Youth Primary Mental Health and Addictions Evaluation

Report for Te Whatu Ora - Health New Zealand

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Disclaimer

Executive Summary

Introduction

This document details the findings of a comprehensive evaluation of the Youth Primary Mental Health and Addictions (Youth PMHA) initiative, applying a Value for Investment (VfI) approach.

The Youth PMHA initiative sits within the broader context of the Expanding Access and Choice initiative.The Expanding Access and Choice initiative has four work streams that will collectively expand access to, and choice of, primary mental health and addiction services. One of the work streams focuses on youth specific services for 12-to 24-year-olds (referred to in this report as Youth PMHA services). The other work streams are kaupapa Māori services, Pacific-led services, and Integrated Primary Mental Health and Addiction services, delivered through general practice teams. The Youth Access and Choice work stream is investing funding of $45 million to increase access to, and choice of primary mental health and addiction services for youth/rangatahi populations (ages 12-24 years, inclusive) who are experiencing mild to moderate levels of distress.

Value for Investment (VfI) is an underlying approach of the Youth PMHA evaluation. The VfI approach is designed to answer evaluative questions about how well resources are used, whether enough value is created, and how increased value could be created from the investment. This approach combines theory and practice from economics and program evaluation, to support accountability and good resource allocation as well as reflection, learning and adaptation.

Methods

Three Key Evaluation Questions (KEQs) guide and structure the evaluation: *How does the Youth PMHA create value? To what extent does the Youth PMHA provide good value for the resources invested? How could the Youth PMHA provide more value for the resources invested?* These KEQs are supported by a theory of value creation that distinguishes three levels of a value chain:

- Looking after resources, equitably and economically
- Delivering Youth PMHA services, equitably and efficiently
- Generating social value, equitably and effectively.

The following key data collection streams were used:

- Interviews with 30 rangatahi participating in interviews/group discussions (including 11 rangatahi Māori), and five whānau.
- An online survey of rangatahi, receiving 23 responses.
- Interviews with provider leadership, encompassing 75 people from 11 contracts and 20 programmes/locations.
- An online survey of providers, with 41 responses.[1]

In addition, service data supplied by Te Whatu Ora – Health New Zealand (Te Whatu Ora) was analysed for reflection against Youth PMHA aims and evaluation criteria, alongside provider

[1] Please note that for the purposes of this report, the terms ‘rangatahi’, ‘youth’ and ‘young people’ are used interchangeably. ‘Rangatahi Māori’ refers specifically to Māori youth.

narrative reporting. Each stream of data collection is reported separately in annexes to this document.

KEQ1: How does the Youth PMHA create value?

Through the lens of **'looking after resources, equitably and economically'**, Youth PMHA generates value by making use of increased funding to build on existing knowledge, networks, and resources to reach more young people. More flexible funding enabled delivery of more agile and responsive services to rangatahi.

Youth PMHA generates value towards **'delivering services, equitably and efficiently'** through reducing barriers to access and offering greater choice, decision-making power, and responsiveness. Culturally-specific interventions, particularly through kaupapa Māori services, as well as services to Pacific and migrant communities enabled the needs of multiple ethnic groups to be more equitably addressed. Similarly, services to rainbow communities have been extended and were valued by rangatahi interviewed. New collaboratives were established across providers, and existing collaboratives were enhanced, to better reach rangatahi and connect across health and social care systems with the services they need.

Youth PMHA **'generates social value, equitably and efficiently'**, through the positive wellbeing outcomes for rangatahi and whānau that are identified through this evaluation. Rangatahi Māori and their whānau consistently reported benefits from engaging with kaupapa Māori services. The logic of feedback also suggests that Youth PMHA services should contribute to better use of resources across the primary care continuum, as well as generating links with secondary care services.

KEQ2: To what extent does the Youth PMHA provide good value for the resources invested?

Overall, across multiple areas of activity, **Youth PHMA is generally delivering good value for the resources invested.**

A more flexible funding environment is evident, enabling agile, responsive, and more connected services. Some improvements in the procurement process are suggested for Youth PMHA to be more adaptive and inclusive. Open and trusting relationships between providers and Te Whatu Ora are emerging, and new foundational training opportunities have emerged for the sector. The salary funding based on DHB benchmarks was seen as an important contribution to attracting and retaining staff.

Some well-tailored approaches are emerging for rangatahi Māori (particularly among Māori providers), and to a lesser extent for Pacific and other diverse groups where further development appears needed.

Greater access and choice of services is evident, and they are highly valued by the young people and whānau engaging in the evaluation. Rangatahi found services to be human and relatable[2];

[2] In the evaluation design process, the phrase 'human and relatable' was used by participants to describe the experience of support received, in terms of showing such qualities as being personable, warm, and engaging with young people.

often described as kind, inclusive and welcoming. Services are demonstrating flexibility in a range of ways.

Providers are proactively seeking to eliminate barriers for young people, including rangatahi Māori. Providers are enabling young people to make their own choices about what support they receive, when and from whom; and this was supported by the experiences of rangatahi interviewed in this evaluation. Services have been designed in consultation with youth, and some are maintaining ongoing contact in the further development of activities. Formal and informal methods have been developed for ongoing learning and improvement in services and organisations.

It is apparent that Youth PMHA was established at a time of some considerable system stress, when COVID-19 was exerting pressures on both services and rangatahi themselves. In this context, and alongside a tight labour market, building system capacity and responsiveness will be challenging and take time to be achieved. It is perhaps not surprising therefore that there are a range of system and service connections emerging, but these are unevenly spread. Increased FTEs are driving service growth, but there is substantial regional variation in staff recruitment and service growth.

Rangatahi and whānau interviewed felt the service supported their wellbeing and helped them to reach their potential. Areas of personal growth included communication and resilience skills, increased understanding of mental wellbeing, and greater connection to their family and communities.

Youth PMHA services appear to contribute to better use of resources across the primary care continuum, based on provider perspectives. Mild to moderate mental health and addiction issues are being identified and addressed at an early stage, and this is likely to reduce the chances of them becoming more serious. There is however insufficient data to understand the extent to which early intervention is reducing the need for higher intensity services.

KEQ3: How could the Youth PMHA provide more value for the resources invested?

A range of potential improvements were raised through this evaluation, acknowledging that Youth PMHA is itself a continuously adapting programme of development, by Te Whatu Ora and providers alike.

To improve the equitable and economic use of resources, recommended areas of development include:

- Introducing more flexibility into procurement processes to match and extend the flexibility that has emerged in contracting.
- Deepening relationships (including funding and contracting) between Māori providers and Te Whatu Ora to embed te Ao Māori mātauranga and reflect a Te Tiriti approach; we note however that the primary Tiriti relationship will be held with Te Aka Whai Ora (Māori Health Authority.
- Extending training into cultural competence in mainstream providers and working with complex needs.

- Considering the need for increased funding for iwi and other kaupapa Māori partners so services can meet high and complex needs of Māori, particularly to reflect the additional resource required to deliver services in isolated and rural areas.
- Streamlining and re-focusing provider reporting.
- Exploring approaches to more consistent measurement, including for outcomes.

To improve the equitable and efficient delivery of services, improvements are more evolutionary and adaptive, acknowledging that Youth PMHA builds on the strengths of services to rangatahi that were already in place. Recommended areas of activity include:

- Continuing to grow overall system capacity and reducing regional variation in staff growth.
- Non-Māori providers deepening outreach and capacity to work with Māori communities.
- Providers building further their responsiveness and capacity to work with Pacific, LGBTQI+, and refugee/migrant communities.
- Mainstream providers building relationships with kaupapa Māori and Pacific providers, to ensure rangatahi have clear choices for accessing primary mental health support, and to foster decolonising practice within organisations.
- Ongoing development of system connections across primary/community and secondary, and with social and other service providers.

Finally, to generate greater social value, equitably and effectively, areas of development include:

- Further growing relationships across systems (primary/community and secondary, and across mental health and other systems) for greater service integration.
- Improving data systems, particularly in understanding flows across primary care settings and between primary and community care, and secondary care.
- Exploring further the value that is being generated by consortia approaches that can offer comprehensive support from a variety of modalities, particularly for those with high complexity in their lives.
- Connecting more with the other Access and Choice streams (Māori, Pacific and integrated primary and mental health care) to provide a more joined up regional approach.

Conclusions

Youth PMHA services are becoming well-established, and at the same time are still on a growth and development trajectory as they look to build capacity to meet the needs of rangatahi. As a system, Youth PMHA services are expected to continue to develop and adapt and are now looking beyond the implementation challenges that COVID-19 posed at the outset of the initiative.

Available evidence indicates that Youth PMHA is meeting its value proposition, and according to most criteria is on a pathway to excellence, particularly in terms of enabling equitable and flexible access to services, and the value and impact that rangatahi and whānau are reporting in their engagement with services.

Key areas of development include reaching more rangatahi; raising the profile and awareness of available services as capacity increases; engagement with and funding to iwi Māori and Māori providers; cultural competence development in mainstream providers; minimising waiting times;

and links between community and clinical settings.

A lack of quantitative data, particularly on service outcomes, represent limitations in the extent to which value can be assessed and is an important area for further development.

Overall, findings suggest that Youth PMHA is a worthwhile use of resources, and justifies both maintaining the direction of development, and further building a culture of learning and improvement.

Summary of evaluative judgements using Value for Investment criteria

The following tables detail key evaluative findings against three areas of Value for Investment:

- Looking after resources, equitably and economically
- Delivering Youth PMHA services, equitably and efficiently
- Generating social value, equitably and effectively

Performance against these criteria have been assessed using a set of standards developed through the evaluation design process (detailed in Annex 7, page 127):

- Not meeting levels of minimum expectations
- Meeting levels of minimum expectations, or 'just good enough'
- Pathway to excellence (between meeting minimum expectations and excellent)
- Excellent performance

Looking after resources, equitably and economically

Table 1: Evaluative assessment - Looking after resources, equitably and economically

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
Procurement and funding processes	Transparency and flexibility in procurement processes	Meeting minimum expectations	Procurement processes appear to have been transparent in Request for Proposal (RfP), and ongoing contract negotiations and management, but a business-as-usual approach to procurement was still commonly perceived.
	Māori provider resourcing	Not meeting expectations	Māori providers generally reported feeling under-resourced, despite some positive shifts in flexibility in funding and relationships with Te Whatu Ora.
Design and knowledge base	Building on knowledge, skills and resources	Pathway towards excellence	Intangible assets of providers have been valued and acknowledged, including cultural capital. Providers felt affirmed and respected in their expertise, including Māori. Local/community connections, knowledge and skills are nurtured and valued, some of which were supporting collaborative approaches. Whāraurau training provides basic training opportunities for staff that has been considered useful; rainbow-focused training less clear.

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
	Engagement with iwi Māori/ hapū/whānau and rangatahi Māori	Meeting minimum expectations	Note clear evidence of excellence among Māori providers who have high levels of engagement with iwi Māori/hapū/whānau and rangatahi Māori during design of services. Less consistent with other providers; also unclear extent to which rangatahi Māori and diverse youth have been in involved in non-Māori services.
Performance management and accountability	Stewardship of resources and accountability to funders	Meeting minimum expectations	Feedback suggests there is a basic framework for reporting. However, it offers only limited meaningful analysis, and is only partially seen as useful by providers. Mechanisms for accountability/ responsiveness to kaupapa partners, including iwi/hapū are not clear. Te Whatu Ora are showing some innovation that suggests that they are moving towards mana whakahaere, such as zooms for providers, being responsive with feedback, and providing free training through Whāraurau.

Delivering Youth PMHA services, equitably and efficiently

Table 2: Evaluative assessment - Delivering Youth PMHA services, equitably and efficiently

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
Equitable and flexible service access	Accessibility and acceptability of service settings	Pathway towards excellence	Settings are typically youth friendly and flexible with lots of different places and ways to meet and communicate. Service settings are comfortable and youth friendly. Kaupapa Māori providers and some others are improving access to services in largely Māori community settings. Some variation in other forms of support (e.g. supporting travel to and from appointments and outreach to rural communities).
	Removing barriers to access	Pathway towards excellence	Providers are working very hard to support rangatahi to access services and break down barriers. Range of support options vary; talking therapy appears dominant in non-Māori services. Services are open to youth when they're needed and they can return. Whānau involvement encouraged if permission is given.
	Accessibility and flexibility of services by priority groups	Pathway towards excellence	Some providers are present in largely Māori community settings, but this is an emerging area for many providers with relationships being formed. Some examples of reaching out to Pacific churches and LGBTQI+, and some refugee/migrant communities.

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
			Services are flexible and are changing to meet the needs of young people; both at an individual session level as well as which programmes they access and who they get support from.
Reaching young people and whānau/family[3]	Service utilisation	Meeting minimum expectations	Total people seen increased over time. One third of clients each month are new to the service (i.e. haven't been seen in the past 12 months). There is significant regional variation in staff as well as number of clients seen (total and per capita); main growth has been in Canterbury and Bay of Plenty. This indicates that improvements in service utilisation could be made in most places to support achievement of greater efficiencies. Activity rates per FTE have remained relatively consistent over time.
	Service utilisation by priority groups	Meeting minimum expectations	Compared to the population aged 10 to 24 years old, there was a substantially greater proportion of Māori clients seen by providers but lower proportions of people of Pacific[4] and Asian ethnicities. The proportion of people of European and other ethnicities was similar to that in the 10- to 24-year-old population.
	Extent of wait lists	Meeting minimum expectations	Some instances of wait lists. Appears to relate to the model of care and high clinician load, and while rangatahi are on a wait list they often receive basic wellbeing support.
	Waiting times	Insufficient data	Waitlist data not sufficiently consistent to analyse.
Shifting the locus of control	Championing rangatahi voice	Pathway towards excellence	Youth involved in design and delivery and examples given about how practice has changed based on feedback. All services clearly prioritise youth being able to choose their support.
	Tailoring to priority/diverse groups	Pathway towards excellence	Kaupapa Māori services offer te ao Māori grounded programmes and hit excellence criteria. Some non-Māori services with links or working hard to deliver culturally responsive services for Māori (and Pacific populations are present) but an area where some acknowledge that improvement is needed. Few services are culturally responsive to Pacific, migrant/refugee and LGBTQI+ populations although they are working on this. Culturally diverse staff is considered by providers, but a challenge because of small workforce.

[3]Population statistics report 10-24 years age bracket. This is different to the Access and Choice age focus (12-24 years) and is the nearest possible close comparison.

[4]Note: there is a Pacific-led stream of Access and Choice services as well which is targeted towards Pacific people, and available to people of all ages, including youth.

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
	Mātauranga Māori and Mana Māori	Pathway towards excellence	All use evidence and experience base, drawing on a wide range of expertise. Kaupapa Māori providers clearly at excellence rating, but there are varying levels of integration of mātauranga Māori in non-Māori providers.
Manaakitanga and cultural fit	Warm, friendly and relatable service provision	Excellent	Strong consensus that staff were helpful and friendly, warm and relatable.
	Comfortable and mana enhancing	Pathway towards excellence	Strong sense that young people had a voice, their reality and values were validated. Work was strengths based, and rangatahi were supported to set goals.
System connections	Access to a range of health, cultural and social services	Pathway towards excellence	Providers have relationships with other local providers that supports referrals; but the extent that the transition to additional services is seamless and timely is unclear, because of resourcing and wait times at other organisations.
	Links between community and clinical settings	Meeting minimum expectations	Providers are offering rangatahi access to clinical support and psychological assessments. This is done well in some places, but not consistently. Some spoke about competition between providers and challenges when making links with secondary mental health services because the relationship and understanding of each others' services was still developing.
	Collaboration with other local services	Pathway towards excellence	Collaboration is evident in almost all providers and is generally seen as beneficial for the rangatahi they serve. Some links with other local services evident for many providers.
Learning and improving	Systems for learning and improvement	Pathway towards excellence	There are systems in place to support learning and improvement, but not consistently across all providers and systems are typically informal and/or ad hoc. There is some evidence of ongoing programme adaptation to meet needs and evidence/experience base.

Generating social value, equitably and effectively

Table 3: Evaluative assessment - Generating social value, equitably and effectively

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
Wellbeing outcomes for rangatahi and whānau	Helping rangatahi and their whānau	Pathway towards excellence	Young people appear to be in a better place as a result of using the service. Some have made notable shifts in a short space of time.
	Developing skills and confidence	Pathway towards excellence	Providers and rangatahi perspectives indicate rangatahi have developed skills, confidence and ability to draw on resources outside the support context, and to better manage their distress. Feedback suggests that youth are able to draw on their internal and external resources, and that youth are being empowered to make better choices. A few young people are exploring volunteering for services and/or pursuing a career in mental health.
	Building skills, resilience and identity	Pathway towards excellence	Findings suggest that support to rangatahi facilitates the strengthening in rangatahi of community networks/resilience and internal skills. Rangatahi Māori spoke of learning/developing more of their identity as Māori, including whakapapa, about taiao and rohe, and rongoā.
	Positive outcomes are gained	Pathway towards excellence	Positive wellbeing outcomes as defined by providers are being achieved, such as youth being more engaged, building skills and confidence, getting better understanding of mental wellbeing, and making good choices. All rangatahi interviewed appeared to be achieving at least one of their goals.
	Responsive services	Meeting minimum expectations	Feedback from both providers and rangatahi indicate that services are responsive to Māori and some extent LGBTQI+; less evident with Pacific however. Mana Tangata: feedback indicates benefits for Māori who access Māori providers, but unclear with regard to other groups or Māori in non-Māori providers
More efficient and equitable use of health care resources	Better resource use through addressing issues at an earlier stage	Pathway towards excellence	Feedback suggests that the Youth PMHA contributes to more integrated, interconnected service delivery. Feedback also suggests that mild to moderate, and in some instances complex issues are being identified and addressed early on before they escalate. Without relevant data it is difficult to indicate if the need for higher intensity services is reduced, but most providers believed this would be the case.

Glossary of te reo Māori terms used in this report

Āhua: The appearance, condition, character, nature of something

Aroha: love, compassion

Hapū: Kinship group made up of a number of whānau and the primary political unit in traditional Māori society

Hauora: Health and wellbeing

Hauora hinengaro: Mental health

Iwi: Extended kinship group, often refers to a large group of people descended from a common ancestor and associated with a distinct territory

Kai: food, meal

Kaimahi: worker, employee, staff

Kaitiaki: guardian, custodian, steward

Kaitiakitanga: guardianship, stewardship

Kapa haka: Māori cultural group, performing group

Karakia: a ritual chant, incantation, prayer or blessing

Kaumātua: An elder, someone with status within that group

Kaupapa: A topic or programme theme

Kaupapa Māori services/providers: Organisations that are underpinned by Māori world views and practices

Kōrero: to tell, say, speak, read, talk, address

Kura: A school or other place of learning, in this report it generally refers to Māori medium schools (kura kaupapa)

Mahi: work, job, employment, practice, occupation, activity, exercise

Mana: prestige, authority, control, power, influence, status, spiritual power, charisma

Mana Māori[5]**:** Enabling Ritenga Māori (Māori customary rituals) which are framed by te ao Māori (the Māori world), enacted through tikanga Māori (Māori philosophy & customary practices) and encapsulated within mātauranga Māori (Māori knowledge)

Mana motuhake: Enabling the right for Māori to be Māori (Māori self-determination); to exercise their authority over their lives, and to live on Māori terms and according to Māori philosophies, values and practices including tikanga Māori

Mana tangata: Achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness

[5] Note that this definition comes from *Whakamaua: Māori Health Action Plan 2020-2* because for the purposes of this report this term was used with reference to the MHAP.

Mana whakahaere: Effective and appropriate stewardship or kaitiakitanga over the health and disability system. Mana whakahaere is the exercise of control in accordance with tikanga, kaupapa and kawa Māori. This goes beyond the management of assets or resources and towards enabling Māori aspirations for health and independence

Manaakitanga: hospitality, kindness, generosity, support – the process of showing respect, generosity and care for others.

Māori: The indigenous people of New Zealand

Marae: An ancestral place of significance to people who connect to the land of that area. Within the marae, there can be a cluster of buildings where people can gather, meet and stay together, and a burial ground to enable people to return to their ancestral lands

Mara kai: Growing vegetables/food), garden

Matakite: Someone who has a strong connection to the spiritual world and has special intuition. Oracle or Seer. Can also be a spiritual healer

Mātauranga Māori: The body of knowledge origination from Māori ancestors, including the Māori world view and perspectives, Māori creativity and cultural practices

Mirimiri/romiromi: Traditional healing massage

Moana: Sea, ocean

Moemoeā: Dream, vision, aspiration

Pou whakahaere: Job title for someone who supports and organises the integration of Māori culture into workplace practices, procedures and policies

Ngahere: Bush, forest

Ngā uara: Values

Pākehā: New Zealander of European descent

Pakeke: Adult

Pūrākau: Myth, ancient legend, story

Rangatahi: Young person, youth. Some providers use the word Rito or Taiohi to describe young people they are working with

Rangatahi Māori: Young person that identifies as Māori

Raranga: Weaving

Ritenga Māori: Māori customary rituals

Rito: Young person, youth

Rohe: district, region, territory

Rongoā: Traditional Māori medicine

Rōpū: Group of people

Taiohi: Young person, youth

Taiao: The natural world, environment

Tāne: Man

Tangata whaiora: A person seeking health

Tangata whenua: People of the land; host people

Taonga: Treasure, anything that is prized or considered to be of value

Tautoko: To support, agree, verify

Te Ao Māori: Māori worldview

Te Tiriti o Waitangi (also referred to as Te Tiriti, Tiriti): The agreement signed in 1840 by representatives of the British Crown and Māori chiefs from the North Island of New Zealand. It is considered a founding document of New Zealand

Te Whare Tapa Whā: Māori health model that includes the four cornerstone of Māori health (Taha Tinana, Taha Wairua, Taha Whānau, Taha Hinengaro)

Tikanga: Correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention, protocol - the customary system of values and practices that have developed over time and are deeply embedded in the social context

Tinana: Physical wellbeing (with reference to Te Whare Tapa Whā)

Tino rangatiratanga: Self-determination, sovereignty, autonomy

Toi Māori: Māori art

Tohunga: Priest, healer

Wāhine: Woman

Wairua: Spiritual wellbeing (with reference to Te Whare Tapa Whā)

Wairuatanga: Spirituality

Whakamana: to affirm, enable, validate

Whakapapa: Genealogy lineage, descent

Whakataukī: proverb, significant saying

Whakawhanaungatanga: Process of establishing relationships, relating well to others

Whānau: Family group, can be an extended family

Whānau Ora: A culturally-based, and whānau-centred approach to wellbeing focused on whānau as a whole.

