Social Policy Evaluation and Research Unit

superu

The Prime Minister's Youth Mental Health Project

LOCALITIES AND NATIONAL PERSPECTIVES EVALUATION

DECEMBER 2016

Malatest International

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 and New Zealand's communities, families and whānau.

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We are particularly grateful to the 24 schools and wharekura who took part in the evaluation, including the students and staff who completed the OurSCHOOL and school staff surveys and/or took part in interviews and focus groups.

Thank you to those who reviewed the case study locality reports and provided feedback at the locality workshops.

We hope this report includes information that will help you all to continue to support youth health and wellbeing in New Zealand.

Malatest International

Executive summary

This report is one of three published as part of the Phase 2 strategic evaluation of the Prime Minister's Youth Mental Health Project (YMHP). The Summative Evaluation Report synthesises the findings and recommendations from this Localities and National Perspectives Evaluation report and the Cost-Benefit Analysis report, as well as available evaluations of individual initiatives. All three reports can be downloaded from www.superu.govt.nz.

The Youth Mental Health Project aims to improve mental health and wellbeing for youth aged 12 to 19

The Youth Mental Health Project was established in 2012. It comprises 26 initiatives aimed at improving the mental health and wellbeing of youth aged 12 to 19 years with, or at risk of developing, mild to moderate mental health issues.

The four-year outcomes of the YMHP are:

- Improved resilience among youth
- Better access to timely and appropriate treatment and follow-up for youth with mild to moderate mental health issues
- Early identification of mild to moderate mental health issues in youth
- More supportive schools, communities, and health and social services
- Better access to appropriate information for youth and their families and whānau
- Improved knowledge about what works to improve youth mental health.

The evaluation of the YMHP

The information in this evaluation report has been provided from the following perspectives:

- National perspective – We interviewed YMHP steering group members and project team members / initiative leads.
- Initiative perspective – We obtained information from agencies on the progress of individual initiatives (including evaluations of the initiatives where these were available).
- Locality perspective – We carried out in-depth studies of six localities to understand how the YMHP has been implemented and what is being achieved. The locality studies included interviews with regional managers of agencies, health and social service providers, school staff and youth, as well as a survey of youth at secondary schools (the OurSCHOOL survey).

The localities

The localities included in the evaluation are:

- Northland (Bay of Islands, Kerikeri and Kawakawa)
- West Auckland (Henderson, Massey and Te Atatu)
- Hawke's Bay (Flaxmere, Hastings and Havelock North)
- Lower Hutt (including Wainuiomata)
- East Christchurch
- Invercargill.

Evidence from the OurSCHOOL survey and qualitative data collection indicates differences and similarities in risk and protective factors and in mental health outcomes across the six localities included in the evaluation.

A notable difference between localities was that in Christchurch a higher proportion of youth reported risk factors and had indicators of anxiety or depression than in other localities.

Key messages

Understanding local communities and their differences is important in developing and implementing national programmes.

How well is the YMHP being implemented?

An interagency response has been achieved at central government level through an interagency steering group. The steering group has developed a strong collective approach to problem solving.

A cross-sectoral approach was less evident in the localities, and collaboration and communication between health and social sector organisations varied. Schools were often not part of local governance/working groups. One of the major challenges observed in the locality studies was the lack of a role with the mandate to look across the different agencies.

Youth Service Level Alliance Teams (SLATs) established in 19 of 20 District Health Boards (DHBs) have the potential to strengthen local service provision through communication and collaboration between key stakeholders and prioritisation of activities to meet local needs.

New Zealand has a devolved service-delivery system for education, health and, to a lesser extent, social services. This allows localities to deliver initiatives that best meet the needs of their populations and to do so in ways that work within local systems. However, it can take longer to implement national initiatives. Schools and providers can choose to not implement initiatives or to implement them in ways that may result in reduced effectiveness.

The 26 YMHP initiatives were progressively implemented between 2012 and 2016. Some were existing initiatives started before the YMHP, while some were new initiatives developed to respond to needs identified through implementing the YMHP. Some initiatives involved developing new programmes, some extended existing programmes, and some were reviews or evaluations.

Key messages

- Continuing an interagency approach will support the changes that need to be made to policies and service delivery in order to respond to youth needs.
- Central government has an important role in enabling local delivery through sharing information and providing adequate resourcing.
- Strengthening the cross-agency approach in regional implementation has the potential to improve local systems to support youth.
- Further communication and collaboration between schools and health and social service provider organisations is essential for improving youth wellbeing.

What is being achieved by the YMHP?

The YMHP is addressing identified challenges in the system such as a lack of integration, information and evidence about what works. Its focus on early identification is supported by findings from the ARACY review (Fox et al. 2015).

Information from evaluations of some of the individual YMHP initiatives provides evidence that they are achieving positive changes for youth that may be expected to result in improved mental health and wellbeing. Evaluations of initiatives and the locality studies also identified priorities for future work.

Key messages

Although positive changes have been reported as a result of the YMHP, the evaluation has identified potential future directions for improving outcomes for youth.

What do YMHP results imply for future youth mental health policies and programmes?

Combining the 26 YMHP initiatives into a single project enabled agencies to be responsive to needs that were identified during implementation and provided a framework for trialling new funding and service-delivery models. Some initiatives that reviewed systems changes have been completed, but the recommendations are still being considered.

The initiative evaluations did not provide enough evidence about outcomes for youth to allow specific recommendations to be made about which initiatives should be continued. While some initiatives demonstrated positive outcomes for youth, others have not been evaluated or have not been operating long enough to allow conclusions to be drawn. Lack of evidence about outcomes does not necessarily mean these initiatives should be discontinued.

Some gaps were identified in the project, including a need for more information for youth, families and whānau about where to go for support for mental health issues.

The different contexts that youth live in are important for developing the best ways to support youth. Understanding youth contexts means identifying local needs, developing initiatives to meet local needs, and targeting services for specific groups of youth.

Some YMHP initiatives are delivered in decile 1 to 3 schools, with the aim of reaching youth most in need. However, mental health issues were identified for youth across all school deciles. An extension of school-based services to at least mid-decile schools would reach more youth in need.

Implementing the initiatives and monitoring and evaluating the YMHP has provided information that furthers understanding about what works to support youth with mild to moderate mental health issues. More information about how initiatives and service-delivery systems influence outcomes for youth is required to inform decisions about which initiatives to continue and which aspects of local systems are effective for youth.

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Introduction to the Youth Mental Health Project

Summary

Adolescence is a time where there are opportunities to improve youth outcomes: the brain continues to grow during what is a time of transition from family influences to increasing peer influence and of increasing exposure to risky behaviours.

The Youth Mental Health Project was established in 2012 and consists of 26 initiatives aimed at improving the mental health and wellbeing of youth aged 12 to 19 years with, or at risk of developing, mild to moderate mental health issues.

The initiatives seek to:

- Promote wellbeing across the entire youth population
- Target support to those who are most vulnerable
- Treat those who need it.

Initiatives target populations, individuals, and systems and processes. Initiatives are delivered in school, community and social service and primary care settings.

1.1_ This report is part of the Phase 2 strategic evaluation of the YMHP

This report is one of three published as part of the Phase 2 strategic evaluation of the Prime Minister's Youth Mental Health Project (YMHP). The Summative Evaluation Report synthesises the findings and recommendations from this Localities and National Perspectives Evaluation report and the Cost-Benefit Analysis report, as well as available evaluations of individual initiatives. All three reports can be downloaded from www.superu.govt.nz.

1.2_ New Zealand has high rates of youth mental health issues

New Zealand youth have relatively high rates of mental health issues and the youth suicide rate is one of the highest in the OECD. One in eight (12.8%) of the youth surveyed in the 2012 Youth2000 survey displayed significant depressive symptoms, 18.4% had seen a health professional for emotional worries, and 24.0% had deliberately self-harmed (Adolescent Health Research Group 2013).

Higher prevalence of mental health issues among Māori and Pacific youth contribute to disparities between Māori, Pacific, and European ethnic groups in a broad range of life outcomes.

Youth with mental health problems have a high rate of comorbidity (The Werry Centre 2010). Mental health issues can affect the way youth engage with others and with schools. They are associated with increases in risky behaviours, and decreased participation and achievement at school, which can flow through to lower rates of workforce participation in future years.

1.3_ Youth wellbeing is influenced by predictable and unpredictable life changes

Adolescence is a period of extensive psychological and biological development that coincides with social and education transitions (e.g. leaving school and developing an identity separate from the family) (Fox et al. 2015; Gluckman 2011). Most youth in New Zealand successfully transition to adulthood, but some do not, mainly due to a complex interplay of genetic, environmental and personal risk factors (Centre for Research and Evaluation 2011).

Factors that increase the risk of unsuccessful transitions include predictable events such as adolescent transitions. Others arise from unpredictable events such as deaths, family changes and natural disasters, and trauma such as forced sexual activity. As risk factors accumulate, the probability a youth will suffer from one or more mental health problems increases.

These risk factors for youth occur in the context of the families, schools, communities, and social and economic conditions in which they live, study or work. Growing up in localities with high unemployment or poor-quality employment is associated with mental health issues. Similarly, social factors such as bullying, lack of cultural identity, and lack of a sense of belonging increase risk.

A New Zealand study found that youth in alternative education are more likely to suffer from depressive symptoms (17% compared to 11% in mainstream), to self-harm (37% compared to 19% in mainstream), and to attempt suicide (18% compared to 5% in mainstream) (Clark et al. 2010). Youth not in education, employment or training (NEET), who are socially isolated (i.e. did not have an adult aged 25 or over in their household), were significantly more likely to experience mental health problems than non-NEET youth (Pleasence, Balmer & Hagell 2015). Other groups of youth with increased risk of mental health issues include youth with a disability, and lesbian, gay, bisexual or transgender (LGBT) youth (Adolescent Health Research Group 2013).

1.4_ Youth who are resilient are better able to manage changes

Resilience involves being able to recover from difficulties or changes. Youth who are resilient can more effectively cope with, or adapt to, stress and challenging life situations. They learn from the experience of effectively managing one situation, strengthening their ability to manage future stresses and challenges. Family and whānau, peers and other people in a community (e.g. religious and cultural leaders and sports coaches) can support and build youth resilience (Centre for Addiction and Mental Health 2012).

Resilience and its influence on youth mental health and wellbeing are not fully understood. Bagshaw (2011) concluded that much of the evidence for the concept of resilience is inferred, and these inferences could be wrong. However, it is likely that multiple factors are important in determining resilience in youth. There is a need for more research to clearly define the effectiveness of interventions that affect resilience.

1.5_ There is an unmet need for some youth who require additional support

The Centre for Research and Evaluation completed a review of research for the Department of the Prime Minister and Cabinet (DPMC) (Centre for Research and Evaluation 2011).[1] The review informed the development of the Youth Mental Health Project and concluded:

- Many youth may have symptoms of poor mental health but not be diagnosed with a mental health disorder.
- There are a significant number of children and youth with relatively severe disorders who do not receive treatment from mental health services (The Werry Centre 2010). There is also a significant level of unmet need for youth with mild to moderate mental illness (Merry & Stasiak 2011; Gluckman 2011).
- Barriers to youth accessing treatment include lack of awareness by youth or their parents about mental health problems, and/or perceptions that suitable services are not available to help them.

1.6_ The Youth Mental Health Project was established to address identified challenges in the system

The directive to establish the YMHP came from the DPMC with the intention of addressing identified challenges in the system, such as a lack of integration, information and evidence about what works.

The YMHP was established in 2012 and consists of 26 initiatives that target youth aged 12 to 19 years with, or at risk of developing, mild to moderate mental health issues. Mental health issues at the mild to moderate level are defined by the Ministry of Health (MoH) 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 mild to moderate mental health issues to worsen and become more long-term if not addressed (MoH 1999).

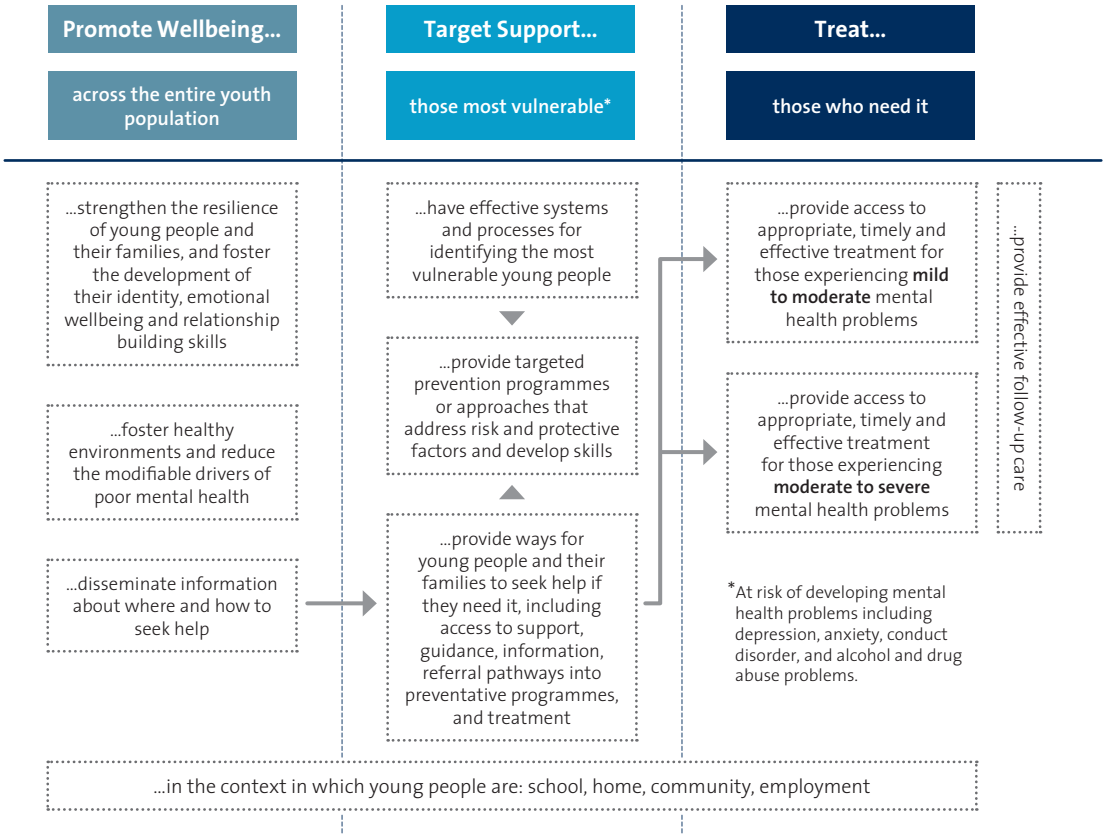
The four-year outcomes of the YMHP are:

- Improved resilience among youth
- Better access to timely and appropriate treatment and follow-up for youth with mild to moderate mental health issues
- Early identification of mild to moderate mental health issues in youth
- More supportive schools, communities, and health and social services
- Better access to appropriate information for youth and their families and whānau
- Improved knowledge about what works to improve youth mental health.

1 The review was updated by Superu and included in the Formative Evaluation Report for the YMHP (Superu 2015).

The YMHP aims to address the four-year goals by promoting wellbeing across the entire youth population, targeting support to those most vulnerable, and treating those who need it (Figure 1). While the majority of initiatives are not specifically aimed at Māori or Pacific youth, there is an expectation that these and other vulnerable groups will benefit from the YMHP. School-based YMHP initiatives target decile 1 to 3 schools, with the aim of reaching youth most in need of support.

Figure 1 _ An overview of the rationale for the YMHP



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

In 2015, Superu developed a logic model based on the above rationale for the YMHP (Appendix 1).

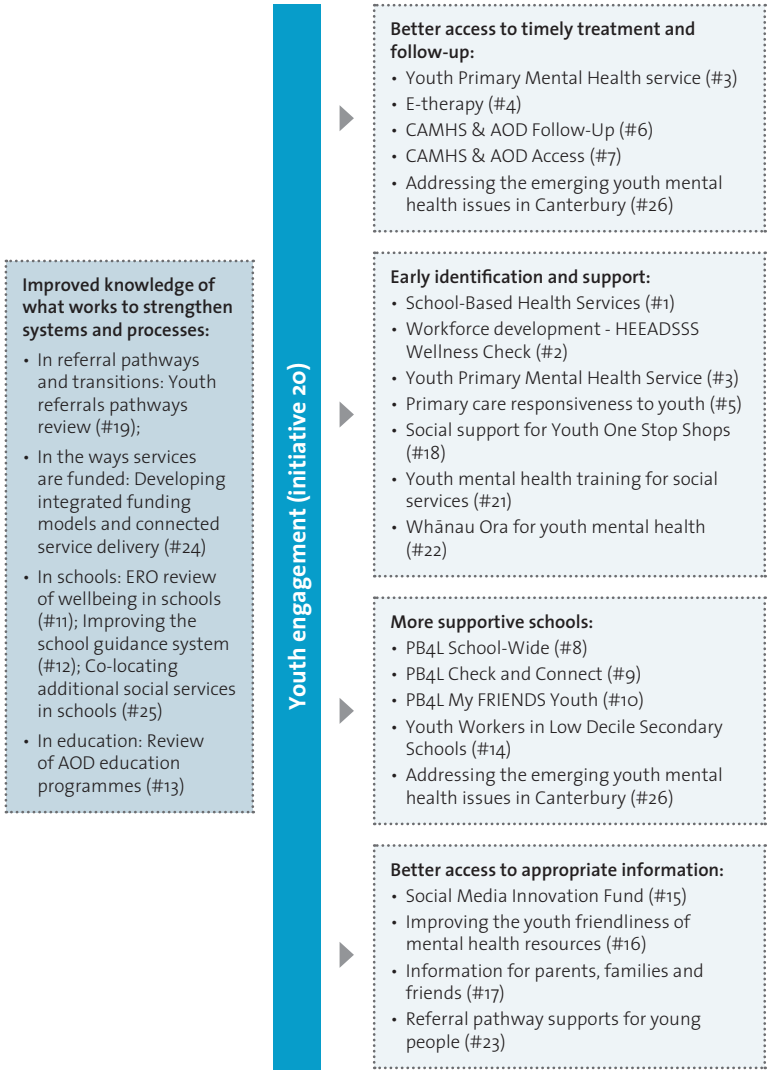
1.7_ The YMHP initiatives

The YMHP operates through initiatives that target systems, service provider organisations, and individual service providers, as well as youth and their families and whānau and communities.

The YMHP initiatives include expanding existing services, developing policy to improve future services, building capacity, implementing new services, trialling new ways of working, and leveraging change. A list of initiatives is provided in Appendix 2. Some initiatives were new programmes, some were existing programmes, and others were 'one-off' activities such as reviews and evaluations of pilots.

The links between the initiatives and the four-year outcomes of the YMHP are summarised in Figure 2. Initiatives that contribute to more than one of these outcomes are aligned with the outcome that is the primary focus of the initiative.

Figure 2 _ Links between YMHP initiatives and four-year outcomes



02

The evaluation of the Youth Mental Health Project

Summary

This evaluation of the YMHP draws on four perspectives (a national perspective, an initiative perspective, in-depth studies in six localities, and an economic evaluation) to answer five key evaluation questions. The national, initiative and locality perspectives are reported in this report. The economic evaluation is reported separately (in a Cost-Benefit Analysis report). A Summative Evaluation Report by Superu brings together information from this report and the economic evaluation.

2.1_ Evaluation questions

The evaluation of the overall YMHP assesses *whether*, *how well*, and *why* the YMHP has achieved its expected outcomes. This report provides information to address the following evaluation questions:

- How well is the YMHP being implemented?
- What is being achieved by the YMHP?
- What do YMHP results imply for future youth mental health policies and programmes?

Additional evaluation questions included:

- To what extent is the YMHP a comprehensive and coherent programme? Are there any gaps in its coverage? – addressed in the Formative Evaluation Report (Superu 2015)
- Does the YMHP represent value for money? – addressed by an economic evaluation completed by PricewaterhouseCoopers (PwC) and reported separately in their Cost-Benefit Analysis report (PwC 2016).

2.2_ Information for the evaluation was sourced from four different perspectives

The four perspectives informing the evaluation (Figure 3) are:

- The national perspective
- The initiative perspective
- The locality perspective
- The economic perspective – reported separately.

Figure 3 _ The four perspectives informing the evaluation

Locality perspective	Initiative pespective	National perspective
Six localities and over 3,000 youth – West Auckland (Henderson, Massey and Te Atatu), Northland (Bay of Islands including Kerikeri and Kawakawa), Hawke's Bay (Flaxmere, Hastings and Havelock North), Lower Hutt (including Wainuiomata), East Christchurch and Invercargill • Interviews with school pastoral care staff, teachers, family/whānau • Interviews and focus groups with youth • Interviews with health and social sector managers and frontline providers • Feedback and follow-up workshops • Surveys of school staff and community • The OurSCHOOL survey of students	• Summary of initiative evaluation findings • Case study lens on the delivery of initiatives and how they work together on the ground	• Interviews with the steering group and project team at the start and end of the evaluation • Interviews with initiative leads at the end of the evaluation
Economic evaluation		
• Using a cost-benefit analysis to determine the overall economic benefit of the YMHP • Calculate the cost effectiveness/economic value of YMHP components • Make recommendations for future investment		

2.3_ The national perspective

The national perspective was informed by interviews with members of the YMHP steering group, members of the project team that supports the steering group, and initiative leads. Steering group members were interviewed at the end of 2014 and in early 2016. The interviews provided information about how the interagency approach functioned, the governance and management of individual initiatives, and the YMHP as a whole.

Evaluators interviewed project team members and initiative leads in early 2016. The interviews explored implementation of the initiatives, what had changed since 2014, progress, and initiative achievements.

2.4_ The initiative perspective

The initiative perspective summarised the progress of individual initiatives from information provided by agencies, evaluation reports, and initiative data where available. Evaluations have been commissioned for 10 of the 26 initiatives. Of the other 16 initiatives, seven of them were reviews of processes or systems and therefore were not individually evaluated (Table 1).

TABLE 01

Summary of the status of evaluation of the YMHP initiatives

Initiatives evaluated and reports received
• Initiative 1: School-Based Health Services
• Initiative 3: Youth Primary Mental Health Service
• Initiative 4: E-therapy (SPARX)
• Initiative 7: CAMHS and AOD Access (formative evaluation of the exemplar service in Southern District Health Board available only)
• Initiative 8: PB4L School-Wide
• Initiative 9: PB4L Check and Connect
• Initiative 10: PB4L My FRIENDS Youth
• Initiative 14: Youth Workers in Low Decile Secondary Schools (as included in the Check and Connect evaluation)
• Initiative 17: Information for parents, families and friends
• Initiative 22: Whānau Ora for youth mental health
Initiatives where evaluation was not applicable
• Initiative 11: ERO evaluation of wellbeing in schools
• Initiative 12: ERO evaluation to improve the school guidance system
• Initiative 13: Review of AOD education programmes
• Initiative 19: Youth Referrals Pathways Review
• Initiative 23: Referral pathway supports for young people
• Initiative 24: Developing integrated funding models and connected service delivery
• Initiative 25: Co-locating additional social services in schools
Other initiatives not evaluated as part of the YMHP
• Initiative 2: HEEADSSS Wellness Checks
• Initiative 5: Primary Care Responsiveness to Youth
• Initiative 6: CAMHS and AOD Follow-Up
• Initiative 15: Social Media Innovation Fund (impact report available)
• Initiative 16: Improving the youth-friendliness of mental health resources
• Initiative 18: Social support for Youth One Stop Shops (YOSS)
• Initiative 20: Youth Engagement
• Initiative 21: Youth mental health training for social services (although Blueprint evaluated their own MH101 workshops)
• Initiative 26: Addressing the emerging youth mental health issues in Canterbury

2.5_ The locality perspective

The evaluation included the locality perspective in order to understand how the YMHP was implemented in six localities and how locality context influenced implementation and achievements.

Evaluators recommended a number of localities, with final selection of localities decided by Superu and the YMHP steering group. The localities included were:

- Northland: Bay of Islands including Kerikeri, Kawakawa, Moerewa and Okaihau
- West Auckland: Henderson, Massey and Te Atatu
- Hawke's Bay: Flaxmere, Hastings and Havelock North
- Lower Hutt, including Wainuiomata
- East Christchurch – from the central city to the east coast, including Mairehau to Rāwhiti and Aranui and down to Sydenham and Bromley
- Invercargill.

Localities were selected to ensure there was diversity in their characteristics. The selected localities included large urban, small urban and provincial localities located in the North and South Islands. Selection decisions also considered the extent to which YMHP initiatives were in place in the localities. Ensuring diversity of schools across the sample as a whole was also important: when considered as a group, across all case studies the sample included a range of school profiles (co-ed, single sex, wharekura, state, state integrated, and other).

The locality studies were completed between April and October 2015 and included:

- Interviews and/or focus groups with youth. Youth were recruited through schools and out-of-school settings:
  - Youth were selected from participating schools to include, in each locality, at least one male and one female focus group from junior students (Years 9 and 10) and at least one male and one female focus group from senior students (Years 11 to 13).
  - Each locality study also included at least one additional group of youth recruited through out-of-school settings such as YOSS or alternative education.
- Interviews and/or focus groups with: members of the community who worked with youth; school staff and Board of Trustees; family and whānau; and representatives from health and social service providers, and agency regional managers.
- A short online survey for communities and school staff to complement the interviews. Survey data were included in reports prepared for each locality, but more robust information about many of the questions is now available from the evaluation reports of individual initiatives.
- A survey of secondary school students – the OurSCHOOL survey, an online survey developed by The Learning Bar and previously used in Canada and Australia. In each of the six localities, all schools and wharekura with Year 9 to 13 students were invited to take part in the survey. A sample of youth from each school completed the survey. Participating schools were required to include youth from each year group. A few schools chose to include all students but most included a sample of year groups. The sample selection was pragmatic and based on timetabling and/or the availability of the school computer suite or another venue where the survey could be completed using tablets and WiFi provided by the evaluators.

- 22 of 43 schools and two of five wharekura agreed to take part, and the survey was completed by a total of 3,170 youth across the 24 schools and wharekura (Appendix 3).
- The school year groups covered and the ethnicity of students from participating schools were broadly representative of all students in the localities, but there were some differences (these are summarised in Appendix 3).

2.5.1 _ The OurSCHOOL survey

The OurSCHOOL survey develops ratings based on groups of questions to identify a range of risk and protective factors and outcomes for youth. The intention of the survey was to provide information about the localities and how risk and protective factors contributed to outcomes for youth, rather than providing clinical measures of mental health outcomes.

The wording of the OurSCHOOL survey questions cannot be reported because The Learning Bar has proprietary rights over the questionnaire, but the topics covered are described in Appendix 4, along with other details about the survey. Appendix 4 also includes a comparison of outcomes for the OurSCHOOL survey and other New Zealand surveys that measure similar outcomes.

New Zealand-specific questions were added to the survey, including the ethnicity question developed by Statistics New Zealand for the 2013 New Zealand Census (Statistics NZ 2013), questions about culture, and questions specific to the YMHP initiatives. Superu intends to provide more detailed analysis of the survey findings at a later date.

The total numbers of youth completing the OurSCHOOL survey in each locality and the numbers of Māori and Pacific students are summarised in Table 2 below. A mistake by The Learning Bar resulted in the ethnicity questions being omitted for three schools in West Auckland, and this reduced the sample size for analysis by ethnicity from 3,170 to 2,709.

TABLE 02

Ethnicity of students included in the OurSCHOOL survey

(Includes all youth who identified with each ethnic group, not just main ethnicity; Percentage shown as proportion of cases with ethnicity data i.e. excluding missing data)

Locality	Total students (# responding to ethnicity question)	Total NZ European	Total Māori	Total Pacific	Total Other
Northland	300 (286)	188 (66%)	150 (52%)	27 (9%)	51 (18%)
West Auckland	714 (242)	139 (57%)	80 (33%)	42 (17%)	102 (42%)
Hawke's Bay	564 (548)	433 (79%)	159 (29%)	51 (9%)	99 (18%)
Lower Hutt	760 (721)	494 (69%)	158 (22%)	131 (18%)	233 (32%)
Christchurch	362 (345)	258 (75%)	68 (20%)	26 (8%)	113 (33%)
Invercargill	470 (450)	391 (87%)	110 (24%)	32 (7%)	104 (23%)
Total	**3,170 (2,592)**	**1,903 (73%)**	**725 (28%)**	**309 (12%)**	**702 (27%)**

2.5.2 _ The workshops

Evaluators produced reports for each locality and distributed them to local stakeholders and to the YMHP steering group. These reports then informed further YMHP development and implementation.

All interviewed stakeholders were invited to workshops held in each locality to discuss locality findings and potential responses. Between 15 and 25 people attended each workshop.

A check back with key stakeholders in each locality in early 2016 provided information about changes since the locality studies were completed.

2.6_ Analysis

Evaluators analysed qualitative data by identifying the main themes. The evaluation questions and interview guides were used as a foundation for organising themes.

Quantitative data were analysed in the Statistical Package for the Social Sciences (SPSS). Analyses were descriptive and used unweighted locality data.

Analysis of ethnicity data collected in the OurSCHOOL survey used the total count approach used by Statistics New Zealand, where students are included in analyses for each ethnic group with which they identify. By contrast, ethnicity data drawn from the MoE's Education Counts website use prioritised ethnicity.

2.7_ Scope of the evaluation

The focus of the evaluation was the YMHP and its 26 initiatives. The evaluation was not tasked with evaluating the YMHP against other ways the funding could have been invested.

2.8_ Ethics

Ethics approval for the evaluation was provided by the Superu Ethics Committee, who reviewed the evaluation plan, questionnaires, interview guides and consent forms. If they were under 16 years old, youth required parental consent to take part in the evaluation.

2.9 Strengths and limitations of the evaluation

The evaluation logic model and outcomes framework provided a theoretical foundation for the development of data collection tools and for the analysis and interpretation of information and data. Incorporating the four perspectives discussed above strengthened the overall evaluation by allowing triangulation of findings.

However, we note the following limitations to the evaluation:

- Initiatives were implemented over different timeframes and some were in place prior to the start of the evaluation, making it difficult to establish a baseline against which outcomes could be measured.
- The YMHP aimed to achieve change through a combination of different initiatives. Other cross-government programmes were implemented in the wider study localities at the same time as the YMHP (e.g. Children's teams in Whangarei and Canterbury (Children's Action Plan 2016), Social Sector Trials in Kaikohe, Ranui and Gore (MSD 2016), and Healthy Families programmes in the Far North, Waitakere, Lower Hutt, Spreydon-Heathcote and Invercargill (MoH 2016)). Because of those other programmes it was not possible to attribute any changes to the YMHP.
- When outcomes data for a project as a whole are limited, data collected from specific initiatives can be used to determine the achievements of the specific initiatives and their contribution to the project's outcomes. However, there are limited data for some of the YMHP initiatives and some of the data available provide information about participation rather than outcomes.
- The Learning Bar's OurSCHOOL survey was selected by Superu to collect information from secondary school students. It was chosen because it was cost-effective, because it had been widely used internationally, and because it could potentially be repeated at the same schools at later points in time to assess any changes. Schools that took part valued the school-specific reports they received from The Learning Bar. However, the use of the OurSCHOOL survey was limited by its proprietary nature, which meant that the survey questions and how they contributed to various outcomes such as indicators of depression and/or anxiety could not be reported. Basic unit record data for monitoring survey completions and analysis were not available until sometime after schools had completed the surveys. The lack of ability to monitor responses made it difficult to pick up errors and omissions in the survey responses, such as the omission of the questions about ethnicity in three West Auckland schools.
- Wharekura within the six locality sites were invited to take part and two participated in the evaluation. The OurSCHOOL survey was translated into Te Reo. However, numbers of students aged 12 to 19 in wharekura were small and the OurSCHOOL survey is unlikely to have adequately captured the viewpoint of wharekura students. Wharekura results were therefore not reported separately but were included in the locality data.
- At each locality, discussion groups with youth were held at YOSS and other youth spaces with the intention of accessing the viewpoints of youth not at school. While this approach included some youth not at school, many of the youth who participated in the youth discussion groups at YOSS were also students at local secondary schools. Focus groups were held in Northland with youth who had been excluded from school and in Lower Hutt with teen parents and youth currently looking for employment. Intercept surveys with youth in settings such as parks also failed to identify NEET youth. Teen Parent Units in the relevant localities were invited to take part in the OurSCHOOL survey but none chose to do so. Therefore, the data collected from youth not at school (including NEET youth) for the evaluation were limited.

