Controller and Auditor-General
Tumuaki o te Mana Arotake

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# Meeting the mental health needs of young New Zealanders

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# Meeting the mental health needs of young New Zealanders

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# Contents

# Auditor-General's overview

E ngā mana, e ngā reo, e ngā karangarangatanga maha o te motu, tēnā koutou.

Mental health concerns are the biggest health issue facing young New Zealanders today.

Although many young people enjoy good mental health and well-being, recent survey data suggests that the mental health and well-being of young New Zealanders has declined rapidly over the past decade.[1]

For young people, mental health concerns can have a significant impact on every aspect of their lives, including their relationships with friends and family and their ability to participate in education, work, and community life.

Early and effective support for young people with mental health concerns can help reduce the lifelong costs of mental illness for individuals, whānau, and society. The human and economic costs of inaction are high. It is estimated that mental illness costs New Zealand about 5% of gross domestic product annually.[2] In 2023, this meant more than $20 billion.

Young people report the highest level of unmet need for mental health care of any age group in the population.[3] However, our work found that many young New Zealanders cannot get mental health support when they need it.

Improving the mental health and well-being of young people was critical to the previous Government's goal of making New Zealand the best place in the world to be a child or young person (as described in the 2019 *Child and Youth Wellbeing Strategy*).

Young people were one of the priority groups in that Government's multi-agency investment of about $1.9 billion of new funding over four years into mental health and addiction (through the 2019 Wellbeing Budget) and in its 2021 *Kia Manawanui* long-term strategy for mental health and addiction.

1 Sutcliffe, K et al (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*, Vol. 57, no. 2, page 280 and Fleming, T et al (2020), *Youth19 Rangatahi Smart Survey, Initial Findings: Hauora Hinengaro/ Emotional and Mental Health*, pages 1-3.

2 Organisation for Economic Development (2018), *Mental Health and Work: New Zealand,* page 26.

3 Ministry of Health, *New Zealand Health Survey* 2022/23 annual data explorer: "Mental health care indicator: Unmet need for professional help for their mental health in the last 12 months".

Since 2018, government spending on mental health and addiction services has increased by 33%.[4] In 2021/22, identifiable public expenditure on mental health and addiction accounted for almost $2 billion of government spending.[5]

I wanted to find out what difference this spending is making for young people.

## What we found

Our audit looked at how effectively government agencies work together to understand and meet the mental health needs of young people aged 12 to 24 years.

Mental health concerns are not evenly distributed in the population. Some groups of young people are particularly affected, including rangatahi Māori, Pacific people, disabled people, Rainbow people, people in care, people not in education, employment, or training, and people in the criminal justice system.

We recognise that determinants of, and supports for, young peoples' mental health and well-being are broad. Not all the answers to the mental health needs of young people will lie in a mental health service. For example, they might be in measures to prevent and respond to family violence or in effective anti-bullying programmes in schools.

### New primary mental health and addiction services are making a difference for young people, but there remains significant unmet need

The previous Government's 2019 investment into new primary mental health and addiction services has made a difference in expanding the availability of primary (or first contact) mental health support for young people with mild to moderate mental health needs. About 3,000 young people each month now access the new youth primary mental health and addiction services funded through this investment.

In time, this increased investment in primary care might relieve demand for more specialised services for people with a more severe level of mental health need, such as those provided through specialist infant, child, and adolescent mental health services.

In the meantime, young people in need of specialist mental health support are waiting longer to access specialist care than they were when the Wellbeing Budget 2019 was released.

4 Our audit encompassed both mental health and addiction (alcohol and other drug) services for young people. We refer to both these collectively in the report as "mental health services".

5 Based on public mental health and addiction services funded through Vote Health. This excludes direct spending on mental health and addiction services by non-Health agencies and the indirect costs of poor mental health to society in lost income and productivity and increased social and justice sector spending.

## Agencies need better information about the extent and distribution of young peoples' mental health needs to effectively target support and services

To be able to meet young peoples' mental health needs, agencies require detailed information on the extent and distribution of those needs. However, we found that agencies currently do not understand enough about the nature and scale of young peoples' needs.

New Zealand's last prevalence survey for mental health, *Te Rau Hinengaro*, was published in 2006 and based on 2004 data, which is now significantly out of date. It did not include children and young people aged under 16 years.

Government agencies need better data on the prevalence of mental health conditions among young people so that funders and policy-makers can make decisions that are well informed and based on population need. Better prevalence data will help give agencies confidence that they are making efficient and effective use of public money by funding the right number and type of services, in the right locations, to meet the needs of young New Zealanders.

## Tailoring support to the specific needs of young people can help overcome the barriers young people face to accessing mental health care

Young people are often expected to fit into services and models of care designed for older adults. Many of the barriers young people experience in accessing mental health support can be overcome if services and supports are tailored to the specific needs of young people.

Tailoring support to the specific needs of young people means ensuring such support is available in places where young people commonly spend time, such as schools and accessible community locations.

Meeting the specific needs of young people also means giving young people a voice in the design and delivery of mental health services. Involving young people in designing services and delivery is a strength of some services. However, more needs to be done to strengthen youth voice and participation across all care settings accessed by young people in distress.

## Addressing gaps in mental health and addiction service provision will require urgent attention to long-standing workforce capacity issues

Throughout this audit, my staff were impressed by the care and dedication of those in the mental health and addiction workforce, who work hard to support young people. However, they are also a workforce under considerable strain due to capacity pressures across the sector.

Sustained effort will be needed to fill workforce gaps by increasing the local education and training pipelines for new and existing types of mental health and addiction practitioners.

In my view, agencies need to focus on planning for and developing the right size and mix of mental health and addiction workforce so that the system is best placed to meet young New Zealanders' ongoing mental health needs.

## Collaborative approaches by agencies and strong system leadership are critical to meeting the needs of young people

The current range of mental health services and support for young people has evolved over time as a collection of services and programmes, often developed in response to a specific need. We saw no coherent system design or vision of how the different parts should fit together as a whole. For young people and whānau who must navigate services, it can feel that the emphasis is on whether young people fit the criteria for a service, rather than on how to meet their needs.

Despite the best intentions and efforts of the many people working in mental health and addiction services, agencies remain too focused on their own programmes and services at the expense of working together to ensure that young people and their whānau are at the centre of the system of support and care.

Co-ordinated approaches by agencies to tailor services and support to the needs of individual young people and their whānau are particularly critical for at-risk groups of young people who are more likely than other young people to experience mental health concerns and to have a range of other health and social needs. These include young people in care, young people not in education, employment, or training, and young people who are in prison.

Building a system focused on the needs of all young people and whānau, rather than agencies and services, will require strong system leadership. It will also need considered design to ensure that young people can access consistent and integrated care as they enter, move through, and leave the care of services.

## What I recommend

The mental health services and support currently available to young people is fragmented, and not all young people have timely and barrier-free access to appropriate mental health care. In a country that prides itself on being a good place to bring up children and young people, this is a matter we should all be concerned about.

I have made nine recommendations designed to support a coherent system of mental health services where all young people can access appropriate and consistent mental health care when and where they need it.

I acknowledge that many of the challenges identified in our report are long-standing and will require significant time and sustained focus by governments to address.

Young peoples' mental health and well-being is an ongoing focus for my Office. I will closely monitor government agencies' work on this, including following up on the recommendations made in this report, so that the public and Parliament can continue to hold the Government and agencies to account.

I thank the many people from government agencies and organisations in the mental health and addiction sector who spoke to my staff for this audit.

I also thank the young people with lived experience of mental health issues who spoke to us and provided their feedback on our audit. Their views were invaluable to our work.

Nāku noa, nā

John Ryan
Controller and Auditor-General | Tumuaki o te Mana Arotake

8 February 2024

# Our recommendations

Our recommendations are designed to support the creation of a coherent system of mental health services so that all young people can access appropriate and consistent mental health care when and where they need it. This will require strong government leadership and co-ordinated approaches from agencies.

We recommend that:

1. the Ministry of Health prioritise work to understand the prevalence of mental health conditions in the population;
2. Te Whatu Ora work with the Ministry of Health, the Ministry of Education, Oranga Tamariki, and other agencies as relevant to evaluate the effectiveness of, and develop consistent guidelines for, the delivery of youth integrated primary health services;
3. the Ministry of Education ensure that sufficient data is collected to understand the effectiveness of the school guidance counselling model for all students;
4. Te Whatu Ora and the Ministry of Education work with other agencies as relevant to better align the objectives and operations of their school-based health and well-being services;
5. Te Whatu Ora, the Ministry of Education, Oranga Tamariki, and the Department of Corrections consider whether appropriate mechanisms for youth voice and participation are built into the design, delivery, and governance of new and existing mental health and well-being services for young people;
6. Te Whatu Ora, the Ministry of Education, Oranga Tamariki, and the Department of Corrections ensure that outcomes data is collected for all mental health and well-being services accessed by young people;
7. Te Whatu Ora work with the Ministry of Health, the Ministry of Education, Oranga Tamariki, the Ministry for Social Development, and the Department of Corrections to ensure that integrated care pathways are in place so that at-risk groups of young people experiencing mental health concerns can access consistent and continuous care as they enter, move between, and leave the care of services;
8. the Ministry of Health work with Te Whatu Ora, the Ministry of Education, Oranga Tamariki, the Department of Corrections, and other agencies as relevant to strengthen its mental health and addiction system leadership role, and to prioritise the development of a cross-agency implementation plan for *Kia Manawanui* with clear agency roles and responsibilities; and
9. Te Whatu Ora and the Ministry of Health work with the Ministry of Education, Oranga Tamariki, the Department of Corrections, and other agencies as relevant to prioritise the development of a national mental health and addiction workforce plan.

# 1 Introduction

1.1 Many young people in New Zealand enjoy good mental health and well-being. However, young New Zealanders experience the highest rates of mental distress of any age group in the population. Recent survey data suggests that the mental health and well-being of young New Zealanders has declined sharply over the past decade.[6]

1.2 The *New Zealand Health Survey* for 2022/23 indicates that one in five 15-24 year-olds reported experiencing "high" or "very high" levels of mental distress in the past four weeks (see Figure 1). In a major survey of secondary school students, the percentage of young people who reported having experienced significant symptoms of depression increased from 13% in 2012 to 23% in 2019. New Zealand's rate of youth suicide is among the highest in developed nations.[7]

We use a range of different terms in this report to refer to mental health, mental illness, and mental well-being. The terms "mental illness" or "mental health condition" refer to diagnosable conditions, which align with internationally recognised criteria. Examples include major depressive disorder, anorexia nervosa, and substance use disorders.

The terms "mental distress" and "psychological distress" refer to a person's emotional state. A person who experiences mental distress will not necessarily meet the criteria for a diagnosable mental health condition.

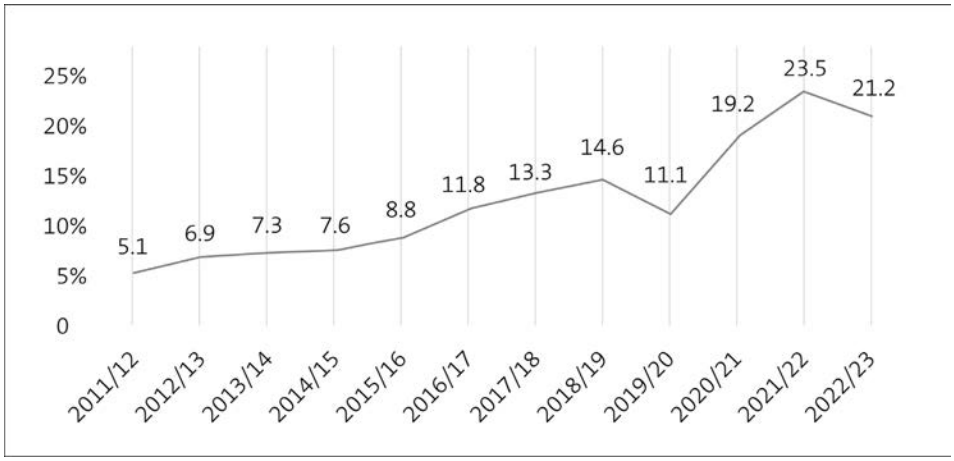
We use the terms "mental health needs" and "mental health concerns" as umbrella terms that encompass mental distress and diagnosable mental health conditions, including substance use disorders.

Mental well-being is a broad concept. Young people and whānau experience positive well-being when they have a good quality of life, have what they need, have hope and purpose, and feel safe and connected to their communities. See Te Hiringa Mahara Mental Health and Wellbeing Commission's *He Ara Oranga Wellbeing Outcomes Framework*.

6 Sutcliffe, K et al (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*, Vol. 57, no. 2, page 280, and Fleming, T et al (2020), *Youth19 Rangatahi Smart Survey, Initial Findings: Hauora Hinengaro/ Emotional and Mental Health*, pages 1-3.

7 Sutcliffe, K et al (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*, Vol. 57, no. 2, page 267 and UNICEF Office of Research Innocenti (2020), *Worlds of Influence: Understanding What Shapes Child Well-being in Rich Countries*, page 13.

**Figure 1**
**Percentage of 15-24 year-olds who reported having experienced high or very high levels of distress in the past four weeks**




Source: *New Zealand Health Survey* 2022/2023.

1.3 Female, Māori, Pacific, Asian, disabled, and Rainbow young people are more likely than other groups of young people to report experiencing mental distress.

1.4 New Zealand is not alone in facing these issues. High and rising rates of mental distress among young people are reported by many developed nations.

1.5 Most mental health conditions start in adolescence or early adulthood.[8] Experiences of trauma and adversity in early life can be formative. Life transitions such as finishing school, starting work or further study, and leaving home can also place pressure on young peoples' mental health and well-being.[9]

1.6 Early evidence shows that young peoples' mental health and well-being has likely been affected more negatively by the Covid-19 pandemic and associated lockdowns compared with older age groups.[10]

8 Solmi, M et al (2021), "Age at onset of mental disorders worldwide: Large-scale meta-analysis of 192 epidemiological studies", *Molecular Psychiatry*, Vol. 27, pages 281-295.

9 Gluckman, P (2011), *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence*, and Social Policy Evaluation and Research Unit (2016), *The Prime Minister's Youth Mental Health Project: Summative Evaluation Report*, page 17.

10 World Health Organization (2022), *World Mental Health Report: Transforming Mental Health for All*, page 31 and Bower, M et al (2023), "A hidden pandemic? An umbrella review of global evidence on mental health in the time of COVID-19", *Frontiers in Psychiatry*, Vol. 14.

1.7 In this Part, we describe:

- why we did the audit;
- what we looked at;
- how we did the audit;
- what we did not look at; and
- the structure of our report.

## Why we did this audit

1.8 Investing in early intervention mental health services and support can help young people experiencing mental health concerns achieve their potential and reduce the lifelong impacts and costs of mental illness for individuals, whānau, and society. Early intervention is linked to a range of positive outcomes, including improved achievement in education, increased lifelong earnings, and greater life expectancy.

1.9 There is a high cost to not addressing mental health concerns as they emerge. People in contact with specialist mental health services die, on average, up to 25 years earlier than other New Zealanders.[11] It is estimated that mental illness costs New Zealand about 5% of gross domestic product (GDP) annually.[12] In 2023, this corresponded to almost $20 billion.[13]

1.10 The previous Government prioritised improving the well-being of children and young people aged 12 to 24 years. The goal of its *Child and Youth Wellbeing Strategy* was to make New Zealand the best place in the world to be a child or young person.

1.11 Early in 2018, the Government launched an inquiry into mental health and addiction. The report from the Government inquiry, *He Ara Oranga*, was published in November 2018.

1.12 The Government considered the recommendations of *He Ara Oranga* together with those of the separate 2018 Organisation for Economic Co-operation and Development report *Mental Health and Work* in New Zealand.