Whānau whanui: The extended whānau

Whanaungatanga: Relationship, kinship, sense of connection. A relationship through shared experiences and working together which provides people with a sense of belonging.

Whare: House, building, dwelling

Whenua: The land

1. Introduction

This evaluation

This document details the findings of a comprehensive evaluation of the Youth Primary Mental Health and Addictions (Youth PMHA) initiative, applying a Value for Investment (VfI) approach. The purpose of the evaluation is to:

- Explore what is working well across the Youth PMHA initiative, including at the provider/local level for improving outcomes for rangatahi and their families/whānau
- Explore what is working for Māori young people, and others who experience inequitable mental health status
- Pilot the use of the Value for Investment (VfI) approach, including an exemplar report that will signpost application of VfI for other evaluations.

This report is structured into five substantive sections that provide the overall synthesis of findings:

- Section 1 sets out the background to Youth Access and Choice and the Value for Investment approach that underpins this evaluation.
- Section 2 details the evaluation design and methods.
- Section 3 explores the way in which Youth PMHA creates value
- Section 4 explores how Youth PMHA creates good value for money, against agreed criteria.
- Section 5 discusses opportunities for potentially leveraging greater value from Youth PMHA in the future.

Annexes to this report detail the findings from each strand of data collection and analysis for this evaluation.

Youth Primary Mental Health and Addiction (PMHA)

The Youth PMHA initiative sits within the broader context of the Expanding Access and Choice initiative and was established with targeted funding of $45 million to meet the needs of rangatahi aged 12-24 years who are experiencing mild to moderate levels of mental health and/or addiction needs.

Other workstreams in the Expanding Access and Choice initiative are Integrated Primary Mental Health and Addiction services delivered through general practices; Kaupapa Māori services; and Pacific led services. Each of the workstreams is intended to be targeted and responsive to the priority populations across all ages, including young people. Therefore, while the youth workstream focuses specifically on delivery of youth services, it is likely that the other three streams will also support young people experiencing mild to moderate mental distress. Each stream is being independently evaluated. This evaluation specifically focused on youth services, and the delivery of the other Access and Choice workstreams to young people is out of scope. However, we acknowledge that Youth PMHA is being delivered to young people in the wider landscape of other Access and Choice workstreams that are also delivering to youth.

The Youth PMHA initiative seeks to **increase access to, and choice of primary mental health and addiction services for youth/rangatahi populations (ages 12-24 years, inclusive) who are**

experiencing mild to moderate levels of distress. It seeks to provide immediate support and ensure that rangatahi are aware of, and utilise, the options available to them. The expectation is that these services will expand the continuum of support, treatment and therapy available for rangatahi experiencing distress and promote early detection and intervention. The initiative provides a mix of activities and programmes which engage rangatahi to build their confidence, support their wellbeing and development, better manage their mental health and/or reduce their alcohol and/or drug use.

The key components of the Youth PMHA Initiative include:

- Evidence informed therapeutic interventions
- Self-management support/self-management education
- Culturally specific interventions
- Peer support
- Access to social supports.

Services need to be easily **accessible for youth, provide a range of options for support, and be able to seamlessly connect youth to cultural, social and community supports.** With specific reference to the health sector, services should **seamlessly connect with primary and secondary health services including general practice, sexual health services and secondary mental health and addiction services as required**; as and when needed to meet the developmental needs of rangatahi and their families and whānau (where appropriate). Service provision may be either offered face-to-face, by a virtual/digital service or a combination of these.

The services are **flexible and able to be tailored to the needs of each young person and their families and whānau** (i.e. not pre-defined packages of care). Services are available for individuals, family/whānau and groups, as needed.

It is expected that the Youth PMHA initiative supports increased equity of access and improved equity of outcomes for youth. To support this, the Youth PMHA initiative includes a focus on providing culturally appropriate support that responds to the needs of youth. The Youth PMHA initiative is expected to engage with and address the needs of rangatahi who experience inequities in mental health and wellbeing, including but not limited to rangatahi Māori, Pacific young people; rainbow rangatahi; rangatahi who are refugees or migrants; and other groups within geographical areas known to experience inequities.

Providers are expected to work with other providers of primary mental health and addiction services in their local area to ensure their services form part of an integrated network of services for young people who are experiencing mild to moderate (including moderate) distress. This will include, where appropriate, joint promotion of services and developing agreed pathways that make it easy for people to move into, through and between primary and secondary mental health and addiction services.

Please note that for the purposes of this report, the terms ‘rangatahi’, ‘youth’ and ‘young people’ are used interchangeably. ‘Rangatahi Māori’ refers specifically to Māori youth.

Value for Investment

Value for Investment (VfI) is an underlying approach of the Youth PMHA evaluation. The VfI approach is designed to answer evaluative questions about *how well resources are used, whether enough value is created, and how increased value could be created from the investment*.[6] Evaluative questions require a judgement to be made – based on evidence, and using a transparent process of reasoning.

This approach combines theory and practice from economics and program evaluation, to support accountability and good resource allocation as well as reflection, learning and adaptation. The VfI framework provides the basis for making and presenting judgements in a way that opens both the reasoning process and the evidence to scrutiny. The VfI approach achieves these aims by:

- Using explicit criteria (dimensions of performance) and standards (levels of performance) to provide a transparent basis for making sound judgements about the use of resources and the value created by Youth PMHA
- Combining quantitative and qualitative forms of evidence to support a richer and more nuanced understanding than can be gained from the use of indicators alone
- Accommodating economic evaluation (where feasible and appropriate) without limiting the analysis to economic methods and metrics alone.

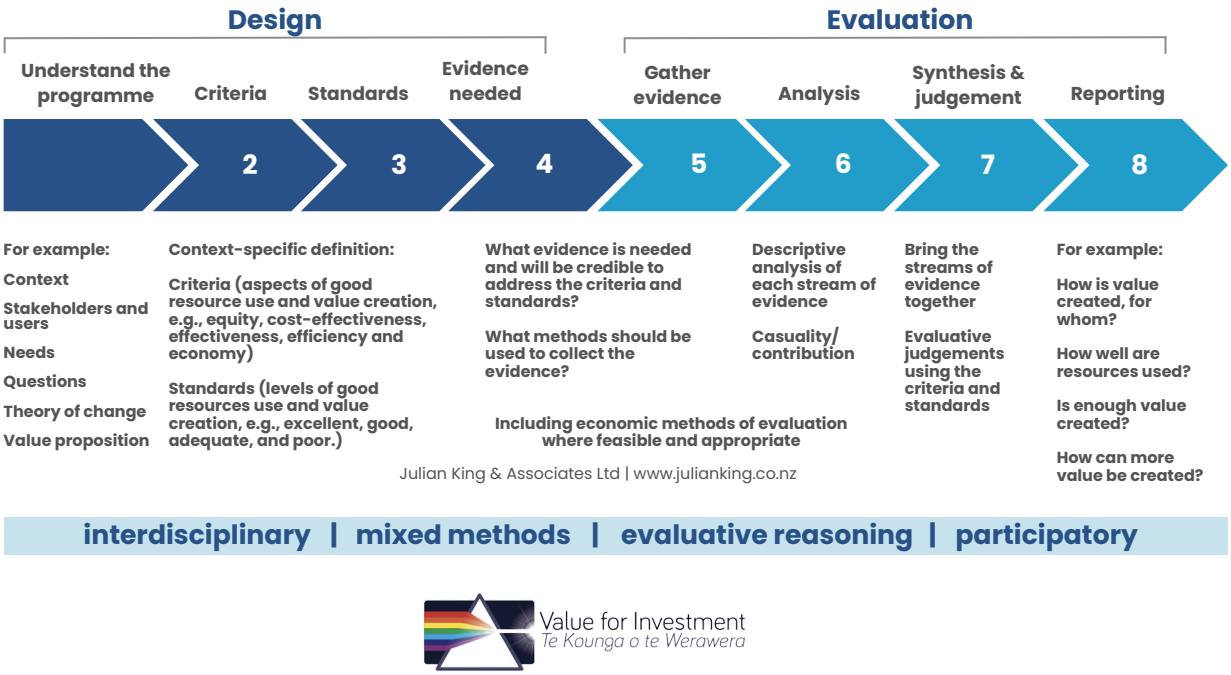
This approach helps determine whether an investment is worthwhile on the basis of observable features of programme delivery, immediate outcomes, contribution to longer-term outcomes, and agreed definitions of what good performance and value would look like.

In Figure 1 below, we set out at a high level the VfI approach, spanning evaluation design, criteria, and standards development, through to data collection, analysis, synthesis and reporting. This approach builds on established evaluative practice, by incorporating specific consideration of the value generated by the programme or service, as opposed to simply the delivery of intended outcomes. This consideration of value spanned all stages of the evaluation including:

- Defining how Youth PMHA creates value, and for whom
- Defining what good value would look like for the investment in Youth PMHA
- Determining what evidence is needed to determine the value of Youth PMHA
- Gathering and organising evidence of performance and value
- Interpreting the evidence on an agreed basis
- Presenting a clear and robust performance story.

[6] King, J. (2017). Using Economic Methods Evaluatively. *American Journal of Evaluation, 38*(1), 101–113.

Figure 1: Value for Investment approach



Theory of change and theory of value creation

A theory of change provides an important reference point for understanding the intended process of change and outcomes.[7] It details how an intervention contributes to a chain of results and ultimately outcomes. The theory of change looks at how the resources or inputs into an organisation or a service such as the staff, the policies, knowledge, and guidance support the activities that then occur and the various outputs that may be delivered. These activities create outcomes and in turn, wider impacts for participants, communities, society, and government.

A theory of value creation is a new and innovative addition to the field of programme theory, which extends a theory of change, and is drawn directly from the VfI approach. This approach details the ways in which an intervention, programme or service is intended to use resources efficiently and effectively, and create sufficient value to justify the resources used (i.e. value for money).[8, 9]

The theory of change and the theory of value creation are summarised in Figure 2 on page 19. The sections that follow describe the elements of the theory of change and the theory of value creation in more detail. The theory of change and the theory of value creation were created in consultation with the Evaluation Advisory Group.

[7] Funnel, S.C., Rogers P.J. (2011). *Purposeful Program Theory: Effective use of theories of change and logic models*. Hoboken: Wiley.

[8] King, J. (2021). *Expanding theory-based evaluation: incorporating value creation in a theory of change. Evaluation and*

[9] *Program Planning*

More information on theories of value creation can also be found at https://www.julianking.co.nz/vfi/tovc/

Theory of change

Resources

There are two main sets of resources that are invested into Youth PMHA. The funding provided in Budget 2019 was the primary source of new funding to strengthen existing or create new mental health services for youth. The second main resource for Youth PMHA is the existing sector resources within the services that are engaged in the initiative.

Inputs

Inputs are what resources are transformed into, to underpin service delivery. These include both tangible and intangible inputs. The tangible inputs include the new youth service roles that are being funded through the initiative. Another set of tangible inputs is the existing infrastructure of the funded providers, such as leadership, offices, and vehicles. All of these contribute to providing services through the initiative. A key value creation opportunity in the initiative stems from funding new people and resources within existing providers and leveraging the infrastructure that already exists.

Services

This section of the theory of change describes the key characteristics of the services offered to young people through this initiative, and which are intended to complement (and change) the overall system. Overall these services will be 'Primary mental health and addiction services that provide immediate support for young people 12-24 years, experiencing mild to moderate distress'.

There is a focus on removing barriers so young people receive support quickly in an accessible and responsive way. This means services are more holistic and responsive to the needs of young people. Further, there is choice available so young people are more able to self-determine what support they receive.

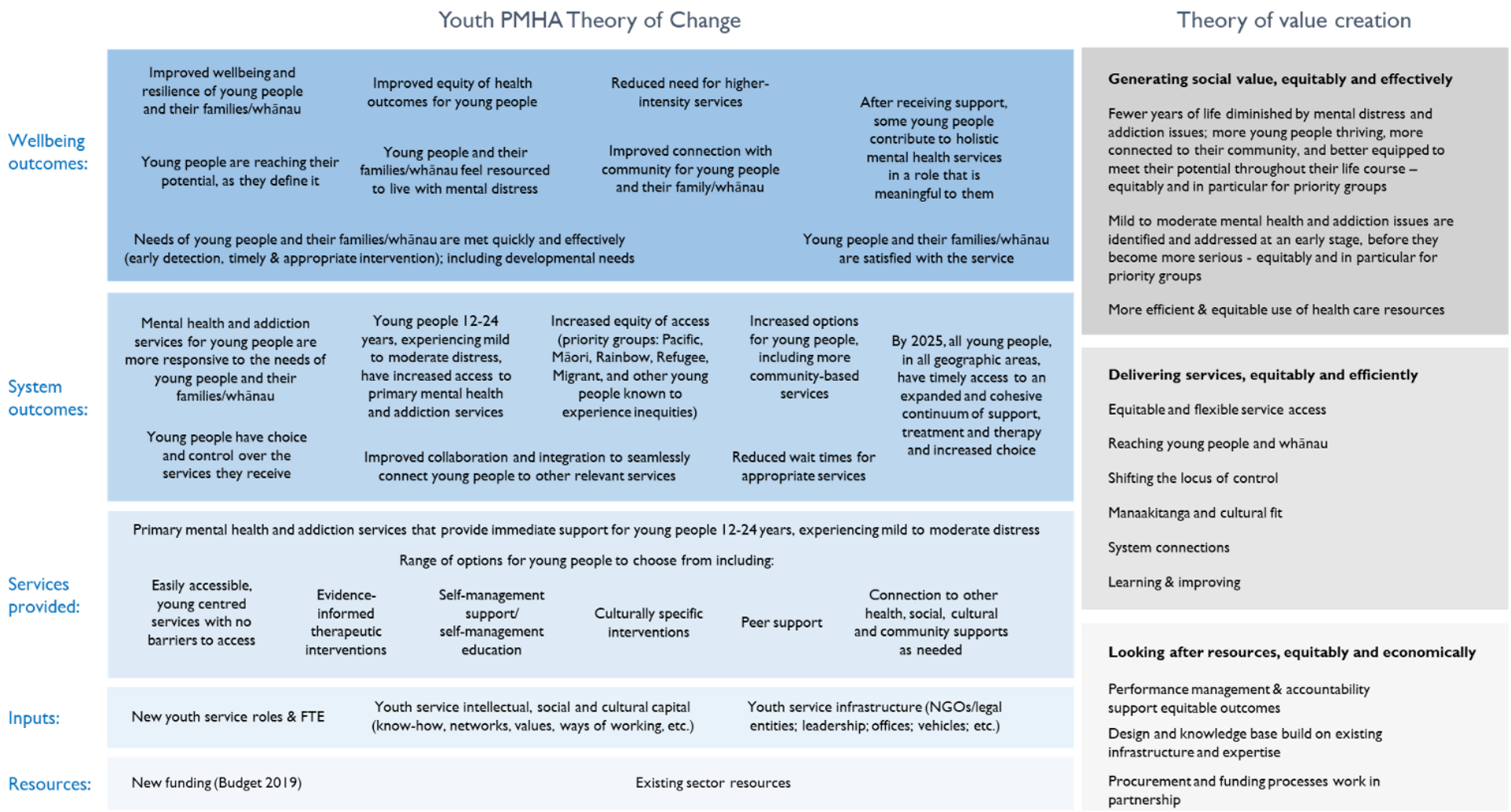
System outcomes

Systems level outcomes reflect the existing challenges in the sector and the intended ways the youth mental health system needs to change to overcome these challenges. These outcomes link to the characteristics outlined in the services section of the theory of change. There is a focus on reducing barriers (e.g., geographical access, reduced wait times, seamless connections to services) and the provision of responsive services. Critical system outcomes are greater choice of services, and that young people are able to choose the services they want. It is not expected that the Youth PMHA initiative by itself will accomplish all these outcomes. The achievement of these outcomes are multi-factorial and influenced by other programmes and system level interventions. However, they need to be included in the Theory of Change to reflect the system-level goals that it is hoped Youth PMHA will feed into.

Wellbeing outcomes

Wellbeing outcomes in the Youth PMHA theory of change reflect what will change for youth, families/whānau after implementation of the initiative. Some outcomes are focused on outcomes for youth and their whānau/families after they engage with the new services. Other outcomes have a more collective focus on the wider community outcomes and changes in equity and health that are a result of youth having greater access and choice.

Figure 2: Theory of Change and Theory of Value Creation



Theory of value creation

While the theory of change describes how change, or outcomes, are intended to be achieved through Youth PMHA, the theory of value creation articulates how Youth PMHA is intended to create value (or how an investment in Youth PMHA creates a level of gain that justifies the investment made).

Throughout the theory of value creation for Youth PMHA are concepts of equity – ensuring benefit to all sectors of society, particularly the identified target groups historically under-served by existing services, and efficiency – maximising outputs from a given level of inputs. The theory of value creation sets out a chain of logic that proposes how resources (funding, expertise, relationships, etc) are transformed into significant social value. It posits that if the initiative looks after resources, equitably and economically, so that services are delivered, equitably and efficiently, the initiative will meet its value proposition by generating social value, equitably and effectively.

Looking after resources, equitably and economically

This level of the theory of value creation corresponds to the 'economy' dimension of a standard VfM framework, which often simply focuses on purchasing services at the most economical price. However, this framework takes a broader view of resources beyond funding and acknowledges the range of resources that contribute to the initiative.

Delivering services, equitably and efficiently

This level of the theory of value creation corresponds to the 'efficiency' dimension of a standard VfM framework, which is typically concerned with maximising outputs from a given level of inputs. In this case, however, the theory of value creation gives primacy to the concept of equity – which in broad terms is conceptualised as reaching people who haven't been well-served by the existing system and ensuring there is an offering that is suitable to them. It recognises that Māori, as tangata whenua, should be involved in developing, delivering, and receiving services equitably. Moreover, this recognises reaching people who are historically under-served, such as Pacific, migrant, low-income and LGBTQI+ communities, will not necessarily be achieved through a process that is just 'efficient' and that there may be trade-offs between the goals of equity and efficiency.

Generating social value, equitably and effectively

The top level of the theory of value creation states that Youth PMHA will meet its value proposition when:

- Fewer years of life are diminished by mental distress and addiction issues; more young people thriving, more connected to their community, and better equipped to meet their potential – equitably and in particular for priority groups; this suggests wellbeing outcomes are achieved.
- Mild to moderate mental health and addiction issues are identified and addressed at an early stage, before they become more serious - equitably and in particular for priority groups; this offers a prospect of downstream impacts of reduced demand for higher intensity services.
- Health care resources are used more equitably and efficiently, which offers the prospect of pressure being taken off other parts of the health system.

Please note that these are long term and system-oriented outcomes, which will not be solely accomplished through the influence of Youth PMHA. As such, there are other contextual factors, including other parts of the health system, that will also influence the achievement of these goals.

2. Methods

In this section, we briefly describe the overall methodology. Please note that a companion report will be published (at the time of writing anticipated for June 2023) that will describe the design and methods in more depth, as both a record of the approach adopted, and a guide for implementing VfI using this evaluation as a case study.

Evaluation design

Evaluation Advisory Group

The evaluation approach was informed by a series of online workshops and engagement with an Evaluation Advisory Group, comprising Ministry of Health (subsequently Te Whatu Ora – Health New Zealand) staff and youth mental health and lived experience partners, and review of background documentation.

Key Evaluation Questions

The Key Evaluation Questions (KEQs) guide all elements of evaluation work – they provide the overarching questions for consideration of the findings, and the structure for reporting. Answering the KEQs will enable 'testing' of the theory of change and theory of value creation and identify any learning that might lead to adjustments in design and implementation of Youth PMHA and initiatives under its umbrella, and to support future decision-making.

The following KEQs, developed in consultation with the Evaluation Advisory Group, guide the evaluation:

- KEQ1: How does the Youth PMHA create value? (What sort of value? Value by who? For whom?)
- KEQ2: To what extent does the Youth PMHA provide good value for the resources invested?
- KEQ3: How could the Youth PMHA provide more value for the resources invested?

KEQ1 (explored in section 3) is a descriptive question to explore how Youth PMHA delivers value, which is addressed by developing and testing the theory of value creation. KEQ2 (discussed in section 4) is a summative evaluation question to explore the extent to which Youth PMHA offers good value for the investment, based on the criteria and standards set out in subsequent sections. KEQ3 (discussed in section 5) is a formative question focusing on learning and how Youth PMHA can be improved, and in the process offer greater value in the future.

Evaluation criteria and standards

Rubrics provide a transparent way of making evaluative judgements, by explicitly identifying how well the programme is expected to perform against key criteria (aspects of performance) and standards (levels of performance). Rubrics provide a way of presenting agreed definitions of quality and value at different levels of development. They make explicit the basis on which

evaluative judgements will be made, and facilitate clarity of evaluation design, data collection, analysis and reporting.[10, 11] Essentially, the evaluation criteria and standards provide the key road map for the evaluation.

In evaluation planning activity with kaupapa partners (stakeholders), we asked participants to identify criteria and standards for the three levels of value creation[12] that were either **adequate** (or meeting minimum expectations) or **excellent**. Anything that does not meet adequate is by definition insufficient for the delivery standards for the initiative; and anything that is above adequate and below excellent can be categorised as on a pathway to excellence. These definitions provided the core structure for analysis that is detailed in section 4.

Through a collaborative process, a detailed set of criteria and standards were developed and refined and were used to guide all evaluative judgements that are evident throughout this report. These are summarised in Tables 1 to 3 (page 9).

