshot of progress to date to support the further development of the programme.

The YMHP was established in 2012 and consists of 26 initiatives aimed at improving the mental health and wellbeing of young people with, or at risk of developing, mild to moderate mental health issues. The YMHP initiatives were started at different times and for different reasons and several have objectives beyond the outcomes established for the YMHP. The initiatives are designed to operate in a variety of school, family, community and online settings. The individual initiatives focus on one or more overarching goals, including: promoting wellbeing; targeting and supporting those most vulnerable; and treating those who need it. The YMHP is being implemented by four government agencies – the Ministry of Health, the Ministry of Social Development, the Ministry of Education[1] and Te Puni Kōkiri – over four years, with the expectation of demonstrating the following outcomes:

1. Improved knowledge of what works to improve youth mental health
2. Increased resilience among youth
3. More supportive schools, communities and health services
4. Better access to appropriate information for youth and their families and whānau
5. Early identification of mild to moderate mental health issues in youth
6. Better access to timely and appropriate treatment and follow-up.

The Social Policy Evaluation and Research Unit (Superu) was contracted to undertake a strategic evaluation of the overall YMHP to assess whether, how well and why the YMHP is progressing towards these outcomes. The scoping of the evaluation was started in March 2013, with an agreed evaluation plan finalised early in 2014. At that point no agreed baselines had been established for the YMHP against which to measure outcomes. The evaluation is designed to answer five key questions:

- To what extent is the YMHP a comprehensive and coherent programme? Are there any gaps in its coverage?
- How well is the YMHP being implemented?
- What is being achieved by the YMHP?
- Does the YMHP represent value for money (VfM)?
- What do YMHP results imply for future youth mental health policies and programmes?

The evaluation seeks to answer questions about governance, process and implementation, and outcomes for different groups of youth. Given the large number of initiatives (26) across a variety of settings, with varying monitoring and evaluation approaches in place, the evaluation is using a range of methods and data sources. These include:

- a research review to highlight protective factors and settings, and good-practice implementation
- an analysis of the evaluation and monitoring data and reports of the individual initiatives
- a range of key informant interviews
- a VfM and/or social-return-on-investment analysis.

See Appendix 1 for more information on the full evaluation design and methodology, including the school-based survey and case studies.

The YMHP is a **new way** of working across government.

The YMHP is a new way of working across government. It is an integrated planning and decision making model. The evaluation of the YMHP is also generating lessons on how to evaluate complex systems when system solutions are sought to address complex population-based concerns.

[1] The Education Review Office is responsible for two initiatives for the Ministry of Education.

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02

Why focus on youth mental health?

In 2012 the Prime Minister's Youth Mental Health Project (YMHP) was established in order to address concerns about mental health vulnerability among young people. According to a recent Ministry of Health analysis, 16 percent of New Zealanders aged 12–19 are affected by mild or moderate mental health conditions, requiring brief or low-intensity treatment.[2] The Ministry of Health defines such conditions as "problems of emotional stability and behaviour, not serious enough to warrant specialist referral, but of concern because they signal that the child or young person is distressed in some way. There is the potential for the problem to become worse and more long-term if it is not addressed".[3]

[2] Crawshaw, J. (2012). *Current Youth Mental Health Initiatives*. PowerPoint presentation. Ministry of Health. It should be noted that mental health issues are more prevalent for Māori and Pacific youth.

[3] Ministry of Health. (1999). *Better Times: Contributing to the mental health of children and young people*. www.health.govt.nz/publication/better-times-contributing-mental-health-children-and-young-people

Key points

- The Prime Minister's YMHP includes existing and new initiatives, serving people between the ages of 12 and 19.
- YMHP initiatives vary in their scale, cost, settings and development stages.
- YMHP initiatives are distributed around New Zealand and generally target lower-decile areas.
- Participating agencies have not fully articulated the linkages between their intended outcomes and those of the YMHP.

2.1 The YMHP

The YMHP was established to better meet the mental health needs of adolescents. Good mental health is defined as "a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".[4]

The YMHP is intended to achieve six broad outcomes:

- improved knowledge of what works to improve youth mental health
- increased resilience among youth to support mental health
- more supportive schools, communities and health services
- better access to appropriate information for youth and their families and whānau
- early identification of mild to moderate mental health issues in youth
- better access to timely and appropriate treatment and follow-up for youth with mild to moderate mental health issues.[5]

Each of the 26 initiatives has its own rationale and outcomes, and each is also intended to contribute to the overall YMHP outcomes in some way. They differ, however, in the degree to which they have developed explicit outcome statements and intervention logics. The new information derived from the implementation lessons learned and from monitoring and stakeholder feedback may assist agencies to develop and refine the intervention logic for the individual initiatives. It should be noted that while each initiative contributes to the YMHP outcomes, some may also contribute to policy goals outside the YMHP.

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4 World Health Organization. (2014). *Mental Health: Strengthening our response*. Fact sheet No. 220. Retrieved 29 April 2015 from www.who.int/mediacentre/factsheets/fs220/en/

5 New Zealand Ministry of Health. (October 2012). *The Prime Minister's Youth Mental Health Project: First Six-Monthly Progress Report*.

The YMHP drew on a range of sources, such as the 2011 report by the Prime Minister's Chief Science Advisor, Peter Gluckman, *Improving the Transition: Reducing social and psychological morbidity during adolescence*, and an advisory group of leading academics. It was intended to build on existing interventions in a range of settings, including schools, the health system, communities and the online environment.

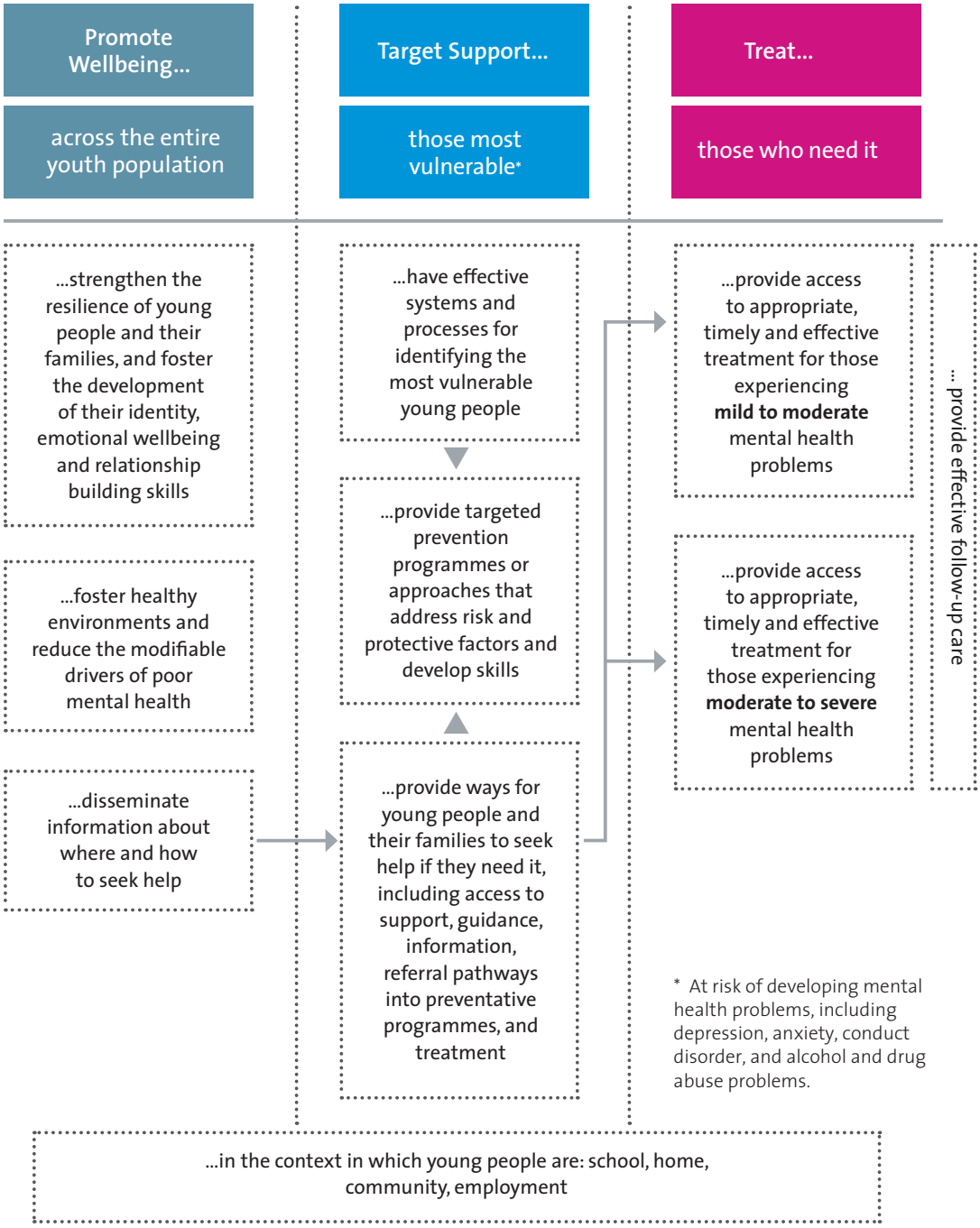
The YMHP was established by re-prioritising $61.9m over four years from Votes Health, Education, Social Development and Māori Affairs. It was initially developed and implemented by the Department of the Prime Minister and Cabinet (DPMC), but responsibility for its leadership was transferred to the Ministry of Health.

2.1.1 _ Theory of change

The DPMC drafted a document entitled *Setting the Direction for Youth Mental Health (interim report)*, dated 30 September 2011. The document provides the following diagram (Figure 2.1). As such it provides a strategic theory of change and key assumptions and aspirations regarding an ideal system of youth mental health.

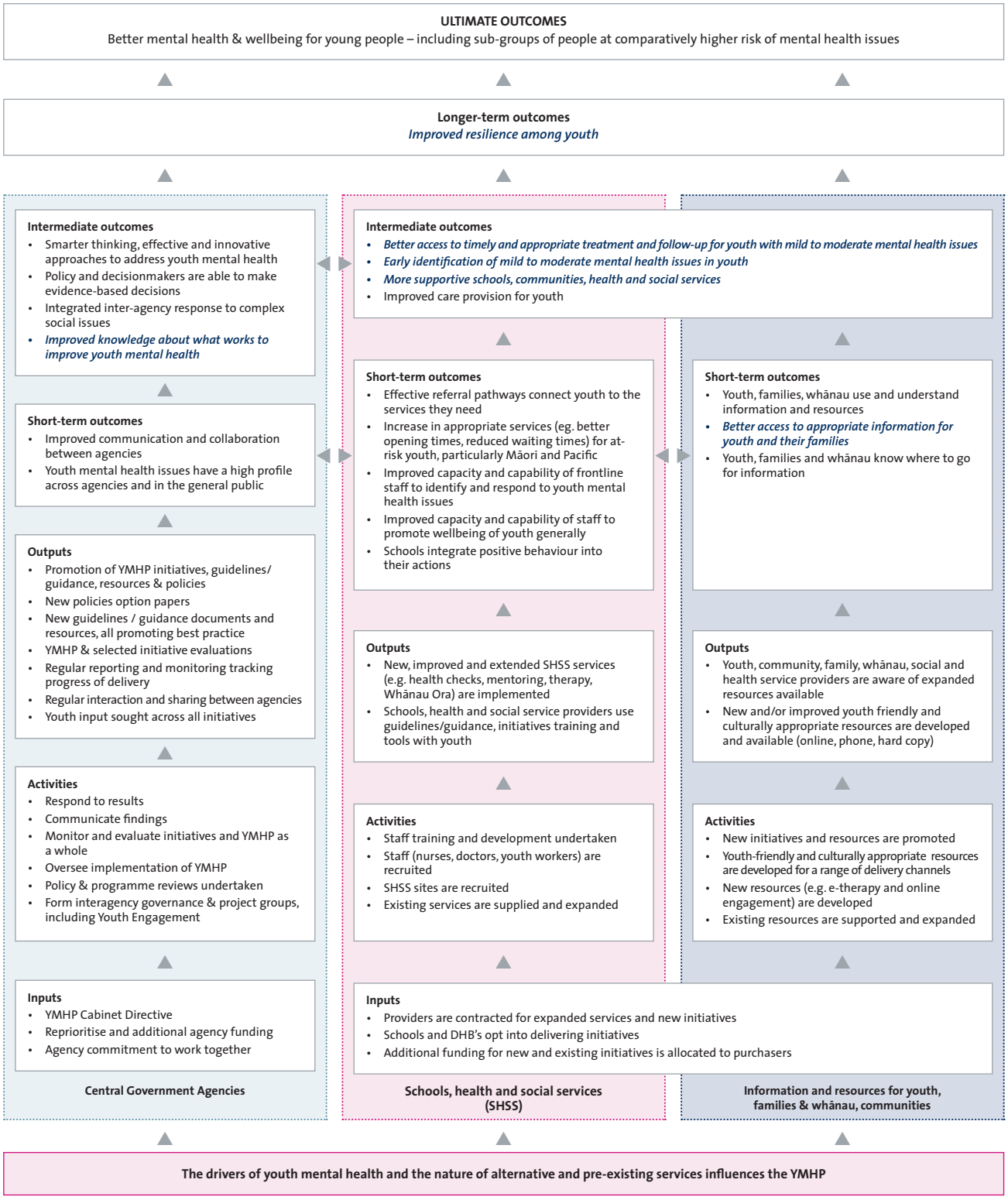
This theory of change allows evaluators to ask more particular questions that test and refine assumptions in the YMHP, and thereby provide a more sophisticated understanding of the system and proposals for its development. The theory of change can be reviewed and updated using supporting evidence and reasoning, proceeding to the development and refinement of a suitable measurement framework. Theory of change-related questions (in contrast to more generic evaluation questions) focus on whether there have been significant changes in particular problem conditions, and look for evidence of movement towards the 'ideal state' (measured qualitatively and quantitatively). It is important to note that the DPMC theory of change applies to the larger youth mental health system. The following logic model outlines particular activities to be undertaken and general goals the YMHP should achieve. These are shaped by the YMHP's focus on promoting wellbeing and preventing or intervening early in relation to mild to moderate mental health issues (refer Figure 2.2).

Figure 2.1 _ A theory of change



Source: Department of the Prime Minister and Cabinet. (30 September 2011). *Setting the direction for youth mental health: interim report.*

Figure 2.2 _ Youth Mental Health Project – Logic Model



A YMHP theory of change should address factors identified as important to the success of any comprehensive social programme, and to the success of social programmes directed at young people. These questions, or suggested areas of focus, sit within broader categories. These include:

1. implementation quality and additionality (what has improved or increased as a result of the YMHP)
2. equity of access to initiatives
3. measuring changes that are theoretically consistent with initiatives
4. drawing on youth development literature to situate youth mental health and wellbeing appropriately in the context of young people's normal developmental experience. The last point is important because there are many potential triggers for youth mental health issues and a variety of mitigating factors that are most readily understood through a youth development lens.

Key theory of change-related questions focus on levels and kinds of change in the following areas:

Implementation quality

- how youth mental health and development services fit with and build on other services not included within the YMHP
- self-evaluation by initiatives and agencies – shared youth development models and outcome measurement, and more insightful reporting (including suitable combinations of situational, process and outcome indicators).

Equity/Responsiveness to vulnerable groups

- comprehensiveness and coverage of prevention and early intervention support across New Zealand – service levels matched to projected levels of need
- uptake of prevention and early intervention services by those who are 'hard to reach'.

Outcomes theoretically consistent with initiatives

- general awareness of youth mental health issues and sources of support (young people, caregivers and whānau)
- youth service workforce capability and capacity
- identification/assessment and referral pathways and consequently appropriate uptake of support services.

Youth mental health situated within and related to youth development

- adoption of a wellbeing and positive youth development lens in all settings where young people are and go, particularly schools and community health services
- more responsive/sophisticated service offerings – sensitive to issues of gender, sexual identity and orientation, ethnicity and cultural affiliation, and situational preferences inherent in locality/community contexts.

These factors will assist in forming the conclusions on and recommendations of future evaluation phases, along with other criteria that may emerge from further stakeholder engagement.[6]

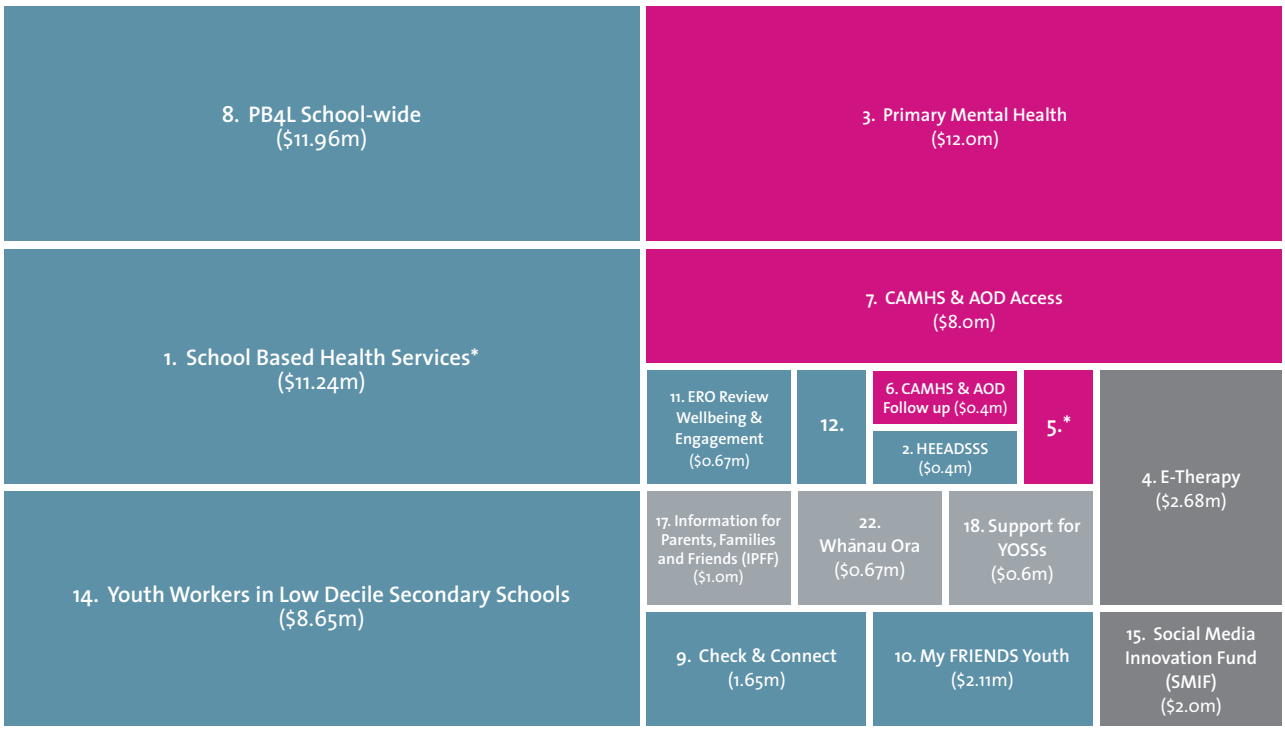
[6] Including discussions with DPMC and Treasury officials concerning the potential benefits and rationale for including mental health interventions in the YMHP – refer Melrose, R. (unpub.) *Investment in Youth Mental Health in New Zealand: The economic case.*

2.2_ Composition of the YMHP

The YMHP consists of 26 initiatives, managed by different agencies, with the overall objective of addressing the needs of young people (12 to 19 years old) with mild to moderate mental health issues. In general, the initiatives aim to encourage a safe and supportive environment for youth development (reducing stressors such as bullying and negatively judgemental teaching practices and adult behaviour), helping young people to become more positively engaged with their peers and others in their schools and communities, getting services to young people who need them, when they need them, and reducing the incidence of mental health issues such as anxiety and depression.

