Under One Umbrella

Integrated mental health, alcohol and other
drug use care for young people in New Zealand

30 June 2023

**A desk-top review of the literature
and possible future directions**

Acknowledgements

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Cross-party Mental Health and Addiction Wellbeing Group

Chlöe Swarbrick

*MP for Auckland Central,
Green Party of Aotearoa
New Zealand*

Young people, like middle-aged and older people, are not a homogeneous group. They have diverse experiences, needs, ideas, hopes and dreams for the future. They deserve services that not only cater to and support those unique identities but help them find their place in their communities.

I see these aspirations come alive when I visit youth one-stop shops. It was from engaging with the champions who have kept these services running through the past few decades on the smell of an oily rag that the idea of this research first came about.

Our young people deserve cross-party commitment to resourcing the services that work for them. Here's the report on what works – and here you see the politicians to be held accountable on ensuring it happens.

Matt Doocey

*MP for Waimakariri,
New Zealand National Party*

Young Kiwis are driving the debate forward on mental health and addiction in New Zealand. They have a vocabulary to talk about mental health that older generations never had, they are more open in talking about their own mental health needs and they face less stigma asking for help. I'm proud of our young Kiwis who are holding Parliamentarians to account for immediate and longer-term mental health policy solutions.

Debbie Ngarewa-Packer

MP, Te Paati Māori

We hear from our rangatahi time and time again that mental health is one of the most pressing issues for their generation. We must adopt a tikanga-based framework. To uphold tikanga, that means acknowledging whakapapa. Who you are and where you come from. We need to properly fund grassroots and whānau-centric services including Whānau Ora and Youth One Stop Shops. We must always be led by the voices of rangatahi.

Mark Cameron

MP, ACT Party

I've joined this cross-Parliamentary committee to help collectively develop a better understanding of the wider issues confronting those affected by mental illness.

I was historically a medicated sufferer of depression and have experienced the highs and lows of mental illness, which serves me now with a unique understanding of some of the issues and how people cope with them.

Glen Bennett

MP for New Plymouth, New Zealand Labour Party

As someone who has worked at the coalface of youth development, both in the community as well as running a home for high-needs teenagers, I understand the challenges and know that our energy and passion need to go into tangible ways to achieve healthy outcomes. We must work together, putting aside our political colours, as we work towards real hope and wholeness for our young people.

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1.   Executive summary

1.1   Introduction

The purpose of this desk-top review is to provide evidence, insights and recommendations that will enable the cross-party Mental Health and Addiction Wellbeing Group to promote a nationally consistent approach to the establishment and development of integrated mental health, alcohol and other drug use (MH&AOD) services for young people in New Zealand.

In conducting this review, the cross-party Mental Health and Addiction Wellbeing Group has sought to take a fresh look at integrated MH&AOD care for young people with a view to reducing the gap between what is possible and what is currently being achieved in New Zealand.

This report complements the current audit by the Office of the Auditor-General of the effectiveness of mental health and addiction services for young people as well as the report on Youth Mental Health by Te Hiringa Mahara | Mental Health and Wellbeing Commission.[1]

1.2   The short version of the story

The good news

Across New Zealand, there are pockets of effective and successful integrated youth MH&AOD services that support thousands of young New Zealanders every day.

Pressure points

Fragmented, inequitable and inconsistent resourcing is putting pressure on these types of youth services, especially at a time when the lives of young people are becoming more complex and the rate of youth mental distress is increasing.

What more needs to happen

To fully realise the promise of a more collaborative approach to health and social services for young people in all regions of New Zealand, government agencies need to collectively prioritise the development of integrated youth services that have a strong MH&AOD component.

The vision

Done well, community-oriented and properly resourced models of integrated youth MH&AOD services can meet the needs of diverse groups of young people and support them to remain healthy and to flourish as they transition to adulthood.

Here's how to make progress

The cross-party group considers that the provision of more effective integrated MH&AOD care for young people is reliant on progress being made in four key focus areas – cross-government activity, service delivery system, research and evaluation and youth voice – with strong inter-dependencies across all four (see Figure 1). The potential opportunities for change are grouped under each of these four focus areas in section 7 of this report.

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1   Te Hiringa Mahara | Mental Health and Wellbeing Commission. (2022). *Young people speak out about wellbeing: An insights report into the wellbeing of rangatahi Māori and other young people in Aotearoa*. Te Hiringa Mahara | Mental Health and Wellbeing Commission.

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Figure 1: Integrated youth MH&AOD care – four key focus areas for success

Cross government

Prioritise cross-sectoral activity on the growth and development of integrated youth services that have a strong MH&AOD component.

Youth voice

Value and amplify the role of young people as a key success factor in the development of integrated youth MH&AOD care.

Service delivery system

Strengthen the infrastructure of the service delivery system to increase its capacity and lift its performance.

Research & evaluation

Generate the evidence that is required for public accountability and ongoing quality improvement purposes.

The 4-step action plan

The cross-party wants to highlight the following four keystone actions that we consider are foundational to a step-change in the system.

1. We suggest that health and social sector leaders prioritise investment in the mental health and wellbeing of young people and co-commission integrated youth programmes that span multiple jurisdictions.

2. We want to see more cross-sectoral activities that facilitate service integration and increase national consistency (service coverage and service quality) while also recognising the need for local flexibility.

3. We want good information to help track progress, improve services and increase accountability.

4. We want to see the voice of young people featured throughout.

Finally, we recommend that Te Hiringa Mahara | Mental Health and Wellbeing Commission monitors and reports on progress against this 4-step plan.

We believe that we will achieve so much more for young people by working together and think that our 4-step plan provides a strong platform for change.

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2. Introduction

2.1 Youth mental health – a national and a global challenge

Young people's mental health and wellbeing is a growing concern in New Zealand and overseas. Despite a number of evidence-based interventions and supports being available to young people, the research indicates that there continue to be problems in accessing high-quality treatment and support options.[2]

The general consensus is that current MH&AOD service delivery systems are struggling to meet the challenging and complex needs of young people and their families/whānau and that the time has come for decision makers to consider young people's requests for access to more youth-centric MH&AOD services that can respond to a wider range of health, cultural and social needs.

This report forms a key part of the cross-party group's response to that call for action and aligns with the stated intention in Te Pae Tata | Interim New Zealand Health Plan[3] to continue the roll out of integrated mental health and addiction services for young people. It will also build on the findings from the current audit by the Office of the Auditor-General into the effectiveness of youth MH&AOD services.

2.2 A Tiriti dynamic approach

Taking a Tiriti dynamic approach provides the Crown with the opportunity to exercise its governance role by delivering equitable access and outcomes for rangatahi Māori and addressing the clear inconsistencies in the commissioning of integrated youth MH&AOD services for rangatahi Māori – as per the initial baseline funding analysis for 2019/20 service investments in Oranga Hinengaro System and Service Framework.[4]

It also provides an opportunity for Māori to exercise greater agency and authority (tino rangatiratanga) over how an integrated youth MH&AOD service should work for rangatahi Māori. This includes a focus on recognising and supporting iwi, hapū and whānau as knowledge holders, decision makers and enablers of Māori mental health and wellbeing.

2.3 The key questions

The report examines the national and international literature and the models of integrated youth MH&AOD care in New Zealand with a view to answering these four questions:

- What does the literature tell us about the key elements that are required to ensure effective integrated MH&AOD care for young people?
- What models of integrated MH&AOD care are currently available to young people in New Zealand?
- Have any of these models been evaluated, and if so, what were the key findings?
- What are the implications for the development of co-ordinated national policies and the provision of integrated MH&AOD services to young people in New Zealand?

Note: In New Zealand, the generally accepted age range for defining young people is 12–24 years, potentially leading to the dissolution of artificial boundaries and the difficult transition points between child and youth MH&AOD services and adult MH&AOD services. This age range has been adopted by the Ministry of Health and Ministry of Youth Development.

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2   Government Inquiry into Mental Health and Addiction. (2018). *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. New Zealand Government.

3   Te Whatu Ora & Te Aka Whai Ora. (2022). *Te Pae Tata | Interim New Zealand Health Plan*. New Zealand Government.

4   Ministry of Health. (2023). *Oranga Hinengaro System and Service Framework*. Ministry of Health.

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3. Fast facts about youth mental health

An overview of the mental health status of young people in New Zealand

- In 2022, approximately 850,000 rangatahi aged 12–24 years were resident in New Zealand, making up 17% of the total population.[5]
- The Youth2000 survey series found that young people in New Zealand are generally healthy and thriving, but some are growing up in circumstances that challenge their ability to stay on a positive trajectory into adulthood.[6]
- High or very high levels of psychological distress were reported by nearly one in four (23.6%) of young people aged 15–24 years in 2021/22, up from 5.1% in 2011/12 (see Figure 2). This trend is consistent with other developed countries around the world.

Figure 2: Percentage of people who reported high or very high levels of psychological distress in the past four weeks by age[7]

Ministry of Health, New Zealand health survey

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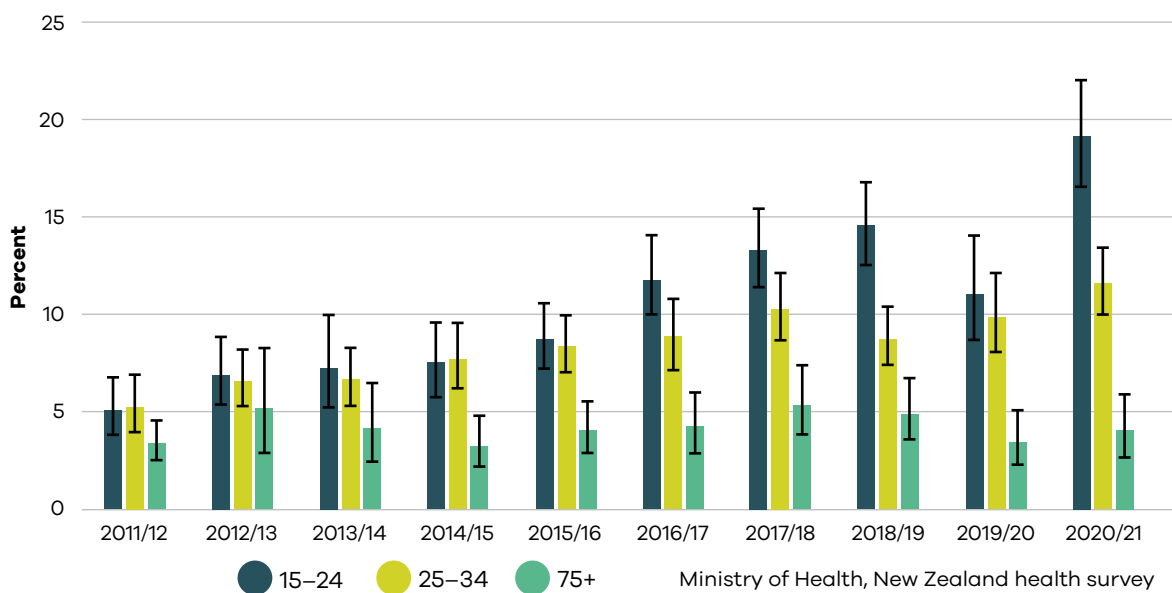
5   Based on data from the 2018 Census.