1.13 The Government accepted, accepted in principle, or agreed to further consider 38 of the *He Ara Oranga* report's 40 recommendations and 18 of 20 recommendations made by the *Mental Health and Work* report.

11 Government Inquiry into Mental Health and Addiction (2018), *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*, page 29 and Cunningham, R et al (2014), "Premature mortality in adults using New Zealand psychiatric services", *New Zealand Medical Journal*, Vol. 23, no. 127, pages 31-41.

12 Organisation for Economic Development (2018), *Mental Health and Work: New Zealand,* page 26.

13 Based on total 2023 GDP of $395 billion. See New Zealand Government (2023), *Financial Statements of the Government of New Zealand for the year ended 30 June 2023*, page 181, at treasury.govt.nz.

1.14 The previous Government invested significant new funding into addressing mental health and well-being. The 2019 Wellbeing Budget included a $1.9 billion multi-agency investment into mental health and well-being over four years.

1.15 Young people were among the priority groups for the Government's multi-agency investment, which included $455 million of new funding over four years for the national roll-out of the Access and Choice programme. This programme aims to provide increased access to, and choice of, primary-level services for people with mild to moderate mental health and addiction needs.

1.16 In 2021, the Ministry of Health released *Kia Manawanui*, the Government's 10-year cross-agency strategy to transform the mental health and addiction system in response to the recommendations of *He Ara Oranga*. *Kia Manawanui* sets out the principles, focus areas, and system enablers to achieve *He Ara Oranga*'s vision of mental well-being for all New Zealanders.

1.17 Since *He Ara Oranga* was published, government spending on mental health and addiction services[14] increased from $1.47 billion to $1.95 billion annually (a 33% increase).

1.18 We wanted to know whether government spending on mental health services is making a difference for young people.

## What we looked at

1.19 We looked at government agencies that support or provide services to young people with mental health concerns. They are:

- the Ministry of Health Manatū Hauora;
- Te Whatu Ora Health New Zealand;
- Te Aka Whai Ora Māori Health Authority;
- the Ministry of Education Te Tāhuhu o te Mātauranga;
- Oranga Tamariki Ministry for Children;
- the Department of Corrections Ara Poutama Aotearoa;
- New Zealand Police Ngā Pirihimana o Aotearoa; and
- the Ministry of Social Development Te Manatū Whakahiato Ora.

1.20 Our audit focused on how well these agencies:

- understand the mental health needs of young people;
- meet the mental health needs of young people; and
- work together to meet the needs of at-risk groups of young people.

14 Our audit encompassed both mental health and addiction (alcohol and other drug) services for young people. We refer to these collectively in this report as "mental health services".

1.21 To answer these questions, we looked at five care settings commonly accessed by young people. These settings are:

- general practices;
- youth-specific integrated primary care services (Youth One Stop Shops);
- school-based services;
- Access and Choice primary mental health and addiction services; and
- specialist infant, child, and adolescent mental health services.[15]

1.22 We also looked at how well government agencies work together to meet the needs of three groups of young people who experience greater risk of mental health concerns. These are:

- young people in care;
- young people not in education, employment, or training; and
- young people in the adult prison system.

1.23 We recognise that these are not the only groups of young people at heightened risk of mental health concerns. Other groups of at-risk young people include migrant and refugee people, homeless people, and young parents.

1.24 We also acknowledge that no individual or group is immune from mental health concerns.

1.25 Although the focus of our audit was on young people aged 12 years and over, there is strong evidence for the value and effectiveness of early intervention to address mental health and behavioural concerns in even younger age groups.[16]

## How we did this audit

1.26 Seeking the views of young people has been an important part of our audit.

1.27 We spoke to a range of established youth advisory groups made up of young people who have used mental health services.

1.28 We have drawn on consultation documents that presented young peoples' input on similar topics. We have also made extensive use of youth mental health research that incorporates young peoples' views and perspectives.

1.29 We asked sector experts Dr Helen Lockett, Professor Cameron Lacey, and Romy Lee (a lived experience advisor) to review this report.[17] Although their expertise

15 Other settings where young people might access services which were not a focus of this report include Accident Compensation Corporation-funded services, inpatient services, paediatric services, adult community specialist mental health services, crisis services, emergency departments, and youth justice and forensic services.

16 Gluckman, P (2011), *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence*, pages 9-10.

17 See Appendix 1 for more information about our reviewers.

informed our work, the findings and recommendations presented in this report are our own.

1.30 We held more than 150 discussions with about 400 people and groups from the government agencies listed in paragraph 1.19 and across the broader mental health sector. These people included frontline staff who directly support young people with mental health concerns and a range of academics and sector experts.

1.31 We looked at a range of documents, including publicly available reports and research and documents requested from government agencies.

1.32 Appendix 1 sets out more information about our audit methodology.

## What we did not look at

1.33 We did not look at:

- mental health and well-being programmes aimed at preventing, or educating young people about, mental illness;
- the effectiveness of, or appropriateness of clinical decisions about, young peoples' care or treatment; or
- wider social determinants or causes of poor mental health and well-being in young people.

1.34 To avoid potential harm, we did not speak to young people who are currently receiving treatment from mental health services.

1.35 Although this report is focused on mental health services, we recognise that young peoples' mental health and well-being is partly shaped by their environment. For this reason, mental health services can be only a part of the solution to preventing and responding to mental distress in young people.

## The structure of our report

1.36 In Part 2, we discuss how well government agencies understand the mental health needs of young people.

1.37 In Part 3, we discuss how well government agencies meet the mental health needs of young people in five key care settings.

1.38 In Part 4, we look at how well government agencies are working together to meet the needs of three groups of at-risk young people.

1.39 In Part 5, we look at how well government agencies are addressing key system constraints that affect their ability to meet young peoples' mental health needs.

# Understanding young peoples' mental health needs

2

2.1 In this Part, we assess how well government agencies understand the mental health needs of young people.

2.2 We expected government agencies to collect data on the mental health needs of young people to ensure that service planning and design are informed by the best available evidence on the extent and distribution of need in the population.

### Summary of findings

2.3 New Zealand lacks up-to-date and comprehensive data on how common mental health conditions are in the population, particularly for children and young people.

2.4 This means that government agencies rely on a mixture of data from general population health surveys, historical service access (use) data, and insights from the mental health sector to guide policy assumptions and forecast demand for services.

2.5 In our view, this information is not enough for agencies to make informed decisions about service funding and planning. There is not enough detail in survey data to reliably forecast the need for services. Service access data and sector insights are poor proxies for need because a high proportion of mental health need goes unmet and because some groups, such as Māori, have poorer access to services.

2.6 Without prevalence data, government agencies cannot be confident that the services they are designing, providing, or funding are best placed to meet the changing needs of young people.

## Better data is required to target funding and services to need

2.7 New Zealand collects and reports a range of mental health data through brief screening tools based on short questionnaires about peoples' symptoms.[18]

2.8 Surveys based on brief screening tools include the annual *New Zealand Health Survey*, the *Youth2000* survey series of secondary school students and the Ministry of Social Development's 2021 *What About Me?* survey of secondary students and young people in community settings.

2.9 Although screening data is useful for identifying trends in the levels of mental well-being or mental distress New Zealanders are experiencing, it cannot be used to diagnose someone or tell us how common certain mental health conditions are in the population.

18 Examples of commonly used screening tools include the Kessler-10 scale for psychological distress and the GAD-7 scale for anxiety.

2.10 There is a risk that screening tools could overestimate the level of need. People might report symptoms of distress that are "mild, situational, or transitory" and do not meet the diagnostic criteria for a mental health condition.[19] Factors such as greater public awareness of mental health might lead to increased reporting of distress, without necessarily reflecting an underlying change in prevalence.[20]

2.11 Epidemiological surveys based on full-length structured interviews by trained researchers are considered best practice for understanding the extent and distribution of mental health conditions in a population.

2.12 New Zealand's only national prevalence survey for mental health, *Te Rau Hinengaro*, was completed in 2006 and based on 2003/04 data. It is now 20 years out of date and surveyed only people aged 16 years and over. This means that there is no useful New Zealand-specific mental health prevalence data for children and young people.

2.13 One of the recommendations of the 2018 *He Ara Oranga* report was to carry out a new prevalence survey. The 2022 government data investment strategy identified a lack of robust data on the population prevalence of mental health conditions as a key data gap.[21]

2.14 The Ministry of Health told us that it recognises the need for better prevalence data for mental health and addiction and that improved data is a strong focus of its work programme under *Kia Manawanui*. It noted that a new prevalence survey will be considered as part of future government decisions about "investment and work programme priorities".

2.15 People we spoke to in the sector told us that a new prevalence survey is needed because the distribution of mental health need in the population might be shifting. We heard concerns that there is an increasing concentration of mental health concerns in younger age groups.[22]

2.16 Although overseas prevalence data could indicate likely trends, a New Zealand-specific survey is needed to understand the extent and distribution of mental health need.

19 Te Pou (2022), *Understanding population mental health and substance use: An overview of current data*, page 6 and Lockett, H et al (2022), "Whakairo: Carving a values-led approach to understand and respond to the mental health and substance use of the New Zealand population", *New Zealand Medical Journal*, Vol. 135, no. 1567.

20 Baxter, A et al (2014), "Challenging the myth of an 'epidemic' of common mental disorders: trends in the global prevalence of anxiety and depression between 1990 and 2010", *Depression and Anxiety*, Vol. 31, Issue 6.

21 New Zealand Government (2022), *Government Data Investment Plan 2022*, page 52.

22 See Sharma, V et al (2023), *Understanding the mental health and impact of substance use on infants, children, and youth in Aotearoa New Zealand: Findings from a scoping review*.

2.17 We heard that a new prevalence survey or survey series is essential for the accurate planning and resourcing of mental health services, for workforce development, for ongoing monitoring and improvement of service effectiveness, and to achieve equitable outcomes for young people, Māori, and other groups who experience greater mental health needs.

2.18 We were told that data on current access to mental health services is not a reliable substitute for prevalence data because many people who experience mental health needs face barriers to accessing these services. For example, *Te Rau Hinengaro* found that only 40% of people who experienced a mental health condition in the past year had accessed mental health support from a service in that time.[23]

2.19 An example of where current service access data is a poor proxy for population need is in eating disorders. *Te Rau Hinengaro* found in 2006 that Māori experience eating disorders at similar rates to non-Māori.[24] However, Māori appear to access eating disorder services at lower rates than other population groups. Researchers attribute the disparities to a range of access barriers, including a lack of culturally appropriate services.[25]

2.20 Over-reliance on access data for future service provision risks perpetuating inequities in service access.

2.21 A minority of people in the sector we spoke with felt that enough is known about population need and that the costs involved in funding a new prevalence survey would be better channelled into services, or that less cost- and time-intensive options might improve knowledge of prevalence without the need for a full-scale survey.

**Recommendation 1**

We recommend that the Ministry of Health prioritise work to better understand the prevalence of mental health conditions in the population.

23 Oakley Browne, M et al (2006), *Te Rau Hinengaro: The New Zealand Mental Health Survey*, page 115.

24 Oakley Browne, M et al (2006), *Te Rau Hinengaro: The New Zealand Mental Health Survey*, page 139.

25 Lacey, C et al (2020), "Is there systemic bias for Māori with eating disorders? A need for greater awareness in the healthcare system", *New Zealand Medical Journal*, Vol. 133, Issue 1514, pages 71-76 and Lacey, C et al (2020), "Eating disorders in New Zealand: Implications for Māori and health service delivery", *International Journal of Eating Disorders*, Vol. 53, no. 12, pages 1974-1982.

# 3 Meeting young peoples' mental health needs

3.1 In this Part, we assess how well government agencies are meeting the mental health needs of young people. Our audit definition of "meeting need", set out in Figure 2, is our summary of the key components of what young people want in mental health services.[26]

**Figure 2**
**The "meeting need" definition used in this report**

| | |
|---|---|
| Rapid and barrier free | **Rapid, barrier-free access to support** – Access to barrier-free support when young people need it.<br>**Services in places and spaces where young people are** – Such as schools, easy-to-access community locations, or online. |
| Tailored support | **Youth-specific care** – Services and models of care that are designed for young people.<br>**Youth voice and participation** – Services that listen to and empower young people, recognise their strengths and mana, and include them in service design, delivery, review, and improvement.<br>**Youth-friendly environments** – Services delivered in environments that are safe, welcoming, and inclusive of all young people.<br>**Services that reflect diverse young people** – Inclusive services and a workforce that reflects young peoples' diverse identities and needs, with the option of separate services for some groups such as Māori and Pacific young people. |
| Relationships | **Relationships** – The importance of relationships and the ability to build ongoing relationships with trusted adults.<br>**Whānau-centred care** – Involving whānau as partners in young peoples' care where appropriate. |

3.2 Appendix 2 has more information on how we applied this definition, including its specific relevance to Māori, Pacific, disabled, and Rainbow young people.

3.3 In this Part, we apply this definition of what young people want in services to five primary and specialist care settings commonly accessed by young people.[27] These are:

- Primary:
  - general practice medical centres (GPs);
  - Youth-specific integrated primary care services (Youth One Stop Shops);
  - school-based services;

26 Based on our discussions with established youth advisory groups, existing consultation documents that presented young peoples' input on similar topics, and our review of the significant body of youth mental health research that incorporates young peoples' views. To avoid the potential of harm, we did not speak to young people who are currently accessing mental health services.

27 We selected these five care settings on the basis that they are commonly accessed by young people or are specifically for young people.

  - Access and Choice primary mental health and addiction services; and
- Specialist – infant, child, and adolescent mental health services (ICAMHS).

3.4 We expected agencies to:

- ensure that all young people have access to timely, barrier-free, and appropriate mental health support;
- understand and address the barriers young people might face to accessing mental health support by tailoring services to the specific needs of young people; and
- ensure that young peoples' input and participation is a part of mental health service design and delivery.

## Summary of findings

3.5 Although GP visits are the usual first step in accessing mental health services in New Zealand, some young people face barriers to accessing GP care.

3.6 There is increasing evidence that youth-specific integrated primary services in schools and accessible community locations are effective youth-friendly alternatives to GP care for young people.

3.7 However, in our view more work is needed to evaluate the effectiveness of such services in New Zealand. Greater co-ordination between government agencies will also be needed to improve the consistency, reach, and sustainability of youth-specific integrated primary care services.

3.8 Investment into new primary mental health and addiction services is improving the availability of primary mental health and addiction support for young people with mild to moderate mental health needs.

3.9 However, young people are waiting longer to access specialist infant, child, and adolescent mental health services and capacity constraints in the specialist system are having a flow-on effect on primary services.

3.10 During our audit, we saw many examples of innovative services leading the way in including youth voice and participation and using youth- and whānau-centred service models. More work is needed by agencies to consider whether new and existing services appropriately incorporate youth voice and input.

3.11 In our view, more work is also needed to improve the quality and consistency of outcomes data collected by services, to ensure that planning and investment into mental health services is underpinned by sound evidence about what works for young people.

## Some young people face barriers to accessing GP care

3.12 In New Zealand, most primary care is accessed through GPs and funded through a combination of patient charges and government subsidies. Children and young people aged 13 years and under can access a GP without charge. GP visits are the usual way people access more specialised services in the health system, including specialist mental health services.

3.13 It is common for people experiencing mental health concerns to see their GP first. A recent survey found that mental health and substance use concerns may make up a third of general practice consultations.[28] General practitioners told us that mental health commonly comes up in their consultations with young people.

3.14 Although GPs remain an important avenue for young people to access mental health support, some young people face barriers to accessing GP care.