Figure 2.3 shows the initiatives by setting and by overall cost according to the most recent YMHP budget (June 2014). As noted earlier, YMHP funding was drawn from agency baselines, re-prioritised from other uses. Some initiatives are not included in the figure because they have no specific funding allocated to them. Some initiatives are integrated across sectors and settings, while others are focused on particular settings. A consideration for the evaluation is whether the degree of integration between initiatives is sufficient for the coherency of the package and whether the funding constraints have affected the efficiency of the project implementation.[7]

Figure 2.3 _ YMHP initiatives budgeted four-year costs[8]



Source: Youth Mental Health Project, Ministry of Health (July 2014)

Key
5. Primary Care Responsiveness to Youth
12. Improving the School Guidance System

Notes
5 * excludes additional YOSS funding under initiative 5b
1 * excludes MOH funding of decile 1 & 2 schools

[7] Some of the identified constraints were: the short timeframe for project implementation, the requirement for all initiatives to be baseline funded and to build on existing or planned agency programmes, a lack of specific funding for data collection and evaluation, and the need to contain expectations.

[8] Note that initiatives funded within existing resources are not shown in the diagram.

The initiatives range in scale and duration. The most significant initiatives in terms of scale and cost are:

- Positive Behaviour for Learning (PB4L) School-wide ($11.96m)
- Primary Mental Health ($12.0m)
- School Based Health Services (SBHS) ($11.24m)
- Youth Workers in Low-Decile Secondary Schools (YWiSS) ($8.65m)
- Child and Adolescent Mental Health Services (CAMHS) and Youth Alcohol and Other Drugs (AOD) access ($8.0m).

Smaller, less costly and/or shorter-term initiatives include:

- E-Therapy
- My FRIENDS Youth
- Information for Parents, Friends and Families (known as Common Ground).

The initiatives have different objectives and are based in different settings, as shown in Table 2.1.

TABLE 2.1

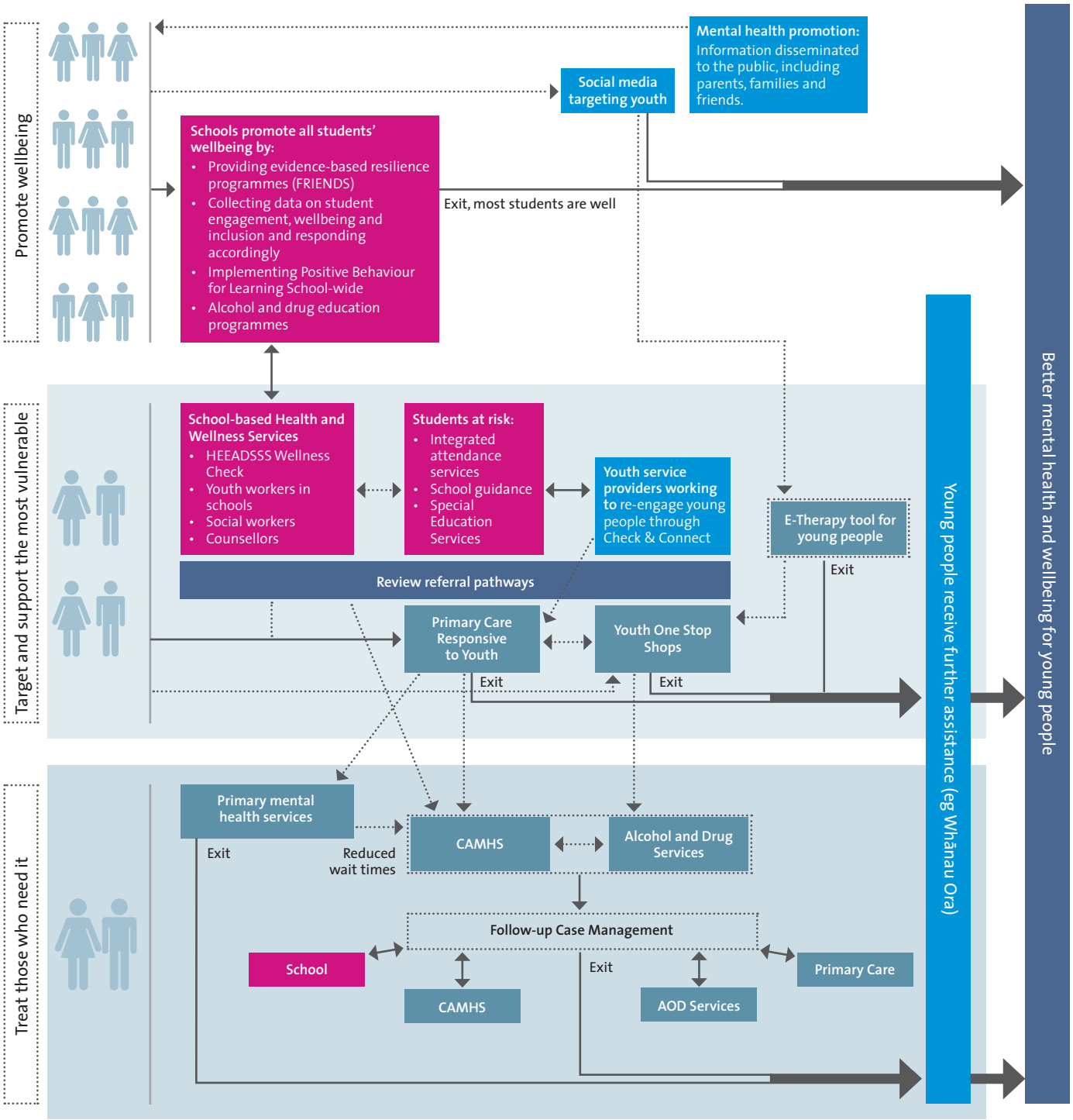
YMHP purpose and settings

	Initiative purpose		
Settings	**Promote wellbeing**	**Targeting of vulnerable youth and prevention**	**Treatment for those with mild to moderate issues**
Schools	4	6	0
Health services	0	4	4
Community	1	5	1
Online	1	1	1

Note: Two of the initiatives have been categorised as supporting both the prevention of mental health concerns and treatment.

The YMHP is a complex and multi-layered strategy for supporting young people. It recognises that there is a need for a level of universal support (where risk is low but a level of promotional support can act as a prevention strategy), progressing increasingly to more targeted support, intervention and treatment for young people at risk. The articulation of the YMHP against key focus areas is also depicted in Figure 2.4, which demonstrates how the specific initiatives align with the focus areas of promotion, prevention and treatment.

Figure 2.4 _ Setting the direction for youth mental health



Source: Superu Youth Mental Health Project Evaluation Plan 2014

2.3 Initiative status summary

The YMHP initiatives are at different stages of implementation, evaluation and completion. This is primarily dependent on the background context of each specific initiative and whether it was developed as part of the package or had already been completed, was already underway or was wrapped into the package at a later date. The spread of initiatives demonstrates the variability in the package as a whole and foreshadows the challenges for the evaluation in dealing with such variability. Fundamental to this challenge is being able to make evaluative judgements in the context of a dynamic scheme (see Table 2.2).

TABLE 2.2

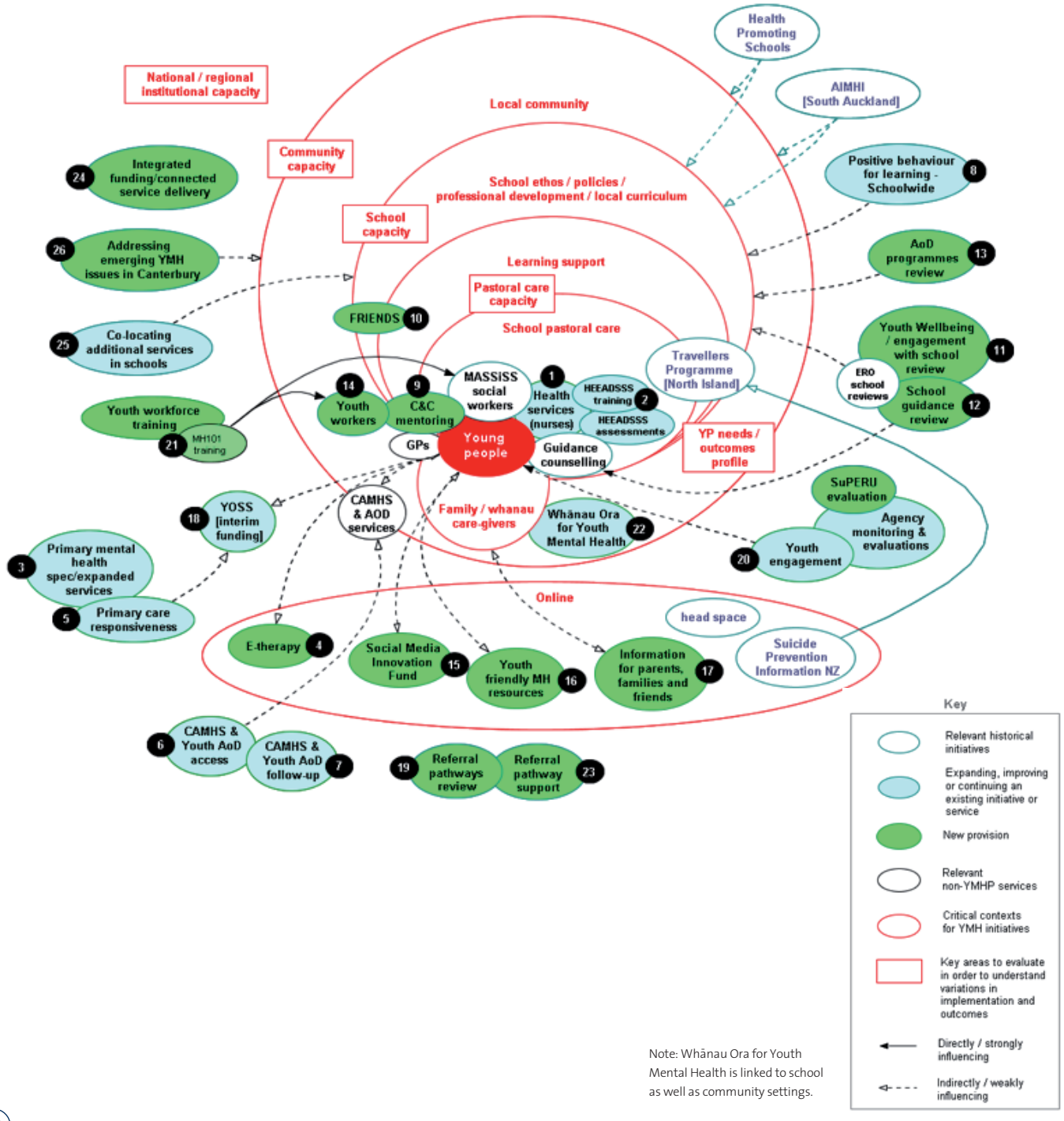
Current state of the initiatives

	Completed	Still in development (trial/pilot)	On-going	New initiative added to YMHP in 2013
Initiative 18: Social Support for Youth One Stop Shops (YOSSs)	✓			
Initiative 19: Youth Referrals Pathways Review	✓			
Initiative 21: Youth Mental Health Training for Social Services	✓			
Initiative 16: Improving the youth-friendliness of resource	✓			
Initiative 9: Check & Connect		✓		
Initiative 10: My FRIENDS Youth		✓		
Initiative 15: Social Media Innovation Fund (SMIF)			✓	
Initiative 12: Improving the school guidance system			✓	
Initiative 1: School Based Health Services (SBHS)			✓	
Initiative 2: HEEADSSS Wellness Check			✓	
Initiative 8: PB4L school-wide			✓	
Initiative 11: ERO review of wellbeing in school			✓	
Initiative 13: Review of AOD education programmes			✓	
Initiative 14: Youth workers in low decile secondary schools			✓	
Initiative 5: Primary care responsiveness to youth (now including Initiative 24)			✓	
Initiative 17: Information for parents, families and friends (Common Ground)			✓	
Initiative 20: Youth engagement			✓	
Initiative 22: Whānau Ora for Youth Mental Health			✓	
Initiative 4: E-Therapy			✓	
Initiative 3: Primary Mental Health			✓	
Initiative 7: CAMHS and Youth AOD Access			✓	
Initiative 6: CAMHS and AOD Follow up			✓	
Initiative 23: Referral pathway supports for young people				✓
Initiative 24: Developing Integrated Funding Models and Connected Service Delivery (now included under Initiative 5)				✓
Initiative 25: Co-locating additional social services in schools				✓
Initiative 26: Addressing the emerging youth mental health issues in Canterbury				✓

* HEEADSSS – stands for: Home, Education/ Employment, Eating, Activities, Drugs, Sexuality, Suicide/Depression and Safety.

The complexity and interplay between initiatives are further demonstrated in Figure 2.5. This diagram shows the mix of initiatives at play in the YMHP, the linkages between them and the rich context within which the YMHP is being implemented. The main point of the diagram is to show that: 1) many of the initiatives are an extension of what was already in place; 2) much effort is going into school-based prevention and online promotion; yet 3) there may be low levels of integration between new and old initiatives and structures that support youth mental health and positive development. The diagram's concentric circles draw attention to the need to think about the capacity of the youth mental health/development system at various levels, from the individual and whānau through to regional and national structures.

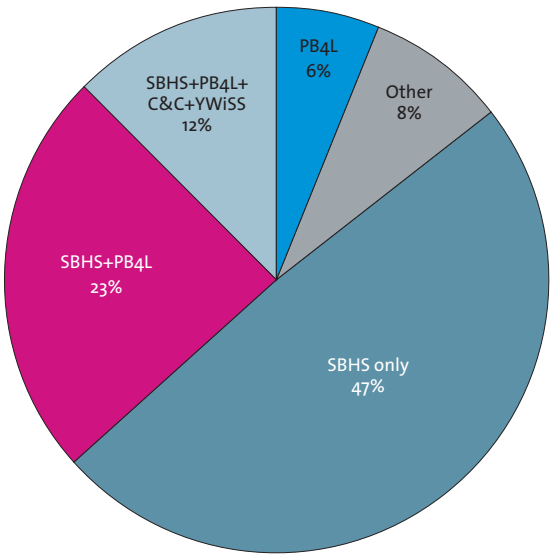
Figure 2.5 _ YMHP initiatives linked to settings and earlier initiatives



Note: Whānau Ora for Youth Mental Health is linked to school as well as community settings.

Adding to this complexity are variations in the manner in which initiatives have been implemented. For example, some initiatives are based in schools, communities and health services, of which many are located in low-socio-economic areas. Some of the initiatives sit entirely within the YMHP while others include elements outside the package. For example, SBHS[9] was implemented in decile 3 schools as part of the package, whereas decile 1 and 2 schools implemented the initiative before the YMHP was established. Some schools have implemented different elements of PB4L that are within the YMHP, such as PB4L School-wide. As shown in Figure 2.6, schools have implemented YMHP initiatives to different degrees and in different combinations. From an evaluative perspective, the complexity of the composition of the package and the implementation of different initiatives within schools provide challenges in the evaluation of the YMHP as a whole, such as the attribution of outcomes. See Appendix 2 for a detailed list of all the initiatives that make up the YMHP.

Figure 2.6 _ Types of YMHP initiative in decile 1–3 schools



Source data: Ministry of Health, 2014

Key

PB4L = PB4L School-wide

C&C = Check & Connect

SBHS = School Based Health Services

YWiSS = Youth Workers in Low-Decile Secondary Schools

A high proportion of Māori and Pacific students attend low-decile schools. This fact supports the importance of including culturally relevant concepts of health and wellbeing in the implementation and evaluation of this programme. Table 2.3 shows the ethnic breakdown of students in decile 1–3 schools, where the majority of the YMHP initiatives are distributed.

9 It is noteworthy that SBHS (initiative 1) is the most commonly implemented initiative, either alone or in combination with other programmes.

TABLE 2.3

Ethnic distribution of students in decile 1–3 schools across New Zealand

Source data: Ministry of Education, 2013

	Percentage	
Year level	**Māori**	**Pacific**
Year 9	47.8%	26.0%
Year 10	46.3%	26.3%
Year 11	44.1%	25.9%
Year 12	39.7%	27.9%
Year 13+	35.2%	28.0%
Total	43.1%	26.7%

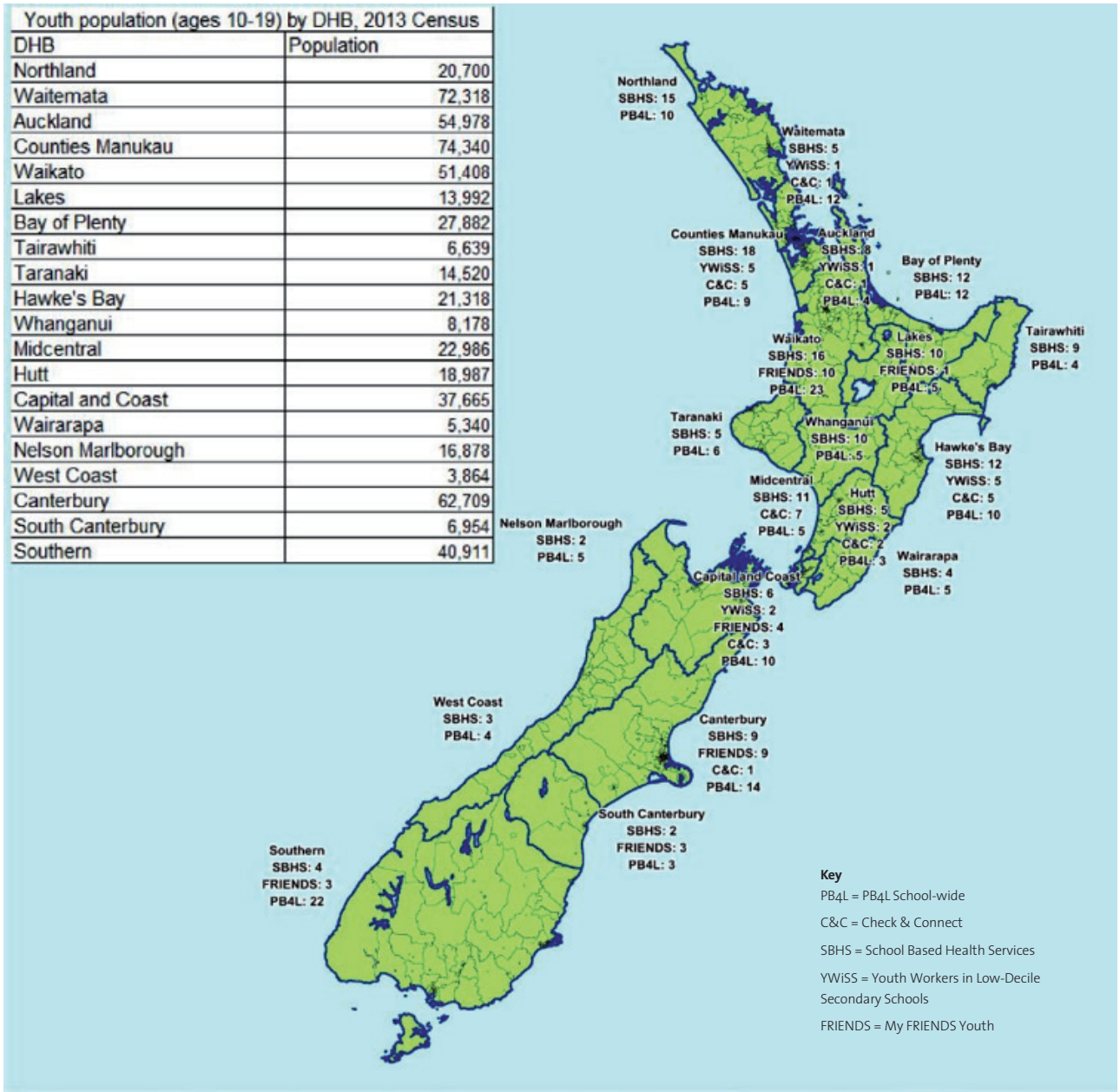
The focus of YMHP initiatives in lower-socio-economic areas is consistent with the higher prevalence of mental health disorders among Māori and Pacific people. It is known that Māori and Pacific people have an excess burden of lifetime mental disorders compared with other groups, even when the younger ages of these groups are taken into account (mental disorders have early onset and younger people are at greater risk).[10] Ministry of Health figures on mental health service usage also point to a higher prevalence of mental health issues among Māori. Statistics on the usage of mental health and addiction services show that in 2009/2010 the usage rate for Māori males (across all ages) was 76 percent higher than the rate for non-Māori males, and the usage rate for Māori females was 43 percent higher than the rate for non-Māori females.[11]

There are also regional variations in YMHP initiative expenditure. Figure 2.7 shows the distribution of mental health initiatives across the country by district health board (DHB) area. The distribution of decile 1–3 schools with YMHP initiatives is broadly representative geographically and nationally.