03

The localities

Summary

Evidence from the OurSCHOOL survey and qualitative data collection indicates differences and similarities in risk and protective factors and mental health outcomes across the six localities included in the evaluation.

A notable difference between localities was that in Christchurch a higher proportion of youth reported risk factors and had indicators of anxiety or depression than in other localities.

Key messages

Understanding local communities and their differences is important in developing and implementing national programmes.

3.1_ Introduction

The in-depth studies of six localities explored: awareness of YMHP initiatives; how health and social service systems functioned; and the interface between schools and other providers.

3.2_ Socio-economic and demographic differences between schools in the localities

Localities were selected to provide examples of different populations and service delivery contexts. Youth living in the six localities had different socio-economic, physical and economic contexts.

The evaluation compared socio-demographic data from MoE's Education Counts website for all secondary schools in the localities. Gender proportions did not differ greatly between the localities, with the exception of Lower Hutt, where a concentration of female-only schools resulted in a higher proportion of female (56%) than male students (44%).

The relative proportion of ethnic groups[2] differed between localities (Table 3). The proportion of Māori students was substantially higher in Northland (46%) compared to all other localities, whereas West Auckland had a higher proportion of Pacific students (21%). Invercargill had the highest proportion of students who identified as New Zealand European/Pākehā (70%).

2 Note that the Education Counts website uses prioritised ethnicity.

TABLE 03

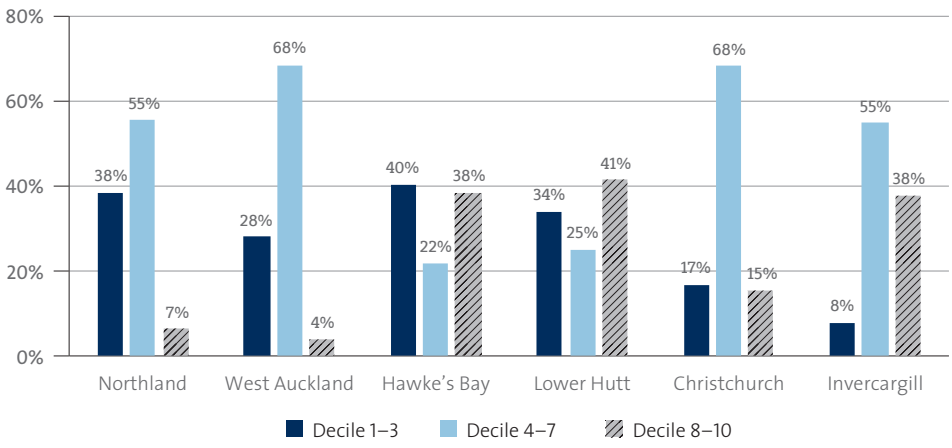
Ethnicity of students across localities in 2015

(Based on Education Counts 2016; Prioritised count that does not include wharekura)

Locality	NZ European	Māori	Pacific	Asian	Other
Northland	46%	46%	1%	3%	4%
West Auckland	38%	19%	21%	16%	6%
Hawke's Bay	56%	31%	7%	4%	2%
Lower Hutt	47%	25%	13%	12%	4%
Christchurch	65%	15%	6%	11%	3%
Invercargill	70%	21%	4%	3%	3%

Some YMHP initiatives targeted decile 1 to 3 schools, so differences in school deciles directly influenced the extent students in different localities were exposed to the YMHP. The proportion of schools in different school deciles differed between localities, as did the number of students in decile 1 to 3 schools (Figure 4).

Figure 4 _ Percentage of students in schools in each decile range across localities[3]



(Based on Education Counts 2016)

Table 4 summarises differences in the wider communities in the localities. Notable differences include:

- Higher rates of unemployment in Northland and West Auckland
- Lower average median personal income in Northland
- Higher proportions of youth in West Auckland living in one-parent families.

3 Decile 8–10 also includes private schools.

TABLE 04

An overview of the locality studies

(Figures based on 2013 Census data for the district or local board encompassing the locality area)

Locality characteristic	Northland	West Auckland	Hawke's Bay	Lower Hutt	Christchurch	Invercargill
Employment						
• Employed full-time	67%	73%	71%	73%	73%	72%
• Employed part-time	23%	18%	23%	19%	22%	22%
• Unemployed	10%	10%	7%	8%	5%	6%
Median personal income	$23,400	$26,800	$26,100	$31,500	$29,800	$27,400
Family type						
• Family couples with children	35%	46%	37%	44%	40%	38%
• Family couples without children	45%	30%	42%	36%	43%	43%
• One-parent families	21%	23%	21%	20%	17%	19%
Formal qualifications	73%	77%	72%	80%	80%	70%

3.3 Northland

Locality: Northland, including Kerikeri, Kawakawa, Moerewa and Okaihau.

Demographics: The locality has a high proportion of young Māori, relatively high levels of unemployment, and a largely rural population. There are small pockets of wealth such as in Kerikeri.

Characteristics: The rural nature of much of the locality meant there was less infrastructure to support youth and their mental health. Local stakeholders identified poverty, drugs, and lack of positive role models as issues for youth mental health. Limited public transport was a barrier to accessing services.

Schools: Five schools and one wharekura (deciles 1 to 6) were invited to take part in the evaluation; the three schools and one wharekura that took part were in deciles 2 to 6. One school that took part in the evaluation had SBHS (not under YMHP) and one school had PB4L School-Wide. Although the case study concentrated on the towns in the area, students attending the schools came from the surrounding rural areas and small towns, some travelling significant distances to get to school.

Health and social services: There was one main Māori health service provider for Kawakawa and Moerewa and multiple small non-governmental organisations (NGOs) in Kerikeri. In Kawakawa there was a youth clinic adjacent to a school, run by a Māori health provider. The clinic provided youth health services for those aged 12 to 25. Its location meant it was accessible for both school students and school leavers.

The YMHP:

- There were no decile 3 schools in the locality so there was no extension of SBHS (Initiative 1). However, the mid-decile school reported they have many students living in high deprivation localities who would benefit from the additional services that lower-decile schools receive.
- One school had adopted PB4L School-Wide (Initiative 8) and they reported positive changes in the school environment.
- PB4L Check and Connect (Initiative 9) and PB4L My FRIENDS Youth (Initiative 10) were not offered in the locality.
- The YPMHS (Initiative 3) included packages of care and support for youth with mental health issues. The PHO in the locality used the funding to develop a model for youth mental health.

3.4 West Auckland

Locality: West Auckland, including Henderson, Te Atatu and Massey.

Demographics: An urban area with relatively high proportions of Māori, Pacific and Asian peoples. Relatively high unemployment, particularly for youth.

Characteristics: The area is fragmented by the North-Western motorway and Henderson Creek, and this can make transport around the locality difficult. There is a Social Sector Trial in Ranui, and youth from Ranui attend school within the locality study area.

Schools: Seven schools and one wharekura (decile 3 to 5) were invited to take part in the evaluation. The two decile 3 schools within the locality study catchment area did not take part in the study: one had SBHS and one did not. The only school in the locality with SBHS declined to take part. The wharekura, which is decile 3, also took part. Two of the participating schools had PB4L School-Wide.

Health and social services: There was a youth hub in Henderson that provided many of the same services as a YOSS but catered to a small geographic area. Service provision in West Auckland was characterised by multiple small NGO providers competing for funding. The services providers offered were not always clear to referrers, such as schools, and potential service users. Schools reported that lack of service co-ordination resulted in some youth receiving services from multiple providers.

The YMHP:

- Most of the schools in the locality study were decile 4 to 5 and therefore not eligible for many of the school-based initiatives such as SBHS (Initiative 1). However, schools said that while they were mid-decile, they still had students from low to high areas of deprivation who would benefit from the same services available to lower decile schools.
- The two large mid-decile co-ed schools both had PB4L School-Wide (Initiative 8) and reported positive changes in the school environment.
- PB4L Check and Connect (Initiative 9) and PB4L My FRIENDS Youth (Initiative 10) were not being offered in West Auckland.
- Additional funding from the YPMHS (Initiative 3) went to enhanced youth mental health packages of care delivered through a youth provider.

3.5 Hawke's Bay

Locality: Hawke's Bay, including Flaxmere, Hastings and Havelock North.

Demographics: A regional area with wide variation in socio-economic status, from areas of extremely high deprivation (e.g. Flaxmere East) to low deprivation (e.g. Havelock North). Three-quarters of Hastings District is New Zealand European (75%) and one-quarter is Māori (24%) (Statstics NZ 2014).

Characteristics: Lack of public transport between towns made it difficult for youth to access services. There were several boarding schools in the area. Schools and youth both said it was difficult for boarding students to access services when they were at home during the school holidays. Additionally, access issues arose if youth lived outside the Hawke's Bay DHB area.

Schools: There were two groups of schools in the Hawke's Bay locality: high-decile (8 to 10) and low-decile (1 to 3). Two decide 4 schools did not take part. There were no decile 5–7 schools. The two decile 2–3 schools and two decile 9–10 schools that took part in the locality study reflected the variation in deciles in the locality. The two low-decile schools both had SBHS. One of the low-decile schools also had PB4L School-Wide and PB4L Check and Connect. Three of the schools had boarding students.

Health and social services: The locality was characterised by a large number of small providers working on short-term contracts. This had the potential to limit continuity of services and made it difficult to recruit qualified staff. There was a YOSS in Hastings but it was open only for limited hours and could be difficult for youth outside Hastings to access. There is a large (nearly 200 staff) Māori health and social service provider. Youth included in focus groups noted limited availability of support for LGBT youth.

Recent suicides in the district had led to a focus on improving links between services and co-ordinating supports for youth. Several providers suggested that communication and information-sharing had improved in recent years, although this was not attributed to the YMHP.

The YMHP:

- The three low-decile schools in the locality study all had SBHS (Initiative 1), including HEEADSSS wellness checks. However, school nurses (employed by the DHB) and school GPs were under different contracts and using different IT platforms, and this limited information-sharing.
- Three of the schools had PB4L School-Wide (Initiative 8) and reported positive changes in the school environment.
- Four youth workers were employed by an NGO to use the PB4L Check and Connect model with youth (Initiative 9). Three of these youth workers were funded under Initiative 14 while the fourth was funded by MoJ. Schools were positive about the work the youth workers were doing but providers said it was difficult for the youth workers to visit all their students in the given timeframe because of the size of the locality.
- The YOSS in Hastings received additional funding through Initiative 18, which was used to increase the provision of mental health programmes for youth with an emphasis on building resilience. Programme topics include bullying, depression and anxiety. This YOSS was relatively small and not as widely known or as closely connected with other services as other YOSS around the country. While the YOSS acknowledged that they could do more to promote their services, they were already operating at capacity. The YOSS also received funding through the YPMHS (Initiative 3) to support the development of Pacific and LGBT youth groups.
- The YPMHS supported additional packages of care for youth. Packages of care were provided through a list of approved counsellors. The PHO reported that the number of packages of care funded did not meet the level of need.

3.6 Lower Hutt

Locality: Lower Hutt, including Wainuiomata.

Demographics: Of those aged 10–19 years, 62% identified as New Zealand European, 24% as Māori, and 16% as Pacific (Statistics NZ 2014).

Characteristics: Lower Hutt is an urban area with diverse socio-economic characteristics. Stakeholders described pockets of wealth and pockets of poverty. School and health providers thought many mental health issues for youth resulted from poverty and deprivation. Transport to youth services in Lower Hutt was particularly difficult for youth living in Wainuiomata.

Schools: Eight schools were invited to take part in the evaluation (deciles 3 to 10). Five schools took part: three schools in deciles 2 to 3, one decile 10 school, and one private school. All three low-decile schools had SBHS provided by the YOSS in Lower Hutt, two had PB4L School-Wide, and one school had PB4L Check and Connect.

Health and social services: Youth mental health service provision in Lower Hutt was centralised around one well-established YOSS, which also provided SHBS. Having one main youth-specific provider helped increase the awareness of the service by youth, school staff and other providers. Other smaller NGOs offered targeted specialist services.

The YMHP:

- One school had recently changed from decile 4 to decile 3. This will mean they can access SBHS in the coming year, but this had not occurred at the time of the evaluation.
- Two schools had PB4L School-Wide (Initiative 8) and reported positive effects on the school environment.
- One school had PB4L Check and Connect. Positive outcomes were reported for students who had continuity with the programme and had consistent mentors. There have been issues with mentors and students leaving.
- PB4L My FRIENDS Youth (Initiative 10) was not being offered in Lower Hutt.
- The YOSS received one-off additional funding as part of the YMHP (Initiative 18). Although the YOSS found the extra money helpful, they said more funding was required to meet the demand for youth services.

3.7_ Christchurch

Locality: East Christchurch, from the central city to the east coast, including Mairehau to Rāwhiti and Aranui and down to Sydenham and Bromley.

Demographics: An urban area with a lower socio-economic population than Western Christchurch and the surrounding area. East Christchurch has more people who identify as Māori and Pacific than other parts of Christchurch.

Characteristics: Youth, school staff and providers all described the ongoing impact of the earthquakes on youth since 2010.

Schools: Nine schools and one wharekura (decile 2 to 8) were invited to take part in the evaluation. Recruitment of schools was more difficult than in other localities as schools reported frequent surveys and other disruptions following the earthquakes. Three schools took part in the evaluation covering deciles 4 to 6. One school had PB4L School-Wide and SBHS and one school had PB4L School-Wide and My FRIENDS Youth. The provider Nurse Maude delivered HEEADSSS wellness checks.

Health and social services: Providers reported an overwhelming demand for mental health services to support youth and their parents and a lack of capacity. Health and social service systems in Christchurch appeared relatively joined-up and there was a clear focus on earthquake recovery. Service provision was characterised by multiple mid-sized and small NGOs, including an alliance group of NGOs and a small YOSS. Multiple connected providers contributed to a system that was responsive to youth needs and reduced the chances of youth being 'passed around' services.

The YMHP:

- Initiative 26 (Addressing the emerging youth mental health issues in Canterbury) was developed to respond to the mental health needs of youth following the earthquakes.
- PB4L School-Wide (Initiative 8) was in four schools in the locality, two of which took part in the evaluation. Of the two that took part, one school had positive feedback and the other was just beginning implementation.
- PB4L Check and Connect (Initiative 9) was not offered in the locality.
- PB4L My FRIENDS Youth (Initiative 10) was in three schools in the locality. Schools that took part in the evaluation reported positive feedback.
- Some funding from the YPMHS (Initiative 3) went to additional youth mental health packages of care delivered through the PHO, and to expanded PHO capacity for brief intervention.

3.8 Invercargill

Locality: Invercargill city.

Demographics: The Invercargill population is largely New Zealand European (88%) and is older than the rest of the country (Statstics NZ 2014), although these demographics are changing.

Characteristics: Invercargill city is relatively compact, with high-deprivation suburbs next to low-deprivation suburbs. The isolation and small size of Invercargill limited the number of services available, especially for rural areas surrounding Invercargill.

Schools: All secondary schools include years 7 to 13. Schools in Invercargill are mostly decile 5 to 6 with one decile 8 school and one decile 2 school. The three schools that took part in the evaluation were all decile 5 to 6. Two of the schools included have boarding students, most of whom go home during the weekends and school holidays. The only school in Invercargill with PB4L School-Wide and SBHS (although not under the YMHP) declined to take part in the evaluation, except for an interview with the guidance counsellor.

Health and social services: Many providers attributed effective working relationships to knowing each other and the small size of the city. The YOSS in Invercargill was relatively small (one nurse FTE and around 10 GP hours per week). There were several NGOs in the region and few services specifically for Māori/Pacific youth.

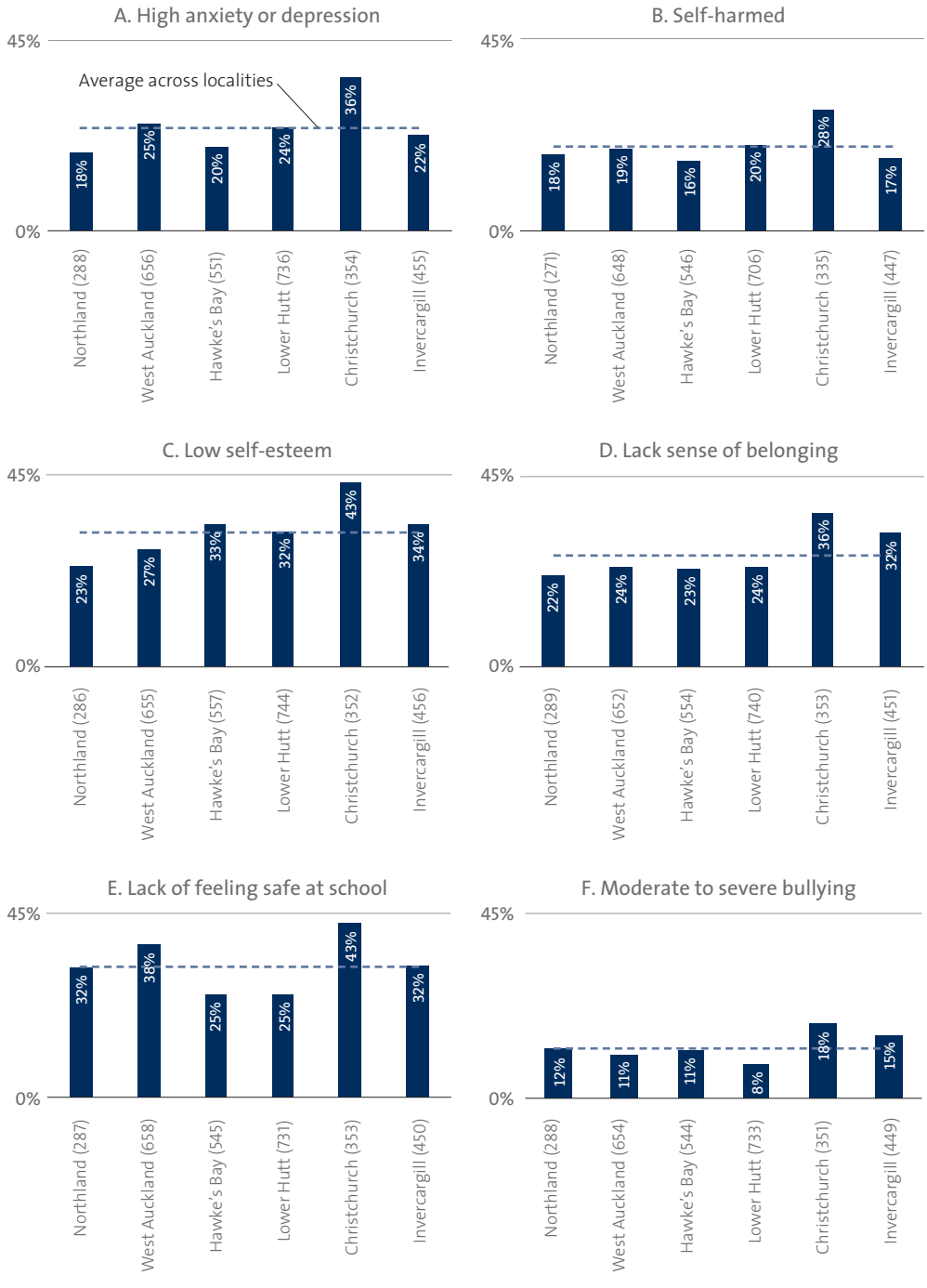
The YMHP:

- The decile 2 school was the only school in Invercargill with SBHS (and the only school eligible for SBHS). This school declined to take part in the evaluation.
- As secondary schools in Invercargill are all Year 7 to 13 there was a suggestion that issues that would be identified in a Year 9 HEEADSSS would likely have been already identified by the school.
- One of the two schools in the locality with PB4L My FRIENDS Youth (Initiative 10) took part in the evaluation and reported positive changes in the school environment.
- PB4L Check and Connect (Initiative 9) was not offered in Invercargill.
- The YOSS in Invercargill received funding from Initiative 18.
- Some providers highlighted high staff turnover as an issue when implementing new programmes.

3.9_ Different risk factors and outcomes for youth between localities

OurSCHOOL survey data indicated some differences between localities in aspects of youth wellbeing and mental health, and those findings were supported by the qualitative data (Figure 5).

Figure 5 _ Locality differences in outcomes for youth



(Source: OurSCHOOL survey, unweighted data)

In considering locality differences it is important to remember that the OurSCHOOL survey included youth who are still attending school. Protective and risk factors and outcomes may be quite different for youth not at school.

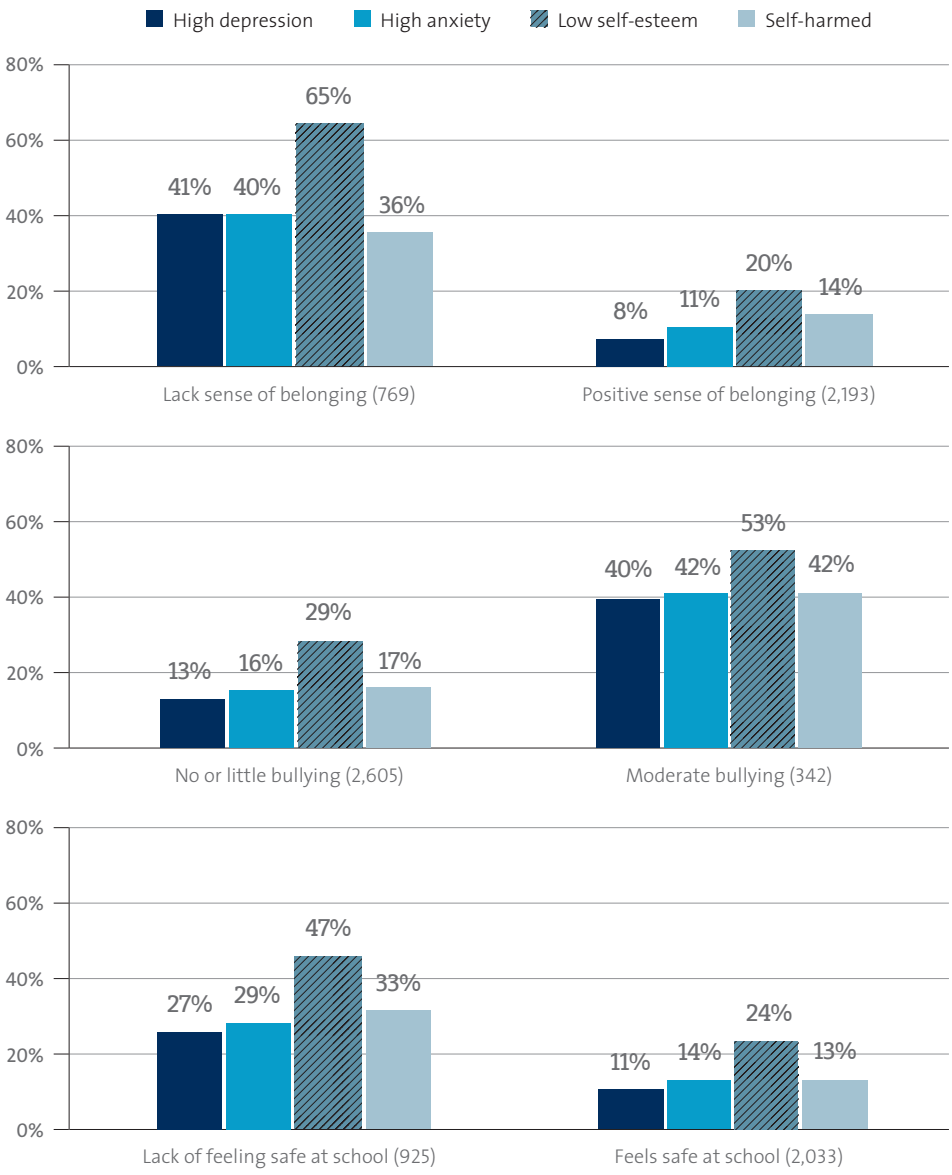
3.10_ Association between protective and risk factors and mental health outcomes

OurSCHOOL survey results showed significant associations between mental health outcomes and protective and risk factors.[4] For example, around two-fifths of students with indicators of moderate or severe anxiety or depression lacked a sense of belonging and of feeling safe at school (Figure 6), compared to 14% and 24% of those without indicators of this mental health outcome. Experience of bullying was also higher among those with moderate or severe anxiety or depression.

A positive sense of belonging is associated with resilience. In interviews, youth at an alternative education provider in Northland talked about their pride in where they lived and their strong sense of belonging. In contrast, the earthquakes in Christchurch had changed the environment for youth in the locality study, and youth described safety concerns associated with changes to their physical environment.

4 Chi-squared test for association showed significant association between the mental health outcomes (moderate or severe depression or anxiety, low self-esteem, self-harming) and risk and protective factors (experiencing of bullying, trauma, asking for help (in or out of school), positive teacher-student relationships, safety at school, and truancy).

Figure 6 _ Prevalence of mental health outcomes by risk and protective factors



(Base count for each group shown on x-axis) (Source: OurSCHOOL survey)

3.11_ What do the evaluation findings suggest as potential future directions for the YMHP?

Locality similarities and differences – key messages	
Understanding local communities and their differences is important in developing and implementing national programmes.	Different socio-demographic profiles and service delivery contexts between localities support the need for national projects and initiatives to respond to local needs.

04

How well is the YMHP being implemented?

Summary

The YMHP was developed as an interagency response to the complex factors that influence youth wellbeing and the need to reach youth in the community, in schools, and through health and social services.

An interagency response has been achieved at central government level through an interagency steering group. The steering group has developed a strong collective approach to problem-solving.

A cross-sectoral approach was less evident in the localities, and collaboration and communication between health and social sector organisations varied. Schools were often not part of local governance/working groups. One of the major challenges observed in the locality studies was the lack of a role with the mandate to look across the different agencies.

Youth Service Level Alliance Teams (SLATs), established in 19 of 20 DHBs, have the potential to strengthen local service provision through communication and collaboration between key stakeholders and prioritisation of activities to meet local needs.

New Zealand has a devolved service-delivery system for education, health and, to a lesser extent, social services. This allows localities to deliver initiatives that best meet the needs of their populations in ways that work within local systems. However, it can take longer to implement national initiatives. Schools and providers can choose to not implement initiatives or to implement them in ways that may result in reduced effectiveness.

The 26 YMHP initiatives were progressively implemented between 2012 and 2016. Some were existing initiatives started before the YMHP, while some were new initiatives developed to respond to needs identified through implementing the YMHP. Some initiatives involved developing new programmes, some extended existing programmes, and some were reviews or evaluations.

Combining initiatives into the YMHP, a single project specifically targeting youth wellbeing and mental health, enabled agencies to be responsive to needs that were identified during implementation. Bringing the initiatives together as a project also provided a framework for agencies to trial new approaches to funding and delivery and to examine the systems in place to support youth.

Key messages

- Continuing an interagency approach will support the changes that need to be made to policies and service delivery in order to respond to youth needs.
- Central government has an important role in enabling local delivery through sharing information and providing adequate resourcing.
- Strengthening the cross-agency approach in regional implementation has the potential to improve local systems to support youth.
- Further communication and collaboration between schools and health and social service provider organisations is essential in improving youth wellbeing.

4.1_ The YMHP is an interagency project

An interagency approach to the YMHP is supported by the breadth of factors that have the potential to influence youth wellbeing and mental health, and the opportunities for health and social services to reach youth in school settings.

The YMHP was designed to be a new way for agencies to work together to deliver "integrated or collaborative services planning and decision-making at a national level" (MSD 2014). It was expected that the YMHP would achieve system change through agencies working together and sharing information to develop policy and deliver services.

> *I think that we were probably one of the first cabs off the rank to actually really have that collective driven focus. – Steering group*

4.2_ Implementing national projects through New Zealand's devolved delivery system

New Zealand has a devolved service-delivery system for education, health and, to a lesser extent, social services. In health, 20 DHBs are each responsible for providing or funding health services in their districts (MoH 2014a). MSD delivers social services through Work and Income service centres as well as contracting NGO providers to deliver social services. Compared to other OECD countries, New Zealand's school system is characterised by a high level of devolution and autonomy. While schools are required to teach within a curriculum, priorities and values of schools can differ (MoE 2010).

Devolved delivery gives localities the ability to respond to the needs of their communities, to focus on their priorities and to not be constrained by the issues in other localities (Pedersen 2002). However, implementing new programmes in a devolved delivery system is complex and takes time because of differences in local systems and local provider networks. Different localities may appropriately prioritise different population groups, resulting in challenges to implementing national changes consistently. As central government involvement and oversight reduces, there is also potential to create a system with less accountability due to different local targets and systems (Londono, Jaramillo & Uribe 1999).

The steps in the process of implementing a new initiative or programme in a devolved delivery system include responsibilities for central government and for local agencies.

Central agency responsibilities include:

- Leadership
- Defining the programme and providing clarity about which elements are essential and where there is scope for local flexibility
- Defining the target groups
- Providing adequate funding and resourcing for local implementation
- Engaging local provider organisations to reach a shared understanding of initiative delivery
- Monitoring and evaluating the initiatives.

Local agencies and provider organisations:

- Agree or are directed to deliver the initiatives
- Provide local leadership
- Decide the delivery mechanism internally
- Monitor and report progress to central agencies.

4.3_ Implementing the YMHP at central government level

The YMHP is led by the Ministry of Health (MoH) and includes the Department of the Prime Minister and Cabinet (DPMC), The Treasury, the Ministries of Education (MoE), Social Development (MSD) and Pacific Peoples (MPP), the Education Review Office (ERO), and Te Puni Kōkiri (TPK).

The 26 YMHP initiatives were progressively implemented between 2012 and 2016. Some were existing initiatives started before the YMHP, while some were new initiatives developed to respond to needs identified through implementing the YMHP. Other initiatives, such as the evaluation of the school guidance system, have been completed by ERO, but responses to the recommendations are still being considered by MoE. Some initiatives involved developing new programmes, some extended existing programmes, and some were reviews or evaluations.

4.3.1 _ Leadership

The interagency steering group: Central government leadership and governance for the YMHP was provided through an interagency steering group. The steering group was formed to bring together the key agencies responsible for delivering services to youth or representing at-risk groups of youth.

> *Its main role is to make sure that the actual... [initiatives] are implemented in the best way possible and then if there's learning to be taken from them then we share that learning and provide advice about what should happen next. – Steering group member*

The steering group took time to form and develop working relationships. Almost all steering group members described the group as effective, and commonly as the most effective interagency group of which they had been a member. They identified the following factors as contributing to its effectiveness:

- Its commitment to improving outcomes for youth
- The knowledge and commitment of the chairperson
- Consistent attendance by representatives of the main agencies delivering programmes
- Effective project management and accountability, which kept the group focused.