6   Fleming, T., Peiris-John, R., Crengle, S., Archer, D., Sutcliffe, K., Lewycka, S., & Clark, T. (2020). *Youth19 Rangatahi Smart Survey initial findings: Introduction and methods.* The Youth19 Research Group, TheUniversity of Auckland and Victoria University of Wellington, New Zealand.

7   Ministry of Health. (2022). *Annual Data Explorer 2021/22: New Zealand Health Survey.* minhealthnz.shinyapps.io/nz-health-survey-2021-22-annual-data-explorer

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Fast facts about substance use from the Youth19 Rangatahi Smart Survey

- Patterns of high-risk substance use among young people are more often explorative, and there is a significant association between high-risk substance use and early experiences of trauma and mental health challenges.[8]

- Binge drinking is down considerably compared to rates in 2012. It is now relatively uncommon in younger adolescents. However, 42% of young people aged 17 years or older reported binge drinking in the past month.[9]

Early age of onset

- Mental health and substance use problems start very early in life with around 75% emerging by the age of 24 years (see Figure 3).

- Young people who experience mental ill health and/or substance use are at higher risk from disengaging from education, training and employment opportunities, thereby significantly increasing their lifetime risk of poor health, social and economic outcomes.[10]

Figure 3: Typical age at onset for selected mental health and substance use conditions[11]

	Median age of onset	Age of onset distribution (25th–75th percentile)
Anxiety disorder	11 years	6–21 years
Mood disorder	30 years	18–43 years
Impulse-control disorder	11 years	7–15 years
Substance use disorder	20 years	18–27 years
Any mental disorder	**14 years**	**7–24 years**

8 Richert, T., Anderberg, M., & Dahlberg, M. (2020). Mental health problems among young people in substance abuse treatment in Sweden. *Substance Abuse Treatment, Prevention, and Policy*, *15*(1), 43.

9 See note 6.

10 McGorry, P., Mei, C., Chanen, A., Hodges, C., Alvarez-Jimenez, M., & Killackey, E. (2022). Designing and scaling up integrated youth mental health care. *World Psychiatry*, *21*(1), 61–76.

11 OECD. (2012). *Sick on the job? Myths and realities about mental health and work.* OECD Publishing.

Priority groups of young people with higher mental health needs

- A range of data sources shows persistent and worsening patterns of inequity for some sub-groups of young people in New Zealand, especially females, Māori, Pacific and Asian students, neurodiverse and rainbow youth and those from high deprivation neighbourhoods.[12,13]

- For youth belonging to disadvantaged populations and marginalised communities, the risks of mental illness, substance use and suicide are much higher than the general population and require targeted attention.[14]

Intersectionality

- Intersectionality is a term used to describe the converging effects of class, ethnicity, culture, gender, sexuality and characteristics that contribute to marginalisation, social identity and wellbeing.[15] In recognition of the increased challenges for these young people, policy makers and decision makers should continue to work at multiple levels to reduce the mental health risks for young people, especially for high-priority groups, and to promote general youth wellbeing.

- Table 1 focuses on the mental health challenges of some high-priority groups of young people in New Zealand while also noting the issue of intersectionality.

12   See note 6.

13   Sutcliffe, K., Ball, J., Clark, T., Archer, D., Peiris-John, R., Crengle, S., & Fleming, T. (2023). Rapid and unequal decline in adolescent mental health and well-being 2012–2019: Findings from New Zealand cross-sectional surveys. *Australian & New Zealand Journal of Psychiatry*, *57*(2), 264–282.

14   See note 2.

15   Seng, J., Lopez, W., Sperlich, M., Hamama, L., & Meldrum, C. (2012). Marginalized identities, discrimination burden, and mental health: Empirical exploration of an interpersonal-level approach to modeling intersectionality. *Social Science & Medicine*, *75*(12), 2437–2445.

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Table 1: Selected fast facts for priority groups of young people in New Zealand

Priority cohort	What we know
Rangatahi Māori	**Rangatahi Māori represent 25% of the total youth population.** Whanaungatanga (connection and nurturing of relationships) is at the heart of wellbeing for rangatahi Māori.[16] Inequities for rangatahi Māori result from the ongoing impacts of colonisation, racism, barriers to accessing MH&AOD services and a lack of culturally appropriate MH&AOD services.
Pasifika	**Pacific young people represent 13% of the total youth population.** New Zealand research shows that young Pacific peoples have the nation's highest rates of depression and anxiety and are also three times more likely than all young people to attempt suicide.
Asian	**Mental health has been identified as an important but neglected health issue among Asian youth** and is heavily influenced by the shame and stigma that comes with addressing MH&AOD concerns.[17] One of the most modifiable factors is ethnic discrimination.
Rainbow community	**Rainbow young people represent 14% of the youth population.** Most rainbow young people report positive family and school contexts. However, this group of young people also face multiple inequities and challenges and are at increased risk of mental health issues.
Youth in the child welfare system	**Approximately 6,400 children and young people are in the child welfare system.** A systematic review and meta-analysis of eight epidemiological studies across different countries in 2016 found that almost half of all children and adolescents in child welfare systems met the criteria for a current mental disorder – a prevalence rate almost four times higher than in the general child and adolescent population.[18] Efforts to uplift the mana and wellbeing of young people and their whānau are required at all levels of the child and youth state care system.[19]
Youth in prisons	**Approximately 9.5% of the total prison population are young people under the age of 25 years.** While the number of young people in the criminal justice system has reduced over time, they continue to have complex developmental, health, social, educational and cultural needs.
Young people with differing abilities	**Disabled young people represent over 9% of the youth population.** Young people with differing abilities are at particular risk of developing a mental health problem, being three times more likely to develop a diagnosable psychiatric disorder compared to their non-disabled peers. On a positive note, there are minimal differences in mental health outcomes for disabled young people under conditions of high social support and low financial hardship.[20]
Young people with refugee backgrounds	**Refugee-background youth** in Aotearoa are growing up in a context with high rates of poverty, mental illness and suicide.[21]
Neurodiverse young people	Between 10% and 20% of the global population is considered to be **neurodivergent.** While neurodiversity can be a strength, there is also evidence of greater rates of mental health difficulties such as anxiety and depression among neurodiverse young people.
Young people in rural areas	**Over 100,000 young people (12%) are living in rural parts of New Zealand.** While the research points to a number of positive aspects to life in remote and rural areas such as community connection, there is also evidence that deprivation and a lack of access to support services is felt more acutely by young people who live in rural areas.

16   Hamley, L., Le Grice, J., Greaves, L., Groot, S., Latimer, C., Renfrew, L., Parkinson, H., Gillon, A., & Clark, T. (2022). Te Tapatoru: A model of whanaungatanga to support rangatahi wellbeing. *Kōtuitui: New Zealand Journal of Social Sciences Online*, *18*(2), 171–194.

17   Suicide Mortality Review Committee. (2019). *Understanding death by suicide in the Asian population of Aotearoa New Zealand.* Health Quality & Safety Commission.

18   Bronsard, G., Alessandrini, M., Fond, G., Loundou, A., Auquier, P., Tordjman, S., & Boyer, L. (2016). The prevalence of mental disorders among children and adolescents in the child welfare system: A systematic review and meta-analysis. *Medicine*, 95(7), e2622.

19   Fleming, T., Archer, D., Sutcliffe, K., Dewhirst, M., & Clark, T. (2022). Young people who have been involved with *Oranga Tamariki: Mental and physical health and healthcare access.* The Youth19 Research Group, The University of Auckland and Victoria University of Wellington.

20   Honey, A., Emerson, E., & Llewellyn, G. (2011). The mental health of young people with disabilities: Impact of social conditions. *Social Psychiatry and Psychiatric Epidemiology*, *46*(1), 1–10.

21   New Zealand Red Cross. (2022). *Humanitarian Migration Report: Current and emerging issues in Aotearoa New Zealand.* New Zealand Red Cross.

Asking for help

- Young people whose primary problem is substance use are less likely to see their overuse as being a problem and are less likely to seek help.
- Internalised factors that stop young people from asking for help include cultural stigma and shame, privacy concerns and worries about being judged or being bullied and talked about negatively by their peers.
- External factors that act as barriers to access include physical location of services, long wait times, negative experiences of services, high-threshold eligibility criteria and the lack of youth-centric services.
- Having access to online or telephone services was found to be particularly important for young people who would not otherwise ask anyone for help, rainbow youth and youth with differing abilities.

The impact of COVID-19

- Many young people have recovered relatively quickly from the lockdowns and the impacts of COVID-19, but others are struggling.
- The evidence to date indicates that the psychosocial impact of COVID-19 on some young people is likely to be extensive and enduring.[22]
- The impacts of the pandemic have been exacerbated for those navigating significant life transitions during the COVID-19 recovery such as leaving school, starting a job, leaving home or going to a university.
- The socio-economic challenges that have been experienced by some families/whānau have led to some students quitting education in order to help improve their family's financial situation.
- Further research is needed to understand and monitor both the short-term and long-term impacts.

Accessing help

- Despite having the highest incidence and prevalence of mental ill health, young people aged 12–24 years have the poorest access to MH&AOD services, highlighting the significant gap between the need for those services and the level of engagement with MH&AOD services.[23]
- In some instances, young people's access to health care is complicated by a range of psychosocial factors, including the lack of safe or adequate housing, inadequate access to financial support, lack of education or employment opportunities and a mistrust of health services.[24]
- Young adults reported the highest rates of unmet need for professional mental health help (16.2% for the 15–24 year age group).[25]
- 17% of Pākehā students reported they did not or could not access health care when they wanted to at least once in the past year. That figure rose to 27% of Māori students and 25% of Pasifika students.[26]
- In addition to making effective youth-specific support more available, targeted evidence-based interventions are required to reduce perceived social stigma and to improve young people's knowledge of mental health problems and available support, including what to expect from both professionals and services.[27]

"Young people are notoriously reluctant to reach out for help; so, when they do, it's usually when things are really bad. If they are not seen and responded to, they may not ask for help again."

Dr Hiran Thabrew (University of Auckland)

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22 Webb, S., Kingstone, S., Richardson, E., & Flett, J. (2020). *Rapid Evidence and Policy Brief: COVID-19 Youth Recovery Plan 2020-2022*. Te Hiringa Hauora | Health Promotion Agency.

23 McGorry, P., Bates, T., & Birchwood, M. (2013). Designing youth mental health services for the 21st century: Examples from Australia, Ireland and the UK. *The British Journal of Psychiatry. Supplement, 54*, s30–s35.

24 Cummings, M., & Kang, M. (2012). Youth health services: Improving access to primary care. *Australian Family Physician, 41*(5), 339–341.

25 See note 7.

26 See note 6.

27 Radez, J., Reardon, T., Creswell, C., Lawrence, P., Evdoka-Burton, G., & Waite, P. (2021). Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies. *European Child & Adolescent Psychiatry, 30*(2), 183–211.