[10] Ministry of Health. (2006). *Te Rau Hinengaro: New Zealand mental health survey.*
[11] Ministry of Health. (2012). *Mental Health and Addiction Factsheet 2009/10.*

Figure 2.7 _ Regional distribution of school-based YMHP services

Youth population (ages 10-19) by DHB, 2013 Census	
DHB	Population
Northland	20,700
Waitemata	72,318
Auckland	54,978
Counties Manukau	74,340
Waikato	51,408
Lakes	13,992
Bay of Plenty	27,882
Tairawhiti	6,639
Taranaki	14,520
Hawke's Bay	21,318
Whanganui	8,178
Midcentral	22,986
Hutt	18,987
Capital and Coast	37,665
Wairarapa	5,340
Nelson Marlborough	16,878
West Coast	3,864
Canterbury	62,709
South Canterbury	6,954
Southern	40,911



Source data: Ministry of Health, 2014

superu

03

Lessons from the research review

A review of international and New Zealand research identified a need for developmentally appropriate, youth-friendly and accessible services.

Key points

- A review of New Zealand and international literature was carried out.
- The review identified principles of effective promotion, prevention and treatment for youth mental health.
- The review stressed the importance of taking a cross-sector approach and having culturally appropriate services.
- The review stressed the importance of using a development framework.
- The review will continue to inform the evaluation.

Superu commissioned a review of the international and New Zealand research on promotion, prevention and early intervention for youth mental health. The research review informs this study. The research review was intended to address:

- key factors that contribute to mental health and wellbeing in young people, with a particular focus on rangatahi Māori and Pacific youth
- an overview of current best practice for promotion, prevention and treatment for youth mental health
- an overview of research into approaches for integrating mental health services for young people from different disciplines or sectors.

The review focused on recent literature on services for youth, largely published outside New Zealand. In light of the large volume of relevant research, it drew mostly on review articles that synthesised other studies. The review drew on research about resilience, mental health promotion, the prevention of mental disorders, and early intervention, among other topics. It excluded research on suicide attempts and severe mental health disorders, specialist mental health services and treatments, and older literature.

The review has implications for the design and selection of initiatives that comprise the YMHP. It identifies eight principles of effective mental health promotion, mental disorder prevention and early intervention for young people. These are:

- placing mental health promotion and prevention within a framework that stresses, among other things, the importance of positive relationships with both adults and peers
- focusing on key risk and protective factors:
  - common risk factors
  - individual factors
  - different settings, including family and school environments
  - societal-level factors
- focusing on both prevention and promotion, using a strengths-based approach
- using a comprehensive approach
- using a cross-sectoral approach
- providing an adequate dosage (extent of treatment) and timeframe
- grounding in both theory and evidence
- ensuring cultural appropriateness.

The research review notes the importance of using a range of promotion, prevention and treatment strategies in different settings such as schools, communities and families. There is support in the research literature for interventions to promote positive wellbeing and resilience and to reduce risk factors for mental disorders, although effect sizes are generally modest and lower than effect sizes for pre-adolescent children.

The review discusses lessons from the literature on good practices for mental health promotion among Māori and Pacific youth. It stresses the importance of whānau-centred and relationship-focused approaches. It describes how mental health promotion can draw on Māori and Pacific models of health, which emphasise balanced views of physical, social, mental and spiritual dimensions of wellbeing. It stresses the importance of a strengths-based approach, rather than targeting specific problem behaviours. An ideal intervention would therefore be highly relational, involve families and whānau and focus on the whole person and their positive development.

This approach, however, needs to be mediated with an understanding of exceptions. There are circumstances in which culturally matched or family-focused interventions will be less effective. This might be the case, for example, in circumstances of endemic violence or sexual abuse. There is a need to ensure that critical assessment and engagement processes are well managed.

The review notes that a mix of interventions is needed, but that the literature does not provide evidence of the most effective mix of services or the most appropriate balance between different interventions.

The review supports the idea of a tiered or stepped approach, starting with the least intrusive interventions such as programmes that aim to create a positive and supportive school climate, and progressing as needed to more targeted interventions aimed at the needs of individuals. The review describes how recent research has emphasised the need to integrate services across multiple settings and sectors, including schools, healthcare providers and community groups. Integrated services across multiple settings provide multiple points of reinforcement and limit the risk of undermining gains made in other settings. The review notes that there is support for integrating a range of treatment and support services to provide continuity of care and seamless support.

The review has implications for the YMHP evaluation. The intended outcomes of the YMHP include greater youth resilience and more supportive environments. The review identifies key factors that underpin youth resilience such as:

- engagement with culture, school and communities
- positive relationships with adults and peers
- strong families and whānau support.

The review supports the idea of a **tiered** or **stepped** approach.

The analysis of factors that underpin youth resilience will inform future analyses of how well the YMHP is addressing the youth resilience outcome. Similarly, the review describes elements of supportive schools and communities, another YMHP outcome. This analysis will also inform the assessment of YMHP outcomes.

There is strong and growing evidence that interventions delivered in home, school and community settings can improve mental health outcomes for young people across the spectrum of promotion, prevention and early intervention.

Table 3.1 provides a summary of the evidence-informed principles for the design and content of effective initiatives. This evaluation assesses the extent to which the YMHP aligns with these principles.

TABLE 3.1

Best practice principles emerging from literature

1. Use of a developmental framework
2. Focus on key risk and protective factors, both individual and environmental
3. Dual focus on prevention and promotion, using a strengths-based approach
4. Socio-ecological model
5. Cross-sectoral approach
6. Adequate dosage and timeframe
7. Informed by theory and evidence
8. Cultural appropriateness

In summary, the key themes in the literature on youth mental health improvement include the need for developmentally appropriate, youth-friendly, accessible services that are designed to meet the mental health needs of young people and provide a community of care. It is important to note that resilience among young people is not just about internal personal competencies and dispositions. It is also socially situated and reinforced, providing significant protective factors for youth during times of transition. These processes are further strengthened by understanding the contribution of environmental stressors, which need to be constantly monitored and moderated. Key success factors identified in the literature include:

- the provision of a highly visible, youth-friendly 'shop-front' for a range of services
- better co-ordination of services
- the need to include physical healthcare in the model to provide a stigma-free entry point.

A further consideration for the YMHP is the extent to which it appropriately considers the range of environmental and structural contexts within which youth mental health concerns and risks emerge. In considering this context, the following key factors should be considered:

- the role of school leadership
- school size
- understanding of stress-anxiety-depression
- alertness to major social stressors
- adversity, targeting and resourcing
- priority given to fostering a positive peer culture, and a peer group for each young person
- intellectually engaging curriculum and teaching
- Teachers positioned as active 'first responders'
- developmental relationships – the 'active ingredient' for positive youth development
- developing the whole person, including positive attachments
- alertness to 'latent potential' and other 'smart practices'
- effective school case management
- diversity of school support structures and programming
- extent and kind of social support
- the significance of entrenched poverty as a mental health concern
- differing modes of delivery.

These themes form important theoretical considerations for improving practice and outcomes and will be explored during the next phase of the YMHP evaluation.

04

What we found out

As discussed earlier, the YMHP is now two years into its implementation and it is now appropriate to assess how well the implementation has proceeded, where there are questions or issues for further consideration as the initiatives start to show results, and what lessons have been learned for the future management of these and other related programmes.

This formative report describes the composition and objectives of the YMHP. It shows how the different initiatives are aligned with the YMHP's overall outcomes, and describes how the initiatives are targeted at the **promotion** of general wellbeing among young people, the **prevention** of mental health issues among young people who are at risk of developing negative mental health outcomes, and the **treatment** of young people who display indications of mild to moderate mental health problems. The three clusters (promotion, prevention and treatment) are then used to analyse the design and coherence of the initiatives, on the basis of an assessment framework developed to set out criteria for initiative set-up and delivery. The assessment framework is included as Appendix 3.

While this report primarily addresses the first two evaluation questions, preliminary information on outcomes emerging in response to questions 3–5 will also be drawn on to form conclusions and develop recommendations. Table 4.1 recapitulates the key evaluation questions that are the focus of this study. The analysis provided in this section is grouped into the five key questions that the formative evaluation is seeking to answer. This is followed by an overall conclusion and recommendations drawn thus far.

TABLE 4.1

YMHP key evaluation questions

Evaluation questions	Sub-questions
A. To what extent is the YMHP a comprehensive and coherent programme? Are there any gaps in its coverage?	1. What initiatives are included in the YMHP? 2. To what extent do the initiatives in the YMHP aim to address all six of the YMHP's four-year outcomes? 3. To what extent does the YMHP align with the mental health needs of 12- to 19-year-olds with, or at risk of developing, mild to moderate mental health problems?
B. How well is the YMHP being implemented?	4. What individuals/groups/organisations are involved in the YMHP? 5. To what extent has the approach to governance been successful and appropriate? 6. How effective is collaboration between partner agencies? 7. How effectively are the YMHP initiatives being implemented? 8. To what extent are processes in place to measure and learn from the success of the YMHP?
C. What is being achieved by the YMHP?	9. What have the individual initiatives achieved? 10. What has worked well in achieving outcomes? 11. What have been the challenges and how have they been addressed? 12. What changes have been made as a result of the YMHP? 13. What was achieved through collaboration of partner agencies/organisations? 14. To what extent have activities to date made progress towards the four-year goals of the YMHP, which aim to contribute to reduced incidence of mental health issues such as anxiety and depression among young people?
D. Does the YMHP represent value for money?	15. To what extent do individual initiatives focus on areas of greatest weakness or need? 16. To what extent are initiatives set up and designed appropriately in order to deliver value? 17. What is the VfM of each initiative in terms of the economy, efficiency, effectiveness and equity? 18. What is the VfM of the YMHP as a whole in terms of economy, efficiency, effectiveness and equity?
E. What do YMHP results imply for future youth mental health policies and programmes?	19. What further knowledge is needed to inform the design and implementation of future YMHP policies and approaches? 20. What aspects of the package might be strengthened or improved, or discontinued to better meet the YMHP ultimate outcomes? 21. What could have been improved in the YMHP process? 22. Is the YMHP a model that could be extended to other cross-sector work?

4.1 Question 1: Is the YMHP a comprehensive and coherent programme? Are there any gaps in its coverage?

The first of the evaluation questions seeks to address the following questions:

- To what extent is the YMHP a comprehensive and coherent programme?
- Are there are any gaps in its coverage?

Critical issues assessed here include:

- what initiatives are part of the package
- the extent to which the initiatives aim to address all six of the YMHP four-year outcomes
- the extent to which the YMHP aligns with the mental health needs of 12- to 19-year-olds with, or at risk of developing, mild to moderate mental health problems.

Earlier sections of this report have identified the YMHP initiatives and identified their costs and other characteristics, addressing the issue of what initiatives are included as part of this package. An issue not addressed in the earlier discussion, however, is the distribution of the initiatives across New Zealand and its alignment with areas of deprivation. Figure 4.1 shows that the YMHP initiatives are largely concentrated in areas of higher relative deprivation, as shown by the New Zealand Deprivation Index.[12]

Key points

- Overall, the YMHP is a comprehensive and coherent programme.
- Each of the YMHP outcomes is addressed by several initiatives, although the linkages may be clearer in some cases than others.
- Three outcomes (providing more supportive schools, communities and health services; early identification of mental health needs; and access to treatment) receive the greatest emphasis.
- The greatest effort is directed towards the prevention of problems, with a lesser focus on promotion and treatment.
- There is some compliance in terms of the YMHP initiative alignment with theory and evidence, and further development is needed.
- The alignment with a comprehensive approach requires further consideration.

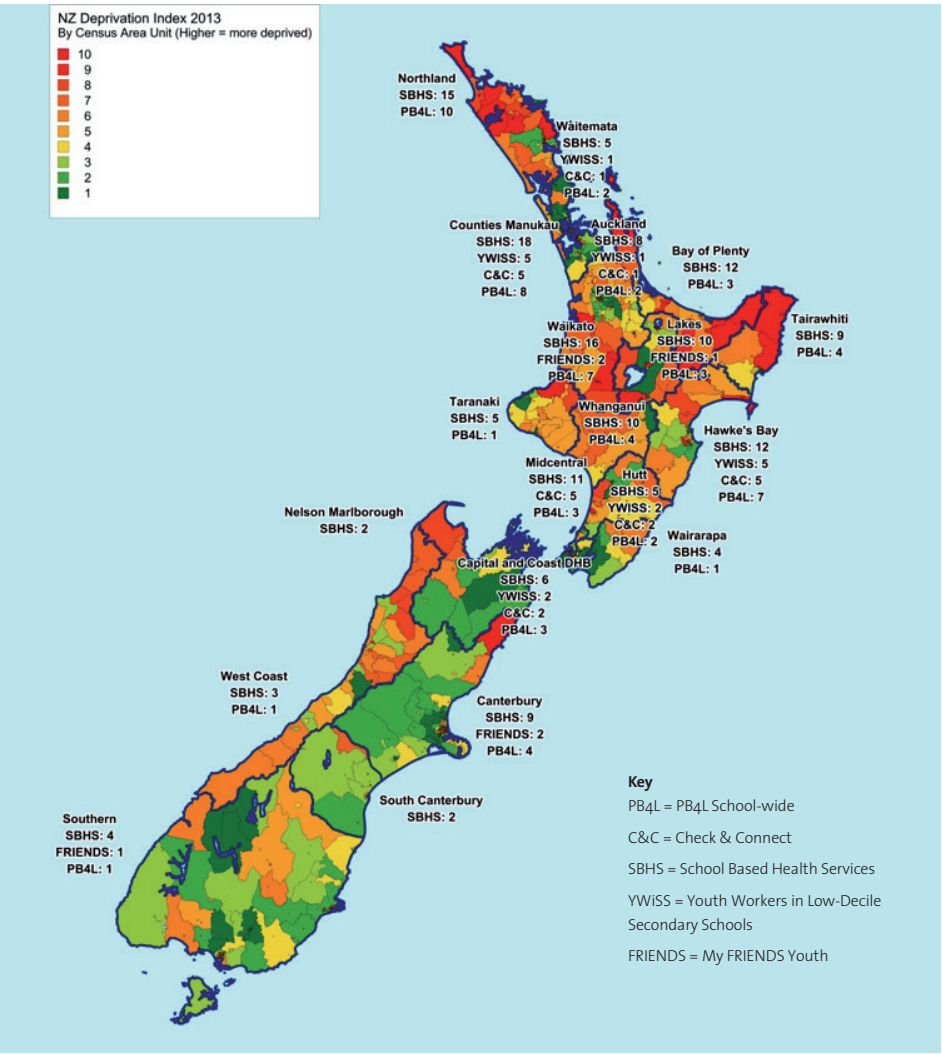
[12] It should be noted that a large proportion of the Māori and Pacific population is located in high-deprivation areas. NZDep2013 combines census data relating to income, home ownership, employment, qualifications, family structure, housing, access to transport and communications. NZDep2013 provides a deprivation score for each meshblock in New Zealand. See. www.health.govt.nz/publication/nzdep2013-index-deprivation

There are regional variations, however, in the number of initiatives being implemented, as shown in the following examples:

- DHBs in the North Island have tended to implement more of the initiatives than those in the South Island.
- Areas with higher deprivation seem to have more schools using PB4L School-wide and SBHS than other initiatives.
- YWiSS is currently only implemented in the Auckland, Wellington and Hawke's Bay regions, and is soon to be implemented in Northland.
- Some DHBs have recently extended the YMHP to decile 4–5 schools, indicating confidence in the initiatives.

The implications of these variations for outcomes will be explored in the next phase of the evaluation.

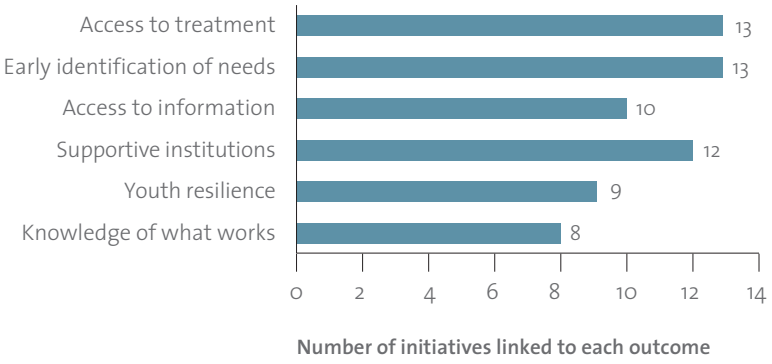
Figure 4.1 _ Distribution of school-based YMHP initiatives by New Zealand Deprivation Index



4.1.1 _ Distribution of initiatives against YMHP expected outcomes

The 26 initiatives have their own objectives, and are linked to one or more of the six outcomes of the YMHP. Some initiatives are intended to support objectives outside the YMHP, including health and justice outcomes, as well as YMHP objectives.[13] An analysis of initiative documentation shows that each of the outcomes is addressed by several initiatives, although the linkages may be clearer in some cases than others. Half of the initiatives (13) address the outcomes of early identification of mild to moderate mental health issues in youth, and better access to timely and appropriate treatment and follow-up. More than a third of the initiatives address the outcomes of more supportive schools, communities and health services (12), and better access to appropriate information for youth and their families (10). Fewer than a third of the initiatives are aligned with the outcomes of increased resilience among youth (9) and improved knowledge of what works to improve youth mental health (8) (see Figure 4.2). Once a theory of change for the programme has been confirmed, it will be necessary to re-examine this mix of initiatives to assess the optimal balance of the package.

Figure 4.2 _ YMHP initiative alignment with expected outcomes



During the stakeholder interviews, project leaders of the five largest initiatives (in terms of funding) were asked to estimate how much of their efforts were directed to each of the six YMHP outcomes, to get a sense of the relative importance of each outcome to the effort expended on different initiatives. The analysis shows that the initiatives are intended to target three outcomes (more supportive school and community environments, early identification of mental health issues, and greater access to treatment) more than the others. Health initiatives are particularly targeted at the identification of needs and access to treatment, while PB4L School-wide is mostly targeted at creating a more supportive school environment. These initiatives put little emphasis on developing a knowledge of what works to improve mental health, develop youth resilience or increase access to information for youth and their families and whānau (see Table 4.2). For SBHS, an estimated 50 percent of efforts are directed towards objectives outside the YMHP. It is important to note that existing evidence puts emphasis on supportive schools as a prerequisite to success. This suggests a need for an increased focus as the programme continues.