Data collection

A detailed evaluation plan and data collection tools were developed and approved by the Health and Disability Ethics Committee (ref 2022 FULL 12479), and subsequently received locality approval across providers participating in the evaluation, which then enabled data collection to proceed.

The following data collection streams were used:

- Interviews with 30 rangatahi participating in interviews/group discussions (including 11 rangatahi Māori), and five whānau
- An online survey of rangatahi, receiving 23 responses
- Interviews with provider leadership, encompassing 75 people from 11 contracts and 20 programmes/locations
- An online survey of provider, with 41 responses.

In addition, service data supplied by Te Whatu Ora – Health New Zealand (hereafter referred to as Te Whatu Ora) was analysed for reflection against Youth PMHA aims and evaluation criteria, alongside provider narrative reporting.

Participating rangatahi were initially approached by providers to gauge their interest in taking part in interviews; this was on HDEC advice to ensure that rangatahi were in a position to be interviewed with minimal risk of distress. Whilst this means that the participants are not necessarily representative of rangatahi using mental health services, they were in a position to offer meaningful reflections on the services. Rangatahi Māori were interviewed by Māori interviewers.

[10] Davidson EJ. 2005. *Evaluation Methodology Basics – The Nuts and Bolts of Sound Evaluation.* Sage Publications, CA.
[11] King J, McKegg K, Oakden J, Wehipeihana N. 2013. Rubrics: A method for surfacing values and improving the credibility of evaluation. *Journal of MultiDisciplinary Evaluation*. Vol 9, No. 21. http://journals.sfu.ca/jmde/index.php/jmde_1/article/view/374
[12] These three levels are those represented in the Theory of Value Creation, i.e., looking after resources, equitably and economically; delivering services, equitably and efficiently; and generating social value equitably and efficiently.

Each strand of data collection is independently analysed and reported in annexes to this report. These annexes also include further information on the methods and participant profiles, where relevant. Sections 3 to 5 of this report provide a synthesis of all findings against the KEQs and evaluation criteria.

3. How does Youth PMHA create value?

In this section we briefly describe how Youth PMHA delivers value in an overall sense through the lens of the theory of value creation.

Looking after resources, equitably and economically – by building on existing knowledge and expertise and enabling a more flexible delivery approach through contracting.
Youth PMHA was established with a funding allocation of $45 million over five years, with a view to increasing access to, and choice of primary mental health and addiction services for youth/rangatahi populations (ages 12-24 years, inclusive) who are experiencing mild to moderate levels of distress.

Value was generated through making use of increased funding to build on existing knowledge, networks and resources to reach more young people. This was indicated by:

- A mix of new and extended services were funded, working through established providers with their own resources, services, and professional and community networks in place, to be able to extend their reach to rangatahi in their regions; and in so doing reach more rangatahi Māori, as well as Pacific, migrant, and rainbow youth, albeit to varying degrees.
- Many providers built new networks with other providers, including Māori providers, and in the process extended and enhanced their capacity to support rangatahi.
- Use of more flexible contracting processes initially with the Ministry of Health (and subsequently Te Whatu Ora from mid-2022), which enabled more agile and responsive services, with more open and trusting relationships with Te Whatu Ora.

Delivering services, equitably and efficiently – by reducing barriers to access, improving choice and tailoring interventions to key populations of need.
This level of the Theory of Value Creation gives primacy to the concept of equity, in terms of reaching people who haven't been well-served by the existing system and ensuring there is an offering that is suitable to them. Notable areas in which value is created through Youth PMHA are:

- Reducing barriers to access and supports for rangatahi, including the ability to self-refer.
- Offering greater choice and responsiveness to young people in a timely way.
- Development and expansion of culturally grounded interventions through kaupapa Māori providers, but to a lesser extent other cultures and rainbow communities; where implemented these were well-received by rangatahi and whānau interviewed in this evaluation.
- Expanded connections and collaboration with other health and social services that improved system connections.

Generating social value, equitably and effectively – through supporting rangatahi and whānau wellbeing, and enabling effective system-wide resource use.
At this early stage of Youth PMHA, qualitative feedback from young people, whānau and providers indicates that:

- Young people are benefiting from the services available and are reporting new skills and confidence to support their wellbeing.
- Rangatahi Māori and their whānau consistently reported benefits from engaging with kaupapa Māori services.
- Youth PMHA services appear to contribute to better use of resources across the primary care continuum, as well as generating links with secondary care services.

4. To what extent does the Youth PMHA provide good value for the resources invested?

In this section, we explore in more depth the creation of value by Youth PMHA, by reviewing the programme delivery against the evaluation criteria. Table 4 details the value creation domains and their accompanying criteria, which are explored in turn.

Table 4: Youth PMHA value criteria

Looking after resources, equitably and economically	Delivering Youth PMHA services, equitably and efficiently	Generating social value, equitably and effectively
Procurement and funding processes Design and knowledge base – building on existing infrastructure and expertise Performance management and accountability	Equitable and flexible service access Reaching young people and whānau/family Shifting the locus of control Manaakitanga and cultural fit System connections Learning and improving	Wellbeing outcomes for rangatahi and whānau/family More efficient and equitable use of health care resources

Looking after resources, equitably and economically

Procurement and funding processes

Table 5: Procurement and funding processes evaluative judgement

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
Performance management and accountability	Transparency and flexibility in procurement processes	Meeting minimum expectations	Procurement processes appear to have been transparent in Request for Proposal (RfP), and ongoing contract negotiations and management, but a business-as-usual approach to procurement was still commonly perceived.
	Māori provider resourcing	Not meeting expectations	Māori providers generally reported feeling under-resourced, despite some positive shifts in flexibility in funding and relationships with Te Whatu Ora.

Some flexibility was evident in the procurement process, but this was undermined by short timeframes and scale of responses required.

When procuring Youth PMHA services, a partnership-based process for procurement and funding would be expected to create the opportunity for providers to work with the Ministry to together design a system that meets the needs of young people, rangatahi and whānau. Providers interviewed acknowledged that the Request for Proposal (RfP) process, in some ways, offered more openness and flexibility than business as usual (BAU) processes, and enabled more innovative and collaborative proposals to emerge. Providers also indicated that their expertise and knowledge, including mātauranga Māori, were valued.

In other respects however, the procurement process was not seen to be a substantial advance on BAU processes. The short response period, the scale of proposals required and the competitive nature of proposals were common frustrations. Overall, this area can be seen to be meeting minimum expectations, against the evaluation criteria, but with further room for improvement.

> *Health New Zealand really needs to think about how they roll out the contracting process, it needs to be less competitive to promote collaboration. So we need to look at what are the different providers strengths and then we need to create an environment where people feel not threatened by each other but are willing to work together. [Youth PMHA provider]*

Flexibility in funding and contracting was widely appreciated, including by kaupapa Māori providers.

Beyond the RfP process however, many providers noted the benefits of flexibility in contracting, and that this allowed for agile and responsive services to emerge. This included flexibility around FTEs and choice between clinical and non-clinical FTEs; ability to reinvest underspend; openness from Te Whatu Ora for contract variations; and flexibility to work outside of contractual parameters. For NGOs, the use of the DHB pay rate for FTE was appreciated and considered fairer than what they would normally get through government contracts, and

enabled providers to attract and retain staff. Providers were also typically pleased with the multi-year funding approach (three years) as it gives some assurance of continuity.

> *And they listened and they changed the wording so that it was much more flexible and it allowed us to really do what we wanted to do differently. [Youth PMHA provider]*

This was echoed by kaupapa Māori providers who felt that funding processes were more flexible than normal and enabled them to function within te ao Māori and embed tikanga principles into the service. There was a general view that Te Whatu Ora to varying degrees has supported kaupapa Māori providers to do what they do best, with a focus on both the programme's design – what it funds, how, and how much – and the broader context in which the programme operates.

A key contention however was that the funding model remained insufficient to the demand or complexity of need; some providers were of the view that overheads were insufficiently covered, although Te Whatu Ora reported that these were factored into funding.

Open and trusting relationships between providers and Te Whatu Ora is developing.
It was generally acknowledged that Te Whatu Ora had made considerable effort to build relationships with providers. Some suggested however that this was driven by the strength of individual relationships. Some suggested that this could be strengthened further through face-to face engagement with providers.

> *We are now at a point of high trust contracting and of commissioning in a way that says 'you're on the ground, you know your community, what do you need and where does it need to go'? [Youth PMHA provider]*

Kaupapa Māori providers expressed frustration at the BAU process and funding that it was felt did not acknowledge Te Tiriti.
In procurement approaches, value can be created through tendering and funding arrangements that balance equity and efficiency. For example, efficiency of procurement processes may be facilitated through a traditional, rigid competitive tendering processes. However, equity may mean procurement processes also provides support and flexibility in the specific requirements to enable a wide array of providers, including Māori providers, to successfully participate in the procurement process.

Some kaupapa Māori providers felt that the competitive process did not reflect their status as Te Tiriti partners. Collaborative approaches working across Māori providers were not seen to be accommodated by traditional RfP processes and entailed a degree of mobilisation against the system as it stands. We note that this is an evolving system, and that Te Aka Whai Ora (Māori Health Authority) is expected to be primarily responsible for maintaining Tiriti relationships; nevertheless Te Whatu Ora will still have a role in commissioning of health programmes and services that look to embed te ao Māori and mātauranga Māori models of care.

Māori providers in particular reported a sense of being under-resourced and needed to work at times outside contract, drawing on their bottom lines to meet the needs of rangatahi Māori; in this regard, minimum expectations against evaluation criteria were not being met. Although

Māori are recognised as a priority target group in Youth PMHA, it was questioned if the level of funding in the current FTE model provides sufficient funding to address the complex needs that iwi and kaupapa Māori providers face, particularly those living in rural and isolated communities. Te Whatu Ora advised however that because there are also separate kaupapa Māori, and Pacific Access and Choice workstreams through which funding is being directed, the Youth PMHA services are not the only primary mental health and addiction services in the community responding to the needs of rangatahi Māori.

Design and knowledge base

Table 6: Design and knowledge base evaluative judgement

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
Design and knowledge base	Building on knowledge, skills, and resources	Pathway towards excellence	Intangible assets of providers have been valued and acknowledged, including cultural capital. Providers felt affirmed and respected in their expertise, including Māori. Local/community connections, knowledge and skills are nurtured and valued, some of which were supporting collaborative approaches. Whāraurau training provides basic training opportunities for staff that have been considered useful; how much rainbow-focused training was available is less clear.
	Engagement with iwi Māori/ hapū/whānau and rangatahi Māori	Meeting minimum expectations	Note clear evidence of excellence among Māori providers who have high levels of engagement with iwi Māori/hapū/whānau and rangatahi Māori during design of services. Less consistent with other providers; also unclear extent to which rangatahi Māori and diverse youth have been in involved in the design of non-Māori services.

Services have built on the foundations of existing services, infrastructure, and knowledge.

Part of the value proposition of the Youth PMHA is to build on the existing infrastructure and expertise of the sector. This approach brings the existing knowledge, expertise, cultural capital, and community networks of services to the initiative. If these resources are used well, this would suggest that Te Whatu Ora is enabling providers to work effectively in their communities and respond to community need. Moreover, services are expected to be designed in consultation with youth and with iwi Māori/hapū/whānau and rangatahi Māori.

It is clear from interviews that the Youth PMHA initiative has enabled the expansion of existing services, and development of new services. These have built on local or community connections, and tapped into existing intellectual, social, and cultural capital; overall these can be seen to be on the pathway to excellence. These enable rapid development and deployment, and expansion or extension of offerings (such as for anxiety, parenting, eating disorders and LGBTQI+), and to new geographic areas. Providers have acknowledged and valued kaimahi existing skills and knowledge and included them in service design and ongoing service development. Providers felt affirmed and respected in their knowledge and skills.

Provider staff received opportunities to develop their knowledge and skills through Youth PMHA.

Te Whatu Ora funded free professional development opportunities through Whāraurau as part of contracting for the overall Access and Choice initiative. These were widely appreciated by providers, particularly for the tailoring, accessibility, and variety, and overall suggests this is progressing towards an excellent level of delivery against evaluation criteria. The training was however considered foundational and were seen to be less relevant for experienced practitioners; areas for development included cultural competency for mainstream providers; and training that reflects the complexity of the rangatahi they work with.

Māori-led services were designed by Māori, in consultation with iwi and rangatahi Māori.

From interviews, kaupapa Māori services are either iwi-led, iwi-mandated or employ staff who are affiliated with the local iwi/hapū, and therefore have iwi involved in design and delivery. Māori services are underpinned by mātauranga Māori, and non-Māori services draw on it in various ways. Most of the programmes delivered by kaupapa Māori providers are based entirely on rangatahi Māori feedback.

However, Māori involvement in non-Māori providers appeared uneven, and similarly the extent of rangatahi Māori involvement. Common aspects of Māori involvement within non-Māori providers included kaumātua advisors, iwi engagement in early implementation, and Māori advisors or collaboration with Māori in collaboratives; and overall can be seen to be meeting minimum expectations.

Services have been designed in consultation with youth, who continue to be involved in ongoing service development.

Providers commonly indicated that they had taken on board youth voices, including rangatahi Māori, who have been involved in service design, development, and governance through a range of ways, including Youth Advisory Groups or rōpū. Providers reported being open to taking on feedback from young people and making changes accordingly. However, it was unclear how diverse the youth voices were that fed into service design.

Performance management and accountability

Table 7: Performance management and accountability evaluative judgement

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
Performance management and accountability	Stewardship of resources and accountability to funders	Meeting minimum expectations	Feedback suggests there is a basic framework for reporting. However, it offers only limited meaningful analysis, and is only partially seen as useful by providers. Basic stewardship (i.e. accountability to funders) criteria have been met. However, mechanisms for accountability/ responsiveness to kaupapa partners, including iwi/hapū about equity of funding are not clear.

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
			Te Whatu Ora are showing some innovation that suggests that they are moving towards stewardship that supports the system to flourish (as per excellence criteria) and mana whakahaere, such as zooms for providers, being responsive with feedback, and providing free training through Whāraurau.

Service providers are required to demonstrate that they meet basic expectations, but the reporting framework is viewed as having limited use.

Performance management and accountability processes are important to ensure good stewardship of resources, ensuring funds are used for their intended purpose and are appropriately managed. Feedback indicates that work in this area is meeting minimum expectations, as providers felt that the monitoring and reporting systems in place were limited in their usefulness and did not reveal the full extent of work that occurs outside of counselling sessions. Quarterly reports were seen most favourably, for their ability to include narrative reports to illustrate young people's journeys, but monthly reports were seen as onerous and of limited value or usefulness for the providers themselves.

Overall, providers felt that the Youth PMHA monthly quantitative contract reporting favours the clinical model of one-to-one counselling, and that other work is not well acknowledged through the current reporting structure. Reporting focuses on consultations and 'did not attend' (DNA) rates, but was not thought to reflect all the work that occurs outside of the counselling session (e.g., texts, phone calls, discussions with whānau), or how the work relates to other contracts. Providers did not feel that this reflected their holistic and integrated approaches, or that it fitted with te ao Māori.

Some provider interviewees sought more consistent reporting, as providers use a variety of measures that are difficult to compare and sought a clearer framework for outcomes reporting. This is an area that Te Whatu Ora has been seeking to implement for some time, but has been met with various challenges (outside the scope of this evaluation).

Te Whatu Ora demonstrates shifts towards mana whakahaere.

Through a range of ways, Te Whatu Ora is working towards mana whakahaere (effective and appropriate stewardship or kaitiakitanga over the health and disability system). For example, their facilitation of quarterly online sessions for providers to learn from each other was highly valued. Feedback from providers that Te Whatu Ora read their reports and engage with them around the data is also evidence of a shift towards supporting more effective service delivery. Further, the provision of free training opportunities by Te Whatu Ora shows a commitment to invest in the sector and helps support equity by providing professional development for smaller organisations that may not otherwise have the resource to do their own.

Delivering Youth PMHA services, equitably and efficiently

Equitable and flexible service access

Table 8: Equitable and flexible service access evaluative judgement

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
Equitable and flexible service access	Accessibility and acceptability of service settings	Pathway towards excellence	Settings are typically youth friendly and flexible with lots of different places and ways to meet and communicate. Service settings are comfortable and youth friendly. Kaupapa Māori providers and some others are improving access to services in largely Māori community settings. Some variation in other forms of support (e.g. supporting travel to and from appointments and outreach to rural communities).
	Removing barriers to access	Pathway towards excellence	Providers are working very hard to support rangatahi to access services and break down barriers. Range of support options vary; talking therapy appears dominant in non-Māori services. Services are open to youth when they're needed and they can return. Whānau involvement encouraged if permission is given.
	Accessibility and flexibility of services by priority groups	Pathway towards excellence	Some providers are present in largely Māori community settings, but this is an emerging area for many providers with relationships being formed. Some examples of reaching out to Pacific churches and LGBTQI+, and some refugee/migrant communities. Services are flexible and are changing to meet the needs of young people; both at an individual session level as well as which programmes they access and who they get support from.

Equitable and flexible service access ensures that the target groups are able to receive services through Youth PMHA, in a way that meets the needs of all, not simply those who have their own access to resources. Services need to be available with sufficient capacity and capability to meet demand, overall and for key target groups. In this area, feedback overall suggests services are on a pathway towards excellence. These findings also suggest a degree of technical efficiency, or 'doing things right', to reach the targeted population group and efficiently deliver youth services to a suitable degree of quality within available resources.

Access to services is evident through a variety of channels, and in settings that are accessible, safe and comfortable for rangatahi.

Many of the rangatahi interviewed had self-referred, and other access points included schools and social supports. Across interviews, rangatahi emphasised that the locations they received services were comfortable, youth-friendly and met their needs. Many were empowered to determine the location of their care, with some receiving a mobile service. Services are being

offered in varied settings, for example out in the natural environment, in youth hubs, marae, schools and other community settings where young people are comfortable. There was also a strong sense among providers that they were able to deliver improved access, with over 90% reporting that they had improved access for young people to a moderate (38%) or high degree (58%).

> *It was nice 'cos occasionally they're allowed to take out people to have their appointments at some of the lovely places we have in [location], like some of the beaches or at the reservoir and those, it's very easy to talk about your troubles surrounded by birdsong or the crash of waves. So those sessions in particular were very lovely. [Rangatahi interviewee]*

The availability of free services is highly valued by rangatahi, whānau and providers.
Rangatahi appreciated the removal of access barriers such as the need for clinical referral, and some shared that the service being free was essential for enabling their access. There is however some variation in supports available, with travel for example being inconsistently supported by providers.

> *I probably wouldn't have even considered it if it wasn't free and I probably would have been stuck in the same situation that I was when I first started counselling. It's really helped me like change my life. [Rangatahi interviewee]*

Services are demonstrating flexibility in a range of ways.
Rangatahi interviewed reported that the service cares about them and is there to support them. Many also appreciated the option to change providers or services, and that there was an open door to re-engage with services in the future. They also noted that they are able to work at their pace and are not forced to adhere to a particular programme of support.

> *You don't give up on people because they miss a couple of appointments. [Youth PMHA provider]*

A range of services are available through Youth PMHA, including individual and group-focused work, although talking therapy is the main option. Within kaupapa Māori services there is also an emphasis on cultural services and activities, and access to tohunga.

> *Because the group was tailored for my age group and the people in it were also in that age group, I felt more heard and understood. I was able to feel safer and included because of this. [Rangatahi interviewee]*

Providers proactively seek to eliminate barriers to young people, including rangatahi Māori.
Rangatahi reported that connecting with the service was experienced as comfortable and straightforward, with clear access criteria, and minimal barriers. All providers are conscious of the barriers that young people face when trying to access mental health and addiction services and indicated that they work hard to reduce or eliminate those barriers. The flexi-fund was seen as an essential tool for providers to reduce and eliminate barriers and was well utilised. Flexi-funds are occasionally used by a few providers to support whānau if this will have a direct impact on the wellbeing of the young person.

> *We can be like 'Who are you, what do you need, how can we support you?' as a collective. I feel like we do have so much flexibility of what that looks like. [Youth PMHA provider]*

Within the kaupapa Māori providers, supporting rangatahi Māori and their whānau to access other services is a central part of the whānau-centred approach they take. They do not operate as single services or even individual contracts. They take a collective approach, acknowledging that no one programme can offer everything, particularly given the barriers that rangatahi Māori and their whānau experience. For rangatahi Māori and their whānau, when they access Youth PMHA support they become a client of the provider, not the recipient of a single programme or service.

There was some strong engagement with LGBTQI+ communities and migrant communities evident, but these appear unevenly spread across providers.

Rangatahi interviewed who identified as LGBTQI+ felt respected and able to be themselves in their interactions with their providers and reported the support met their needs. There was also some evidence across interviews of engagement with migrant communities, and the competence of providers in supporting rangatahi of diverse cultures. Rangatahi from migrant communities shared that their providers were empathetic, respectful, and understanding of their culture.

> *I am bisexual and they were very welcoming to that. They welcome anyone. It's quite amazing. Like they respect pronouns, it's amazing. [Rangatahi interviewee]*

Reaching young people and whānau/family

Table 9: Reaching young people and whānau/family evaluative judgement

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
Reaching young people and whānau/family	Service utilisation	Meeting minimum expectations	Total people seen increased over time. One third of clients each month are new to the service (i.e. haven't been seen in the past 12 months). There is significant regional variation in staff as well as number of clients seen (total and per capita); main growth has been in Canterbury and Bay of Plenty. This indicates that improvements in service utilisation could be made in most places to support achievement of greater efficiencies. Activity rates per FTE have remained relatively consistent over time.
	Service utilisation by priority groups	Meeting minimum expectations	Compared to the population aged 10 to 24 years old, there was a substantially greater proportion of Māori clients seen by providers but lower proportions of people of Pacific[13] and Asian ethnicities. The proportion of people of European and other ethnicities was similar to that in the 10- to 24-year-old population
	Extent of wait lists	Meeting minimum expectations	Some instances of wait lists. Appears to relate to the model of care and high clinician load, and while rangatahi are on a wait list they often receive basic wellbeing support.
	Waiting times	Insufficient data	Waitlist data not sufficiently consistent to analyse.