Interagency work on the YMHP has extended beyond the steering group to include joint work on other issues.

The steering group could have been enhanced by more active involvement of MPP and TPK. MPP regularly attended steering group meetings but noted the need to develop initiatives that focused on enhancing the wellbeing of Pacific youth through a strengths-based approach. TPK attended steering group meetings irregularly. Their absence was identified as a gap by other agencies. However, TPK emphasised the need for small agencies to prioritise their work and that other agencies aside from TPK also have a responsibility to understand and effectively provide services for Māori.

The project team: The steering group was supported by a project team comprising senior agency personnel and some initiative leads. The project team has continued to meet regularly throughout the project. Personnel changes and the completion of some of the one-off initiatives contributed to a loss of historical knowledge and to some initiative leaders becoming less connected to the project as a whole – both within their own agency and with other agencies.

Communications: The YMHP has a communications strategy and an interagency communications group that meets regularly. The communications group members share information about what their respective agencies are planning and support each other to make sure messaging is consistent.

4.3.2 _ Defining the project

The scope of the YMHP as a whole was defined by DPMC and the lead agencies. Grouping initiatives into the YMHP, a single project specifically targeting youth wellbeing and mental health, enabled agencies to be responsive to needs that were identified during implementation. For example, Initiative 26 was added to the project to respond to needs identified for youth in Christchurch after the earthquakes, while Initiatives 23, 24 and 25 were developed in response to findings of Initiative 19 (Youth Referrals Pathways Review).

Bringing the initiatives together as a single project provided a framework for agencies to examine funding and delivery systems and trial new approaches. New approaches included developing cross-agency funding and resourcing for providers that delivered multiple services under contracts with more than one agency (e.g. YOSS). Initiative 24 also had a focus on funding. It developed integrated funding models and connected service delivery.

Developing integrated funding models and connected service delivery (Initiative 24) – MoH

Aim: To address recommendations from the Youth Referrals Pathways Review (Initiative 19), which included:

- Identify further opportunities to develop more integrated funding models and connected service delivery to allow for multi-disciplinary approaches to address mild to moderate mental health issues in a broader social sector context
- Investigate existing 'Youth Wellness Hub' services in order to provide a youth-friendly service that offers integrated services across social services and primary health care in identified demonstration sites.

Implementation: Initiative 24 was developed from the findings of the report on youth referral pathways prepared as part of Initiative 19 (Youth Referrals Pathways Review). In April 2014, approval was given by the YMHP steering group to fold Initiative 24 into Initiative 5 (Primary Care Responsiveness to Youth). Continued work on Initiative 24 will be implemented through Initiative 5, as the objectives of this initiative will deliver the intention of Initiative 24. This combined approach aims to enhance the implementation of both initiatives.

4.3.3 _ Defining the initiatives

Partly due to timeframes, some of the initiatives initially included in the YMHP were based on work agencies were already doing or were extensions of existing initiatives/programmes. Other YMHP initiatives were developed to examine existing systems and make recommendations for improvements. One of the aims of the YMHP was to learn more about what works. Following the Phase 2 evaluation, time has been allocated for reviewing the initiatives and responding to evaluation findings.

Early in the project, the project team developed a project definitions document that detailed the initiatives. Some initiatives, such as the PB4L initiatives, were defined programmes and fidelity to the programme design was important. Other initiatives, such as the Youth Primary Mental Health Service (Initiative 3), were defined at local level by DHBs or by PHO and/or NGO providers that were contracted to deliver the initiative.

Central agencies also have a role in sharing information and evidence to avoid duplication of effort by local providers. The evaluation of the YPMHS concluded that central agencies sharing information with DHBs about what works is likely to help districts develop innovative ways of supporting youth. Another example is central agencies' roles in developing and trialling exemplar programmes such as the development and formative evaluation of the Southern DHB's AOD service (Initiative 7).

4.3.4 _ Providing adequate funding and resourcing

New funding was attached to the YMHP initiatives that were delivered locally (e.g. SBHS, YPMHS, PB4L My FRIENDS Youth) except for Initiative 26 (Addressing the emerging youth mental health issues in Canterbury), which was delivered within MoH baseline funding.

One-off funding was also used to fund the establishment of new services. MoH provided $1.65 million in one-off funding to 15 DHBs under Initiative 5. The funding was for DHBs to work with Social Sector Trials and YOSS to improve local Alcohol and Other Drug services.

A number of central agency initiatives were delivered through baseline funding (e.g. the review of AOD education programmes by MoE and the review of referral pathway supports for young people by MSD). Funding for some initiatives has since been baselined. For example, funding for PB4L School-Wide (Initiative 8) has now been baselined within existing MoE funding and the programme will continue beyond the YMHP.

Despite increased funding, providers interviewed in the locality studies commonly talked about being under-resourced and working at capacity. In the YPMHS evaluation, some DHBs reported difficulty in finding local service providers to take up the initiative as providers viewed the funding as insufficient to set up a new service and were concerned about long-term sustainability.

The locality studies also identified opportunities to strengthen local systems within existing funding levels:

- Rationalising the numbers of small providers to avoid overlap and enhance the delivery of evidence-based services
- Improving co-ordination between providers and referral pathways
- Workforce development and initiatives such as co-location of services that may reduce the numbers of youth referred to specialist services.

These are discussed in later sections of the report.

4.3.5 _ Engaging local provider organisations

Delivery of initiatives was devolved to local organisations. In the social sector, regional delivery is provided through Work and Income service centres and through contracts with national and regional providers. Work and Income has devolved service delivery of the Youth Payment (YP) and the Young Parent Payment (YPP) to Youth Services in each region. In Lower Hutt for example, this service is provided by the local YOSS.

In the health sector, DHBs were tasked with delivering health initiatives, and many were contracted to local provider organisations such as PHOs and other NGO providers.

In education, local agencies were tasked with promoting initiatives to local schools. Schools had choices about whether or not to take up initiatives such as PB4L School-Wide (e.g. schools need 80% of school staff to buy in to PB4L by means of a vote before starting PB4L School-Wide).

As a result of the devolved delivery system, there was not a strong cross-sectoral approach in the localities studied. Stakeholders were aware of YMHP initiatives that affected their sectors but many were not aware of the YMHP as a whole. However, many did note an increased awareness of youth mental health. Several key messages, such as that every door is a right door, that no one size fits all, and that there is a need for multiple interventions in multiple settings and domains, were repeated by providers in each locality.

4.3.6 _ Monitoring and evaluating initiatives

There were monitoring and reporting requirements for initiatives that provided services directly to youth. Some data were being collected and some initiatives such as SPARX (Initiative 4) had outcomes incorporated into their delivery. The devolved nature of delivery, and differences both in provider systems for recording information and in the priority placed on reporting, meant that the consistency and quality of the information reported back to funders varied.

Local providers commonly complained about the time required to comply with reporting requirements. Monitoring templates were provided by central agencies and focused on usage information such as the number of youth seen. NGOs and YOSS that may have multiple contracts with multiple agencies (e.g. MSD, MoH, DHBs, MoE, MoJ) are often expected to complete multiple reporting templates. Providers, especially frontline staff, are more likely to take the time to provide accurate reporting if they can see the benefits of the reporting to their organisations.

These issues are being addressed. For example, a new reporting template for SBHS was introduced in late 2015 to better inform policy and local quality improvement. It is hoped the new reporting template will provide more accurate and useful data, including what proportion of referrals are related to mental health.

The evaluation of the YPMHS recommended that MoH develop a consistent way of measuring the effectiveness of different service models and interventions in improving youth mental health and wellbeing and that this be aligned with the National Population Outcomes framework.

4.4_ Implementing the YMHP regionally

Local agencies delivered and/or contracted local services to implement the YMHP initiatives.

Factors were observed in the locality studies and through the evaluation of initiatives that contributed to or were barriers to effective local implementation of the YMHP.

> *Let's look at what were the enablers that achieved integration in this area versus the problems in this area; and how do we learn from that and repackage the benefits from the areas which hadn't improved, integrated... versus the others. – Steering group*

4.4.1 _ Local leadership

Strong leadership helps to create a coherent and well-connected system. It can help direct localities to make the changes needed to provide the best service possible. Effective leadership by someone in a role with a mandate to look across different agencies can give a strong voice to the issue of youth mental health and keep it on governance agendas. Lack of a local role fitting this description was one of the major challenges to effective implementation observed during the locality studies and in locality workshops.

In some localities with Social Sector Trials, cross-sector collaboration was evident.

I come across enough instances where people are working together really well, and it's people that are making it work, not the system. – Steering group

Initiative 5a included the development of youth SLATs to bring together key people involved in delivering services to youth. Youth SLATs are now established in 19 of the 20 DHBs, although some were established prior to the YMHP. It takes time for providers to develop trusting relationships and work together setting aside potential competition for funding. The benefits of youth SLATS are likely not yet evident in the districts where they are newly established. However, in localities where youth SLATs (or equivalent groups) are well-established, stakeholders report they are an effective way of bringing together networks of providers and setting local priorities.

Primary Care Responsiveness to Youth – sustainable youth-centred model of care (Initiative 5a) – MoH

Aim: Make primary care services more responsive to youth by improving youth access to appropriate services, and by improving integration of youth-specific services.

Implementation: A sustainable youth-centred model of care for primary care including the development of youth SLATs.

Achievements: SLATs developed in 19 of 20 DHBs. The remaining DHB (Taranaki) is being supported to set up a SLAT as soon as possible. Although the maturity and effectiveness of SLATs is variable, a number of DHBs now use their youth SLAT to lead planning and delivery of all youth services across the health sector and with links to the social sector.

Māori and Pacific youth: There is no information about Māori and Pacific youth representation on youth SLATs.

4.4.2 _ Decide the delivery mechanisms within their agencies

Regional agency managers had the responsibility of contracting services to local providers. Local provider networks influence how new initiatives can be delivered. The number of different providers, provider capability and capacity, and workforce availability (particularly Māori and Pacific workforce) are influential factors. The way providers deliver services also influences the extent to which youth can access those services – for example, whether services are youth-friendly, whether youth have transport to reach services, and whether the times that services are available work for youth (discussed further in Section 9).

Interagency communication is essential in establishing an effective local system for youth mental health. Effective communication can help providers work together and create a seamless service for youth and their families. The locality studies found that interagency communication occurred through local networks and groups, including multidisciplinary team meetings to discuss youth.

For example, in Canterbury there are regular meetings with a wide range of youth providers, including the DHB, PHOs and various youth mental health and AOD providers. These meetings provide a forum for determining referral processes and training needs for the workforce, and identifying gaps in services and what other things need to be done.

So having this group has helped a lot. We have a single referral form now. – Specialist provider (Christchurch)

Schools were not often part of local governance/working groups. Further engagement with schools is essential in improving youth wellbeing. The school environment is crucial in promoting youth wellbeing and in engaging youth with health and social services either in the school setting or away from the school setting (Section 8). Some providers said that some schools were difficult to engage with, while some schools were unaware of the various providers available in their locality.

For any service, trying to get into a school is difficult. Schools are communities in themselves. Hard to get in if it's not compulsory or funded. – Provider (West Auckland)

Not sure how many services there are or what they all provide. I don't know what other organisations are available or where to go looking for them. – School perspective (Hawke's Bay)

Having multiple small providers may make it easier for youth to find the specific service that best suits them with regards to location, gender, ethnicity and the provider's focus (e.g. mentoring, counselling, AOD, and sport- or music-based). However, one of the potential challenges of having multiple small providers, observed in the locality studies, is that schools and health services may not know who or where to refer youth. Contracting with multiple providers is also more complex for provider organisations and can lead to different youth having access to different types of service depending on where they live.

Cross-sectoral collaboration can be more difficult for small providers, who may find it difficult to fund time to build relationships and collaborate. This issue was highlighted by stakeholders in West Auckland.

A lot of these providers are small organisations with little resource.... No one gets paid to collaborate, to go to meetings. It's not recognised. – Community provider (West Auckland)

There's always patch protection... we integrate to an extent, but the moment we came to funding application everybody kind of pulls back. – Primary care provider (West Auckland)

A common theme from locality stakeholders was that they were not adequately resourced (financially or in terms of workforce capability) to respond to increasing need for support for mental health issues. The literature reports that competing for limited resources is counterproductive and discourages collaboration between services (Jenkins et al. 2011).

4.5 Youth engagement

There is evidence of the value of consumer-provider partnerships for strengthening governance, leadership, co-design and direct healthcare. Initiative 20 (Youth Engagement) was provided by the Ministry of Youth Development (MYD) and intended to provide the resources and support for other YMHP initiatives to engage with youth.

The Hart model of youth participation (Hart 1992) was used by MYD to describe different levels of youth participation. Youth participation ranges from:

- High levels of participation where youth lead and initiate action and youth and adults share decision-making
- Low levels of participation:
  - Youth are assigned but informed
  - Youth are consulted and informed
  - Youth participate in decision-making but it is initiated by adults
- Non-participation, including manipulation, decoration and tokenism.

Both MYD and the Werry Centre have developed comprehensive resources describing youth participation and how to achieve effective youth participation (MYD 2009; The Werry Centre 2009).

Although there is increasing evidence of the value of consumer engagement, youth participation has not been adequately researched to determine its impact on outcomes (Fouché et al 2010).

Youth Engagement (Initiative 20) – MYD/MSD

Aim: Ensure that youth involvement is endorsed, supported and recorded for all initiatives.

Implementation: MYD trained youth to sit on funding panels, facilitated surveys and focus groups with youth to inform other initiatives, and ensured that youth sat on advisory/reference groups as appropriate. MYD promoted opportunities for youth to have their say on Facebook and through their newsletter about a range of issues related to the YMHP.

Officials from MYD, as advocates for youth, have been involved in provider selection, have sat on stakeholder groups, and have provided feedback to agencies on their engagement plans.

One of the challenges for youth engagement was that it could only be effective if other initiatives chose to engage with youth (i.e. it can encourage but cannot 'force' other initiatives to engage with youth).

Achievements: The success of Initiative 20 is reflected in how much the other initiatives engaged youth within the design and delivery of programmes and services. While some initiatives encouraged youth to engage, 'push-back' was reported from others.

Agencies suggested that without Initiative 20 there would have been some youth engagement but probably not to the same extent.

However, there was also acknowledgement that there is still room for improvement, particularly around youth engagement within CAMHS and education-focused initiatives.

Māori and Pacific youth: Māori and Pacific youth were included in youth consultation.

The evaluation of the YPMHS supported the need for youth engagement.

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

In addition to Initiative 20, other initiatives also engaged with youth. Examples of youth participation seen in the locality studies and in the evaluation of the YPMHS included the following:

- In the locality studies, youth participation was evident in the YOSS, where youth were involved in advisory groups to help the future direction of services.
- Initiative 5a focused on local governance and provided the opportunity to include youth in youth SLATs to provide a youth voice at a strategic level. This was based on the assumption that having youth representation can help providers to deliver services in a relevant and youth-friendly way.

  It's great having the kids involved – they can really make things work better for youth because they know. – Community provider (Lower Hutt)

- Youth participation in MidCentral DHB's Youth Wellness Advisory Group aimed to improve provision of health services for youth through optimised service development and delivery processes. The group meets once every two months and each group member has an associated young person they bring to meetings (mostly secondary school students in Years 11–13). The current chairperson was a 16-year-old secondary school student.

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

- In Lakes DHB, the Anemata CAFE (Clinics and Advice For Eveyone) youth service has a group of Year 12 and 13 secondary school students who were recruited by the health promoter/youth worker and board to provide youth advice, leadership and a voice to guide the work CAFE does, both at the CAFE and in the community.

4.6_ What do the evaluation findings suggest as potential future directions for the YMHP?

Implementation – key messages	
Continuing an interagency approach will support the changes that need to be made to policies and service delivery in order to respond to youth needs.	An interagency approach is needed in order to respond to the complex factors that influence youth wellbeing and to reach youth in a number of settings, including in the community, in schools, and through health and social services.
Central government has an important role in enabling local delivery through sharing information and providing adequate resourcing.	Central government guidance about the key elements of initiatives and the strengths and challenges of different approaches would support local implementation and avoid some duplication of resources.
Strengthening the cross-agency approach in regional implementation has the potential to improve local systems to support youth.	More effective engagement of local provider organisations and development of a cross-sectoral approach may require additional support from central government agencies in the form of resourcing a person with a mandate to work across the different sectors.
Further communication and collaboration between schools and health and social service provider organisations is essential in improving youth wellbeing.	The school environment is crucial in promoting youth wellbeing and in engaging youth with health and social services either in the school setting or away from the school setting.

05

What is being achieved: Access to appropriate information

Summary

Friends, family and whānau are an important source of information and support for youth.

Some youth say they would not ask anyone for support if they were upset. Youth who would not ask for support are more likely to have indicators of anxiety or depression or self-harm or to identify as LGBT.

A small number of YMHP initiatives focused on providing information to youth, family and whānau, and these primarily focused on developing websites as information hubs and developing guidelines for information for youth.

Key messages

- Youth, family and whānau need more information about youth mental health.
- Reducing the stigma around seeking help is likely to improve the extent youth, family and whānau will seek help for mental health issues.
- More promotion of currently available information is required to reach youth, family and whānau.
- While online information is used by some youth, others prefer in-person contact. An increased focus on promoting other sources of information is required.

5.1 Introduction

Evidence from studies has demonstrated that youth are most likely to go to friends or family and whānau for help if they are upset (Boldero & Fallon 1995; Schonert-Reichl & Muller 1996; ERO 2013b). One of the goals of the YMHP was to provide better access to high-quality appropriate information for both youth and their family and whānau. Making information more accessible to youth and communities also has the potential to reduce the stigma associated with mental health.

5.2_ Youth are most likely to go to friends or family and whānau for help

Students who completed the OurSCHOOL survey and took part in the focus groups confirmed the importance of informal support from peers and family for youth who need help with mental health issues.

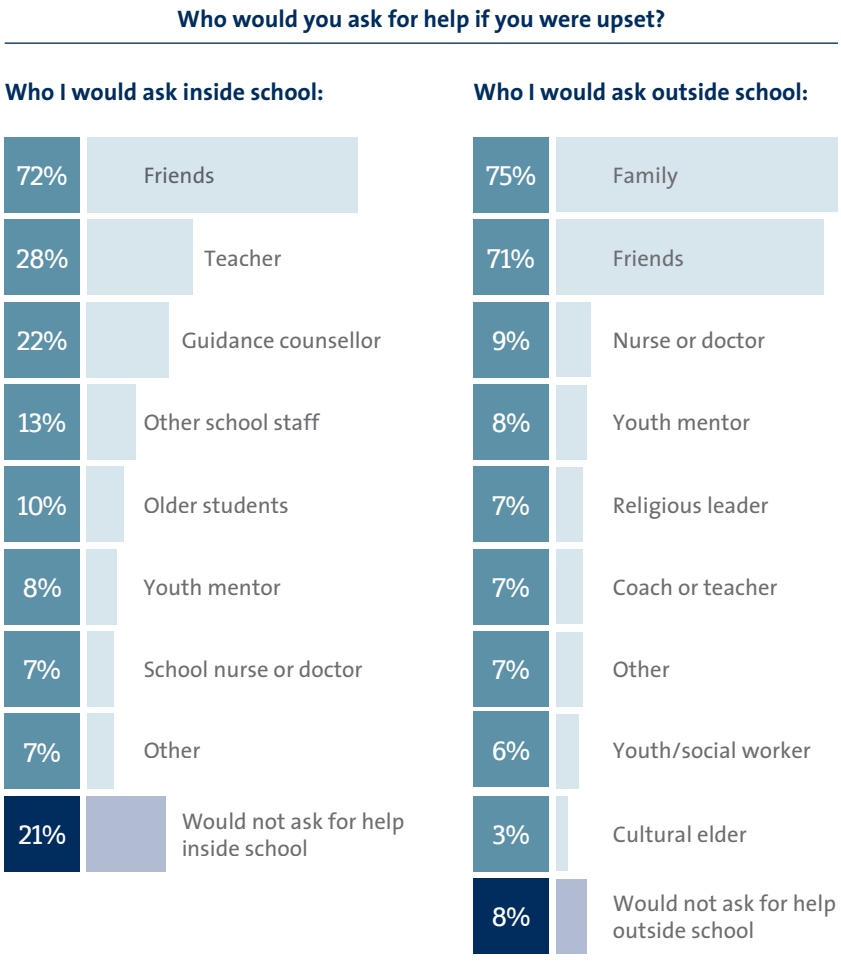
Almost three-quarters of youth completing the survey said they would ask friends for help in both a school setting (72%) and an out-of-school setting (71%).

Friends keep you happy because you can talk to them if you need to... Can vent to them if you're having a bad day. – Youth at school (Invercargill)

Family and whānau were important out of school, with 75% of youth saying they would seek help from family (Figure 7). The proportion of youth who would seek help from family did not vary significantly across the year groups.

I'd talk to my mum first before I talked to anyone else. – Youth at school (Hawke's Bay)

Figure 7 _ Who youth ask for help if they are upset



(Source: OurSCHOOL survey) (n = 2,815-2,976)

Youth included in focus groups had mixed views about whether they would prefer to speak to someone they already knew about personal matters such as mental health concerns. While an advantage of speaking to someone they knew was that they already had an established relationship, this also raised concerns around confidentiality.

Sometimes it's harder to talk to people you know about private stuff than it is to talk to people you don't know. – Youth at school (Lower Hutt)

Older youth said they might not talk to family and whānau about issues relating to contraception and sexuality. Conversely, they suggested they might talk to family members rather than friends about things such as depression.

It really depends on the problem. For problems at school, my list starts at friends at the top and probably my parents last. But if I was like depressed I would talk to my parents. – Youth at school (Northland)

When the OurSCHOOL survey results were compared between localities, in Christchurch fewer youth (62%) said they would ask family and whānau for help than in other localities (74% to 84%).

So the most likely people I would talk to is probably my friends and the least likely would probably be my family. I just wouldn't be comfortable telling them some stuff. So some stuff I would talk to them about but then other stuff, no way. – Youth out of school (Christchurch)

5.3 Use of online and telephone support by youth

All of the youth spoken to in group discussions were aware of some anonymous phone or internet services such as Youthline or What's Up as well as the media campaigns, but were unsure if they would use them. Some youth liked the idea that they could anonymously call a phone service or look for help online, but others wanted a personal connection.

I would rather talk to a person I know and in person but I guess other people might like that anonymous thing. – Youth out of school (Christchurch)

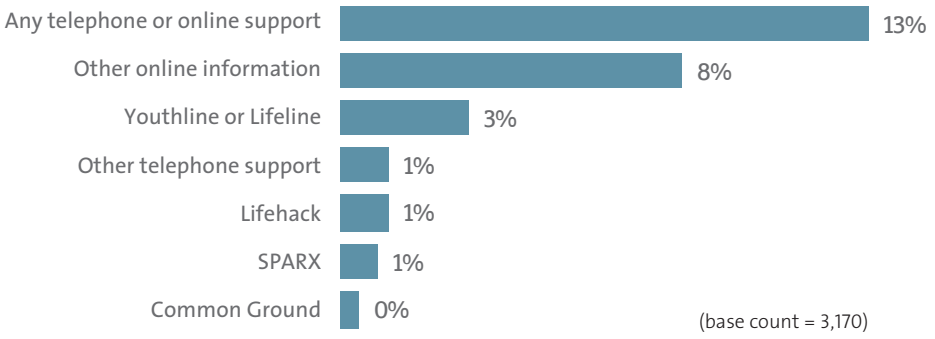
Nah I wouldn't use them [phone helpline] because you don't have a bond with them, because you don't know them. – Youth at school (Northland)

Just over one in 10 (13%) of the students who completed the OurSCHOOL survey had used some form of telephone or online support in the last 12 months (Figure 8).

Rates of accessing online or telephone support were higher among those who said they would not ask anyone for help in school or outside of school (22%) than for youth who said they would ask at least one person for help (15%).

In discussion groups, Māori and Pacific youth were more likely to say they preferred to speak to someone they already had a relationship with, than ring a phone line.

Figure 8 _ The total proportion of students who had accessed any telephone or online support in the last 12 months and the proportions who had accessed specific support



(Source: OurSCHOOL survey)

There was limited awareness of the SPARX or Common Ground websites in the locality studies. Only 3% of school staff and 2% of parents in the community survey were aware of Common Ground and less than 1% of students who completed the OurSCHOOL survey said they had accessed either of the websites in the last 12 months. Actions to increase Common Ground's reach are included in its current strategic plan.

Many youth said they would use the internet to find out where to go for help if they needed it.[5]

I would go to the internet for stuff I'm embarrassed about. – Youth at school (Northland)

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

Like I can think straight away of the Mitre 10 Mega ads, but I can't think of the depression ads, they aren't out there enough. – Youth at school (Christchurch)

Providers who were aware of these websites were positive about the quality of the information.

There's some really good websites out there like Common Ground and the Lowdown... that are just making it much more youth-friendly and accessible. – Community provider (Invercargill)

5 Initiatives 4, 15 and 17 all focused on online or app-based tools to support youth mental health and wellbeing, whether through providing information (Initiatives 15 and 17) or the use of e-therapy tools (Initiative 4).

5.4_ Some youth say they would not ask anyone for help

OurSCHOOL survey responses showed some youth would not seek help from anyone if they were upset. This result was supported by comments in youth focus groups.

> *I personally wouldn't talk to anyone. I just don't feel comfortable doing that... If I'm not going to talk about it with my best friend, then I'm not going to talk about it with an adult. – Youth aged 19+ (Hawke's Bay)*

Some youth would not ask for help because they were concerned about 'dumping' their problems on other people in their lives who were themselves experiencing stress and other negative emotions. Proportions of youth who would not ask anyone for help in or outside of school were similar across all ethnic groups.

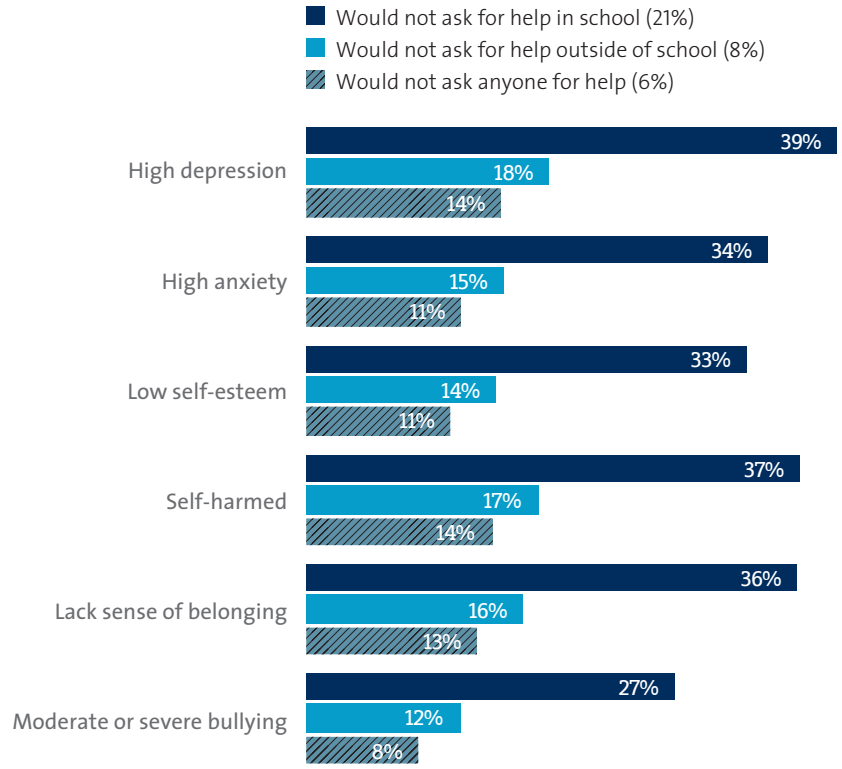
> *I don't really talk about stress. I don't want to go up to my friends and be like 'oh, I've got to do this'. I feel like a dick. You're putting your baggage on them. – Youth at school (Hawke's Bay)*

A higher proportion of youth with indicators of depression or anxiety said they would not seek help from anyone (Figure 9):

- One-fifth (21%) of all survey respondents would not seek help from anybody at school, compared to around one-third to two-fifths of students with indicators of high levels of depression (39%), high levels of anxiety (34%), and low self-esteem (33%).
- Of the 586 students who had self-harmed within the last 12 months, 37% said they would not ask for help at school if they were upset and 17% would not ask for help outside of school. These rates of not asking for help among this highly vulnerable (self-harming) population were around double those of the survey population as a whole.

Youth who identified as LGBT were also more likely to say they would not ask anyone for help if they were upset (Section 12.5).

Figure 9 _ Proportion of students with indicators of mental health outcomes and risk and protective factors who would not ask for help in school, outside of school, or neither



(Source: OurSCHOOL survey)

5.5_ Stigma about talking about mental health issues is a reason why some youth do not seek help from others

The stigma associated with seeking support for mental health was frequently mentioned in discussion groups. The stigma attached to mental health that inhibits youth from seeking help was also highlighted in the ERO 2013b report.

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

I think there's an awful lot of undiagnosed depression in young people in our community. And adults. It's still got a huge stigma attached to it and so much heartache through people not seeking help early enough. – Parent perspective (Hawke's Bay)

Stigma was a particular issue for some rural youth included in the focus groups who suggested that seeking help for a mental health issue was a sign of weakness.

Government thinks we should have a guidance counsellor in every school, but there's centuries of tradition and culture saying "Man up". – Youth at school (Hawke's Bay)

They don't want to go to the guidance counsellor... it's not manly. – Parent perspective (Invercargill)

I think we still have very traditional gender roles. Very conservative. Men don't cry or show emotions... Has a huge impact on wellbeing. – School perspective (Invercargill)

[If a friend was upset I] would tell them to harden up. – Youth at school (Hawke's Bay)

My Dad tells me to deal with it, he'll help me but like he'll just say, "Get over it, you're a guy" – Youth at school. (West Auckland)

A small number of parents in the community focus groups suggested that youth needed to develop resilience and learn to rely more on themselves rather than on external supports.

Kids, they make so much drama about things these days. Just suck it up and get on with it. – Parent perspective (Invercargill)

Promoting the acceptability of discussing mental health issues can be effective. For example, in Christchurch we heard that there were fewer stigmas around mental health issues resulting from the earthquakes, but there was still stigma attached to discussing other mental health issues.

There is still a huge stigma around mental health and people are still quite loathe to admit that is what they are suffering from. – School perspective (Christchurch)

Stigma associated with mental health has been addressed indirectly by some of the YMHP initiatives e.g. Common Ground (Initiative 17), MH101 (Initiative 21), locating SBHS at schools (Initiative 1) in the aim of making them more accessible. However, the evaluation findings suggest the need for specific initiatives that aim to reduce the stigma associated with youth mental health.

5.6_ Many youth, family and whānau are not sure where to go for information or for help about youth mental health

In the locality studies, many youth and their family and whānau said they did not know where to go for help if they, or a youth they knew, was experiencing mental health issues. School staff (excluding guidance counsellors), community providers, and youth all voiced a need for more information. Parents in particular said they struggled to know where to go for help. For example, in the community survey, half the parents (43%) said they were not at all or only a little confident they could help a youth get the support or services they needed if the youth required extra support for emotional wellbeing or mental health. Parents often suggested that their first point of contact would be their local GP. Parents who already had a relationship with the school were more likely to say they would contact the school guidance counsellor and/or a member of the senior leadership team.