[13] These other objectives should be considered to ensure they don't detract from the YMHP outcomes and that a rational cost allocation can be made between the various objectives for input to the YMHP VfM assessment.

TABLE 4.2

Effort targeted to YMHP four-year outcomes for five YMHP initiatives

Note: Distributions are presented in ranges due to the imprecision of the available data, and rows do not sum to 100 percent.

Initiative	Effort targeted to YMHP four-year outcomes for five YMHP initiatives					
	Improved knowledge	Resilience	Information access	Early identification	Access to treatment	Support
1: SBHS	5 – 10%	5 – 10%	5 – 10%	5 – 10%	5 – 10%	5 – 10%
3: Primary Mental Health	10 – 15%	10 – 15%	10 – 15%	25 – 30%	25 – 30%	10 – 15%
7: CAMHS & Youth AOD Access Access	5 – 10%	5 – 10%	5 – 10%	40 – 45%	40 – 45%	5 – 10%
8: PB4L School-wide	0 – 5%	0 – 5%	0 – 5%	20 – 25%	20 – 25%	60 – 65%
14: YWiSS	10 – 15%	10 – 15%	20 – 25%	20 – 25%	20 – 25%	20 – 25%
Average assessments	5 – 10%	5 – 10%	5 – 10%	20 – 25%	20 – 25%	20 – 25%

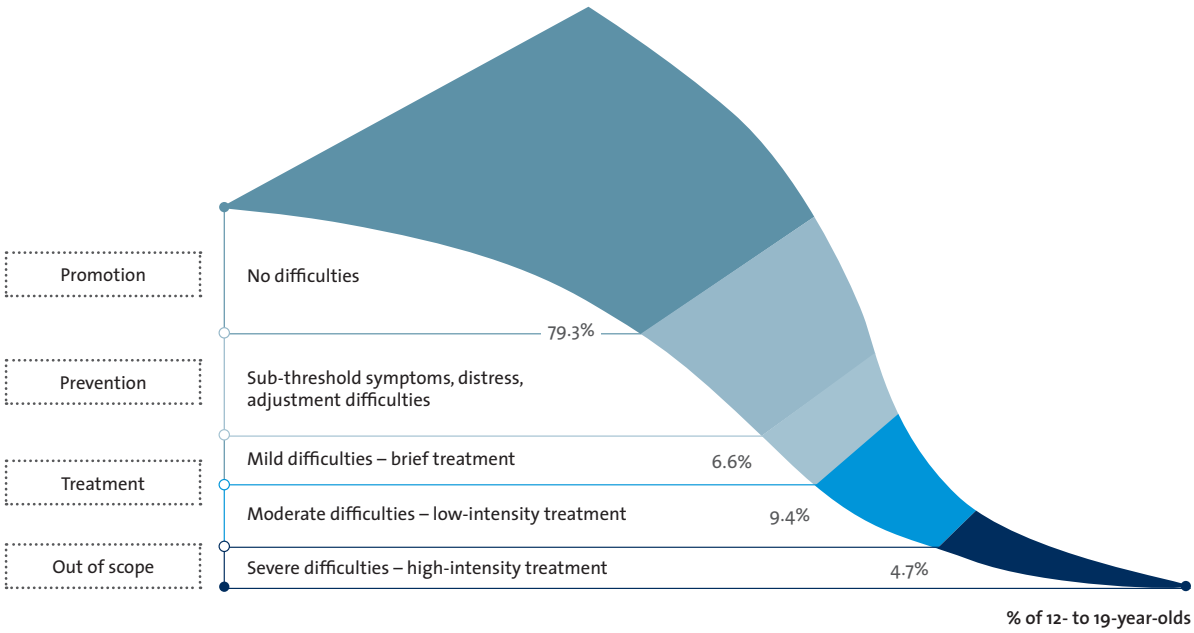
It should be noted, however, that, as indicated in the project documentation, some initiatives did not explicitly link their outcomes to the YMHP four-year expected outcomes.[14] It should also be noted that initiatives began at different times and for different reasons, and address more than the YMHP four-year outcomes.

4.1.2 _ Alignment with the mental health needs of 12- to 19-year-olds, including those with, or at risk of developing, mild to moderate mental health problems

The YMHP initiatives are intended to address a range of mental health needs. As noted earlier, the YMHP initiatives may be clustered into three groups according to their purpose, which include the promotion of general wellbeing, targeted support to prevent the development of mental health issues, and the treatment of young people with mild to moderate mental health issues. Most of the focus is on wellbeing promotion and the prevention of mental health problems. As illustrated in the following diagram, Ministry of Health figures show that almost 80 percent of young people have no mental health difficulties or show only symptoms at a level below the threshold for diagnosis. The boundary between 'no difficulties' and 'sub-threshold symptoms', in the course of normal development, is shown as a dashed line in Figure 4.3 because young people may move between these two categories, making it difficult to assess how large each group is. Promotion and prevention initiatives address the needs of this group. Ministry of Health figures show that 16 percent of young people have mild to moderate difficulties, addressed by the YMHP through treatment programmes. The remainder of young people have severe difficulties and require more intensive treatment, outside the scope of the YMHP (see Figure 4.3).

[14] Youth Mental Health Project Definitions (version 2 – June 2014).

Figure 4.3_ Alignment of YMHP clusters to youth population needs



Source: Dr John Crawshaw (2012), *Current Youth Mental Health Initiatives* (presentation)

All initiatives were assessed, on the basis of available documentation, to see whether their approaches had been tailored to fit their target populations. This was one element of a framework developed for assessing the design and implementation of the initiatives. The analysis showed that 20 out of the 26 initiatives demonstrated evidence of targeting their approaches to their contexts and target populations. Six out of 12 of the prevention-oriented initiatives, however, provided low confidence that they had targeted their services for more effective delivery to their target populations. In addition, it was not clear whether the initiatives were targeted at meeting young people's needs at critical times, such as in the transition to high school or out of high school and into further education or employment. If interventions are not reaching their target populations, this is likely to affect the effectiveness of the programme. The issue of targeting will be discussed further with the agencies responsible for the initiatives, as it will be critical for achieving outcomes.

As discussed earlier, the YMHP as a package focuses on the promotion of wellbeing, the prevention of disorders, and treatment where needed. However, on balance the YMHP is mainly preventive with a lesser focus on promotion.

Principle 1 _ Use a developmental framework

The YMHP is focused on young people between the ages of 12 and 19. This age range has been identified as a transition period between childhood and adulthood, during which young people must balance different factors related to positive development patterns. Adolescence introduces significant new biological and social factors that affect developmental competencies, particularly related to behavioural decision-making. A useful metaphor or description of this phase of development is that adolescence is a phase of having a 'high-performing engine' with 'an under-developed braking system'. This phase can be characterised with mood swings, under-developed self-regulation and increased situational challenges. A developmental approach should take these challenges into account but ensure that a strengths-based framework is applied.

The YMHP engaged with youth to ensure that the views of young people were included in the development and implementation of the project initiatives.[15] For example, YWiSS (initiative 14) was the subject of a baseline assessment report that drew on concepts of pastoral care in schools. Pastoral care approaches are generally understood to address the developmental needs of young people, which suggests a link to a developmental framework. The ERO Review of Wellbeing Indicators (initiative 11) identifies desired outcomes for young people in this age range, which may be presumed to reflect an understanding of developmental needs.

In other cases, it is less clear whether a developmental approach has been incorporated in different initiatives. Primary Mental Health (initiative 3), for example, uses a stepped care model that prioritises the delivery of the most effective and least resource-intensive services first, with more costly services to follow where and when needed. Whether this stepped care approach reflects the changing developmental needs of young people has not yet been explored. At this stage the evaluation is not in a position to recommend a particular development model or approach. The evaluative assessment suggests that this is an area in the YMHP requiring further development.

Principle 2_ Focus on key risk and protective factors, both individual and environmental

The literature shows that risk factors for mental disorders are both individual and environmental. They can include: socio-economic status; family status and history; disengagement from school; and life shocks. Protective factors for youth include: engagement in all areas of school, family, culture and community; and the development of strong pro-social relationships with peers and supportive adults. Any package of interventions aimed at both mitigating risk factors and supporting protective factors at the individual and environmental levels enables the building of mental resilience in young people.

[15] Youth Engagement (initiative 20) is led by the Ministry of Youth Development and guided by the *Youth Development Strategy Aotearoa*. Its kaupapa is informed by all Ministry of Youth Development work with YMHP agencies.

There is strong evidence that enhancing supportive environments in the pre-teen and teenage years (eg through whole-school interventions and parenting interventions) can improve a range of outcomes for young people, including improved mental health and reduced teen pregnancy, substance use and behaviour problems.[16] Some of the YMHP initiatives, such as PB4L School-wide, are intended to make the school environment more supportive for young people. PB4L My FRIENDS Youth is another universal programme, teaching coping skills for students starting secondary school.

Other initiatives are targeted at individual behaviours. Individually targeted programmes tend to focus on factors such as skill development, a positive sense of self and social connectedness.

Principle 3_ Focus on both prevention and promotion, using a strengths-based approach

As discussed earlier, the YMHP as a package focuses on the promotion of wellbeing, the prevention of disorders, and treatment where needed. However, on balance the YMHP is mainly preventive with a lesser focus on promotion.

Principle 4_ Draw on a comprehensive approach

The YMHP does not have an overall model to show where its efforts could be targeted or how the different initiatives are expected to lead to the overall shared outcomes (a theory of change). Some initiatives have such models, including a recognition of the nested contexts of family, peer group, school, neighbourhood and the larger culture.

Case studies for the evaluation will take into account the nested individual and community relationships within which young people live, and address the impacts of different initiatives acting at the different levels.

An early evaluative assessment suggests that alignment with this principle may require significant consideration.

Principle 5_ Use a cross-sectoral approach

The YMHP is overseen by a cross-sectoral governance structure, discussed in greater detail later in this report in connection with the YMHP implementation. Project documents show that agencies have identified a high degree of interconnection between the initiatives. PB4L School-wide, for example, was identified as linked to other school-based initiatives, including health services delivered through schools. However, while many initiatives are 'co-located' (eg in schools), the levels of linkage and complementarity are less clear.

[16] Jackson, C.A., Henderson, M., Frank, J.W., & Haw, S.J. (2012). 'An overview of prevention of multiple risk behaviour in adolescence and young adulthood'. *Journal of Public Health* (Oxford, England), 34 Suppl 1, i31–40. doi:10.1093/pubmed/fdr113.; Institute of Medicine and National Research Council. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and possibilities*. Washington, DC: The National Academies. Press.

Principle 6_ Ensure adequate dosage and timeframe

The literature notes that sufficient intervention intensity and duration are important for achieving long-term positive outcomes. Initiatives that lend themselves to this assessment include My FRIENDS Youth and Check & Connect. Initiative evaluations and case studies will address the question of how much intervention is needed, over what timeframes, and with what demands on resources over time.

Principle 7_ Inform the intervention by theory and evidence

An assessment of the 26 initiatives against the design and implementation assessment framework showed that nearly all demonstrated some basis of theory and evidence. Some initiatives were based on similar programmes developed and evaluated in other countries. Check & Connect (initiative 9) and PB4L School-wide (initiative 8) are examples of initiatives that draw on overseas development and testing. These initiatives are being tested to assess their application in the New Zealand context, which will provide a further evidence base for their use. Some, such as e-therapy (initiative 4) drew on an evidence base developed in New Zealand. The documentation for Primary Mental Health (initiative 3) noted that increased access rates were an adequate proxy for the percentage of the population accessing mental health services,[17] while the Youth2000 national youth health and wellbeing survey provided some evidence of the effectiveness of school-based health services.[18]

Some initiatives, including those based on online services, are explicitly intended to test innovative approaches. Innovative approaches require grounding in a clear theory of change to inform monitoring and evaluation. It is acknowledged that there can only be a limited evidence base for new and untested ideas.

Principle 8_ Ensure cultural appropriateness

Whether service delivery through the YMHP initiatives is done in a culturally appropriate way will be assessed through initiative evaluations and case studies. These assessments will provide an opportunity to learn how initiatives are designed and implemented to ensure cultural appropriateness and to what extent the initiatives demonstrate cultural responsiveness to Māori and Pacific youth.

Consideration will be given to indigenous models of wellbeing, such as Mason Durie's Te Whare Tapa Whā model and Pacific understandings of biological, psychological, social and spiritual health. See Appendix 4 for a description of Māori and Pacific models of health and their application. Overall, this principle needs further exploration in order to determine an evaluative position.

[17] Access rates are based on the assumption that the people seen are the people whom we expect to require service based on prevalence rates across the population (personal communication with YMHP team, Ministry of Health 2014).

[18] Denny, S., Grant, S., Galbreath, R., Clark, T.C., Fleming, T., Bullen, P., Dyson, B., Crengle, S., Fortune, S., Peiris-John, R.,Utter, J., Robinson, E., Rossen, F., Sheridan, J., & Teevale, T. (2014). *Health Services in New Zealand Secondary Schools and the Associated Health Outcomes for Students*. University of Auckland, Auckland, New Zealand.

4.2_ Question 2: How well is the YMHP being implemented?

The second key question aims to assess how well the YMHP is being implemented. This question will be addressed more fully after case studies have been conducted in different areas, providing a wider range of perspectives on how the initiatives work within their community contexts. The key issues considered include:

- what individuals/groups/organisations are involved in the YMHP
- the appropriateness and success of the approach to governance
- the effectiveness of collaboration between partner agencies
- the effectiveness of YMHP initiatives being implemented
- the extent to which processes are in place to measure and learn from the success of the YMHP.

Key points

- Most YMHP initiatives are on track to deliver against their direct goals.
- The YMHP is overseen through an interagency governance structure led by the Ministry of Health.
- Initiatives are generally designed and set up well but some lack indicators of achievement in terms of intended outcomes and baseline data against which to measure improvement.
- Oversight of the initiatives is strong, but several initiatives are weak on issues such as collecting data and sharing information.
- Most initiatives have not collected baseline data, which will restrict their ability to demonstrate success against their intended outcomes.

This section discusses how the YMHP has been implemented and managed as an interagency collaboration aimed at accomplishing a set of collectively agreed objectives. It draws on a range of information sources, including routine YMHP reports, interviews with leaders of the larger initiatives and discussions with some external stakeholders. Two separate assessment instruments used to assess the YMHP implementation were developed independently and administered to different types of stakeholder.

The assessment framework included key factors for effective design and implementation and was applied to all initiatives. This supported a consistent assessment of the implementation process across all YMHP initiatives. A framework for assessing interagency governance arrangements, called the Collective Impact Framework, was also used in consultation with the agencies involved.

The Collective Impact Framework has five elements:

1. Common agenda: a common understanding of problems and challenges, a shared vision for change, and a joint approach for achieving change through agreed actions
2. Effective governance and dedicated support for the operation of the YMHP (known as a backbone function), co-ordinating activities between the participating organisations
3. Shared measurement system: a consistent approach for collecting data and measuring results across the participating organisations
4. Mutually reinforcing activities, co-ordinated through a shared plan of action
5. Continuous communication: consistent and open communication among participants to build trust, address shared objectives and create common motivation.

A selection of officials from the Steering Group and project management office, and separate initiative leads, were asked to do their own assessments of how well the YMHP has performed in terms of the Collective Impact Framework. They were asked to rate the YMHP against each element on a five-point scale, with 1 indicating that the element was not present and 5 indicating that it was fully in place and operating consistently. They were also asked to provide clarifying comments on each element of the framework. These officials expressed the view that the YMHP had performed best in terms of having an effective governance structure and maintaining continual communication. They rated the YMHP a little lower but still at a high level for having a common agenda and co-ordinated activities. They rated the YMHP lowest (at just over 2 out of 5) for having a shared measurement system for demonstrating the impacts of separate initiatives on the collective objectives of the YMHP.

There was general agreement that certain organisational factors were predictive of the successful introduction of change, and were relevant across widely different interventions; these included: system-readiness for change; culture; and the role of leaders.[19] The evaluation of the YMHP initiative implementation drew on an assessment framework capturing key design and implementation factors. For each factor, the initiatives were rated high, medium or low. One set of factors addressed the design and set-up of the initiatives, while the second set addressed their oversight and tracking.

The assessment of the YMHP implementation included a review of governance arrangements and interagency collaboration, as noted in the evaluation questions. The six outcomes constituted a collective or cumulative impact for the project as a whole.

4.2.1_ Who is involved in the YMHP?

The initiatives and responsible agencies involved in the YMHP are outlined in Appendix 2 to this report. The Ministry of Health has been responsible for the oversight of the programme and for the support of the interagency Steering Group. The governance of the YMHP and collaboration between agencies are discussed in the following sections.

[19] Institute of Medicine and National Research Council. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and possibilities.* Washington, DC: The National Academies Press.

4.2.2_ Governance

The YMHP governance structure includes dedicated project management support. The YMHP team both has a governance oversight and project management role in the YMHP and co-ordinates agency inputs into the overall programme. It has established a cross-agency Steering Group that meets regularly and reports through the Social Sector Chief Executives' Forum to the Cabinet Social Policy Committee. The project team provides the Steering Group with regular monthly and quarterly reports on progress of the individual initiatives and maintains an implementation plan of high-level deliverables and key milestones. The project team tracks the performance of initiatives against the key deliverables and manages risks by maintaining a programme risk register. While the project outputs are being tracked through the regular progress reports, there is no tracking of overall results as there is currently no agreed monitoring framework to measure the project outcomes. However, a number of initiatives are collecting data from administrative sources, which will be used to measure outcomes in the last two years of the project. Further, a shared and agreed theory of change will aid the data collection to enable overall results to be gauged.

The YMHP has been characterised by regular co-ordination among participating agencies to share information and agree on actions, and by co-ordinated communication activities through the project office, using agency websites and other communication mechanisms.

Most initiative leaders endorsed the YMHP governance structure as highly effective. They cited the clear reporting requirements and regular interagency meetings as elements of effective governance, which linked the initiatives into a broader programme. They assessed the YMHP as having clear accountabilities running from individual teams through to the overall Steering Group.

4.2.3 _ Effective collaboration

Project documents show that agencies have identified connections between many initiatives, for various reasons. They may provide services to the same groups, share funding or have other connections. Most initiatives have been linked to several others across the agencies. Interviews with initiative leaders, however, provided few concrete examples of how such linkages work in practice or what results are made possible through these linkages. Some of those interviewed said that more information was being shared by different service providers at the local level than before.

For school-based initiatives it appears that there has been a lot more interagency collaboration in the form of shared meetings. All three of the school-based initiative leads pointed to the monthly school-based initiatives' interagency meetings with varying degrees of satisfaction as an example of interagency collaboration.

Linking YMHP services to the wider primary care system was cited as a general issue, with a need for greater consistency in services and joint change management processes to bring different services into alignment. SBHS and other efforts were identified as needing to be integrated with other services delivered through the wider health system.

A need was also cited for different stakeholders to work in partnership to co-construct their services for different clients and to communicate effectively about all aspects of their programmes. More effective interaction between the different elements of the YMHP, as well as between YMHP initiatives and outside services, was called for.

While the majority of these conversations were largely based on collaboration at the initiative level, there were also some discussions about collaboration across agencies in a broader sense. It was within these conversations that some clear challenges were identified. In particular, it was difficult for agencies to work closely with one another where different methodological approaches and professional languages had to be understood.

It was noted, however, that the implementation of the YMHP initiatives has shown that it takes more time than expected to establish effective collaboration between agencies and programmes.