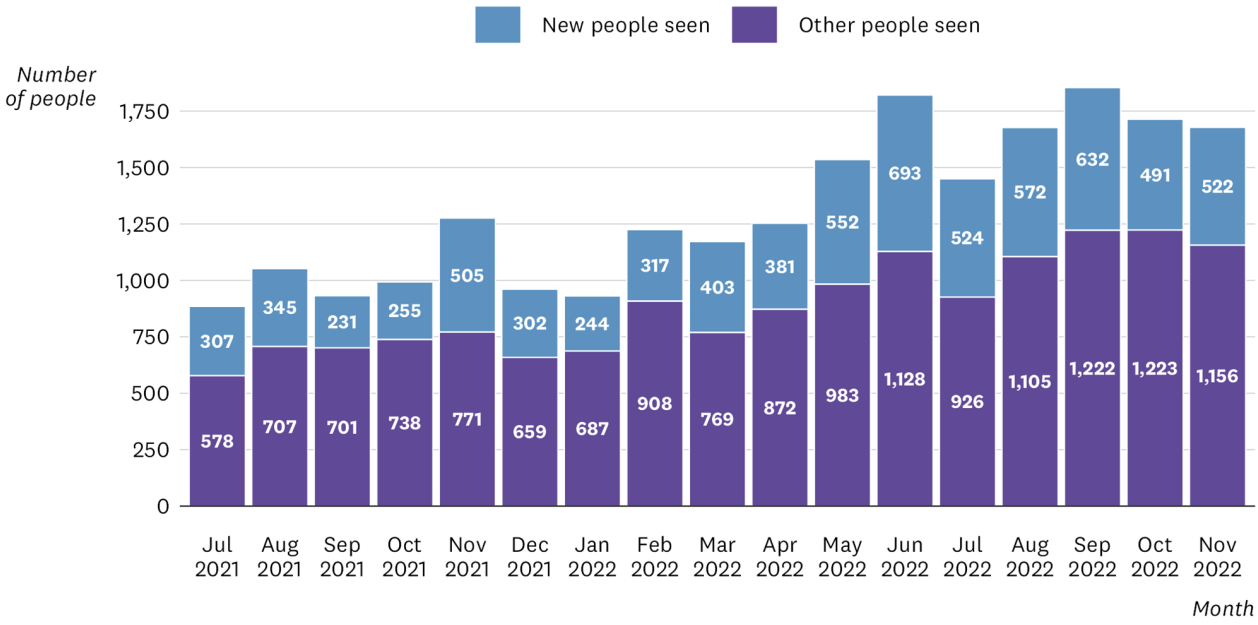
[13] Note: there is a Pacific-led stream of Access and Choice services as well which is targeted towards Pacific people, and available to people of all ages, including youth

In the design of this evaluation, reaching young people and whānau was seen to be about availability of services, as well as who and how many people access services, and how long they wait to access them. It is intended that those accessing the services will reach people who have been previously underserved such as Māori, Pacific, refugee/migrant and LGBTQI+ youth. Services should reach youth in sufficient numbers to be viable and efficient and wait times should be minimised. Analysis of service data and interviews indicate that Youth PMHA is meeting minimum expectations in this area.

Services are well-utilised and growing, driven by increases in FTE.

The total number of people seen through Youth PMHA has increased over time to an average of around 1,700 per month over the last six months of data (June to November 2022), with one-third being new clients seen in the month who have not been seen during the prior 11 months, and two-thirds being clients who have been seen during the prior 11 months (Figure 3). The total number of sessions provided per month has grown over time in line with client numbers. Over the last six months of data, an average of around 3,900 sessions were provided per month, with around 94% of these being individual sessions.

Figure 3: Total number of people seen per month



A growing workforce is evident.

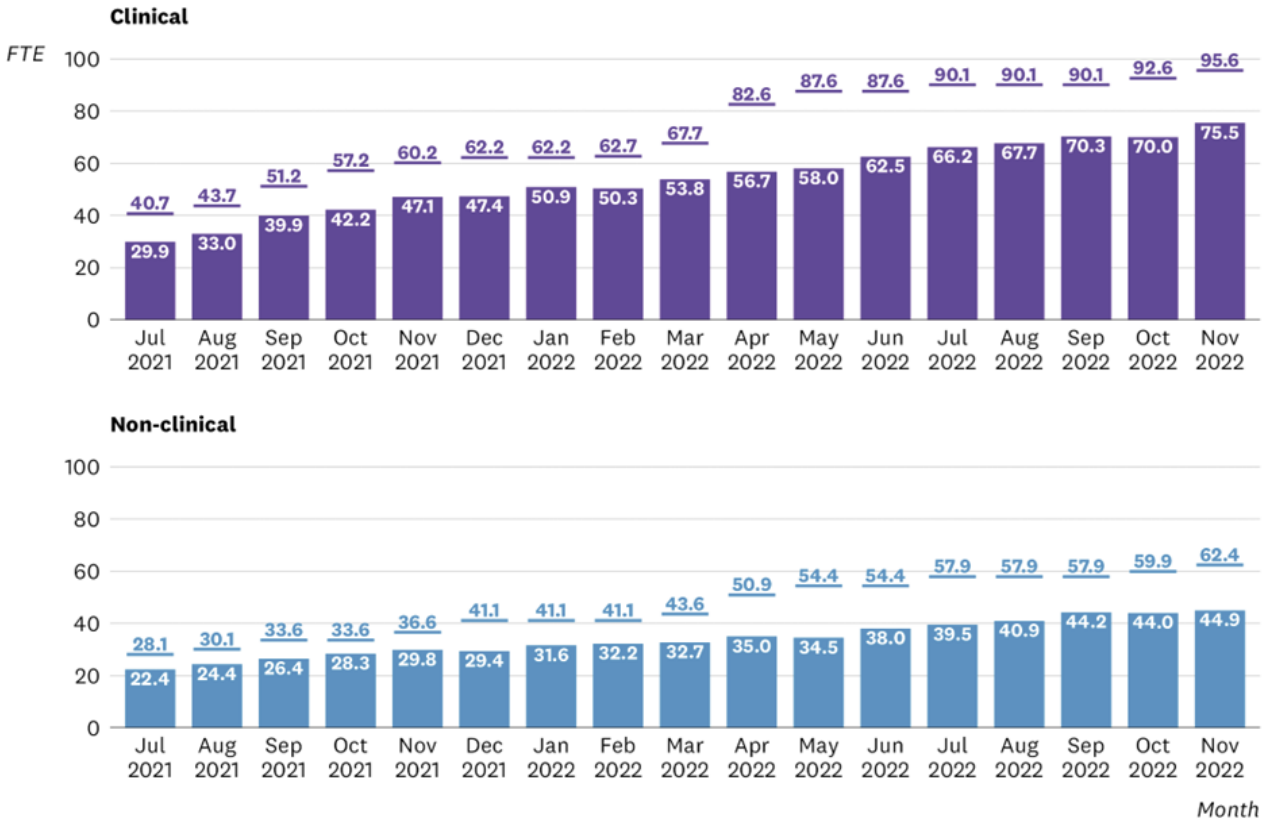
The workforce across all districts combined more than doubled between July 2021 and November 2022 for both clinical and non-clinical roles (Figure 4). Actual full-time equivalent (FTE) numbers have remained consistently below the contracted levels. In November 2022 there was a shortfall of around 20 clinical and 17.5 non-clinical FTE, which represent 21% and 28% of the contracted workforces respectively.

It is apparent that Youth PMHA was established at a time of some considerable system stress, when COVID-19 was exerting pressures on both services and rangatahi themselves. In this context, building system capacity and responsiveness will be challenging and take time to be achieved. It is not surprising therefore that a lag in recruitment is occurring, and even in the normal course of events, can be expected in a programme that is steadily gearing up capacity to respond to need. In discussions informing this report, Te Whatu Ora advised that the FTE rate is generally expected to be 60-80% of planned recruitment during implementation, and that this is

a new project of work and a significant roll out. A lag between programme funding allocation and recruitment, and then working with rangatahi can therefore be expected, and the FTE levels are thought to be at the high end of what was expected given that timeframe and the context of COVID-19.

There is also significant regional variation in recruitment, with significant growth in Canterbury and Bay of Plenty regions; at the same time we also note that actual FTE has fallen as a proportion of contracted FTE over time in Auckland and Waitematā districts.

Figure 4: Actual (solid bars) and contracted (lines) FTE by type of role



There is a growth in delivery to Māori, but relatively lower proportions seen of Pacific and Asian populations.

Compared to the population aged 10 to 24 years old, there was a substantially greater proportion of Māori clients seen by providers but lower proportions of people of Pacific and Asian ethnicities. The proportion of people of European and Other ethnicities was similar to that in the 10- to 24-year-old population.

Waiting times vary and are measured inconsistently.

The measurement of waiting times varies across providers and cannot be accurately assessed. However, some instances are evident of longer waiting times than the 3-5 days envisaged. This appears to relate to the model of care and high clinician load; we note, however, that while they are on the waitlist they often receive basic wellbeing support. Most rangatahi we interviewed who engaged with mainstream providers experienced a wait time for their first contact with a clinician or support person, which generally ranged from 1 to 3 weeks. In contrast, the rangatahi engaging with kaupapa Māori providers and one mainstream youth community service received immediate support and contact with the services.

There was a waiting list… maybe three weeks or so and during the three weeks one of the nurses would kind of touch base with me and see if I'm doing okay, like once a week or so. It would have been good if it was shorter than that but I mean there's a lot of demand I guess. [Rangatahi interviewee]

Shifting the locus of control

Table 10: Shifting the locus of control evaluative judgement

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
Shifting the locus of control	Championing rangatahi voice	Pathway towards excellence	Youth involved in design and delivery and examples given about how practice has changed based on feedback. All services clearly prioritise youth being able to choose their support.
	Tailoring to priority/diverse groups	Pathway towards excellence	Kaupapa Māori services offer te ao Māori grounded programmes and hit excellence criteria. Some non-Māori services with links or working hard to deliver culturally responsive services for Māori (and Pacific where Pacific populations are present) but an area where some acknowledge that improvement is needed. Few services are culturally responsive to Pacific migrant/refugee and LGBTQI+ populations although they are working on this. Culturally diverse staff is considered by providers, but a challenge because of the small workforce.
	Mātauranga Māori and Mana Māori	Pathway towards excellence	All use evidence and experience base, drawing on a wide range of expertise. Kaupapa Māori providers clearly at excellence rating, but there are varying levels of integration of mātauranga Māori in non-Māori providers.

Shifting the locus of control refers to services providing choice and control for young people in determining the support they receive (including by Māori for Māori, and by Pacific for Pacific models of service delivery). Overall, services can be seen to be on a pathway to excellence in this area.

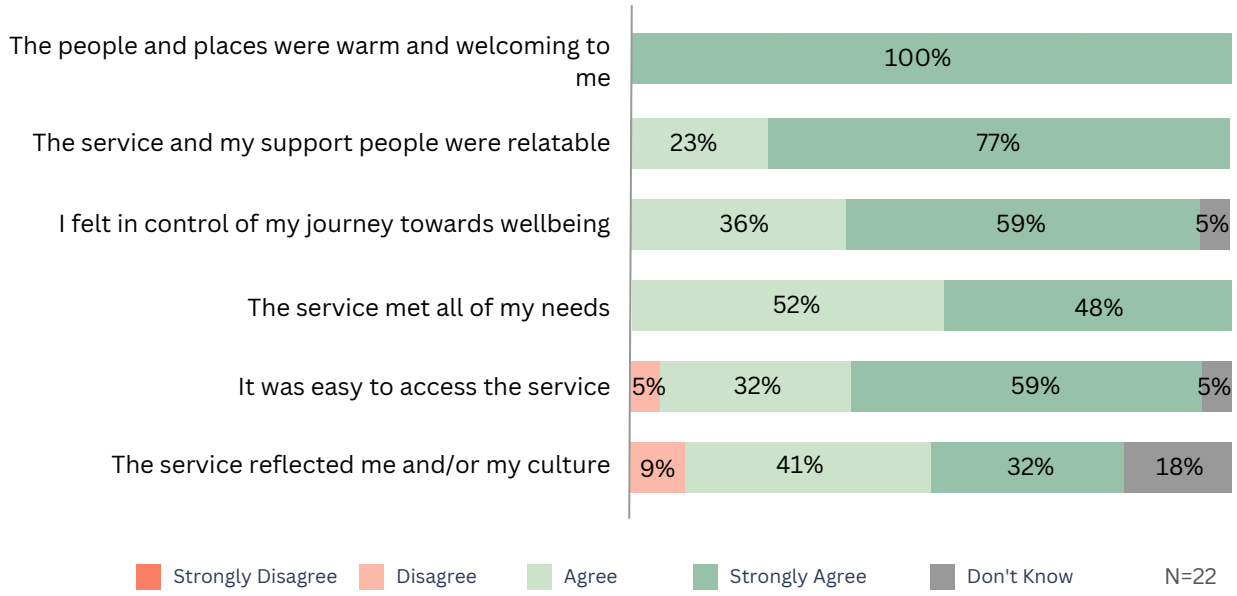
Services prioritise self-determination by rangatahi in the nature, location, and timing of support.

Providers prioritise young people making their own choices about what support they receive, when and from whom. Interviews clearly indicate that rangatahi have felt in control of their treatment journey in many different ways. Rangatahi generally experienced a high degree of flexibility in where they received services. Sessions took place in locations of their choosing and providers took care to communicate that they had a choice, and ensured changing needs were accounted for.

We go through different approaches. When I started she wanted me to try doing an affirmation type thing and I was like "it's not working for me, I feel weird doing this", and she was like "Okay, that's fine, we'll just move on." So she's very adaptable. [Rangatahi interviewee]

Although based on a small sample of rangatahi (22 respondents), Figure 5 below gives support to feedback indicating a responsive service that enabled young people to feel in control of their journey.

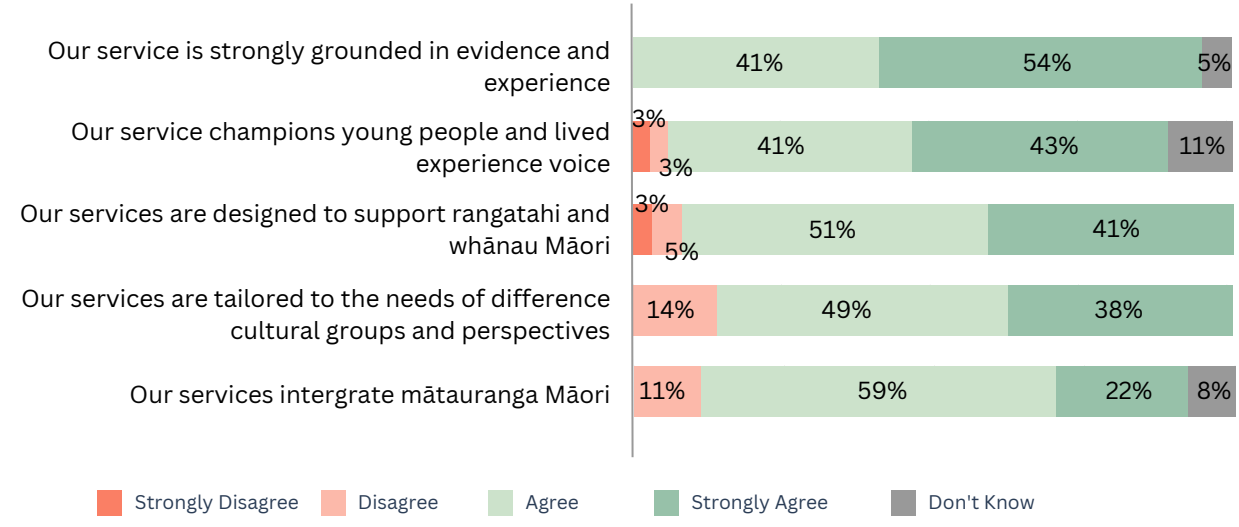
Figure 5: Rangatahi feedback on the services they received



Rangatahi voice and lived experience is championed and respected by providers in design and delivery.

As noted earlier, youth voice is considered in design and ongoing delivery for Youth PMHA providers. Examples were given as to how practice has changed based on feedback. Some providers indicated that their youth voice roles were reflective of the diversity they were serving. Figure 6 below indicates a strong sense among providers that their services champion young people and lived experience and are designed to support rangatahi and whānau Māori; and to a lesser extent integrate mātauranga Māori and are tailored to the needs of different cultures. These perceptions generally tended to be supported by rangatahi interview data.

Figure 6: Provider perceptions of service design



Culturally grounded and culturally responsive programmes are available for rangatahi Māori; less so for Pacific, LGBTQI+ and refugee/migrant communities which are at an earlier stage of development.

Findings from provider interviews identify that non-Māori providers have culturally responsive practices to varying degrees. The kaupapa Māori providers interviewed as part of this evaluation are delivering culturally framed programmes to all their rangatahi Māori and offering culturally grounded therapies such as traditional healing practices and reconnection to marae and whakapapa. Kaupapa Māori providers also have relationship with other providers to enable their rangatahi to receive the support that meets their needs.

Whilst there was a strong focus on supporting the needs of rangatahi Māori there were few other examples of programmes that were responsive to the other priority groups such as Pacific, LGBTQI+ and refugee/migrant populations. There is only one Pacific provider contracted under Youth PMHA, although we acknowledge that there is also a Pacific Access and Choice stream that is available to people of all ages, including youth.

Some providers were intentionally focused on providing support for LGBTQI+ young people and creating relationships with Pacific organisations, but these relationships are typically in the early stages. Several interviewees identified that more could be done to tailor their programmes to these population groups and other underserved groups. Culturally diverse staff is considered by providers, but remains a challenge because of small workforce and recruitment challenges.

Mātauranga Māori is well-integrated among Kaupapa Māori providers, and to a lesser degree non-Māori providers. There is an effort to uphold mana Motuhake and mana Māori.

Youth PMHA is delivered by Māori and non-Māori providers, and there is also a standalone Kaupapa Māori Access and Choice stream. The kaupapa Māori providers spoken to as part of this evaluation were deeply grounded in te ao Māori. Their practice was based on tikanga principles including tino rangatiratanga, whakapapa, kaitiakitanga and manaakitanga. Te Tiriti o Waitangi is a foundational document for these providers which underpins the relationships they have with the Crown, and their role to challenge systemic racism and barriers, that hinder whānau from receiving needed services.

Some non-Māori Youth PMHA providers are also integrating mātauranga Māori within the scope of what is possible as a mainstream organisation. Examples include establishing pou whakahaere positions, integrating expertise from local kaumātua, and collaborations with kaupapa Māori providers. Providers are also offering holistic support options, generally based on Te Whare Tapa Whā, that consider the entire wellbeing of young people. In addition, some providers are committed to also supporting the whānau of the young people they are working with. Some providers have a set of te ao Māori framed principles that underpin their practice, but these are not always given effect in their practice.

Manaakitanga and cultural fit

Table 11: Manaakitanga and cultural fit evaluative judgement

VfI criteria	**Sub-criteria**	**Evaluative judgement**	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
Manaakitanga and cultural fit	Warm, friendly, and relatable service provision	Excellent	Strong consensus that staff were helpful and friendly, warm, and relatable.

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
	Comfortable and mana enhancing	Pathway towards excellence	Strong sense that young people had a voice, their reality and values were validated. Work was strengths based, and rangatahi were supported to set goals.

Manaakitanga and cultural fit[14] provide a safe and welcoming space with concordance between people receiving services and those offering services, in a way that is responsive to and aligned with the needs, world views and preferences of participating young people. In this area, services were broadly seen to be meeting criteria for excellent or pathway towards excellence. This area delivers on relational efficiency, by providing: effective communication and collaboration with youth and between providers across the sector, a clear lens of Te Tiriti and cultural fit in delivering services; these recognise that without effective relationships, resources are wasted.

Rangatahi found services to be human and relatable; often described as kind, inclusive and welcoming.

Interviews indicate that rangatahi experienced their services as friendly, relatable, and easy to engage with. Young people described the providers they worked with as kind, welcoming, inclusive, open, and genuine. For some, that providers were young, or had shared background or experience helped them feel a sense of connection. Rangatahi commented that appointments were a "safe space" and they were treated with care, in a non-judgemental way and that they felt able to be themselves.

Rangatahi felt they were free to express themselves. The approach has evidently contributed to rangatahi experiences of feeling comfortable and respected, with many sharing they don't feel rushed and know the service will be there for them if they need it. Several young people report provider staff offering support with open-mindedness and inclusivity, fostering a space that is therapeutic and without judgement.

Rangatahi felt comfortable in service settings, and services were often reflective of their cultures.

Many rangatahi Māori interviewed noted they were also reconnected with te ao Māori in different ways and were encouraged to reconnect with their culture and identity as Māori. Services, activities, and programmes were developed by kaupapa Māori providers to whakamana (support and validate) the experiences and voices of rangatahi Māori. Kaupapa Māori providers explicitly introduce ngā uara (values), exploring them with rangatahi as part of their service approach and also rangatahi Māori hauora (wellbeing) pathways. This approach helped rangatahi Māori feel a sense of belonging to the organisation and service.

Whānau involvement was offered and fostered communication and connection.

Interviews indicate that rangatahi were given the option of whānau involvement in their care and were engaged to various degrees where permitted. While most of the rangatahi we interviewed engaging with mainstream Youth PMHA services did not take up the offer of whānau involvement

[14] Goodwin D, Sauni P, Were L. 2015. Cultural fit: An important criterion for effective interventions and evaluation work. *Evaluation Matters — He Take Tō Te Aromatawai.*

(something that was generally echoed by provider interviews), feedback indicates that when this did happen the approach was tailored to the context and needs of rangatahi and was valuable for both parties.

> *It's just learning those tools to instead of hold it all in actually to start communicating what he's feeling which is quite important. If we don't know what's going on we can't help so that communication has certainly improved a lot over the last few months. [Whānau interviewee]*

Some whānau learned tools to strengthen their ability of effectively support their rangatahi and were able to learn and reflect on their own parenting approaches in the context of the issues their rangatahi was facing.