3.15 Young people aged 15-24 years visit GPs at the lowest rate of any age group in the population.[29] Although the low rates of young people accessing GPs might be explained by the fact that young people typically experience better physical health than other age groups, young people also report high levels of unmet need for GP care.[30]

3.16 Known barriers faced by young people to accessing GP care in general include cost (for those aged 14 years and older) and lack of transport. Young people might feel embarrassed or ashamed to talk with their general practitioner about mental health concerns. They might worry about whether the information they share is confidential (even when it is).

3.17 Barriers to GP care are greater among Māori, Pacific, Rainbow, and disabled young people, those living in rural areas, and young people not in education, employment, or training.

3.18 The low rate of young people accessing GPs reflects global trends. Internationally, researchers have attributed low rates of young people accessing GP care to factors such as staff attitudes, young people not perceiving GP clinics as youth-friendly

28 Royal New Zealand College of General Practitioners (2021), "Survey results raise concern for the health and sustainability of general practice", at rnzcgp.org.nz. Note that New Zealand does not collect standardised primary care data for health care accessed through GPs.

29 Ministry of Health, *New Zealand Health Survey* 2022/23 annual data explorer: "Primary health care use indicator: Visited GP in past 12 months".

30 Ministry of Health, *New Zealand Health Survey* 2022/23 annual data explorer: "Barriers to accessing primary care" and Te Tāhū Hauora Health Quality & Safety Commission (2021), "Atlas of Health Care Variation: Health Service Access", at hqsc.govt.nz.

environments, and young people not feeling sufficiently involved in their care by their nurse or general practitioner.[31]

## Integrated primary care models can make care more accessible to young people

3.19 Youth-specific integrated[32] primary care models combine a range of primary physical, mental, and sexual health and other social and vocational services for young people in a single service. Examples of integrated youth primary health care models in New Zealand are Youth One Stop Shops and school-based health services. Although not youth-specific, whānau ora services also provide integrated support for rangatahi in their whānau context.

3.20 There is increasing international evidence to support the effectiveness of youth-specific integrated primary care services as an accessible alternative to GPs that meet a range of young peoples' health and well-being needs.[33]

3.21 An existing model for integrated youth-specific primary health and mental health care for 12-24 year-olds in New Zealand is Youth One Stop Shops. The model has existed in New Zealand since the 1990s and many Youth One Stop Shops have a high profile in their local communities. In 2021/22, Youth One Stop Shops received combined government funding of about $19 million.[34]

3.22 We spoke to staff at a range of Youth One Stop Shops as part of our audit. The model appears to meet many of the characteristics of what young people want in a mental health service. Youth One Stop Shop services are "for" young people (aged 12-24 years), are free, can be accessed without a referral, and offer a range of services that meet young peoples' holistic needs (that is, their physical, mental, vocational, and social needs) in one community location.

3.23 Locating multi-disciplinary teams on a single site allows for "warm" in-person handovers of young people to other professionals without the need for external referrals, which is a known risk factor in young people "falling through the gaps" between services.

31 Over a third of New Zealand young people surveyed in 2018 reported that their general practitioner or practice nurse did not involve them in their care as much as they would have liked. See Te Tāhū Hauora Health Quality & Safety Commission (2021), "Atlas of Health Care Variation: Health Service Access", at hqsc.govt.nz.

32 Integrated care is defined as care that is "collaborative, co-ordinated, comprehensive, continuous, holistic, flexible and reciprocal" and where responsibility and accountability is shared. See Cross-party Mental Health and Addiction Wellbeing Group (2023), *Under One Umbrella: Integrated mental health, alcohol and other drug use care for young people in New Zealand*, page 29.

33 Hetrick, S et al (2017), "Integrated (one-stop shop) youth health care: Best available evidence and future directions", *Medical Journal of Australia*, Vol. 207, no. 10, pages S5-S18.

34 Cited in Cross-party Mental Health and Addiction Wellbeing Group (2023), *Under One Umbrella: Integrated mental health, alcohol and other drug use care for young people in New Zealand*, page 31.

3.24 Staff described to us a range of measures they take to create a service environment where young people feel comfortable and want to spend time. These include offering employment and mentoring to young people, offering kai and drinks to visitors, and running youth events and recreational programmes. The aim, as one youth health expert described it to us, is to help young people feel comfortable on good days so they show up on bad days.

3.25 Youth voice and participation is embedded into the service model of many Youth One Stop Shops, through mechanisms such as youth co-design, youth advisory groups, and employing young people on staff.

3.26 Young people played a leading role in developing the 502 Rangatahi Ora youth hub in Porirua. 502 Rangatahi Ora was established in 2021 as a collaboration between Te Rūnanga o Toa Rangatira, a local iwi organisation, and Partners Porirua, a non-government organisation (NGO).

3.27 The care model of 502 Rangatahi Ora emphasises building trust and genuine connections with young people and empowering them to make decisions about their lives. This service has a strong Māori and Pacific cultural focus, reflecting the input of the young people who took part in the co-design of the service.

3.28 The Youth One Stop Shop model was evaluated in 2009. The evaluators noted the overwhelmingly positive feedback that Youth One Stop Shops received from both staff and clients. However, the evaluators were unable to assess the model's effectiveness due to a lack of consistent outcomes data.[35]

3.29 Currently, Youth One Stop Shops are not available in all regions. There is also no consistent funding, objectives, outcomes data, or performance measures for Youth One Stop Shops nationwide.

3.30 Although some Youth One Stop Shops have a strong record of attracting rangatahi Māori, the model has not been specifically evaluated for its effectiveness with Māori.[36]

3.31 We also note that no universal integrated service is likely to work for all young people. The option of separate services is important for some groups, such as Māori and Pacific young people (see Appendix 2). Although school-based services can improve school students' access to primary care (see paragraphs 3.33-3.65), alternative options are needed for young people who are not in school.

35 Communio and the Ministry of Health (2009), *Evaluation of Youth One Stop Shops*, page 11. Some individual Youth One Stop Shops have also carried out their own evaluations to demonstrate the positive effects of their services.

36 Data provided to the Cross-Party Mental Health and Addiction Wellbeing Group indicates that rangatahi Māori make up 28-85% of young people accessing individual Youth One Stop Shops. See Cross-Party Mental Health and Addiction Wellbeing Group (2023), *Under One Umbrella: Integrated mental health, alcohol and other drug use care for young people in New Zealand*, page 23.

3.32 In our view, an evaluation of Youth One Stop Shops and other community-based youth integrated primary care models should be carried out to compare the relative effectiveness of approaches to youth integrated primary care services and to inform the development of nationally consistent service guidelines.[37]

**Recommendation 2**

We recommend that Te Whatu Ora work with the Ministry of Health, the Ministry of Education, Oranga Tamariki, and other agencies as relevant to evaluate the effectiveness of, and develop consistent guidelines for, the delivery of youth integrated primary health services.

## School-based services are critical to improving primary care access for students

3.33 The Ministry of Education and Te Whatu Ora fund health and well-being services in New Zealand secondary schools. Some secondary schools fund health services through other sources, such as annual operating grants.

3.34 Accessible integrated primary health care (including mental health) services in schools are important to overcoming the barriers that some young people can experience in accessing GP care.[38]

3.35 Individual schools are responsible for understanding and responding to any mental health needs that could affect student well-being or be a barrier to their learning. The Ministry of Education supports schools with this. In a 2023 survey, secondary school principals described supporting student mental health and well-being as the top challenge facing schools today.[39]

3.36 The Ministry of Education does not require schools to report back to the Ministry any data they might collect on the mental health needs of students.[40]

3.37 The Ministry acknowledges that "robust data" is necessary to understand student mental health needs and monitor service effectiveness but told us it must balance the need for improved data against other considerations, such as minimising reporting burdens for service providers and schools.

37 Also referenced in Cross-Party Mental Health and Addiction Wellbeing Group (2023), *Under One Umbrella: Integrated mental health, alcohol and other drug use care for young people in New Zealand*, page 25.

38 Denny, S et al (2017), "Characteristics of school-based health services associated with students' mental health", *Journal of Health Services Research & Policy*, 0(0), pages 1-8.

39 Alansari, M et al (2023), *Secondary principals' perspectives from NZCER's 2022 National Survey of Schools*, page 29.

40 The Ministry of Education told us it is in the early stages of developing a student well-being measurement tool for use in schools.

## The Ministry of Education does not know how many students access guidance counselling services or how effective these are

3.38 The Ministry of Education acknowledges the many positive benefits from having mental health support in schools. Benefits include reduced mental distress, improved engagement and retention, increased student achievement, and reduced suicide risk.[41]

3.39 The Ministry of Education funds guidance counsellors in secondary schools through a "guidance staffing" entitlement calculated by roll size. The Ministry told us it spends about $95 million annually on guidance entitlement staff funding.[42] Guidance counsellors employed using this staffing entitlement must be registered teachers. They usually also have a post-graduate qualification in counselling.

3.40 The Ministry of Education does not require schools to report on how they spent the guidance entitlement. The Ministry also does not set guidelines or standards for how many guidance counsellors schools should employ.

3.41 The ratio of counsellors to students appears to vary widely between schools, from 1:167 for a secondary school in the central North Island to 1:1150 for one large inner-city Auckland school.

3.42 Although the Ministry can tell from payroll data how many staff are employed through the guidance entitlement by region, it cannot tell how many services it is funding, if they are meeting students' needs, or whether schools are using guidance entitlement funding for its intended purpose.

3.43 The Ministry of Education has produced best practice guidance for schools on guidance counselling and pastoral care, *Te Pakiaka Tangata*.[43]

3.44 The Ministry's guidance in *Te Pakiaka Tangata* appears to reflect many of the characteristics of what young people want in mental health services, such as youth-friendly clinic spaces, youth input and participation, and the need for services to be culturally responsive. However, *Te Pakiaka Tangata* is guidance for schools and not mandatory.

3.45 The Education Review Office has previously expressed concern about the guidance counselling that is provided in schools. In a 2013 national review of guidance counselling, the Education Review Office described guidance counselling and

41 The Ministry of Education (2017), *Te Pakiaka Tangata: Strengthening Student Wellbeing for Success*, page 8.

42 Based on estimated funding for 2023/24, supplied to us by the Ministry of Education. Other school-based programmes funded by the Ministry of Education include the Counselling in Schools initiative, which funds counselling services in about 200 primary and intermediate schools.

43 Ministry of Education (2017), *Te Pakiaka Tangata – Strengthening Student Wellbeing for Success*.

pastoral care as "poor" in up to a third of secondary schools sampled, with some schools offering no counselling services.[44]

3.46 The New Zealand Association of Counsellors and the Ministry of Education co-commissioned a study that found most students who saw school guidance counsellors benefited from the service but that the students accessing counselling were mostly female and Pākehā.[45] The study was based on a sample of 16 secondary schools.

3.47 The Ministry of Education acknowledges that it lacks evidence on how accessible and effective the guidance counselling model is for Māori and Pacific students.

**Recommendation 3**

We recommend that the Ministry of Education ensure that sufficient data is collected to understand the effectiveness of the school guidance counselling model for all students.

## Te Whatu Ora has expanded its school-based health services, but less than half of schools are eligible

3.48 Te Whatu Ora funds nurse-led school-based health services in about 300 decile 1 to 5 secondary schools.[46] This covers about 35% of Year 9 to 13 students.[47] However, most secondary school students (about 65%) are enrolled in decile 6 to 10 schools, where this Te Whatu Ora-funded service is not available.

3.49 School-based health services are made up of four components:

- the Year 9 home, education/employment, eating, activities, drugs and alcohol, sexuality, suicide and depression, and safety screening assessments;
- individual clinic time with students;
- external referrals; and
- health promotion activities in schools.

3.50 The time nurses spend on each of these activities varies between schools. Te Whatu Ora told us that about one in nine visits to school nurses in 2022 were for mental health concerns.

44 Although the Education Review Office has not repeated this national review, issues concerning a school's provision of guidance counselling and pastoral care may be raised in its reporting on individual schools.

45 Manthei, R et al (2020), *Evaluating the Effectiveness of Counselling in Schools*, page 11.

46 From 2023, the decile system was discontinued and replaced by an Equity Index. Te Whatu Ora informed us it has not yet decided how it will align school-based health service funding to the Equity Index.

47 Before the 2022 health reforms, school-based health services were funded by a combination of direct Ministry of Health funding and devolved funding to district health boards. School-based health services received $19.6 million of new funding from the 2019 Budget to cover decile 5 schools.

3.51 School nurses are expected to collect data from student screening assessments. However, school-based services are required to report only the percentage of assessments completed, not the data on student need that is identified through screening.

3.52 District health board control of school-based health services funding has led to a high level of regional variability in service delivery between eligible schools. The amount of funding per year for each student varied between regions. For example, in the Bay of Plenty it was $22 for each student and in Auckland it was $243 for each student. Nurse to student ratios between district health boards ranged from one nurse for every 400 students to one nurse for every 1500 students.

3.53 A youth health framework and self-review checklist is available to assist services to assess their responsiveness to students' needs in a range of domains, such as youth participation and youth-friendly clinic spaces. However, not all school-based health services have completed quality improvement plans based on this framework.[48]

3.54 Te Whatu Ora is aware of the funding, equity, and consistency issues with the school-based health service and are addressing these issues through an "enhancements programme".

3.55 This has involved working with the sector and a youth advisory group, Māngai Whakatipu, to refocus school-based health services and consider how well services meet the needs of priority groups such as Māori, Pacific, Rainbow, and disabled young people.

3.56 It has also included the co-design, with the youth sector and young people, of a new values-based framework, Te Ūkaipō. This will provide the basis for measuring and reporting school-based health service outcomes.[49]

3.57 However, we note that the current enhancements programme for school-based services applies only to schools eligible for the service. Most secondary school students are enrolled in schools that do not currently offer a Te Whatu Ora-funded school health service.

48 In 2017/18, only half of school-based health service providers submitted satisfactory quality improvement plans, as reported by district health boards.

49 Te Whatu Ora intended to begin training school-based health service staff in Te Ūkaipō from late 2023.

## Greater cross-agency collaboration is needed to improve the consistency and efficiency of services in secondary schools

3.58 Research on school-based integrated primary health care services shows that they are most effective when delivered by well-resourced, multi-disciplinary teams that are integrated into the school setting.[50]

3.59 The buy-in and support of school staff and leadership is important – for example, to ensure that there are suitable clinic spaces for services, to facilitate student referrals to services and access to appointments in class time, and to promote awareness of services among the student body.

3.60 The involvement of several government agencies in funding health and well-being services in secondary schools increases the need for them to collaborate. This is to ensure that their objectives are complementary and aligned and the risk of duplication or inefficiency is reduced.

3.61 A promising recent initiative that has seen several government agencies work together to deliver primary health and well-being services to primary- and intermediate-age students was Mana Ake, funded by Te Whatu Ora.

3.62 Mana Ake began with a pilot in Canterbury in 2018. It is being rolled out to seven other regions, including Hawke's Bay and Tairāwhiti following the 2023 floods. Mana Ake in Canterbury is overseen by a joint leadership team made up of senior representatives from the Ministry of Health, the Ministry of Education, Te Whatu Ora Canterbury Waitaha,[51] and local service providers.

3.63 An evaluation of Mana Ake in Canterbury described the critical factors in the programme's success as local co-design and effective cross-sector leadership that has made the most of existing networks.

3.64 The evaluators described the partnership approach taken by the Ministry of Health and the Ministry of Education as "enrich[ing] the thinking of both sectors", with Ministry of Education input "essential to develop a wellbeing initiative that worked in school settings" while "Health sector involvement brought expertise in wellbeing interventions".

3.65 In our view, Mana Ake is a good example of agencies working together towards a shared vision incorporating the principles of local co-design. This could provide useful insights for other agencies when collaborating on integrated primary health and well-being services in school-based settings.

50 Denny, S et al (2017), "Characteristics of school-based health services associated with students' mental health", *Journal of Health Services Research & Policy*, 0(0), pages 1-8.