For youth, the need for help can arise suddenly and information has to be at hand and easily available. Youth said that while they remembered the local YOSS and/or guidance counsellor being mentioned when they first started at the school, some did not recall where to go or how to make an appointment. This was a particular issue at schools where the guidance counsellor and/or school nurse was only available on-site for specific days or times each week.

They need to tell everyone how to talk to them, go over it with people. They told us once in Year 9 but I forgot it by the next day. The school needs to tell us about all these options we have. – Youth at school (Hawke's Bay)

The nurse does come at certain times but you have to book in or something, I don't know. – Youth at school (Hawke's Bay)

I'm not sure what sorts of things you can go to the guidance counsellor about. How serious do things have to be? – Youth at school (Hawke's Bay)

Youth highlighted a need for more promotion about what information and services were available and how to access these services.

Have it more advertised to enable all people to realise if they need help, then help will be there for them. – Community survey (youth aged 16–19) (Hawke's Bay)

There isn't much programmes or adverts saying where you can get help. It's not publicised enough about where you can get help. It's not something that you can go to straight away. Like I can think straight away of the Mitre 10 Mega ads, but I can't think of the depression ads. They aren't out there enough. – Youth at school (Christchurch)

5.7_ YMHP initiatives included guidelines for youth mental health resources and websites where youth, families and whānau can go for information

Two YMHP initiatives specifically focused on improving access to appropriate online information about youth mental health for youth and their parents, family and whānau, and friends:

- Initiative 15 (Social Media Innovation Fund) included the development of Lifehack, which has worked on apps and social media to improve youth wellbeing and mental health.
- Initiative 17 (Information for parents, families and friends) saw the development of the Common Ground website, which provides information to parents, families and friends about youth mental health and where to seek further help.

Social Media Innovation Fund (Initiative 15) – MSD

Aim: Improve the mental health and emotional wellbeing of youth through the innovative use of social media technology. Increasingly youth are accessing information and advice through online tools such as apps for cell phones, tablets and computers.

Implementation: 450 youth (aged up to early 20s) have attended workshops around the country to develop apps to support youth wellbeing (lifehackhq.co/). Lifehack joined with Massey University to run a 12-week double paper with third-year design students to focus on designing responses to improve everyday wellbeing (Lifehack 2015).

Achievements: The Lifehack community has worked on more than 45 projects and ventures and 11 different catalyst and support programmes, including:

- 0800 What's Up online chat pilot – after five months 0800 What's Up counsellors had completed over 1,400 online chat sessions.
- Go Flo – an iOS app available at the App Store that focuses on creative expression as a path to wellbeing.

As per the YMHP April 2016 quarterly report, agreement has been reached with Lifehack to implement a strategic plan to direct their activity. Under the plan Lifehack will promote mental wellbeing for youth through targeting hard-to-reach communities and groups, promoting collaboration, and developing relationships with business and philanthropic funders.

The original target was to engage youth experiencing mental health issues but this group was difficult to engage; instead the initiative targeted youth up to 24 years to develop apps to support youth with mental health issues. A key learning was the time it takes to develop successful technology-based solutions.

Māori and Pacific youth: Some ventures developed from Lifehack have specifically focused on Māori and Pacific youth, including:

- Beast – A programme to activate resilience among young Māori men by targeting them through rugby networks in a space where they are more comfortable and therefore more open to change (currently being piloted in Wellington).
- Kamp Kaitiaki – A residential programme for young Māori girls in Kaitaia that focuses on preventative mental health and resilience strategies. The programme's themes are based on 5 Ways to Wellbeing and Te Whare Tapa Whā.

Information for parents, families and friends (Initiative 17) – MSD

Aim: To improve access for parents, families and friends to quality information on youth mental health and wellbeing, and on where to seek help.

Implementation: Completed development of the website Common Ground (www.commonground.org.nz) as an online hub for information about youth mental health for parents, families and friends. Real-time support is provided by Youthline.

Achievements: A recent evaluation (Dommett & Coker 2016) found that Common Ground is a high-quality resource and those who have used it were positive (e.g. 91% said the quality of information was 'excellent' or 'good'). The website is targeted at parents and families of youth and the most common reason for visiting Common Ground was to gain a 'better understanding of the different challenges faced by young people'. However, while feedback from those who have used the website is positive, awareness remains low and this is indicated by low activity on the website. Additionally, Google Analytics show that 49% of those who visit the site view only one webpage.

Māori and Pacific youth: In a survey of people using the Common Ground website, 32% identified as Māori and 11% identified as Pacific (compared to 15% and 7% respectively of the population as a whole) (Dommett & Coker 2016).

The YMHP also aimed to improve the quality of information and resources about mental health provided to youth and their families. For example, Initiative 16 (Improving the youth-friendliness of mental health resources) focused on making youth mental health resources more youth-friendly and therefore more accessible for youth.

Improving the youth friendliness of mental health resources (Initiative 16) – MSD

Aim: Increasingly youth are accessing information and advice 'on the move' and there has been huge growth in accessing the internet through mobile technologies. This initiative encourages agencies to overhaul their information and the way it is provided to ensure that it is up-to-date, youth-friendly and accessible.

Implementation: Youthline developed guidelines to assist mental health agencies to improve the youth-friendliness of their resources. These guidelines were developed based on current best practice knowledge in youth development, as well as information gathered from consultation with agencies and youth. The guidelines are available on the MYD website (www.myd.govt.nz/documents/resources-and-reports/publications/youth-mental-health-resource-guidelines.pdf).

Achievements: The guidelines have been disseminated to the wider youth mental health sector, although it is unclear whether any agencies have changed or updated their resources as a result of these guidelines.

Māori and Pacific youth: The guidelines highlighted the importance of using images that represent the diversity of youth in New Zealand, including images of Māori and Pacific youth, to allow them to see themselves reflected in the resources (Youthline 2015).

5.8_ What do the evaluation findings suggest as potential future directions for the YMHP?

Better access to appropriate information – key messages	
Youth, family and whānau need more information about youth mental health.	Youth, family and whānau need more information about youth mental health and about where to go for support for mental health issues.
Reducing the stigma about seeking help is likely to improve the extent that youth, family and whānau will seek help for mental health issues.	There is already a national anti-stigma programme (Like Minds, Like Mine) in which youth are identified as a key focus. This and other programmes could be extended to continue to help reduce the stigma associated with mental health.
More promotion of currently available information is required to reach youth, family and whānau.	Those using websites such as the Lowdown and Common Ground are positive, but awareness remains low.
While online information is used by some youth, others prefer in-person contact, and an increased focus on promoting other sources of information is required.	Not all youth want to use online information and not all youth have access to online information. Other ways of promoting support for youth are required to complement online information. For example, schools have services in place (e.g. guidance counsellor, SBHS) but students may be unaware of what these services are for and how to access them.

06

What is being achieved: Supportive communities

Summary

More supportive communities can improve outcomes for youth. Locality stakeholders described a need for positive things for youth to do and safe places in the community for youth.

Families and whānau provided different levels of support for youth. Youth who reported a lack of family interest in their wellbeing at school were significantly more likely to have indicators of mental health issues than youth with more engaged families.

The YMHP has not had a strong focus on building supportive communities.

Key messages

- Encouraging safer communities.
- Including youth and communities in identifying local needs and in developing local responses such as developing safer places for youth is likely to strengthen responses to improve youth wellbeing.
- Parenting programmes for parents of teenagers was recommended by stakeholders.

6.1 Introduction

The YMHP aims to develop more supportive communities. More supportive communities can improve outcomes for youth through:

- Creating positive environments for youth
- Accepting that youth may have mental health issues and being available and prepared to discuss issues with youth
- Supporting youth who need to engage with an external provider.

The Youth Development Strategy Aotearoa (Ministry of Youth Affairs 2002) describes a supportive community as including a safe, crime-free environment, housing in good repair with no overcrowding, stable long-term residents, adequate educational and recreational facilities, little local criminal involvement (weapon use and drug use and sale), good employment levels, neighbours and local people who watch out for youth and provide supervision, informal limit setting and support (this can include local businesses and services such as police, church and youth organisations), local people who provide work opportunities after school, and recreational opportunities.

The YMHP includes initiatives that aim to increase access to appropriate information. However, while improving access to appropriate information is important, Sally (2001) suggests that building a supportive community is more than a set of resources, and identifies that building capacity into a community is a whole community process that can include community development and community action. Community development and community action can include management and services but also events, programmes and targeted interventions.

6.2 Positive environments for youth

Youth and many other stakeholders from all localities highlighted a need for things for youth to do and safe places to go during their free time.

We need more lunchtime activities. Because I reckon the reason people get involved in bad stuff is because most of the time we've got nothing to do. – Youth at school (Northland)

[We need] more places to go to for activities like bowling alleys. – Youth at school (West Auckland)

There's no stuff to do. What are we supposed to do? McDonalds is probably the place to go... You have a licence, you can do a bit more – but where do you go? – Youth at school (Hawke's Bay)

Some of our young people do feel quite isolated, there's not a lot to do. – Community provider (Invercargill)

In a workshop we held, one thing that arose from the feedback was that they found that there was nothing really to do, there was nowhere to go. – School perspective (Lower Hutt)

The extent youth could participate in activities and access services in their communities was limited by:

- Poverty – Poverty was highlighted as having a major impact on youth mental health. From a youth perspective the effects of poverty and unemployment were seen in a variety of ways. Some saw it as leading to crime while others saw employment as giving youth a purpose. Youth agreed that having the essentials was important for their wellbeing, as well as less essential services like the internet.

  There's nothing to do around town except for shopping. And a lot of people don't have money so they steal. – Youth at school (Invercargill)

  Jobs give you a sense of purpose and initiative to do things. Lots of students work at supermarkets here. – Youth at school (Invercargill)

  Having enough food is important. – Youth at school (Christchurch)

  Phones and the internet give you options for what you're interested in, how to do stuff. Just something to keep you busy. – Youth at school (Invercargill)

- A lack of public transport or not being able to afford public transport

  Getting to somewhere like [the YOSS] is hard because of the transport. Coming out from Wainuiomata is hard. Sometimes the bus never comes and it costs too much money. – Youth at school (Lower Hutt)

  There's no public transport... if you live outside the city you're a little bit stuck. – Community provider (Invercargill)

- Not feeling safe – Some youth said they felt unsafe at the local shopping centre and/or using public transport or school buses. Gangs were seen as an issue in some parts of the country.

  [No mufti days at school because] most kids would just rock up in their gang colours. – Youth at school (Hawke's Bay)

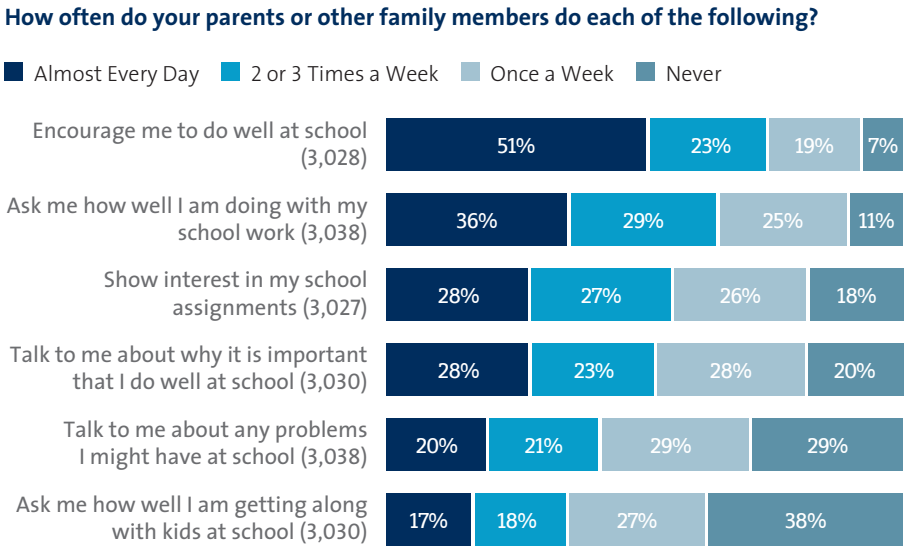
6.3_ Youth receive different levels of support from their family and whānau

Having a supportive caring family is a protective factor against mental health issues for youth. Some youth come from very supportive family environments where they have positive role models, rules and expectations, and parents, family and whānau are engaged with their lives. Others lack some or all of these. For example, in three localities, stakeholders described numbers of youth who did not have a home and instead 'couch surf', that is, sleep at friends' and extended family members' homes on a night-by-night basis.

> *There are all the housing issues attached with mental health issues like young people with no fixed abode and couch surfing. – Provider perspective (Christchurch)*

The OurSCHOOL survey explored student relationships with other family and whānau in the context of their reported experiences relating to school (e.g. the extent that family showed an interest in their school work and offered encouragement to do well at school). While for over three-quarters of youth surveyed family members offered regular (twice a week to daily) encouragement to do well at school, this level of interest was less likely to extend to asking about relationships with other students and talking about problems at school (Figure 10).

Figure 10 _ Family members' interest in youth wellbeing at school



(Source: OurSCHOOL survey; base count (number of responses) for each factor shown in brackets)

Youth who reported a lack of family interest in their wellbeing at school were significantly more likely to have indicators of mental health issues than youth with more engaged families (Figure 11). Youth without adequate family support require different types and intensity of support and interventions to support their wellbeing and respond to mental health issues than youth who are well-supported by family and whānau and friends.

Figure 11 _ Proportion of youth with indicators of moderate to severe depression or anxiety by frequency of family interest in youth wellbeing at school

How often do your parents or other family members do each of the following?		Indicators of moderate or severe anxiety or depression	Base count
Encourage me to do well at school	Almost every day	22%	1,546
	Never	34%	216
Ask me how well I am doing with my school work	Almost every day	22%	1,078
	Never	33%	326
Show interest in my school assignments	Almost every day	21%	852
	Never	35%	553
Talk to me about why it is important that I do well at school	Almost every day	23%	852
	Never	29%	601
Talk to me about any problems I might have at school	Almost every day	22%	609
	Never	30%	888
Ask me how well I am getting along with kids at school	Almost every day	22%	512
	Never	28%	1,155

(Source: OurSCHOOL survey)

Education programmes for parents about parenting teenagers were frequently mentioned by locality stakeholders. Parenting education was recommended in the ARACY review as an effective intervention for age groups up to the middle years (Fox et al. 2015).

6.4_ What do the results imply for future youth mental health policies and programmes?

More supportive communities – key messages	
Encouraging safer communities	Some youth highlighted a need for safe areas in their communities to spend time socialising with other youth. One of the barriers to accessing services often mentioned by all stakeholders was a lack of reliable and accessible public transport. Bus stops were sometimes seen as unsafe places.
Including youth and their peers, family and whānau and communities in planning and developing local responses to improve youth wellbeing has the potential to better respond to local needs	Including youth and communities in identifying local needs and in developing local responses is likely to strengthen efforts to improve youth wellbeing. Potential approaches include: • Strengthening youth representation and other community voices on youth SLATs • As suggested by youth in one regional workshop, peer support initiatives to let other youth know about how they can support each other.
Parenting programmes	Parenting programmes for the parents of teenagers were identified as a gap in each locality workshop.

07

What is being achieved: Supportive schools

Summary

In the locality studies, there was considerable variation between schools in the extent to which they support student wellbeing.

The YMHP uses school decile as a way to target some YMHP initiatives. All stakeholders emphasised that mental health issues were not limited to students at lower-decile schools. Many recommended extensions of school-based services to at least mid-decile schools.

Positive Behaviour for Learning (PB4L) School-Wide (Initiative 8) was included in the YMHP with the aim of promoting a more positive school environment. PB4L My FRIENDS Youth (Initiative 10) was another way the YMHP aimed to support wellbeing and build resilience in schools, by teaching students about relationships and self-esteem. PB4L Check and Connect was offered to provide mentoring and monitoring for youth who had become disengaged from school. It focuses on goal setting and mentoring. Positive changes in school environments were reported in schools that had implemented one or more of the PB4L suite of programmes.

Key messages

- Schools could improve their focus on wellbeing and make the school environment more supportive by responding to the recommendations provided by ERO.

7.1 Introduction

YMHP initiatives focus on the school environment because of its potential to positively influence student wellbeing. The school environment is seen as ideal for developing social and bonding skills between youth and between youth and adults, as well as a venue for meaningful participation and creating partnerships with families and communities (Brooks 2006).

The school environment can also have negative effects on youth wellbeing and mental health. Bullying, especially social media bullying, was identified as a major problem in the locality studies.

7.2_ The school environment varied between schools

It is difficult to comment about the overall achievements of the school-based programmes, as the school contexts and how they prioritised wellbeing varied across the 24 schools included in the locality studies.

7.2.1 _ School rules and teacher support

Teachers at low-decile schools reported being overwhelmed by the need to respond to issues related to poverty. Poverty affects youth wellbeing through hunger, homelessness, lack of hope of employment, and the effects of parental stress on youth. Poverty also limits youth engagement with school (limited workspaces, no money for uniforms or school/non-school activities, family responsibilities such as caring for siblings or elders).

It was evident from site visits and observation that teachers at some schools provided tremendous support to youth, including through paying for food and sports club memberships out of their own money, taking youth to events, and facilitating youth attendance in classes by allowing siblings to come along. At some schools the uniform requirements are flexible so that they accommodate youth who may not be able to afford to purchase new items of clothing (e.g. allowing students to wear a non-uniform jacket).

> *Teachers do a lot: we drive them, feed them, clothe them, coach their sports teams, set up lunchtime sports, take kids aside for one-on-one stuff at lunch and after school. – School perspective (Lower Hutt)*

> *We've got an awesome staff who go well above their roles and hours they are paid for to look after students. We've got a real ethos of caring for kids here. – School perspective (Northland)*

By contrast, in our interviews with youth who had been excluded from school, they explained the ways in which their schools had not supported them – these included: expectations about youth based on where they lived, rigid uniform criteria, insufficient time allowed for youth to transition to a much larger school environment than they were used to, and/or detentions because they were late to school due to looking after siblings and/or part-time jobs.

> *I think those schools are just worried about the uniform instead of the education... Most kids around here don't even go to school because of their uniform. – Youth not at school (Northland)*

7.2.2 _ Sexuality and sexual health services

Sexual health services and information provided to students about sexuality varied across the schools included in the evaluation. The evaluation of school-based health services emphasised the variation in sexual health services provided at schools (Adolescent Health Research Group 2014). Some schools did not allow any sexual or reproductive health services on school grounds, while other schools allowed some as long as they were not spoken about openly or advertised within the school. Other schools offered full sexual health services, including pregnancy and STI screening, and access to contraception including condoms, oral and injectable contraceptives, and emergency contraception.

Locality stakeholders commonly suggested that the YMHP should also include the intermediate years. Although sexual attraction and intimate relationships may be discussed during sexual education in the intermediate years, practical contraception advice and access to healthcare is not offered until secondary school. Sexual education at intermediate years is focused more around puberty, body development and image, human reproduction, and risks and issues that can arise online and when using social media (MoE 2015b). Teachers explained that some youth are exposed to risky behaviours earlier than age 12, including in their homes. Early sexual maturity can lead to youth being sexually active at a younger age, highlighting the need for education about safe sex in intermediate school settings.

> *I had an example not long ago – she was 13 and having sex, was talking to the counsellor and then was referred on to me and then I got her and had to say well I'm going to have to report this because underage sex is happening. – Primary care provider (Northland)*

> *Like we have all these anti-smoking campaigns, but if you're brought up in a house of smokers and you're given a smoke at 11 how much choice do you have, you know? So there are real social determinants. – Agency perspective (Northland)*

7.2.3 _ Mental health outcomes across schools

The OurSCHOOL survey included questions associated with mental health outcomes and factors that may contribute to or reduce a youth's vulnerability to mental health issues.[6] Responses to the OurSCHOOL survey demonstrated considerable variation between schools in mental health outcomes, and in school-based risk and protective factors. For example, on average across the whole survey, 40% of youth were identified as having indicators of moderate or severe depression or anxiety,[7] but this varied between schools from 20% to 60% (Figure 12). Similarly, there was wide variation in school-based risk factors associated with bullying[8] and feeling unsafe.[9] The survey showed on average 12% of students had experienced moderate to severe bullying and 32% felt unsafe, but in one school bullying affected just over one-quarter of students and half of students felt unsafe at school.

6 Each outcome and factor was derived from a number of different individual questions (usually six), responses to which were combined to create an overall score that was subsequently used to derive categorical indicators of outcomes, risks or protective factors.

7 This measure was created from the two survey indicators of mental health outcomes (depression and anxiety) to include all students who were identified as having indicators of moderate or severe levels of either depression or anxiety.

8 Bullying was a combined measure based on responses to questions about physical, verbal, social and cyber bullying.

9 The measure of an individual's perception of safety was derived from six individual survey questions that explored experience of fights, being threatened by other students, and being a victim of theft.

Figure 12 includes two examples of protective factors in the school environment: sense of belonging[10] and positive student-teacher relationships.[11] These were evident for the majority of students, with three-quarters having a positive sense of belonging and positive student-teacher relations. However, in some schools around one-third to two-fifths of students lacked a sense of belonging and positive student-teacher relationships.

Figure 12 _ School mental health outcomes, risk factors and protective factors showing an average across all schools and a minimum and maximum rate for a school

		Average	Min	Max
Outcome measure	Moderate-high depression	30%	15%	48%
	Moderate-high anxiety	32%	17%	54%
	Moderate-high depression or anxiety	40%	20%	60%
	Low self-esteem	32%	12%	52%
	Self-harm	20%	11%	38%
Risk factors	Moderate-severe bullying	12%	4%	26%
	Lack of feeling safe at school	32%	11%	53%
Protective factors	Sense of belonging	74%	50%	88%
	Positive teacher-student relations	75%	61%	89%

(Source: OurSCHOOL survey)

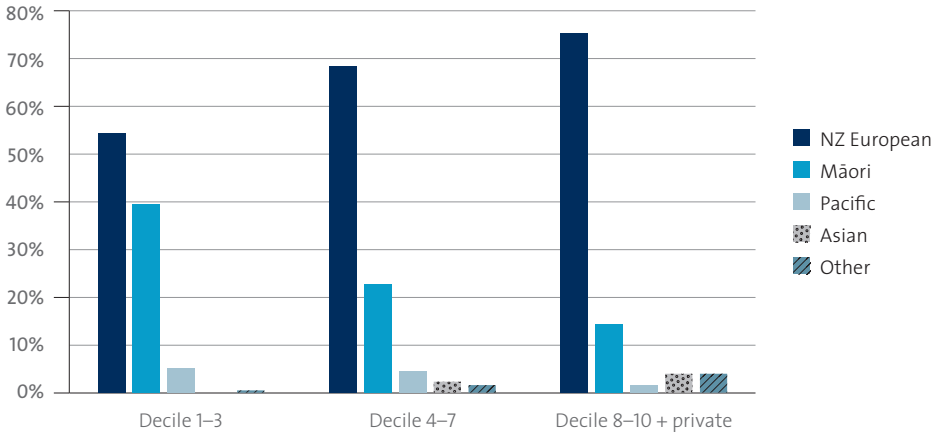
7.3_ The YMHP uses school decile to target some initiatives

Some school-based YMHP initiatives (such as SBHS including Year 9 HEEADSSS assessments (Initiative 1) and Youth Workers in Low Decile Secondary Schools (Initiative 14)) target decile 1 to 3 schools as a way of reaching more vulnerable groups of youth, including Māori and Pacific youth. National data shows higher proportions of Māori and Pacific youth in decile 1 to 3 schools (Figure 13).

10 The 'sense of belonging' indicator was derived from six survey questions that explored a youth's sense of feeling included and accepted at school.

11 The indicator 'positive student-teacher relationships' was based on six statements about how they felt treated by teachers in the classroom (e.g. treated fairly, praised, needs were supported and accounted for).

Figure 13 _ Ethnicity by decile for all localities included in the evaluation



(Source: Education Counts 2016; Prioritised count)

In the locality studies, schools and health and social sector stakeholders critiqued the use of deciles as a way of targeting services. All stakeholders emphasised that mental health issues were not limited to students at lower-decile schools.

> *Mental health is not a decile 1 to 3 [problem] only. – Education provider (Invercargill)*

> *I do know of a couple of cases ... and you can be surprised. You know their parents and you think 'wow' they are supportive and a good family and yet they are self-harming. You can only guess. – Parent perspective (Hawke's Bay)*

Others explained that decile was a blunt instrument as mid- and high-decile schools also included youth from very low income families and more youth would be reached with a universal approach.

> *I think the way the decile rating is done is appalling. It's just not representative of the actual kids in school. – Parent perspective (Christchurch)*

Mid-decile schools suggested students at their schools faced many of the same challenges as low-decile schools but schools did not receive additional funding and services through initiatives such as the YMHP. Their students' parents were also less able to pay for private services (e.g. psychologists) than those from high-decile schools. Mid-decile schools therefore reported that their students often 'fell in between'.

> *We don't have enough funding to address all of the need in the school. [Our decile] means we miss out. I mean, to have a trained nurse on-site here would be fantastic, to have a social worker would be really good. I'm absolutely sure they would be used because I believe we have a need. – School perspective (Northland)*

Many stakeholders recommended extending school-based initiatives to at least mid-decile schools. Analysis of data from the OurSCHOOL survey showed that across all deciles there were youth who needed additional support for mental health issues (Figure 14). This is consistent with the findings from ERO (2013c), which found that schools and wharekura were providing guidance and counselling for students who presented with many different problems. These problems were apparent in all types, deciles and locations of schools.

The 2007 survey in the Youth 2000 series also found no differences across school deciles in reported serious thoughts about suicide, reporting a suicide plan, reported self-harm, students with a significant number of depressive symptoms, rates of seeing a health professional for emotional worries, and students who reported binge drinking (Fortune et al. 2010).

Figure 14 _ Indicators of mental health outcomes by school decile group

	Decile group	Low (863)	Mid (1,616)	High (691)	Total (3,170)
Outcome measure	Moderate-high depression	23%	32%	36%	30%
	Moderate-high anxiety	23%	35%	37%	32%
	Moderate-high depression or anxiety	31%	43%	46%	40%
	Low self-esteem	26%	32%	38%	32%
	Self-harm	19%	20%	19%	20%
Risk factors	Moderate-severe bullying	13%	14%	6%	12%
	Lack of feeling safe at school	36%	37%	16%	32%
Protective factors	Sense of belonging	78%	71%	77%	74%
	Positive teacher-student relations	76%	73%	77%	75%

(Source: OurSCHOOL survey; Base count (number of respondents) for each group shown in brackets; Decile groups: Low = 1–3; Mid = 4–7; High = 8–10. Note no decile 1, 7 or 9 schools in survey sample)

7.4_ Promoting a positive school environment

Positive Behaviour for Learning (PB4L) School-Wide (Initiative 8) was included in the YMHP with the aim of promoting a more positive school environment. Evidence for PB4L School-Wide was derived from an international context.

PB4L School-Wide has three levels of implementation: tier 1, 2 and 3. Most schools in New Zealand are currently at tier 1, which is a whole-school initiative to promote student wellbeing, while tier 2 specifically targets at-risk students. Schools cannot move from tier 1 to tier 2 until they have an 80% score from MoE for two years in a row.

PB4L School-Wide was evaluated by the New Zealand Council for Educational Research (NZCER) to examine its effectiveness in a New Zealand context. The evaluation (Boyd & Felgate 2015) concluded that PB4L School-Wide is successful in improving the overall school culture.

Positive Behaviour for Learning: School-Wide (Initiative 8) – MoE

Aim: Reduce challenging behaviours in schools by implementing a school-wide programme that supports learners to improve their behaviour and to increase their resilience and mental wellbeing.

Implementation: PB4L School-Wide is offered to primary, intermediate and secondary schools. The YMHP provided funding to expand the programme into more secondary schools. As at 21 June 2016, there were 196 New Zealand secondary schools trained in PB4L School-Wide, with 188 schools actively implementing the programme: 153 at tier 1 and 35 at tier 2.

Achievements: The NZCER evaluation suggested positive benefits, including an improved school culture and increased consistency in approaches to behaviour, a more respectful and inclusive school culture, improved school systems for collecting and reporting behaviour data, and a decrease in major behaviour incidents (Boyd & Felgate 2015). Most schools included in this evaluation were at tier 1 of the PB4L School-Wide programme.

Staff at some PB4L School-Wide schools that were visited as part of the locality studies said early indicators suggested reduced stand-downs and increases in NCEA achievement at their school following the implementation of PB4L School-Wide.

Schools in the case study localities that have taken up PB4L School-Wide gave generally positive feedback. School staff thought that PB4L School-Wide had created a calmer atmosphere with less violence, and kept students in school rather than expelling or suspending them.

> *PB4L pulled it together and really focused the school on the core values. It has reinforced their sense of belonging... There are now some clear-cut guidelines on what a value looks like within the school. – School perspective (Hawke's Bay)*

Māori and Pacific youth: School values and culture influenced by the ethnic groups within the school are promoted as part of PB4L School-Wide. The evaluation of PB4L School-Wide (Boyd & Felgate 2015) gives examples of how schools weave together PB4L School-Wide and te ao Māori – for example, forming relationships with local iwi and kaumātua, revisiting the cultural geography of the school, or embedding whakatauākī of well-known Māori leaders into their school values. For example, at Makoura College in Masterton a new principal consulted the local community when the school developed their new school values.

> *With new leadership in place at the school and on the board of trustees, a commitment to mend community-school relationships was a high priority. For positive change to take place, the new school leadership needed community buy-in and support... As part of the commitment to mending relationships, the kaumātua worked with the school to take teachers on visits to local marae to help them appreciate local Māori culture and whakapapa. Through this relationship-building process the school worked to select a school motto and values that reflected the aspirations of mana whenua and the new direction of the school. The reo Māori teacher explained how these values are connected to whakatauākī and are used to create school waiata. Values are also reinforced by having 'kaumātua here and present' at the school. (Boyd & Felgate 2015, p. 21)*

Schools require support from 80% of school staff to begin the PB4L School-Wide programme and this can be a barrier to taking up the initiative. Some schools in the locality studies (particularly state-integrated schools) considered they did not need PB4L School-Wide because they already had well-established school values and a positive school culture.

> *We have a lot of the things that PB4L has anyway... I would like to see us return to some of that work around values... but think we can do that without a PB4L focus. – School perspective (Invercargill)*

My FRIENDS Youth (Initiative 10) was another way the YMHP aimed to support wellbeing and build resilience in schools, by teaching students about relationships and self-esteem. While My FRIENDS Youth is viewed as having a positive influence, the current business model (e.g. having to purchase workbooks for each student) was considered by MoE to be unsustainable on a larger scale. Increasing the number of schools taking part in the programme without an equivalent increase in the number of MoE staff employed to operate the programme may also lead to issues around maintaining fidelity of the programme.

Positive Behaviour for Learning: My FRIENDS Youth (Initiative 10) – MoE

Aim: (1) Increase mental health resilience among young people by building their self-esteem and providing practical skills to help them cope with life challenges, and (2) improve knowledge about what works to improve young people's mental health through demonstrating whether and how the My FRIENDS Youth programme works in New Zealand.

Implementation: The YMHP trialled PB4L My FRIENDS Youth programme to Year 9 and 10 students at 26 schools as part of the health curriculum. My FRIENDS Youth is a 10-session programme based on a CBT approach to help build students' self-esteem and resilience, to help them cope with depression and anxiety.

Teachers all received training prior to running the programme and this allowed for fidelity to the programme. The evaluation identified staff turnover as a potential risk to the programme, especially as the two-day training programme is mandatory for teachers to complete before they facilitate My FRIENDS Youth.