4.2.4 _ Assessment of initiative design and oversight

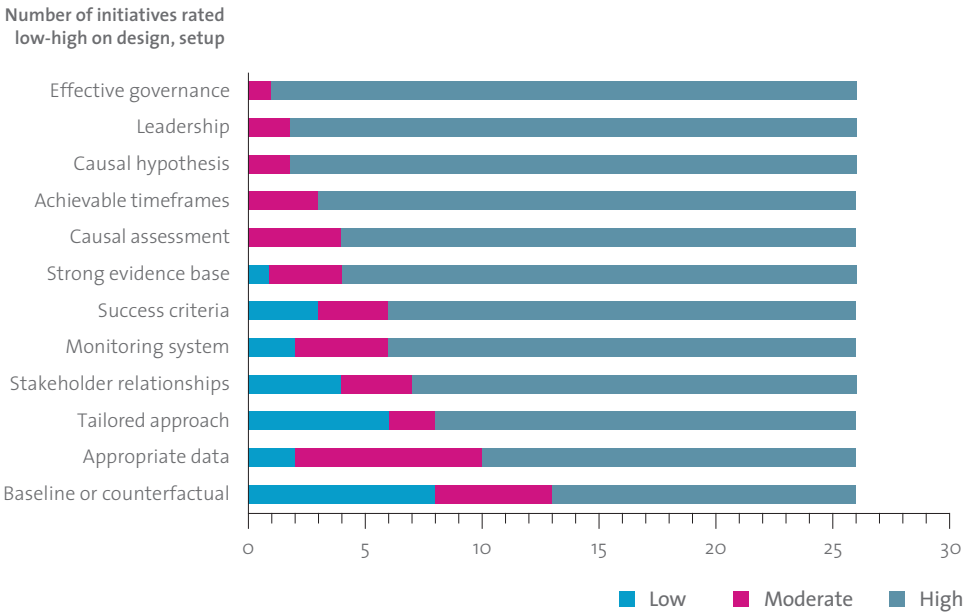
The YMHP is now two years into implementation and all of its initiatives are underway. Initiative documents were reviewed to assess how well they had been designed and set up, and what they showed about initiative effectiveness. Additional information on implementation was provided by agencies leading different initiatives. More extensive interviews were conducted for the larger initiatives. All conclusions at this point should be considered tentative and subject to confirmation through further research and analysis. Initiatives' set-up and design were assessed against the following criteria:

- an underlying hypothesis that clearly outlines how the initiative contributes to the YMHP outcomes
- use of a research and evidence base for the chosen approach
- effective governance and accountability mechanisms
- timeframes for the initiative, including key milestones and decision points
- stakeholders are engaged in effective working relationships
- clear criteria for measuring the success or failure of the initiative
- a system for regular monitoring and reporting of budgets, schedule and performance
- appropriate data to allow measurement of initiative success
- a clear baseline, counterfactual or other basis for determining the value added by the initiative
- appropriate team leadership and capability
- an assessment can be made of the extent to which the initiative leads to the intended outputs and outcomes
- the initiative's approach has been tailored to fit the context and target population.

An analysis of the initiative assessments against these criteria is shown in Figure 4.4.

Implementation of the YMHP initiatives has shown that it takes more time than expected to establish **effective collaboration** between agencies and programmes.

Figure 4.4_ Alignment of YMHP initiatives with set-up and design criteria



The analysis shows that initiatives generally had clear governance and leadership arrangements. Most initiatives had timeframes that were achievable and included key milestones and decision points. There was, however, variability in the extent to which initiatives had effective or sufficient implementation plans with adequate risk management strategies. Project documents generally demonstrated a link between their activities and intended outcomes, although these did not necessarily extend beyond the initiatives' direct outcomes to address the YMHP objectives. As shown, there were greater issues with regard to factors such as providing baselines or counterfactuals to demonstrate positive impacts, tailoring delivery approaches to intended target populations, having clear criteria for success, and collecting appropriate data. Most initiatives had not collected baseline data, which will restrict their ability to demonstrate success against their intended outcomes.

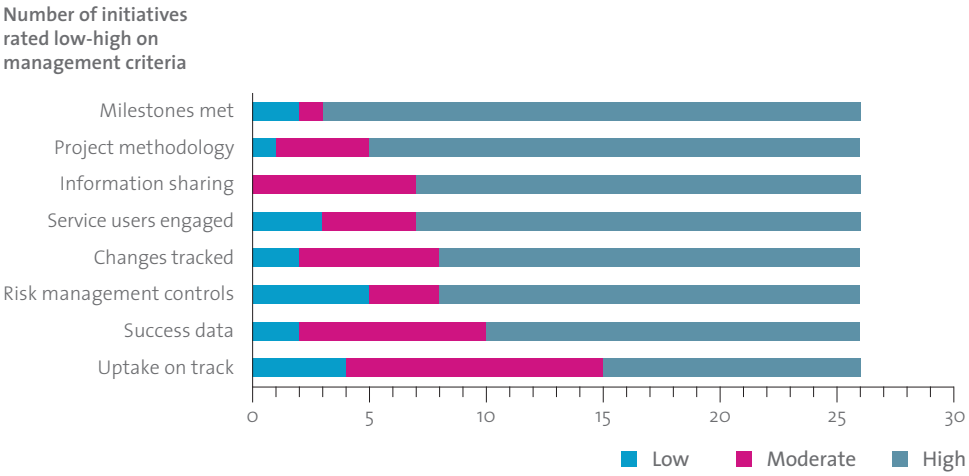
The YMHP initiatives were also assessed against criteria for deciding whether they were being managed and kept on track for delivering the intended results. These criteria included:

- a formal, documented methodology for the initiative
- effective risk management controls
- information-sharing in place with relevant stakeholders, where and when appropriate
- regular collection of data to measure initiative success
- major changes to scope, budget and lessons learned captured and reported
- milestones being met
- uptake of initiative by youth is on track
- service users engaged, participating in the initiatives, demonstrating early outcomes.

Figure 4.5 shows a generally high level of confidence, on the basis of information

available at this point, that initiatives are being monitored and managed for effective delivery, but with some areas of concern. For example, fewer than half of the initiatives were assessed as providing high confidence that they were on track to get the intended uptake of services by intended users. An assessment of initiative documentation showed concerns in several areas about risk management, engagement of users, tracking of changes resulting from the initiatives, and the collection of data to demonstrate the success of the initiatives.

Figure 4.5_ Alignment of YMHP initiatives with management criteria



As the evaluation proceeds it will collect further information about how the initiatives have been implemented and how they are operating. The case studies will test whether programme delivery is co-ordinated between initiatives in different regions.

4.2.5 _ Lessons learned by the agencies implementing the YMHP

The YMHP team directed participating agencies to identify lessons learned from implementing their initiatives, and has provided this information to the Steering Group. An analysis of the lessons reported by initiative leaders showed the following themes.

Contracting: Improvements are needed in contracting processes and funding arrangements. In some cases there were issues with DHBs requiring time and assistance to contract local service providers to deliver elements of the initiatives. There were issues about what service providers were contracted to deliver, and how the service delivery was to be structured.

Relationship development: Stakeholder engagement is important in the successful implementation of programmes to achieve outcomes.[20] All initiative leads spoken with felt that the overarching goal of the YMHP of improved youth mental health made it easier for individual initiatives to generate interest and get buy-in from relevant stakeholders. In particular, school-based services recognised the importance of engaging school leaders and securing their willing co-operation, since school boards and principals decide whether to take part in the initiatives.

Cultural appropriateness: Meeting the needs of Māori and Pacific is important given their high representation in decile 1–3 schools and evidence from the research review that health promotion and prevention programmes should be culturally relevant in order to be applied successfully. A document analysis indicates that the majority of initiatives have identified Māori and Pacific youth as target populations. However, few initiatives have incorporated cultural components in their design or implementation strategies, with some exceptions such as Check & Connect and Whānau Ora for Youth Mental Health. It should be noted that the pilot nature of some initiatives, eg My FRIENDS Youth and Check & Connect, which are both imported programmes, included an explicit focus on determining how best to go about achieving cultural responsiveness in the use of these programmes in Aotearoa. There was also an identified lack of take-up of SBHS by kura, requiring further exploration. DHBs may choose to adapt their services to better align with cultural needs or belief systems in different schools, while maintaining fidelity to the original programme design and intent.

Monitoring and reporting: Most of the initiatives had monitoring systems in place to track activities and outputs, but put less emphasis on tracking outcomes. The research review points to empirical research that identifies external monitoring and support as contributing to implementation success. The cross-agency Steering Group's quarterly reports for the YMHP provide monitoring dashboards and variance explanations for all project initiatives that monitor the status of work programme deliverables. To track progress across the four-year outcomes it will be desirable to develop common indicators across all the initiatives (where appropriate) and common formats for reporting.[21]

Numerous issues, however, were identified with the collection and reporting of appropriate, consistent and timely data on delivery performance and outcomes.[22] It was noted that monitoring data should include both delivery and financial information, and should be planned for at an early stage. It was also noted that access to some data requires negotiation with providers, which must be addressed early in the implementation. Initiative leads agreed with this assessment, noting that although they had reporting templates, the degree to which relevant and accurate data was actually being collected varied significantly across the initiatives. This was particularly prevalent for health-based initiatives, with all three of the initiative leads who were interviewed indicating that there were concerns with the accuracy,

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[20] This includes early communication with critical stakeholders for buy-in in terms of relevance. "Interest in an intervention is likely to be greater if it is culturally relevant and embraced by the community. Lack of relevance may contribute to interventions being implemented with limited fidelity and resultant limited outcomes" (Institute of Medicine and National Research Council 2009, p 333)"

[21] The YMHP team has acknowledged the need for a common measurement framework to monitor overall project outcomes. A proposed outcome measurement framework is presented in Appendix 5.

[22] It is important to note, however, that for all those that were identified as having significant issues with their data, there were changes being made to what and how data is to be collected into the future.

consistency and validity of data currently being collected. Agencies are taking steps to address these concerns about data, and the issue will be examined further as the evaluation continues.

While some initiatives had good processes that included the collection of baseline data, the majority had not collected baseline data at all. The evaluators have limited confidence that sufficient data exists to allow the initiatives to measure success and to reflect on progress, as there is little evidence of the existence of clear baselines or counterfactuals for determining the value added from the initiatives.

The YMHP has also been characterised by a lack of consistent and reliable information about programme delivery and the achievement of its shared outcomes. When a selection of initiative leads and Steering Group members were asked to rate various components of the YMHP as a whole, they rated the project lowest (at just over 2 out of 5) for having a shared measurement system for collective objectives. While other initiatives demonstrated stronger data-collection processes, there is no consistent measurement system across the programme that could be used to measure the success of the programme as a whole.

Overall, most initiatives are following formal, documented methodologies based on well-researched logical frameworks, and have effective implementation plans with adequate risk management strategies. The cross-agency Steering Group's quarterly reports for the YMHP provide monitoring dashboards and variance explanations for all project initiatives that monitor the status of work programme deliverables. However, there is less confidence that the data required to measure the success of the project is being collected. Most initiatives have met their planned milestones to date, and there is some evidence that the expected uptake by target populations is on track.

Some initiatives had good processes that included the **collection of baseline data**, but the majority had not collected baseline data at all.

4.3 Question 3: What is the YMHP achieving?

The third key question seeks to assess what is being achieved by the YMHP. More specific evaluation questions focus on the following issues:

- What the individual initiatives have achieved separately?
- What has worked well for each initiative in achieving its intended outcomes?
- What challenges the initiatives have faced and how those challenges have been addressed?
- What changes to policy or operations the participating agencies have made as a result of the YMHP?
- What has been achieved through the collaboration of partner agencies/organisations?
- To what extent activities to date have made progress towards the four-year goals of the YMHP, which aim to contribute to a reduced incidence of mental health issues such as anxiety and depression among young people?

Key points

- The YMHP initiatives are at different stages of development and completion, often at the stage of delivering services but generally not at the point of demonstrating results.
- It is therefore too early to determine what outcomes have been achieved or how much the YMHP initiatives will be shown to contribute to observed changes in outcomes.
- Early results linked to outcomes for the YMHP can be demonstrated for some initiatives such as PB4L School-wide and SBHS, although these outcomes are not clearly linked to the broader YMHP outcomes.
- More detailed individual theory of change/logics for each initiative and YMHP as a whole should be developed to support future outcome evaluations.

As this is a formative evaluation, there are only early indications of progress towards some of the YMHP outcomes, such as improved knowledge of what works to improve mental health. Many of the YMHP initiatives are relatively new and are still being tested and implemented. Some examples of outcomes have been identified by the agencies involved. These examples are summarised as follows:

- The initiatives that focus on the treatment of mild to moderate mental health issues are showing some early signs that youth are being provided with better access to timely and appropriate treatment and follow-up, and that mental health issues are being identified and diagnosed early. For example, the evaluation of SBHS found that there was less depression and suicide risk among students in schools that had higher levels of health services.[23]

[23] Denny, S., Grant, S., Galbreath, R., Clark, T.C., Fleming, T., Bullen, P., Dyson, B., Crengle, S., Fortune, S., Peiris-John, R.,Utter, J., Robinson, E., Rossen, F., Sheridan, J., & Teevale, T. (2014). H*ealth Services in New Zealand Secondary Schools and the Associated Health Outcomes for Students*. University of Auckland, Auckland, New Zealand.

- Phase one of the evaluation of PB4L School-wide found that there were shifts in student outcomes, such as positive changes in student awareness of behaviour expectations and consequences, staff acknowledgement of positive behaviour and students' ability to self-reflect and manage their behaviour, and increases in on-task behaviour and engagement in class.[24]
- The HEEADSSS assessment is an example of an initiative that has successfully achieved the outcome of early identification of mild to moderate mental health issues. The HEEADSSS assessment not only supports the engagement of youth with clinical support, but also informs their clinical assessments and initial needs assessments.[25]

The final evaluation report will address outcomes achieved to a greater extent. A provisional outcomes framework, which will be refined and applied in co-operation with YMHP agencies, is attached as Appendix 5. The framework will help to address the need for data to support evaluations of YMHP outcomes.

Each of the 22 original initiatives identified intended short- and longer-term outcomes, and generally made some connections between these outcomes and the six four-year outcomes for the YMHP as a whole. In reporting their achievements to date, they referenced their initiative objectives rather than the four-year expected outcomes of the YMHP.[26] In most cases the initiatives reported outputs such as numbers of young people receiving services. Nonetheless, linkages between the short-term outcomes identified for each initiative and the four-year YMHP outcomes can be identified. Table 4.3 shows the short- and medium-term outcomes reported by the 22 original initiatives and relates them to the broader YMHP outcomes. It does not include initiatives 23 to 26 because they are new, so no results have yet been reported for them. The results shown in this table were taken from YMHP reports and have not been verified.

In assessing YMHP achievements, the short- to medium-term outcomes can be contextualised in terms of where they are located in the journey towards the four-year outcomes, showing whether they are:

- contextual indicators at the business case phase
- process indicators at the planning and preparation or delivery phase
- outcome indicators at the results phase.

The summative evaluation report will assess the extent to which all of the four-year outcomes have been achieved for the YMHP as a whole.

[24] Boyd, S., Dingle, R., & Herdina, N. (2014). *PB4L School-wide evaluation: Preliminary findings.* New Zealand Council for Education Research.

[25] *Quarterly Report for the Youth Mental Health Cross-Agency Steering Group*, June 2014.

[26] Youth Mental Health Project Definitions (version 2 – June 2014).

TABLE 4.3

Progress towards outcomes reported by initiatives

Note: Distributions are presented in ranges due to the imprecision of the available data.

Initiative	Phase	Progress markers	Related YMHP outcomes
1: SBHS	Delivery	• More young people have access to SBHS – 18,084 students at 40 decile 3 secondary schools now have access to SBHS as of term 1, 2014. This is 1,000 more than at the end of 2013	3: supportive institutions 6: access to treatment (pathway)
2: HEEADSSS Wellness Check	Delivery	• Increased number of Year 9 students receiving HEEADSSS assessments with the expansion of SBHS to include decile 3 schools • The HEEADSSS initiative has been extended to primary care, especially for general practice, as this was the second part of the focus for this initiative	3: supportive institutions
	Planning and prepartion	• Raising awareness of HEEADSSS through promotion by The Werry Centre for Child and Adolescent Mental Health • Making training more accessible to health professionals • Development of e-learning HEEADSSS training to improve accessibility • Development of train the trainer to ensure sustainability of the training	5: early identification of needs 6: access to treatment
3: Primary Mental Health	Delivery	• As of June 2014, more young people are receiving primary mental health services. Although the national dataset is still incomplete, the number of young people receiving primary mental healthcare has increased in the past year, with 7,516 young people seen since July 2013	5: early identification of needs 6: access to treatment
4: E-Therapy	Delivery	• An online adolescent e-therapy programme has been developed – SPARX is a clinically tested self-help tool developed especially for young New Zealanders by the University of Auckland • Young people are starting to have access to an online treatment option for depression as a result of a nationwide launch commenced in May 2014 • Since the launch there have been 7,947 visits to the SPARX website and 1,267 registrations, which suggests that the implementation is progressing	6: access to treatment
5: Primary Care Responsiveness to Youth	Results	• Improved the immediate sustainability of the most vulnerable YOSSs	3: supportive institutions
	Planning and prepartion	• All 20 DHBs are now developing youth-specific Service-Level Alliance Teams so that during 2014/2015 each team will be planning, funding and implementing more integrated services for young people	
6: CAMHS and AOD Follow-up	Planning and prepartion	• Four pilot sites have been chosen for the implementation of the best practice guideline for the transition of young people from AOD services: Altered High (Waitemata DHB), Counties Manukau DHB, Bay of Plenty DHB and MidCentral DHB • As a result of the publication of the guideline and implementation by DHBs, young people will start to have access to appropriate post-discharge follow-up delivered in a nationally consistent way	6: access to treatment

Key to phases

- Business case
- Planning and prepartion
- Delivery
- Results

Initiative	Phase	Progress markers	Related YMHP outcomes
7: CAMHS and AOD Access		• Nationally, 93.5 percent of 12- to 19-year-old specialist mental health clients were seen within eight weeks of referral as at 30 December 2013. This compares with 92.8 percent in July 2012. Nine DHBs have met or exceeded the 2015 eight-week target of 95 percent • Nationally, 90.9 percent of 12- to 19-year-old AOD clients were seen within eight weeks of referral as at 30 December 2013. This compares with 88.7 percent in July 2012. Four DHBs have met or exceeded the 2015 eight-week target of 95 percent	6: access to treatment
8: PB4L School-wide		• Early indicators of reduced stand-downs and increases in NCEA (National Certificate of Educational Achievement) achievement. Statistically significant positive outcomes in comparison with a matched sample of schools • Most schools lift performance on the key implementation indicators, which are independently verified • Improved implementation of PB4L School-wide essential features over time	3: supportive institutions
9: Check & Connect		• Model for implementing Check & Connect with schools, NGOs and government agencies • Monitoring framework for trialling Check & Connect	1: knowledge of what works
		• High number of Māori and Pacific students participating in the programme	2: youth resilience
		• Short-term benefits for students • Lessons learned from evaluation of Christchurch Check & Connect service	3: supportive institutions
10: My FRIENDS Youth		• Students consistently are able to recall the key skills and ideas in the programme and can offer examples of how they have used them • Students recognise that there are alternative ways to act, even though they don't always choose positive actions • Students report being happier, knowing what makes them happy and what they are grateful for • Teachers engaged in Phase One were really keen to be part of Phase Two	2: youth resilience
11: ERO Review of Wellbeing & Engagement in School		• The draft wellbeing indicators have been published and distributed to schools and are being used in the current evaluation by ERO of student wellbeing in schools • ERO is on track to provide a report(s) on the findings of this evaluation later in 2014	1: knowledge of what works
12: Improving the School Guidance System		• Review is completed and a work programme to address review recommendations is being developed	3: supportive institutions