51 Before the district health boards were disestablished in 2022, senior representatives from Canterbury District Health Board were part of the joint leadership team.

**Recommendation 4**

We recommend that Te Whatu Ora and the Ministry of Education work with other agencies as relevant to better align the objectives and operations of their school-based health and well-being services.

## Primary mental health support is now available to more young New Zealanders

3.66 Youth Access and Choice is one of four new service streams offered under the Access and Choice primary mental health and addiction initiative. Access and Choice aims to expand the range and choice of mental health support available for young people aged 12-24 years in primary care settings, addressing a key recommendation of *He Ara Oranga* to increase support options for people with mild to moderate mental health needs. Other Access and Choice service streams are the all-ages GP-based Integrated Primary Mental Health Service, the Kaupapa Māori service stream, and the Pacific service stream.[52]

### Youth Access and Choice services has increased the range of primary mental health support available to young people

3.67 Youth Access and Choice aims to offer immediate, barrier-free, and accessible support to young people aged 12-24 years who are experiencing mild to moderate mental health concerns. Services that are part of Youth Access and Choice must offer a range of support options that are tailored to young people and their whānau and facilitate the transition to other services when required.

3.68 Te Whatu Ora told us that as of mid-2023, 22 Youth Access and Choice services were contracted and operational across all 20 former district health board districts. In October 2023, these services were providing around 5,200 individual or group sessions to 2,900 young people each month.

3.69 Te Whatu Ora expects that full roll-out of all Access and Choice services will be complete by June 2024. From June 2025, the end of the first full year of service delivery, Te Whatu Ora expects that 325,000 New Zealanders will have access to the new primary mental health and addiction services each year.

3.70 Youth Access and Choice funding has been used to establish new services and expand existing services. New services funded through Youth Access and Choice include He Kakano Ahau, a Northland-wide service delivered by local providers using the Te Ūkaipo framework that was prepared for school-based health services.

52 Initially commissioned by the Ministry of Health, Access and Choice services are now contracted and funded by Te Whatu Ora.

3.71 Existing services include Ease Up in Auckland, Waitematā, and South Waikato. Ease Up is a mobile youth primary mental health and addiction service delivered in partnership by a mix of mental health clinicians and peer support workers.

## The Youth Access and Choice service meets many young peoples' service needs

3.72 The service specification for Youth Access and Choice reflects many of the themes of young peoples' feedback on what they want from mental health services.

3.73 Youth Access and Choice services use a range of innovative approaches to make their services attractive and accessible to young people. These include clinics in schools and accessible community locations, mobile services that travel to where young people are, and online or face-to-face options for engaging with mental health practitioners.

3.74 Youth Access and Choice services appear to be well integrated into local communities and can adapt to local needs. They also seem to be successful at attracting young Māori and young Pacific people as clients. Recent data shows that rangatahi Māori made up 33% of those using Youth Access and Choice services, while young Pacific people made up 11%.[53]

3.75 Some Youth Access and Choice contracts are held by Māori providers. Others cater specifically to the needs of rangatahi Māori by, for example, using a whānau ora approach. In addition, some Kaupapa Māori Access and Choice stream services have a specific focus on rangatahi, such as a Heretaunga (Hastings) service that connects with rangatahi through outdoor activities such as surfing and diving for kai moana.

3.76 Many Youth Access and Choice services demonstrate a strong commitment to youth voice and participation by, for example, embedding youth advisory groups into their governance structures. A recent evaluation of Youth Access and Choice has found the new services "champion" youth voice in service design and delivery and that young people accessing the services felt empowered to choose how, when, and where to access support.

3.77 Although the importance of youth voice and participation has been a major theme in young peoples' feedback during government consultation on the development of Youth Access and Choice, it is not a mandatory part of the Youth

53 Based on the average percentage of Youth Access and Choice clients of Māori and Pacific ethnicity, 1/11/2022 to 31/10/2023.

Access and Choice service specification.[54] Te Whatu Ora told us that it plans to strengthen the emphasis on youth involvement in future contract variations for Youth Access and Choice.

3.78 Te Whatu Ora also told us it has developed a youth-specific outcomes tool for Youth Access and Choice, which it is currently trialling with a small group of providers. In the future, collecting outcomes data will be required of all Youth Access and Choice providers.

## Youth Access and Choice has added to the complexity of the service landscape for young people

3.79 Youth Access and Choice services are part of a complex landscape of youth primary mental health and addiction services for young people.[55] This includes primary and specialist services established by the former district health boards and delivered by primary health organisations and NGOs, as well as school-based health services.

3.80 In many cases, Youth Access and Choice contracts have been in addition to one or more existing contracts with existing providers of youth mental health or related services. This approach likely helped roll out much-needed support to young people more rapidly, as it allowed Youth Access and Choice to build on existing provider relationships and infrastructure.

3.81 However, the roll-out of Youth Access and Choice has added to the administrative burden on providers and made the service landscape more complex. This complexity can be a barrier for potential referrers or for young people wanting to access a service because it can make it harder to find out what support is available in their area.

3.82 Health agencies told us they see the centralisation of service commissioning under the health reforms as an opportunity to consolidate similar youth primary mental health contracts. Doing so would reduce duplication and the demands on community providers by streamlining the number of contracts they are required to report against. We support this.

3.83 Overall, we saw that Access and Choice services are beginning to make a significant difference by making youth-appropriate primary mental health support more available to young people across New Zealand.

54 The Ministry of Health did not carry out specific engagement with young people as part of the development of Youth Access and Choice. It instead included a specific question about young peoples' preferences for mental health services as part of an existing consultation with young people that the then Ministry of Youth Development was carrying out for its Youth Plan in 2019.

55 These include youth primary mental health services established as part of the Prime Minister's Youth Mental Health Project 2012-2017, and those resulting from specific district health board or primary health organisation initiatives.

3.84 The 2023 evaluation of the Youth Access and Choice service has found that the new service is generating good value for money by investing in early intervention supports for young people and that services are highly valued by young people and their whānau.

3.85 Overall, young people aged 12-24 years make up about 21% of people using Access and Choice services. Because young people make up about 17% of the population, this means that young people are over-represented among those accessing Access and Choice services.[56]

## More work is needed to address capacity constraints in specialist child and adolescent mental health services

3.86 Infant, Child, and Adolescent Mental Health services (ICAMHS) provide specialist services to children and young people aged 0-17 years with moderate to severe mental health concerns. Specialist mental health services for young people aged 18 and older are provided through adult specialist mental health services. Te Whatu Ora ICAMHS for people aged 0-17 years are available in New Zealand's main centres and in many regional centres.

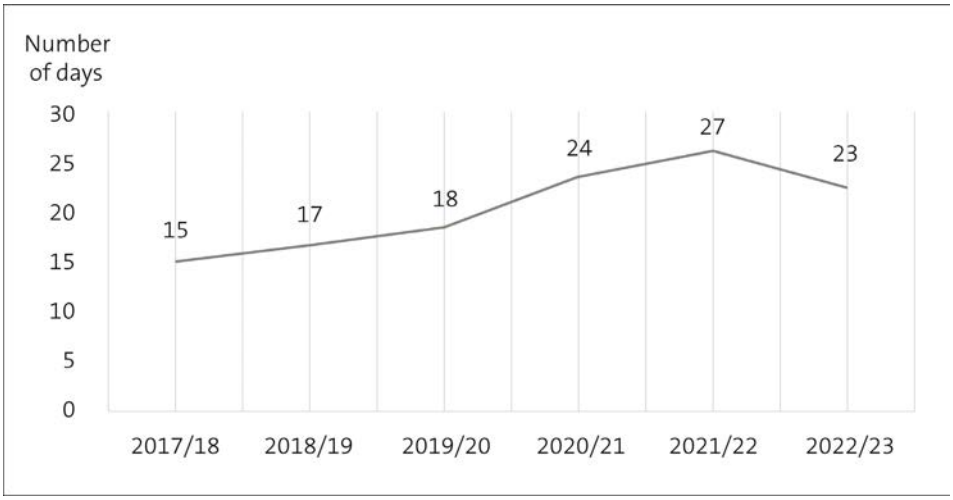
3.87 Although *He Ara Oranga* called on the Government to address the needs of New Zealanders with mild to moderate mental health concerns, it also told the Government that it must continue to prioritise access to services "for people with the more severe needs".

3.88 In particular, *He Ara Oranga* called on the Government to act with urgency to reduce waiting times for specialist child and adolescent mental health services. *He Ara Oranga* described increasing demand faced by such services as a "tidal wave of increased referrals".

56 Te Hiringa Mahara Mental Health and Wellbeing Commission (2022), *Access and Choice programme report: Improving access and choice for youth*, pages 5-6.

3.89 However, young people today are waiting longer to access specialist mental health services than they were when *He Ara Oranga* was published in 2018 (see Figure 3).

**Figure 3**
**Average number of days 12-19 year-olds spend waiting, after referral, for their first appointment with a district health board specialist mental health service**




Source: Data provided by Te Whatu Ora.

3.90 ICAMHS prioritise the care of children and young people who are clinically assessed as having acute or urgent care needs. Health agencies have provided us data that shows ICAMHS are continuing to provide timely care to young people in need of acute care, despite young people in this category increasing from 30% in 2015 to 36% in 2023.

3.91 However, the Ministry of Health told us that ongoing demand and capacity pressures have led to a raising of eligibility thresholds in many ICAMHS. This means that the level of urgency or severity of mental health need required to have an ICAMHS referral accepted might be higher than in the past.

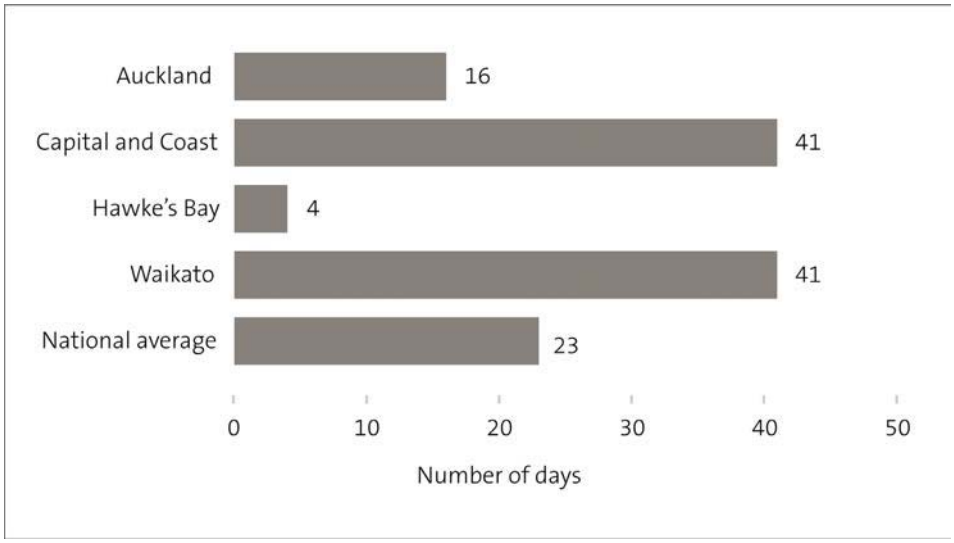
3.92 Clinicians told us that young people not in need of urgent care can have severe overall needs due to the levels of distress they experience. This distress can affect their ability to function and participate in education and everyday life.

3.93 ICAMHS are expected to meet government wait-time measures for non-urgent referrals (80% of patients are seen within three weeks of referral and 95% are seen within eight weeks).[57] Unlike equivalent adult specialist services, ICAMHS do not meet these measures. In 2023, 63% of young people aged 19 and under were seen within three weeks of referral, and 85% were seen within eight weeks.

57 Waiting times are calculated as the percentage of people who are referred to and seen by a specialist mental health service, having not been seen for at least a year, counted from the time the referral is received to the first appointment with a mental health professional.

3.94 There is also considerable variation in how long young people wait to access ICAMHS in different regions. For example, in 2022/23 young people in Hawke's Bay waited four days on average for their first appointment with an ICAMHS clinician. By contrast, in the former Capital and Coast and Waikato District Health Board areas, the average waiting time was almost six weeks (see Figure 4).[58]

**Figure 4**
**Regional variations in average days 12-19 year-olds spent waiting for a district health board specialist mental health service in 2022/23**




Source: Data provided by Te Whatu Ora.

3.95 Long waiting times are a barrier to accessing mental health services. Research has linked long waiting times to a reduced likelihood of accessing mental health support, lower engagement and satisfaction with services, poorer outcomes, and inequitable service access because some people have a greater ability to "work the system".[59]

58 Based on 2022/23 data provided by Te Whatu Ora on the average time a 12- to 19-year-old waited from referral to first appointment with an ICAMHS.

59 Te Pou (2022), *Wait time measures for mental health and addiction services: Key performance indicator literature review*, pages 10-11.

3.96 Services with long waiting times can take steps to improve young peoples' experience of care by offering interim support or treatment options for people waiting to be seen by a specialist.[60] Some ICAMHS we spoke to provided examples of the support they provide to young people on waiting lists, such as regular phone-check ins or employing NGO providers to support young people on the waiting list. However, we heard that such supports are not universal across ICAMHS.

3.97 Specialist waiting times are not a reliable indicator of young peoples' overall need for specialist services due to the barriers many young people experience to accessing mental health support. Knowing that waiting lists are long can pose a barrier to referral. We heard that some GPs and schools are reluctant to refer young people to ICAMHS because of the long wait times.

3.98 Not all ICAMHS referrals are accepted. Te Whatu Ora provided us with data showing that the likelihood of a young person's referral to ICAMHS being accepted has declined – the proportion of declined referrals increased from 9% in 2012/13 to 14% in 2022/23.

## Funding for child and adolescent specialist services has not kept pace with demand

3.99 Although funding for specialist services for children and adolescents has increased in the last decade, it has failed to keep pace with the increasing demand for services among younger age groups.

3.100 Documents provided to us by the Ministry of Health show that former district health board spending per year on specialist child and adolescent mental health services increased by 24% from 2011/12 to 2019/20, from $147.5 million to $182.3 million. Over the same period, the number of children and young people accessing ICAMHS increased by 30%.

60 Te Pou (2022), *Wait time measures for mental health and addiction services: Key performance indicator literature review*, pages 12-13.

## ICAMHS are seeking to improve efficiency and reduce waiting times for young people

3.101 In recent years, many ICAMHS have adopted a United Kingdom model, Choice and Partnership, to manage demand and capacity and eliminate waiting lists for children and young people using specialist services.[61]

3.102 Choice and Partnership aims to streamline access to services by offering all children and young people and their families/whānau a timely "choice" appointment on referral. The clinician works with the young person and their whānau to agree on treatment goals. The clinician then presents "partnership options" based on those goals. Options include self-help strategies, referrals to other services, or staying with the specialist service.

3.103 Young people who choose to remain with the ICAMHS are booked in for a full series of "partnership" appointments for treatment or therapy. There is an emphasis on "letting go" (early discharge) after the support needs of the young person and their whānau are met.

3.104 Evaluations of Choice and Partnership suggest that it is likely to achieve its objective of eliminating waiting lists only if the model is fully implemented. Whāraurau, the government workforce centre for infant, child, and adolescent mental health, offers support and guidance for ICAMHS implementing Choice and Partnership.

3.105 However, we heard that many ICAMHS only partially implement the Choice and Partnership model. Part of the reason could be because fully implementing the model depends on external system factors, which individual ICAMHS have limited control over.

3.106 For example, fully implementing the Choice and Partnership model relies on referral or early discharge of some patients to other, typically primary-level, services. However, this can occur only if appropriate primary services exist and have capacity to take referrals. Clinicians told us they often struggled to find a suitable provider to discharge young people to, due to a lack of available services or frequent changes in NGO contracts.