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4.   Youth perspectives

4.1 What young people want from mental health workers

One powerful influence on young people's engagement with MH&AOD care is their relationship with treatment providers. Stubbing and Gibson[28] identified five themes that summarised young people's priorities for an ideal mental health clinician/worker:

- Someone who is like me.
- Someone I connect with.
- Someone who protects my space.
- Someone who treats me as an equal.
- Someone who works in the right way for me.

Importantly, the interconnections between these five themes highlight the fact that most young people desire to work with staff who balance a warm and comfortable personal style with professional expertise and boundaries.

4.2 The service preferences of young people in New Zealand

Stubbing and Gibson[29] have also explored young people's views on the creation of MH&AOD services in New Zealand that would better serve young people's needs and that they would be more likely to attend. The thematic analysis from this research identified the following seven themes:

Service preferences

- **A place that is comfortable** – in which young people could feel safe and relaxed.
- **A place that is accessible** – the physical location and cost of services is important. What works best is spaces that are regularly frequented by young people, close to public transport and either no cost or low cost.
- **A place that will welcome me** – no referral and no delay. Easy to contact. Informal and non-stigmatising environments.
- **A place that is embedded in the community** – embedded and visible within the community, not a siloed space for therapy only.
- **A place that treats us holistically** – considers multiple aspects of a young person's mental health, including physical health, social health and cultural and spiritual wellbeing.
- **A place that is adaptable** – offers a range of different treatment approaches that can be specifically tailored to serve their individual needs.
- **A place that is youth focused** – that is separate from services for children and where young people are treated as equals and not judged.

These themes closely align with the general principles for youth-specific services that are described in the international literature as well as the feedback from the National Youth Committee on School Based Health Services in New Zealand (see Figure 4).

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28 Stubbing, J., & Gibson K. (2022). What young people want from clinicians: Youth-informed clinical practice in mental health care. *Youth, 2*(4), 538–555.

29 Stubbing, J., & Gibson, K. (2021). Can we build 'somewhere that you want to go'? Conducting collaborative mental health service design with New Zealand's young people. *International Journal of Environmental Research and Public Health, 18*(19), 9983.

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Figure 4: What youth need out of health services[30]

Environment
- More comfortable space
- Normalising talking about health, especially mental and sexual health
- Discreet location – prevent whakamā
- Listening in depth
- Not making conversations awkward

Hua (Benefits)
- Connections
- Positive support systems e.g. whānau, kaiako, counsellors
- Well-rounded support (in schools connected to home & community)
- Health & wellbeing

Goal
- Weaving in Te Ūkaipō
- More focus on the outcome of the experience
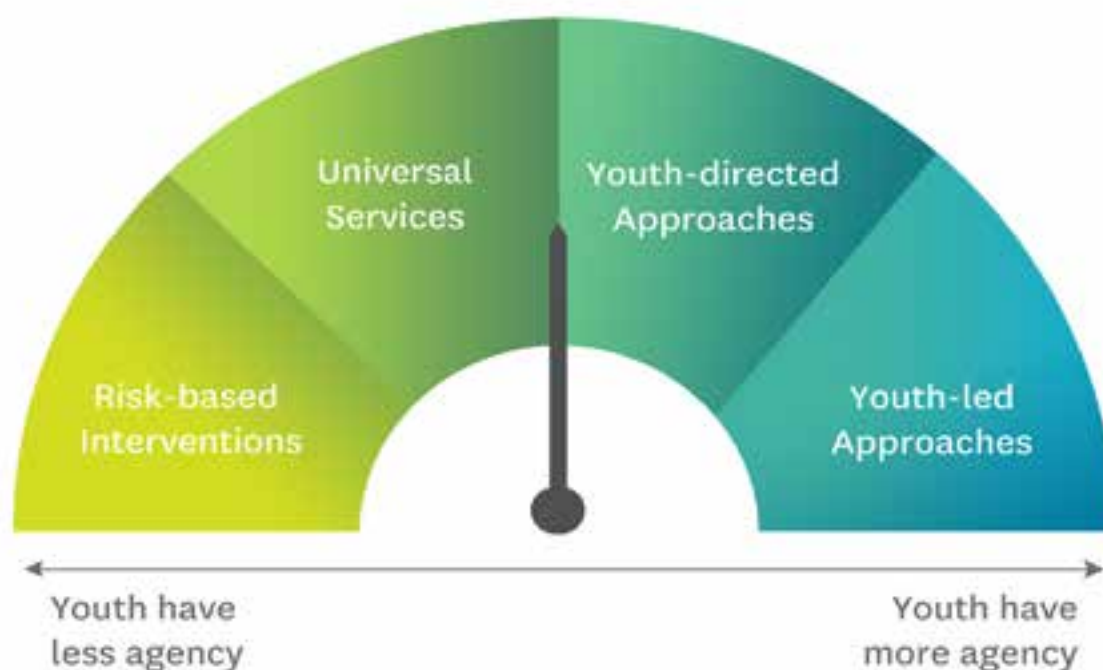
4.3 Youth voice

Youth mental health and wellbeing in New Zealand is supported and enabled by a complex ecosystem of government services, non-government service providers, community-based initiatives, philanthropic investors and youth-focused funders. The whole ecosystem is shaped by and responsive to legislation and policy, social and population trends and other environmental influences, including the voices and leadership of young people.

Internationally, youth participation is a common component in the planning, design and delivery of youth MH&AOD services. By including the voice of young people in the change process, it has been demonstrated that there is significantly more potential for the proposed solutions to be successful.

In 2018, the Centre for Social Impact developed a continuum-based mapping framework as a useful way to describe the breadth of policy, service design, service provision and investment approaches that exist in relation to youth wellbeing and development (see Figure 5). This framework is also a useful way to describe the alignment of these policies, services and investment approaches with established principles of good-practice youth development – principally, the extent to which young people have agency and are able to participate on their own terms and/or influence, shape and lead activities or decision making.

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30 National Youth Committee of School Based Health Services. (2021). *School Based Health Services Enhancement Partnership*. Te Tatau Kitenga | Society for Youth Health Professionals, p. 4.

Figure 5: Youth development continuum-based mapping framework[31]

It is essential that mechanisms for incorporating youth voice be focused on working with young people in a more youth-centric and proactive way. The promotion of meaningful engagement is important so that young people are able to make a genuine contribution towards positive changes in the youth MH&AOD system.

While the voice of young people is generally valued in New Zealand, the current MH&AOD system lacks the formal mechanisms, at multiple levels, that would enable diverse (and often under-represented) groups of young people to actively participate in decisions about national MH&AOD policies and/or investments that might impact on them.

The inconsistent application of effective youth-centric approaches across the country's youth mental health and wellbeing ecosystem places it at the lower end of the continuum. This issue is something for government agencies to consider as they start to address the inequities in the funding of child and youth MH&AOD services recently highlighted in the Ministry of Health's *Oranga Hinengaro System and Service Framework*.[32]

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31   Centre for Social Impact. (2018). *Evidence review: The youth development ecosystem – Mapping the context for the review of the Youth Development Strategy Aotearoa*. Centre for Social Impact, p. 10.

32   See note 4.

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5. New Zealand models of integrated MH&AOD care

This section of the report describes the four most common models of integrated MH&AOD service delivery that are available to young people in New Zealand – primary health care, school-based services, youth one-stop shops and a whānau-centred approach. All four models are centred on primary/community settings with linkages to specialist MH&AOD services and represent different points on the integration continuum.

It is noted that some service providers operate across two or more models at the same time, which makes it difficult to review the four models as stand-alone examples of integrated care. This limitation needs to be kept in mind when looking at the findings from the reviews and evaluations that have been conducted on each model.

5.1 Integrated primary MH&AOD health care for youth

Prime Minister's Youth Mental Health Project (2012–2016)

The Prime Minister's Youth Mental Health Project (YMHP) was implemented in 2012 to improve outcomes for young people with mild to moderate mental health problems or at risk of developing these. It consisted of 26 initiatives with one initiative specifically targeting opportunities to develop more integrated funding models and Youth Wellness Hub services to support intergrated youth

service provision across social services and primary care.[33]

A summative evaluation of the YMHP was completed in 2016[34] and found that, overall, the various initiatives were cost-effective, returned social and economic benefits to the local community and improved quality of life for young people. These key areas were identified as needing further attention:

- Improving connectedness and integration at the local service delivery level.
- Encouraging more youth-friendly and co-located services, particularly in schools.
- Sorting out the bottlenecks for youth who are referred on to other services.
- Targeting specific youth populations that could be better served.

Access and Choice programme (2019 – ongoing)

A new model of integrated primary mental health and addiction services is in the process of being implemented across New Zealand by Te Whatu Ora. This model of care is part of suite of services that is being developed to expand access to and choice of primary mental health and addiction support.

The integrated primary mental health and addiction services model includes an evidence-based approach to providing mental health support within general practice. It has been adapted, piloted and provided in various regions in New Zealand since 2017 and forms a key part of the Access and Choice programme.[35]

The Access and Choice programme has been

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33 Social Policy Evaluation and Research Unit. (2016). *The Prime Minister's Youth Mental Health Project: Localities and national perspectives evaluation*. Superu.

34 Social Policy Evaluation and Research Unit. (2016). *Improving youth mental health: What has worked, what else could be done*. Superu.

35 Te Pou. *Approaches to integration*. www.tepou.co.nz/initiatives/integrated-primary-mental-health-and-addiction/skills-for-integration-in-primary-and-community-health-settings/approaches-to-integration

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expanded over time across a range of settings and now includes kaupapa Māori, Pacific, community and youth settings.

In 2022, Te Hiringa Mahara assessed the extent to which the Access and Choice programme had increased access to and choice of services for youth (12–24 years) over the first three years of the five-year rollout of the Access and Choice programme.[36] Key points from this assessment included the following:

- The main concern was that many young people are still not aware of these types of services, which limits access to them.
- Young people represented 21% of the total number of people using the Access and Choice services, with a relatively high proportion being rangatahi Māori.
- With minimal barriers to access, many young people are presenting with moderate to severe levels of mental distress.
- Youth services are not resourced to provide more intensive support over longer timeframes, which may threaten the ability to reach a sufficent population and impact ongoing sustainability.
- There is a sense that the real potential of the Access and Choice programme has yet to be realised.

Practice example: Manu Ka Rere, community youth MH&AOD initiative, Canterbury

Manu Ka Rere[37] is an integrated, cross-agency, mobile MH&AOD initiative that is available to young people and their whānau in a range of youth venues. The staff come from diverse professional backgrounds such as social work, counselling, nursing, occupational therapy, support work and alcohol and drug clinician roles.

Summary

It is essential that youth-focused services prioritise youth voice and youth-centric approaches to working with young people in order to be successful. This is as much of an organisational challenge as it is a workforce development challenge, particularly for mainstream primary health care services as the evidence indicates that young people experience significant barriers to accessing general practice care in New Zealand.[38]

5.2 School-based health services

Schools are crucial environments for promoting and supporting youth mental health and wellbeing. School-based health services are primarily a nurse-led primary care service available to decile 1–5 mainstream secondary schools, kura kaupapa, special character schools, teen parent units and alternative education sites nationally. The most common issues for students who use these services include acute and chronic physical health conditions, mental health and wellbeing, sexual health, alcohol and other drug abuse, school engagement, teenage pregnancy and accident and emergency presentations.