> *The things that we talked about that were concerning [name] at the time I could see that a lot of the stuff that I was probably doing wasn't great. So I kind of learned a little bit about myself I guess, maybe had some lightbulb moments and realised some of the things [that] would be helpful for me to do. [Whānau interviewee]*

System connections

Table 12: System connections evaluative judgement

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
System connections	Access to a range of health, cultural and social services	Pathway towards excellence	Providers have relationships with other local providers that supports referrals; but the extent that the transition to additional services is seamless and timely is unclear, because of resourcing and wait times at other organisations.
	Links between community and clinical settings	Meeting minimum expectations	Providers are offering rangatahi access to clinical support and psychological assessments. This is done well in some places, but not consistently. Some spoke about competition between providers and challenges when making links with secondary mental health services because the relationship and understanding of each others' services was still developing.
	Collaboration with other local services	Pathway towards excellence	Collaboration is evident in almost all providers and is generally seen as beneficial for the rangatahi they serve. Some links with other local services evident for many providers.

System connections promote efficient and effective delivery through linkages and collaboration between health, cultural and social service providers. Overall, Youth PMHA is on a pathway towards excellence, but with further improvement required across both primary and secondary settings, as well as addressing the broader needs of whānau. Taken together with earlier findings, these suggest that Youth PMHA is delivering allocative efficiency, or 'doing the right things', to reach the right people and deliver efficiently. In this case, delivering culturally responsive interventions (particularly for Māori, but to a lesser degree other cultures), in a range of settings with a suitable mixture of clinical and non-clinical roles, with the prospect of this initiative

enabling better use of resources across the primary care continuum (e.g. by taking pressure off general practice).

Services are providing some access to other health, cultural and social service providers, but this is variable.

Some rangatahi are being connected with a range of clinical and other services via their Youth PMHA providers. In terms of enabling access to clinical services, some were referred to psychological and other clinical services for assessments and diagnosis, and a few were supported at appointments with a range of clinicians. Some providers are supporting access and transition to secondary services.

In terms of connections with community supports and services, some providers are well informed of the resources available and work proactively to connect rangatahi with relevant assistance. These included assessing housing and housing support services, disability services, and driving lessons, as well as study and employment services. Some received assistance directly from their Youth PMHA support people in preparing for and finding employment, while others were connected with other providers working in this area.

> *[There is] some kind of youth support service based in Wellington and they have social workers that can help you with like employment and study and stuff… and my counsellor said that she could put me on the waiting list to work with [them]. [Rangatahi interviewee]*

Rangatahi that set practical goals during their intervention mentioned their support persons' scaffolding the process of reaching out to other social, cultural and health services they would otherwise not have access to.

System connections were widely seen as important and valued, but require intentional resourcing.

Providers identified their links with other providers of youth services as beneficial and valuable. These connections provided more choice for young people as well as supporting learning within the providers about how their Youth PMHA offering could be improved.

> *Reassuring our whānau that there are other services that they can tap into, like how you said they may have a bad experience with a counsellor beforehand and it's just introducing them to other counsellors and getting them to come and join one of our sessions and just so then they can have a taste of who the person is, how they work and then have a kōrero afterwards and say did you like that person, do you think that's something you'd like to tap into and usually I find that's worked really well and it's just showing our rangatahi and whānau options of different types of support. [Kaupapa Māori Youth PMHA provider]*

An intention of Youth PMHA was for providers to maintain connections with clinical and other local providers, but that this would develop organically. However, several providers mentioned a lack of awareness or service directories to draw from within their local networks, particularly among those who have recently been established. There appears to be a lack of knowledge of what services can be leveraged for their rangatahi, their access criteria, and the staff who provide these services.

There is a realisation now from Te Whatu Ora and providers that for this to effectively occur it needs to be intentionally resourced, such as for developing and maintaining relationships and ongoing coordination/relationship management roles; these would likely improve the ability of services to work together efficiently and effectively for the benefit of young people.

Whānau Ora providers appear to be an important link for kaupapa Māori providers, and also have relevance to other providers.

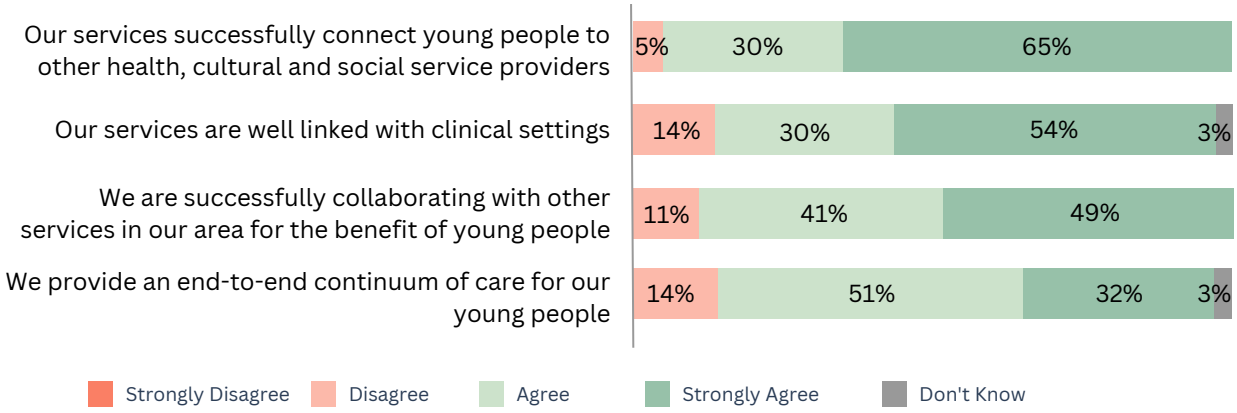
Kaupapa Māori providers spoke of having relationships with other providers, and in particular links to Whānau Ora providers were seen as critical. Many service providers have a wide range of services for whānau to access, or to access via referral. This includes Whānau Ora, kai support packages, home-based support packages, ACC support, employment, housing, and general practice health care services.

Most providers had links with secondary mental health services, although this varied.

There were varied relationships with secondary services. Some providers saw themselves as support for young people who were waiting for secondary care; others indicated that they want to "hold the space" for primary mental health and addictions services rather than be an add-on to an overworked secondary sector and potentially erode the availability of services for mild to moderate need rangatahi. Most providers, however, did have a relationship with secondary mental health and addiction services and were committed to working with them to better support young people. Some providers said that they valued the opportunity to support young people when they couldn't be supported by secondary services. The providers acknowledged that it took time to get to a point where appropriate referrals came from clinical settings.

Figure 7 below indicates providers in general consider themselves to be connecting across a range of services, but with some disagreement around links with clinical settings and end-to-end continuum of care.

Figure 7: Provider perceptions of system connections



Collaboration within provider consortia is adding value.

There are several examples of collectives that have joined forces to deliver a suite of Youth PMHA services or provide services over a larger geographic region to better serve young people. One collaborative has invested considerable time getting to know and trust each other at all levels of the organisation, across kaimahi, management and governance. Most providers working as part of a collaborative identified early tensions and conversations around boundaries and

how the collective will work together. This is to be expected even when providers within a collaboration are already known to each other.

> *We can all feed off each other and help each other in a sense. And that's the whole fun of it. [Collaborative] is breaking down those barriers as well… …we meet up every month, so we actually get to gain that trust with other people but because we all work together under this collaborative, it's made it easier for us to trust these people because we're all doing it for the same reason. [Youth PMHA provider]*

Learning and improving

Table 13: Learning and improving evaluative judgement

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
Learning and improving	Systems for learning and improvement	Pathway towards excellence	There are systems in place to support learning and improvement, but not consistently across all providers and systems are typically informal and/or ad hoc. There is some evidence of ongoing programme adaptation to meet needs and evidence/experience base.

Learning and improving at the service level is supported by structures and processes to collect and review evidence and feedback, reflect on performance, and adapt to become more efficient, equitable and effective over time. For Youth PMHA this is a supported process with involvement from Te Whatu Ora and the evaluation team. Overall, we saw positive signals of learning and adaptation that are above minimum expectations and on a pathway towards excellence. This brings a level of dynamic efficiency, through learning and adapting in order to improve other forms of efficiency over time.

Formal and informal learning methods were identified for organisational improvement.

Some, but not all providers spoke of the ways they learn and adapt their programmes to meet the needs of young people. For example, setting up new groups to meet an emerging need in the community, and bringing in different activities and support people to meet rangatahi needs. Both formal and informal learning methods were identified and some spoke of an organisation-wide learning focus. Continual adaptation based on youth feedback was a common learning tool as was learning from others within the team. Within collaboratives, learning from other providers was also noted as a key tool to support ongoing adaptation.

> *We're sitting all around a table and we can pull from other people in different areas, their expertise in that area and actually say "Oh my gosh that's an awesome way that they delivered that, that's something we can adopt in our own practice." You wouldn't find that anywhere else. [Youth PMHA provider]*

Ongoing adaptation based on feedback common learning tools.

Some providers said that they aim to continuously evaluate their services, gather feedback from their rangatahi on what they would like to see within their service provision, and gather demographic data of the groups of rangatahi being reached.

We learn from our taiohi and that helps us become more flexible so that we can cater our programme to the young people in our group. Their feedback is really appreciated because we are able to see what works and what does not work. [Youth PMHA provider]

It is a standard practice among some providers to offer an opportunity for their clients to complete a rangatahi and whānau satisfaction survey, where feedback is kept both anonymous and confidential, and is used to further strengthen provider service delivery. While feedback is often positive and combined with promising engagement statistics, providers on occasion receive feedback that prompts the service to review its delivery and pursue avenues to address issues identified.

Some kaupapa Māori providers identified learning and critical reflection spaces.
Two of the kaupapa Māori providers spoke of creating a learning and critical reflection space within their organisation and engaging in cycles of continuous improvement. They see this as being accountable to themselves and their whānau.

Generating social value, equitably and effectively

In this section, we review the evidence from the evaluation to explore the extent to which there are wellbeing outcomes for rangatahi and whānau, and more equitable and efficient use of health care resources. This is drawn from qualitative and survey data and does not seek to 'measure' any particular outcomes. Based on the data available, there is evidence to support an evaluative judgement of a pathway towards excellence for both dimensions.

Wellbeing outcomes for rangatahi and whānau

Table 14: Wellbeing outcomes for rangatahi and whānau evaluative judgement

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
Wellbeing outcomes for rangatahi and whānau	Helping rangatahi and their whānau	Pathway towards excellence	Young people appear to be in a better place as a result of using the service. Some have made notable shifts in a short space of time.
	Developing skills and confidence	Pathway towards excellence	Providers and rangatahi perspectives indicate rangatahi have developed skills, confidence, and ability to draw on resources outside the support context, and to better manage their distress. Feedback suggests that youth are able to draw on their internal and external resources, and that youth are being empowered to make better choices. A few young people are exploring volunteering for services and/or pursuing a career in mental health.
	Building skills, resilience, and identity	Pathway towards excellence	Findings suggest that support to rangatahi facilitates the strengthening in rangatahi of community networks/resilience and internal skills. Rangatahi Māori spoke of learning/developing more of their identity as Māori, including whakapapa, about taiao and rohe, and rongoā.

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
	Positive outcomes are gained	Pathway towards excellence	Positive wellbeing outcomes as defined by providers are being achieved, such as youth being more engaged, building skills and confidence, getting a better understanding of mental wellbeing, and making good choices. All rangatahi interviewed appeared to be achieving at least one of their goals.
	Responsive services	Meeting minimum expectations	Feedback from both providers and rangatahi indicate that services are responsive to Māori and some extent LGBTQI+; less evident with Pacific however. Mana Tangata: feedback indicates benefits for Māori who access Māori providers, but unclear with regard to other groups or Māori in non-Māori providers.

Rangatahi were engaged in the services, and feel the service helped them to reach their potential.

Rangatahi interviewed in this evaluation were clearly well-engaged in their services, and feel they helped them be better equipped to meet their potential. Some have made notable shifts in a short space of time and reported that their mental wellbeing had improved as a result of their time with services. Some whānau have also received and are making use of support, skills, and strategies.

> *I think right now I'm doing so much better than I was before. I'm definitely on my road to recovery… I made a promise to myself that, we made a promise together I guess that I wouldn't or I would try not to be in that position ever again and they also told me that if I ever want to refer myself or get referred to them, I can just flick them a text, flick them an email and they could easily hook me up. [Rangatahi interviewee]*

Rangatahi are developing skills that they can apply in their own self-care.

Examples shared by rangatahi of the progress they had made over the course of their work with Youth PMHA providers include increase in confidence and self-acceptance; growth in communication and relationship skills; greater understanding of mental wellbeing, and the protective factors that support their health; and buildingresilience and confidence.

> *It opened my eyes a lot as to actually what is important in my life and what's not and how to figure [that]… and learning to let things go has been a big one for me. I've had a lot of job issues, especially recently, and I was having them when I was seeing [counsellor] and I've had them again afterwards and I felt like I've handled them a lot better afterwards. So that's good, I've seen a bit of growth there. And I've just come to learn to think more about myself I would say. [Rangatahi interviewee]*

Significantly, a small number shared they no longer struggled with suicidal ideation, in large part due to the support of their Youth PMHA provider.

They came at a really good time because like yeah, I could be really open, I could talk about whatever I wanted, even if it was for like an hour or two hours a week. They are definitely the reason or one of the big reasons why I'm here today and I'm alive. [Rangatahi interviewee]

All rangatahi interviewed were able to achieve at least one of their goals.

Rangatahi have been supported to identify and focus on what is meaningful to them, and to set and work towards goals that feel important and relevant; with all those interviewed reporting achieving at least one of their goals. Providers and rangatahi perspectives indicate rangatahi have developed skills, and increased their confidence. Further, they reported drawing on these skills outside the support context, to manage their distress. Feedback suggests that rangatahi are able to draw on their internal and external resources, and are being empowered to make better choices.

Some young people report feeling more connected to their family and communities.

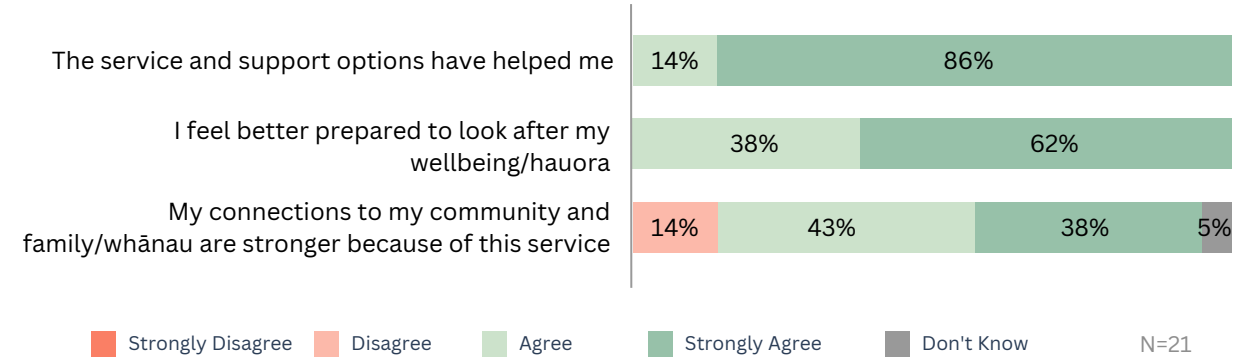
Feeling more connected to their whānau and communities were frequently cited by rangatahi as outcomes of their engagement with Youth PMHA services. Interviewees shared that services helped them to communicate, to reconnect with their family values, foster understanding and acceptance of their histories or the behaviour of others, and enabled them to appreciate the experience of loved ones. Findings suggest that support to rangatahi facilitates the strengthening in rangatahi of community networks/resilience and internal skills. Providers also noted how their rangatahi have reengaged with their community networks, including their peers, their studies, and extracurricular activities.

For kaupapa Māori providers, part of the support is also about recognising rangatahi Māori as individuals who sit within a whānau. The whānau centred approach is holistic, addresses the broad wellbeing needs of whānau whanui and focuses on building relationships with groups of people rather than individuals. This has helped rangatahi Māori understand and navigate the contexts they find themselves in. Rangatahi Māori spoke of learning/developing more of their identity as Māori, including whakapapa, about taiao and rohe, and rongoā, supported actively by the kaupapa Māori providers they partner with. Kaupapa Māori providers in particular noted that rangatahi Māori are talking more to adults in their lives, and that they are better able to build relationships with them, including parents, other whānau, and people at school.

They always tell me that they feel like lighter and they feel like they have the skills to manage their wellbeing and mental health and that they're growing like capacity to communicate with their whānau about this stuff, cos there's still a lot of stigma around mental health and addictions so our mental health team is really supporting our rangatahi to communicate with their whānau and have them involved in their wellbeing journeys. [Kaupapa Māori Youth PMHA provider]

Some interviewees shared that they are now motivated to support others facing mental health challenges, and a few young people are exploring volunteering for services and/or pursuing a career in mental health. Although based on a small sample, Figure 8 below gives support to the benefits reported by rangatahi.

Figure 8: Rangatahi perception of wellbeing outcomes



More efficient and equitable use of health care resources

Table 15: Efficient and equitable use of health care resources evaluative judgement

VfI criteria	Sub-criteria	Evaluative judgement	**Rationale for evaluative judgements** (see Annex 7 for more detail about evaluative criteria)
More efficient and equitable use of health care resources	Better resource use through addressing issues at an earlier stage	Pathway towards excellence	Feedback suggests that the Youth PMHA contributes to more integrated, interconnected service delivery. Feedback also suggests that mild to moderate, and in some instances complex issues are being identified and addressed early on before they escalate. Without relevant data it is difficult to indicate if the need for higher intensity services is reduced, but most providers believed this would be the case.

Youth PMHA services appear to contribute to better use of resources across the primary care continuum.

Previous sections have illustrated that Youth PMHA has contributed to increased access to services for young people. Data also suggest that Youth PMHA has contributed to more collaboration and integration between local providers and services. This indicates better use of scarce resources across the primary care continuum by supporting improved access and greater efficiency in the way services are delivered.

Whether as existing service collaboratives, or new provider collectives, kaimahi are able to coordinate and communicate with each other to ensure young people are getting the support they need, that progress is happening, and that any issues that arise are addressed and resolved. Providers also noted that Youth PMHA is likely to help reduce the need for support over time, and that they are more likely to seek help at the right time, next time they need it.

While provider feedback suggests that these positive changes apply to rangatahi Māori and to some extent LGBTQI+ youth, it is less clear to what extent other diverse groups may have benefited. As such, it is difficult at this early stage of implementation to say whether better use of resources also represents equitable use of resources.

As noted above, this feedback is based on provider perceptions and cannot be quantified from the data available. However, the logic of the feedback received indicates that more efficient use of health care resources is being achieved through Youth PMHA.

Mild to moderate mental health and addiction issues are being identified and addressed at an early stage, and it is likely that this reduces the chances of them becoming more serious.

Feedback indicates that mild to moderate issues are being identified and addressed at an early stage, before they have time to escalate. The ability to meet young people when they present is a key enabler. Where clinical support is not immediately available, providers are able to hold the young people and/or offer other supports in the meantime through their internal services, or services provided by their collaborative partners.

Being able to offer young people other types of supports that are not mental health focused can help build independence and address underlying causes of distress. Providers described how their services focus on building skills and strategies for young people to manage their own wellbeing, can also reduce the risk of mental health issues becoming more serious.

> *I was in the clinical service before this and I don't think I've ever been able to have this kind of immediate, direct impact on youth as I have in this role [Youth PMHA provider]*

Feedback indicates that rangatahi Māori who access kaupapa Māori Youth PMHA services have wrap around support that affirms them as Māori and are given the opportunity to experience outcomes as Māori. Considering there are well-established links between cultural efficacy and greater psychological resilience amongst Māori,[15] it is likely that these services, if sufficiently resourced, could help reduce pressure on other parts of the system over time.

> *It helps shift their state from te pou, where it's all dark and there's no light to being able to see the light again. [Kaupapa Māori Youth PMHA provider]*

It should also be noted that a key theme of provider feedback was that the complexity of the young people who present, is often higher than mild to moderate. As such, providers – who do not want to turn young people away – are finding that they are often addressing more complex needs than what Youth PMHA set out to do.

There is insufficient data to understand the extent to which early intervention is reducing the need for higher intensity services

The Youth PMHA goal that early intervention reduces the need for higher intensity services – more equitably and in particular for priority groups – is a long-term, high level systemic change. As such, providing conclusive evidence of this is beyond the scope of this evaluation. There is a general sense among providers that services are reducing the need for more intensive support services, and this feedback is consistent with what was expected given the stage of the programme and the data available.

[15] See, for example: Muriwai, E., Houkamau, C. A., & Sibley, C. G. (2015). Culture as cure? The protective function of Māori cultural efficacy on psychological distress. *New Zealand Journal of Psychology*, 44(2), 14–24.

5. How could the Youth PMHA provide more value for the resources invested?

Youth PMHA is at an early stage of development and implementation, and after two years, providers are steadily gaining momentum and connection with rangatahi in their regions. In this context, the programme's development should be seen through a lens of continuous reflection and adaptation, which this evaluation can contribute to.

Overall, this evaluation has found widespread evidence to show that Youth PMHA is offering good value for money and is generally delivering on the intentions of its investment. In this section, we offer some suggestions for ways in which Youth PMHA can offer more value for the resources invested.

Looking after resources equitably and economically

Key areas of development in this area of Youth PMHA value are the following:

- Providers generally appreciated the improved flexibility in contracting, and there is a need for similar flexibility in Te Whatu Ora procurement processes to challenge existing BAU processes; this could include early conversations between Te Whatu Ora and potential RfP respondents, and use of Expression of Interest processes.
- Deepening relationships (including contracting and levels of funding) between Māori providers and Te Whatu Ora to embed te ao Māori mātauranga, reflect a Te Tiriti approach, and improve capacity to respond to rangatahi Māori; we note however that the primary Tiriti relationship will be held with Te Aka Whai Ora (Māori Health Authority).
- Longer-term contracting, with a focus on building capability and capacity over time, particularly with Māori providers.
- Considering the need for increased funding for iwi and other kaupapa Māori partners so services can meet high and complex needs of Māori, particularly to reflect the additional resource required to deliver services in isolated and rural areas.
- Non-Māori providers developing further their relationships partnerships with iwi/hapū and diverse groups.
- Extending training into cultural competence and working with complex needs.
- Consultation and engagement on useful and meaningful data for reporting.
- Streamlining and re-focusing reporting, including outcomes focus; we note that outcomes measurement tools are approaching a stage of implementation with providers at the time of this evaluation's conclusion.