3.107 A known risk associated with Choice and Partnership is that even if they receive a timely initial assessment, young people might wait for a long time for subsequent appointments (shifting the wait from before the first appointment to between the first and subsequent appointments).[62] This can occur when services lack the capacity to meet demand and when clinicians are unable to discharge their patients to another service.

61 By 2013, 16 of New Zealand's 20 ICAMHS were reported to be using Choice and Partnership in some form. Choice and Partnership has also been adapted for use in Kaupapa Māori ICAMHS teams.

62 We note that this risk of internal wait lists developing is not unique to Choice and Partnership but is also a feature of traditional approaches to managing ICAMHS service capacity.

3.108 We asked Te Whatu Ora for data on the waiting times for first, second, and third appointments with ICAMHS because young people usually begin treatment at the third appointment (see Figure 5). The data shows that in 2022/23, a young person aged 12-19 years waited on average over 60 days (9 weeks) from the time of first referral until starting treatment.

**Figure 5**
**Average number of days waiting for first, second, and third appointments for 12-19 year-olds referred to district health board specialist mental health services**

| Year | Average wait time for first appointment (days) | Average wait time for second appointment (days) | Average wait time for third appointment (days) | Total average wait time (days) |
|---|---|---|---|---|
| **2017/18** | 15 | 20 | 17 | 52 |
| **2018/19** | 17 | 20 | 18 | 54 |
| **2019/20** | 18 | 21 | 19 | 58 |
| **2020/21** | 24 | 24 | 22 | 69 |
| **2021/22** | 27 | 27 | 23 | 77 |
| **2022/23** | 23 | 24 | 21 | 64 |

Source: Data provided by Te Whatu Ora.

3.109 When more young people presenting to an ICAMHS have acute needs, it can also affect the ability of ICAMHS to follow Choice and Partnership. The need to urgently see young people in crisis might lead to partnership appointments being delayed (see paragraph 3.103).

3.110 Documents we reviewed indicate that health agencies recognise the pressures facing ICAMHS to be primarily a problem of resourcing, rather than efficiency.

3.111 In a 2022 briefing to the then Prime Minister, Ministry of Health officials expressed their view that "the ICAMHS sector is delivering the best it can within current resourcing and circumstances, while also maintaining quality improvement efforts".

## Capacity pressures within ICAMHS have flow-on effects for primary services

3.112 The previous Government expected that its investment in primary-level services will reduce demand on specialist mental health services in the long term.

3.113 It is too early to say how Government investment in primary services might affect specialist services in the long term. However, in the shorter term, we observed that capacity constraints in child and adolescent specialist services were having an effect on the ability of primary services (including some of the new Access and Choice services) to meet the needs of young people.

3.114 Youth One Stop Shops told us that an increasing proportion of the young people they see are either on waiting lists for specialist services or have had a referral declined. Young people in this category generally have more severe needs and might require longer and more intensive treatment, which Youth One Stop Shops are not resourced for.

3.115 Similarly, some Youth Access and Choice services report that high levels of demand from young people who cannot access specialist services are affecting their ability to provide timely accessible care to all young people who seek help. Some Youth Access and Choice services have introduced waiting lists.

3.116 We heard that when primary-level mental health services receive large volumes of referrals of young people with a high level of need, it can threaten their scope as a primary-level service offering immediate access to brief interventions for young people with mild to moderate needs.

## Not all young people can access age- or culturally appropriate specialist mental health services

3.117 Eligibility for ICAMHS is currently restricted to people aged 17 and under. There is some flexibility to extend this upper age limit on a case-by-case basis.

3.118 Many young people accessing ICAMHS will not require ongoing treatment after their discharge from child and adolescent specialist services. Those who do must, in most cases, transfer to adult specialist mental health services from age 18.

3.119 Young people accessing ICAMHS receive care and treatment suited to their life stage and developmental needs. In adult specialist mental health services, young people might be expected to fit into models of care designed for older adults.

3.120 Many young people accessing ICAMHS find the transition to adult mental health services difficult, particularly the contrast in culture and practices from child and adolescent services.

3.121 Young people who described this transition to Te Hiringa Mahara Mental Health and Wellbeing Commission contrasted the more holistic, strengths-based approaches of ICAMHS with the overly diagnostic or medical-based model of adult mental health services that often offered few or no treatment options tailored to their needs as a young person.[63]

3.122 We heard that the requirement to transfer from child/adolescent to adult mental health services at age 18 takes place when young people are usually experiencing other major life changes, such as leaving school, or starting employment or further study, and is a key factor in young people being "lost" to services.

3.123 Health agencies acknowledge that adult mental health services might not be appropriate to the developmental and life-stage needs of young people, and that the transition to adult services is often challenging for young people and their whānau.

3.124 Te Whatu Ora intend to raise the age limit for child and adolescent mental health services to 24 years, with the ability to transfer to adult services voluntarily from age 20. However, Te Whatu Ora has not yet set a timeline for this change.

3.125 Options for Māori and Pacific young people to access a culturally specific ICAMHS are limited. Only some ICAMHS offer separate kaupapa Māori teams or services. We are aware of only one ICAMHS team catering specifically to the needs of Pacific young people. Most Māori and Pacific young people access "mainstream" ICAMHS.

3.126 Te Whatu Ora recognises that current investment in Māori ICAMHS is low in three of its four regions, and that there is a need to expand these services into more regions.

## More work is needed to embed youth voice and participation into ICAMHS

3.127 *Kia Manawanui* highlights the importance of including the input of people with lived experience of mental health services into the planning, commissioning, delivery, and ongoing monitoring of mental health services.

3.128 Our conversations with those working in the mental health sector suggest that there is still a considerable way to go in embedding meaningful youth voice and participation into ICAMHS.

3.129 Some ICAMHS employ youth consumer advisors to represent young people who are current service users. However, not all ICAMHS have youth consumer advisor roles. In other services, the position is established but the role is not filled.

3.130 The experiences of youth consumer advisors varies between ICAMHS. Some youth consumer advisors we spoke to feel that their role is valued and that they can make a genuine difference. However, most stated they do not always feel

63 Te Hiringa Mahara Mental Health and Wellbeing Commission (2023), *Youth Services focus report: Admission of young people to adult inpatient mental health services*, pages 12-14.

that their roles are valued by clinicians or leadership. Some saw youth consumer advisor roles as tokenistic.

3.131 A common complaint of youth consumer advisors is being expected to provide meaningful input in extremely short time frames. This can make it difficult for them to consult with young people about a particular issue or decision. Many are employed for limited hours, such as one day a week, and this can also limit their influence on services.

**Recommendation 5**

We recommend that Te Whatu Ora, the Ministry of Education, Oranga Tamariki, and the Department of Corrections consider whether appropriate mechanisms for youth voice and participation are built into the design, delivery, and governance of new and existing mental health and well-being services for young people.

## Improvement is needed in the way specialist services measure outcomes for young people

3.132 Te Whatu Ora collects comprehensive service use data for specialist mental health services, including ICAMHS, through its PRIMHD[64] dataset.

3.133 The PRIMHD dataset incorporates data on patient outcomes, which is completed by clinicians using a United Kingdom-developed mental health outcomes tool called the Health of the Nation Outcomes Scale, and the Alcohol and Other Drug Outcome Measure for adult community addiction services. A child- and youth-specific outcomes tool, Health of the Nation Outcomes Scale Child and Adolescent, is available.

3.134 In our 2017 report on mental health services, we found that low completion rates for Health of the Nation Outcomes Scale (including Child and Adolescent) reduced the reliability of outcomes data for specialist mental health services. Low completion rates remain a significant issue with the child and adolescent outcomes data.[65] This was confirmed by our conversations with people in the sector.

3.135 We also note that Health of the Nation Outcomes Scale Child and Adolescent is a clinician-completed outcomes scale, which means it does not incorporate the voices of young people and whānau accessing services. This is a significant omission, as young peoples' perspectives on how well a service met their needs might differ from those of the clinician delivering the service.

64 Programme for the Integration of Mental Health Data. This includes government services and those provided by NGOs.

65 In the first quarter of 2023, only about 30% of 4-17 year-olds had outcomes data collected on admission to, and discharge from, community specialist mental health services, compared to a target of 80%. See Te Pou (2023), *PRIMHD summary report – HoNOSCA: Health of the Nation Outcomes Scales – child and youth report for New Zealand*, page 21.

**Recommendation 6**

We recommend that Te Whatu Ora, the Ministry of Education, Oranga Tamariki, and the Department of Corrections ensure that outcomes data is collected for all mental health and well-being services accessed by young people.

## Capacity constraints within specialist services limit the ability of specialist clinicians to support the rest of the system

3.136 Although specialist services such as ICAMHS are focused on people with a severe level of mental health need, they also support primary-level and front-line services.

3.137 Community outreach services are an important and established part of specialist mental health services. Their aim is to ensure that professionals in community settings (such as general practitioners and guidance counsellors) and other primary settings can readily access specialist support and advice as needed.

3.138 Community outreach services can take a range of forms, including training sessions for primary-level professionals (such as guidance counsellors) or co-locating specialist clinicians in primary services.

3.139 During our audit, we saw an example of community outreach in the close working relationship between Kāpiti Youth Support (a Youth One Stop Shop) and the local ICAMHS. These two services shared the care of some clients, had fortnightly joint assessments with Youth One Stop Shop staff and an ICAMHS psychiatrist, and ICAMHS clinicians provided professional supervision to Youth One Stop Shop staff.

3.140 Strong community outreach from specialist services has several benefits. Closer working relationships between primary- and specialist-level clinicians can help build the capability of staff in primary services and mutual understanding of each other's relative roles and expertise. It can reduce inappropriate referrals to specialist services and increase the confidence of specialist clinicians to transfer or discharge patients to primary-level services.

3.141 Close working relationships between primary- and specialist-level services can prevent the need for some young people to transition between services. Young people can stay with a primary-level service while benefiting from specialist-level care, as needed.

3.142 Although specialist clinicians recognised the value of community outreach, many told us that their heavy caseloads mean that they often could not spare time for non-clinical work. We heard that as capacity pressures have increased, some ICAMHS have been less likely to engage in community outreach activities than in the past.

# Working together to meet the needs of at-risk groups of young people

4

4.1 Effective communication and collaboration between government agencies is important for providing mental health services and support to all young people. This is particularly critical for at-risk groups of young people because they are more likely than other young people to have a range of health and social needs.[66]

4.2 In this Part, we discuss how well government agencies are working together to understand and meet the needs of three groups of young people who experience a greater risk of mental health concerns.

4.3 These three at-risk groups of young people are:

- young people in care;
- young people not in education, employment, or training; and
- young people in prison.[67]

4.4 We expected agencies to:

- clearly understand their own and others' respective roles and responsibilities in relation to the mental health and well-being needs of at-risk groups of young people; and
- communicate clearly, share information, and work together in a co-ordinated way to ensure that the multiple, holistic needs of at-risk groups of young people are met.

## Summary of findings

4.5 Young people in care, not in education, employment, or training, or in prison are all at significant risk of experiencing mental health issues. However, the agencies involved in supporting them might have little understanding of their mental health needs or barriers to accessing mental health care.

4.6 In our view, there is a lack of clear and integrated care pathways through the mental health system for at-risk groups of young people to access mental health support. Without these pathways, some of our most at-risk young people could miss out on the support they need to address their mental health needs.

66 See New Zealand Productivity Commission (2015), *More effective social services*, page 2.

67 We note that there is a high degree of overlap between the three at-risk groups discussed in this Part.

## Cross-agency support is needed for young people in care

4.7 Young people in care or who have been involved with Oranga Tamariki are at high risk of experiencing mental health issues. Compared with other young people, those who have been involved with Oranga Tamariki are more than twice as likely to report symptoms of depression and more than four times as likely to have attempted suicide in the past year.[68]

4.8 Māori, Pacific, disabled, and Rainbow young people are over-represented in the numbers of young people with past or current Oranga Tamariki involvement and young people in care.[69]

### Oranga Tamariki does not know whether it meets the mental health needs of young people in its care

4.9 Oranga Tamariki is required to assess, and take all reasonable steps to meet, the health and mental health needs of the children and young people in its care.[70]

4.10 Oranga Tamariki is aware that young people involved with Oranga Tamariki are disproportionately at risk of developing mental health concerns. In a recent needs assessment, Oranga Tamariki acknowledges that such young people "often have high mental health and wellbeing support needs, including depression and suicidal ideation, anxiety, mood disorders and substance use".

4.11 Although information on the mental health needs of young people in care might be recorded in individual client casefiles, this information is not available to Oranga Tamariki at a system level through its national client management system.

4.12 The Independent Children's Monitor has a statutory role to monitor Oranga Tamariki's performance. Recently, the Independent Children's Monitor found that Oranga Tamariki does not collect enough data to know whether it meets its obligations to assess and meet the mental health needs of children and young people in its care.[71]

4.13 Oranga Tamariki uses several general screening tools to assess the needs of children and young people in its care, including:

- **Tuituia**, a needs assessment across multiple domains of well-being; and

68 Fleming, T et al (2022), *Young people who have been involved with Oranga Tamariki: Mental and physical health and healthcare access*, page 4.

69 See Oranga Tamariki (2023), *Mental health and wellbeing needs of children and young people involved with Oranga Tamariki: In-depth assessment*, pages 3-4, Oranga Tamariki (2020), *Children and young people with impairments*, page 8, and New Zealand Government (2022), *Oranga Tamariki Action Plan*, page 10.

70 Oranga Tamariki (National Care Standards and Related Matters) Regulations 2018, section 35.

71 Independent Children's Monitor (2023), *Experiences of Care in Aotearoa: Agency Compliance with the National Care Standards and Related Matters Regulations*, pages 12-13.

- the **Gateway Assessment**, an interagency health and education needs assessment carried out when young people enter into care.

4.14 Oranga Tamariki informed us that the Gateway Assessment is under review and that it plans to discontinue Tuituia and introduce a new holistic needs assessment tool in its place.

4.15 Although Oranga Tamariki is required to assess the health needs of children and young people in its care (see paragraph 4.9), specific screening tools for mental health or alcohol and drugs are rarely used. Often these tools are used only when a young person is in crisis or has previously been diagnosed with a mental health condition. Oranga Tamariki's 2021/22 review of 756 casefiles found that only 21 children and young people had been specifically screened for mental health, substance use, and suicide risk, while a further 18 had received suicide risk screening only.[72]

4.16 Some Oranga Tamariki staff and young people with lived experience of the care system consider that mental health screening and support should be universal for children and young people in care. This is because of the high levels of trauma these children and young people are likely to have experienced.

4.17 However, improved screening for mental health conditions among young people in care and at-risk groups is only likely to be beneficial if it is followed by timely access to appropriate services. Without clear care pathways, young people might have expectations for support that are not met.

## Young people in care are often unable to get the mental health support they need

4.18 Oranga Tamariki social workers receive basic mental health training but might lack the specialist knowledge of mental health and trauma to cope with the level of mental health need experienced by young people involved with Oranga Tamariki.

4.19 Oranga Tamariki provides a mixture of in-house and contracted services to support the mental health needs of children and young people involved with Oranga Tamariki.

4.20 Towards Wellbeing, one of the contracted services, provides social workers with clinical advice on suicide risk. Oranga Tamariki told us that about 600 tamariki and young people nationally are monitored under Towards Wellbeing each year.

72 Independent Children's Monitor (2022), *Experiences of Care in Aotearoa: Agency Compliance with the National Care Standards and Related Matters Regulations*, pages 84-85. Oranga Tamariki has excluded questions about the use of specific mental health screening tools from its 2022/23 casefile review as it lacks data on how many young people have mental health needs that would warrant such screening.