The enhancement and expansion of school-based health services was a key initiative of Budget 2019's Taking Mental Health Seriously package of initiatives.

Reviews and evaluations of school-based health services

A study of the characteristics of school-based health services associated with students' mental health[39] found the following:

36 Te Hiringa Mahara | New Zealand Mental Health and Wellbeing Commission. (2022). *Access and Choice Programme Report: Improving access and choice for youth.* Te Hiringa Mahara | Mental Health and Wellbeing Commission.

37 www.manukarere.org.nz

38 McKinlay, E., Morgan, S., Garrett, S., Dunlop, A., & Pullon, S. (2021). Young peoples' perspectives about care in a youth-friendly general practice. *Journal of Primary Health Care, 13*(2), 157–164.

39 Denny, S., Howie, H., Grant, S., Galbreath, R., Utter, J., Fleming, T., & Clark, T. (2018). Characteristics of school-based health services associated with students' mental health. *Journal of Health Services Research & Policy*, *23*(1), 7–14.

- Well-resourced and comprehensive school-based health services are associated with better mental health among students.

- School-based health services are an important avenue for support and help for young people experiencing difficulties in their life, especially around mental health issues.

- To be most effective, school-based health services need multi-disciplinary teams well integrated in the school.

- Greater levels of nursing hours and doctor hours were associated with lower self-reported suicidality among students.

- School-based health services need adequate resourcing so that clinical staff have the time to support and follow up on the issues that are causing student distress.

The formative evaluation of the school-based health services enhancement programme in 2022[40] summarised the findings from the first year of the programme and provided an overview of the different models used to deliver school-based health services around the country as well as the points of difference across the regions. The evaluation found rangatahi referrals to community-based mental health services were a common referral pathway and that the ongoing relationships between kaimahi and external services were important for providing continuity of care for rangatahi.

The evaluation also reported that all informants would like to see school-based health services extend their hours of availability to better meet the needs of rangatahi. The current time available within schools was considered insufficient to meet high student demand.

This finding is similar to the results of the study by Denny et al.[41]

Te Tumu Waiora pilot – school-based mental health care

Since 2013, a number of mental health initiatives have been implemented in metro Auckland that have evolved over time into an integrated approach to primary mental health and addiction care called Te Tumu Waiora.[42] All of the Auckland initiatives have been evaluated at different points in time, with the most recent evaluation noting positive outcomes for adults, but low rates of access to primary health services by young people.[43,44] This finding is not surprising given what we already know about young people's perspectives on general practice services.[45]

In response to the low access rates for young people, the Auckland Collaborative implemented a small pilot that involved placing a health improvement practitioner into a secondary school with significant Māori and Pacific student populations with access to Awhi Ora[46] services (MH&AOD NGO support). The six-month review of the pilot offers some promising signs of success as well as highlighting a few areas for improvement. Initial data analsyis has shown that:

- access rates have been high

- access rates are highest for Pacific and Māori students

- the ratio of follow-up sessions is relatively high

- most students report a positive change as a result of seeing the health improvement practitioner

- 75% of students said they would recommend the health improvement practitioner to their friends and whānau.

It is important to note that this particular school has a wide range of health and social services available to its students – nurses, school counsellors, youth workers and access to referral-based support services outside the school, including a pathway to the local

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40   Malatest International, (2022). *Formative evaluation report: School Based Health Services*. Te Whatu Ora.

41   See note 39.

42   www.tetumuwaiora.co.nz

43   Codyre, D., Sharon, C., Didsbury, L., Henry, R., & Crozier, D. (2021). Te Tumu Waiora: The integrated primary mental health and addiction model. *New Zealand Doctor*, 17 February, 31–36.

44   Codyre, D., Cribb-Su'a, A., & Todd, D. (2023). Te Tumu Waiora – three years on. *New Zealand Doctor*, 15 February.

45   See note 38.

46   www.aklwellbeingcollab.co.nz/awhi-ora.html

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Child and Adolescent Mental Health Service when needed. This raises the issue of how well the different services work together as a collective in order to meet the individual needs of each student who might need help. Given the evidence supporting an integrated comprehensive service, it would be useful to assess the overall effectiveness of the MH&AOD response that is available in school settings in addition to assessing the effectiveness of individual components of that response.

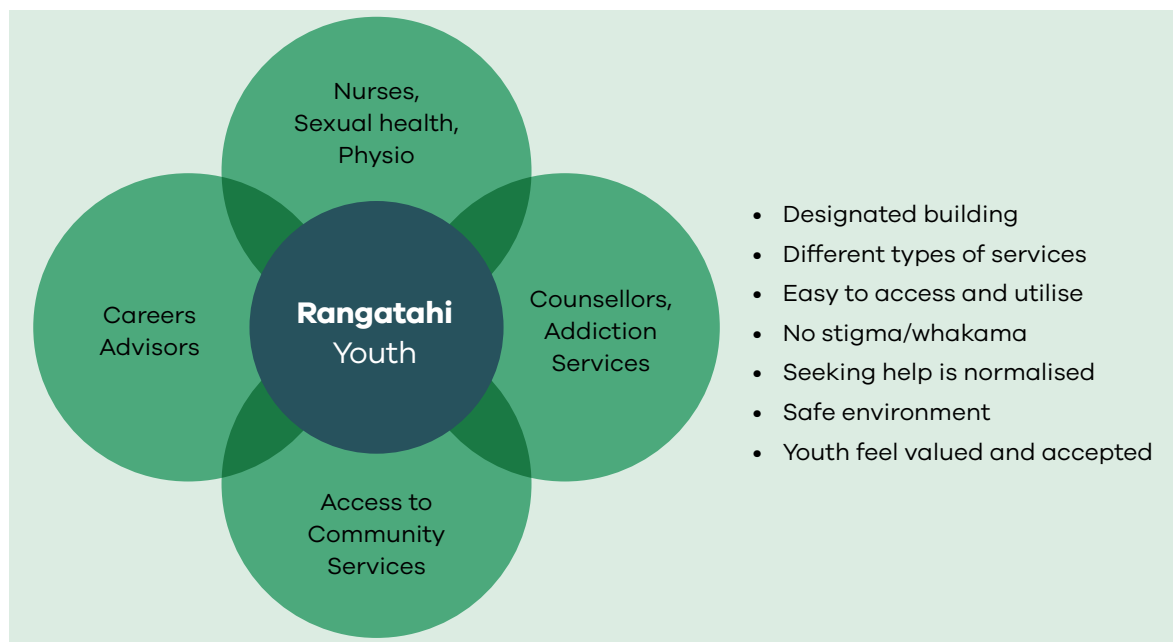### *Practice example: Waypoint, East and South Auckland*

The goal of Waypoint[47] is to improve the wellbeing of rangatahi and taiohi, young people aged 12–24 years who live in East and South Auckland. The collborative is comprised of five service providers that work together to support young people both within and outside school settings. The service offerings include a school-based youth development programme for young people whose lives are influenced by alcohol and other drugs. Two community-based services are available to support Māori and Pacific young people (aged 12–24 years) to build their connection with extended whānau and their cultural identity.

Summary

The school-based health services enhancements programme partnership is currently reviewing the school-based health services models of care and the associated workforce with a view to strengthening health supports for students in secondary schools. This work could offer a platform for considering opportunities to enhance the MH&AOD response such as:

- broader utilisation of health improvement practitioners in school settings

- provision of additional MH&AOD training and support for health practitioners who are already working in school-based health teams and want to increase their scope of practice to include MH&AOD

- MH&AOD support for school counsellors as a member of the multi-disciplinary team

- the further development of **integrated school-based health services Wellbeing Hubs** that safely and competently deliver effective MH&AOD supports for young people in conjunction with other services and in accordance with the ideal school-based health services model developed by the National Youth Committee of School Based Health Services (see Figure 6).

Figure 6: Our ideal school-based health hub[48]

- Designated building
- Different types of services
- Easy to access and utilise
- No stigma/whakama
- Seeking help is normalised
- Safe environment
- Youth feel valued and accepted

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47   www.waypoint.org.nz

48   See note 30, p. 10.

5.3 Youth one-stop shops

The integrated approach has been part of the vanguard of reform in youth mental health & alcohol and other drug services in New Zealand since 1994 when the first community-based YOSSs were established in the central region of the North Island. This developmental approach differentiates them from the headspace model, which had its origins in the success of the early intervention psychosis services in Australia.

There are 10 YOSSs that belong to the national YOSS network – five are located in the central region of the North Island, one in Whangārei, two in the Te Manawa Taki region and two in the South Island. These YOSSs were brought together by government over the years to enable officials to more easily engage with them on various matters of interest. There are at least four other integrated youth services in the country that could possibly call themselves a YOSS but are not part of the national network – for example, The 502 in Porirua.

The YOSS model is one of the most explicitly youth-centric models of care discussed in this review and typically involves the integrated delivery of free MH&AOD services, primary health care, cultural support and social services such as vocational assistance, educational supports and housing services all under one roof in a community-based setting.

The underlying youth development principles mean that YOSSs remain focused on young people's strengths and are able to respond to their diverse and unique needs through the quality of their relationships. It also means that young people are well represented and are active participants in the decision-making process at all levels of the organisation.

Each YOSS is embedded in its local community and continues to be responsive to the needs of each community. While this type of adaptive, community-orientated approach is very flexible, it has led to a degree of variation between each YOSS. The differences are largely underpinned by the funding models and contract opportunities available in each geographical area, which directly impact service delivery and governance arrangements.[49]

What all YOSSs share is a holistic, strengths-based approach that supports young people to create healthy, positive journeys into adulthood and achieve economic and social independence.

The YOSS model of care removes barriers to access, especially for high-priority sub-groups of young people who are often harder to reach and the most vulnerable. This is reflected in the registered population within the 10 YOSSs, which are engaged with 28–85% rangatahi Māori (collective data, national YOSS network, 2022).

The majority of young people aged 10–25 years who attend a YOSS report a very positive experience as evidenced by the following comments supplied by Kāpiti Youth Support.

- *The service is probably the reason why I am still alive today.*

- *I just feel like they were really there for me when I needed them.*

- *You always listened and gave me advice, but you didn't tell me what to do and you did things with me. I always knew what was going on.*

The lack of a national integrated approach to YOSSs has made them vulnerable to shifts in government policy and very dependent on their individual relationships with multiple funding agencies, with Health NZ being the largest funder (56%) followed by Oranga Tamariki (28%) in 2021/2022 – see Figure 7.

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49   Communio. (2009), *Evaluation of Youth One Stop Shops.* Ministry of Health.