Delivering services, equitably and efficiently

In this domain, we received generally very positive feedback about the quality of engagement with rangatahi. This is also an area where capacity is being developed to meet needs, and capabilities are being built to engage with previously under-served populations. With this in mind, noted areas of development are:

- Continuing to grow overall system capacity and reduce regional variation in FTE growth.
- Non-Māori providers deepening outreach and capacity to work with Māori communities.
- Providers building further their responsiveness and capacity to work with Pacific, LGBTQI+, and refugee/migrant communities.

- Mainstream providers building relationships with suitably resourced kaupapa Māori and Pacific providers, to ensure rangatahi have clear choice for where and how they access primary mental health support.
- Ongoing development of system connections across primary/community and secondary, and with social and other service providers.
- Funding development of local directories of services that can support system connections for providers.

Generating social value, equitably and effectively

The value generated by Youth PMHA, in terms of both wellbeing and system outcomes, is influenced by other factors beyond the control of Youth PMHA, including the wider health system and societal context that youth are situated in. Youth PMHA is therefore not solely responsible for value generation at this level. However, some areas of activity that are likely to support social and system-level value are:

- Further growing relationships across systems (primary/community and secondary, and across mental health and other systems) for greater service integration.
- Strengthening relationships between primary and community providers to ensure rangatahi are connected to and receive the most appropriately targeted care.
- Improving data systems, particularly in understanding flows across primary care settings and between primary and community care, and secondary care.
- Exploring further the value that is being generated by consortia approaches that can offer comprehensive support from a variety of modalities, particularly for those with high complexity in their lives.
- Connecting more with the other Access and Choice streams (Māori, Pacific and integrated primary mental health and addiction (IPMHA)) to provide a more joined up regional approach.

6. Conclusions

Youth PMHA services are becoming well-established, and at the same time are still on a growth and development trajectory as they look to build capacity to meet the needs of rangatahi. As a system, Youth PMHA services are expected to continue to develop and adapt and are now looking beyond the implementation challenges that COVID posed at the outset of the initiative.

Available evidence indicates that Youth PMHA is meeting its value proposition, and according to most criteria is on a pathway to excellence, particularly in terms of enabling equitable and flexible access to services, and the value and impact that rangatahi and whānau are reporting in their engagement with services.

Key areas of development include reaching more rangatahi; raising the profile and awareness of available services as capacity increases; consideration of increased funding to iwi Māori and Māori providers to support them to meet high and complex needs of rangatahi Māori, particularly in rural and isolated settings ; further cultural competence development in mainstream providers, and building wider understanding of the particular needs of Māori; continuing to grow system capacity; minimising waiting times; links between community and clinical settings; and capacity of secondary services to meet more intensive mental health needs.

A lack of quantitative data available for this evaluation, particularly on service outcomes, together with the experiences of rangatahi who disengaged from services, represent limitations in the extent to which value can be assessed and are important areas for further development. A further area of data systems development is in understanding the flows across primary, community and secondary settings.

Overall, findings suggest that Youth PMHA is a worthwhile use of resources, and justifies both maintaining the direction of development, and further building a culture of learning and improvement.

Annex 1: Rangatahi interviews

Approach

This annex shares the findings from interviews with rangatahi and their whānau undertaken over the course of November and December 2022. In total 33 were people included in the rangatahi and their whānau interviews, comprising 29 rangatahi and 4 whānau members, including parents, guardians, and partners. The majority participated in one-on-one interviews, either in-person or via video conference, with a small number of rangatahi interviewed alongside another rangatahi service user, or a whānau member. Data collection included one group discussion with 6 rangatahi. Interviews ranged from 10 to 40 minutes.

Participating rangatahi and whānau had engaged with 7 different Youth PMHA contracts out of a possible 15 contracts, of which 4 were kaupapa Māori providers included in this analysis.

Delivering Youth PMHA services equitably and efficiently

Equitable and flexible service access

Services are delivered in settings that are accessible, safe, and comfortable for rangatahi.
Across interviews, rangatahi emphasised that the locations they received services were comfortable and met their needs. Many were empowered to determine the location of their care, with some receiving a mobile service. Office-based sessions were the default for others, however many of these rangatahi shared they were aware they could meet elsewhere if they wanted or needed to, or if the focus of their work together required a different location.

> *Usually I just come here but if we're doing like some kind of [particular] session, like exposure therapy for like anxiety and stuff, like we've gone to the public library and to a café before. [Rangatahi interviewee]*

For some rangatahi, agency over their service setting was a point of difference in comparison to others they had used. One rangatahi, for example hugely appreciated the greater comfort and privacy that came with accessing counselling outside of their school setting, while others valued the option to determine location based on their mood and preference on a given day.

As noted, meeting at provider premises appeared to be the only option for some rangatahi, and interviews indicate that transport barriers have prevented some attending their appointments. None of the young people interviewed reported accessing telehealth or online services, with the exception of isolating due to COVID-19.

> *Sometimes [transport]... can be an issue but if I can't get here for some reason I will just ring them up and rebook for another time. [Rangatahi interviewee]*

Those that met in office settings saw them as comfortable, calm, inclusive environments which they experienced as relaxing and private. A few rangatahi described provider offices as places they could “hang out” and do things they enjoy, such as play table tennis. Offices were generally reported to be centrally located and easy to travel to.

> *In the rooms they have like calming messages on the wall in English and te reo and offers for support for LGBTQ and they would have calming artwork and just colour*

schemes that aren't too loud and structures inside that weren't too jagged or harsh or lighting that wasn't too clinical, as you would see in maybe a doctor's office or a hospital. [Rangatahi interviewee]

Many young people appreciated the option of meeting outdoors in places that they experienced as quiet, calming, or private. For some rangatahi this was an option at each session. One rangatahi spoke of being able to meet at their "special spot" they often go to when they feel down. Kaupapa Māori providers intentionally designed activities to support the (re)connection for rangatahi to te taiao (environment) and te ao Māori. Rangatahi Māori shared that walking in the ngahere (bush) helped their healing and moving to a more healthy positive mindset.

It was nice 'cos occasionally they're allowed to take out people to have their appointments at some of the lovely places we have in [location], like some of the beaches or at the reservoir and those, it's very easy to talk about your troubles surrounded by birdsong or the crash of waves. So those sessions in particular were very lovely. [Rangatahi interviewee]

It was always good... Like there was never a place I felt uncomfortable. [Rangatahi interviewee]

Service access channels are appropriate, accessible, and break down barriers.

Rangatahi generally reported that the process of accessing their Youth PMHA provider met their needs. While pathways varied, connecting with the service was experienced as comfortable and straightforward, with clear access criteria and minimal barriers.

I just googled it and it came up and because I was under 24 I qualified. I did a self-referral, I didn't need a doctor to refer me, so that was helpful as well, it sped up the process and they got in touch with me really quickly, and then I just had to wait. [Rangatahi interviewee]

Roughly half of those interviewed were referred by organisations, and the remainder self-referred. Across these pathways, a positive reputation (among peers, other touchpoints with a provider, and among other services), helped rangatahi feel comfortable accessing these services. This was particularly so for those that self-referred, who mainly found their service via word of mouth.

For many rangatahi we spoke to, services were visible in places they frequented and were comfortable. Of those that connected via organisations, most engaged through a school setting, either referred via counsellors or support groups (including a rainbow support group), or because providers were delivering services within their school. Others found out about services through accessing social supports, including other offerings of the Youth PMHA provider organisation. However a few shared they "accidentally" found out about the service through social service organisations and felt it could be better promoted.

Rangatahi Māori felt welcomed and were made to feel comfortable by kaimahi Māori and organisational settings that reflected their culture, through toi Māori and taonga.

Rangatahi appreciated the removal of access barriers such as the need for clinical referral, and some shared that the service being free was essential for enabling their access. Rangatahi Māori

were also grateful for being able to access services in traditional Māori practices like rongoā and wairuatanga. This affirmed rangatahi and their experiences as Māori.

> *I probably wouldn't have even considered it if it wasn't free and I probably would have been stuck in the same situation that I was when I first started counselling. It's really helped me like change my life. [Rangatahi interviewee]*

Some range in support options, but 1:1 talking therapies are the dominant delivery mode.
With the exception of rangatahi Māori, interviews indicate that the support options of individual providers were limited, with most offering 1:1 talk therapy only. One or two rangatahi however did shared that they were offered a range of support options and had also engaged in some form of group work with their provider. Nonetheless, rangatahi were offered a range of tools, modalities and approaches within their 1:1 sessions.

Across the kaupapa Māori providers activity-based therapy including raranga (weaving), mara kai (growing vegetables/food) or group breathing and meditation sessions were used.

> *I thought it was just one-on-one counselling. I'm sure they would have told me if there was like different options. [Rangatahi interviewee]*

Rangatahi feel that the service cares about and is there for them.
Interviews indicate that rangatahi felt their provider cared about them and worked hard, even going "above and beyond", to give them the best possible care. Youth PMHA providers were seen to be there when they needed them. Some offered "check-ins" where they reach out to rangatahi between appointments and times when they are "struggling". A few shared that although they met with their provider fortnightly, they were told they could text or call for support if needed.

Rangatahi were grateful that they had someone working alongside them who believed in and would not give up on them. Across interviews, the reassurance offered by the sense of an 'open door' was clear; to know that post intervention, there was potential to re-engage should they feel at risk or need further support. We heard that a few providers still actively check up on rangatahi after support has ended. A number of rangatahi explained that while they were hopeful for the future despite still struggling with ongoing issues, they were comforted by the thought that they can return for further support if needed:

> *I'm still struggling with one big thing that I did struggle with going into the counselling, which is still a big issue and it's still playing a part now but it's better than it was. So I am hopeful that if I keep going on the track and it was made clear to me that right up until I turn 25 I can go back. So that's comforting to know too. So yeah I am hopeful. [Rangatahi interviewee]*

> *I think right now I'm doing so much better than I was before. I'm definitely on my road to recovery… I made a promise to myself that, we made a promise together I guess that I wouldn't or I would try not to be in that position ever again and they also told me that if I ever want to refer myself or get referred to them, I can just flick them a text, flick them an email and they could easily hook me up. [Rangatahi interviewee]*

Some whānau interviewed reinforced this perspective that staff cared about their rangatahi and their wider support network. One caregiver noted that the counsellor checks in with them and their rangatahi, and that they see this as evidence of genuine care:

> *When we were at school there was just the school counsellors and that was it. But I think this particular, with [service name] they… actually do seem to care, so that makes a huge difference. [Whānau member interviewee]*

Rangatahi experienced a reasonable degree of flexibility of service.

Services are working in ways and flexing to meet the needs of rangatahi. While offering structured programmes and activity based opportunities, rangatahi are able to choose levels of engagement that suit them. They are able to work at their pace and are not forced to adhere. Rangatahi shared how the providers offer consistent support, a sense of security, while giving them the space to engage when they are ready. Providers have also able adapted and developed their services from rangatahi feedback.

Some strong engagement with LGBTQI+ communities, connections with migrant communities less clear.

Feedback indicates that providers are reaching rangatahi that identify as LGBTQI+, with three of the 29 rangatahi interviewed either sharing they identified as LGBTQI+ or had accessed support from their provider in relation to their sexuality or gender. Rangatahi felt respected and able to be themselves in their interactions with their providers and reported the support met their needs.

> *I am bisexual and they were very welcoming to that. They welcome anyone. It's quite amazing. Like they respect pronouns, it's amazing. [Rangatahi interviewee]*

One rangatahi received what they described as very significant and transformative support to address their "gender issues" via medical affirmation; supporting them to contact and access endocrinology services and ultimately to achieve their goal of receiving hormone therapy:

> *… she helped me get in contact with the hospitals… to an endocrinologist and she even came with me to that appointment, which was great, 'cos I was having like breakdowns, thinking that was such a faraway thing, that I was never going to be able to get it because it's so expensive… she's really gone above and beyond cos even she injected me with the hormone as well. [Rangatahi interviewee]*

There was also some evidence across interviews of engagement with migrant communities, and the competence of providers in supporting rangatahi of diverse cultures. Two rangatahi from migrant backgrounds participated in our interviews, with both sharing that their providers were empathetic, respectful, and understanding of their culture. One rangatahi shared their counsellor supported their desire to explore the role of their cultural background and upbringing in aspects of their current challenges, and to build skills for resilience in these areas.

Service engagement process and timeframes met the needs and expectations of most rangatahi.

Once a connection was made, rangatahi experienced services as proactive and friendly, with acknowledgement that they had received their referral or application and will make contact shortly. Rangatahi shared that services reached out to them in ways that were informative, engaging and friendly.

However the timings and process following this initial contact varied for rangatahi. The majority of those engaging with mainstream providers we interviewed experienced a wait time for their first contact with a clinician or support person, which generally ranged from 1 to 3 weeks, with the average being around 2 weeks. While the rangatahi engaging with kaupapa Māori providers and one mainstream youth community service received immediate support and contact with the services.

Some rangatahi reported being contacted and/or offered supports, such as weekly check-ins, while waiting for services. This was appreciated and meant they did not feel alone or unsupported.

> *I think I had to wait about a week for [support person] to contact me but it wasn't excessive, and I was initially contacted by someone at the office within a couple of days to acknowledge that they'd received my report. [Rangatahi interviewee]*

> *There was a waiting list... maybe three weeks or so and during the three weeks one of the nurses would kind of touch base with me and see if I'm doing okay, like once a week or so. It would have been good if it was shorter than that but I mean there's a lot of demand I guess. [Rangatahi interviewee]*

This was not the case for all however, and some rangatahi reported waiting for extended periods without contact from their service while they waited to formally engage.

> *I think now though [the wait time is] two weeks, which is good, but I know for me it was a while longer and I think being able to reduce the waiting time would be amazing... but for them to be able to provide something else, like resources and stuff that you can look into before going into that service would definitely be really, really good. [Rangatahi interviewee]*

Shifting the locus of control

Services prioritise self-determination by rangatahi in the nature, location, and timing of support.

Interviews clearly indicate that rangatahi have felt in control of their treatment journey in many different ways.

Rangatahi generally experienced a high degree of flexibility in where they received services. The majority we spoke to reported that sessions took place in locations of their choosing and that providers took care to communicate that they had a choice, and ensure changing needs were accounted for. For example, those collected by car were often asked where they would like to go, and staff sometimes suggested options, including meeting in the natural environment or other places that rangatahi felt calm and comfortable.

> *[Staff member] would pick me up from school and be like "Where would you like to go? You could go to a café, sit by the lake," it was very open, go for a walk and stuff. I felt quite in control and quite happy with my decisions and my choices and I knew that if I didn't want to do something I was comfortable enough to be able to say if I don't want to do that. [Rangatahi interviewee]*

Agency over appointments extended to the date and time of sessions, and rangatahi stressed they had the ability to reschedule at short notice, without it being “a big hassle”. Providers made time for rangatahi and ensured that appointments “fitted in” with their preferences, schedules, and commitments. They clearly went to lengths to ensure rangatahi were aware that it was important their needs were met, and that doing so did not an any way make them a problem or burden. The agency rangatahi were empowered to have over the location and timing of sessions was often experienced as mana enhancing. For rangatahi Māori, as they started to feel stronger and gain a better understanding of their mental health and self-care this supported a growing sense of self and (re)affirmed mana.

> *They kept reassuring me… like “you can message us any time you want. We can always schedule around you, you're never a hassle to us”, stuff like that, ‘cos obviously like to this day I still don't really know about mental health services and stuff, so I just thought I was a pain in the butt to them, I felt like they were just going out of their way and stuff like that. Yeah, I just felt real bad but like they kept reassuring me, they kept going like “Oh no it's totally okay, it's not your fault at all. We are meant to schedule ourselves around you,” and they made me feel really comfortable, which is awesome. [Rangatahi interviewee]*

Interviews indicate that while some mainstream providers offered treatment options, 1:1 talking therapy was the only offering available to most rangatahi receiving non-kaupapa Māori services. Despite this, they were generally satisfied with the support received. Rangatahi report having control over the focus and approach of their sessions and being able to select from a range of tools and modalities. Sessions are often pre-planned collaboratively with rangatahi, but with flexibility to change the approach based on what emerges. In other cases, rangatahi reported that the provider would ask at the opening of each session what they wished to focus on.

> *[I feel] Very in control. They would ask what I would like to focus on for each appointment and if I couldn’t think of anything they'd give helpful ideas or ask what I'm struggling with to give a more direct approach to what could be helped with immediately, so things like that, so very in control. [Rangatahi interviewee]*

Furthermore, some rangatahi reported that services employed different tools in their sessions (including practical exercise, tasks to take home and discuss in-session, visual resources, and readings/books) to cater to preferred communication modes and learning styles.

We also heard that providers were responsive to changing needs, with rangatahi feeling able to change the approach and tools used in sessions and to say when something was not working for them.

> *We go through different approaches. When I started she wanted me to try doing an affirmation type thing and I was like “it's not working for me, I feel weird doing this”, and she was like “Okay, that's fine, we’ll just move on.” So she's very adaptable. [Rangatahi interviewee]*

Self-determination is also evident with regards to who rangatahi receive services from. While most were highly comfortable with their assigned clinician or support person and often found they “clicked” from the outset (discussed in more detail in relation to Manaakitanga and Cultural Fit), there was scope and support to change things to better meet their needs if required.

One rangatahi interviewed did opt to change their clinician and experienced this as an easy process as she was invited early on to share about her experience. The service asked how their care was working for them, and created an environment where they felt able to be honest:

> *I have had two [counsellors]. I guess the first one, it did go really well but I didn't, it wasn't the right connection. You've got to have a connection with the counsellor I guess. But the second one definitely worked out… They just asked me how are you feeling about this, like are you alright, how's it going? And yeah, I was honest. [Rangatahi interviewee]*

This flexibility and sense of agency was impactful for this rangatahi who had accessed other services previously, but had been unable to connect with somebody they found "easy to talk to".

Manaakitanga and cultural fit

Rangatahi believe services feel human and relatable.

Interviews indicate that rangatahi experienced their services as friendly, relatable, and easy to engage with. Young people described the providers they worked with as kind, welcoming, inclusive, open, and genuine. For some, that providers were young, or had shared background or experience helped them feel a sense of connection. Rangatahi commented that appointments were a "safe space" and they were treated with care, in a non-judgemental way and that they felt able to be themselves. A few shared that they enjoyed and looked forward to their appointments.

> *She just made it so easy to just be who I wanted to be, and it was very easy to be 100% truthful with her. I didn't feel like "I might have to hide that in case she … I don't know what she thinks about that." It was very easy to be open and honest with her. She wasn't judgmental at all, she was very supportive. It was great. [Rangatahi interviewee]*

> *I did get really lucky with my support worker 'cos I think we clicked really well 'cos he was just asking me questions all the time and he always like let me know that it was okay if I didn't want to answer a question, it was okay if I didn't want to tell him stuff… it's like he cared. He cared about me, he wanted to learn more about me. So that was really touching I guess. [Rangatahi interviewee]*

Providers were able to connect with rangatahi as people, not their illness or diagnosis. Staff were evidently skilful at taking the time to build relationships with rangatahi, who appreciated that they "started off slowly" in getting to know them, before getting into the "tough stuff".

> *My counsellor, I found that I was able to connect with her really easily. Like she would talk to me as if we were friends rather than I was like another problem patient, which I felt was really good 'cos that made me feel really comfortable and the first session wasn't really about whatever was going on, it was kind of more like what's it like with your home life, school, like just getting to actually know me instead of diving into the deep end like what's your problem. I feel like that was really good for me. [Rangatahi interviewee]*

Services are experienced as mana enhancing and reflective of the world view of rangatahi.
Youth PMHA's 'open door' approach has evidently contributed to rangatahi experiences of feeling comfortable and respected, with many sharing they don't feel rushed and know the service will be there for them if they need it. Many rangatahi compared their experiences with other providers where they had felt "interrogated", "pushed through" or "let go" by services.

> *Well at the other place I felt like they just wanted to get me in and help me as much as they can and then finish with dealing with me but here [name] told me that she will keep seeing me as long as I need to. It's a lot nicer. [Rangatahi interviewee]*

Rangatahi felt providers wanted to understand them beyond "simply surface level", that they had a voice, and were free to fully express themselves and to be honest without fear of judgment. Many felt this was the first time they had connected with a provider, felt listened do, and able to be open. For a few rangatahi this was the first time that they didn't feel judged or labelled.

> *She was just like really encouraging and supportive, like there's kind of no one else in my life that's supportive in the ways that she is. [Rangatahi interviewee]*

> *The way that they approached me and how I was feeling, like I felt like she was into me and genuinely wanted to help me. Like at the other place I just felt like she was kind of doing it just cos it was her job. [Provider] was just, like she wanted to help. [Rangatahi interviewee]*

The problems and feelings rangatahi experienced were validated, and some expressed that they were never made to feel like they were "silly for coming" or that their challenges were "not a big deal". This was highlighted by a caregiver who had attended some of her son's sessions:

> *… when you're in the moment and you're young… [and] you've got something big. Just someone validating it, going "That must be horrible, that must be hard," gosh, that's really important, he did that a lot. It was great… massive for me 'cos we didn't have that when I was young. [Rangatahi interviewee]*

Kaupapa Māori providers explicitly introduced ngā uara (values), exploring them with rangatahi as part of their service approach and also rangatahi Māori hauora (wellbeing) pathways. This approach helped rangatahi Māori feel a sense of belonging to the organisation and service.

Rangatahi were supported to set goals that were important to them.
Interviews indicate that Youth PMHA providers employed a strengths-based approach whereby rangatahi were supported to cultivate their interests and explore their values, and then utilise these in their recovery work.