Key to phases

- Business case
- Planning and prepartion
- Delivery
- Results

Initiative	Phase	Progress markers	Related YMHP outcomes
13: Review of AOD Education Programme		• At a Social Sector Forum in February 2014, deputy chief executives recommended that a social sector trial-type approach be taken to disseminating the findings of the review • Consideration is being given to how best to make review findings known to schools • Collaboration with the Health Promotion Agency. New Zealand Police interested in being involved in follow-up actions	3: supportive institutions
14: YWiSS		• Service design and contracting for service provision complete • Fifteen youth workers recruited, trained and actively working with young people • Project scope expanded to implement four remaining youth workers in Northland	3: supportive institutions
15: Social Media Innovation Fund		• Eleven projects were developed at Lifehack weekends in 2014. These projects include online tools and platforms, social media promotions for events and social media/online strategies for services • A framework for supporting ideas and participants in weekends has been developed and will be implemented in 2014	1: knowledge of what works 2: youth resilience
		• Four regional Lifehack weekends in May and June • A Development Sprint will be held to progress an idea to the prototype stage • A Lifehack Lab will be held to bring together key young people, ideas and mentors	
		• Young people are reporting increased wellbeing and engagement after taking part in Lifehack events	
16: Improving the Youth-Friendliness of Mental Health Resources		• Youthline produced an evidence-based document that was well tested with the target market through the government advisory group and through its youth contacts • This document has been downloaded 711 times in the 12 months to June 2014. Downloads have been relatively consistent across the 12 months, suggesting that the resource continues to be relevant • The Family and Community Services directory was updated with input from Youthline. For example, this included adding a section on youth advisory groups so that NGOs could find ways of accessing the opinions of young people	4: access to information
17: Information for Parents, Families and Friends (Common Ground)		• An online portal/hub (Common Ground) was launched in July 2014	4: access to information

Key to phases

- Business case
- Planning and prepartion
- Delivery
- Results

Initiative	Phase	Progress markers	Related YMHP outcomes
18: Social Support for YOSSs		• Twelve YOSSs received interim funding of $50,000 each through the Ministry of Youth Development. This support funding was invested primarily in additional programmes for better working with young people with mental health issues. The Ministry of Social Development was satisfied with the expenditure of this funding, as evidenced in status and final reports through Ministry of Youth Development reporting processes. Key lessons from this initiative were incorporated into initiative 5b, which sought options for more sustainable funding for the YOSS sector. This was based on their track record in social supports and youth mental health work. This resulted in additional Budget 2014 funding for YOSSs	3: supportive institutions 5: early identification 6: better access
19: Youth Referrals Pathway Review		• Three projects developed (YMHP 23, 24 and 25) that respond to the six recommendations in the YMHP initiative 19 report	1: knowledge of what works 3: supportive institutions 6: access to treatment
20: Youth Engagement		• Most of the initiatives have included a youth engagement aspect; this has added value to the quality of delivery • The overall evaluation of the project includes a strong youth engagement component	3: supportive institutions
21: Youth Mental Health Training for Attendance Service, Youth Service and YWiSS Staff		• Eighteen MH101 (a nationwide mental health learning programme) workshops delivered to 246 frontline Youth Services, Attendance Services and YWiSS (initiative 14) staff • Positive response from all service delivery arms and acceptance that MH101 is a standard item in training/professional development contexts for recognising the signs of, and knowing how to refer appropriately for, young people with mild to moderate mental health issues. Incorporated into contracting. Uptake/interest by other agencies and initiatives. From this initiative MH101 was also considered as part of initiatives 19 and 23	3: supportive institutions
22: Whānau Ora for Youth Mental Health (trial)		• The key goal highlighted for the youth has been to meet their educational needs. The youth like and prefer to be at school; however, risk behaviours towards their peers and teachers at school continue to affect their enrolment throughout the year • The key goal highlighted for the youths' families has been to find appropriate accommodation. Housing New Zealand has been the preferred provider to assist them with their accommodation needs	3: supportive institutions

Key to phases

- Business case
- Planning and prepartion
- Delivery
- Results

Source: Youth Mental Health Project Definitions (version 2 – June 2014)

4.4 Question 4: Does the YMHP represent value for money?

The fourth evaluation question asks whether the YMHP represents value for money. To address the issue of VfM, a team led by KPMG assessed the five largest initiatives, collectively covering about 80 percent of the total YMHP expenditure.[27] Its analysis was independently peer reviewed. The peer reviewer concluded that the VfM analysis was methodologically sound,[28] of good quality and fit for purpose in addressing the evaluation questions.[29]

The KPMG analysis covered four issues:

- the extent to which each initiative focuses on areas of greatest need
- whether each initiative was set up in a way that provides confidence it will deliver maximum value
- the VfM of each initiative in terms of economy, efficiency, effectiveness and equity
- the VfM of the YMHP as a whole in terms of economy, efficiency, effectiveness and equity.

Key points

- A VfM analysis was carried out by KPMG, reviewing the five largest initiatives by funding.
- KPMG generally concluded that the initiatives were set up and delivered well, consistent with results reported earlier, but raised questions about targeting.
- KPMG rated the initiatives highly in some areas such as governance and project management but identified concerns in areas such as clear baseline data and the ability to show that initiatives meet the need of target groups.
- KPMG identified both strengths and opportunities for improvement across the largest initiatives.
- Future work should consider a broader definition of VfM, the involvement of wider stakeholders and a greater consideration of different cultural perspectives.

[27] KPMG. (7 October 2014). *Youth Mental Health Project: Formative evaluation of value for money*. Available from Superu on request.
[28] According to the review, a limitation of the methodology was its agnostic stance on cultural sensitivity.
[29] Julian King & Associates Ltd. (12 August 2014). *Review of YMHP Formative VfM Draft Report*. Available from Superu on request.

To address the four issues identified above, KPMG presented its results in a 'traffic light' format for ease of comprehension. For each of the four elements assessed, one of five ratings was made:

1. **Green:** All or almost all criteria for VfM are met and the initiative performs strongly, with few improvements needed.
2. **Green-amber:** Most criteria for VfM are met and the initiative performs well, but some improvements should be made.
3. **Amber-red:** Some criteria for VfM are met but the initiative is not performing well overall, and significant improvements should be made.
4. **Red:** Few VfM criteria are met, the initiative performs poorly, and major changes should be made.
5. **Grey:** An assessment cannot be made because information is not available or not tracked consistently, and monitoring is required in the future.

4.4.1 _ Focus on areas of greatest need

KPMG concluded that the five largest initiatives focused predominantly on three outcomes: more supportive schools, communities and health services; early identification of mild to moderate mental health issues in youth; and better access to timely and appropriate treatment and follow-up. It rated the largest initiatives in terms of their focus on areas of greatest need as amber-red, with particular questions about the extent to which initiatives have been shown to meet the needs of target groups, and their levels of uptake.

4.4.2 _ Confidence that initiatives are set up to deliver value

To assess how well initiatives were set up to deliver value, KPMG assessed the five initiatives against a set of seven factors, with each including more detailed conditions. The seven factors were:

- quality of measurement of outputs, outcomes and sustainability
- clarity of baseline
- budgeting and tracking
- quality of governance and project management
- meeting the needs of the target group
- stakeholder management and delivery team capability
- the initiative as part of the wider programme.

KPMG's overall assessment in this area was green-amber. It raised questions about whether or not the initiatives had established clear baselines and budget mechanisms or demonstrated that they met the needs of target groups, but rated the initiatives more highly in terms of: measuring outputs; governance and project management; stakeholder management and delivery team capability; and setting up the initiatives as part of the wider programme.

4.4.3 _ Economy, efficiency, effectiveness and equity of each initiative

KPMG assessed the five initiatives in terms of economy, efficiency, effectiveness and equity by rating them against a series of factors. Economy was assessed in terms of costs, including overheads, and the mix of inputs used. Efficiency was assessed in terms of the outputs produced and the level of outputs produced for a given expenditure level. Effectiveness was assessed in terms of the outcomes achieved, their alignment with the six YMHP outcomes, the performance data available, the timeliness of services and the mix of channels used to deliver services. Equity was assessed as a function of the recognition of the needs of different groups and the ability to match services to those needs.

KPMG gave the five largest initiatives a rating of green-amber in the four dimensions of VfM, with the lowest rating given for effectiveness. It noted that there were questions about how the level of funding provided would achieve the overall intended outcomes, and whether the impact of the initiatives will be sustainable over time. KPMG's assessments of the five initiatives are shown in Table 4.4.

TABLE 4.4

Value for money findings by initiative

Source: KPMG report on *YMHP Formative Evaluation of Value for Money* (7 October 2014)

Initiative	Overall assessment	Set-up assessment	VfM assessment	Comments
1: SBHS	Green-amber 	Green-amber 	Green-amber 	This initiative is largely set up appropriately to drive maximum value. One exception is that the Ministry of Health has limited visibility over how much the full delivery costs are overall (noting that some analysis has been undertaken by the Ministry to better understand costs incurred by DHBs). A second exception is that outcomes are not tracked for the initiative. This means that the initiative is not tracking achievement of outcomes and it is not possible to determine whether the outcomes will be sustained over the long term. It is, however, early days. Targets should be clearly defined and measures put in place to track these over time. It is noted that 50 percent of the focus of the initiative is outside the YMHP.
3: Primary Mental Health	Amber-red 	Green-amber 	Amber-red 	This initiative extends primary mental health services to youth through increased funding to providers. Overall, a key challenge is to understand how the level of funding provided will achieve the overarching desired outcome, and whether this will be sustainable over the long term. The amber/red rating is in part a reflection of this challenge. Whilst the initiative has been set up appropriately to deliver maximum value, there are a number of issues around economy, efficiencies and effectiveness that, if addressed, will help increase the value delivered.
7: CAMHS and Youth AOD Access	Green-amber 	Green-amber 	Amber-red 	This is an innovative and challenging initiative. In the main, it has been set up appropriately to drive maximum value, the main exceptions being a lack of knowledge of both take-up and the sustainability and impacts of outcomes. It is, however, early days. There is an opportunity to target transient youth more effectively. In terms of VfM, a greater focus on effectiveness by measuring and monitoring take-up and outcomes would add value.
8: PB4L School-wide	Green-amber 	Green-amber 	Green-amber 	The green/amber rating is in part a reflection of the challenging and innovative nature of this initiative. In general, the initiative has been set up appropriately to deliver maximum value. However, there are a number of issues around efficiencies and effectiveness that, if addressed, will help increase the value delivered.
14: YWiSS	Green-amber 	Green-amber 	Green-amber 	The initiative is challenging and innovative. Overall, the initiative has been set up robustly to deliver maximum value. The main exceptions are that the initiative is giving and gaining little synergy from being part of a wider programme. In terms of current VfM of the initiative, economy, efficiency, effectiveness and equity are broadly in a good position with some opportunities to build efficiency in particular and to learn if youth feel the services are making a difference.

4.4.4 _ Economy, efficiency, effectiveness and equity of YMHP as a whole

KPMG carried out a cross-cutting analysis of the five largest initiatives and identified both strengths and opportunities for improvement.

Cross cutting themes – strengths:

1. **Robust initiative set-up:** Broadly speaking, the five initiatives have been set up robustly and the five initiatives have been rated green-amber.
2. **Strong project governance, project management and risk management:** This is established across the YMHP. This includes clear timeframes for delivering the initiative, having a methodology in place that is generally being followed and having high-quality change management procedures.
3. **Strong focus on prevention:** Most of the initiatives, as intended by this programme, focus on preventing the development of youth mental health issues rather than reacting to them via interventions or treatments once they emerge. Three-quarters of the spend of the largest five initiatives is focused on prevention.
4. **Increased motivation from being part of a wider programme:** Simply by being part of a larger programme, individuals in the initiatives appear to be more motivated. This is both at a Ministry level and at the 'front line', eg in schools with YMHP initiative champions, teachers and principals.
5. **Effective use of the Prime Minister's title:** Attaching the Prime Minister's title to the programme appears to have been effective in increasing the speed at which the programme was set up, the level of attention and oversight (doors get opened) and the motivation of participants.

Cross-cutting themes – opportunities:

1. **Increase the measurement of and focus on VfM:** In general, the initiatives are not measuring VfM well. This has meant that the VfM evaluation has had to rely predominantly upon qualitative information due to the lack of quantitative data. It is acknowledged that addressing measurement has a cost, but the absence of outcome measures in particular creates a 'blind spot' so that the full VfM of the project will not be known unless this investment occurs.
2. **Increase the focus on delivering outcomes and sustainability:** The initiatives focus mainly on outputs rather than outcomes. The initiatives generally do not have measures in place to determine whether the outcomes are being, or will be, achieved. The lack of knowledge on the delivery of outcomes means that the sustainability of outcomes is a risk.
3. **Increase the integration and synergies resulting from initiatives being part of a single programme:** Teams from Ministry of Health initiatives felt more part of the programme compared with Ministry of Education and Ministry of Social Development teams. Few specific impacts or benefits were identified that have resulted from being part of a single programme. Rather than integration, in some instances initiative managers stated that a degree of competition existed for resources within agencies and across agencies that were part of the programme.
4. **Increase the targeting of services to those most in need:** As indicated in the project scope, the initiatives currently prioritise low-decile and particular geographies. Therefore there is limited focus on ethnic, gender or other segmentation. For example, the initiatives currently focus mainly on youth who are actually in schools. It is likely, however, that youth who fail to attend schools, such as truants and transient youth, will have greater needs.

5. **Improve the mix of the set of initiatives that would best form a coherent programme – opportunity for future programmes:** The programme was set up over a short period. A number of initiatives were already in place. Potentially further consideration could have been given to identifying the optimum mix of initiatives to make up the YMHP.
6. **Improve the mix of inputs for the initiatives:** Initiatives were set up over a short period. Potentially insufficient consideration was given to identifying the optimum mix of inputs and resources, such as the types and levels of people involved. Based on interviews, now that the initiatives are well established, some are reviewing whether the optimal mix of resources is being employed.
7. **Improve channel selection:** Potentially insufficient consideration was given to alternative delivery channels. The channels selected are largely face to face, which is usually the most costly and may be less effective for youth. However, initiatives are currently reviewing other channels that may be more effective.
8. **Tighten subcontracts to retain accountability for delivering outcomes and improve reporting by subcontractors:** A number of initiatives contract to third parties for the delivery of services. This process has meant that accountability for outcomes is reduced due to contracts not requiring sufficient reporting on and oversight of the services delivered. Some initiative leads feel that obtaining accurate cost data from DHBs is challenging since the initiative spend has become part of their business as usual.

4.4.5 _ Limitations of the VfM analysis

The VfM analysis was largely qualitative, drawn from interviews with initiative teams. This approach was used because there was insufficient quantitative data available, such as per-person costs for delivering services. It was based on five initiatives only, selected because they represented 80 percent of the YMHP expenditure. The analysis may not apply as well to other initiatives. The analysis relies largely on information from initiative leaders, not from stakeholders in communities affected by the YMHP.

The independent review of the VfM analysis recommended the use of a broader definition of VfM in future, described as "the value derived from the resources used in the YMHP". It also recommended taking a broader approach to merit determination, including value provided to affected downstream stakeholders, and giving consideration to the multicultural validity of the evaluation. Superu will consider how to apply these recommendations in the next evaluation phase.

4.5_ Question 5: What do YMHP results imply for future youth mental health policies and programmes?

The final key question (question 5) is about an overall assessment of the YMHP and understanding what the results to date imply for future youth mental health policies and programmes. Key factors investigated here include:

- what further knowledge is needed to inform the design and implementation of future YMHP policies and approaches
- what aspects of the package might be strengthened or improved or discontinued to better meet the YMHP ultimate outcomes
- what could have been improved in the YMHP process
- whether the YMHP model could be extended to other cross-sector work.

Key points

- There is a strong commitment to a cross-sector approach.
- There is a need to review and revise the underlying theory of change for the package as a whole.
- There is a need for the development of a consistent approach to monitoring and data collection.

The research review identified a number of implications for the design and selection of a youth mental health package. It identified eight principles of effective mental health promotion, mental disorder prevention and early intervention for young people, and provided a basis for making an overall judgement. Added to these categories are the principles of intentional innovation and good implementation practice, both drawn from a knowledge of implementation science and stakeholder perceptions of and interests in both innovation and quality implementation.

Table 4.5 demonstrates the extent to which there is broad alignment between these principles and the current YMHP initiatives. In general, we found broad alignment between what is considered 'best practice' and the YMHP. This reflects the initiatives as presently implemented. Strengths in the package included:

- a focus on a cross-sectoral approach in the prevention-oriented initiatives
- the presence of some elements of good implementation in some of the initiatives
- the overall coherence of the project in terms of best-practice principles.

The evaluation results provide the following views and observations, which should be considered further and tested with stakeholders:

- Apart from Whānau Ora for Youth Mental Health, the YMHP lacks a focused initiative on the needs of Māori and Pacific youth based on a kaupapa Māori approach and Pacific models of health such as the Fonofale model.
- Initiative design should consistently develop clear underlying theories and apply available evidence.
- Consideration should be given to whether the most suitable people are engaged in mentoring and other roles in initiatives being applied locally.
- Consideration needs to be given to cross-sector requirements when developing new initiatives.
- Wellbeing indicators, including those developed by ERO, may be applied more widely to give initiatives explicit development approaches and to monitor and manage them.

TABLE 4.5

YMHP initiative clusters aligned with best practice themes

Best practice themes	Promotion	Prevention	Treatment
Generally conforms to principles of effective youth mental health promotion and treatment	• Improving the youth-friendliness of mental health resources (16) • Social Media Innovation Fund (15) • Information for parents, families and friends (17) • Youth Engagement (20) • Youth mental health training for social Services (21)	• Primary Care Responsiveness to Youth (5) • My FRIENDS Youth (10) • Youth Engagement (20)	• Primary Care Responsiveness to Youth (5) • E-Therapy (4) • Child and Adolescent Mental Health Services (CAMSHS) and youth Alcohol and Other Drugs Follow-up (6) • Youth Engagement (20) • Primary Mental Health (3)
Implementation good practice (ensuring sustainability and improvement focus across the relevant youth services, identifying and focusing on priority areas, capability building, involving programme users)	• Review of Alcohol and Other Drugs Education Programmes (13) • Youth Engagement (20) • Youth mental health training for social services (21)	• Improving the School Guidance System (12) • Social support for YOSSs (18) • Youth Referral Pathways Review (19) • Referral pathway supports for young people (23) • Integrated funding models and connected service delivery (24) • Co-locating additional social services in schools (25)	• Child and Adolescent Mental Health Services (CAMSHS) and youth Alcohol and Other Drugs (AOD) access (7) • CAMSHS and AOD follow-up (6)

Best practice themes	Promotion	Prevention	Treatment
Cross-sectoral approach		• YWiSS (14) – Check & Connect (9) • SBHS (1) • Address emerging mental health issues in Canterbury (26) • Youth Referral Pathways Review (19) • Referral pathway supports for young people (23) • Integrated funding models and connected service delivery (24) • Co-locating additional social services in schools (25)	• Address emerging mental health issues in Canterbury (26)
Focus on key risk and protective factors, both individual and environmental	• My FRIENDS Youth (10)	• HEEADSSS (2) • Whānau Ora for Youth Mental Health (22) • YWiSS (14) – Check & Connect (9)	
Dual focus on prevention and promotion, using a strengths-based approach	• PB4L School-wide (8) • Social Media Innovation Fund (15)	• PB4L School-wide (8) • YWiSS (14) – Check & Connect (9)	
Informed by theory and evidence		• My FRIENDS Youth (10) • SBHS (1) • YWiSS (14) – Check & Connect (9) • HEEADSSS (2)	• E-Therapy (4)
Use of a developmental framework		• HEEADSSS (2) • YWiSS (14)	
Socio-ecological model	• ERO review of wellbeing and engagement in schools (11)	• PB4L School-wide (8) • Whānau Ora for Youth Mental Health (22)	
Cultural appropriateness		• YWiSS (14) – Check & Connect (9) • Whānau Ora for Youth Mental Health (22)	
Intentional innovation	• Social Media Innovation Fund (15) • Whānau Ora for Youth Mental Health (22)		
Adequate dosage and timeframe	There are few programmes where this applies. Where programmes are manualised there is insufficient evidence to support dosage and timeframe benchmarks within the New Zealand context.[30]		

[30] While this statement is true of New Zealand evidence, there is an international evidence base to support programmes originating elsewhere, including Check & Connect and My FRIENDS Youth.