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Figure 7: Government funding breakdown ($000) for YOSSs in 2021/2022 – information supplied by the national YOSS network
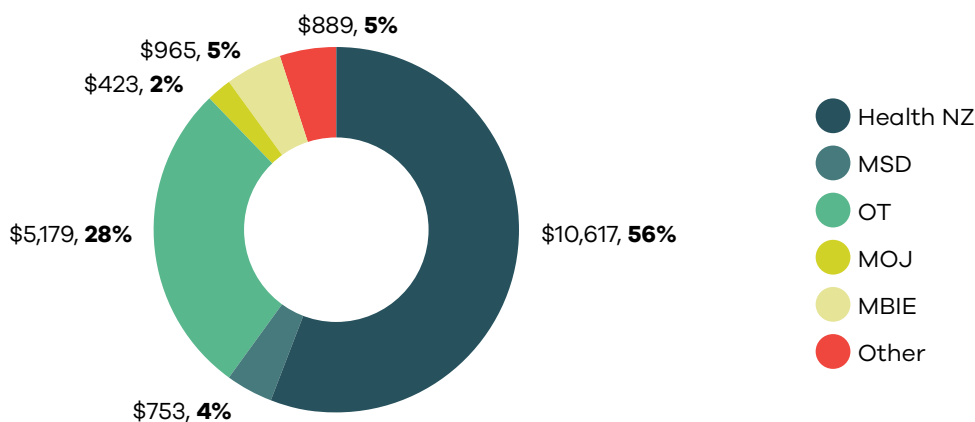
Note that the exact configuration of the above funding streams is very different for each individual YOSS – for example, the majority of Ministry of Social Development (MSD) funding is for two YOSSs only.

> The national YOSS network has also provided a high-level breakdown of YOSS service expenditure and workforce composition for the 2021/22 financial year, which is reported in Appendix 1.

The Ministry of Youth Development funds three YOSSs to support the resilience and wellbeing of specific sub-groups of young people – rainbow, Pacific and youth impacted by COVID-19. MSD contributes funding to two of the 10 YOSSs to support young people to achieve wellbeing through sustained education, work-based learning or employment. It is noted that MSD's Employment and Social Outcomes Investment Strategy 2022–2025[50] includes a focus on areas that can help promote labour market equity for young people (aged 16–24 years) and people with health conditions (including MH&AOD). There are opportunities to increase the availability of employment supports for young people in both MH&AOD and community services settings through greater cross-agency collaboration as part of a cross-government approach.

The feedback from YOSSs is that a few of them have closed their doors – for example, *Waves* in New Plymouth and *Directions* in Hawke's Bay. This is predominantly due to uncertain and inconsistent funding practices involving multiple funders, which makes it difficult for YOSSs to plan ahead and to respond to significant increases in the demand for youth services, complexity of presentations and workforce development challenges. Examples of inconsistent funding practices include *Number 10* in Invercargill, which has not received any mental health funding since 2012 despite 23% of the clinical appointments being for young people who are struggling with MH&AOD challenges.

It Is clear that, in order for an integrated, equitable and sustainable youth MH&AOD model to be successful, it will require a collaborative cross-sectoral approach that involves all of the government agencies that currently fund YOSSs.

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50 Ministry of Social Development. (2022). *Employment and Social Outcomes Investment Strategy 2022 -2025.* Ministry of Social Development.

Reviews and evaluations of youth one-stop shops

The critical success factors, operational challenges and opportunities for New Zealand YOSSs have been described in a series of reviews.[51,52,53,54] In addition, some individual YOSSs have undertaken their own evaluations to help demonstrate the positive impact that their service is having on young people's lives – for example, Kāpiti Youth Support and Te Tahi Youth.[55,56]

The Communio evaluation of YOSSs in 2009[57] made several recommended changes in a number of key areas including networking, workforce development, service funding models, contract reporting, organisational governance, outcome measurement, evaluation and service gaps. The gaps in youth-specific service provision at that time included the provision of primary mental health care, alcohol and other drug services and services specifically targeted or configured for rangatahi Māori.

The feedback from the national YOSS network is that the findings of the Communio evaluation did not lead to any specific actions that improved the capacity of YOSSs to respond to a wide range of change pressures. As a consequence, many of the challenges that YOSS services are currently facing are the same ones that were reported in 2009. That said, the national YOSS network has worked proactively over the years with various government officials to continue developing different aspects of the model (eg, funding arrangements) and to address a range of issues. Some outputs from that work include:

- agreement in principle to form a national body with a national framework and set of standards
- agreement for a national set of outcome and output measures that can be used consistently across the YOSS sector to inform a national dataset
- collection and analysis of financial data from the YOSS collective
- engagement of a financial consultant to work on the change process.

Summary

- The YOSSs are an important part of the wider youth health, MH&AOD and social sector ecosystem.
- The available evidence suggests YOSSs are seen as an effective service delivery model by both youth health professionals and the young people who utilise YOSS services.
- The development of an integrated cross-sectoral approach to YOSSs would support the expansion and scaling up of a sustainable best-practice YOSS model in the future.
- A collaborative cross-sectoral approach would need to consider the inherent complexities between a nationally prescribed integrated YOSS service model and a flexible, community-oriented model that continues to be responsive to local needs.
- Note that there is a lack of comparable data for young people who do not choose to utilise a YOSS service, thereby making it difficult to determine the extent of service coverage with regard to the youth population in each local area.

51 Bagshaw, S., & McKay, S. (2006). Survey of the Network of Youth Health Service Providers (NYHSP). *New Zealand Medical Journal, 119*(1243), U2266.

52 Milne, S., & McBride, P. (2008). *Are we doing a good job? Providing evidence of the effectiveness of Youth One Stop Shops: The development of self-evaluation capacity and an evaluation framework*. Report by Youthline for the Counties Manukau District Health Board.

53 See note 49.

54 Fleming, T., & Elvidge, J. (2010). *Youth health services literature review*. Waitematā District Health Board.

55 Bailey, R., Torrie, R., & Osborne, R. with Bagshaw, S., Blyth, S., Davidson, J., Merry, S., Munford, R., Pipi, K., Porima, L., Sanders, J., Stasiak, K., Wehipeihana, N., & Wilde, V. (2013). *How we know what we're doing works: Measuring youth outcomes at Kapiti Youth Support. Impact evaluation – summary report 2013*. Health Research Council of New Zealand, Kāpiti Youth Support and Evaluation Works.

56 Campbell, L., Martin, O., Luke, D., & Leonard, C. (2022). *Korowai Youth Wellbeing Trust (298) evaluation: Promoting the wellbeing of rangatahi in Canterbury*. Ihi Research.

57 See note 49.

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5.4 Whānau-centred approaches

Whānau-centred services focus on the whānau as a whole and build on whānau strengths to deliver better outcomes. These services promote te ao Māori concepts while acknowledging whānau diversity and offer effective ways of delivering a range of supports to rangatahi Māori who are experiencing MH&AOD problems in the context of their whānau.

> *The centrality of whanaungatanga aligns strongly with Māori models of wellbeing, which emphasise the importance of whānau, whanaungatanga and Whakawhanaungatanga in providing a foundation for wellbeing. This focus on relationships supporting wellbeing is also a consistent theme that weaves across more general youth development models both internationally and within Aotearoa New Zealand. Whanaungatanga then has been positioned as central to supporting rangatahi wellbeing within the Aotearoa Youth Development literature.*[58]

Out with the old, in with the new to move forward. In order to do that from a hauora perspective, we need to whakamana the rangatahi, uplift their mauri and to enter a mauri ora mindset.

Youth Leadership Symposium, 2022

Reviews and evaluations of whānau-centric approaches

The Ministerial review of Whānau Ora in 2018[59] endorsed the work of Whānau Ora and identified two key approaches to help realise the potential for whānau-centred approaches to be applied more widely:

- The first approach includes embedding requirements for the health and social sector to progress whānau-centred approaches through current strategies and legislation – for example, the Child and Youth Wellbeing Strategy and associated National Youth Plan.

- The second approach relates to the culture shift that is needed across sectors. To this end, the report recommended that Te Puni Kōkiri exercise its leadership role and work closely with other agencies (Health, Oranga Tamariki, Ministry of Social Development and Education) to help grow the influence of whānau-centred policy and investment in Whānau Ora services across government and into local communities – for example, integrated youth MH&AOD care.

The possible opportunities for change described in section 7 of this report reflect these two approaches.

Rangatahi Māori voice

The Oranga Hinengaro Lived Experience team (Te Aka Wai Ora) offers an important connection to whānau voice and, along with Te Kete Pounamu (Te Rau Ora), provides national system leadership to rōpū lived experience. There is an opportunity to utilise current programme activity and existing networks to further develop and amplify rangatahi Māori voice as part of ongoing discussions about integrated youth MH&AOD care.

Practice example: He Kakano Ahau, Te Kaupapa Mahitahi Hauora – Papa o Te Raki Trust, Northland

He Kakano Ahau[60] services are delivered by seven teams across the rohe with the support of Ngāti Hine Health Trust, Whangārei Youth Space, Te Rūnanga o Whaingaroa, Te Hā Oranga, Ki A Ora Ngātiwai, Hokianga Health and Te Hiku Hauora. Each community team provides support to taitamariki (aged 12–24 years) and their whānau through youth nurses, mental health professionals, peer support workers, youth workers, youth wellness clinicians and health improvement practitioners. The service also ensures pathways for youth into wider community supports, including social services, if this is needed.

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58   See note 16, p. 17.

59   Te Puni Kōkiri. (2018). *Whānau Ora review: Tipu Matoro ki te Ao – Final report to the Minister for Whānau Ora*. Te Puni Kōkiri.

60   mahitahihauora.co.nz/supporting-whanau-and-communities/health-and-wellbeing-services/he-kakano-ahau

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6. Literature review – a summary of the evidence

6.1   What is integrated care?

The concept of integrated care is complex, which is why there is no single universal definition for the term. However, much of the literature supports the conceptualisation of integrated care as being on a continuum (see Table 2), with fully integrated care supporting a transformed approach to the delivery of health services.

Bartholomeusz and Randell[61] developed take-home messages (described below) to help develop a common frame of reference for different stakeholders involved in the design, development, funding and delivery of integrated care initiatives.

Table 2: Levels of integrated care defined[62]

Coordinated Care Key Element: Communication		Co-Located Care Key Element: Proximity		Integrated Care Key Element: Practice Change	
Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Minimal Collaboration	Basic Collaboration at a Distance	Basic Collaboration Onsite	Close Collaboration Onsite with Some System Integration	Close Collaboration Approaching an Integrated Practice	Full Collaboration in a Transformed/ Merged Integrated Practice

Key take home messages about integrated care

- In 2016, the World Health Organization published a scoping review that proposed three definitions based on the intended purposes of its use and the perspective from which it is viewed (process based, user-led and systems-based definitions). Common to all three definitions is that care should be centred on the needs of individuals, their families and local communities.

- There are different types, modes and levels at which integrated care can take place.

- Some models of integrated care are described in the literature as being more integrated than others, with co-ordinated and co-located care considered to be at lower levels on the integration continuum.

- The core values of integrated care identified in the literature are that it is collaborative, co-ordinated, comprehensive, continuous, holistic, flexible and reciprocal, there is shared responsibility and accountability, and it is led by whole-systems thinking.[63]

61   Bartholomeusz, C., & Randell, A. (2022). *Defining integrated care and its core components in youth mental health. Part 1: Complexities and values of integrated care*. Orygen.

62   Getch, S., & Lute, R. (2019). Advancing integrated healthcare: A step by step guide for primary care physicians and behavioral health clinicians. *Missouri Medicine*, *116*(5), 384–388, p. 386.