Rangatahi were encouraged to explore and set positive goals for themselves, and then supported to take practical steps towards their achievement. For example, one rangatahi shared how they were encouraged to get back into their art practice and out of their "comfort zone" by working towards participating in an art gala event.

The extent to which activities were focused on personal values and what rangatahi respected was clear across interviews. Accounts of how Youth PMHA support had enabled rangatahi to identify and connect or re-focus on their values and what is important to them, and then keep

these things at the forefront in how they lived going forward were numerous.

> *A lot of the activities that we did were focused around my values and what I respected and what I needed in my life. All of them were actually. Every session was something about what was important to me. [Rangatahi interviewee]*

> *It opened my eyes a lot as to actually what is important in my life and what's not and how to figure [that]... and learning to let things go has been a big one for me. I've had a lot of job issues, especially recently, and I was having them when I was seeing [counsellor] and I've had them again afterwards and I felt like I've handled them a lot better afterwards. So that's good, I've seen a bit of growth there. And I've just come to learn to think more about myself I would say. [Rangatahi interviewee]*

Rangatahi Māori were encouraged to reconnect with their culture and identity as Māori. Services, activities, and programmes were developed by kaupapa Māori providers to whakamana (affirm) the experiences and voices of rangatahi Māori. Rangatahi Māori were supported to think about their hinengaro hauora (mental health) holistically as part of their overall wellness and connection with tinana, wairua, and whānau. A key aspect of kaupapa Māori services was strengthening mātauranga Māori – building a strong cultural foundation and identity for rangatahi.

Whānau involvement was offered and fostered communication and connection.

Interviews indicate that rangatahi were given the option of whānau involvement in their care and were engaged to various degrees where permitted. While most of the rangatahi we interviewed engaging with mainstream Youth PMHA services did not take up the offer of whānau involvement, feedback indicates that when this did happen the approach was tailored to the context and needs of rangatahi and was valuable for both parties.

> *[Name] has asked me a couple of times if I want to have a session with my mum and I said no every time she has asked. [Rangatahi interviewee]*

> *My counsellor actually had a talk with my mother around how my mental health was doing, which was kind of interesting 'cos I've never had a mental health thing happen like that before and ... [the approach we used focused around] my culture. We based our way on how well I'm doing mentally around Lord of the Rings... my family is incredibly book orientated so it made talking around all the things I've been talking about with my therapist, in a sort of roundabout way, it's made me able to talk about that with my family. [Rangatahi interviewee]*

Some whānau, including parents and partners, were included in several of the sessions their rangatahi attended with their provider. Opening and strengthening lines of communication appeared to be a key outcome of these shared sessions. Parents felt these sessions, as well as the intervention overall, improved the ability of their rangatahi to communicate their problems and needs.

> *It's just learning those tools to instead of hold it all in actually to start communicating what he's feeling which is quite important. If we don't know what's going on we can't help so that communication has certainly improved a lot over the last few months. [Whānau interviewee]*

One couple that received support together noted the impact their sessions had on their communication as they have developed the skills to "actually listen" and respond to each other with "openness" as opposed to reacting or getting angry. Furthermore they reflected on the significance of this shift on their young children.

> *We can communicate way better… certainly we're in a way better mind space as a couple anyway and obviously I think we're better parents 'cos obviously your kids are pretty much like a reflection of you, so our kids are doing way better now, especially our son… he was struggling but he's good now. He's blossomed alright and he's learning and he's shown, we're seeing it all everyday like the stuff that he does. [Whānau interviewee]*

Some whānau learned tools to strengthen their ability to effectively support their rangatahi. For example, one parent who participated in sessions with their rangatahi was able to learn and reflect on how their parenting was contributing to the issues their rangatahi was facing. Building on this insight they explored different approaches and strategies that might be more helpful for rangatahi and better support their recovery:

> *The things that we talked about that were concerning [name] at the time I could see that a lot of the stuff that I was probably doing wasn't great. So I kind of learned a little bit about myself I guess, maybe had some lightbulb moments and realised some of the things [that] would be helpful for me to do. [Whānau interviewee]*

Whānau connections (again with permission) also took the form of regular communication with a caregiver, checking in via text or phone call, coordinating appointments, asking about the wellbeing of their rangatahi and informing them of work together and progress towards goals. One parent shared that such contact helps them feel connected to their child's care.

System connections

Services are providing some access to other health, cultural and social service providers, but this is variable.

Interviews indicate that some rangatahi are being connected with a range of clinical and other services via their Youth PMHA providers. In terms of enabling access to clinical services, rangatahi perspectives show that some providers are supporting access and transition to secondary services, as a small number were supported to access secondary care. We heard one account of a provider stepping in to refer a rangatahi in distress after their doctor forgot to process their referral. Another interviewee shared that during their second intervention round with their Youth PMHA provider they were eventually referred to and supported during their transition to secondary services as their needs extended beyond than the service scope:

> *I've gone through [provider service] twice in the past year… It did help the first time but I think I needed some extra help, which is why I got redirected to [secondary service], which is the moderate to severe because [provider service] works through the mild to moderate and so that's kind of why I went back, just to transition over to there. [Rangatahi interviewee]*

Some interviewees were referred to psychological and other clinical services for assessments and diagnosis, and a few were supported at appointments with a range of clinicians. A few

recounted that with their provider's support and advocacy they were able to connect with services they had struggled to access previously. For example one rangatahi identifying as LGBTQI+ was referred by their provider to endocrinology services and was able to receive hormone blockers after wishing to do so for some time. Another was supported to have a psychological assessment for an ADHD, after trying unsuccessfully to access a specialist independently. The support person referred them to the clinician and then supported them attend the appointment and make informed decisions regarding medication. Her provider's support and ultimate diagnosis made "an incredible difference" on the interviewee's life, and she is now taking helpful medication.

> *They were the ones that got me in touch with a doctor for an ADHD assessment… They were useful the whole way through but I had been trying for months and months to get anywhere near an ADHD specialist and got nowhere at all. And so then getting me an ADHD appointment, which resulted in a diagnosis, was extremely helpful to my situation. [Rangatahi interviewee]*

In terms of connections with community supports and services, interviews indicate that some providers are well informed of the resources available and work proactively to connect rangatahi with relevant assistance. While some actively share information and offer to make connections or referrals, others advised they were able to offer further information if required. Assessing housing and housing support services, disability services, and driving lessons in order to work towards their goal of gaining a licence were among examples shared of the services they had been connected to.

> *It was just them but they let me know that like they were able to help me, not refer me but like give me the numbers of some people or give me help with other areas that I needed help with. [Rangatahi interviewee]*

Study and employment services are further areas where rangatahi report receiving system connections. Some received assistance directly from their Youth PMHA support people in preparing for and finding employment, while others were connected with other providers working in this area.

> *[There is] some kind of youth support service based in Wellington and they have social workers that can help you with like employment and study and stuff… and my counsellor said that she could put me on the waiting list to work with [them]. [Rangatahi interviewee]*

Rangatahi that set practical goals during their intervention mentioned their support persons' scaffolding the process of reaching out to other social, cultural and health services they would otherwise not have access to. Some rangatahi spoke of being unsure of the types of support they needed, "don't really know what questions to ask" or are using the service to figure out what further supports they needed to escape a state of helplessness. For many rangatahi, referral to clinical support, receiving psychological assessments and accessing social supports were pivotal in their wellbeing journey.

Generating social value, equitably and effectively

Wellbeing outcomes for rangatahi and whānau

Rangatahi feel the service helped them to explore and reach their potential.
Interviews overwhelmingly indicate that rangatahi were engaged in their services, and feel they helped them be better equipped to meet their potential. Some have made notable shifts in a short space of time.

Rangatahi have been supported to identify and focus on what is meaningful to them, and to set and work towards goals that feel important and relevant; with all those interviewed reporting being to achieve at least one of their goals.

Examples shared by rangatahi of the progress they had made over the course of their work with Youth PMHA providers include:

- Increase in confidence and self-acceptance,
- Growth in communication and relationship skills,
- Learning to "let go" of ideas, behaviours, or relationships that are not serving them well,
- Greater understanding of mental wellbeing, and the protective factors that support theirs,
- Building resilience and confidence to draw on internal and external resources when faced with challenges,
- Acquiring practical tools to cope with and manage distress,
- Learning to challenge negative framing, thoughts, and self-perceptions
- Feeling more connected to whānau and communities.

Across interviews, rangatahi reported that their mental wellbeing had improved as a result of their time spent engaging with services. They felt happier, healthier, and more resilient. Significantly, a small number shared they no longer struggled with suicidal ideation, in large part due to the support of their Youth PMHA provider.

> *My mental health in general, it's become so much better... my coping with things, 'cos before it was very unstable and there was like talk of borderline personality disorder and stuff like that and that was a real struggle and there was a lot of instability and now it's really helped to level it out and finding ways of managing. [Rangatahi interviewee]*

> *They came at a really good time because like yeah, I could be really open, I could talk about whatever I wanted, even if it was for like an hour or two hours a week. They are definitely the reason or one of the big reasons why I'm here today and I'm alive. [Rangatahi interviewee]*

Rangatahi report developing the skills and confidence for ongoing resilience.
Growth in communication and relationship skills was one of the intervention outcomes most frequently cited by rangatahi. Feeling more confident and equipped to communicate and act on many aspects of their lives. Rangatahi highlighted how their relationships with parents, partners and children were strengthening as a result of these new skills. For some, this has meant learning to be more self-assertive in their relationships:

She's definitely instilling more confidence in me to assert myself because really I was very just go with whatever, people pleasing, and she's helping me to stand up for myself more, which I have had that problem my entire life and just helping realising the bad behaviour in other people that I don't like, if that makes sense. [Rangatahi interviewee]

Confidence was a term that rangatahi used frequently to describe the impact of services on their lives. Many felt they know themselves better and some expressed that their growth in confidence extends to better trusting their own judgment and feeling more resourced to act on what they know and feel. Some shared stories of how this confidence and insight had helped them through a difficult time, relationship, or decision.

When I first started counselling... I just felt very low and I just didn't know what to do next and I was in a not so ideal relationship and I was struggling to leave it. And talking to my counsellor helped me see, like gain a different perspective on my life and then build up the courage to make a change and so I've left that relationship now... quite a big step for me as well, which was encouraged or inspired through my counselling sessions. [Rangatahi interviewee]

If I look back on myself like a year ago, I've definitely improved and developed and I think that's really important to me. I'm more confident in my body and with who I am. [Rangatahi interviewee]

Gaining a different perspective on diverse aspects of their lives – from their self-perceptions and relationships, to work and future goals was a further notable change for many rangatahi. For some, acquiring new strategies and tools had helped them identify and challenge negative framing, and deal with situations more effectively.

... reframing sections of my life was very important to how I see myself and how I can see myself going forward. [Rangatahi interviewee]

I remember when I first started counselling I was not in a very good head space and I was constantly doubting myself and constantly doubting that I could get better but now I can challenge those thoughts and I'm not so down. [Rangatahi interviewee]

Interviews indicate rangatahi have developed skills, confidence, and ability to draw outside the support context to manage their distress. Rangatahi report being able to draw on their internal and external resources and feel a greater sense of agency over their wellbeing journey.

My counsellor was also very good at educating me. She would give me resources and books and stuff that I could look at further outside of the counselling session... it was like therapy outside of therapy. I could do something to look after myself... and I think that part of educating myself definitely really helped me. [Rangatahi interviewee]

Many were supported to develop self-management skills and strategies for a healthier lifestyle, including better eating and sleep schedules, and budget management skills. Some rangatahi learned to break down goals or challenges that feel too large or overwhelming and learned “to do things one step at a time”. As a result, rangatahi reported having better routines and being empowered to make smarter choices. Strategies for managing in social situations was another

important area of learning. When reflecting on the tools they had acquired, rangatahi shared that they used them often and descried them as relevant and easy to use and remember.

> *[They are] things that you work towards everyday with every aspect of your life and... it is a work in progress and, to be honest, it will always be a work in progress, just as part of life, but the strategies are indeed incredibly helpful and I do look back on those often to remind myself. [Rangatahi interviewee]*

> *It's been like massive... I've just gotten a lot better at processing and feeling supported and having coping mechanisms and just kind of rejigged everything in my head pretty much cos I was pretty, started off at a real low and we just kind of worked up and found, she helped me find my right place in the world as opposed to just kind of being stuck where I was put, which is where I was. [Rangatahi interviewee]*

Interviews also indicate that whānau have received and are making use of new supports, skills, and strategies.

Rangatahi feel more connected and some have been empowered to take up leadership positions within communities and services.

Feeling more connected to their whānau and communities were frequently cited by rangatahi as outcomes of their engagement with Youth PMHA services. Interviewees shared that services helped them to communicate, reconnect with their family values, foster understanding and acceptance of their histories or the behaviour of others, and enabled them to appreciate the experience of loved ones. Subsequently, rangatahi report outcomes including acknowledging the importance of their whānau, a closer relationship to a parent, and connecting with relations they had not seen for a long time.

> *I think I communicate more in a healthy way so that we have a healthy relationship and also dealing with a lot of, understanding of their thoughts and my childhood and what happened there and reaching forgiveness and like going at my own pace with my family to see where I feel comfortable now and definitely I've formed a way better relationship with my dad now than I had, and yeah a lot healthier. [Rangatahi interviewee]*

Kaupapa Māori providers supported rangatahi Māori to connect with whakapapa and shared their whakapapa. This approach underpins whanaungatanga and helped to build strong positive relationships between rangatahi and providers.

Having deeper insight into themselves and their experiences and/or condition were further positive outcomes for rangatahi. For some, these shifts have contributed to a desire to take up leadership positions or to contribute to achieving better outcomes for others.

Some interviewees shared that they are now motivated to support others facing mental health challenges, with a few actively passing on what they have learned in their sessions to their peers who are also struggling with similar issues or have been unable to access counselling themselves. A few young people are exploring volunteering for services and/or pursuing a career in mental health, and one person has started a career in health, working as a healthcare assistant.

Annex 2: Rangatahi survey findings

Approach

A brief survey was distributed among participating providers within the Youth PMHA initiative in October-December 2022. The survey aimed to gather perceptions and experiences of rangatahi accessing their youth primary mental health service, using both open-ended and closed-response questions.

The survey initially could be accessed online and advertised via a survey flyer within the premises of participating providers. Later, a paper survey was added upon request from providers with variable internet access in the region, or who felt this would be a more suitable option. All providers within the initiative were invited to distribute the survey among young people accessing their services; of the 14 providers who agreed, 6 providers received survey responses.

Young people who had accessed a Youth PMHA provider (N=23) aged 14-23 participated in the survey. The 15-question survey asked rangatahi to share how they feel the service has responded to their needs, their level of comfort expressing their culture, the difference the service has made for them, and any suggested changes they would make to the support they received. Several demographic questions were included and are reported in the final sections of this annex. Due to a small number of responses and limited qualitative detail to draw from, these findings should be seen as illustrative of the broader findings in this report and not representative of all youth receiving support through the Youth PMHA services.

Delivering Youth PMHA services equitably and efficiently

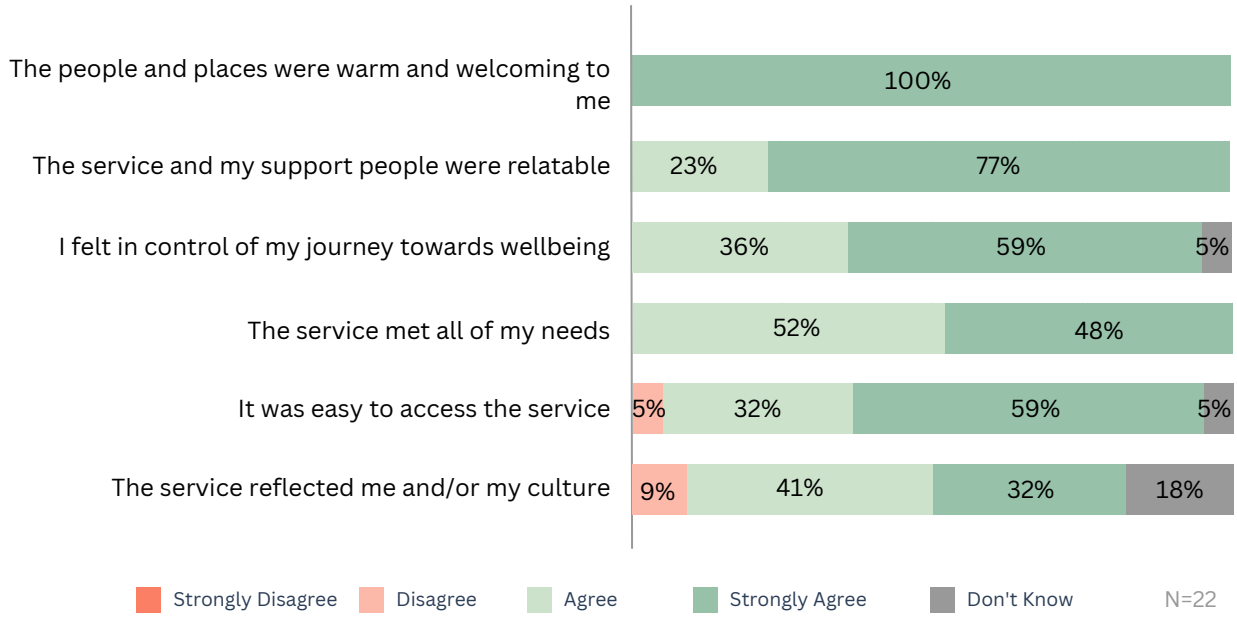
Shifting the locus of control

Survey respondents were asked a series of statements about their experience accessing their youth PMHA provider and the degree to which they felt the service had responded to their needs. Respondents were asked to rate the statements from 'strongly disagree' through to 'strongly agree'; don't know/not applicable answers were also possible (Figure 9).

There was strong agreement that the service was easy to access and offered helpful and comprehensive support in most areas.

- There was very high agreement that the service space and support people rangatahi engaged with were warm and welcoming, relatable, easy to access and that they felt in control of their journey towards wellbeing.
- When things changed in their life, rangatahi had high agreement that their service provider responded to these changes, and there was general agreement that the service met the needs rangatahi presented with.
- The main area of disagreement or uncertainty was the extent to which services reflected the young person and/or their culture. While a majority generally agreed, a higher proportion disagreed compared to other responses.

Figure 9: Perception of support received



When elaborating on how the service responded to their needs, rangatahi frequently noted the following themes:

- Feeling safe, included, and understood
- Talking freely, and feeling heard
- Help with managing emotions
- Help to manage anxiety and depression
- Restoring a sense of self-control and agency

Rangatahi spoke fondly of the support they received, expressing the ease of the relationship with their provider, which fostered security, inclusivity, and a deeper level of understanding of themselves and their needs. This was not only within the context of those working with rangatahi in a one-on-one setting, but also within group support settings where rangatahi report feeling well matched to their age and demographic group. Overall, rangatahi feel listened to and understood.

> *Because the group was tailored for my age group and the people in it were also in that age group, I felt more heard and understood. I was able to feel safer and included because of this. [Rangatahi survey respondent]*

One rangatahi spoke of their experience with a group specifically for young men, where the supportive environment enabled them to open up and share their feelings with a group of like-minded tāne, and feel more positive about their past, present, and future. For another rangatahi, these were a safe place to talk, and get to know people. Likewise, one rangatahi mentioned forming a close relationship with their support person, having come away feeling ‘inspired’ to pursue their goals, despite difficulty when faced with mental health and addiction challenges.

Rangatahi expressed appreciation for being listened to, feeling heard, and receiving practical mechanisms to cope. Treatment options were developed with the young person’s best interest in mind and resonated with the unique contexts and interests of each young person.

I felt heard and supported throughout the months. They listened to what I had to say and helped me in every way they could. [Rangatahi survey respondent]

Rangatahi reported feeling accepted and respected by those they work with. Sessions offered practical tools and coping mechanisms for rangatahi to successfully manage their emotions themselves and regain control of their lives, linking life events to their subsequent behaviours and feelings. This includes anxiety and depression where rangatahi reported receiving help for their complex and unique issues. As one rangatahi mentioned, the service 'helped me to help myself', initiating their journey toward wellness and restoring a sense of agency to regain control of their emotions, behaviours, and life goals.

[The service] Helped me compartmentalise my problems and not get so overwhelmed and directed me to work on specific things and helped me manage my emotions. [Rangatahi survey respondent]

It was a great service for anxiety and sad/depressive thoughts and has therefore really helped me specifically pertaining to my exact issues. [Rangatahi survey respondent]

Overall, there was little feedback given to improve the extent to which rangatahi felt they had control over the support they received. One rangatahi noted that they would have liked the option to message their support person online before their first meeting, or only meet with one support person when discussing their support plan.

It would have been easier in the first meeting to have one person in the room/ not meet in the room at school, or text a bit first. But I understand. [Rangatahi survey respondent]

Despite this, there was consensus that the primary mental health service rangatahi were accessing was easy to access, relevant, and helpful within each unique context.

Manaakitanga and cultural fit

Survey respondents were asked if they feel comfortable expressing their culture when attending their primary mental health service. Most rangatahi stated yes (76%), while some weren't sure (19%), and a small number said no (5%).

When prompted to elaborate on how comfortable they felt expressing their culture, almost all rangatahi reported feeling safe and welcomed by their service provider and support persons. Several young people report provider staff offering support with open-mindedness and inclusivity, fostering a space that is therapeutic and without judgment. Rangatahi, therefore, feel comfortable approaching their treatment as they are, and feel supported in doing so. In group settings, rangatahi report feeling accepted and their culture respected.

Very welcoming place. Staff are lovely and very supportive. Overall, a safe place to be yourself [Rangatahi survey respondent]

[I] Learned to be proud of myself and to express who I really am. [Rangatahi survey respondent]

Because we all respect for each other with our culture and help each other if they have problems. [Rangatahi survey respondent]

Our group was very diverse, accepting, and welcoming with every discussion topic. [Rangatahi survey respondent]

While there was little mention of the use of tikanga Māori within service provisions, one young person made note of enjoying the frequent use of te reo Māori at their service provider. One rangatahi, however, did not experience this occurring. For those whose culture was relevant to address in their support options, there appeared to be appropriate respect and understanding in most cases.