4.21 The in-house specialist clinical services in Oranga Tamariki are tailored to the specific mental health needs of young people in care, who have often experienced trauma. Oranga Tamariki told us that this service is available in 11 of 12 Oranga Tamariki regions. However, the agency described its in-house services to us as severely over-subscribed and unable to keep up with high demand.[73]

4.22 Where appropriate, Oranga Tamariki refers children and young people to Te Whatu Ora mental health services. However, Oranga Tamariki staff told us that they often struggled to get referrals of children and young people accepted by ICAMHS.

4.23 When young people in Oranga Tamariki care cannot access timely support from publicly funded services, the agency might purchase private services. However, the private services it uses often have waiting lists. Oranga Tamariki told us that it spent about $2.4 million on private mental health services in 2021/22.[74]

4.24 Children and young people in care could change care placement multiple times. On average, children and young people in care will have four caregivers over the course of their time in care. Some will have many more.

4.25 We heard that meeting the mental health needs of young people in unstable or unsuitable living situations is often a source of tension between health agencies and Oranga Tamariki. ICAMHS staff told us that Oranga Tamariki is responsible for ensuring that young people in its care have a stable placement. ICAMHS staff also told us that the therapies they provide are only effective if young people have stable relationships with whānau or caregivers.

4.26 However, underlying mental health or substance-use concerns can be a factor in why young peoples' placements break down in the first place.

4.27 We heard that, in some regions, Oranga Tamariki's care and protection residences house young people with a severe level of mental health need who might require specialist support that staff in residences do not have the experience or training to provide.

4.28 In some regions, Oranga Tamariki and ICAMHS have established ways of working together to meet the specific needs of children and young people in care. There is, for example, a dedicated Children in Care Team working in the Canterbury ICAMHS service.

4.29 However, these types of arrangements appear to vary throughout the country. Health services do not have access to Oranga Tamariki data and therefore cannot

73 Although the focus of this section is Oranga Tamariki care and protection services, we note that Oranga Tamariki also works with Te Whatu Ora youth forensic teams and in-house staff to provide mental health support to young people in the custody of its youth justice residences.

74 This figure excludes Oranga Tamariki's expenditure on private services in related areas such as mentoring.

routinely identify if young people are in care unless this information is shared by the young person being treated.

4.30 In addition, health records might not be accessible if a young person changes locations, which disproportionately affects young people in care who could have frequent changes in placement and caregiver.

## Government agencies recognise improved co-ordination between agencies is needed to meet the needs of young people in care

4.31 Health agencies and Oranga Tamariki recognise the need for greater cross-agency collaboration to meet the mental health and well-being needs of young people in care. They described to us a range of joint initiatives they are carrying out to improve the mental health and well-being of children and young people involved with Oranga Tamariki.

4.32 These include joint actions under the *Child and Youth Wellbeing Strategy* and the 2022 Oranga Tamariki Action Plan. The 2022 Oranga Tamariki Action Plan is a joint plan by children's agencies[75] to ensure that the holistic well-being needs of children and young people in "core populations of interest" to Oranga Tamariki are met.[76]

4.33 Specific cross-agency initiatives include:

- the 2023 publication of a specific needs assessment on the mental health needs of children and young people in care;
- the establishment of a cross-agency data and insights group to improve data sharing between Oranga Tamariki and health agencies; and
- "ring-fenced" 2022 Budget funding for ICAMHS focused on meeting the needs of young people with mental health concerns who are under the care of Oranga Tamariki.[77]

4.34 The health agencies and Oranga Tamariki also plan to review the specialist mental health support available to children and young people involved with Oranga Tamariki. This is to better understand barriers to mental health care for this group and why agencies "are not reliably connecting around individual children and young people", with the aim of developing a new integrated service model to meet the needs of this group.[78]

75 The children's agencies are Oranga Tamariki, New Zealand Police, the Ministry of Education, the Ministry of Social Development, the Ministry of Justice, and the Ministry of Health.

76 The "core populations" of interest to Oranga Tamariki are defined in the Children's Act 2014, section 5. They are children and young people with past or current involvement with care and protection and youth justice systems, or those at risk of becoming involved with these systems.

77 To date, this funding has been used to employ ICAMHS clinicians to work with young people in care in the Te Whatu Ora Southern District and in the Oranga Tamariki Care & Protection residence at Epuni.

78 Oranga Tamariki (2023), *Prioritising mental health and wellbeing needs of children and young people involved with Oranga Tamariki: Cross-agency plan for implementation*, page 4.

4.35 This acknowledgement from health agencies and Oranga Tamariki that the existing approach is not working well for many young people in care is important.

4.36 We support the commitment of health agencies and Oranga Tamariki to work together to improve the pathways for young people in care to receive mental health support. We will look to see if prioritisation of this work continues when we review how agencies have responded to our report.

## Agencies need to work together better to assist young people into study or work

4.37 Young people who are not in education, employment, or training are at high risk of experiencing mental health concerns. A recent New Zealand study found that 70% of these young people had experienced "significant depressive symptoms" over the past 12 months, and almost one in three (29%) had attempted suicide in the past year.[79]

4.38 At the end of 2022, 11% of young New Zealanders aged 15 to 24 years were not in education, employment, or training.[80] Māori, Pacific, and disabled young people are over-represented in this group; almost 20% of rangatahi Māori and almost 17% of young Pacific people are not in education, employment, or training. About a third of disabled young people are not in education, employment, or training.[81]

4.39 No government agency specifically collects data on the mental health needs of young people who are not in education, employment, or training.

### Several government agencies offer services for young people who are not in education, employment, or training or are at risk of becoming so

4.40 The Ministry of Education and the Ministry of Social Development both fund or provide services for young people who are not in education, employment, or training or are at risk of becoming so.

4.41 None of these services are mental health services. However, a high proportion of young people who use these services experience mental health concerns. For many of these young people, their underlying mental health concerns could be a contributing factor to why they are not in education, training, or work.

79 Clark, T et al (2022), *Youth19 Rangatahi Smart Survey: The Health and Wellbeing of Youth who are Not in Education, Employment or Training (Y-NEETs)*, page 3.

80 Ministry of Business, Innovation, and Employment (2022), "Monthly Labour Market Fact Sheet – December 2022", page 1, at mbie.govt.nz.

81 Office of Disability Issues (2022), "Labour Market Statistics as at the June 2022 quarter", at odi.govt.nz.

4.42 The success of government programmes aimed at assisting young people into study or employment is likely to have beneficial flow-on effects for a young person's mental health. This is because being in work or education is a strong protective factor for young peoples' well-being.

## There is no data on mental health as a factor in declining school attendance

4.43 Regular school attendance is strongly linked to students' mental health and well-being.[82] Mental health can be an underlying factor in non-attendance, and lower school attendance is linked to poorer mental health outcomes.

4.44 School attendance in New Zealand has been declining since 2015 and is significantly lower than comparable countries, such as Australia. From 2015 to 2023, the percentage of New Zealand students regularly attending school fell from just under 70% to 46%. Only a third of Māori and Pacific students attend school regularly.[83]

4.45 Recording and monitoring student attendance and ensuring that students attend school regularly is a responsibility of individual schools, with support from the Ministry of Education. Although it is not mandatory for schools to submit attendance data to the Ministry of Education, about 90% of schools do.

4.46 The Ministry of Education contracts providers to deliver a national attendance service to support students aged 6 to 16 years who are either not enrolled in or attending school to return to school.

4.47 The Ministry of Education requires providers of Attendance Services to understand and address the "underlying root causes of poor or non-attendance". However, it does not require providers to report back data on the reasons for students' poor attendance.

4.48 The Education Review Office considers increasing mental health issues to be a key factor in falling school attendance over the past decade.[84] Many submissions to a recent parliamentary inquiry into school attendance highlighted that mental health concerns are a significant contributor to student absences and that Covid-19 had exacerbated this problem for some students.

82 The Ministry of Education defines regular school attendance as students who have attended more than 90% of the term. For the links between attendance and student well-being, see Education Review Office (2022), *Missing Out: Why Aren't Our Children Going to School*, pages 10-11.

83 The Ministry of Education (2023), "Education Counts: Attendance", at educationcounts.govt.nz.

84 Education Review Office (2022), *Missing Out: Why Aren't Our Children Going to School?*, pages 19 and 35-39.

## Alternative Education services are a common intervention for young people disengaged from school

4.49 A common intervention for young people who are chronically absent from (or who are suspended, expelled, or excluded from) school is enrolment in Ministry of Education-funded Alternative Education services.

4.50 Alternative Education services offer an alternative learning option for people aged 13 to 16 who are disengaged or at risk of disengaging from school, with the aim of assisting them to return to school or into further study or work.

4.51 A recent New Zealand study of students in Alternative Education found that almost three-quarters reported clinically significant symptoms of depression.[85] The Education Review Office found that almost a third of students enrolled in Alternative Education had previously accessed specialist mental health services.[86]

4.52 Despite this high level of need, we heard that Alternative Education and Attendance providers can struggle to get students with mental health concerns the help they require from publicly funded mental health services.

## The Ministry of Social Development also offers services for young people who are not in education, employment, or training

4.53 The Ministry of Social Development provides and funds services for young people who are not in education, employment, or training or at risk of becoming so. These services are:

- Youth Services, which supports young people aged 16-17 who apply for certain youth benefits, and young people aged 15-17 who self-refer to a Youth Service provider for support or are identified through an automated referrals system to be in high need of support.[87]
- He Poutama Rangatahi, which supports young people aged 15-24 (with a focus on rangatahi Māori) who are risk of long-term unemployment.[88]

85 Clark, T et al (2023), *Youth19 Rangatahi Smart Survey: The Health and Wellbeing of Young People in Alternative Education*, page 3.

86 Education Review Office (2023), *An Alternative Education? Support for our most disengaged young people*, page 29.

87 The automatic referrals system matches data from Ministry of Education, Oranga Tamariki, and the Ministry of Social Development to identify young people at high risk of needing support. Such young people typically have a range of risk factors, including previous Oranga Tamariki involvement, a history of past education interventions (such as a stand-down or suspension or enrolment in Alternative Education), and mental health factors such as "severe anxiety" or "suicide ideation".

88 For a description of He Poutama Rangatahi and how it is improving outcomes for rangatahi Māori, see Controller and Auditor-General (2023), *Four initiatives supporting improved outcomes for Māori*, at oag.parliament.nz.

4.54 Although there is no specific data on the mental health needs of young people who are not in education, employment, or training, Ministry of Social Development staff told us that mental health was among the top issues in youth service providers' reporting.

4.55 Youth service providers told us that although most young people they see would benefit from specialised mental health care and treatment, the providers often struggled to find timely or appropriate mental health services for the young people they support.

### Improved co-ordination is required to meet the mental health needs of young people not in education, employment, or training

4.56 The interconnected nature of young peoples' mental health and well-being and their ability to participate in education or employment means that siloed approaches by government agencies are unlikely to work for at-risk groups of young people.

4.57 For example, a young person experiencing unresolved alcohol or drug concerns is unlikely to keep a job long-term, even if assisted into employment. The efforts of attendance services to help a student experiencing extreme social anxiety to return to school are less likely to succeed if no support is available for their underlying mental health concerns.

4.58 Receiving only part of the support needed increases the chances that at-risk young people will not benefit from services, making it more likely that they will experience negative outcomes or need more intensive and costly support later in life.

4.59 In our view, government agencies need to work more closely together to ensure that young people who are not in education, employment, or training (or at risk of becoming so) can access the mental health support and services they need to make a successful transition to school, study, or employment.

## Agencies need to work together better to support young people in prison

4.60 The Department of Corrections (Corrections) is aware that mental health concerns are extremely common among people in prison. Over 60% of prisoners have experienced a mental health condition in the past 12 months, and 91% of prisoners have experienced a mental health condition in their lifetime.[89]

4.61 Today, people aged under 25 years make up less than 10% of the adult prison population, with most of these in the 20 to 24 year age group.[90]

89 Indig, D et al (2016), *Comorbid substance use disorders and mental health disorders among New Zealand prisoners*.

90 Very few young people aged 19 and under are in adult prisons. In 2023, prisoners aged under 20 made up 1.3% of the prison population (115 individuals).

4.62 Corrections operates specialised youth units for young men aged under 20. Corrections told us that in 2023, its youth units could accommodate up to 32 people. This means that most young people in prison aged under 25 are housed in adult units.

## Screening is available for young people on entry to prison but might not detect all mental health concerns

4.63 Corrections told us that there are different points during a young person's stay in prison where potential mental health concerns could be detected.

4.64 When prisoners enter Corrections' custody, they undergo initial basic screening for mental health and substance use.[91]

4.65 Prisoners are not routinely re-screened for mental health concerns after the initial screening. However, they might be screened again if they are involved in an incident in prison or if their behaviour causes custodial staff to suspect they are experiencing mental health concerns.

4.66 Corrections is aware that the prison environment can create or exacerbate mental health concerns for prisoners after initial screening is complete.

4.67 Corrections told us that since 2021, 845 community corrections and custodial staff have completed "Mental Health 101" training to assist them in identifying signs of a potential mental health condition in prisoners.

## Young people in prison face barriers accessing mental health and substance use services

4.68 Corrections recognises that addressing prisoner mental health and addiction is critical to achieving its goals of reducing reoffending and equipping prisoners to re-enter the community.

4.69 New Zealand's rates of imprisonment are high compared to comparable countries overseas and many people released from prison will offend again. Almost 55% of people released from prison are re-convicted within two years, and over 35% are reimprisoned. Rates of re-offending and re-conviction are higher among younger prisoners.[92]

4.70 Corrections funds several mental health and substance use services for adult prisoners. The Improving Mental Health Service, a primary mental health service

91 Tools used are the Structured Dynamic Assessments, which collects data on prisoner need based on a range of protective and risk factors, and ASSIST, which focuses on prisoners' alcohol and drug use and its impact on their lives. Suicide risk for people starting community sentences is screened using the Columbia-Suicide Severity Rating Scale.

92 The Department of Corrections (2023), *Annual Report 2022/2023*, page 206.

provided by NGOs, is offered to remand and sentenced prisoners with a mild to moderate level of mental health need.[93]

4.71 For remand and sentenced prisoners with moderate to severe mental health needs, Corrections employs multi-disciplinary mental health teams at seven of the 17 sites it manages. Remand and sentenced prisoners at a further seven sites can access support from specialist mental health nurses.

4.72 Corrections offers 18 alcohol and other drug programmes at 14 sites. All but two of these programmes are restricted to sentenced prisoners. Corrections told us that brief alcohol and other drugs interventions have been available to remand and sentenced prisoners at two prison sites since 2023, and will be available at a further seven sites in 2024.

4.73 Corrections told us that for some prisoners, contact with mental health services in prison are the first time their underlying mental health or substance use concerns have been detected or treated.

## Mental health services provided by the Department of Corrections might not be youth- or culturally appropriate

4.74 Corrections' youth units offer age-appropriate programmes and support aimed at meeting the needs of young male prisoners. However, as previously noted, most young people aged under 25 are accommodated in adult units.

4.75 Corrections staff told us that its mental health services in adult units are designed with older adults in mind and might not be well suited for young prisoners. However, Corrections told us that its mental health practitioners "consider each individual's needs and preferences when engaging with them".

4.76 Although Corrections did not previously collect data on the age of people accessing its mental health services, all mental health staff employed or contracted by Corrections now have access to a new data reporting system which will allow age-based reporting by early 2024.

4.77 Corrections told us that young people aged 18 to 24 years made up about 15% of people accessing its addiction services from 2017 to 2022.

4.78 Corrections told us it is currently reviewing its mental health services for prisoners and that this will include work to improve the collection of outcomes data and assess the suitability of existing outcomes tools for use in prison environments.[94]

93 Corrections received $129 million of new funding in the 2019 Budget to fund expanded mental health and addiction services for prisoners.

94 Corrections currently uses the Kessler-10 psychological distress scale as a self-report outcome measure for prisoners who access its Improving Mental Health Service.