63   Zonneveld, N., Driessen, N., Stüssgen, R., & Minkman, M. (2018). Values of integrated care: A systematic review. *International Journal of Integrated Care*, *18*(4), 9, 1–12.

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6.2 Why is integrated MH&AOD care so important for young people?

Integrated MH&AOD health care is a widely endorsed approach for young people because of its capacity to promote health service utilisation, meet the complex cultural, health, social and developmental needs of young people and deliver better outcomes when compared to standard care.[64] The Youth Advisory Team at Whāraurau also report that young people in New Zealand have a less siloed view of health and wellbeing – perhaps due to learning about health through te ao Māori lens in schools.

The strongest evidence for integrated MH&AOD care for young people comes from the research into the efficacy of early intervention psychosis services.[65] This model led to the development of headspace as the flagship innovation for youth mental health in Australia.

6.3 The headspace model and its effectiveness

From its inception in Australia in 2006, headspace[66] has grown to being the largest national network of enhanced primary care youth mental health centres in the world.[67] The overall success of the headspace model has influenced integrated youth service developments in other countries, including the UK, Ireland, Canada, USA, Europe, Asia and New Zealand, albeit in different forms, at different times and through different mechanisms.[68] Because of the significant influence of the headspace model and Australia's close proximity to New Zealand, this section of the report considers the evidence about the effectiveness of the headspace

model while noting that other integrated YOSSs in other parts of the world vary a lot in the types of services that are offered and how they are provided (for example, the Danish model).[69]

The Australian headspace programme supports young people aged 12–25 with mild to moderate high-prevalence mental health conditions and those experiencing episodic or situational need. Young people with more intensive needs who present to headspace are supported to access other specialised services through partnerships and service system linkages.

The headspace programme provides holistic support for young people across four streams – mental health and wellbeing, physical and sexual health, work and study support, and alcohol and other drug services. These services can be delivered in person at headspace services and through telehealth (including online and telephone services). The provision of these services in multiple formats is intended to help ensure young people are able to access mental health supports when they are needed, particularly for those young people who live in regional and remote areas. In addition to these services, separate support is also provided through eheadspace – a national online and telephone support service delivered by headspace National Youth Mental Health Foundation.

The headspace model clearly articulates the core service components and enabling components that underpin the operation of a headspace centre. These components reflect what is currently understood to be best practice in youth MH&AOD care and describe what makes a headspace centre unique. While headspace centres have flexibility in how they deliver these components, all components need to be implemented in some way in order for the centre to be licensed to operate.

The headspace programme has been evaluated in 2009, 2015 and, more recently, by KPMG in 2022.[70] The KPMG evaluation reported

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64 See note 11.

65 Fusar-Poli, P. (2019). Integrated mental health services for the developmental period (0 to 25 years): A critical review of the evidence. *Frontiers in Psychiatry*, *10*, 355.

66 headspace.org.au

67 Rickwood, D., Paraskakis, M., Quin, D., Hobbs, N., Ryall, V., Trethowan, J., & McGorry, P. (2019). Australia's innovation in youth mental health care: The headspace centre model. *Early Intervention in Psychiatry*, *13*(1), 159–166.

68 See note 11.

69 World Economic Forum. (2020). *A Global Framework for Youth Mental Health. Supplementary Material 3: Youth mental health case studies*. World Economic Forum.

70 KPMG & Social Policy Research Centre. (2022). *Evaluation of the National headspace Program: Final report*. Department of Health.

positive outcomes for young people with mild to moderate MH&AOD problems but mixed results for the 'hard-to-reach' groups. This is particularly the case for young people dealing with intersectionality issues (culturally diverse young people).[71] In addition, some questions were raised about the effectiveness of the model for young people with sub-threshold presentations of severe mental disorders.[72]

Young people who present to headspace with high levels of mental distress and access multiple sessions achieve the greatest improvements in mental health, noting that 36% of all episodes have just one occasion of service.

The KPMG evaluation also notes that there is considerable variation in the cost-effectiveness of headspace services across Australia. However, where less-stringent assumptions are used to assess the treatment benefits, headspace services appear to be more cost-effective than the base case.

Similar to the trend that is being observed across the world, the recent Australian National Mental Health Survey[73] revealed that the annual prevalence of mental ill health in young people aged 16–24 years had surged from 26% in 2007 to 39% in 2020/21– an unprecedented increase of 50% in 15 years in that country. The increase in both demand and complexity is creating significant challenges for headspace services and leading to discussions about the need for greater investment, different funding streams, workforce development, possible changes to the model of care, how headspace integrates with state-based services and innovative responses for the 'missing middle' – young people who are often too unwell for primary care but not unwell enough for specialist MH&AOD services. These developments are interesting and informative for the New Zealand situation, but need to be considered in the distinct and unique context of New Zealand and the evolution of YOSSs in this country (see Table 3).

Table 3: Comparison of headspace and youth one-stop shop (YOSS) models

headspace (Australia)	Youth one-stop shops (New Zealand)
National initiative established by the Australian Government in 2006.	The first YOSSs were established by the Central Regional Health Authority in 1996.
Medical model origins.	Community and youth development origins.
In June 2022, the headspace network included 150 headspace sites operating across rural, regional and metropolitan areas of Australia.	In June 2023, there were approximately 10 YOSSs operating in different parts of New Zealand.
Headspace centres are funded by the Australian Department of Health and locally commissioned by the Primary Health Networks.	YOSSs are funded by multiple government agencies, with the majority of funding (84%) coming from Te Whatu Ora and Oranga Tamariki.
Received funding of $278.6 million in 2021/22.	Received funding of $18.8 million in 2021/22.
Offers early intervention services to young people in four key areas – mental health and wellbeing, physical (including sexual health), work, school and study, alcohol and other drugs.	Offers wrap-around support to young people –mental health, primary health (including sexual health), cultural support, employment, training and vocational assistance, housing services, alcohol and other drugs.
The core service components are clearly articulated and reflect what is understood to be best practice in youth MH&AOD care.	Service components vary according to local need and funding agency requirements.
All headspace centres need to be licensed in order to operate.	YOSSs do not need a licence in order to operate.

71   See note 70.

72   Cross, S., Scott, J., Hermens, D., & Hickie, I. (2018). Variability in clinical outcomes for youths treated for subthreshold severe mental disorders at an early intervention service. *Psychiatric Services*, *69*(5), 555–561.

73   Australian Bureau of Statistics. (2022). *National Study of Mental Health and Wellbeing: Reference period 2020–21*. www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release

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6.4 A rapid review of the other literature

A systematic review of integrated youth MH&AOD care in 2017[74] considered 45 completed and ongoing evaluations and involved 18 different networks or services, including the YOSS model in New Zealand. The scope of the review included at least one aspect of the outcome of interest for integrated mental health services for children and young people.

A 2019 scoping review of the literature on integrated youth service hubs[75] found that they all share common key principles while providing comprehensive services to young people with mental health challenges. Programme characteristics revealed similarities (for example, youth-centric spaces) with some differences (for example, care co-ordination methods), some of which were potentially attributable to a lack of information about the key ingredients of the service. It was noted that outcome research was limited, with few rigorous evaluations. The review concluded that there is a need for a common measurement framework and generation of sufficient information to enable evaluations, implementation, replication, knowledge exchange and dissemination of findings about what works, for whom and in what settings.

The key points from a number of reviews of integrated youth MH&AOD models are captured in the following summary.

The good news

- Recent reviews of integrated youth services have identified that there are a range of models being applied nationally and internationally that take a collaborative approach to the provision of multiple health and social services with the objective of meeting young people's needs with a comprehensive, co-ordinated response.
- Integrated youth-centric services are more successful when young people are actively involved in the design, development and delivery of the services.

- The data indicates that young people who may not have otherwise sought help are accessing these types of MH&AOD services.
- Where evaluated, young people report having benefited from and being highly satisfied with these types of integrated youth-centric services.

Areas for further investigation and improvement

- There is a growing body of evidence (although variably robust) on the effectiveness of integrated MH&AOD care on a range of young people's outcomes and service performance measures (for example, access, satisfaction, acceptability and appropriateness).
- Some young people such as those with more severe presenting MH&AOD problems and those who received fewer treatment sessions have failed to benefit, indicating a need for further integration with more specialist MH&AOD care.
- There is a lack of research on Whānau Ora approaches to integrated youth models.
- There are very few cost-effectiveness studies.
- Efforts are under way to articulate the standards and core features to which youth integrated care services should adhere as well as to further evaluate young people's outcomes.

6.5 Barriers and enablers for youth care professionals

The provision of integrated MH&AOD care is influenced by multiple factors. A systematic review of the facilitators and barriers that professionals experience when providing integrated youth care showed it is a complex and multi-component process that can improve the quality of care and youth satisfaction, noting that the evidence is mixed and that it emphasises the importance of customised

74 Hetrick, S., Bailey, A., Smith, K., Malla, A., Mathias, S., Singh, S., O'Reilly, A., Verma, S., Benoit, L., Fleming, T., Moro, M., Rickwood, D., Duffy, J., Eriksen, T., Illback, R., Fisher, C., & McGorry, P. (2017). Integrated (one-stop shop) youth health care: best available evidence and future directions. *Medical Journal of Australia*, *207*(S10), S5–S18.
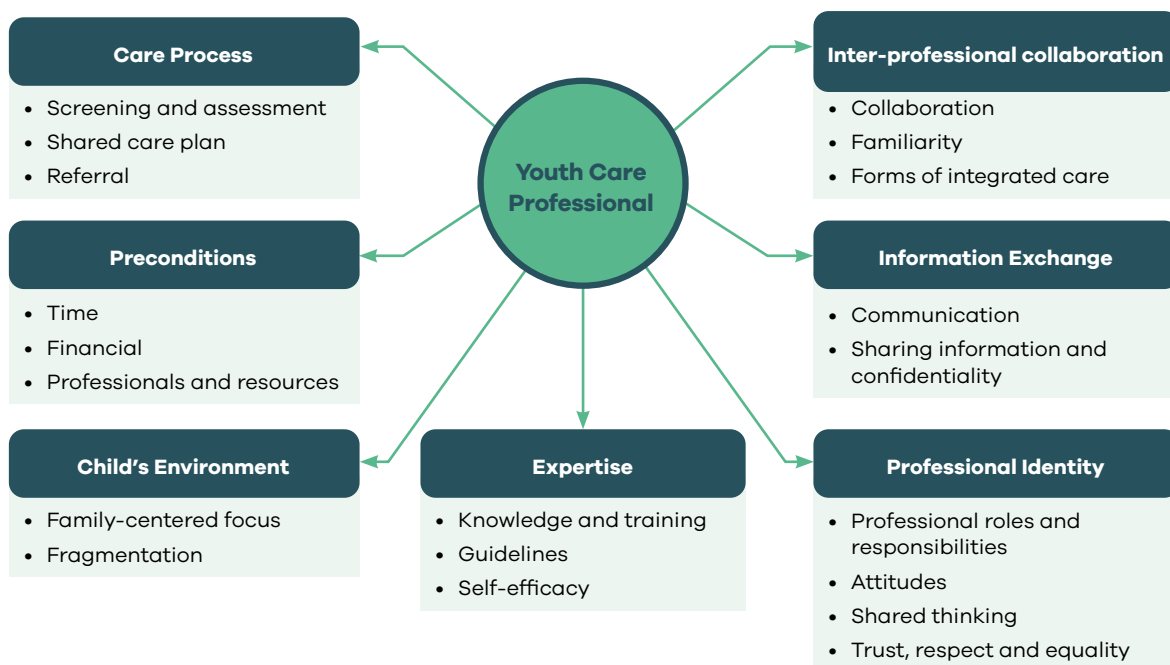
75 Settipani, C., Hawke, L., Cleverley, K., Chaim, G., Cheung, A., Mehra, K., Rice, M., Szatmari, P., & Henderson, J. (2019). Key attributes of integrated community-based youth service hubs for mental health: A scoping review. International Journal of Mental Health Systems, *13*, 52.

interventions or models that serve a specific population, setting or context.[76]

The findings from this review were clustered into themes, with each theme functioning as both a barrier and a facilitator (see Figure 8). For instance, interprofessional collaboration has been described as a critical element in an integrated model but it is also time-consuming, so the lack of sufficient time to develop interprofessional ways of working becomes a barrier rather than a facilitator.