Achievements: PB4L My FRIENDS Youth was evaluated using data from the 26 schools that trialled the programme in 2014. These data included Wellbeing@School surveys completed by over 2,000 students before and after the programme, a survey of 31 teachers, and case study interviews with 17 staff and 160 students at five secondary schools (MacDonald et al. 2015).

Findings were positive, with most students agreeing the programme was worth doing and that what they had learned would be useful in the future. Teachers were also positive about the programme, with 78% reporting that students were more aware of their feelings as a result of the programme. The programme was found to be appropriate in a New Zealand context (MacDonald et al. 2015).

The current model may not be continued because of the cost of scaling up (i.e. the cost of the programme but also the cost of purchasing a workbook for each student).

Māori and Pacific youth: Three-quarters of teachers believed it was an appropriate programme for Māori (74%) and Pacific (71%) students (MacDonald et al. 2015).

> *Pacific students identified learning more from the programme than their teachers reported: most teachers (65%) were unsure whether the programme had made a difference for Pacific students, compared with 62% of Pacific students who agreed or strongly agreed that they used strategies from the programme. (MacDonald et al. 2015)*

7.5 Supporting youth at risk of disengaging

As part of Initiative 14, MSD funded the salaries of youth workers in low-decile secondary schools, most of whom used the Check and Connect model as funded by MoE through Initiative 9. As part of Initiative 9, MoE also provided funding for staff training and data collection for the evaluation.

NZCER evaluated the Check and Connect trials and found positive results (described further below). Youth workers in Northland funded by MSD under Initiative 14 did not use the Check and Connect model, although the reasons for this are unclear; they were therefore not included in the NZCER evaluation.

The Check and Connect programme is also being offered in Horowhenua (funded through existing Social Sector Trial funding) and at Ōtaki College, as well as through the YMHP.

Positive Behaviour for Learning: Check and Connect (Initiative 9) – MoE

Aim: PB4L Check and Connect is based on a programme from the USA. It provides mentoring and monitoring for young people who have become disengaged from school, and focuses on goal setting and mentoring.

Implementation: The YMHP trialled, evaluated and expanded the PB4L Check and Connect youth mentor programme in selected secondary schools in Auckland, Hawke's Bay and Wellington as part of Initiative 14 (Youth Workers in Low Decile Secondary Schools). Youth workers work with youth for two years.

	Number of schools with youth workers funded as part of Initiative 14	Using Check and Connect programme funded as part of Initiative 9
Northland	4	No
Auckland	7	Yes
Hawke's Bay	5	Yes
Wellington	4	Yes
Christchurch	None	A pilot of the Check and Connect programme was conducted in Christchurch in 2011–2013

Achievements: The evaluation of the Check and Connect programme by NZCER (Wylie & Felgate 2016) found that:

- Most students had made changes sought by the programme (e.g. just under three-quarters of students said they now put more effort into schoolwork and had better results; around two-thirds had a better sense of their own strengths and better ways of dealing with things that upset them).
- Just over one-third of students had made substantial changes – this was more likely for students who had been involved in the programme for 18 months or longer.

- Most students who participated in NCEA Level 1 gained numeracy and literacy standards, and 57% gained NCEA Level 1, which is relatively high given the generally low academic performance of the students before they entered the Check and Connect programme.
- While most students made improvements, most mentors had worked with one or more students for whom they said the Check and Connect approach was not so effective (e.g. difficult to maintain weekly school-based sessions with students who have very low or irregular school attendance).
- All mentors had previous experience with youth. Students who took part in the Check and Connect programme were all positive about their relationship with their mentor.
- One issue highlighted by both mentors and a small number of students was that the mentoring sessions took place during class time and therefore the students were 'taken out of class' to meet with their mentor.
- While mentors were largely positive about their relationship with the students' schools, 76% wanted to change some aspect of this relationship (e.g. schools to have a better understanding of the Check and Connect programme) and many also highlighted a need for timely access to data on student attendance, behaviour and NCEA progress.
- Nine of 10 "school champions" and all six school principals surveyed would recommend the Check and Connect programme to other schools.

Māori and Pacific youth:

- Most students taking part in Check and Connect were Māori or Pacific. Similar proportions in each group had made just a few changes. Māori students were more likely to have made 'many changes' around improved school engagement and results, and improved support and managing feelings (Wylie & Felgate 2016).

Youth Workers in Low Decile Secondary Schools (Initiative 14) – MSD

Aim: Improve school engagement, wellbeing and achievement through mentoring a small number of students at four case study sites over two years.

Implementation: The Youth Workers in Low Decile Secondary Schools (YWiSS) service provides qualified youth workers in selected decile 1 to 3 secondary schools. They support students and their families and whānau by targeting young people in Years 9 and 10 who are disengaging or at risk of disengaging from school and who may have unmet mental health needs.

At the time of the evaluation, there were 19 youth workers and seven NGO providers delivering the YWiSS service in 20 low-decile secondary schools in four targeted areas: Northland, Auckland, Hawke's Bay and Wellington (including the Hutt Valley and Porirua).

Achievements: As Initiative 9 (Check and Connect) above.

Māori and Pacific youth: As Initiative 9 (Check and Connect) above.

7.6_ Wellbeing and school guidance systems

All schools are required to provide some form of pastoral care to ensure the emotional health of their students. For example, section 77 of the Education Act 1989 requires that the principal of a state school "shall take all reasonable steps to ensure that students get good guidance and counselling; and that a student's parents are told of matters that, in the principal's opinion, are preventing or slowing the student's progress through the school; or are harming the student's relationships with teachers or other students".

The ways schools choose to meet their students' wellbeing needs varied widely and largely depended on the priorities of the senior management team and Board of Trustees. This variation was reflected in the ERO review of wellbeing in schools (Initiative 11), which identified various wellbeing indicators schools could use when undertaking internal evaluation (ERO 2015c).

As part of Initiative 11, ERO (2016a) identified five vital aspects of schools that successfully promote and respond to student wellbeing:

- The school has agreed values and vision underpinning the actions in the school to promote student wellbeing
- The school's curriculum is designed and monitored for valued goals
- Students are a powerful force in wellbeing and other decisions
- All students' wellbeing is actively monitored
- Systems are in place and followed to respond to wellbeing issues.

At the schools included in the locality studies, school guidance counsellor hours varied, from a subject teacher with an allocated number of hours per week for guidance, to multiple teaching and counselling-qualified staff who were employed full-time as specialist guidance counsellors. Some schools chose to supplement the full-time teacher equivalent (FTTE) entitlement using money from their operations budget (see ERO 2013c).

Students' awareness of and attitudes to school guidance counsellors differed across the schools included in the locality studies. In some schools, students respected the guidance counsellors and said they felt comfortable speaking to them.

> *She's cool, she's the favourite. If you're sad you can go to her room and she'll make you milo and talk. You can go to her for anything and if she can't help you she will get someone else. – Youth at school (Northland)*

> *She's the bomb. – Youth at school (Hawke's Bay)*

At other schools, the students either did not like their guidance counsellor or did not know who it was.

> *They are too old and they can't relate to you. The school guidance counsellors are not confidential; everybody knows when you go to them. – Youth at school (Lower Hutt)*

> *I think at the school I'm at now I've seen the guidance counsellor and she is good but at my last school I wouldn't go and see her. So it really depends on the person. – Youth out of school (Christchurch)*

Students at some schools viewed the guidance counsellor as aligned with teachers and as not providing confidentiality, especially if the guidance counsellor also had a disciplinary role.

Some students said there was stigma around seeing the guidance counsellor.

> *Some people ostracise you because you've been [to the guidance counsellor]... and they're like 'Oh you should deal with your own problems'. – Youth at school (West Auckland)*

However, guidance counsellors generally stated that there was no stigma around accessing their services.

> *There's no shame in coming to the counsellor. Lots of kids come here. – School perspective (Invercargill)*

In ERO's *Guidance and Counselling in Schools: Survey Findings* (2013b), almost two-thirds of students said it was socially acceptable at their school to see someone about guidance and counselling, while the remaining one-third said it was not socially acceptable.

The physical space used by the pastoral care team and the processes around making appointments influenced how comfortable students felt using the services. For example, some schools in the locality studies had dedicated purpose-built areas (either a wing of a building or a stand-alone facility) specifically for the guidance counsellor, school nurse, doctor, and any other relevant people (e.g. visiting AOD counsellors).

> *A conscious decision was made to have the guidance counsellors and other support services in here... Easy to get to but... kids wouldn't see... It's discreet. – School perspective (Invercargill)*

While having a dedicated space was an investment for a school, it helped to reduce barriers to access. By housing careers counsellors and administration staff in the same space, students were assured that people seeing them in this space would not know they were going for mental health issues. The importance of having a private space for guidance and counselling that is less conspicuous to access is also reflected in the ERO (2013b) report.

Conversely, at other schools with no dedicated space students sometimes found it difficult to make an appointment without others knowing about it.

> *[To make an appointment you have to] slip a note under his [the guidance counsellor's] door... hoping that no-one else is looking... You want to be discreet, but you look dodgy putting something under the door. You always feel a bit self-conscious going in there. – Youth at school (Invercargill)*

> *The waiting room for the guidance counsellor has lots of glass in it. So people will be able to recognise you and see you. Then people would talk and gossip. – Youth at school (Northland)*

At one school students raised concerns that the slip to leave class to see the guidance counsellor was a different colour from other slips.

> *The whole class knows you're going to see the guidance counsellor. It's a different coloured note so everyone knows that you're going. – Youth at school (Hawke's Bay)*

The locality studies provided examples of other ways schools supported their students. Some schools employed youth workers or social workers to support their students. Other schools provided various forms of peer-led programmes (e.g. peer mentoring and peer support) as well as varying levels of support through their form-class system.

ERO evaluation of wellbeing in schools (Initiative 11) – ERO

Aim: Schools are responsible for student's physical and emotional safety under the National Administration Guideline 5. This initiative reviewed how well schools promote and respond to student wellbeing. This was linked to ERO's *Wellbeing for Success: Draft Evaluation Indicators for Student Wellbeing* (2013a).

Implementation: ERO developed draft indicators for wellbeing followed by evaluations of wellbeing at both primary and secondary schools. These reports were both published in February 2015 as *Wellbeing for Children's Success at Primary School* (ERO 2015a) and *Wellbeing for Young People's Success at Secondary School* (ERO 2015b). The draft indicators were incorporated into *School Evaluation Indicators* (ERO 2015c).

The review found that support for wellbeing varied across the schools sampled. For example, 11 of the 68 secondary schools had cohesive systems aligned with school values and were well-placed to promote and respond to student wellbeing, 39 schools had elements of good practice, and 18 schools had a "range of major challenges that affected the way they promoted and responded to student wellbeing". Four of these schools were considered to be "overwhelmed by their issues."

Achievements: Based on these findings ERO published the final two wellbeing publications on 21 March 2016: *Wellbeing for Success: Effective Practice* (ERO 2016a) and *Wellbeing for Success: a resource for schools* (ERO 2016b). These have been sent to all schools and are available on ERO's website.

Māori and Pacific youth: The reports make some mention of how schools may focus on Māori and/or Pacific youth. In the *Wellbeing for Success: Effective Practice* report (ERO 2016a), an example is given of one school that used a 'place-based curriculum' around the significance of local features to Māori while another school focuses on outcomes for Māori and Pacific students based on student-teacher relationships.

ERO evaluation to improve the school guidance system (Initiative 12) – ERO/MoE

Aim: ERO reviewed guidance and counselling in schools to provide an evidence base about current models of practice that will inform MoE policy development.

Implementation: ERO completed a report on improving the school guidance system (ERO 2013c) and recommended that MoE:

- Review the formula used to calculate the Guidance Staffing Entitlement to ensure this funding better aligns with roll size
- Consider ways to support schools and wharekura to appropriately use the Guidance Staffing Entitlement to suit their particular approach and school context
- Provide guidelines/expectations for schools and wharekura about the provision of guidance and counselling
- Provide targeted professional learning and development for school leaders and people working in guidance and counselling roles
- Encourage schools and wharekura to include goals and approaches related to student wellbeing and/or guidance and counselling in charters, and in annual and strategic planning, and to report on these
- Ensure schools have appropriate and sufficient access to external agencies and support services to meet the wellbeing needs of students, including MoE working with other government departments in the health and social sectors to facilitate this.

Achievements: ERO completed the two evaluation reports within set timeframes and to MoE's expectations:

- *Guidance and Counselling in Schools: Survey Findings* (ERO 2013b)
- *Improving Guidance and Counselling for Students in Secondary Schools* (ERO 2013c).

MoE has convened a Guidance and Counselling Workshop Group with representatives from the Post-Primary Teachers' Association (PPTA) and the New Zealand Association of Counsellors. The Workshop Group is currently developing a work programme to respond to the report recommendations and improve the quality of guidance and counselling for young people in and across schools.

Māori and Pacific youth: Guidance counsellors reported working with a wide range of Māori and Pacific health and service providers and community organisations (ERO 2013c). Five wharekura were included in the ERO report (2013c). Two of the wharekura were in the group of 14 schools doing very well in their provision of guidance and counselling support, and examples were provided of some of the good practice at these two wharekura.

7.7_ Supporting schools

In addition to YMHP initiatives that promoted a positive school environment (e.g. PB4L School-Wide), two of the YMHP initiatives specifically aimed to support schools:

- Initiative 26 (Addressing the emerging youth mental health issues in Canterbury) was the only locality-specific initiative and focused on providing support for youth in Christchurch following the 2010/2011 earthquakes.
- Initiative 13 (Review of AOD education programmes) focused on developing an evidence base around AOD education in New Zealand in order to provide recommendations to schools on how to choose effective AOD education programmes for their students.

Addressing the emerging youth mental health issues in Canterbury (Initiative 26) – MoH

Aim: The initiative aimed to help promote other school-based initiatives, to support school guidance counsellors, and to provide a school-based youth mental health team (SBMHT).

Implementation: An SBMHT was established to help schools address the mental health needs of the school community as well as help support the pastoral care teams with mental health guidance.

SBMHT activities ranged from regular meetings with school principals and senior management about pastoral care and the wellbeing of staff and students, to promoting community events and workshops for students and parents. In certain cases youth were offered treatment, but the primary focus of the SBMHT was to help give schools the tools to help them manage and improve the wellbeing of their students.

Canterbury guidance counsellors meet every term. These meetings provide professional development on certain topics and help build stronger networks within the school guidance counsellor community. The SBMHT helps to provide speakers at these meetings and provides a quarterly newsletter.

Achievements: The quarterly newsletters and guidance counsellor meetings are continuing to run, with good attendance and positive feedback. The SBMHT has produced an information booklet called 'Issues to Resources' for school and other youth providers. The booklet is a comprehensive list of the issues that youth can be facing and what resources are available for those particular issues.

Contact with the team varied between schools. As of May 2016, the SBMHT was involved with 102 schools, of which 31 were composite or secondary schools. The SBMHT has also been consulted about the All Right? campaign.

Māori and Pacific youth: A Māori mental health worker in the SBMHT helps support the local wharekura with pastoral care. A school-by-school approach is used to identify the most appropriate support to offer.

Review of Alcohol and Other Drug education programmes (Initiative 13) – MoE
Aim: Build an evidence base about what works with regards to AOD programmes in schools so schools can make informed decisions on what AOD programmes to use at their schools. **Implementation:** MoE commissioned Dr Jenny Robertson to independently review government-funded AOD education programmes. Her report suggested AOD education programmes do not directly influence behaviour change. Instead, it is better to focus on developing protective factors and minimising risk factors (e.g. to avoid risk-taking behaviours). It is difficult to determine how effective various programmes in New Zealand are since there have been limited opportunities to carry out comprehensive evaluations (often due to limited resourcing). However, most programmes were found to be aligned with international best practice principles. **Achievements:** Guidelines for schools are available on the MoE website (http://health.tki.org.nz/Teaching-in-HPE/Policy-guidelines/Alcohol-and-other-drug-education-programmes), although the guidelines have not been further disseminated at this point. MoH intends to work in partnership with the Health Promotion Agency, which has also developed guidance for schools on responding to situations where students have become 'harmful users'. **Māori and Pacific youth:** The guidelines state that: *All AOD education programmes must take account of Māori and Pasifika worldviews. These worldviews focus on nurturing potential, identifying opportunity, investing in people, local solutions, and tailoring education to the learner. Both communities should be consulted in the schools, homes, marae and churches. Educational initiatives should be grounded in Māori and Pasifika ways, which involve Māori and Pasifika people and distinct traditions. (MoE 2014a, p. 5)*

7.8_ What do the evaluation findings suggest as potential future directions for the YMHP?

More supportive schools – key messages	
Improving schools' focus on wellbeing by responding to the recommendations provided by ERO.	The extent and ways schools support wellbeing varied. ERO evaluated wellbeing and guidance systems and provided recommendations that need to be considered in the context of systems for supporting youth wellbeing (ERO 2016a; 2016b). Particular areas of school life that influenced youth wellbeing and were frequently mentioned in the locality studies include: more support for exam stress, bullying and safety, including social media bullying.

08

What is being achieved: Supportive health and social services

Summary

Youth have different needs from adults. YMHP initiatives have made health and social services more accessible to youth:

- Expanding health and social services to school settings – This has increased access to health services at school through an extension of school-based health services to decile 3 schools and co-location in schools of other health and social services for youth.
- Providing funding security for YOSS – YOSS provide a service that meets the needs of many youth. Funding has been a challenging issue because YOSS provide a mix of health and social services. A successful Budget bid provided YOSS with ongoing and secure funding over four years. Providers report that YOSS are reaching Māori and Pacific youth who may not be attending mainstream primary care.
- Increasing primary care responsiveness to youth – Mainstream primary care services are important for youth and their family and whānau. There is an existing network of mainstream providers, and increasing the youth responsiveness of these providers is likely to improve access for youth.

Key messages

- A continued focus on youth-specific and youth-friendly delivery of health and social services is supported by the evaluation.

8.1_ Making services more youth-friendly and accessible to youth

Youth have different needs from both adults and children. Research shows youth respond better to services that are youth-specific rather than being an 'add-on' to an existing child or adult service (Mathias 2002). Services that are youth-friendly are more likely to be used by youth. The World Health Organization (2009) describes youth-friendly health services as being:

- Accessible: Adolescents are able to obtain the health services that are available
- Acceptable: Adolescents are willing to obtain the health services that are available
- Equitable: All adolescents, not just selected groups, are able to obtain the health services that are available
- Appropriate: The right health services (i.e. the ones they need) are provided to them
- Effective: The right health services are provided in the right way, and make a positive contribution to their health.

In the locality studies, youth service providers emphasised the interconnection between mental health and physical health for youth, and also the need for a holistic approach to supporting youth through adolescence that includes a focus on the youth's environment, family and whānau as well as the individual (MoH 2011).

The YMHP initiatives included several approaches to making health and social services more youth-friendly and accessible. This was done through both central government initiatives and local implementation of YMHP initiatives:

- Extending School-Based Health Services (Initiative 1)
- Co-locating additional social services in schools (Initiative 25)
- Improving primary care responsiveness to youth, including additional funding to YOSS (Initiatives 5 and 18)
- Improving access to youth primary mental health services (Initiative 3)
- Improving both access and follow-up to CAMHS and AOD services for youth (Initiatives 6 and 7)
- Youth mental health training for social services (Initiative 21)
- Whānau Ora for youth mental health (Initiative 22).

8.2_ Expanding health and social services in schools

Many youth aged 12 to 19 years spend much of their time at school. Several YMHP initiatives focused on providing health and social services in schools as a way of reaching youth in a place where they already are – especially youth under 16 years.

8.2.1 _ School-Based Health Services

SBHS can meet youth needs by placing the service in a convenient and familiar youth-friendly location, offering a holistic approach to health that meets their unique physical and mental health needs. SBHS can:

- Improve youth access to primary care, which can result in higher educational outcomes (Winnard, Denny & Fleming 2005) and a reduction in depression and suicide risk (Adolescent Health Research Group 2014)
- Encourage the establishment of healthy behaviours in adolescence (e.g. being smoke-free) (Winnard, Denny & Fleming 2005)
- Reduce youth use of emergency departments, which suggests they are able to access earlier interventions (Mathias 2002; Adolescent Health Research Group 2014).

Initiative 1 (SBHS) maintained existing SBHS funding for decile 1 and 2 secondary schools, teen parent units and alternative education providers, and expanded SBHS to all decile 3 secondary schools, including wharekura. Funding was also provided through Initiative 1 for HEEADSSS assessments for all Year 9 students at eligible schools with SBHS.

Stakeholders in the locality studies were positive about SBHS, as they believed having health services on school grounds reduced barriers to youth accessing services (e.g. transport, travel time, opening hours clashing with the school day) and may reduce some of the stigma associated with youth seeking help for mental health issues.

For some teenagers, acknowledging that they have a problem to their families is difficult, maybe mental and sexual health. I think that if the services weren't at the school then they just wouldn't engage with the services at all. – School perspective (Hawke's Bay)

Think people are more comfortable if things are done in school. Otherwise people ask what you're doing. – Youth at school (Lower Hutt)

This is particularly the case when the nurse is well-embedded with the school pastoral team and therefore becomes known by the students. It's really hard for the public health nurses who go to the high schools, because they only go in for like an hour a week. So the kids never get to know them, whereas the school nurses have the opportunity to really get to know a lot of the students at the schools. – Primary provider (Christchurch)

While students may initially see the school nurse for physical health concerns, the nurse (or GP) may also uncover mental health concerns.

The nurse's role is really interesting because you are initially looking at physical things... but there are those situations where you dig a bit deeper, you actually find out there is a lot of stuff going on for them. – School perspective (West Auckland)

The majority of students in the locality focus groups who knew who the school nurse was were positive about the SBHS and saw it as a good place to go (especially for physical or sexual health concerns, but also mental health if there was a good relationship).

You can go to the nurse for any problem, which is good because if the counsellor is busy then you can knock on the nurse's door too, so that's good. – Youth at school (Christchurch)

In schools where the nurse was only there for a short clinic, students were less aware of the service. In the locality studies, a few youth commented that where the nurse was only available at the school for limited hours per week, this increased the stigma associated with visiting a health professional, as students assumed that you would only go to the school-based nurse for things you could not discuss with your parents.

There's a nurse on Mondays. I don't know but it's in the notices... Nobody really knows who she is. – Youth at school (Invercargill)

There's kind of a stigma around the health nurse, like 'are you pregnant?!', otherwise why not go to the normal doctor. – Youth at school

School-Based Health Services (Initiative 1) – MoH

Aim: Improve student access to health services by expanding SBHS into decile 3 schools as well as screening all Year 9 students at decile 1 to 3 schools using the HEEADSSS Wellness Check. Low-decile schools were targeted, as students in high deprivation areas have greater difficulty accessing health care and are more at risk of poor health.

Implementation: There are currently 177 decile 1 to 3 secondary schools, kura, Teen Pregnancy Units and alternative education sites with SBHS, and all of these schools also do HEEADSSS assessments for Year 9 students. MoH has continued to fund 10 schools that moved out of decile 1 to 3 following decile changes in 2015, as well as extending funding to the 13 schools that moved into decile 1 to 3.

Achievements: Based on preliminary data for 2015, students made approximately 110,000 visits to SBHS and approximately 9,500 Year 9 students received a HEEADSSS assessment.

SBHS were evaluated in 2013 through an add-on to the Youth 2000 survey (Denny et al. 2014). 8,500 students across 125 schools were surveyed and the report concluded that high-quality SBHS (those that have on-site staff who are well-trained in youth health, with sufficient time to work with students and to perform tasks like routine HEEADSSS assessments) impact positively on student health and wellbeing outcomes in areas such as depression, suicide risk, sexual health, alcohol misuse and school engagement.

In the locality studies, schools that had SBHS said the services were well-utilised by students for physical, sexual and mental health issues. The extent to which SBHS were linked with the pastoral care teams within the schools varied. Some issues were highlighted around a lack of information-sharing across IT systems (between the school, the nurses, and the GPs) and a lack of physical space for the SBHS to operate.

Māori and Pacific youth: School-Based Health Services are targeted at decile 1 to 3 schools; nearly half (48%) of students at decile 1 to 3 schools with students in Years 9 to 13 nationwide identify as Māori while over one-quarter (26%) identify as Pacific (Education Counts 2016). Targeting services at decile 1 to 3 schools therefore includes a large number of Māori and Pacific youth. Some kura also have SBHS under the YMHP.

Some higher-decile schools had SBHS funded from outside the YMHP. Denny et al. (2014) found that the most common model of school-based health service provision was by visiting health professionals (56% of schools). Other schools had on-site health professionals: 20% had a health professional (a school nurse) and 12% had a collaborative health team of health and other professionals on-site for most of the week. Some schools funded their own health services, some services were provided through DHB public health nursing services, and some through YOSS or GP and nurse clinics funded by DHBs and/or PHOs.

In the locality studies, the different ways SBHS were provided had different implications. For example, nurses employed by schools were described as being part of the school team and it may be easier for them to work alongside school pastoral care teams. However, nurses employed by schools could lack professional supervision and be isolated from their peers. The in-depth locality studies found that new school nurse educator roles have been developed in some localities to help support nurses employed by schools.

8.2.2 _ Co-locating specialist services in schools

As well as SBHS, other YMHP initiatives also focused on co-locating various health and social service providers at schools. For example:

- Co-locating specialist services including youth psychologists, AOD counsellors, smoking cessation services, and CAMHS workers (YPMHS – Initiative 3)
- Combined Alliance Challenge Training Unit Support (CACTUS) programmes offered at three schools in MidCentral DHB (YPMHS – Initiative 3)
- Some guidance counsellors said they allowed students to use school computers to access SPARX (E-therapy – Initiative 4)
- Youth Workers in Low Decile Secondary Schools (Initiative 14).

Initiative 25 reviewed the feasibility and value of co-locating social services at schools.

Co-locating additional social services in schools (Initiative 25) – MoE

Aim: Investigate the feasibility and value of co-locating social services in schools (e.g. school nurses and youth workers, pastoral care team, various programmes and/or community-run initiatives).

Implementation: The report has been completed. It was based on a literature review, surveys and interviews about co-location of social services, including school-based models. The report concluded that the greatest benefit of providing school-based services is improved educational outcomes.

Achievements: The report did not appear to have been widely shared with schools (i.e. there has been no implementation or roll-out of any new resources as a result of the review). MoE continues to investigate ways to encourage schools to co-locate or provide social services.

Māori and Pacific youth: Findings from the youth survey suggested that "Māori/Pasifika students don't really access services in school more than others" (MoE 2014b, p. 24).

8.3_ Funding youth-friendly health and social services

While locating health and social services at schools may make these services more accessible for youth at school (see Section 8.2), they do not support youth who have left or disengaged from school. Youth-friendly services such as YOSS may be more important for these youth, particularly for youth who may struggle to engage with or access more mainstream services.

YOSS combine youth services in one place and work to reduce access barriers for youth by providing low-cost or no-cost services, youth-friendly opening hours, youth-friendly settings, and staff skilled in working with youth.

They have an amazing reputation in the community; young people are comfortable coming here. – Primary care provider (Invercargill)

An evaluation of 12 YOSS in New Zealand in 2009 (Communio 2009) was not able to quantify the effectiveness of YOSS in improving youth access to services as no pre- and post-YOSS implementation figures were available. However, demand for YOSS services (especially mental health services including counselling) often exceeds capacity, which suggests youth are utilising the services.

An evaluation of Kapiti Youth Support in 2013 found that most youth using the service reported positive changes. Notably, the youth who had the greatest need for positive health and wellbeing changes reported the best outcomes (Bailey et al. 2013).

Co-locating social services and youth specialist mental health services at a YOSS can reduce barriers to access and facilitate continuity of care (particularly between referrals if the service being referred to is also on-site). This can be particularly beneficial if youth are able to see specialist services such as CAMHS in the more youth-friendly environment of the YOSS rather than having to go to the hospital.

> *Seems really important for youth to have everything done in one place. They're not keen to go to various buildings to talk to others to tell their story again. – Primary care provider (Hawke's Bay)*

Examples of co-locating services were described in the evaluation of the YPMHS, including specialist mental health clinicians in primary care in Lakes DHB. Brief intervention services and packages of care are often offered on-site at YOSS or other youth-friendly locations.

8.3.1 _ Strengthening funding streams for YOSS

Funding YOSS has been challenging, as they provide both health and social services and do not easily fit MoH's or MSD's traditional funding streams.

> *YOSS are great and effective but funding models are difficult because they do not clearly fit into MoH or MSD funding models. We've been trying to sort this out for years and the YMHP was a good framework to allow this to happen. – Project team*

In the case study localities, a common issue raised by YOSS and other NGO providers was the difficulty in managing multiple funding contracts and uncertainty about ongoing funding, which also affected recruitment of staff.

Two of the YMHP initiatives specifically focused on funding for YOSS. Initiative 18 (Social Support for YOSS) provided one-off interim funding to 12 YOSS nationwide, while a large part of Initiative 5b (Primary Care Responsiveness to Youth) was policy work that resulted in a successful Budget bid in 2014 that secured ongoing funding and funding stability for YOSS. Securing ongoing funding for YOSS is expected to result in significant improvements in reporting and outcomes measurement within the YOSS sector.

Social support for Youth One Stop Shops (Initiative 18) – MSD

Aim: Interim funding to support YOSS while ongoing funding streams could be established via Initiative 5 (Primary Care Responsiveness to Youth).

Implementation: One-off funding of $50,000 to each of the 12 YOSS nationwide. Funding was well-received, and assisted many of the YOSS with funding pressure. The funding mainly went towards training, clinical assessment programmes, supporting existing programmes, supporting youth advisory groups, and extending staff availability and capacity.

Achievements: Helped to quantify the degree of social support provided by YOSS (approximately 30% of their work), built a strong sector relationship with YOSS, and helped develop the following criteria for YOSS:

- Provide health care plus a range of other services
- Actively model youth development principles
- Are open sufficient hours (at least 20 a week)
- Take a holistic approach to clients, supporting them and extending the opportunities available to them.

Learnings from this initiative were fed directly into the preparation of options for YOSS sustainable funding as part of initiative 5b (see below).

Māori and Pacific youth: All 12 YOSS were required to provide reports to MSD on how they had spent this money, and all spoke of clients they had worked with within the previous reporting period, including Māori clients.

A 2013 evaluation of the YOSS in Paraparaumu (Kapiti Youth Support) found that around 45% of Kapiti Māori youth were using the KYS services and that KYS was working well for all youth irrespective of gender or ethnicity (Bailey et al. 2013).

A 2009 evaluation of YOSS by Communio found:

- Most YOSS reflect principles of Te Tiriti o Waitangi and several use holistic Māori-specific processes in the delivery of their services, such as the Te Whare Tapa Whā approach.
- Outreach and satellite services are provided in communities with large populations of Māori, including alternative education and kura kaupapa.
- Nationally, Māori account for approximately 30% of clients accessing YOSS.
- The majority (67 out of 72) of Māori clients surveyed for the evaluation found YOSS to be effective in providing access to the health services they needed.

Primary Care Responsiveness to Youth – funding for YOSS (Initiative 5b) – MoH

Aim: Make primary care services more responsive to youth by improving youth access to appropriate services, and by improving integration of youth-specific services.

Implementation: Improve the sustainability of YOSS through policy work to establish ongoing funding streams.

Achievements: A successful bid to Budget 2014 resulted in an extra $8.4m over four years through MSD (routed through MYD) to support YOSS and their social supports.