With regard to the integration of initiatives and agencies, a number of factors have been identified that have implications for future initiatives and cross-sector work.

Overall, SBHS and other efforts need to be better integrated with other services delivered through the wider health system. Linking YMHP services to the wider primary healthcare system was identified as a general concern, with a need for greater consistency in services and joint change management processes to bring different services into alignment. In this context it is also important to take into account the perspectives of young people as the main recipients of these services.

Different stakeholders need to work in partnership to co-construct their services for different clients, and to communicate effectively about all aspects of their programmes. More effective interactions between the different elements of the YMHP, as well as between YMHP initiatives and outside services, are called for.

It is important to note that it takes longer than generally anticipated to establish effective collaboration between agencies and projects.

There were numerous issues to do with the collection and reporting of appropriate, consistent and timely data on delivery and performance. It is recommended that monitoring data include both implementation and financial information, and be planned for at an early stage based on a clear programme theory/logic.

Reporting has also been inconsistent with different agencies using incompatible formats and templates. Developing consistent formats and data standards would be helpful for both intervention accountability and the overall evaluation.

Finally, a significant issue to be addressed is the negotiation of data access with providers, contingent on consent from young people. Given that trust and shared understanding need to be established to ensure data access and quality, this task should be undertaken early in the implementation cycle.

These areas for development should be taken into account when designing any new initiatives, especially if they are cross-sectoral and expected to address complex social policy concerns.

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Recommendations

The formative evaluation has identified issues relevant to the ongoing development and implementation of the YMHP. In this section, recommendations to address these issues are provided.

Understanding programme expectations

We recommend the Steering Group review and revise its understanding of expectations from the YMHP so that there is a strong basis for understanding how the different initiatives collectively contribute to the overall YMHP outcomes – the added value of being a programme will then be fully understood. This work will help to describe the expectations the Steering Group have about how the initiatives work together as a package. It will build on developmental work done by the Department of Prime Minister and Cabinet (DPMC) on the high level intention of the project.

Monitoring mechanisms

We recommend that the YMHP agencies establish stronger monitoring and reporting mechanisms to measure progress towards achieving the expected outcomes, consistent with the project's expectations. These mechanisms should provide baseline data prior to the start of the YMHP as well as measures of the YMHP outcomes over four years.

Funding resources

We recommend that agencies provide more comprehensive information on the resources that are being used for the YMHP, how cost effectively the initiatives are being delivered, and where they should be targeted, ensuring adequate uptake and the appropriateness of settings and delivery channels. Superu will give the Steering Group guidance on the level of financial information that is necessary for making reasonable judgements and for making these judgements efficiently.

Cultural appropriateness – meeting the needs of Māori and Pacific youth

We recommend that agencies place a greater emphasis on ensuring that the needs of Māori and Pacific youth are met. In particular we recommend that the project monitor whether the initiatives are adequately targeting, and being taken up by, vulnerable groups such as Māori and Pacific youth.

Appendix 1

Evaluation design and methodology

As previously outlined, the YMHP is a complex programme that includes a range of initiatives, in a range of settings, aiming to achieve a range of outcomes. This evaluation seeks to answer questions about governance, process and implementation, and outcomes for which a variety of research methods are used. In particular, the formative evaluation provides robust and useful information about the coherence of the project, its implementation and key lessons learned. To answer the evaluation questions, the evaluation design included a mix of methods (quantitative and qualitative) and a range of data sources that enabled the gathering of information from different perspectives and within the different settings in which the initiatives have been located (ie in the community, schools and health services, and online). There were six main information sources for addressing the evaluation objectives:

- a literature review
- a school-based survey
- case studies
- stakeholder interviews
- a VfM analysis
- a monitoring and evaluation assessment based on project plans, quarterly reports and other documentation generated by YMHP initiatives and governance activities.

A1.1 Māori and Pacific perspectives

The YMHP in decile 1-3 schools is largely found in areas with high Māori and Pacific populations. It is therefore important that Māori and Pacific perspectives are included in the YMHP evaluation and that consideration is given to holistic models of health and wellbeing in both Māori and Pacific cultural contexts. A taxonomy for Māori research was drawn on to position the research as 'Māori centred' rather than take a 'kaupapa Māori research approach'.[31] 'Māori centred' better reflects the evaluation approach where Māori are significant participants in the YMHP evaluation and the expectation that Māori methods and analysis will be applied appropriately.

A Māori-centred approach will enable the evaluation team to engage and work with a sample of kura kaupapa Māori schools in more culturally responsive ways. Surveys and interview schedules have been adapted to the New Zealand context and then translated into te reo Māori. Māori advisors on the Experts Advisory Group and a senior Māori member of Superu are providing design and implementation advice throughout the life of the evaluation.

Consideration will also be given to the Pacific population and to working in culturally appropriately ways, particularly in the case studies approach. A Pacific expert advisor on the Experts Advisory Group and a senior Pacific member of Superu will provide guidance and advice throughout the evaluation of the YMHP.

Population and service user data is disaggregated to ensure that all evaluative analysis can be conducted through the lens of culture – potentially accounting for differences in programme exposure, quality of experience, and kinds and levels of outcome in relation to the YMHP. The holistic, strengths-based approach recommended for Māori and Pacific youth is not limited to them, but is relevant to all young people.

A basic explanation of the Te Whare Tapa Whā and Fonofale models of health and the application of cultural analysis and interpretation is provided in Appendix 4.

Each of the information sources used for the evaluation is briefly summarised below.

A1.2 Research review

A research review of international and national studies was undertaken to provide a context within which to conduct the evaluation, and to inform the development of optimal theories of change/logics for mental health interventions for young people, and for the programme as a whole. The review aimed to provide evidence of good- and best-practice design and delivery of youth mental health programmes and to investigate the assumed links between protective factors, such as social and intellectual engagement, within schools and communities and subsequent mental health outcomes. The review intended to provide a definition of 'good practice' in building youth resilience, how young people are brought in to and 'graduate' out of mentoring relationships, and investigating what health promotion approaches are most suitable for youth mental health. The output from the review informed the development of the proposed outcomes framework and the selection of case study variables.

[31] Cunningham, C. (2000). 'A framework for addressing Māori knowledge in research, science and technology.' *Pacific Health Dialog* 7(1).

A1.3 Case studies

Case studies provide a way of investigating complex programmes like the YMHP in depth, across all their dimensions and within their real-life contexts. Case studies will provide one method for assessing how effectively the initiatives of the YMHP work for young people and their families and whānau, schools, communities and agencies.

A case study pilot was carried out in two areas of the Wellington region. The pilot drew on demographic information about the area and on interviews and survey data. The pilot tested the potential for case studies to provide information on whether changes in the observed outcomes are influenced by the YMHP or other influences within the same areas. The demographic information provided a population profile of the community, including age and ethnic composition as well as indicators of deprivation and socio-economic status. The interviews were conducted with school principals and with teachers involved with the YMHP initiatives. A focus group of young people was organised to provide a youth voice to the evaluation and to provide the perspectives of intended beneficiaries of the YMHP.

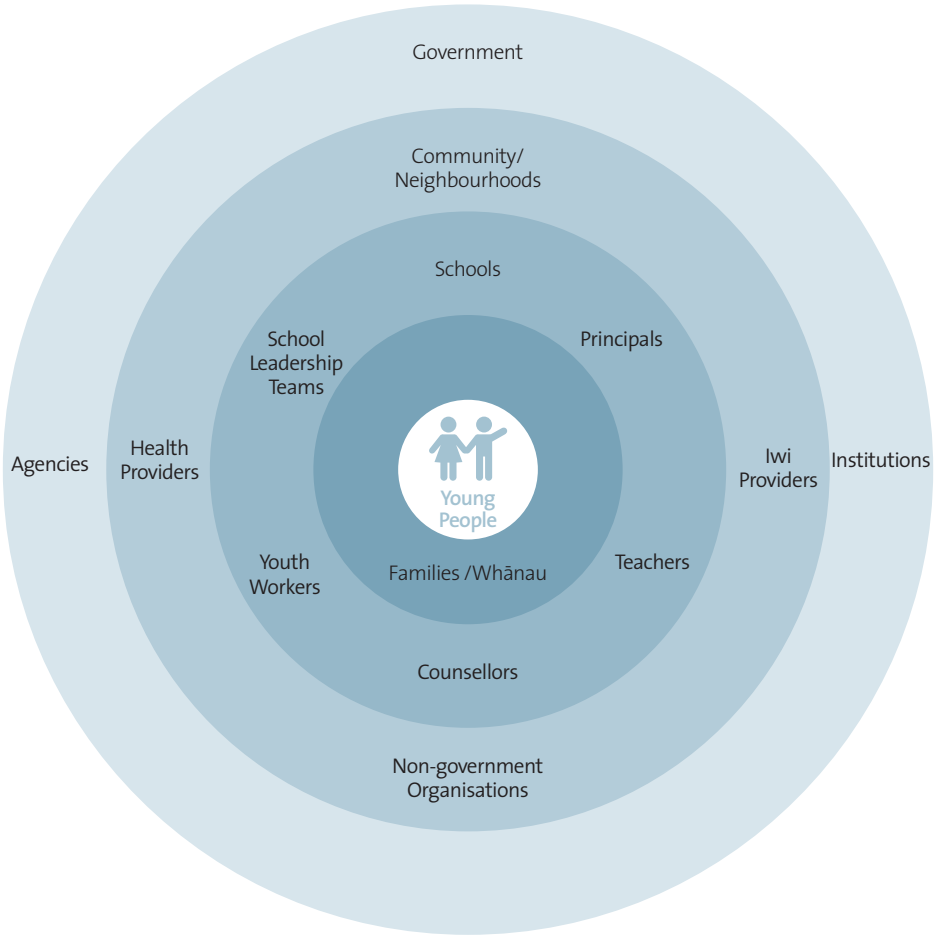
The pilot demonstrated the feasibility of the case study approach. Lessons learned for future case studies are described in Appendix 6.

A socio-ecological model has been used to conceptualise how these different aspects of the YMHP affect the lives of young people and youth mental health and wellbeing. The socio-ecological model places the young person at the centre. Case studies may be seen as taking a slice across the concentric circles of the model, bringing together a range of perspectives on the activities of YMHP initiatives in different contexts.

Young people are at the centre of this model, surrounded by those closest to them (families and whānau), embedded firmly in their school environment and within their neighbourhoods and local communities. There are two-way interactions between the young people, significant others and settings. For example, at the periphery of the model the broad government structures and institutions influence what resources are available, including how and where they can be accessed.

Schools, principals and school counsellors have enormous roles to play in the lives of young people and their sense of wellbeing and connectedness to their school environments. Another layer of support for young people is the wider context of community and neighbourhoods, providers and NGOs (see Figure A1.1).

Figure A1.1_ Socio-ecological model for understanding youth mental health initiatives



A1.4 School-based survey ('Tell Them From Me')

The 'Tell Them From Me' (TTFM) survey[32] is designed to provide information on the perceptions and attitudes of young people towards their families, their schools and their communities as well as their engagement in protective and risky behaviours.

The TTFM is based on an international theoretical model of healthy child and youth development with a specific focus on the role of schools and families. It collects information on five domains:

- engagement outcomes
- health outcomes
- academic outcomes
- drivers of student outcomes
- demographic profiles.

Survey questions were customised for use in New Zealand schools, so that the language and terminology were clear and appropriate. A number of people were consulted, including the Expert Advisory Group, Youth Advisory Groups and Māori youth, on the approaches, scope and wording of the survey being used in schools.

The survey was administered via a web-based questionnaire to Year 9 students in two pilot schools. The pilot demonstrated the feasibility of using the TTFM survey in different schools with the participation of school administrators and teachers. It is intended that the survey will be administered more widely and in consecutive waves over the next two years. The selection of schools to be surveyed will be discussed and agreed with the Ministry of Education before inviting individual schools to participate in the TTFM survey.

A1.5 Stakeholder interviews

Stakeholder and key informant interviews were conducted to engage with project teams, providers and interested/involved parties. The stakeholders interviewed included selected initiative leaders and teams, members of the YMHP Steering Group and project team, and a service provider (YOSS). Information on the design, planning and implementation of the individual initiatives was obtained directly from initiative leads. The interviews also provided insights into the collective impacts of the initiatives, typically focusing on five criteria:[33]

- a common agenda
- effective governance
- a shared measurement framework
- mutually reinforcing activities
- continual and transparent communication.

[32] Tell Them From Me is a survey tool provided through The Learning Bar Inc: www.thelearningbar.com.

[33] Preskill, H., Parkhust, M., & Juster, J. (2014). *Guide to Evaluating Collective Impact: Learning and evaluation in the collective impact context*. www.collectiveimpactforum.org.

A1.6_ Value for money analysis

The VfM analysis is a critical component of the strategic evaluation design, and answers the question 'Does the YMHP represent value for money?'

The focus of the preliminary analysis is on whether five of the largest initiatives (in terms of cost) are focused on the areas of greatest weakness or need and whether they have been set up and designed to deliver the greatest value. Information on the planning and design of the initiatives and the status of implementation was sought from initiative leaders. This involved reviewing initiative documents and conducting interviews using the confidence checklist and a set of specific VfM questions. The VfM analysis also contributes to the overall conclusions with regard to outputs and outcomes, for both the individual initiatives and the project as a whole, on economy, efficiency, effectiveness and equity.

KPMG was contracted to conduct the VfM component of the evaluation, and a summary of its preliminary findings is included in this report (see section 4.4).

A1.7_ Collection of evaluation information

In order to assess the design and implementation of the YMHP, a single assessment framework (see Appendix 3) was applied consistently across all initiatives, using common evaluation criteria. The assessment framework was firstly used to determine the extent to which each project had been designed and established appropriately. Secondly, it was used to determine the level of confidence that the project was being implemented as planned and was on track to deliver the targeted benefits. To answer both of these questions, information contained in the project plan, and progress and evaluation documents from agencies, were assessed using the assessment framework. In some instances additional information was sought from the individual initiatives to fill any significant information gaps identified in the first round of data collection and analysis.

A third question was then asked to determine the extent to which each initiative contributed to the aims and outcomes of the YMHP. An analysis of the assessments enabled an overall assessment to be made of the extent to which the initiatives, considered together, made a cohesive package or programme across the six expected outcomes of the YMHP.

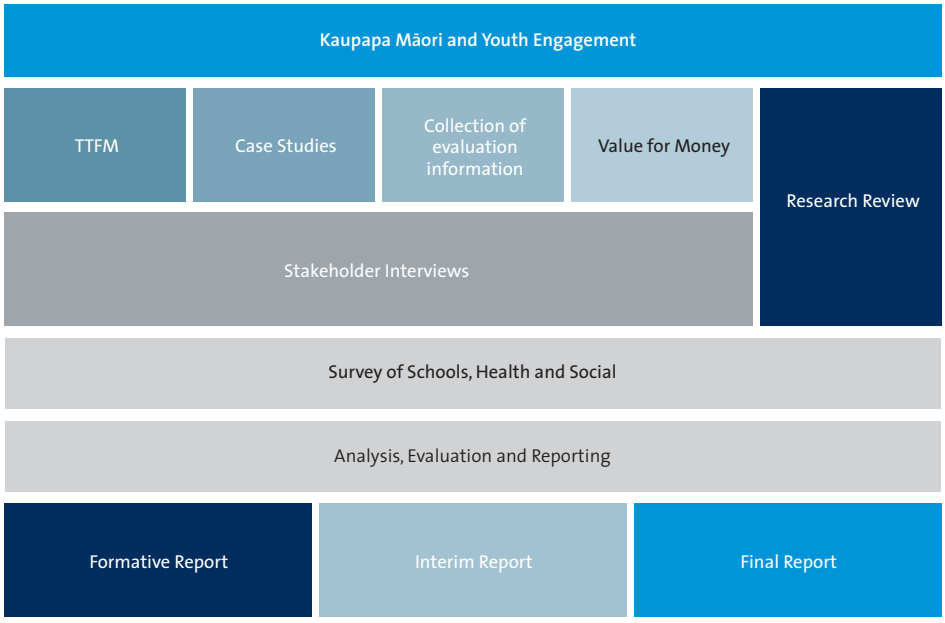
A1.8_ Overarching evaluation framework

These components of the evaluation enabled a triangulation of results to assess the success or otherwise of the YMHP and are captured in Figure A1.2, which provides a pictorial model of the overarching evaluation framework or approach used for the YMHP evaluation.

A1.9_ Limitations of the evaluation

The evaluation has been affected by a lack of clear and consistent data on intended and achieved outcomes for those who receive YMHP services and those who do not. The available information does not show whether initiatives have been consistently interpreted in different areas, resulting in consistent services. Some elements of the evaluation, including case studies and the VfM analysis, are still at an early stage. The ongoing evaluation will need to look further at incorporating perspectives of Māori and Pacific youth and practitioners. The new elements of the evaluation have not yet provided much evaluative information, which has limited the analysis possible at this stage. A consideration of formative evaluation questions will therefore continue in the next stage of the project.

Figure A1.2_ Overarching evaluation framework



Appendix 2

YMHP initiatives

Initiative	Lead agency	Initiative
1	MoH	School Based Health Services (SBHS)
2	MoH	HEEADSSS Wellness Check
3	MoH	Primary Mental Health
4	MoH	E-Therapy
5	MoH	Primary Care Responsiveness to Youth
6	MoH	Child and Adolescent Mental Health Service (CAMHS) and youth Alcohol and Other Drugs (AOD) Follow-up
7	MoH	Child and Adolescent Mental Health Service (CAMHS) and youth Alcohol and Other Drugs (AOD) Access
8	MoE	PB4L Positive Behaviour for Learning School-wide
9	MoE	PB4L Check & Connect
10	MoE	PB4L My FRIENDS Youth
11	MoE – ERO	Education Review Office (ERO) review of wellbeing and engagement in school
12	MoE – ERO	Improving the School Guidance System
13	MoE	Review of Alcohol and Other Drug Education Programmes
14	MSD	Youth Workers in Low-Decile Secondary Schools (YWiSS)
15	MSD	Social Media Innovation Fund
16	MSD	Improving the youth-friendliness of mental health resources
17	MSD	Information for parents, families and friends
18	MSD	Social Support for Youth One-Stop Shops (YOSS)
19	MSD	Youth Referrals Pathways Review
20	MSD	Youth Engagement
21	MSD	Youth mental health training for social services
22	TPK	Whānau Ora for Youth Mental Health
23	MSD	Referral pathway support for young people
24	MoH	Developing integrated funding models and connected service delivery
25	MoE	Co-locating additional social services in schools
26	MoH	Addressing the emerging youth mental health issues in Canterbury

MOH – Ministry of Health
MSD – Ministry of Social Development
MoE – Ministry of Education
ERO – Education Review Office
TPK – Te Puni Kōkiri

Appendix 3

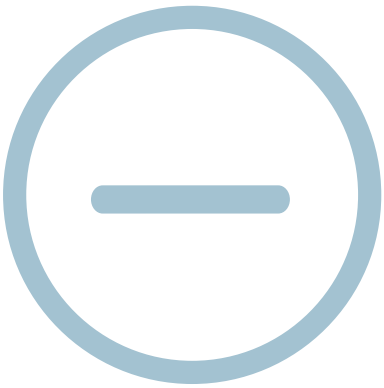
Initiative assessment framework

A3.1_ Anticipated outcomes of the initiative

Points for discussion in this section:
1. What are the overall aims and objectives of the initiative?
2. How do the anticipated outcomes align with the YMHP four-year goals (high, medium, low) or 'other' goals?
3. Does a rationale exist that clearly outlines how the initiative contributes to anticipated outcomes?
4. Are there clear criteria for measuring the success or failure of the initiative?
5. Are there sufficient and appropriate data to allow the initiative to measure success and to reflect on progress?
6. Does the evidence indicate that benefits will be sustained?