The identified facilitators and barriers were generally consistent across studies, indicating broad applicability across settings and professional disciplines. Future service developments should capitalise on the facilitators of integrated youth MH&AOD care and address the barriers in order to provide an environment that fosters collaborative and integrated ways of working.[77]

Figure 8: Thematic overview of barriers and facilitators for youth care professionals providing integrated care[78]

Care Process
- Screening and assessment
- Shared care plan
- Referral

Preconditions
- Time
- Financial
- Professionals and resources

Child's Environment
- Family-centered focus
- Fragmentation

Youth Care Professional

Expertise
- Knowledge and training
- Guidelines
- Self-efficacy

Inter-professional collaboration
- Collaboration
- Familiarity
- Forms of integrated care

Information Exchange
- Communication
- Sharing information and confidentiality

Professional Identity
- Professional roles and responsibilities
- Attitudes
- Shared thinking
- Trust, respect and equality

6.6 Discussion

The available literature was unable to provide any empirical evidence regarding the effectiveness of any one type of integrated service delivery model over another, although the research suggests that different models suit different sub-groups of young people in different settings. For example, while secondary school students value the confidentiality and ease of access to integrated school-based services, such services are of limited utility to young people who have either left school early or who are between the age of 18 and 25 years.[79]

76 Nooteboom, L., Mulder, E., Kuiper, C., Colins, O., & Vermeiren, R. (2021). Towards integrated youth care: A systematic review of facilitators and barriers for professionals. *Administration and Policy in Mental Health and Mental Health Services Research*, *48*, 88–105 (2021).

77 See note 63.

78 See note 77, p. 96.

79 Craig, E., Adams, J., Oben, G., Reddington, A., Wicken, A., & Simpson, J. (2013). *The health status of children and young people in New Zealand.* Report for the Ministry of Health by the NZ Child and Youth Epidemiology Service, University of Otago.

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The evidence indicates what is also required:

- Further development and strengthening of integrated youth-centric services such as YOSSs, inclusive of a strong MH&AOD component.

- Formal mechanisms that privilege youth voice as a critical element of success.

- Targeted improvements to mainstream primary/community health care services, especially those that are active participants in current and emerging integrated networks of youth-centric services.

- The further development of integrated school-based health services that safely and competently deliver effective MH&AOD supports for young people in conjunction with other community and specialist services.

- Many integrated youth MH&AOD models place a significant emphasis on technology-based services and digital solutions – for example, Piki.[80] This component will become an increasingly important area for future development and evaluation and should be considered as part of a comprehensive strategy that includes a wide range of community services and supports for young people.[81] However, it is important to be aware of the potential to increase current inequities, with those young people facing the greatest challenges to their mental health also being the least able to afford online interventions.

- Increased investment in the research and evaluation of whānau-centric models of integrated MH&AOD care that are known to work for rangatahi Māori. The literature in this area is sparse, and there is minimal information available to support practitioners.

Practice example: Te Hurihanga ō Rangatahi | The Youth Hub, Christchurch

Te Hurihanga ō Rangatahi[82] will be New Zealand's first purpose-built, cross-agency, one-stop shop to support youth health and wellbeing. The first stage is scheduled for completion in 2024. It will connect socially supportive organisations under one roof to deliver a holistic one-stop model of wrap-around services, including mental health, medical, education, employment, training, transitional housing, recreation, creativity and social entrepreneurship. Importantly, it will do all of this in a youth-centric and accessible environment.

Artists impression of Te Hurihanga ō Rangatahi (see website)

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80 piki.org.nz

81 DaRocha, M., Chinn, V., Ormerod, F., & Fleming, T. (2021). *Aotearoa New Zealand digital tools for mental health and wellbeing: Stocktake*. Te Hiringa Hauora | Health Promotion Agency.

82 www.youthhubchch.org.nz

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7.   Possible future directions

The promotion of effective integrated responses for young people who experience mental health and/or substance use challenges will require sustained action at multiple levels of the health and social system.

The following opportunities for change have been identified as high-impact actions that could help accelerate the development of integrated youth MH&AOD care in New Zealand. The actions have been categorised under one or more of the core building blocks of an effective MH&AOD system.

Icon key: Core building blocks of an effective MH&AOD system

🔴 Investment	🟢 Workforce	🔵 Information	🔴 Leadership
⚫ Policy	🟣 Technology/digital	🟠 Commissioning	🟡 Evidence-based treatment

7.1 Cross-government activity – potential opportunities

There is an opportunity to capitalise on current national policy priorities and the associated work programmes and action plans that are focused on achieving wellbeing outcomes for children and young people. Note that, in some instances, a key strategic choice will need to be made about the balance between central prescription and local responsiveness.

Objective: Prioritise cross-sectoral activity on the growth and development of integrated youth services that have a strong MH&AOD component.

Potential opportunities for change

#	Icon	Description	Lead(s)
1	🟠	**Commissioning** – Take specific steps towards making the partnered commissioning of integrated youth MH&AOD and social services standard practice across the public sector.	Social sector chief executives through the Social Wellbeing Board
2	🔴	**Investment** – Increase the share of cross-government investment in equitable, effective, integrated community-based MH&AOD services for young people in line with other OECD countries and in accordance with te Tiriti obligations.	Social sector chief executives through the Social Wellbeing Board
3	⚫	**Policy** – Promote equity and improve the targeting of evidence-based interventions available across the country to help support young people who are experiencing mental health and substance use challenges to succeed in education, employment and training.	Social sector chief executives through the Social Wellbeing Board
4	⚫	**Policy** – Extend the Whānau Ora approach to include development of more integrated MH&AOD hubs for rangatahi Māori (and their whānau) across the country.	Social sector chief executives through the Social Wellbeing Board

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7.2 Service delivery system – potential opportunities

Objective: Strengthen the infrastructure of the service delivery system to increase its capacity and lift its performance.

Potential opportunities for change

#	Icon	Description	Lead(s)
5	●	**Workforce** – Provide advice to the Ministers of Education and Health on how to upskill the health and social service workforce so that youth-focused, trauma-informed and interprofessional ways of working become standard practice for anyone working with young people who are experiencing MH&AOD challenges.	Ministry of Education, Ministry of Health, Ministry of Youth Development, Ministry of Social Development
6	●	**Workforce** – Fund MH&AOD workforce development opportunities to improve the skills and confidence of staff who are working with young people, particularly in mainstream community and primary health care settings.	Te Whatu Ora, Te Aka Whai Ora, Ministry of Social Development, Ministry of Youth Development, Oranga Tamariki, Ministry of Education
7	●●	**Investment and workforce** – Continue the targeted development of school-based health services whereby MH&AOD health professionals are fully integrated into school settings, are clinically supported and have strong connections with local primary health, community supports and specialist MH&AOD services.	Te Whatu Ora, Te Aka Whai Ora, Ministry of Education, Oranga Tamariki
8	●	**Commissioning** – Implement a cross-government national outcomes and service performance framework that will support a culture of accountability as well as a process of continuous quality improvement among integrated youth MH&AOD services.	Social sector chief executives through the Social Wellbeing Board
9	●●	**Evidence-based treatment and digital options** – Ensure that young people have equitable access to effective e-therapies and other digital MH&AOD supports as part of an integrated approach that makes this option available in health services, educational institutions, workplaces, employment services, prisons and Oranga Tamariki residences.	Ministry of Health, Ministry of Education, Ministry of Business, Innovation and Employment, Oranga Tamariki, Ministry of Social Development

7.3 Research and evaluation – potential opportunities

Good-quality evidence is widely recognised as a key contributor to improving youth MH&AOD services and in delivering better outcomes for young people. There are opportunities to share lessons from existing good practice for potential adaptation and application across the country in accordance with the needs of each local community.

Objective: Generate the evidence that is required for public accountability and ongoing quality improvement purposes.

Potential opportunities for change

#	Icon	Description	Lead(s)
10	●	**Information** – Develop a nationally agreed research and evaluation agenda about integrated youth MH&AOD models that will generate the evidence that is required to fill the knowledge gaps (for example, whānau-centric approaches, cost-effectiveness studies of different models).	Social sector chief executives through the Social Wellbeing Board
11	●	**Information** – Identify and evaluate specific integrated youth MH&AOD services that are already working well for specific sub-groups of young people, learn from them and share the learnings with other services in a systemic way – possibly via an Innovation Hub.	Te Whatu Ora, Te Aka Whai Ora
12	●	**Digital options** – Continue to evaluate the uptake, impact and effectiveness of e-therapies and other online tools as a core component of an integrated MH&AOD response that targets young people.	Te Whatu Ora, Te Aka Whai Ora

7.4 Youth voice – potential opportunities

Attitudes towards children and young people's involvement in policy-making processes have shifted significantly in recent years in accordance with the United Nations Convention on the Rights of the Child (1990). The most recent evidence of this shift in New Zealand is the amendment to the Children's Act 2018, which initiated the development of the national Child and Youth Wellbeing Strategy.[83]

The current refresh of the associated National Youth Plan by the Ministry of Youth Development offers an opportunity to re-engage with young people about the actions that will help accelerate the development of integrated youth MH&AOD (and wellbeing) services and ensure that the youth voice is heard and acted on at all stages in the process.

It is important to emphasise that meaningful, sustained and well-designed engagement with young people is essential to success. Many existing practices for youth engagement fall far short of what is considered to be true youth engagement, limiting the potential for youth voice to meaningfully contribute to the most-effective changes.

Objective: Value and amplify the role of young people as a key success factor in the development of integrated youth MH&AOD services.