Māori and Pacific youth: See Initiative 18 (Social support for YOSS).

8.3.2 _ Increasing primary care responsiveness to youth

Two initiatives specifically focused on increasing youth access to primary care:

- Initiative 3 developed the Youth Primary Mental Health Service
- Initiative 5a focused on making primary care services more responsive to youth.

DHBs were able to decide how to use the additional funding from Initiative 3 to respond to local needs and opportunities. Initiative 3 is described in more detail in Section 11. There were four broad approaches:

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

8.4_ Improving mental health literacy to make social services more approachable

Initiative 21 (Youth mental health training for social services) provided funding for frontline Work and Income staff involved with youth re-engagement and school attendance to attend a Mental Health 101 (MH101) workshop for training in youth mental health. The training aimed to help staff recognise the signs and know how to respond or refer youth on when they presented with mild to moderate mental health issues.

Parents... will come in with their child and we get to talk more about the children than themselves which is good too ...They'll open up about [what is] not quite right with their child and we can start a process then and support and get them into the right direction with providers. – Social service provider

Youth mental health training for social services (Initiative 21) – MSD

Aim: Provide consistent youth mental health training across the social sector to ensure that there are better referral pathways and that a trained workforce is able to recognise the signs and able to make referrals and take action when youth who present with mild to moderate mental health issues access their services.

Implementation: Eighteen MH101 sessions were delivered to 246 frontline Youth Services and Attendance Service staff. This initiative is completed, but MoH continues to fund 40 MH101 workshops per year, although places are limited.

Achievements: New youth-focused services involved with youth engagement and school attendance received identical, validated and relevant training in youth mental health so they can recognise the signs and know how to respond or refer youth on when needed. A number of other agencies, having noted the initiative's success, have purchased MH101 workshops from their own baselines (e.g. Work and Income for all frontline staff).

Māori and Pacific youth: The MH101 workshop reflects Māori culture, including the use of the Te Whare Tapa Whā model of health. One-third (36%) of those who attended the six MSD/Work and Income MH101 workshops in August 2012 were Māori and 11% were Pacific (Blueprint for Learning 2012).

8.5_ What do the evaluation findings suggest as potential future directions for the YMHP?

More supportive health and social services – key messages	
A continued focus on youth-specific and youth-friendly delivery of health and social services is supported by the evaluation.	Youth and youth-focused providers highlighted the need for health and social services to be more youth-friendly. Access to health and social services was improving through YMHP initiatives extending School-Based Health Services and supporting YOSS. Stakeholders recommended extending school-based services to higher-decile schools. Youth-specific services were improving access for some youth because they are youth-friendly. However, youth-specific services were operating at or beyond capacity. Youth-specific services cannot be located everywhere, and there is a need for mainstream services such as general practices and CAMHS to continue to develop youth-friendly ways of providing services.

09

What is being achieved: Early identification of mild to moderate mental health issues

Summary

Early identification of youth who need additional support is expected to result from:

- Improved access to appropriate information about youth mental health for youth and families/whānau
- Increased awareness of youth mental health by social service providers
- Improved access to primary care services, including youth-specific services
- Improved access to school-based health services.

In addition, the YMHP includes:

- HEEADSSS wellness checks for all Year 9 students at decile 1 to 3 schools through the extension of SBHS
- HEEADSSS training to increase the use of HEEADSSS wellness checks by a range of primary care providers.

Providers in school setting and other settings were positive about the value of HEEADSSS wellness checks. In the school setting, HEEADSSS wellness checks seemed to be most effective when delivered by school-based health service providers rather than as part of a separate contract. A major challenge for school health providers was responding to the multiple issues for some youth that were identified through the HEEADSSS wellness checks. Providers reported difficulty in accessing services to refer youth on to, and time constraints in meeting volume targets for wellness checks and managing responses to the issues they identified.

Outside of the school setting, many youth service providers were aware of HEEADSSS assessments and were using the assessments to varying degrees.

Key messages

- Positive responses from providers support the continuation of HEEADSSS wellness checks and training.
- Consider how to provide an effective system for responding to multiple issues identified in HEEADSSS assessments.

9.1 Introduction

Youth are not particularly good at identifying mental health issues and may not recognise when they need help for them, although this improves with age (Kelly, Jorm & Wright 2007). Instead, poor mental health may be revealed through risky behaviours that influence physical health (e.g. alcohol and drug use, smoking, and unprotected sex).

The use of screening tools such as the HEEADSSS wellness checks (Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety) may help identify youth experiencing mental health issues.

Great as a way of getting standardised assessments across a lot of different services and that's really good value from the national perspective. So being able to standardise some of the tools that staff are using is really helpful and being able to recommend outcome measures that can be used. – Agency perspective (Hawke's Bay)

9.2_ Screening tools: HEEADSSS assessment for Year 9 students

Initiative 1 (SBHS) funded additional HEEADSSS wellness checks through SBHS and had resulted in 9,500 Year 9 students being screened in 2015/16. In most localities, HEEADSSS wellness checks were completed by the SBHS nurses. As well as screening youth and identifying health issues, providers described the checks as a way of building relationships with youth so youth would know where and whom they could seek help from if needed. In some localities, Year 9 student HEEADSSS wellness checks were completed by providers separate from the SBHS. This approach had the potential to limit the extent the checks could be used to develop relationships between youth and providers.

Youth in the locality focus groups who had had a HEEADSSS wellness check had varying opinions. Some found it extremely helpful for addressing any health concerns or for just talking to someone, while others found the personal nature of the questions uncomfortable.

I loved mine [HEEADSSS check], like the nurse she was so open about it. She had that face that just says "I'm not going to judge but I'm going to keep asking questions, I know what it's like and I'm still going to be here". – Youth at school (Northland)

It is quite full-on... Like you're only 13 and they are asking about "Have you had sex? Have you tried to hang yourself? Are you bisexual?" – Youth at school (Northland)

School nurses highlighted the length of time taken for a thorough HEEADSSS wellness check (usually 30 to 45 minutes in a school setting). Referrals that stemmed from the HEEADSSS assessments could also be somewhat time-consuming.

The HEEADSSS takes up to two hours potentially. Most are one hour. But if there is any liaising with other providers it can take a long time. We take as long as it takes. If we get a student who has issues regarding mental health it is a big piece of work. We're contacting families, CAT, the police, the guidance teacher. It all takes time. – School nurse (Lower Hutt)

School nurses commented that it could also be difficult to refer youth to specialist services due to long wait times or strict criteria, even when the school-based provider considered that treating the youth was beyond their capability.

What to do with the information when we get it would be good, especially relationship stuff and social work stuff! – School perspective (Hawke's Bay)

9.3_ Screening tools: HEEADSSS wellness check training for providers

Initiative 2 (HEEADSSS) was initially developed, promoted and delivered as face-to-face workshops. Workshop locations were selected to ensure that all regions had access to a workshop, as it was recognised that access is easy in Auckland but not easy for remote regions. These workshops were also used to inform the development of online training. The online training was developed as a means of enabling access to the training for more health professionals in wider primary care settings.

HEEADSSS Wellness Check (Initiative 2) – MoH

Aim: The development, promotion and delivery of face-to-face and online training about HEEADSSS wellness checks, to support the expansion of the use of these checks in schools and primary care settings as part of the YMHP as well as to promote checks (especially within primary care).

Implementation: Contracted the Werry Centre to develop and deliver a HEEADSSS training programme.

Achievements: Nine HEEADSSS training workshops were delivered to 206 participants. 1,891 users accessed online training, 'An Introduction to HEEADSSS Assessment', between December 2013 and February 2016.

More youth had HEEADSSS assessments as part of School-Based Health Services (Initiative 1). However, no data were collected on how many youth received HEEADSSS assessments in primary care (i.e. outside of school), as this was not part of Initiative 2.

Māori and Pacific youth: Kaumātua and a Pacific Advisor from the Werry Centre were part of the Expert Advisory Group for the development and implementation of the training.

It is assumed that increasing the number of people trained to use HEEADSSS assessments increases the number of HEEADSSS assessments completed, and that in turn this will allow for earlier identification of mental health issues. However, data collection about HEEADSSS usage in community-based primary care was out of scope for Initiative 2.

In the locality studies, providers who were interviewed were positive about HEEADSSS assessments as a means of early identification of potential mental health issues. In response to a survey of 317 people involved in youth primary mental health services completed for the evaluation of the Youth Primary Mental Health Service, 23% said they used HEEADSSS wellness checks as part of a formal screening process and a further 51% used the checks partially or informally.

> *I'll do a HEEADSSS assessment on every kid but I don't do a HEEADSSS assessment on every kid every time I see them, but you might kind of ask a couple more questions and say, "Oh yeah last time I saw you, you were doing … how's that going?". Or "How's school going cos last time I saw you, you were having some trouble?" Sometimes it's about kind of actually just picking up different pieces just to go back to. – Youth provider (West Auckland)*

9.4_ What do the evaluation findings suggest as potential future directions for the YMHP?

Early identification – key messages	
Positive responses from providers support the continuation of HEEADSSS wellness checks and training.	Provider views that HEEADSSS checks are an effective way of screening and identifying youth who are at risk supports continued provision of training in using HEEADSSS assessments.
Consider how to provide an effective system for responding to multiple issues identified in HEEADSSS assessments.	Although HEEADSSS assessments are well-received by providers, school nurses often found they could not refer to specialist services due to long wait times or strict criteria, even when the youth was beyond their capability to treat. For high-need youth the administration tasks associated with referrals can often take a significant amount of time (several hours), which is often not factored into contracts/budgets.

10

What is being achieved: Access to timely treatment and follow-up

Summary

The YMHP has increased access to youth primary mental health services. The development of innovative ways of delivering services – such as co-location of youth specialists in youth-specific primary health services, in mainstream general practice and in schools – has increased the range of services available for youth.

Secondary mental health services have achieved waiting time targets for first referral and there are improved follow-up processes from CAMHS and youth alcohol and drug services. However, waiting times between first assessment and accessing DHB secondary services were reported in all localities.

Transitions between services are problematic in most localities and there is a need to further improve waiting times or referral practices.

The SPARX e-therapy tool is demonstrating effectiveness in improving outcomes for some youth, as assessed by the mood scores within the tool.

Key messages

- Respond to recommendations in the evaluation of the Youth Primary Mental Health Service (YPMHS) that the YPMHS should continue to be developed.
- Consider how to improve transitions between services.
- Further work is needed with the sector to understand the issues that underpin waiting times after first assessment.
- Promote the SPARX e-therapy tool further, as it has been demonstrated to be effective for some youth.

10.1_ Introduction

The YMHP aimed to provide better access to appropriate, timely and effective treatment for those experiencing mild to moderate mental health issues. One of the main barriers to accessing services was lack of capacity, particularly for youth-specific services and specialist care.

10.2_ Increasing the capacity of primary mental health services

Initiative 3 (Youth Primary Mental Health Service) focused on improving access to youth mental health services by increasing service capacity through increasing FTE and through providing new and innovative ways of delivering services. The initiative provided funding to each DHB to extend the adult primary mental health service to youth.

Youth Primary Mental Health Service (Initiative 3) – MoH

Aim: Additional funding to DHBs to improve youth access to primary mental health services.

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

- Expanding the age range of existing primary mental health services
- Adapting existing primary mental health services for youth
- Expanding existing NGO or community-based initiatives
- Developing new initiatives to meet local needs.

Achievements: The number of youth receiving primary mental health services has increased from 3,300 youth in the first quarter of 2014/15 to approximately 4,200 youth in the first quarter of 2015/16.[12]

DHBs had flexibility to implement the initiative in their localities to best meet local needs and the capacity of local providers. In most cases, DHBs contracted PHOs or other local providers to deliver the YPMHS.

The evaluation of the initiative found it had contributed to an improvement in the quality, safety and experience of care through enhanced youth-friendliness, development of new and innovative approaches to supporting youth, and an up-skilling of the workforce. However, some providers reported that caps on accessing packages of care limited the number of youth able to access these services, which suggests that the volume of care provided may not reflect total demand or need for the service.

Māori and Pacific youth: The initiative contributed to improved health and equity for youth. Some funding went towards supporting Māori-specific services. Between July and December 2015, the proportion of Māori youth accessing YPMHS was higher than the Māori proportion of the general population, while the proportion of Pacific youth accessing the service was approximately the same as the proportion of Pacific people in the general population.

12 This is based on actual numbers recorded by 20 January 2016. Note, however, that as providers submit numbers for subsequent quarters, changes may be made to update previous quarters – for example, to include data not received prior to the cut-off date for the quarterly reporting. Therefore, numbers reported may not align with the most recent MoH quarterly reports.

10.3_ Increasing access to specialist youth mental health services

We frequently heard that while youth were seen within waiting time targets for a first assessment, many did not meet the threshold for urgent care. Their GP or another provider was required to provide support while they waited for specialist care. In many cases they did not feel able to provide the level of care required.

All locality studies highlighted limited capacity of specialist services as an issue. Waiting times are a combination of:

- Insufficient capacity to meet the increasing demand described by providers in all localities

  We have real capacity issues, and I have no doubt that a lot of the other providers do too. – Primary provider (Christchurch)

- The need to improve communication between primary care and specialist services

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

- Over-referral by primary providers who lack confidence in providing support for youth at the moderate to severe end of the spectrum (for example, a GP who refers to secondary services because she does not feel confident she can help a youth with moderate to severe anxiety or depression)

  GPs get frustrated – "What can I do with this youth?" – and refer them to CAMHS. (NGO provider)

- Lack of innovation in secondary service provision, resulting in missed appointments and inefficiencies (for example, specialist services running their appointments as they would with an adult population and not getting adequate engagement with youth clients).

  [Our] support gets young people to professionals without going through CAMHS and the stigma attached... As a funder it is hard to justify but the outcome speaks for itself. (Youth service provider – YPMHS evaluation)

Prior to the YMHP there was no single consistent model for the delivery of youth AOD treatment services in New Zealand. The development of new models of care such as the CAMHS and AOD exemplar model (Initiative 7, CAMHS and Youth AOD Access) can increase efficiency and improve youth access to specialist youth mental health services. CAMHS developed significantly between 2009 and 2015. Despite steady increases in demand, access rates are up, waiting times are down, service provision gaps in eating disorders and youth forensic mental health have been addressed, and CAMHS productivity has improved.

Funding from the YPMHS supported new and innovative models of care to improve the transitions between services – for example, co-located specialists at youth-specific services and schools.

CAMHS and AOD Access (Initiative 7)

Aim: Unlike adult mental health and addiction services and child and youth mental health services, there is no single consistent model for the delivery of youth Alcohol and Other Drug (AOD) treatment services in New Zealand. This initiative aimed to increase access to youth AOD treatment services through improved integration with CAMHS.

- **Workstream 1:** Increase access to youth AOD treatment services through the wait time targets
- **Workstream 2:** Deliver a nationally consistent model of care for youth with AOD problems.

Implementation: Rather than distributing the funding across all DHBs, DHBs were invited to submit proposals for funding. Proposals were received from six regions. The bulk of the funding was contracted to Southern and Northern DHBs (joint venture between the DHB and a local NGO) to develop exemplar models, while four other DHBs (Whanganui, Bay of Plenty, Capital and Coast, and Waikato) received funding to increase capacity. All six DHBs received additional funding for future planning and change management for future services.

Achievements:

- **Workstream 1:** Wait times have decreased. In the year ending December 2015, targets of 80% being seen within three weeks and 95% being seen within eight weeks were being met or were very close to being met (84.7% of 12–19 year olds contacting a youth AOD service were seen within three weeks and 94.6% were seen within eight weeks; 77.7% of 12–19 year old specialist mental health clients were seen within three weeks and 93.8% were seen within eight weeks of referral).
- **Workstream 2:** The formative evaluation of the exemplar youth AOD and co-existing problems (CEP) mental health services in Southern DHB concluded that "Mirror HQ has successfully implemented an AOD CEP service based on best practice" (Litmus 2015). The evaluation of the Northern DHB model is not yet available.

Māori and Pacific youth: With the introduction of the new AOD CEP service in Southern DHB the number of Māori youth accessing Mirror's counselling services has increased from three in 2012/13 (12% of all clients aged 12–22 years) to 47 in 2014/15 (22% of all clients aged 12–22 years) (Litmus 2015). The evaluation of the Northern DHB model is not yet available.

10.4_ Referral pathways are still problematic

In every locality most stakeholders said it was difficult to know who and where to refer youth. They also reported difficulties with waiting times and transitions between services. The youth-specific providers who were interviewed in the locality studies reported they were at capacity. Services that were at capacity explained that there was no value in them promoting their services to schools or other providers. In the locality studies, one YOSS reported "closing their books" to process the overload before accepting new referrals, one did not maintain a waiting list, and another did not promote the services it offered as it was at capacity.

> *Demand has been through the roof, and capacity to meet that, i.e. staff numbers, have been dropping. – Primary care provider (Hawke's Bay)*

> *We can't keep a waitlist anymore because the list was just getting too long and we were never getting through them. It was almost triaging by need. But it results in having more moderate clients and the other clients never even get a look in. – Primary care provider (Invercargill)*

CAMHS services had capacity constraints that meant they only saw youth at the most severe end of the spectrum. Although secondary services are not part of the YPMHS, the interface between primary and secondary services drives behaviours and service models. It was particularly difficult for schools and providers to find services for youth who fell just below the CAMHS threshold. These were youth with moderate mental health issues that were more serious than an NGO or primary care provider felt comfortable treating, but not serious enough for secondary services.

> *When you try to get help for somebody they either aren't bad enough for this one or they're too bad for that one. – School perspective (West Auckland)*

> *Needs to be another team in the stepped care model. Primary do mild to severe. And then secondary do moderate to severe. But there needs to be another team that sits within that moderate range. – Primary care provider (Invercargill)*

In smaller localities, personal networks were important for knowing who to refer youth to for extra support, and those working in youth mental health often had personal relationships outside of their professional roles.

> *Because we're a small town we tend to know who to ring, so we can ring and talk to them personally and they'll say "Yeah, bring them down". – School perspective (Invercargill)*

In larger localities and where there were multiple small providers, schools and primary care providers said it was difficult for them to know who to refer to, and that criteria for access for youth were unclear and frequently changed. Some were critical of the quality of service provided by some smaller NGO services and therefore avoided referring to those services.

Initiatives 19 and 23 specifically focused on reviewing referral pathways and making recommendations for how these could be improved. Initiatives 23, 24 and 25 were developed to address gaps identified in the review undertaken as part of Initiative 19 (Youth Referrals Pathways Review). Initiative 23 (Referral pathway supports for young people) resulted in the development of navigator support guidelines for people dealing with youth experiencing mental health issues. These guidelines are available online but have not been widely disseminated.

Youth Referrals Pathways Review (Initiative 19) – MSD

Aim: To assess the integration, consistency and effectiveness of referral pathways for young people who have, or are at risk of developing, mild to moderate mental health issues.

Implementation: A review report of the current system, based on 62 interviews around the country with youth, providers and schools across Rotorua, Taupō, Wellington and Christchurch, combined with New Zealand and international literature.

Achievements: The report was completed. Initiatives 23, 24 and 25 were developed as a result of the review in order to address identified gaps and carry out further work as recommended in the report.

Māori and Pacific youth: The report had input from Māori mental health providers.

Referral pathway supports for young people (Initiative 23) – MSD

Aim: Identify at what points in the pathway access to support for youth mental health could be improved (this responds to the first three findings of Initiative 19, Youth Referrals Pathways Review – see above), including assessing the feasibility of establishing 'navigator' support functions across community, education and health settings to guide a young person and their family and whānau through their pathway of support.

Implementation: Navigator support guidelines have been produced and are available on the MSD website (www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/brochures/supporting-young-people-stress-anxiety-depression.pdf). A simplified four-page brochure has been finalised for wider distribution and the MSD communications team are currently developing a digital messaging plan to use social media to promote this document.

Achievements: No data are available on whether and how these guidelines have been used.

Māori and Pacific youth: The navigator support guidelines (MSD 2015) highlight the importance of being culturally responsive. Māori culture was specifically mentioned – this included:

- Recognising Māori as tangata whenua
- The Te Whare Tapa Whā model
- Focusing on a young person in the context of their family and whānau
- Integrating cultural processes and protocols when engaging with youth
- Holding discussions in environments that can assist in enhancing cultural identity and connections such as marae, schools, church and community places
- Using Māori values and practices as well as Te Reo where possible.

10.5_ Improving follow-up processes

Providing post-discharge follow-up is an important element of the continuum of services required to promote recovery and resilience of youth and reduce the risk of relapse. Youth with mental health and addiction problems have a risk of relapse, particularly in the period immediately following treatment.

Primary care services in the locality studies asked for more feedback from the secondary and tertiary services they refer to.

> *[Nearly two months after making a referral] we got a letter back saying they hadn't been seen. – Primary care provider (West Auckland)*

As with referral processes themselves, how much feedback and follow-up providers received after a referral may depend on personal networks.

> *We don't get feedback from referrals. We'd like to be able to share. Currently it is just if you have connections, which is not the way to build a sustainable system. All we want is the best possible outcome for that particular person. – Agency perspective (Hawke's Bay)*

Some school staff were frustrated with not knowing what was happening with their students after they referred to an external service, although they acknowledged that confidentiality was important.

> *So we make referrals to [primary providers], then they do what they do, often with very little feedback to us. I wouldn't expect them to feedback to people like us [senior management] but I hoped that they could share back in a confidential way with the guidance counsellor (who like them lives in the world of confidentiality). That would be good. – School perspective (Northland)*

Rather than referring to 'discharge', Initiative 6 (CAMHS & AOD Follow-Up) used the term 'transition' to emphasise the important of building ongoing relationships. Transition focuses on developing a conversation at the beginning of treatment, including discussing who the youth can ask for help if their mental health issues worsen after discharge.

CAMHS and AOD Follow-Up (Initiative 6) – MoH

Aim: Transition planning is critical to achieving the best outcomes for youth receiving Alcohol and Other Drug services. This initiative involved implementing a changed approach to follow-up care for those discharged from CAMHS and youth AOD services, in order to improve the transition of youth from specialist service to primary care.

Implementation: The initiative contracted the Werry Centre to develop and trial new guidelines. Following a successful pilot, DHBs are now implementing these guidelines as part of their discharge planning (www.health.govt.nz/publication/transition-planning-guidelines-infant-child-and-adolescent-mental-health-alcohol-and-other-drugs).

Achievements: From July 2014 DHBs were required to report on the percentage of children and youth exiting from specialist services that have a transition plan in place. As at the second quarter 2015/16:

- 16 DHBs had transition plan reporting in place (compared with 15 in the previous quarter)
- Four DHBs had transition plans in place for 95% or more children and youth exiting from specialist services. Nelson Marlborough, Waikato and Whanganui DHBs maintained their 95% coverage from the first quarter 2015/16.
- MoH is following up with four DHBs who were unable to provide transition plan data and with those DHBs not yet meeting the 95% target.

Currently data are collected on the number of youth with transition plans at discharge, but no data are available as to the quality or usefulness of these transition plans.

Māori and Pacific youth: No specific data are available.

10.6_ Increasing access through the use of online tools

Online tools can reach youth who may not access face-to-face services. Online tools are also less likely to be impacted by lack of capacity. Such tools can be particularly useful for youth in regional areas where transport and distance to services may be a barrier. However, poor internet access was highlighted as a barrier for some very rural areas. Initiative 4 (E-therapy) involved the promotion of SPARX, an evidence-based online e-therapy tool.

SPARX is awesome, it's great. It's free, it's youth-friendly... It's just fantastic. – Primary care provider (Invercargill)

E-therapy (Initiative 4)

Aim: To review and implement an internet-based e-therapy tool for youth.

Implementation: The SPARX website has been developed as an e-therapy tool based on CBT. Currently the site has been promoted to providers but to date there has been little direct promotion of SPARX to youth. Continuous development and improvement of SPARX's IT platform is required to achieve high performance and address lower adherence issues.

Achievements: Between October and December 2015, 1,573 youth completed Module 1, 380 completed Module 4, and 158 completed Module 7. Based on SPARX moods scores, improvements were noted by 51% to 60% of youth who had symptoms when completing the first SPARX module. An evaluation of SPARX by Malatest International in early 2016 found that promotion to health providers working in the youth mental health sector had been effective, with two-thirds (62%) of these providers being aware of SPARX. Further promotion to youth was underway following a re-development of the IT platform.

Māori and Pacific youth: Māori clinicians were consulted during the development of the SPARX website and specific resources are available in Māori and/or for whānau. Māori designs are included on costumes and on buildings.

A randomised controlled trial of SPARX concluded that it worked equally well across different ethnic groups in New Zealand. Dr Matthew Shepherd carried out a study on the effectiveness of SPARX for taitamariki and concluded that SPARX worked as well as usual care in reducing symptoms of depression and anxiety, and that taitamariki and whānau appreciated the Māori elements within the programme (SPARX 2015).

There has been lower take-up of SPARX among Māori and Pacific youth – 21% of youth aged 10 to 19 are Māori (Statstics NZ 2014) but only 13% of those registered to use SPARX identified as Māori, while 11% of youth aged 10 to 19 identified as Pacific (Statstics NZ 2014) but only 3% of those registered to use SPARX (October to December 2015 data) identified as Pacific. However, SPARX is in the early stages of implementation.

10.7_ What do the evaluation findings suggest as potential future directions for the YMHP?

Access to treatment – key messages	
Respond to recommendations in the evaluation of the YPMHS that this service should continue to be developed.	The YPMHS has increased awareness of youth mental health, has improved access to primary mental health, and is improving outcomes for youth (largely based on qualitative data). Feedback from providers suggests an ongoing need for the YPMHS and for further development of services to increase capacity and focus on the identified gaps.
Consider how to improve transitions between services.	The evaluation of the YPMHS provides some suggestions about how to develop a more effective and efficient system for supporting youth with mental health issues. Transition between services is an important aspect of an effective and efficient system.
Further work with the sector is needed to understand the issues that underpin waiting times after first assessment.	Waiting times may be the result of over-referral, lack of capacity, and/or different criteria for what should be referred. Evaluation findings suggest the need for further work to understand the drivers of waiting times and to develop solutions.
Promote the SPARX e-therapy tool further, as it has been demonstrated to be effective for some youth.	While the tool has been promoted to health professionals, it has not been widely promoted to youth themselves. SPARX provides an alternative for youth who may not have access to or want to access services where they live. However, it is important to continue to monitor outcomes for youth who use SPARX.

11

Protective factors, risk factors and outcomes for specific groups of youth

Summary

There were some differences in risk and protective factors for Māori and Pacific youth in the OurSCHOOL survey. However, qualitative data from the locality studies suggest that differences between Māori and Pacific youth and youth from other ethnic groups may be more marked among youth not in school.

The YMHP is reaching Māori and Pacific youth through initiatives such as SBHS, the YPMHS, and youth-specific services such as YOSS. Localities with a high proportion of Māori and/or Pacific youth have developed local services that aim to meet the needs of Māori and Pacific youth. Initiatives for Māori youth include a focus on increasing the cultural identity of disengaged youth.

Engaging with TPK and MPP to review YMHP initiatives and Māori and Pacific models of care is likely to strengthen the extent to which the YMHP improves outcomes for Māori and Pacific youth.

Other groups of youth at higher risk of mental health issues included youth with disabilities and youth who identified as LGBT. There were no specific YMHP initiatives that aimed to support disabled youth and youth who identified as LGBT.

In smaller localities, it was harder for youth with specific needs and their family and whānau to access appropriate services. Online services may help to fill this gap.

Key messages

- The YMHP initiatives are reaching specific groups of youth through universal services, but there is a need to target initiatives more specifically to groups of youth who have a higher risk of mental health issues.

11.1 Introduction

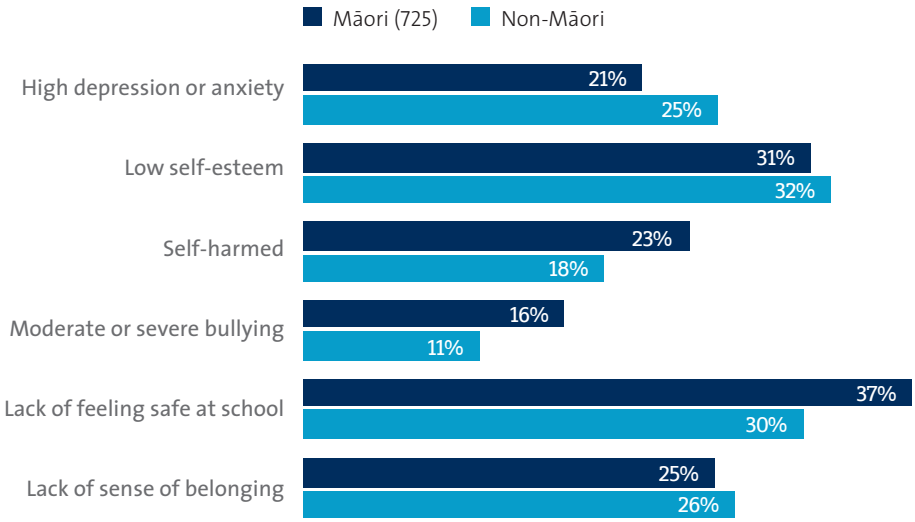
The locality studies and OurSCHOOL survey data provided information about differences for youth from different population groups.[13]

13 It is important to note that low numbers for some localities prevented meaningful analysis by ethnic group within localities.

11.2_ Māori youth

Māori youth who completed the OurSCHOOL survey showed some differences from youth from other ethnic groups in the incidence of risk and protective factors. While a smaller proportion had indicators of high depression, Māori youth were less likely to feel safe at school and more likely to report self-harming and experiencing moderate to severe bullying (Figure 15).

Figure 15 _ Mental health outcomes and risk factors, by Māori and all other youth



(Source: OurSCHOOL survey; total count approach, with the base count for each group shown in brackets)

Māori students (375) in Years 11 to 13 had higher rates of risky behaviours than other ethnic groups (excluding Pacific) in Years 11 to 13:

- Smoking occasionally to daily – 16% compared to 7%
- Use of marijuana occasionally to daily – 19% compared to 7%
- Engaged in sexual activity – 51% compared to 37%
- One drink twice or more per week over the last four weeks – 15% compared to 8%.

Rates were likely to be higher for youth not in school. Stakeholders in the Northland locality study highlighted substance abuse as a major issue for youth mental health and wellbeing.

> *We know that a lot of these things are what is causing the mental health issues – being abused, drinking underage, underage sex, all that kind of jazz. – Primary health provider*

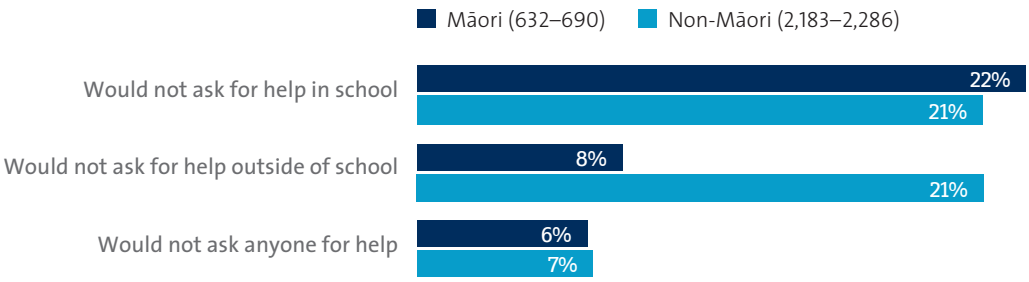
> *There are lots of issues which affect their wellbeing. There is all of that wider social issues and also with the physical health issues such as the sexually transmitted diseases. There the early pregnancies, lots of kids who are self-harming, [using] drug and alcohol. – Primary care provider*

Poverty and lack of employment opportunities were also identified as a major issue.