4.79 Corrections aims to give Māori prisoners, who make up 52% of the adult prison population, access to culturally appropriate mental health and alcohol and other drugs programmes.

4.80 Corrections has made some progress in improving the cultural appropriateness of its services for Māori. For example, there are Māori mental health practitioner roles in all its seven in-house multi-disciplinary mental health teams. Nine of its 15 addiction service providers are kaupapa Māori services.

4.81 Corrections told us that it has more work to do "with respect to meeting the needs of Māori [prisoners]". It expects that the ongoing review of its mental health services in prisons will have a positive effect.

4.82 Te Whatu Ora also provides specialist (forensic) mental health services for prisoners with a severe level of need.

4.83 Corrections staff told us that lack of capacity in forensic mental health services often leaves prisons supporting prisoners whose needs are better aligned to a forensic service. Likewise, a provider of prison-based services told us that capacity constraints in forensic services means that their referrals of patients are often declined.

## Young people in prison face many barriers to accessing mental health support

4.84 Young people can experience greater difficulty accessing mental health services in prisons than older age groups. Young people are often a transitory population in prisons and are more likely than older age groups to be in prison on remand or short sentences.

4.85 This increases the chance that young people might be screened for mental health and substance use concerns when they enter prison but be unable to access appropriate mental health support. In other cases, young people might begin mental health treatment in prison, only to have that service stop when they leave.

4.86 We heard that prisoners are sometimes transferred between prison sites despite them accessing mental health services. This can cause the trust and rapport they develop with a professional to be disrupted. Corrections told us it is aware that transfers can be disruptive to prisoners and whānau but are sometimes needed to safely manage the prison population.

4.87 Corrections told us it is reviewing its procedures to ensure that prisoner health needs and continuity of care are met when they are transferred between sites.

4.88 When prisoners want to access mental health care, custodial staff are required to facilitate their attendance at therapy sessions, such as by making referrals, escorting prisoners to therapy and remaining in sight (although not in hearing distance) during the session.

4.89 The role of custodial staff in facilitating access to prison-based services could be a barrier for young people who do not have a positive or trusting relationship with custodial staff.

4.90 Corrections confirmed to us that services needing custodial staff escorts or presence are currently curtailed in many of its sites due to staff shortages. This means that the mental health services that Corrections provides may not be currently available to many prisoners.

## Agency roles and responsibilities for the mental health needs of young people reintegrating into the community lack clarity

4.91 On leaving prison, prisoners with ongoing mental health needs must transfer from the care of prison-based services to publicly funded health services.

4.92 As with any care transitions, prisoners who transfer between prison-based mental health services and services in the community require increased and co-ordinated support to ensure that their mental health needs can continue to be met after they leave prison.

4.93 However, we were told that essential information such as health notes and prescriptions are not always transferred between prison and community-based services in a timely way. This could mean that people with mental health conditions are released from prison without medication or ongoing care plans.[95]

4.94 Corrections told us that it is working on strengthening procedures for referrals, discharge, and transfer of care so that people with mental health needs who are being released from prison (or transferred to other areas) can access and transition effectively between services.

**Recommendation 7**

We recommend that Te Whatu Ora work with the Ministry of Health, the Ministry of Education, Oranga Tamariki, the Ministry for Social Development, and the Department of Corrections to ensure that integrated care pathways are in place so that at-risk groups of young people experiencing mental health concerns can access consistent and continuous care as they enter, move between, and leave the care of services.

95 Office of the Chief Coroner of New Zealand (2023), *Recommendations Recap: A summary of coronial recommendations and comments made between 1 January and 31 March 2023*, pages 84-85.

# 5 Addressing key system constraints

5.1 In this Part, we assess the progress of government agencies in addressing system constraints impacting mental health services for young people in four key areas:

- system design, leadership, and oversight;
- existing models for mental health funding;
- the mental health and addiction workforce; and
- social service commissioning.

5.2 We expected government agencies to understand, and to be actively addressing, any constraints that impact their ability to meet the mental health needs of young people.

## Summary of findings

5.3 Placing the needs of young people at the centre of system design and ensuring that they can access timely, appropriate, consistent, and continuous care as they enter, move through, and leave the care of services will require government agencies to address significant and long-standing system and capacity constraints.

5.4 In our view, greater oversight and leadership is needed over the design and performance of the wider system of mental health and addiction, including the significant share of mental health services and support for young people that are funded or provided by non-health agencies.

5.5 We urge government agencies to consider whether current funding models for specialist services are based on the best available evidence on need and the benefits of early intervention, and whether they are fit for purpose to provide equitable services to all New Zealanders.

5.6 In our view, government agencies should prioritise work on cross-sector workforce planning to ensure that New Zealand can access the right number and mix of skilled practitioners to meet our mental health needs into the future.

5.7 Community providers raised their concerns with us about restrictive and onerous commissioning practices. The Government intended to address these concerns through work to review and improve social service commissioning models.

## Greater system oversight and leadership is needed

5.8 Publicly funded mental health services and support for young people are provided by a range of health and non-health agencies.

5.9 The distribution of mental health services for young people across multiple agencies and sectors makes health system oversight and leadership critical. This is needed so that young people and their whānau receive consistent and continuous mental health care no matter how or where they enter the system.

5.10 Young people told us that it often feels that the emphasis is on whether young people meet the criteria for a particular service, rather than whether their needs are being met. People who work in the mental health and addiction sector described the system as "disjointed", "siloed", "confusing", and difficult for young people and their whānau to understand.

5.11 The Department of the Prime Minister and Cabinet's Implementation Unit has highlighted a lack of health system leadership and oversight over mental health services funded and provided by non-health agencies, for whom mental health service delivery is not "core business". Strengthening mental health and addiction system leadership at all levels is a main aim of *Kia Manawanui*.

5.12 In 2020, the previous Government established an independent Mental Health and Wellbeing Commission (Te Hiringa Mahara Mental Health and Wellbeing Commission) to improve "cross-agency oversight, monitoring and accountability" over mental health and addiction services and the Government's approach to implementing the findings of *He Ara Oranga*.

5.13 Te Hiringa Mahara has increased its oversight and monitoring over the share of mental health and addiction services funded by health agencies. To date, its annual monitoring has not extended to mental health services funded by non-health agencies, although non-health funded services may be included in its future monitoring work.

5.14 The Ministry of Health is mandated by legislation to oversee and monitor most mental health services provided or funded by non-Health agencies.[96] However, the Ministry of Health told us that being unable to access and request information from non-Health agencies is a barrier to fully exercising its mandated role.

5.15 In 2023, the Ministry of Health released *Oranga Hinengaro System and Service Framework*. A key action under *Kia Manawanui*, *Oranga Hinengaro* maps the range of mental health and addiction services that will be available locally, regionally, and nationally as a guide for health funders and planners.

96 The Ministry of Health's system oversight and monitoring role is provided for under the Health Act 1956, the Health and Disability Services (Safety) Act 2001, and the Pae Ora (Healthy Futures) Act 2022. However, there are some exceptions. For example, the 2001 Act does not apply to services provided in prisons or Oranga Tamariki residences.

5.16 However, *Oranga Hinengaro* is intended to map only the mental health and addiction services funded under Vote Health, not those funded or provided by other non-health agencies.

5.17 Although *Kia Manawanui* provides a clear cross-agency strategy for how government will achieve the vision of *He Ara Oranga*, it lacks an implementation plan clearly setting out the roles and responsibilities of agencies, the actions they will take, how they will work together, and how collective progress against the outcomes sought will be measured and monitored.

5.18 Strong system leadership and design will be required to create a cohesive, fully integrated, and fit-for-purpose mental health and addiction system that centres the needs of young people and their whānau and ensures that they can access all the system supports that they need to experience improved well-being.

**Recommendation 8**

We recommend that the Ministry of Health work with Te Whatu Ora, the Ministry of Education, Oranga Tamariki, the Department of Corrections, and other agencies as relevant to strengthen its mental health and addiction system leadership role, and to prioritise the development of a cross-agency implementation plan for *Kia Manawanui* with clear agency roles and responsibilities.

## Existing funding models have not led to equitable service access

5.19 New Zealand's current funding model for specialist mental health services originated in the 1990s. During this time, the country was transitioning from large psychiatric institutions to community care as the preferred care model.

5.20 In 1994, the Government set a benchmark of 3% for the proportion of the population expected to experience a severe level of mental health need each year (and who would require a specialist level service).

5.21 The 3% benchmark appears to have been adapted from a 1991 Australian prevalence study and adopted as an access target for specialist mental health services in subsequent national mental health plans of the 1990s.

5.22 After the district health boards were established in 2001, the Government devolved central government funding for mental health to the newly established boards. At the same time, it set a specialist service funding "ringfence" to ensure that district health boards used mental health funding for its intended purpose.

5.23 The mental health specialist ringfence required district health boards to fund enough specialist mental health and addiction services to meet the needs of the 3% of their population who were expected to experience a severe level of mental health need. Only after the needs of the 3% were met could district health boards invest in primary-level mental health services.[97]

## Previous mental health funding models have not resulted in equitable access to services

5.24 The 3% specialist ringfence was based on the best available prevalence data in the 1990s. Since the mental health ringfence was introduced, New Zealand's 2006 prevalence study, *Te Rau Hinengaro*, found that the proportion of New Zealanders who experience a severe level of mental health need was 4.7%, which is almost 2% higher than the ringfence benchmark. The ringfence was not adjusted in line with the latest data.

5.25 The historic concentration of government investment in specialist services for the 3% of the population with the most severe needs also failed to address the needs of the much larger proportion of the population estimated to experience mild to moderate mental health needs each year.

5.26 The prevalence of mental health conditions is not evenly distributed across the population. Some groups, such as young people and Māori, are particularly affected. The benefits of early intervention in younger age groups in reducing the lifelong costs of mental illness are also well recognised. A single national access measure might not, by itself, be enough to meet the needs of groups who experience a greater level of need.

## Existing funding models are being revisited following the health reforms

5.27 After the recent health reforms, there remains a mental health funding ringfence. Although the ringfence initially applied only to specialist mental health services, to meet the needs of the 3% of the population who were expected to experience a severe level of mental health need, the ringfence has now been broadened to include primary mental health services, such as the new Access and Choice services.[98]

97 Although some primary service funding was made available outside the ringfence, the share of funding available for primary services remained small, making up only 2% of mental health expenditure.

98 The Access and Choice benchmark is that at least 325,000 people will access the new primary mental health and addiction services from mid-2025. This would correspond to around 6% of the population accessing ringfence-funded services based on current population figures. With the existing 3% ringfence for specialist services, this equates to about 9% of the population accessing ringfence-funded services from mid-2025.

5.28 We note that some Te Whatu Ora services which support young peoples' mental health needs, such as school-based health services, remain outside of the ringfence.

5.29 There is still support in the sector for continuing protected funding for mental health and addiction to prevent mental health funding being used for more general health services.

5.30 Te Whatu Ora told us that it has started work to assess the equity of current investment in mental health and addiction services.

5.31 Given the uneven distribution of need and proven benefits of early intervention, it would, in our view, be appropriate that any future national access measures for mental health services incorporate a range of sub-measures reflecting the needs of groups at higher risk of experiencing mental health concerns, such as young people and Māori.

5.32 We note that any more comprehensive mapping of service access to population need will be dependent on improved prevalence data on the extent and distribution of mental health conditions in the population.

## National planning is required to address mental health and addiction workforce issues

5.33 New Zealand's mental health workforce is diverse and made up of clinical and non-clinical roles across multiple government agencies, not-for-profit community providers (such as NGOs, iwi, and Māori providers), and the for-profit sector.

5.34 Clinical roles include nurses, addiction practitioners, clinical psychologists, psychiatrists, social workers, counsellors, and occupational therapists. Non-clinical roles include support workers, youth workers, employment support advisors, peer workers, and cultural advisors.

5.35 Government agencies employing or funding the mental health workforce include Te Whatu Ora, Te Aka Whai Ora, the Ministry of Education, the Department of Corrections (Corrections), Oranga Tamariki, the New Zealand Defence Force, and the Accident Compensation Corporation (ACC). The for-profit sector employs

a significant proportion of the mental health workforce, including those that provide publicly funded or subsidised services (such as GPs, and services funded through ACC or Oranga Tamariki).

## The mental health and addiction workforce faces long-term capacity and capability issues

5.36 New Zealand's mental health and addiction workforce faces significant and long-term shortages. A range of government organisations have highlighted that these shortages are a significant risk to being able to maintain current service levels and to deliver *Kia Manawanui*.[99]

5.37 New Zealand relies on overseas-trained workers to maintain its mental health and addiction workforce. Some mental health specialties in particular rely on an international workforce. Psychiatry, for example, has the highest proportion of overseas graduates of any medical specialty in New Zealand.

5.38 New Zealand is not alone in these challenges and must compete in the global recruitment market for mental health practitioners such as nurses, doctors, and clinical psychologists.

5.39 Health officials told us there are several disadvantages with New Zealand's dependence on overseas recruitment to fill workforce gaps that cannot be filled by locally trained mental health practitioners. We heard from health officials that hiring overseas professionals can be more costly for services in the long term because they might need lengthy induction.

5.40 Overseas-trained mental health practitioners are less likely to understand or to be competent in addressing the needs of New Zealanders from diverse cultural backgrounds, particularly Māori and Pacific peoples. Overseas practitioners also have higher turnover rates than locally trained staff.

5.41 Because of these factors, people we spoke with in the sector were in broad agreement that the current dependence on an overseas-trained mental health and addiction workforce to fill gaps in the locally trained workforce is not a sustainable solution to New Zealand's mental health and addiction workforce challenges.

5.42 There is also broad recognition in the sector that New Zealand cannot solve its workforce issues simply by expanding existing mental health and addiction roles, which can have long training pipelines. New skillsets and career pathways are needed, such as peer support and Māori and Pacific cultural workforces and practitioners.

99 This includes reports by the Department of the Prime Minister and Cabinet, Te Hiringa Mahara Mental Health and Wellbeing Commission, and the Health Workforce Advisory Board.

## The Government invested in growing the local workforce in the 2019 Wellbeing Budget

5.43 The Government acknowledged that more investment was needed to grow the mental health and addiction workforce and develop training and career pathways for new types of mental health practitioners. It allocated $77 million of new funding over four years under Budget 2019 towards workforce development as part of its Access and Choice programme.[100]

5.44 To date, this $77 million has funded a range of initiatives aimed at:

- building the capacity and capability of existing workforces;
- expanding local training places for key mental health professions such as clinical psychologists and nurses; and
- rolling out training to improve the responsiveness of mental health practitioners to Māori, Pacific, and Rainbow communities.

5.45 Comparable overseas initiatives to Access and Choice have sought to expand population access to primary mental health services. These overseas initiatives have been accompanied by significant investment in designing and developing training and career pathways for new types of mental health practitioners.

5.46 For example, the United Kingdom's Increased Access to Psychological Therapies programme, established in 2008, delivers primary mental health services to 1.2 million people annually. An important part of this initiative's roll-out was the development of a year-long course to qualify as a "Psychological Wellbeing Practitioner" able to provide brief talking therapies.

5.47 Although the Government's 2019 Access and Choice investment also involved creating new roles (Health Improvement Practitioner and Health Coach) to staff the GP-based Integrated Primary Mental Health and Addiction services, training data suggests that most staff employed in these new roles are existing clinicians such as nurses or social workers who were already employed in mental health services or the wider health sector.

5.48 Te Whatu Ora told us that it is exploring options for an equivalent role to the Psychological Wellbeing Practitioner in New Zealand.

100 Te Hiringa Mahara Mental Health and Wellbeing Commission (2021), *Access and Choice Programme: Report on the first two years*, page 12.