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83   www.dpmc.govt.nz/our-programmes/child-and-youth-wellbeing-strategy

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Potential opportunities for change

#	Icon	Description	Lead(s)
13	●	**National policy and leadership** – Young people are actively involved in shaping the specific actions that will help accelerate the development of integrated youth MH&AOD (and wellbeing) services, including the refresh of the National Youth Plan.	Te Whatu Ora, Te Aka Whai Ora, Ministry of Health, Ministry of Youth Development, Youth Plan Cross-Agency Working Group
14	● ● ●	**National policy, leadership and commissioning** – Establish clear formal mechanisms for active youth/rangatahi Māori participation in the design, development, commissioning and delivery of youth MH&AOD and social services in New Zealand in accordance with best-practice youth development principles.	Te Whatu Ora, Te Aka Whai Ora, Ministry of Health

7.5   Conclusion

Addressing the mental health challenges of young New Zealanders is a top priority for the cross-party group. We believe that community-based integrated youth MH&AOD care has the potential to support young people's journey towards adulthood and address some of the long-standing service delivery issues for young people who are in need of help.

While the 14 potential opportunities for change are all necessary and important, the cross-party group wants to highlight the critical few keystone actions that we consider are foundational to a step-change in the system.

For the purposes of clarity, here is our quick 4-step plan to improve young people's access to integrated youth MH&AOD services:

1   We suggest that health and social sector leaders prioritise investment in the mental health and wellbeing of young people and co-commission integrated youth programmes that span multiple jurisdictions.

2   We want to see more cross-sectoral activities that facilitate service integration and increase national consistency (service coverage and service quality) while also recognising the need for local flexibility.

3   We want good information to help track progress, improve services and increase accountability.

4   We want to see the voice of young people featured throughout.

Finally, we recommend that Te Hiringa Mahara | Mental Health and Wellbeing Commission monitors and reports on progress against this 4-step plan.

We believe that we will achieve so much more for young people by working together and think that our 4-step plan provides a strong platform for change.

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Appendices

Appendix 1: Key facts about
New Zealand youth one-stop shops

The following data was supplied by the ten YOSSs that comprise the membership of the national YOSS network. The data applies to the 2021/22 financial year.

Figure 9: YOSS expenditure breakdown ($000) for the 2021/22 year

- Personnel Costs
- Accommodation Costs
- Other Operating Costs

$4,766 **25%**
$847 **4%**
$13,903 **71%**
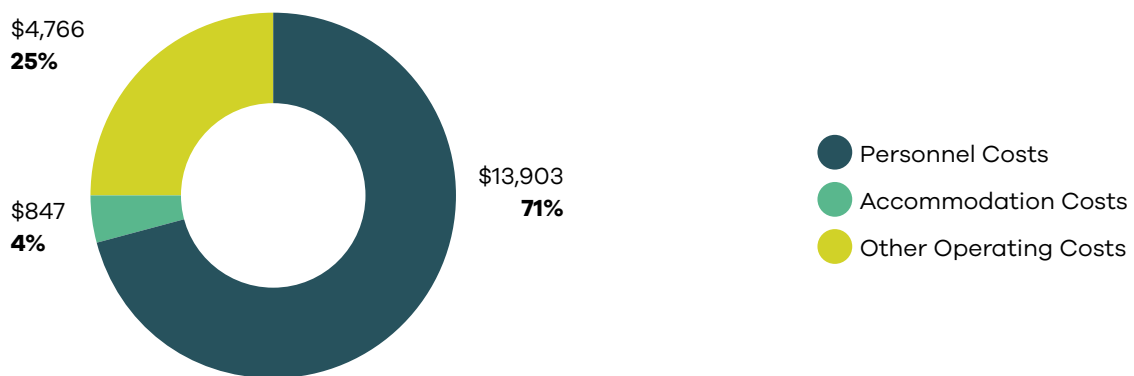
Figure 10: YOSS FTE breakdown in 2021/22

17, **10%**   10, **5%**   32, **18%**   19, **11%**   10, **5%**   8, **4%**   12, **6%**   3, **2%**   52, **28%**   20, **11%**

- Medical (Doctors)
- Nursing
- Mental Health
- Social Workers
- Youth Workers
- Peer Support
- Admin
- Financial
- Reception
- Management
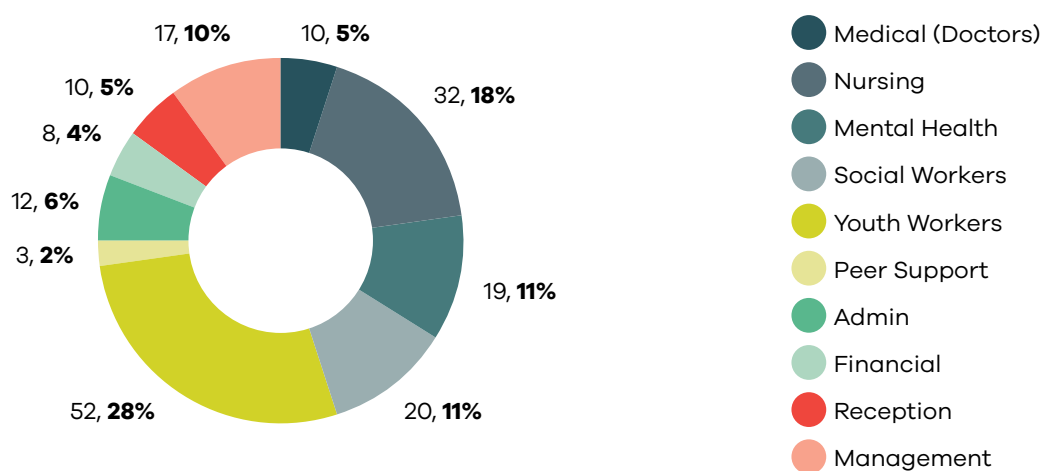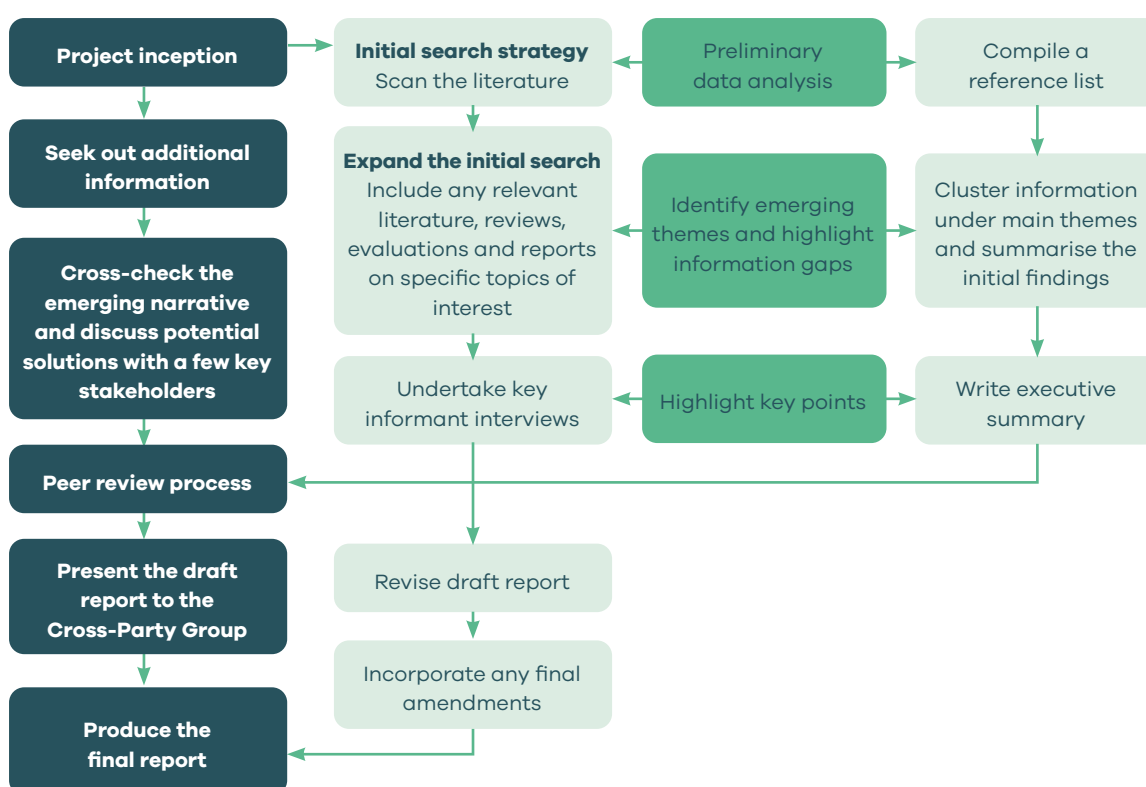
Note: This data does not include information from *The 502* in Porirua or similar youth-centric services as they are not members of the national YOSS network.

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Appendix 2: Methodology

Methodology

This report is based on a desk-top review of the best available national and international evidence for integrated care for young people who are experiencing mental health and/or substance use problems.

```
Project inception  →  Initial search strategy      ←  Preliminary        →  Compile a
                       Scan the literature             data analysis          reference list
     ↓                        ↓                                                     ↓
Seek out additional    Expand the initial search                          Cluster information
information            Include any relevant         Identify emerging  →  under main themes
                       literature, reviews,       ← themes and highlight    and summarise the
     ↓                 evaluations and reports      information gaps        initial findings
                       on specific topics of
Cross-check the        interest                                                    ↓
emerging narrative            ↓
and discuss potential  Undertake key               Highlight key points  →  Write executive
solutions with a few   informant interviews      ←                          summary
key stakeholders
     ↓                        ↓
Peer review process
                       Revise draft report
     ↓                        ↓
Present the draft
report to the          Incorporate any final
Cross-Party Group      amendments
     ↓                        ↓
Produce the         ←
final report
```

Process to test accuracy, relevancy and applicability

The key findings and associated recommendations were shared with selected key stakeholders for their review with an emphasis on testing both the accuracy of the report as well as the relevancy and applicability of the opportunities for change.

The report was subsequently presented to a meeting of the cross-party group for their consideration on 14 June 2023 before being finalised.

Limitations

The following limitations of this review warrant consideration:

- All of the international literature that was reviewed was focused on integrated youth MH&AOD models that operate in high-income, English-speaking countries.

- The review did not consider the effectiveness of other types of integrated community-based models for young people (for example, sexual health and reproductive services) other than to note that access to one service might serve to facilitate easier and earlier access to other services.

- Inevitably, there is unidentified relevant literature, particularly the grey literature.

- The evaluations relating to integrated youth MH&AOD models in New Zealand are mostly over 10 years old, apart from the evaluations associated with recent investments in primary mental health options for young people and the 2022 evaluation of the YOSS in Christchurch.

- The number of stakeholder interviews was limited due to the time constraints for the project.

- There were fewer opportunities to discuss and explore emerging issues in any depth with relevant stakeholders.

- There was little time to circulate the draft report and develop further iterations based on stakeholder feedback.

- There is a lack of empirical evidence about the effectiveness of various models of integrated youth MH&AOD care in the literature, but the evidence does indicate that the young people who choose to access these types of services find them helpful.

- There is very little research about integrated youth MH&AOD models from the perspectives of rangatahi Māori, Pasifika, Asian, rainbow and disabled young people.

Further New Zealand-oriented evaluation and research activity will be important to help monitor progress and address the gaps in the evidence base.

Southern Cross

The cross-party group would like to thank Southern Cross for supporting the development and production of this report.

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