> *We've got families living in cars because they've got nowhere to go. Over the years I've had people sleeping in trees at the domain, sleeping in cars. These are families doing this, so the car is the mum and two or three kids. – Community provider*

Overall, Māori students did not differ from others in attitudes to asking for help in and outside of school, nor in whom they would ask for help (Figure 16). However, youth (both Māori and other) had different attitudes to asking for help across the localities (see Section 4).

Figure 16 _ Proportion of Māori youth who would not ask for help in school, outside of school, and neither in nor out of school



(Source: OurSCHOOL survey; total count approach, with the base count for each group shown in brackets)

There was little difference in rates of accessing online or telephone support between Māori youth at school (14%) and others (13%).

11.2.1 _ Supporting Māori youth

Evidence suggests that for some Māori service users it is important to have a service provider who shares their Māori understanding of health and wellbeing (Dowell et al. 2009) – for example, a focus on more holistic care and whānau involvement.

Whānau Ora was developed to recognise the importance of family and whānau for Māori and Pacific families and the importance of a holistic, whānau-wide response to youth mental health issues. At its core is the concept of family wellbeing. The Whānau Ora framework is based around putting whānau at the centre of decision-making about the services and opportunities they need and how they access them.

Stakeholders raised the following points to be considered for Māori and Pacific youth:

- The need to take a strengths-based approach and build on positive role models

  > *I really wanted to share the other side of the coin and obviously culture and identity and language are big here, and those are kind of I guess protective factors in some way for good mental health. – Steering group*

- Use of a Māori model of health and wellbeing such as Te Whare Tapu Whā when considering systems to support youth
- Ensuring initiatives and systems work for all ethnic groups and address the underlying causes of different outcomes

- The importance of community engagement and co-design
- The importance of understanding cultural issues – for example, some youth may face additional barriers to seeking help that are related to religious or cultural beliefs.

The locality studies provided many examples of ways schools and providers were supporting Māori students. One school had set up a Māori advisory group to better meet the needs of Māori students. One school had augmented their pastoral care system by employing a local Māori woman as a school 'whaea' (aunty). While she was employed as a tutor, she also worked within a wider role at the school encouraging students and supporting their resilience. She had a particular focus on Māori students but worked with students across the school. Another school encouraged teachers and senior Māori students to enrol in a correspondence course on tikanga Māori where the two groups could study together.

The [students] have the knowledge and the teachers have the writing ability. More in keeping with the essential Māori philosophy of working in groups. – School perspective (Hawke's Bay)

Services for Māori youth were available in localities with a high proportion of Māori youth. For example, in Northland, providers reported that the focus was for services that would meet the needs of Māori youth.

In localities with a smaller proportion of Māori, accessing services provided by a Māori provider was harder and some providers suggested that some Māori youth may specifically choose to utilise non-Māori services to increase anonymity.

The 2 or 3% who come here do so because they don't want to connect with a Māori organisation... The Māori community here is quite close... so sometimes they want the independence to go somewhere that's not [Māori]. – Primary care provider (Invercargill)

In Hawke's Bay, CAFS offers a 'cultural pathway' system for Māori youth under the age of 19 who require secondary care. They can use it to access a Māori model of care where CAFS works closely with the Māori provider. Providers made very positive comments about this organisation.

While much has been put in place to ensure culturally appropriate care, this is not always possible in acute cases.

There's still gaps in the system. If someone's acutely unwell in the A & E department after they tried to end their own life, you're not always going to get a Māori clinician. – Secondary care provider (Hawke's Bay)

We have to borrow from adult mental health services for our cultural support and they are very good, but again, not enough to go around. – Specialist care provider (West Auckland)

11.2.2 _ YMHP support for Māori youth

The YMHP aimed to reach Māori youth through the following initiatives:

- Initiative 1: School-Based Health Services. Services targeted decile 1 to 3 schools to reach greater proportions of Māori and Pacific youth. SBHS were offered to wharekura.
- Initiative 3: YPMHS. The YPMHS is likely to be contributing to reducing disparities between ethnic groups, as services were reaching Māori youth at higher rates than their proportion in the population. Examples of the ways YPMHS funding had been used to improve the wellbeing of young Māori by building cultural identity included:
  - A PHO has formed a partnership with a Community Trust. Programmes at the Trust include a tutorship carving programme based on attachment theory where male youth learn to carve and then share those skills with their fathers.
  - Māori mental health workers – YPMHS funding went to an iwi provider to employ a Māori man to work as a positive role model (particularly for young Māori men).
  - An iwi provider delivers programmes aimed at developing youth resilience and developing a sense of connection to their whānau and their tūrangawaewae.
- Initiative 22: Whānau Ora for youth mental health – a pilot specifically focused on Māori youth (in Hastings) and Pacific youth (in Counties Manukau).

Whānau Ora for youth mental health (Initiative 22) – Te Puni Kōkiri

Aim: Trial a whānau-centred approach to addressing the mild to moderate mental health needs of youth aged 12–19 years, or those at risk of developing such needs. The initiative recognised the collective capacity of whānau and developed a cross-sectoral approach to working with and achieving best outcomes for whānau, including evaluating the extent to which participating whānau/aiga developed their own ability to navigate through systems of support and build greater resilience. One of the main aims was keeping youth in school and finding appropriate accommodation for them and their families.

Implementation: Two providers worked with 20 youth and their whānau/aiga to support their mental health and wellbeing:

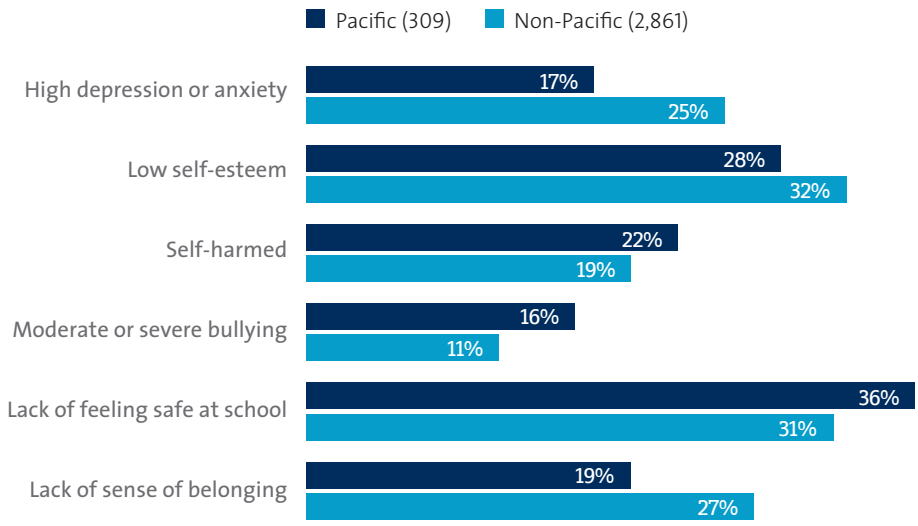
- Central Health (Hawke's Bay) with Māori youth
- The Project (Counties Manukau) with Pacific youth.

Achievements: The developmental evaluation (Goodwin et al. 2014) in August 2014 found that providers were successful in developing unique exemplars that incorporate key aspects of the Whānau Ora approach. The providers developed and utilised specific cultural approaches, frameworks and ways of working that were highly effective in engaging Māori and Pacific families and youth. The initiative was completed in June 2015.

11.3_ Pacific youth

Pacific youth who completed the OurSCHOOL survey showed some differences from youth who were from other ethnic groups. Smaller proportions of Pacific youth had indicators of high depression or anxiety, low self-esteem, and low sense of belonging. However, higher proportions did not feel safe at school, experienced bullying, and self-harmed (Figure 17). Rates for youth not in school may be different.

Figure 17 _ Proportion of Pacific youth with indicators of poor mental health and risk factors, compared to all other youth completing the survey



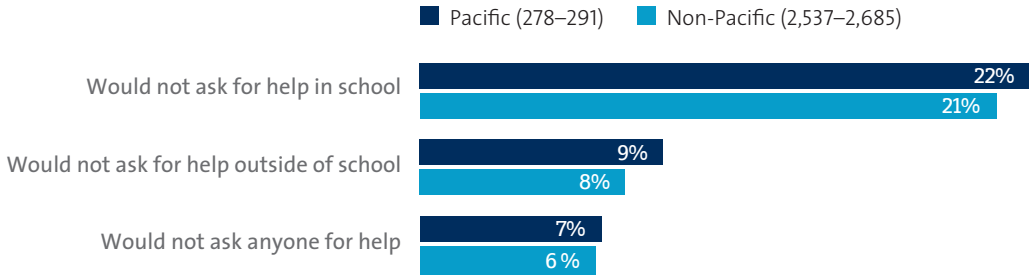
(Source: OurSCHOOL survey; total count approach, with the base count for each group shown in brackets)

Pacific students (approximately 160) in Years 11 to 13 had higher rates of smoking tobacco and marijuana and rates of sexual activity than other ethnic groups (excluding Māori) in Years 11 to 13:

- Smoking occasionally to daily – 14% compared to 8%
- Use of marijuana occasionally to daily – 14% compared to 9%
- Engaged in sexual activity – 51% compared to 39%.

Similar proportions of Pacific students as youth from other ethnic groups said they would not ask for help (Figure 18).

Figure 18 _ Proportion of Pacific youth who would not ask for help in school, outside of school, and neither in nor out of school



(Source: OurSCHOOL survey; total count approach, with the base count for each group shown in brackets)

11.3.1 _ Supporting Pacific youth

Pacific people in New Zealand come from very separate and diverse Pacific ethnic groups. The majority of Pacific people are born in New Zealand and a growing number of Pacific youth belong to multiple ethnic groups and are exposed to different cultural influences than their parents. Parents may be influenced by traditional beliefs that mental health is a spiritual imbalance, perhaps caused by ancestral spirits taking possession of the person after they or members of their family (immediate and extended) have broken certain customs or spiritual covenants in some way. Such beliefs can act as barriers to seeking help for mental health issues for Pacific youth.

Other barriers to seeking help include: cost of visits and/or prescriptions; concerns about confidentiality; embarrassment and not wanting to make a fuss; travel; lack of culturally appropriate services; lack of appropriate and accessible services and information; lack of knowledge about services; and perceptions that communication between adults and youth is sometimes authoritarian, judgemental and patronising (Craig et al. 2008).

Pacific peoples view mental health as an intrinsic component of overall health. Pacific cultures do not have words that translate easily into 'mental illness', and mental health is considered to be inseparable from the overall wellbeing of the body, soul and spirit.

There are several Pacific concepts of health and wellbeing that are based on a holistic approach to health and mental health, including the Samoan Fonofale model (Crawley et al. 1995), the Tongan Kakala model (Foliaki 2001), and the Cook Islands Tivaevae model (Ma-Ua Hodges 2000). The Fonofale model is one of the earliest and most recognised concepts (Suaalii-Sauni et al. 2009). This model provides a holistic view of Pacific health through the depiction of a traditional Samoan meeting house (fale) that shows the family as a base support (the foundation) and cultural values as the shelter (the roof) for physical, spiritual, mental and other aspects of health (the pou or posts), all of which are encompassed by the environment, time and context.

More recent models of Pacific health and wellbeing include the Seitapu model (Polutu-Endemann et al. 2007) and the Real Skills plus Seitapu framework (Le Va 2009). These models identify core cultural competencies and skills that are essential for the mental health and addiction workforce, organisations and others to work and engage effectively with Pacific clients and families.

The YMHP has not to date utilised a Pacific-specific model for youth mental health, although local services providing support for Pacific youth may use Pacific models of care. MPP emphasises the importance of using Pacific models of care and of developing specific approaches to improve wellbeing for Pacific youth. MPP emphasises the value of approaches that build on the strengths of Pacific communities.

Pacific populations in New Zealand are characterised by strong communities. Being part of a community is said to provide Pacific peoples with a sense of collective identity and security. Churches are an important part of Pacific communities. The 2013 Census found that 79% of Pacific people aged 15 to 29 were affiliated with at least one religion, only slightly lower than the rate of 80% for Pacific people of all ages. Cultural beliefs can act as barriers to discussions of mental health issues, particularly suicide – this can include both sacred beliefs (spiritual and religious) and secular ones (e.g. traditional roles and responsibilities for men, women, elders, youth and those with leadership positions). However, initiatives delivered through churches provide an opportunity to engage with substantial numbers of Pacific youth and their families.

11.3.2 _ YMHP support for Pacific youth

The YMHP aimed to reach Pacific youth through the following initiatives:

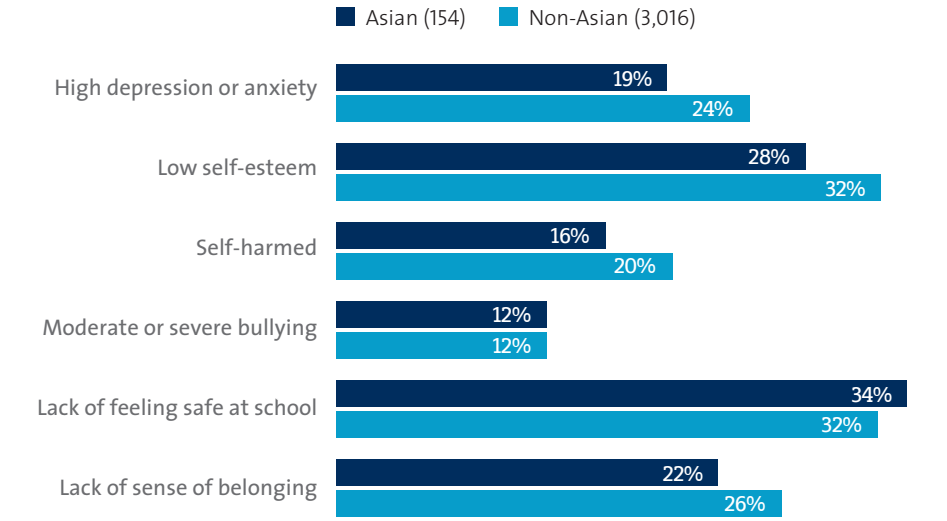
- Initiative 1: School-Based Health Services – Services targeted decile 1 to 3 schools to reach greater proportions of Māori and Pacific youth.
- Initiative 3: YPMHS – Services were reaching Pacific youth at similar rates to their proportion in the population. An example of the ways YPMHS funding had been used to address the barriers to access for Pacific youth was the addition of a clinical psychologist to the SBHS. Having a psychologist within schools has normalised mental health care and has allowed more flexibility in the care given. It has also reduced the stigma of mental health issues, as well as the effect of traditional cultural beliefs and influences in stopping some Pacific youth from seeking help. The result of moving care into the schools has seen an increase in Pacific youth numbers accessing care. The success of this model has seen it also moved into some other identified schools that sit above the decile 3 threshold.
- Initiative 22: Whānau Ora for youth mental health – This was a pilot specifically focused on Māori youth (in Hastings) and Pacific youth (in Counties Manukau) and described in Section 11.2.2.

11.4_ Asian youth

The OurSCHOOL survey included small numbers of Asian youth – 154 across all localities. There was also limited feedback provided in the focus groups and interviews that differentiated Asian youth from other youth.

In the OurSCHOOL survey, responses from Asian youth suggested generally lower rates of indicators of high depression or anxiety, low self-esteem, and self-harm (Figure 19).

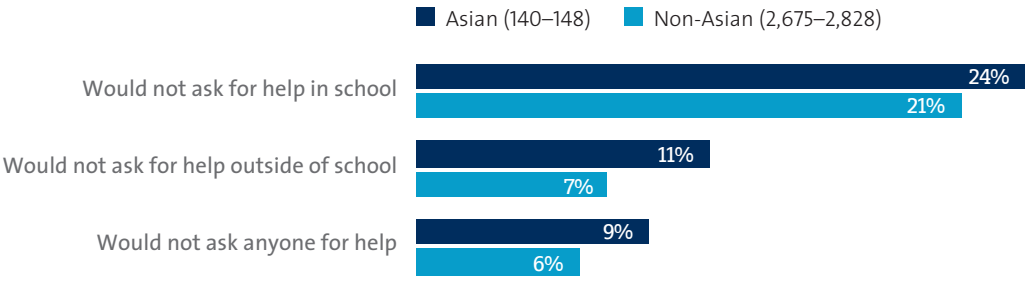
Figure 19 _ Proportion of Asian youth with indicators of poor mental health and risk factors, compared to all other youth completing the OurSCHOOL survey



(Source: OurSCHOOL survey; total count approach, with the base count for each group shown in brackets)

Asian youth may be slightly less likely than youth from other ethnic groups to ask for help inside or outside school, or at all (Figure 20), but numbers were too small to draw conclusions. There was a small difference in the proportion who said they had used any phone or online services when compared to all other ethnicities (16% compared to 13%).

Figure 20 _ Proportion of Asian youth who would not ask for help in school, outside of school, and neither in nor out of school



(Source: OurSCHOOL survey; total count approach, with the base count for each group shown in brackets)

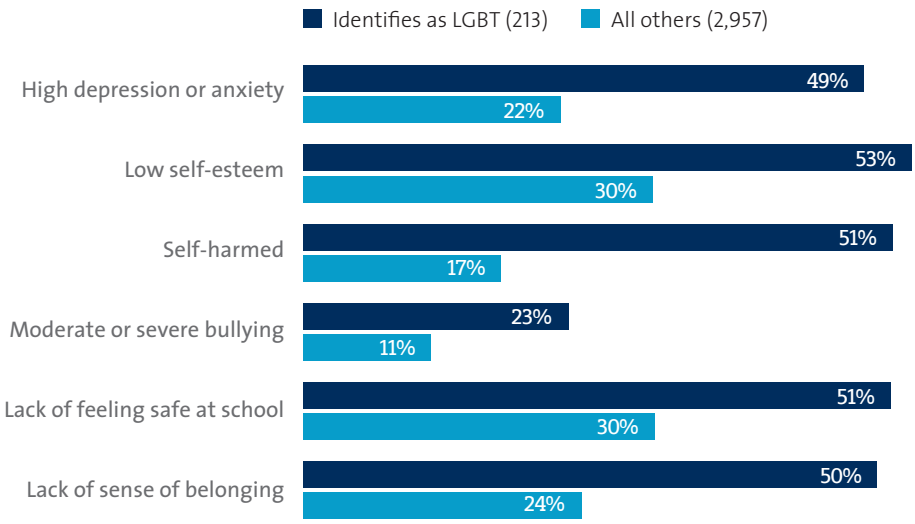
Asian youth have access to YMHP initiatives through universal services offered to all youth.

11.5_ LGBT youth

Lesbian, gay, bisexual or transgender (LGBT) youth have increased risk of mental health issues (Adolescent Health Research Group 2013). As stated on The Lowdown website,[14] being LGBT does not cause mental health issues, but LGBT youth may experience a lot of pressures that go along with being LGBT and may not feel understood by family and whānau, which may negatively impact their wellbeing.

In total, 213 students (7%) who completed the OurSCHOOL survey identified as LGBT. Higher proportions of students who identified as LGBT had low self-esteem, indicators of depression or anxiety, felt unsafe at school, and lacked a sense of belonging, compared to other students. Most noticeably, over half (51%) of LGBT students said they had self-harmed in the last 12 months, compared to only one-sixth (17%) of students who did not identify as LGBT (Figure 21).

Figure 21 _ Proportion of LGBT youth with indicators of poor mental health and risk factors, compared to all other youth completing the OurSCHOOL survey

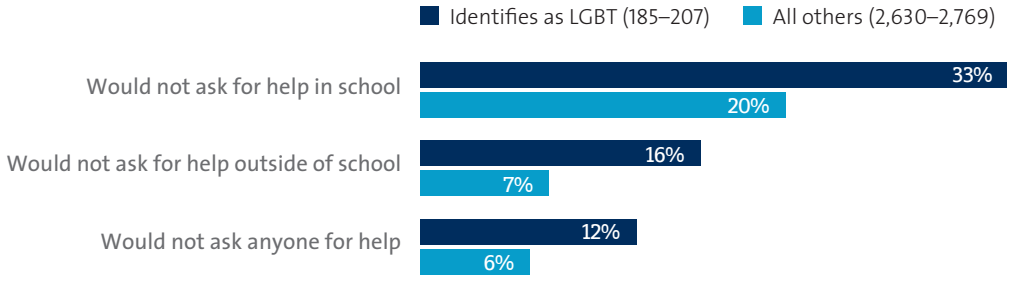


(Source: OurSCHOOL survey; total count approach, with the base count for each group shown in brackets)

Youth who identified as LGBT in the OurSCHOOL survey were more likely than other youth to say they would not ask anyone for help. One-third (33%) of LGBT students said they would not ask anyone at school for help, while one-eighth (12%) would not ask anyone for help either at school or outside of school (Figure 22).

14 https://thelowdown.co.nz/categories/identity/sexualgender-identity

Figure 22 _ Proportion of LGBT youth who would not ask for help if they were upset (in school, outside of school, and neither in nor out of school), compared to all other youth completing the OurSCHOOL survey



(Source: OurSCHOOL survey; total count approach, with the base count for each group shown in brackets)

At school, slightly fewer LGBT than non-LGBT students would ask for help from friends (58% versus 68%) and teachers (20% versus 27%). Outside of school two-thirds (68%) of non-LGBT students said they would ask their family or whānau for help if they were upset compared to less than one-half (46%) of LGBT students.

LGBT students were more likely to have used some form of telephone or online support compared to non-LGBT students (30% of LGBT students compared to 12% of non-LGBT students).

11.5.1 _ Supporting youth who identify as LGBT

In the locality studies, youth and providers highlighted a need for more services and support for LGBT youth. This was a particular issue in rural areas (especially Hawke's Bay and Invercargill).

> *There's no-one else really to refer to for that. There is online support... there's more and more people questioning their sexuality. – School perspective (Invercargill)*

> *In Auckland they have this big rainbow community... Here there's just a closed-in group that nobody really knows about. – Youth not at school (Hawke's Bay)*

Some stakeholders specifically mentioned a lack of services to support transgender youth.

> *Kids who aren't sure about what gender they are... they're the ones that do really struggle. – Parent perspective (Invercargill)*

In the locality studies, some school staff (particularly those at state-integrated schools) said that the school discouraged the discussion of services targeting LGBT youth. For example, at one school the guidance counsellor said they had been asked to remove a poster in a public corridor promoting an LGBT youth support group as this did not fit with the values of the school. Students at some schools also highlighted subjects that were not allowed to be openly discussed at the school.

> *We're not allowed to talk about sex that much. We're not allowed to talk about suicide. We're not allowed to talk about teenage pregnancy... They're trying to avoid it happening. – Youth at school (West Auckland)*

The Common Ground website includes pages on supporting youth who are questioning their sexual orientation[15] or gender identity,[16] and the evaluation of Common Ground suggests that there were 150 'sessions' or visits to the gender identity page (Dommett & Coker, 2016). The Lowdown website also includes a section for youth questioning their sexual/gender identity.[17]

The higher reported use of online services by youth who identify as LGBT suggests an increased focus on reaching LGBT youth through online supports, including e-therapy tools such as SPARX.

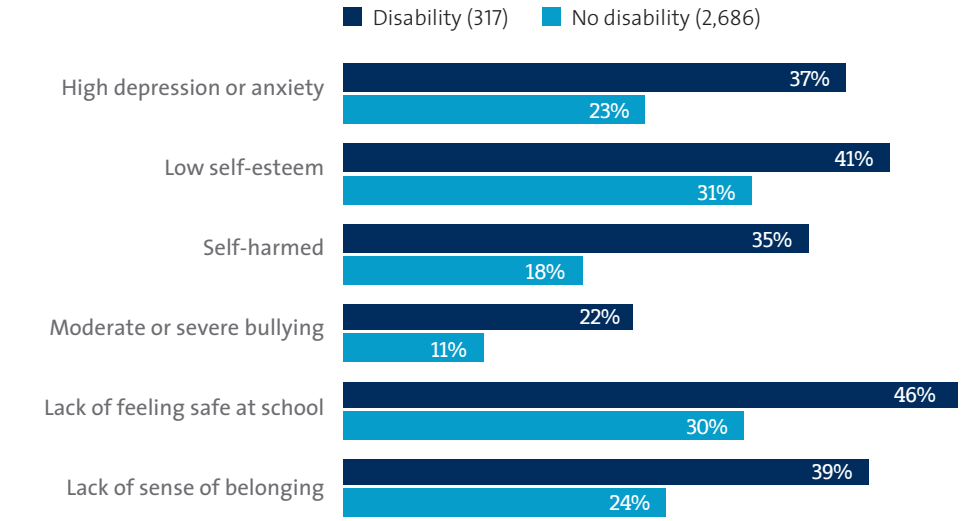
11.6_ Youth with a disability

Youth with a disability have an increased risk of mental health issues (Adolescent Health Research Group 2013). In total, 317 students (11%) who completed the OurSCHOOL survey said they had a disability that limits their participation in school and activities and learning.[18]

Approximately two-fifths of students with a disability (37%–45%) had low self-esteem, indicators of depression or anxiety, felt unsafe at school, or lacked a sense of belonging, compared to only one-quarter to one-third (23%–31%) of students without a disability. One-third (35%) of students with a disability said they had self-harmed in the last 12 months, compared to only one-sixth (18%) of students who do not have a disability. Similarly, students with a disability were twice as likely to say they had experienced moderate or severe bullying in the last 12 months (22% compared to 11% for students without a disability) (Figure 23).

15 www.commonground.org.nz/common-issues/identity/sexual-orientation/
16 www.commonground.org.nz/common-issues/identity/gender-identity/
17 https://thelowdown.co.nz/categories/identity/sexualgender-identity
18 This is the wording used in the survey. There were some missing data: 167 respondents did not answer the question, hence the base count here is 3,003.

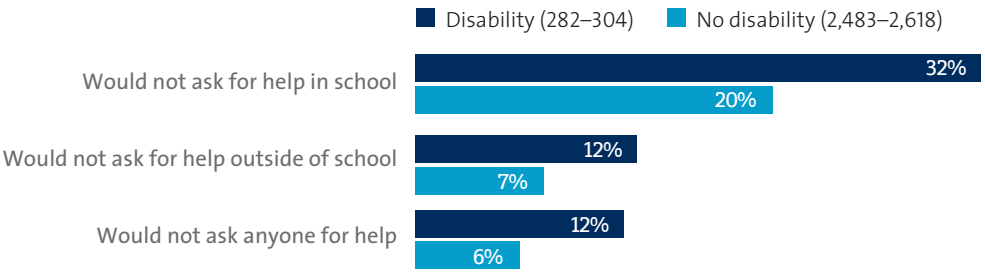
Figure 23 _ Proportion of youth with a self-reported limiting disability with indicators of poor mental health and risk factors, compared to all other youth completing the OurSCHOOL survey



(Source: OurSCHOOL survey; total count approach, with the base count for each group shown in brackets)

Students with a disability were more likely to say they would not ask anyone for help. One-third (32%) of students with a disability said they would not ask anyone at school for help, while one-tenth (12%) would not ask anyone for help either at school or outside of school (Figure 24).

Figure 24 _ Proportion of youth with a self-reported limiting disability who would not ask for help in school, outside of school, and neither in nor out of school



(Source: OurSCHOOL survey; total count approach, with the base count for each group shown in brackets)

Fewer students with disabilities would ask for help from friends either at school or outside of school compared to students without disabilities (58% compared to 72% at school; 54% compared to 67% outside of school). Outside of school 60% of students with a disability said they would ask their family and whānau for help if they were upset, compared to 70% of students without a disability.

Students with disabilities were much more likely to have used some form of telephone or online support compared to students without a disability (25% of students with a disability compared to 12% of students without a disability).

The evaluation of Common Ground suggested that more could be provided on the website for youth with disabilities as they "face similar issues regards bullying, identity, relations etc. as those struggling with sexuality and gender etc. but often feel invisible in the mental health or resource sites" (Dommett & Coker 2016, p. 28).

Students with a disability are likely to benefit from the YMHP initiatives through improved access to school-based services and enhanced primary care responsiveness for youth.

11.7_ What do the evaluation findings suggest as potential future directions for the YMHP?

Reaching specific groups of youth – key messages	
The YMHP initiatives are reaching specific groups of youth through universal services but there is a need to target initiatives more specifically to groups of youth who have a higher risk of mental health issues.	In a devolved delivery system, central government is responsible for ensuring that service design accommodates the needs of different groups within the population. While there are services specifically targeting Māori and Pacific people, providers noted these services could be difficult to access. New Zealand's increasingly multi-cultural society (particularly Auckland) raises other issues with regards to ethnicity and religious beliefs. Youth sexuality was raised by some who said support was more difficult to find for LGBT youth, especially in smaller localities where there were relatively few LGBT youth. More understanding and knowledge of LGBT youth is needed, particularly in rural and regional areas that youth and providers suggested may be more 'traditional' or 'conservative'.

12

What do YMHP results imply for future youth mental health policies and programmes?

Summary and key messages

The YMHP is addressing identified challenges in the system such as a lack of integration, information and evidence about what works. Its focus on early identification is supported by findings from the ARACY review (Fox et al. 2015).

The YMHP has established the interagency response required to address the complex challenges facing youth in adolescence. Strengthening interagency work at the local level could better support YMHP initiatives to achieve positive outcomes.

The 26 YMHP initiatives have all been implemented. Combining the initiatives into a single project enabled agencies to be responsive to needs that were identified during implementation and provided a framework for trialling new funding and service-delivery models. Initiatives focused on systems changes were completed and, in some cases, their recommendations are still being considered.

The YMHP initiatives are demonstrating positive outcomes for youth. Many initiatives have made changes that may be expected to improve mental health outcomes for youth.

The initiative evaluations did not provide enough evidence about outcomes for youth to make specific recommendations about which initiatives should be continued. While some initiatives demonstrated positive outcomes for youth, others have not been evaluated or have not been in place long enough for conclusions to be drawn. Lack of evidence about outcomes does not necessarily mean these initiatives should be discontinued.

Some gaps were identified in the project, including a need for more information for youth, families and whānau about where to go for support for mental health issues and a need to reduce the stigma associated with mental health issues.

The different contexts youth live in are important for developing the best ways to support them. Understanding youth contexts means identifying local needs, developing initiatives to meet local needs, and targeting services for specific groups of youth.

Some YMHP initiatives are delivered in decile 1 to 3 schools with the aim of reaching youth most at need. However, mental health issues were identified for youth across all school deciles. An extension of school-based services to at least mid-decile schools would reach more youth in need.

Implementing the initiatives and monitoring and evaluating the YMHP has provided information that allows better understanding about what works to support youth with mild to moderate mental health issues. More information about how initiatives and service-delivery systems influence outcomes for youth is required to inform decisions about which initiatives to continue and which aspects of local systems are effective for youth.

12.1_ Interventions to improve outcomes for youth

New Zealand youth have high rates of mental health issues that affect their wellbeing, educational achievement, and engagement with the workforce. These issues represent a substantial economic and social cost to the country.

A recent review of the literature about research and practice for prevention and early intervention (Fox et al. 2015) concluded that there are effective and important preventative interventions in multiple domains of wellbeing and across the life course, and the review describes the focus of interventions at different life stages. The review identified:

- Early childhood as a crucial window of opportunity – Here there is the potential to shape long-term trajectories given the brain development occurring between birth and three years.
- Adolescence – This is another window of influence: the brain continues to grow during what is a time of transition from family influences to increasing peer influence and of increasing exposure to risky behaviours.