## The mental health and addiction workforce is facing significant well-being and retention issues

5.49 Throughout our audit we saw the depth of dedication and care shown by practitioners working in mental health services. The staff we spoke to were driven by their concern for young people and their desire to ensure that young peoples' needs were met.

5.50 However, long-standing capacity constraints, the effects of the Covid-19 pandemic, and persistent workforce shortages have placed the mental health and addiction workforce under considerable strain. These pressures on the existing workforce were evident to us in our discussions with frontline staff.

5.51 Staff shortages appear to be most acute in the small and highly specialised ICAMHS workforce. ICAMHS clinicians told us about the level of distress that increasing caseloads are having on job satisfaction and the ability to offer quality care to all young people who need it. They told us how their own mental health and well-being, and that of their colleagues, have been affected by heavy caseloads.

5.52 These strains on the ICAMHS workforce are reflected in turnover rates, which reached 19% nationally in 2021 (almost twice the average turnover for health care, of 10%).[101]

5.53 There is little to be gained in investing in the training and development of new mental health and addiction workforces if services cannot retain staff. It is critical that workforce retention issues are addressed to ensure that the expertise of current mental health and addiction practitioners is not lost.

## National mental health and addiction workforce planning is required

5.54 Health agencies acknowledge that national workforce planning will be fundamental to achieving the Government's strategic goals for mental health and addiction.[102] However, no such national workforce plan for mental health and addiction has been developed.

101 Whāraurau (2021), *2020 Stocktake of Infant, Child and Adolescent Mental Health and Alcohol and Other Drug Services in New Zealand*, page 17.

102 The Ministry of Health (2023), *Oranga Hinengaro System and Service Framework*, page 64.

5.55 An immediate barrier to national workforce planning is likely to be the lack of data on the capacity and capability of the current workforce. Although several stocktakes exist for the Te Whatu Ora-funded workforce, there is currently no stocktake of the workforce employed by other government agencies or the private sector.[103]

5.56 In our view, addressing long-standing workforce capacity issues in the sector requires concerted and co-ordinated workforce planning and development across the multiple agencies that currently employ the mental health and addiction workforce.

5.57 The Ministry of Health is leading a cross-agency working group on the mental health and addiction workforce. Te Whatu Ora, Te Aka Whai Ora, the Tertiary Education Commission, ACC, the Ministry of Justice, Corrections, the Ministry of Education, the New Zealand Defence Force, and Oranga Tamariki are part of this group. This is a promising sign that agencies recognise the mental health and addiction workforce as a cross-agency and cross-sector issue.

5.58 We urge health agencies to prioritise the development of a national mental health and addiction workforce plan that will put a clear pathway in place for how the Government will deliver on its strategic objectives in the face of these persistent and continuing workforce challenges.

**Recommendation 9**

We recommend that Te Whatu Ora and the Ministry of Health work with the Ministry of Education, Oranga Tamariki, the Department of Corrections, and other agencies as relevant to prioritise the development of a national mental health and addiction workforce plan.

## The commissioning of services from non-government organisations needs to improve

5.59 Community providers, such as NGOs, iwi, and Māori providers play a key role in delivering mental health services and support. Community providers work with people across the full spectrum of mental health need and employ a broad workforce, including clinical psychologists, psychiatrists, social workers, cultural advisors, and support workers. About 35% of people accessing specialist mental health and addiction services did so through an NGO service in 2021/22.

103 Te Whatu Ora contracts Te Pou and Whāraurau to provide regular stocktakes of Te Whatu Ora and the Te Whatu Ora-funded NGO mental health and addiction workforces.

5.60 We heard that community providers are part of, and know, their own communities and so are often best placed to understand and respond to the needs of young people and their families and whānau. These providers told us that they can "do things differently" and can reach communities who might not trust government agencies. We frequently heard that community providers go over and above their contracts to meet people's needs.

5.61 We also heard from many in the community sector that their efforts to tailor their support to meet the needs of young people are often hampered by restrictive public sector contracts and procurement processes. This feedback from community providers repeats what we heard during our 2023 audit looking at how government agencies meet the needs of people affected by family violence and sexual violence.[104]

5.62 Common concerns we heard from providers include:

- having to juggle multiple small short-term contracts with little effort on the part of health and social sector agencies to align or consolidate funding streams;
- onerous accountability requirements that do not reflect what is important to young people and whānau; and
- difficulties attracting and retaining experienced staff because of inadequate resourcing, lack of funding certainty, and competition from other agencies or sectors.

5.63 Although providers told us they wanted to work in partnership with the government, commissioning agencies often favoured "top-down" approaches that seek to minimise risk by closely controlling spending. Several providers cited high-trust approaches used during the Covid-19 pandemic as a potential model for future commissioning.

5.64 For those not in the system, such as young people and whānau wanting to access services or potential referrers, the landscape of community services can be complex, fragmented, and difficult to navigate.

5.65 The issues raised by the community sector are not new nor are they confined to the mental health and addiction sector. They echo the findings of successive government reports over the past two decades and are currently the subject of a Ministry of Social Development-led project to change how agencies commission health and social services.

104 See Controller and Auditor-General (2023), *Meeting the needs of people affected by family violence and sexual violence*, at oag.parliament.nz.

5.66 Government work to improve social service commissioning is ongoing. It is too early for us to comment on the likely effects of this project on community providers working in the mental health and addiction sector. We will look to see how this work is progressing when we review how agencies have responded to this report.

5.67 In the meantime, health agencies told us they are aware of the community sector's concerns and are already moving towards new commissioning approaches. These new approaches are intended to strike a better balance between community organisations' desire for greater flexibility, trust, and certainty, and health agencies' responsibilities as custodians of public funds to ensure accountability and value for money.

# Appendix 1
# How we did this audit

We carried out more than 150 interviews with about 400 people as part of our audit. We are grateful to everyone who took time to speak to us.

In addition to employees of the audited organisations, we spoke to a range of people and organisations within the mental health and addiction sectors. These included community (non-government organisation, Māori, and Pacific) providers of mental health and addiction services; Youth One Stop Shops; secondary schools; providers of Alternative Education and Attendance Services; primary health organisations and general practitioners; the government workforce development centres Te Pou, Whāraurau, and Le Va; sector advocacy groups, peak bodies, and professional associations; and a range of academics and other sector experts.

We are grateful to the staff from a range of other government agencies who spoke to us or provided input into or information for our audit. They include Te Hiringa Mahara Mental Health and Wellbeing Commission, the Health and Disability Commission, the Education Review Office, Whaikaha the Ministry for Disabled People, the Health Quality & Safety Commission, the Accident Compensation Corporation, the Office of the Children's Commissioner, Te Pukenga, and the Ministry for Youth Development.

The interviews and document reviews for this audit were carried out from June to November 2022. Where newer or updated data or information has been published or made available to us by agencies, we have incorporated this in our report.

Our summary of key themes on what young people want in services is drawn from:

- conversations with young people in youth advisory roles;
- existing consultation documents based on young peoples' input and feedback on related topics; and
- existing youth mental health research centring young peoples' views and perspectives.

We are grateful to the young people in youth advisory roles and to those who work with young people who spoke to us as part of our audit. They were:

- members of the youth advisory team from Whāraurau;
- youth consumer advisors employed in Te Whatu Ora/district health board roles;
- representatives of disabled young people;
- representatives of Deaf young people;
- representatives of Rainbow young people; and
- members of Youthline's youth advisory committee.

We are also grateful to Voyce Whakarongo Mai, which represents care-experienced young people, for providing us with a summary of its input to a previous government consultation on the preferences of care-experienced young people for mental health support.

We thank Dr Cameron Lacey, Romy Lee, and Dr Helen Lockett for independently reviewing our draft report.

Dr Cameron Lacey (Te Āti Awa) is a professor and psychiatrist within the Department of Psychological Medicine at the University of Otago, Christchurch. Cameron is also the Clinical Director of Research for Te Whatu Ora, Waitaha. Cameron is Principal Investigator on four Health Research Council-funded projects investigating mental illness among Māori.

Romy Lee is a young person and trained mental health and addiction practitioner. Romy is Youth Advisory/Peer Workforce Development Lead at Whāraurau, the national workforce centre for the infant, child, and youth mental health and addiction sector.

Dr Helen Lockett is a researcher and strategic advisor in mental health and addiction, with expertise in the areas of mental health and employment and physical health equity and epidemiology. Helen is currently strategic lead with Te Pou, the national workforce centre for mental health, addiction, and disability. Her role at Te Pou involves supporting ongoing collaborative work in the sector to scope a series of mental health and addiction prevalence studies.

Although we have drawn on their expertise to support our understanding of the mental health and addiction system, the judgements and recommendations in this report are entirely those of the Office of the Auditor-General.

The following documents and published research have been important in informing our summary of the key themes of what young people want in services:

- Elliot, M (2017), *People's Mental Health Report: A Crowdfunded, Crowdsourced Story-based Report*.
- Fleming, T et al (2022), *What should be changed to support young people? The voices of young people involved with Oranga Tamariki*.
- Fleming, T et al (2020), *Youth19: Youth Voice Brief*.
- Fraser, G et al (2022), "Mental health support experiences of rainbow rangatahi youth in Aotearoa New Zealand: results from a co-designed online survey", *Journal of the Royal Society of New Zealand*, Vol. 52, no. 4, pages 472-489.
- Gibson, K (2021), *What Young People Want From Mental Health Services: A Youth Informed Approach for the Digital Age*.

- Hamley, L et al (2023), "Te Tapatoru: a model of whanaungatanga to support rangatahi wellbeing", *Kōtuitui: New Zealand Journal of Social Sciences Online*, Vol. 18, no. 2, pages 171-194.
- Orygen and the World Economic Forum (2020), *A Global Framework for Youth Mental Health: Investing in Future Mental Capital for Individuals, Communities and Economies*.
- McGorry, P et. al. (2013), "Designing youth mental health services for the 21st century: examples from Australia, Ireland and the UK", *The British Journal of Psychiatry*, Issue 54, s30-5.
- Mental Health and Addiction Wellbeing Cross-party Group (2023), *Under One Umbrella: A report into integrated mental health, alcohol and other drug care for young people in New Zealand*.
- Society of Youth Health Professionals Aotearoa New Zealand and Te Tatau Kitenga (2021), *School Based Health Services Enhancement Partnership: National Youth Committee of School Based Health Services*.
- Office of the Children's Commissioner (2019), *What makes a good life? Children and young people's views on wellbeing*.
- Stubbing, J (2021), *"Nobody has ever asked me that": Reimagining mental health care through collaborative research with young people from New Zealand*.
- Stubbing, J et al (2023), *A summary of literature reflecting the perspectives of young people in Aotearoa on systemic factors affecting their wellbeing*.
- Stubbing, J and Gibson, K (2022), "What Young People Want from Clinicians: Youth-informed Clinical Practice in Mental Health Care", *Youth*, Vol. 2, no. 4, pages 538-555.
- Stubbing, J and 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*. Vol. 18, no. 9.
- Te Hiringa Mahara Mental Health and Wellbeing Commission (2023), *Young people speak out about Wellbeing: An insights report into the Wellbeing of Rangatahi Māori and other Young People in Aotearoa*.
- Te Rourou, One Aotearoa Foundation (2023), *I Feel Really Good When: Strengthening youth mental health and wellbeing in Murihiku Southland*.
- Whāraurau and DMC (2021), *He Mana Taiohi: Understanding Mana Motuhake*.
- Whāraurau and DMC (2019 and 2022), *Youth-Informed Transformation*.

# Appendix 2
# What young people want in mental health services

The definition of "meeting need" we used in this work is based on the themes and findings in the table below. This is drawn from our discussions with youth advisory groups, previous consultations on similar topics that presented young peoples' views, and our review of the extensive published research on youth mental health services including young peoples' views and perspectives.

| Theme | What all young people want | What rangatahi Māori and other priority groups of young people want |
|---|---|---|
| **Youth-specific care** | Services and models of care that are for young people. Not expecting young people to fit into services designed for adults. | |
| **Rapid, barrier-free access to support** | Access to support when young people need it, without the need for a referral or a waiting list.<br>Young people may be on low income or financially dependent on whānau, so services need to be free or low cost to be accessible.<br>Flexible ways to access support, such as through services offering drop-in sessions, making appointments available outside of working hours, and offering a variety of channels (such as text or webchat) for young people to engage with mental health practitioners. | Physical accessibility of services and, where appropriate, assistance to travel to services is particularly critical for disabled young people. |
| **Services in places where young people commonly spend time** | Services located in locations where many young people are such as schools, tertiary institutions, or accessible community locations.<br>Mobile services are a youth-friendly option for bringing services to young people.<br>Internet-based services are an attractive option for many young people. However, not all young people can or want to access services online, and it is important for services to offer face-to-face alternatives. | |

| | | |
|---|---|---|
| **Youth-friendly environments** | The physical space in which mental health services are delivered is extremely important to young people and can be a deciding factor in whether young people choose to use or stay with a service.<br>Young people want to access services in environments that are safe, welcoming, and where they want to spend time. They may find clinical or hospital-like settings stigmatising and offputting.<br>Young people may feel stigma about accessing a mental health service. Young people also worry about the confidentiality of the information they share with professionals. For these reasons, settings which allow their need for privacy are extremely important. | For rangatahi Māori, creating time and space for meaningful connections to grow, in contexts that nurture their wellbeing (such as in te taiao – the natural environment) is particularly important.<br>Rainbow young people told us that service environments need to be explicitly inclusive and welcoming of Rainbow young people for them to feel comfortable. |
| **Youth voice and participation** | Young people want services to listen to them and empower them. They want services that recognise their inherent value and potential and treat them as partners in their own care.<br>Young people want to be involved in all stages and levels of services, from their design to their delivery, governance, and ongoing monitoring and evaluation.<br>We heard that including young people in service delivery, such as through employing them as peer support staff, can help make services more relatable for other young people. | Rangatahi Māori want services to uphold and enhance their mana and tino rangatiratanga. |

| | | |
|---|---|---|
| **Relationships** | Young people value the ability to develop ongoing relationships with trusted adults who can relate to young people and are non-judgemental.<br>It is important that services allow young people the time and space for relationships to develop. | The importance of relationships characterised by mutual trust and reciprocity are encapsulated in the Māori value of whanaungatanga.[105]<br>It may require extra time for rangatahi and whānau who have experienced discrimination or other negative experiences with government services to build up trust in professionals. |
| **Whānau-centred care** | Involving whānau (however a young person chooses to define their natural supports) in decision-making over their care is important to young people.<br>However, some young people seek privacy and autonomy from whānau and it is important for services to respect young peoples' preferences, so far as is possible within the constraints of safety and consent. | Connectedness to whānau and where they're from is important to rangatahi Māori well-being.<br>Connection to culture and identity is also particularly important to Pacific young people. |
| **Services and a workforce that reflect diverse young people** | Young people are diverse, and services and the workforce need to accommodate and celebrate this diversity.<br>Young people do not want a single universal service. Rather, they want services that understand and reflect their diverse "identities, world views, and needs". | Rangatahi Māori and Pacific young people may be reluctant to engage with or remain in a service if mental health practitioners do not understand their culture or if the models of care do not align with their worldview. Examples of this could be lack of accommodation for whānau or services not following tikanga.<br>In practical terms, responding to young peoples' diverse needs is likely to involve offering the choice of separate services or care models for some groups of young people, such as rangatahi Māori and Pacific young people, and improving the inclusiveness of "mainstream" services for groups such as disabled and Rainbow young people. |

105 Hamley, L et al (2023), "Te Tapatoru: a model of whanaungatanga to support rangatahi wellbeing", *Kōtuitui: New Zealand Journal of Social Sciences Online*, Vol. 18, no. 2.

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Office of the Auditor-General
PO Box 3928, Wellington 6140

Telephone: (04) 917 1500

Email: reports@oag.parliament.nz
Website: www.oag.parliament.nz