A3.2_ Selection of initiative design

Points for discussion in this section:
1. Is there a sound business case tailored to the size and specific features of the initiative that sets out the costs, benefits and risks and indicates this approach as the preferred option?
2. Where on the spectrum of innovative elements (from business as usual to breaking ground) does the design of the initiative sit? Elements of innovation may include: • new approaches or elements of practice • relationships with young people • philosophy • organisation or management • other.



A3.3_ The budget for the initiative

Points for discussion in this section:
1. What is the budget for the initiative?
2. Is the budget realistic?
3. Is the initiative on track with its defined budget?

A3.4_ Initiative governance and accountability

Points for discussion in this section:
1. Are timeframes clearly defined and achievable and do they include key milestones and decision points?
2. Is there a documented initiative methodology in place and being followed?
3. Are risk management controls effective?
4. Are appropriate measures in place to track scope changes and lessons learnt?
5. Has effective governance, including accountability (particularly for outcomes), been established?
6. Does the initiative have appropriate organisational factors (ie system readiness, culture change and defined roles of the leaders)?

A3.5_ Target group or focus

Points for discussion in this section:
1. Is the target group or focus well defined (includes geography, socio-economic, age, ethnicity, degree of mental health)? • geography • socio-economic • age • ethnicity • degree of mental health.
2. Does the initiative utilise an adequate and appropriate developmental framework (that engages with the target population in a staged manner)?
3. Does the initiative focus on environmental (eg school, community) factors as well as individual factors?
4. Does the initiative adequately meet the needs of the target population?
5. Does the initiative align with the norms, values and languages of the target population, particularly including those of Māori?
6. Is there evidence of actual or potential uptake by the target population?

A3.6_ Other key stakeholders, other than target population

Points for discussion in this section:
1. Who are the other key stakeholders that are involved in the initiative, including the Senior Responsible Officer (the key person responsible and accountable for the initiative)?
2. Has adequate training and support been provided to the implementation team?
3. Are stakeholders engaged in effective working relationships and taking part in the initiative?
4. Is information being shared with other initiatives, where relevant?

A3.7_ Final thoughts

Points for discussion in this section:
1. Has the initiative felt like part of a programme?
2. What are your key concerns/fears?
3. Is there anything we haven't asked you that you think we should have?
4. Is there anything else we haven't seen (project documents) that would be useful?

Appendix 4

Application of Te Whare Tapa Whā and Fonofale models of health

A4.1 Te Whare Tapa Whā model of health

Te Whare Tapa Whā is a model that depicts a holistic Māori worldview of health. The model was developed by Professor Sir Mason Durie during the 1980s and is widely recognised and accepted as a Māori health perspective.[34] The Te Whare Tapa Whā model compares Māori health with the four walls of a house or wharenui, where all sides are required in order to ensure strength and balance.

The following model shows the characteristics of the Whare Tapa Whā model.

TABLE A4.1

Te Whare Tapa Whā model

	Taha Wairua	Taha Hinengaro	Taha Tinana	Taha Whānau
Focus	Spiritual	Mental	Physical	Extended family
Key aspects	The capacity for faith and wider communion	The capacity to communicate, to think and to feel	The capacity for physical growth and development	The capacity to belong, to care and to share
Themes	Health is related to unseen and unspoken energies	Mind and body are inseparable	Good physical health is necessary for optimal development	Individuals are part of wider social systems

There are four dimensions to the Te Whare Tapa Whā model that contribute to overall good health and wellbeing. Taha Wairua (Spirituality) represents the interrelationships between people and the environment. Recognition of a person's affiliation with a particular religious denomination is but one way of expressing spirituality. The relationship with the natural environment, as in land, rivers, lakes and mountains, also has a spiritual importance for Māori. Lack of access to these tribally significant places can lead to ill health as these features are fundamental to one's identity and essential to one's overall sense of wellbeing.

Te Taha Hinengaro (Mental) is the expression of thoughts and feelings. Emotional communication as well as the unspoken signals can be viewed as forms of expressing one's feelings according to Durie.[35]

[34] Durie, M. (1998). *Whaiora: Māori health development* (2nd ed.). Oxford University Press, Australia and New Zealand.
[35] Durie, p 71.

Te Taha Tinana (Physical or Bodily Health) has more in common with traditional Pakeha health perspectives but in te ao Māori there is a separation between certain parts of the body and particular functions of the body. For instance the head of a person is seen as more sacred (or tapu) than other parts of the body.

Te Taha Whānau (Extended Family) is the fourth dimension of health from a Māori perspective. This dimension acknowledges the central importance of whānau in the lives of Māori. Whānau provide care and nurturing from a physical, cultural and emotional standpoint for individuals. Individuals see themselves as part of a collective identity and a sense of purpose is also derived from Te Taha Whānau.

A4.2_ Fonofale Pacific model of health

The Fonofale model of Pacific health perspectives has similarities to Te Whare Tapa Whā.

This model was developed by Fuimaono Karl Pulotu-Endemann in the 1980s.[36] In 2002 it was endorsed by the Mental Health Commission. The model was consulted on by a diverse range of Pacific populations and includes the values and beliefs of many of these Pacific populations. The Fonofale model uses the concept of a Samoan house or fale to depict the fundamental dimensions of health from a uniquely Pacific worldview. Consideration is given to Pacific peoples born in New Zealand and those who were born and raised in their Pacific lands.

Figure A4.1_ The Fonofale model

[36] Pulotu-Endemann, F.K. (2001). *Fonofale Model of Health*. Retrieved 31 August 2014 from www.hauora.co.nz/resources/fonofalemodelexplanation.pdf

The model uses the floor of the house to represent the Family as the fundamental foundation of all Pacific cultures. The Family as the foundation is what binds Pacific peoples to titles, lands, islands, sea and the Gods of the Pacific Islands. The roof is a representation of cultural beliefs and values that provide shelter and protection for Pacific families. There is some fluidity between traditional and contemporary beliefs and values for Pacific families who have adapted their lives in Aotearoa New Zealand. According to Endemann (2001), they may live their lives in a continuum that stretches from a traditional Pacific cultural orientation to a Palagi cultural orientation.

There are four posts, or pou, which represent the physical, spiritual, mental and other aspects that comprise good health and wellbeing from a Pacific worldview. The spiritual dimension is about the sense of wellbeing. It can accommodate Christianity as well as traditional spirituality. This realm also includes the linkages to the natural environment and to history and ancestors.

The physical dimension relates to biological or clinical wellbeing in a similar way to Taha Tinana in Te Whare Tapa Whā.

The mental dimension relates to the wellbeing and health of the mind. Like Taha Hinengaro in Te Whare Tapa Whā, thoughts and emotions are significant.

The Fonofale model has a pou called the 'other'. This relates to several variables that can affect health and wellbeing either directly or indirectly, such as gender, sexual orientation, age and socio-economic position.

The Fonofale and its dimensions are surrounded by or contained within a framework of time, environment and context. This depicts the dynamism of culture and its ability to adapt to particular changes in environment and time.

Appendix 5

Provisional YMHP outcomes framework

Outcomes	What we expect to see	How we will measure what we expect to see (Outcomes measures)	Information Sources		
			National level	Local case study	Initiative data
BETTER mental health & wellbeing for youth	Improved mental health	Prevalence of anxiety, depression, serious emotional and behavioural problems in youth	IDI-potential Youth 2000		CAMHS & AOD
		Improved employment, education, and training rates for youth			
	Reduction in risky behaviours	Prevalence of self-harm; alcohol and substance use and misuse, including tobacco, by youth			
Improved resilience among youth	Youth adapt to stress and challenging life situations	Youth report they have strategies to deal with distress	Youth2000 NZ General Social Survey	Interviews	My FRIENDS Youth Check & Connect (C&C) PB4L SW
	Youth have positive attitudes about themselves	Youth report good self-esteem, life satisfaction, confidence			
	Youth are engaged at school and in the community	Youth participation in organised sports or cultural activities; adult advocacy at school; values and school outcomes; intellectual engagement; effort at school; interest and motivation at school; expectations for academic success; attendance at school; student aspiration; cultural identity	Youth 2000 MOE data	TTFM Interviews	
		Trends in attendance, disruptive student behaviour			
	Youth have connected relationships	Youth report positive relationships; a sense of belonging; not being lonely			

4 year outcomes

Outcomes	What we expect to see	How we will measure what we expect to see (Outcomes measures)	Information Sources		
			National level	Local case study	Initiative data
Better access to timely and appropriate treatment and follow up	Timely & appropriate referrals to specialist services	Services provide positive feedback on referrals process and access to treatment		Interviews	CAMHS & AOD SBHS
		Waiting-times for youth to access treatment are within good practice timeframes (AOD & mental health)	NZ Health Survey		
		Referrals accepted as appropriate referrals by the treatment service			
		Providers know when and who to refer to treatment or other services			
	Increased primary mental health interventions	Number of youth receiving brief interventions / counselling sessions/ group therapy provided by PMH clinicians		Locality data	E-therapy PMH, YOSS, SMIF
		(DHB & NGO) funding per head of (Infant) child & adolescent population	Werry Stocktake	Interviews	
		Number of clients accessing (infant), child & adolescent mental health & AOD services			
	Effective care pathways connect youth to services	Schools, health and social services providers use care pathways			Referral pathway, SBHS
		Schools, health and social services provide integrated care (joined up services) to youth at risk	DNA rates		
	Increased access to self-directed care	The number of youth who use e-therapy to manage mild & moderate mental health			E-therapy

Outcomes	What we expect to see	How we will measure what we expect to see (Outcomes measures)	Information Sources		
			National level	Local case study	Initiative data
Early identification of mild to moderate mental health issues in youth	Youth with mild or moderate needs are identified earlier	Youth with emotional or behavioural problems are identified	NZ Health Survey		
		Number of youth screened		Interviews	HEEADSS PMH SBSH YOSS
		Number of services using screening tools to diagnose mental health.			
	More youth access primary health services	Youth visit primary health services (including GPs, YOSS, school-based health services)			
		Youth visit a practice nurse (for mental health issues)			
More supportive schools, communities, social and health services	Youth perceive their schools, communities, social and health services as supportive	Youth feel supported: family and whānau advocacy outside of school, advocacy at school by an adult	Wellbeing Youth 2000	TTFM, Interviews	PB4L SW, C&C, My FRIENDS Youth, SBHS, YWISS, Whanau ora, School guidance
		Youth can identify a person/service(s) that supports them		Interviews	
		Youth consider health and social services are youth friendly			
		Youth agree they would access existing services if they needed to			
	Increase in capacity of appropriate services	Youth, families and whānau consider services as accessible (e.g. opening hours, location, cost, stigma, culturally appropriate)	NZ Health Survey Youth 2000	Interviews	CAMHS Youth AOD Access PB4L SW
		Rate of youth reporting unmet need for after-hours health care services due to cost			
		Rate of youth reporting unmet need for primary care services due to cost			
		Services meet the needs of Māori and Pacific youth			
	Improved capacity and capability of frontline staff to respond to YMH issues	Providers and staff know what to do to support youth (eg are trained, have access to information, undertake referrals)		Interviews Online survey	SBHS, HEEADSS, PB4L SW, PMH, YWISS
		School staff, health and social services providers are confident they can recognise youth with signs of psychological distress and a developing mental health issue			
		Risk management plans are in place			
		More staff (e.g. nurses, youth workers, social workers, guidance counsellors) are available in the places where youth go			
	Schools integrate positive behaviour initiatives into the environment	Schools adopt practices that support positive behaviour and manage risky behaviour (e.g. PB4L School Wide, Check & Connect, ERO wellbeing indicators)	Youth 2000	Interviews TTFM	ERO Wellbeing, PB4L SW, C&C
		Youth experience of bullying; feeling safe at school; positive learning climate at school			

Better access to appropriate information for youth and their families & whānau	Youth, family/ whānau and communities access and understand information and resources	Youth, families and whānau understand the signs that a youth needs support and how to respond		Interviews	Resources, Information PB4L SW, Check & connect
		Youth, families and whānau know when and how to ask for help for mental health related issues			
		Youth, families and whānau know what YMH services are available to them			
	New and improved youth friendly and culturally appropriate resources are developed and distributed	Youth agree that resources are easy to understand and are appealing			
		Youth recommend YMHP interventions and resources to their friends			
		Youth, family and whānau and communities know where to access resources when they have a concern			
Improved knowledge of what works to improve mental health	Processes are in place to support system change	Inter-agency decisions are made about improving YMH services from a system perspective	Interviews	Interviews	
		Agencies provide examples of inter-agency alignment of projects e.g. Canterbury response			
		Agencies describe what has changed about how information is being shared between by agencies and providers at national, regional and local level			
	Policy and decision-makers are able to make evidence-based decisions	Agencies demonstrate how evidence (from evaluations, monitoring, reviews, experience) is used to support decision making at national, regional and local level			
	Interagency responses to complex social issues is standard practice	Ministers and officials identify and consider inter-agency initiatives as an option to address complex social issues			
		Lessons from interagency governance and management of YMHP are applied to other complex social issues at national, regional and local level			
	Smarter thinking, effective and innovative approaches to address YMH	Agencies review YMH services and provision in light of new knowledge and evidence and make recommendations on improvements that will deliver better mental health outcomes for youth			
		New initiatives to address specific gaps in mental health provision and support			
		Ineffective YMHP initiatives are discontinued			
		A cross-agency national-level monitoring framework for youth mental health and wellbeing is established			

Appendix 6

Lessons learned from pilot case study

A pilot case study was carried out in the Wellington region in selected communities, with a mix of secondary schools. The pilot case study was used to test the approaches used for engaging different community members, as well as to test the interview questions and survey questionnaire used. This summary identifies a series of lessons learned that will inform the next phase of the evaluation.

A6.1 Engagement and recruitment

Case studies require the participation of different stakeholders, including young people, their families and whānau, schools, and other community groups and institutions. The engagement process must recognise the burden of research in schools and communities, the importance of building trust and the application of kaupapa Māori principles such as manaakitanga.

Considerable attention was paid to demonstrating the value of the TTFM survey to schools. This required personal contact with the school principals to gain their support for carrying out surveys in their schools. Principals were offered the opportunity to add up to four questions (two open-ended and two multiple choice) to the survey, to be asked in their schools only and with open-ended responses provided only to those schools. The principals approached agreed to take part in the survey and to support further discussions with staff in either interviews or focus groups. The three schools approached about the survey nominated school co-ordinators as their primary points of contact for the survey. Schools were given leeway in deciding how many students to include in the survey. One school chose to administer the survey to all students in Year 9, but another school chose a smaller sample of students. Clear expectations will need to be set for future school surveys about how large the sample should be, and how it should be selected.

The pilot showed the importance of the following steps, required for conducting the TTFM survey:

- Approach school administrators about the survey.
- Set up a meeting with the school principal.
- Agree on a school co-ordinator for the survey.
- Agree on when and how the survey will be administered.
- Agree on when to conduct an interview or focus group with the principal and/or school staff.
- Have regular communication with the school co-ordinator for support.
- Send relevant information sheets, consent forms and survey training information.

Actions required for wider stakeholder engagement in the pilot areas included:

- Meet local health provider.
- Confirm dates and attendance.
- Organise a focus group discussion with young people
- Conduct key informant interview/focus group.

A6.2 Ethics

An ethics application for the school-based survey was approved by Superu's Ethics Committee in February 2014. The application showed how informed consent for participation would be obtained, and how information from the survey or interview and focus group respondents would be kept confidential. It was noted that the initial round of surveys would be carried out in conjunction with the area-based case studies. The Ethics Committee should also review the full case studies.

An internal quality assurance process has been undertaken for the school-based survey, information sheets and consent forms. This will also be conducted for the interview/ focus group information sheets and consent forms.

A6.3 Cultural approach

As relationships lie at the core of whānau and kaupapa Māori thinking and practices, it was important that we approached kura appropriately. It was for this reason that a senior Māori member of the evaluation team forged the way in the engagement and maintenance of key relationships with tumuaki, kura whānau and rangatahi. The pilot illustrated the important role of a senior Māori analyst in the engagement with kura and in ensuring that kaupapa Māori principles were visible and practised throughout the evaluation.

The TTFM survey was translated into te reo by an external expert. The translation was to be a literal translation of the English version into te reo for compatibility and ease of transfer of the results into the English reports. It is noted, however, that the literal translation of the questions may not capture nuanced understandings and cultural contexts and may have an impact on the analysis of the data. The translated survey has not yet been applied in the setting of a kura, but it will be tested further to ensure that is able to be understood by students. Precognitive testing of the survey will be essential to any roll-out.

A6.4 Case study instruments

As noted earlier, the pilot case study tested the use of the TTFM school-based survey as well as the interview and focus group guidelines.

A6.5 School-based survey

The TTFM survey is a web-based computer questionnaire developed in Canada by Dr J Doug Wilms and Patrick Flanagan. To ensure that the tool was suitable for young people in New Zealand, the questions were customised to avoid unfamiliar terms or language usage. Questions relevant to the evaluation were selected and additional questions added as needed. Appropriate images were selected for the survey website and documents to encourage greater participation by New Zealand students. The survey was also translated into te reo.

A6.6 Interview/focus group guidelines

The interview and focus group guidelines were developed for school staff, health providers and youth focus groups. Questions in each guideline were aligned with the overall evaluation questions and the YMHP's six outcomes.

In general, the individual interviews and focus group discussions aimed to investigate:

- what YMHP initiatives were carried out by schools and health providers
- what schools are doing outside the YMHP initiatives to support the wellbeing of young people
- the needs of young people
- the support conditions in rural and urban neighbourhoods
- any issues in the implementation of the YMHP initiatives
- perceptions of the value for money of the YMHP initiatives.

A6.7 Data and analysis

The pilot was able to collect quantitative and qualitative data from a variety of sources, including the census, TTFM survey, individual interviews and focus group discussions. Data was collected from July to August 2014, involving a desk research of the region's profile, quantitative survey data and qualitative interview and focus group data.

The pilot showed that it will be possible to triangulate data from the different sources within each case study area. School surveys will provide data on outcomes of interest, such as the quality of young people's engagement with schools and the strength of their relationships with peers and adults, which contribute to the outcome of youth resilience. This data will be analysed in the context of the communities in which youth live.

Appendix 7

Youth Mental Health Project acronyms

AOD – alcohol and other drugs

CAMHS – Child and Adolescent Mental Health Services

DHB – District health board

DPMC – Department of the Prime Minister and Cabinet

ERO – Education Review Office

HEEADSSS Wellness Check – stands for: Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide/Depression and Safety

NGO – Non-government organisation

PB4L – Positive Behaviour for Learning

SBHS – School Based Health Services

Superu – Social Policy Research and Evaluation Unit of the Families Commission

TTFM – Tell Them From Me (school survey)

VfM – value for money

YOSS – Youth One-Stop Shop

YMHP – Youth Mental Health Project

YWiSS – Youth Workers in Low Decile Secondary Schools

Social Policy Evaluation and Research Unit

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Families Commission Kōmihana ā Whānau

The Families Commission operates under the name Social Policy Evaluation and Research Unit (Superu)