The YMHP was developed to target 12 to 19 year olds and the changes that appear in adolescence. It complements other government initiatives for the early years and other life stages.

The YMHP is addressing identified challenges in the system such as a lack of integration, information and evidence about what works. Its focus on early identification is supported by findings from the ARACY review (Fox et al. 2015).

12.2_ Implementing the YMHP

The complex protective and risk factors for youth and the different contexts in which they live, as well as the need to reach youth in a number of settings, contribute further to the need for an interagency approach.

An effective interagency steering group is in place at central government level to continue to develop the policy and service-delivery responses necessary to improve youth mental health and wellbeing. The cross-sectoral approach in the localities was not well-established, but the establishment of youth SLATs has the potential to improve cross-sectoral engagement for the health and social services. Schools are not usually part of local governance/working groups and there is a need to strengthen the interface between schools and health and social service providers.

Strengthening interagency work at the local level could better support YMHP initiatives to achieve positive outcomes. Local communities and stakeholders are aware of local issues but may need additional external capacity and/or capability to develop the cross-sectoral local responses needed to collate the knowledge and effect change.

The 26 YMHP initiatives were implemented between 2012 and 2016. Some were existing initiatives started before the YMHP, while some were new initiatives developed to respond to needs identified through implementing the YMHP. Some initiatives involved developing new programmes, some extended existing programmes, and some were reviews or evaluations. Some initiatives had not been implemented sufficiently to demonstrate their full potential, and there is a need to respond to the recommendations of initiatives that reviewed system-level changes.

The initiative evaluations did not provide enough evidence about outcomes for youth for specific recommendations to be made about which initiatives should be continued. While some initiatives demonstrated positive outcomes for youth, others have not been evaluated or have not been in place long enough for conclusions to be drawn. Lack of evidence about outcomes does not necessarily mean these initiatives should be discontinued.

Some gaps were identified in the project, including a need for more information for youth, families and whānau about where to go for support for mental health issues. An increased focus on building supportive communities and addressing the stigma associated with mental health is required.

12.3_ Taking locality contexts into account is important

Where youth live influences their wellbeing in multiple ways. Localities can have positive influences on youth wellbeing by providing supportive environments. We heard from groups of very vulnerable youth living in economically deprived localities about their pride in their towns and communities. The context of a locality can also negatively impact youth mental health. This can be through the influence of gangs or through a community environment that does not cater for youth (e.g. no sporting facilities or places for youth to 'hang out').

Poverty influences health in a number of negative ways (Craig et al. 2013). Limited employment opportunities have been shown to negatively impact mental health (Commission on Social Determinants of Health 2008). Stakeholders in socio-economically deprived localities reported that high unemployment leads to a sense of hopelessness as youth see few job prospects and high levels of poverty around them.

Stakeholders in the locality studies described the need for extra support for youth in adolescence. They noted that the number of youth requiring extra support has increased over recent years. Some attributed increases in youth need to greater poverty in the family and whānau they worked with and the negative impacts of poverty on youth wellbeing.

Poverty was also identified as a barrier to accessing mental health services for some youth:

- Youth may not be able to afford general practice fees or transport to travel to a general practice or to a youth-specific service.
- For some youth, especially in parts of Northland and in rural localities, public transport was not available.

Individual events can impact youth mental health – for example, suicides in the community or regional events such as the Christchurch earthquakes. Risk factors and indicators of depression and anxiety identified in the OurSCHOOL survey were present for a notably higher proportion of youth in Christchurch than in other localities.

> *So the capacity of a lot of families to manage their lives diminished hugely after the earthquake. – Provider perspective (Christchurch)*

Initiatives are implemented within local systems. The systems of service delivery were different across the localities. The number, size and experiences of local providers influence the ways services are delivered to youth.

12.4_ Targeting some services by school decile aimed to reach those who most need it

Suicide rates at population level are linked to socio-economic status. The self-harm hospitalisation rate of the most deprived New Zealanders was more than twice that of the least deprived New Zealanders in 2011 (82.2 per 100,000 population for the most deprived quintile compared with 38.6 per 100,000 for the least deprived quintile) (MoH 2014b).

Some YMHP initiatives are delivered in decile 1 to 3 schools with the aim of reaching youth most at need. However, mental health issues were identified for youth across all school deciles. An extension of school-based services to at least mid-decile schools would reach more youth in need.

12.5_ Other potential changes suggested by stakeholders

Locality stakeholders commonly suggested that the YMHP should also include the intermediate years. Although sexual attraction and intimate relationships may be discussed during sexual education in the intermediate years, contraception and access to healthcare is addressed at secondary school. Teachers explained that some youth are exposed to risky behaviours earlier than age 12, including in their homes. Early sexual maturity can lead to youth being sexually active at a younger age, and this highlights the need for education about safe sex in intermediate school settings.

12.6_ As a result of the YMHP there is more information about what works in improving youth mental health, but more evidence is needed to guide decisions

Implementing the initiatives and monitoring and evaluating the YMHP has provided information that furthers understanding about what works to support youth with mild to moderate mental health issues.

Some initiatives were based on evidence of their effectiveness (e.g. SPARX and the PB4L programmes) but further evaluation of their efficacy in a New Zealand, real-world context was warranted. Hence, each of those initiatives has been evaluated separately, but further evaluation is recommended.

Other YMHP initiatives have also been evaluated. Some evaluations were limited by a lack of measurement of outcomes. Some initiatives were based on a theory of change and still need to be evaluated.

Some initiatives, especially the reviews that may underpin changes to systems, have not been implemented sufficiently to demonstrate their full potential.

Processes are in place to incorporate all of the evaluations of individual initiatives along with the strategic evaluation of the YMHP as a whole into ongoing programme planning.

Evidence about what works is important for guiding investment decisions. More evidence is needed about the effectiveness of individual initiatives and programmes, and about how initiatives work together to provide a system to support youth mental health and wellbeing.

Lack of evidence is not the same as lack of effectiveness. Collection of consistent outcomes data would improve the information available for funding decisions.

12.7_ Attributing changes in youth outcomes to the YMH

The YMHP initiatives are demonstrating positive outcomes for youth. Many initiatives have made changes that may be expected to improve mental health outcomes for youth, but for others more work is required to realise their full potential benefits. Work to improve each local system as a whole may support the effectiveness of individual initiatives.

More information about how initiatives and service-delivery systems influence outcomes for youth is required in order to inform decisions about which initiatives to continue and which aspects of local systems are effective for youth.

The YMHP aimed to gather evidence about what works in youth mental health. The experiences of implementing the initiatives and the evaluations have increased understanding of youth mental health. However, challenges in collecting consistent data and in particular data about outcomes for youth have limited the learnings from the many YMHP initiatives.

Monitoring changes over time in indicators of youth wellbeing and mental health provides some information about progress towards improving youth outcomes. Superu has developed an outcomes framework as part of the formative evaluation of the YMHP (Superu 2015).

The attribution to the YMHP of any observed changes to outcomes for youth will always be difficult. Data available come from observational studies, and interpretation of changes is complicated by the concurrent implementation of other initiatives such as Children's Teams and the Social Sector Trials, and by the lack of comparison groups.

12.8_ How can programmes such as the YMHP be effectively monitored and outcomes for youth assessed?

Looking ahead to the continuation of the YMHP the following recommendations are made to enable a more effective evaluation approach:

- Time should be invested during the planning phase in reviewing the logic model and outcomes framework that were developed following the formative evaluation of the YMHP (Superu 2015) and in making adjustments to include any changes in focus.
- An evaluation framework should be developed that includes process evaluation measures as well as an outcomes framework.
- Although the YMHP initiatives have been implemented nationally, localities could be set up as pilot sites where the collective impact of the YMHP initiatives on the system as a whole could be examined in detail using qualitative and quantitative data. Ways of collecting data that could be used to monitor outcomes could be developed with providers at the pilot sites.
- The plethora of different surveys that are administered in school settings should be rationalised to establish one survey that can be repeated over time to provide a measure of the wellbeing and mental health outcomes of secondary school-aged youth.

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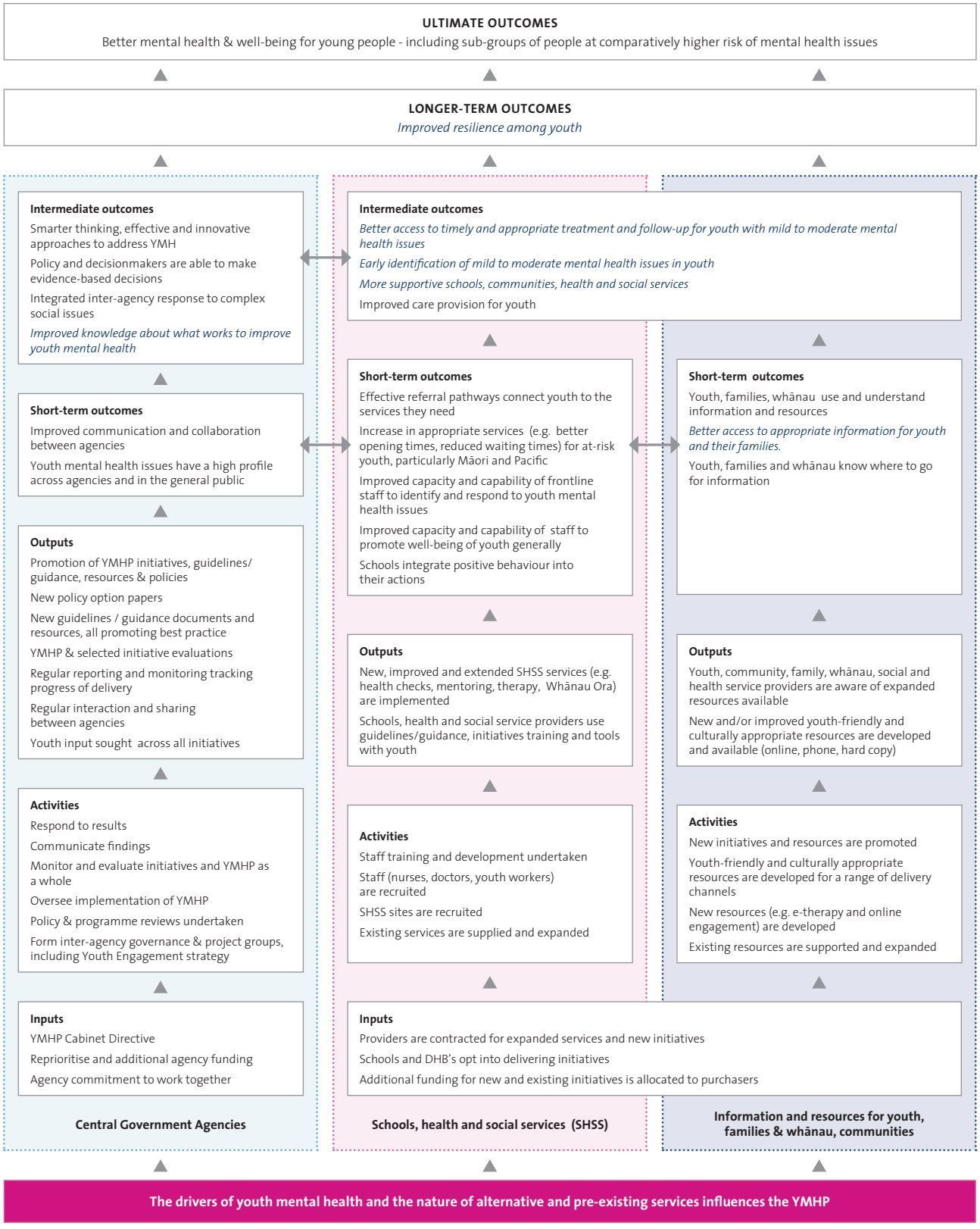
Appendix 1:

Youth Mental Health Project Logic model



Appendix 2:

The YMHP initiatives

Initiative and lead agency		Investment
Ministry of Health		
1.	**School-Based Health Services (SBHS)** Maintain and expand funding to School-Based Health Services to decile 3 secondary schools.	$10.87 million
2.	**HEEADSSS Wellness Check (HEEADSSS)** Expand the use of the HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety) wellness checks in schools and primary care settings.	$400,000
3.	**Youth Primary Mental Health Service** Expand funding to extend the current primary mental health service to all youth in the 12-19 year age group and their families.	$11.3 million
4.	**E-therapy** Review and implement an internet-based e-therapy tool for young people to provide treatment that will focus on common anxiety and depression.	$2.68 million
5.	**Primary Care Responsiveness to Youth** a) Improve the responsiveness of primary care to youth, including through drop-in services b) Youth One Stop Shops (YOSS) – Interim funding and secure funding pathways.	$1.65 million on-off funding AOD services; $500,000 (YOSS)
6.	**CAMHS & AOD Follow-Up** Review and improve follow-up care for those discharged from Child and Adolescent Mental Health Services (CAMHS) and youth Alcohol and Other Drug (AOD) services.	$400,000
7.	**CAMHS and Youth AOD Access** Improve access to CAMHS and youth AOD services through DHB wait time targets and integrated case management services.	$7.17 million
24.	**Developing integrated funding models and connected service delivery (Integrated funding models and service delivery)** Identify opportunities to develop more integrated funding models and Youth Wellness Hub services to support integrated youth service provision across social services and primary care.	Agency baseline
26.	**Addressing the emerging youth mental health issues in Canterbury** Develop and implement a local health and education joint (Ministry of Health, Ministry of Education and Canterbury District Health Board) action plan to specifically address the emerging youth mental health issues in Canterbury.	Agency baseline
Ministry of Education – Project Leadership & Co-ordination		
8.	**Positive Behaviour for Learning (PB4L) School-Wide (PB4L School-Wide)** Expand PB4L School-Wide to include more secondary schools. PB4L School-Wide is a whole-school programme that focuses on teaching positive behaviour, communicating clear behaviour expectations, and creating a school culture that supports responsibility for behaviour.	$11.96 million
9.	**Positive Behaviour for Learning (PB4L) Check and Connect (PB4L Check and Connect)** Trial, evaluate and expand the PB4L Check and Connect programme in secondary schools. PB4L Check and Connect provides mentoring and monitoring for youth who are at risk of disengaging from school.	$1.65 million
10.	**Positive Behaviour for Learning (PB4L) My FRIENDS Youth (PB4L My FRIENDS Youth)** Trial the PB4L My FRIENDS Youth programme in secondary schools to help build students' self-esteem and resilience to help them cope with depression and anxiety.	$2.11 million

11.	**Education Review Office evaluation of wellbeing in schools (ERO evaluation of wellbeing)** Develop indicators of student wellbeing for schools to use in self-review to identify and implement priorities for changes.	$670,000
12.	**Education Review Office evaluation to improve the school guidance system** Review the school guidance system, including the use of guidance funds and the role of guidance staff in schools, and the quality of provision, professional standards, training and accountability.	$250,000
13.	**Review of Alcohol and Other Drug education programmes (Review of AOD education programmes)** Review government-funded Alcohol and Other Drug education programmes for young people.	Agency baseline
25.	**Co-locating additional social services in schools** Investigate the feasibility and value of co-locating additional social services in schools.	Agency baseline
Ministry of Social Development		
14.	**Youth Workers in Low Decile Secondary Schools (YWiSS)** Provide youth worker support services using the PB4L Check and Connect education mentoring model to students in targeted low-decile secondary schools who are at risk of disengaging.	$8.65 million
15.	**Social Media Innovation Fund** Improve the mental health and emotional wellbeing of young people through the innovative use of social media technology.	$2 million
16.	**Improving the youth-friendliness of mental health resources** Work with providers to increase use of new technology and improve the youth-friendliness of online mental health resources.	Agency baseline
17.	**Information for parents, families and friends** Improve access to quality information on youth mental health, wellbeing, and where to seek help for parents, families and friends.	$1 million
18.	**Social Support for Youth One Stop Shops** Provide one-off funding for Youth One Stop Shops (YOSS) for 2012/13.	$600,000
19.	**Youth Referrals Pathways Review** Review the integration, consistency and effectiveness of referral pathways for young people and make recommendations for improvements.	Agency baseline
20.	**Youth Engagement** Ensure the views of young people are included in the development, implementation or evaluation of the Youth Mental Health Project initiatives as appropriate.	Agency baseline
21.	**Youth mental health training for social services** Training for youth re-engagement and school attendance providers in recognising and working with young people with mental health issues.	Agency baseline
23.	**Referral pathway supports for young people** Identify actions to improve awareness of youth mental health issues and knowledge of available services; strengthen workforce capability; and assess the feasibility of 'navigator' support functions.	Agency baseline
Te Puni Kōkiri		
22.	**Whānau Ora for youth mental health** Contract two providers to work with 40 Māori and Pacific young people and their whānau/aiga to address youths' mental health needs within the context of building leadership and capability within the whānau/aiga.	$480,000

Appendix 3:

Details of school-based data collection

	Principal/ DP	BOT chair	Pastoral care/ guidance counsellor/ school nurse/ doctor	Youth worker	Other (e.g. RTLB teacher)	School staff survey completions	Student discussion group	OurSCHOOL survey completions (students)	Parents discussion group
Northland									
N1	2	1	1	1	-	28	4	79	1
N2	1	-	1	-	-	40	4	120	1
N3	-	1	1	-	1	25	2	93	1
N4	-	-	-	-	-	1	-	8	-
West Auckland									
WA1	1	-	3	-	-	23	1	195	1
WA2	1	1	3	-	1	4	4	126	1
WA3	1	1	2	-	-	43	4	201	1
WA4	2	-	1	-	-	52	2	142	-
WA5	-	-	-	-	1[a]	-	1	50	-
Hawke's Bay									
HB1	1	-	1	-	-	9	1	155	-
HB2	1	1	4	-	-	23	1	86	-
HB3	1	1	2	-	-	63	2	117	1
HB4	2	1	2	-	-	13	1	206	-
Lower Hutt									
LH1	-	-	1	-	-	22[b]	-	184	-
LH2	1	-	1	-	-	-	4	193	-
LH3	2	-	1	-	-	26	2	184	-
LH4	1	-	1	-	-	8	4	131	1
LH5	1	-	1	-	-	-	-	68	-
LH6	-	-	1	-	-	-	-	-	-
Christchurch									
C1	1	-	1						
	-	-	40	2	127	1			
C2	-	-	1	-	-	18	2	105	1
C2	-	-	1	-	1	11	2	130	-
C4	-	-	1	-	-	-	-	-	-
C5	-	-	1	-	-	-	-	-	-
Invercargill									
I1	1	-	2	-	-	18	1	158	-
I2	1	1	2	-	-	17	1	160	1
I3	1	1	2	-	-	-	1	152	1
I4	-	-	1	-	-	-	-	-	-
Totals	**22**	**9**	**39**	**1**	**3**	**484**	**46**	**3,170**	**12**

a At this school there was one discussion group that included five teachers and three students.
b These 22 survey completions were not included in the original Lower Hutt locality report totals as this school took part in the evaluation after the rest of the Lower Hutt locality.

Locality profiles

The schools were broadly representative of all schools in the locality in terms of school year group, gender and ethnicity. Exceptions are summarised in Table 5 below.

TABLE 05

School and student participation in the OurSCHOOL survey

(Source: Education Counts website; Note: ethnicity data are grouped using prioritised ethnicity)

Locality	OurSCHOOL sample / all students	Differences between OurSCHOOL survey sample and locality population
Northland	300 / 2,738	• Year 11s slightly under-represented (15% compared to 22%) and Year 13s slightly over-represented (17% compared to 14%) • New Zealand European under-represented (34% compared to 46%) and Māori over-represented (52% compared to 46%) • Missing 7–10 decile band (one private school)
West Auckland	714 / 7,439	• Females slightly under-represented (47% compared to 50%) • New Zealand European slightly under-represented (27% compared to 38%), Pacific under-represented (10% compared to 21%), and other ethnicities over-represented (20% compared to 6%) • Missing 7–10 decile band (one private school)
Hawke's Bay	564 / 5,175	• Females over-represented (62% compared to 49%) • Other ethnicities slightly over-represented (9% compared to 2%) • Missing 4–6 decile band (two decile 4 schools missing)
Lower Hutt	760 / 5,960	• Females over-represented (73% compared to 56%) • Year 10s slightly over-represented (26% compared to 22%) • Asian slightly under-represented (6% compared to 12%) and other ethnicities over-represented (17% compared to 4%) • Missing 4–6 decile band (one decile 6 school missing)
Christchurch	362 / 6,747	• Females over-represented (70% compared to 49%) • Year 9s slightly over-represented (26% compared to 22%) and Year 11s slightly under-represented (15% compared to 21%) • New Zealand European under-represented (48% compared to 65%), Māori slightly over-represented (20% compared to 15%), Asian under-represented (3% compared to 11%), and other ethnicities over-represented (23% compared to 3%) • Missing 1–3 decile band (one decile 2 and one decile 3 school missing) and missing the 7–10 decile band (two decile 6, one decile 8 and one decile 10 school missing)
Invercargill	470 / 4,962	• Year 9s slightly over-represented (27% compared to 22%) and Year 11s slightly under-represented (17% compared to 21%) • New Zealand European under-represented (58% compared to 70%) and other ethnicities over-represented (13% compared to 3%) • Missing 1–3 decile band (one decile 2 school missing) and missing the 7–10 decile band (one decile 8 school missing)

Profile of providers included in the locality studies

	Agency managers interviewed	Health and social service providers interviewed	Community leaders	Youth not at school (group or individuals)	Community/ provider survey completions
Northland	CYF DHB MoE (x2)	Bay of Islands Counselling CAMHS Team (Te Roopu Kimiora) DHB – Public health nurses (x2) He Iwi Kotahi Tatou Trust (x3) Kerikeri Medical Centre Manaia Health PHO Mid North Family Support Ngāpuhi Iwi Social Services Ngati Hine Health Trust Supporting Families Northland Te Tai Tokerau PHO The Rural Beat	R. Tucker Thompson Sail Training Trust	Pou Herenga Tangata (alternative education)	12
West Auckland	DHB (x2) MoE (x2) MYD Police Work and Income	Blue Light CADS Altered High Youth Service Crescendo Trust DHB-employed school-based nurses HealthWest Youth Hub Marinoto West CAMHS Odyssey House Procare PHO T.Y.M.S Tuilaepa Mentoring Trust Thrive Teen Parent Support Unitec (mental health advisor) West Fono Health Trust What's Up Youth Horizons Trust Youth Health Hub Youthline Zeal Education Trust	Sport Waitakere	Zeal Education Trust	35
Hawke's Bay	CYF DHB (x4) MoE Police (x2) Work and Income	Akina Activity Centre Directions Youth Health Centre Dove Hawke's Bay Family Works Hawke's Bay Gains Psychology Health Hawke's Bay (PHO) Te Ikaroa Rangatahi Social Services Inc Te Taitimu Trust Te Taiwhenua o Heretaunga	Salvation Army Napier	Directions Youth Health Centre Hastings District Council – youth representative	40

	Agency managers interviewed	Health and social service providers interviewed	Community leaders	Youth not at school (group or individuals)	Community/ provider survey completions
Lower Hutt	DHB (x2) MoE (x2) MYD Work and Income	Capital Training ICAFS (CAMHS) Kokiri Hauora Health Services Pacific Health Service Q-nique / WellTrust / Pact Ropata Medical Centre Te Awakairangi Health PHO Te Paepae Arahi Trust Vibe (x4) Weltec Whai Oranga o Te Iwi Health Centre Youthline Wellington	Hutt City Council Ignite Sport Naenae Boxing Academy Samoan Congregational Christian Church	Vibe (x2) Youth Infusion (Lower Hutt Youth Council)	12
Christchurch	CAFS CYF DHB MYD Police	298 CAF Link Canterbury Youth Workers Collective Christchurch PHO Harakeke He Waka Tapu Home and Family Counselling Male Survivors of Sexual Assault Odyssey House Pegasus PHO School-Based Health Services School-based Mental Health Team (x2) Southern Regional Health School St John of God Waipuna Stepping Stone Trust Youth Specialty Services	-	Opportunistic interviews in 298 waiting room (x3)	11
Invercargill	CAFS Invercargill CYF DHB MoE Police Work and Income	Adventure Development Limited Awarua Whānau Services Family Works Invercargill Invercargill Student Support Network Murihiku Young Parents Learning Centre Number 10 Pact Youth South Supporting Families Southland Well South PHO (including Brief Intervention Service) (x2) Youthline Southland	Invercargill City Council Māori Wardens Pacific Island Advisory and Cultural Trust (PIACT) Southland YMCA	Number 10	33
Total	**37**	**85**	**11**	**11**	**143**

Appendix 4:

OurSCHOOL Survey

The OurSCHOOL survey was selected by Superu as the method for collecting information from youth. The survey was accessed online by students, allowing them to provide their opinions and feedback in a safe and anonymous setting. The survey was completed by a selection of classes within each school from Years 9 to 13.

The OurSCHOOL survey was designed to measure factors that influence physical and social outcomes for youth attending schools, as outlined in Table 6 below.

TABLE 06

Survey domains included in the OurSCHOOL survey

Survey domains	Topics	Measures (selected examples)
Physical health outcomes	Risky behaviours	Tobacco use, marijuana use, other drugs, alcohol, gambling, sexual health Smoking, marijuana use, alcohol and sexual activity were the main measures of 'risky behaviour' used in analysis and defined as follows: Smoking: occasionally or every day Marijuana: occasionally or every day Alcohol: at least one alcoholic drink two or more times a week Sexual health: engaged in sexual activity.
Social engagement outcomes	Social engagement	Participate in sports, organised groups, sense of belonging, positive relationships, using ICT and phones Who youth would go to for help when upset both in school and/or outside of school
	Institutional engagement	Student values school outcomes, truancy, student behaviour
	Emotional health	Anxiety, depression, self-esteem are each based on a set of scale questions to generate a score, from which categorical variables were derived (low, moderate, high for anxiety and depression; low or other for self-esteem). For the purpose of the evaluation, depression and anxiety were combined to create a measure of 'moderate or high anxiety or depression' (i.e. student displays indicators of at least moderate levels of one of these mental health outcomes).
Drivers of student outcomes	School context	Bully victim (this included experience of physical, verbal, social and cyber bullying, to create an indicator of moderate to severe bullying) Feeling safe attending school (included at school and on way to/home from school and experience of fights, being threatened, victim of theft) Advocacy at school (based on statements about school staff showing an interest in them/their work)
	Classroom context	Teacher-student relations, learning climate, expectations for success
	Family context	Advocacy outside of school
	Traumatic/stressful events	Death of close family member or friend, divorce or parental separation, learned about traumatic event affecting the family, earthquake or other natural disaster, been involved in an accident or sustained a serious injury, personally affected by violence.
Demographic factors		School year, sex, socio-economic status, age, language spoken at home, change schools, ethnicity, disability.

Measure construction – defined by the Learning Bar

A number of composite measures of outcomes have been developed from the individual questions. Students complete the OurSCHOOL survey by answering questions with multiple response options. Converting students' responses on the OurSCHOOL survey to measure scores is different for measures that use an interval scale (i.e. 10-point scale) and measures that are categorical (i.e. bullied or not bullied).

When measures are represented as an interval scale, the students' average response is calculated to represent their score for that measure. The average score is then multiplied to calculate the results on a 10-point scale. Only cases with at least two valid answers are considered.

When measures are categorical, students with an average score above theoretically-derived and empirically-substantiated thresholds are considered to be in one category (e.g. 'bullied', 'engaged'), where students below the threshold are placed in an alternate category (e.g. 'not bullied', 'disengaged').

Other measures including the demographic variables, ethnicity and birth place are presented as frequencies.

School-level measures are created by aggregating student scores. In the case of interval scale scores, the average scaled score for students is given as a school-level score. In the case of categorical measures, the percentage of students above the categorical threshold is given.

Outcomes used in our analysis

A. Anxiety or depression was created from two separate survey measures of mental health outcomes to include all those with indicators of moderate or severe anxiety of depression.

B. Self-harmed in last 12 months (yes/no).

C. Self-esteem, measured on a scale derived from 7 statements.

D. Sense of belonging, measured on a scale derived from 6 statements about feeling included and accepted at school.

E. Perception of safety, measured on a scale derived from 6 statements related to feeling safe on way to/from school and at school (includes fighting or being threatened, and witnessing either).

F. Bullying, measured on a scale derived from 4 statements (includes physical, verbal, social and cyber bullying).

As can be seen in Table 7, the rates of certain outcomes vary between the OurSCHOOL survey and other surveys measuring similar outcomes. Differences arise because the way different outcomes were measured varied across different surveys. For example, the Youth 2000 survey used the Reynolds Adolescent Depression Scale – Short Form and the NZ Health Survey is based on clinical diagnoses.

TABLE 07

Comparison of OurSCHOOL results with comparable NZ surveys

	OurSCHOOL	Youth 2000 (2012)	NZ Health Survey 2014/15 (child)	NZ Health Survey 2014/15 (adult)
Age/School year	Year 9-13	Year 9-13	10-14 years old	15-17 or 15-24
Anxiety	18.6% (Indicators of severe anxiety)	-	4.2% (Ever diagnosed with anxiety disorder)	(Age 15-24) 6.3% (Diagnosed anxiety)
Depression	16.3% (Indicators of severe depression)	12.8% (Significant depressive symptoms)	1.9% (Ever diagnosed with depression)	(Age 15-24) 8.1% (Diagnosed depression)
Bullying	11.9% (Moderate to severe bullying)	6.2% (Bullied at school weekly or more)	-	-
Tobacco use	7.1% (Occasionally to daily)	11.1% (Current cigarette use, have ever smoked and did not report that they no longer smoke)	-	(Age 15-17) 6.1% (have smoked more than 100 cigarettes in lifetime and currently smoke at least once a month)
Alcohol	7.1% (1 drink twice or more per week)	8.3% (Drink alcohol at least once a week)	-	(Age 15-17) 10.8% (Hazardous drinkers, AUDIT score>8)
Marijuana	6.8% (Occasionally to daily)	3.2% (Weekly or more often)	-	-
Sexual activity	32.7% (Ever engaged in sexual activity)	24.4% (Ever had sex, does not include abuse)	-	-
Deliberate self-harm	19.5%	24.0%	-	-

Abbreviations

AOD	Alcohol and Other Drug
BOT	School Board of Trustees
CAFS	Child, Adolescent and Family Services
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive behavioural therapy
CEP	Co-existing problems (i.e. AOD and mental health)
CYF	Child, Youth and Family
DHB	District Health Board
DP	Deputy Principal
DPMC	Department of the Prime Minister and Cabinet
ERO	Education Review Office
FTE	Full-time equivalent
GP	General practice or general practitioner
HEEADSSS	Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety
LGBT	Lesbian, gay, bisexual, transgender
MoE	Ministry of Education
MoH	Ministry of Health
MoJ	Ministry of Justice
MPP	Ministry of Pacific Peoples
MSD	Ministry of Social Development
MYD	Ministry of Youth Development
NEET	Youth not in employment, education or training
NGO	Non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
PB4L	Positive Behaviour for Learning
PHO	Primary health organisation
RTLB	Resource teacher learning and behaviour
SBHS	School-Based Health Services
SLAT	Service Level Alliance Team
TPK	Te Puni Kōkiri
TPU	Teen Parent Unit
YMHP	Youth Mental Health Project
YOSS	Youth One Stop Shops
YPMHS	Youth Primary Mental Health Service
YWiSS	Youth Workers in Low Decile Secondary Schools

Social Policy Evaluation and Research Unit

superu

Families Commission Kōmihana ā Whānau

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