Others felt as though their culture didn't need to be addressed or wasn't relevant to the support they were receiving. One rangatahi acknowledged their privilege as Pākehā and felt no barriers to being included or respected when receiving support.

I'm not sure if I was thinking about this much. This could be because I have a lot of privilege in the fact that my culture isn't discriminated against in NZ. Because of this, I felt included and comfortable expressing my culture. [Rangatahi survey respondent]

Generating social value, equitably and effectively

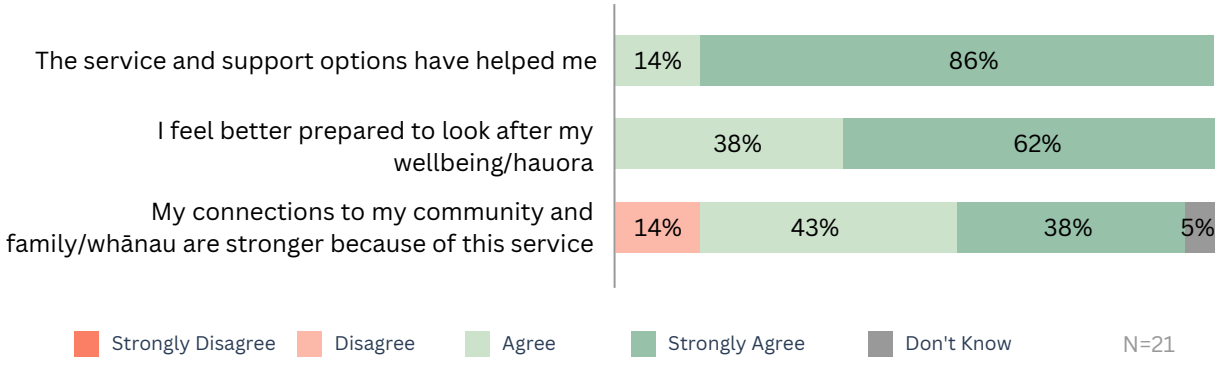
Wellbeing outcomes

Rangatahi were given a series of statements about the outcomes of the support they received and the degree to which the service has helped improve their wellbeing. (Figure 10)

There was general agreement overall that the service had produced positive outcomes for rangatahi:

- There was very high agreement that the service and support options rangatahi received were helpful, and that rangatahi felt better prepared to manage their wellbeing/hauora.
- There was general agreement that the support received strengthened the young person's connections with their community and family/whānau, but with some small disagreement as well.

Figure 10: Perception of wellbeing outcomes



Several outcomes were mentioned by survey respondents when asked to provide a statement on the biggest difference the service has made to them.

Rangatahi who had found previous experiences with mental health services unhelpful had mentioned that the support they received from their primary mental health service provider within the initiative made an important difference in their treatment journey. The self-management tools they learned were useful, easy to understand, and possible to implement which has made a difference in the young person's life.

> *It was the first-time skills made full sense and really worked for me. [Rangatahi survey respondent]*

> *It has helped me to get to 30 days clean. [Rangatahi survey respondent]*

Others found that the biggest difference the service had made for them was mending their relationships with others. While some experienced an improved relationship with their whānau, some passed on this knowledge to their peers.

> *It made it easier to communicate with my family. [Rangatahi survey respondent]*

> *It has made me happier I've also taught others what I've learned in group, and they've found it helpful. [Rangatahi survey respondent]*

Others had simply experienced an improved relationship with themselves, learning self-acceptance and initiating the first steps toward their personal goals.

> *I'm now open to other people and now made a big step for my dream. [Rangatahi survey respondent]*

More generally, some survey respondents reflected on their experiences with their Youth PMHA provider as an important and helpful intervention that should be accessed and promoted more widely.

> *I think therapy like this is extremely important and I believe it should be made more widely available and publicized so more people are aware of the help they can receive. [Rangatahi survey respondent]*

> *I think it would be very helpful to many young adults. It was kind of heart-breaking to see not many males. I recommend this service to everyone and anyone. [Rangatahi survey respondent]*

Respondents profiles

Of the 22 respondents, 55% self-identified as female, 41% as male, and 4% as gender diverse. LGBTQIA+ and disabilities identification are detailed in Table 5 below.

Table 16: LGBTQIA+ identification, and disability status of respondents

(N=22)	Do you identify as part of the LGBTQIA+/Rainbow community?	Do you self-identify with any disabilities?
Yes	32%	23%
No	64%	63%
Prefer not to say	4%	14%

Age, ethnicity, and region of respondents are detailed in Figures 11 to 13 below.

Figure 11: Age of respondents

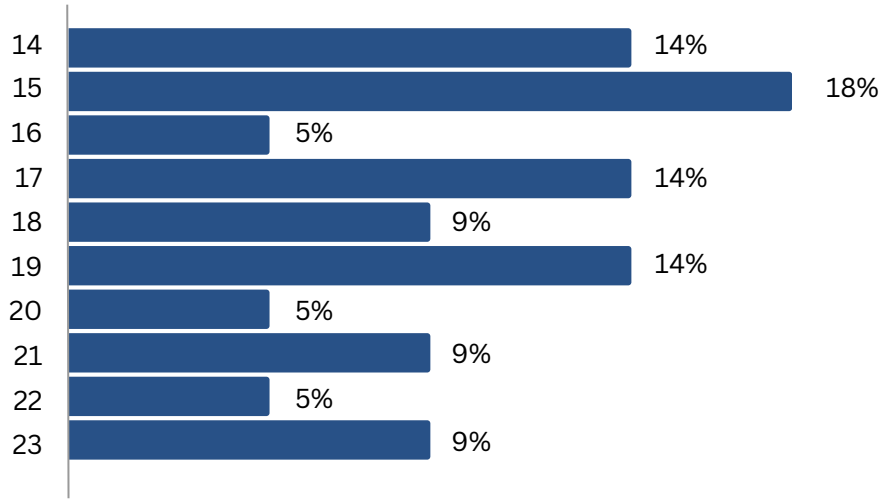
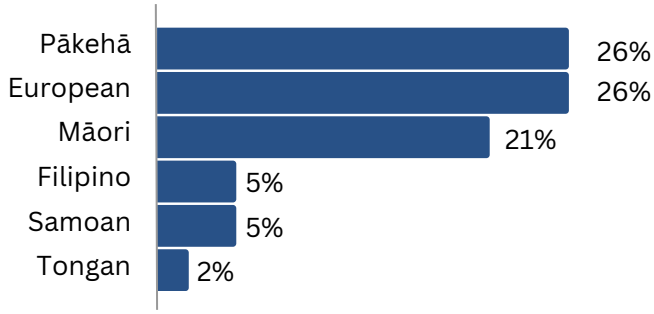
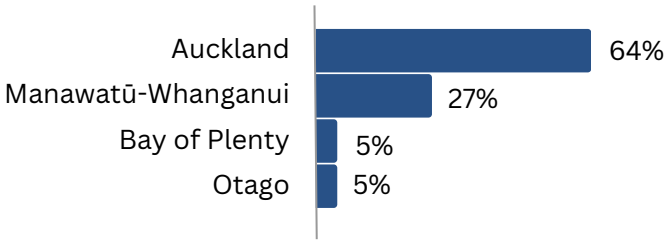


Figure 12: Ethnicity of respondents



*Note respondents could identify with multiple ethnicities

Figure 13: Region of respondents*



*With a small sample size, the spread of survey respondents is unlikely to match the national distribution. The high proportion from Auckland indicates that providers in this region were more likely to support rangatahi to complete the survey.

Annex 3: Provider interviews

Approach

This annex shares the findings from the provider interviews. In total there were 74 people included in the provider interviews, many of whom participated in group discussions, but some were individually interviewed. Participants came from a variety of roles, including senior leadership, middle management, and workers (kaimahi). Provider interviews covered 20 locations and represented 11 different Youth PMHA contracts out of a possible 15 contracts. There were four kaupapa Māori providers (representing three different contracts) included in this analysis. This represents only half of the eight kaupapa Māori providers contracted or sub-contracted through Youth PMHA.

Looking after resources, equitably and economically

Procurement and funding processes work in partnership[16]

More flexibility in the request for proposal (RfP) process was acknowledged, but overall, it felt like business as usual (BAU).

Most providers felt that the RfP process offered more openness and flexibility than they were used to in government procurement processes; a very welcome change. In particular, providers considered that Te Whatu Ora had been more open to innovative ideas and collaborative approaches than normal, as well as to their expertise and knowledge, including mātauranga Māori.

> *I think the fact that they accepted the RfP with people's different kind of innovative ideas and agreed to a collaborative like in and of itself from the outset was pretty significant. [Youth PMHA provider]*

Most providers found the RfP was clear about geographic target areas and groups, what was required of them, what was available and how funding was to be allocated.

> *This made it easier to develop the proposal and be certain of what we were going for. [Youth PMHA provider]*

Further, in areas where no other proposals had been received, Te Whatu Ora supported providers who didn't meet all the criteria to get their proposals over the line, which was appreciated.

Meanwhile, there were aspects of the RfP process that providers considered "pretty standard". Primarily, these centred on timeframes and scope (further discussed below) and it being a competitive process, which providers noted, does not help build and maintain relationships and often forces providers to offer more for less.

[16] This section defines procurement processes as the formal request for proposal and selection process. Funding processes are the initial contract negotiation and then ongoing funding and contractual variation arrangements.

> *Health New Zealand really needs to think about how they roll out the contracting process, it needs to be less competitive to promote collaboration. So we need to look at what are the different providers strengths and then we need to create an environment where people feel not threatened by each other but are willing to work together. [Youth PMHA provider]*

Kaupapa Māori providers highlighted that competitive procurement processes do not reflect the status they have as Te Tiriti partners. They feel they still have to "work against the system" when these standard processes are applied. A range of local Māori forums now exist as a means to work around these types of procurement processes, and to ensure the 'right' service is developed, and that it sits with the 'right' provider. They decide together where the contract should sit, and develop their response based on this. This takes time however and is not necessarily accounted for in traditional RfP processes. One kaupapa Māori provider described the process as typically 'top down'.

> *It's still that approach where, we've [Te Whatu Ora] got a pocket of money, we want you [the provider] to do something, this is how we kind of want you to do it and so you've got to follow our processes'. [Youth PMHA provider]*

Feedback indicates that the experience of procurement is different for Māori than non-Māori. They come into it with historical distrust, based on failed promises, and are often met with a lack of understanding and belief in kaupapa Māori approaches. Subsequently, they do not necessarily want a relationship with Te Whatu Ora districts (formerly district health boards (DHBs) or government departments. With no other options available to them however, they've had to learn to navigate their way through these processes without losing sight of their values and principles. Subsequently, they are used to having to work 'outside of the 'traditional process' to make it work for their people. Tino rangatiratanga, the right for whānau to self-determine, drives all service development, and resources are used in a way that enables this; providers take a flexible service approach and make use of resources focused on outcomes.

One provider questioned the extent to which the procurement process had been responsive to the 2018 Government Inquiry into Mental Health and Addiction.

> *The whole contracting process remains exactly the same and so I guess it's a little bit like, how do we learn from that as we move forward if we are going to talk about wanting to transform the health system [...]. You can't just try and reshape the service if you don't reshape the whole end to end process around how you contract people to provide those services. [Youth PMHA provider]*

While the Youth PMHA procurement process provides a snapshot in time (i.e., processes were different when the RfP went out in 2019, and have changed since), interviewees identified some opportunities for how these types of processes could be improved. This included:

- More early conversations between Te Whatu Ora and RfP respondents about what might be possible, as a way of advocating and guiding investment.
- Using an Expression of Interest, rather than a RfP process for this type of initiative.
- Having young people work with Te Whatu Ora through the whole procurement process.

The short timeframe and large scope of the RfP process were challenging.

Many noted that the response period was very short, and that the scope of the proposal was rather large. As such, responding to the RfP in the first instance was a challenge for many. One provider noted that despite their DHB paying for a proposal writer, it was still a large task for them to get the proposal over the line. They indicated that they would not have been able to respond without this resource, and questioned whether other providers, particularly smaller ones, would have had the capacity and capability to participate. In another locality, the local provider forum took the time they needed to develop their proposal to ensure it was appropriate for the needs of their community and whānau; subsequently submitting it late.

Many considered the RfP process stressful, so it was frustrating for some providers who then had substantial delays before contracts were signed off. They acknowledged that the delays were largely COVID related but felt that the communication during that time could have been better.

Flexibility in contracting has allowed for agile and responsive services.

While Te Whatu Ora wanted some consistency across Youth PMHA contracts, they recognised each region's offering would need to be different. As such, there are some components consistent across all contracts. But Te Whatu Ora notes that there are also individual service specifications that have been carefully reviewed by providers and agreed on through an iterative process. This more consultative approach, perceived by Te Whatu Ora as different to BAU, allowed them to consider and better meet providers' needs.

This difference is reflected in provider feedback. Dealings with Te Whatu Ora, once contracts had been signed, have been largely positive and there has been more flexibility in aspects of contracting than many have experienced before.

> *And they listened and they changed the wording so that it was much more flexible and it allowed us to really do what we wanted to do differently. [Youth PMHA provider]*

In particular, providers highlighted:

- Flexibility around FTEs, including the ability to: choose between clinical and non-clinical FTEs, or have both, in initial service designs; adjust the number and/or type of FTE over time (e.g., as demand increases/change); and, where appropriate, use FTE funds for other aspects of service delivery or have both.
- Ability to reinvest underspend, and to determine the best place for that reinvestment themselves (e.g., could go to governance or professional development, rather than FTE).
- Openness from Te Whatu Ora for contract variations and refinements to service models.
- Flexibility, where appropriate, for providers to work outside of contractual parameters.
- Te Whatu Ora taking on board feedback from providers, such as changing the registration requirements for clinical staff to include NZAC registered staff, expanding the pool of clinicians they can reach, and alleviated some recruitment challenges.

Kaupapa Māori providers also believed the funding processes were more flexible than they had experienced in the past. Feedback from some kaupapa Māori providers indicates that they have had some control over the contract and how they wanted it to look, and that they have been able to function within te ao Māori, embedding tikanga practices in the service.

Meanwhile, there were also some contrasting experiences. Two providers felt they had been asked to respond with something innovative but were then told to fit into a "cookie cutter shape". These providers had not experienced the same level of flexibility around FTEs as others had either. They believed it would have benefited Te Whatu Ora and providers if there had been more engagement to discuss issues of the contract that didn't feel right.

The funding model goes some way to addressing need, but is not sufficient.

Generally, providers were positive about the funding model. Contracting for FTE rather than a role has allowed providers to flex and put people where they can best meet the need. The FTE model was seen to contribute to transparency, as FTE in various locations are paid the same. For NGOs, the use of the DHB pay rate for FTE was appreciated and considered fairer than what they would normally get through government contracts. Providers were also typically pleased with the multi-year funding approach (three years) as it gives some assurance of continuity.

Further, feedback about the flexi-fund was mostly complementary. It allows more capacity and resource, enables providers to support youth with what they need (and occasionally with what the whānau needs to support their young person). This increases trust in the provider, and the health system more broadly.

A key contention about the funding model was that it is not enough. Many providers were under the impression overheads are not recognised in the FTE formula and named a range of activities that take up a lot of time and resource. These included general administration and reporting, programme set up, recruitment, networking and relationship building, ongoing service design and refinement, management, responsibility, risk associated with subcontracting, and administration and coordination associated with collective approaches. However, Te Whatu Ora reported that the FTE rate does leave room for overheads (20% over and above a comparative salary in Auckland), and that implementation costs, in some cases, had been contributed towards.

Further, it was noted that the FTE formula does not match the demand, or the complexity of need, which providers highlighted, were often over and above the mild to moderate levels covered by the contract. One kaupapa Māori provider is funded for five FTE but employs seven. The FTE formula was not seen to allow for much creativity with service design or diversity of staff either.

> *I suppose they have given us a bit of flexibility between clinical and non-clinical, they just haven't got the formulas right and they haven't got enough of it [Youth PMHA provider]*

> *So if we were just going off the contract itself, we wouldn't have the diverse group that we have now because that's not economical. [Youth PMHA provider]*

It was also noted that although the flexi-fund is "great" and allows better access for individuals and whānau (e.g., through fuel vouchers, mobile top ups, etc.), it is not sufficient to support the growth and flexibility needed to reach more people. Some interviewees were under the impression it could not be used for whānau – which they believed limited their ability to make a difference. Feedback from Te Whatu Ora indicates that while the intention for the flexi-fund was not for whānau, they have not criticised this use if it was deemed to address the needs of a young person.

Providers have to reach into their own pockets to cover costs associated with the above. This is particularly challenging for smaller organisations, and iwi and kaupapa Māori providers who have to use their bottom line to make things work. This is not a new problem for many providers, who indicated that they generally deliver more than they are funded for. However, being on the back foot already was exacerbated by increased demand from COVID.

There are open and trusting relationships between providers and Te Whatu Ora, but partnership requires more.

The direct relationship is unique, since historically, NGOs have worked with DHBs and their funding and planning divisions. Feedback from Te Whatu Ora indicates that this has been an exciting opportunity to do things differently, and that they have worked hard within the resources available to develop good relationships. Provider feedback indicates that they have been successful, and that flexibility in contracting and the responsiveness of Te Whatu Ora staff in particular have supported open and trusting relationships. Multi-year funding and transparency around contracting and decision-making have also contributed.

Providers spoke highly of their relationship manager in Te Whatu Ora. They felt they could have free and frank conversations, they felt listened to and understood, and considered their conversations with Te Whatu Ora to be solutions focused (there to support rather than question). Providers noted that their relationship manager had direct access to decision makers, which is not always the case with government contracts. This has enabled questions to be answered quickly and issues to be addressed promptly. Some providers felt advocated for by their relationship manager. Feedback also indicates that relationships are reciprocal and high trust.

> *It's now a relationship where they [Te Whatu Ora] will contact us to be a sounding board, which is amazing. [Youth PMHA provider]*

> *We are now at a point of high trust contracting and of commissioning in a way that says 'you're on the ground, you know your community, what do you need and where does it need to go'? [Youth PMHA provider]*

One provider went as far as saying they could go to Te Whatu Ora "about any issue, as an equal", while another said that out of almost 50 contracts, "this is an easy one".

Not everyone believed that the positive relationships they have now would benefit them in future dealings with Te Whatu Ora however. They felt it is very much the individual relationships that are working well, and that this is more about the people and their values (e.g., passionate about supporting communities to make a difference) than Te Whatu Ora itself.

Overall, feedback indicates that relationships and trust could be strengthened further through face-to-face engagement. Many providers would like Te Whatu Ora to visit onsite so that they can better understand the services and how they interrelate with other contracts and/or other local services. Te Whatu Ora acknowledged that relationships would benefit from more face-to-face engagement, but that this had been impacted by COVID. They are also stretched with staff.

Kaupapa Māori providers offered suggestions for how Te Whatu Ora might move closer to a Te Tiriti partnership model in procurement and funding processes. Primarily, these centred on giving effect to tino rangatiratanga and mana motuhake by acknowledging iwi/kaupapa Māori

providers as partners and trusting that they will do the right thing for their people. The suggestions included:

- Stepping away from standard government contracts, to contracts that better reflect a Te Tiriti partnership approach. This would require Te Whatu Ora to work closely with iwi and kaupapa Māori providers to draw these up.
- Longer-term contracting, with more of a sustainability focus (e.g., work with iwi on a contingency plan to build local capacity and capability over time).
- Consider better approaches for contracting iwi providers, in that having to go through a procurement process was not seen to reflect a Te Tiriti partnership.
- Support growth by co-funding iwi and other kaupapa Māori providers for services that can meet needs in more isolated areas.
- Bulk fund, to allow kaupapa Māori providers decide how to best utilise the funds.

Procurement and funding processes recognise priority groups and young people, but further development is needed to achieve equity.

Te Whatu Ora noted the importance of considering equity in the wider Access and Choice programme context. They highlighted that, through this lens, equity is reflected in having Māori and Pacific populations identified as priority groups across the whole programme, including the integrated and youth streams, and by having kaupapa Māori and Pacific specific services. Young people can access the programme through either of these streams – not just the youth one. It is notable also that a youth specific fund was created through the Access and Choice programme, as for a long time Ministry of Health funding has been skewed towards adult mental health. As such, equity across Access and Choice is reflected through the variety of providers and services that are covered under the entire programme – so each different person experiencing mental distress will have multiple choices for where and how they access support.

Further, Te Whatu Ora noted that equity in contracting for Youth PMHA was being clear in the RfP process that there were priority groups. It has also been about developing close working relationships that support an equitable approach (e.g., being flexible, responsive, following through on requests, addressing needs). Te Whatu Ora also considered the level of tangible assets in the implementation and set up costs and considered giving more to those who had more to do to get set up.

However, as indicated above, the general perception from providers was that they are underfunded, particularly in the context of increased demand during and post-COVID lockdowns. For kaupapa Māori providers this is further exacerbated as they feel they are already underfunded, and work with their whānau in a 'we do what it takes' approach. Although Māori are recognised as a priority target group in the Youth PMHA initiative, it is not clear to what extent the FTE model recognises historical and continuing underfunding for the higher and more complex needs iwi and kaupapa Māori providers face. An equity approach is about differential access to needed resources for people to achieve hauora. It does not appear as if the current FTE formula acknowledges what it takes to deliver a whānau centred approach to whānau that often live in rural, isolated communities.

To achieve equity, providers felt that Te Whatu Ora should better understand what it takes to meet needs in their communities, and resource accordingly. For example, one provider felt that the population-based funding formula, used to determine the funding for each locality, does not fully recognise the nuances of how needs present in different communities.

Design and knowledge base build on existing infrastructure and expertise

Youth PMHA initiative has enabled the expansion of existing services, as well as the development of new ones but within existing infrastructure.

Te Whatu Ora acknowledged there is variable contribution of assets from each provider to the initiative. Some providers already had tangible assets in places and were widening their scope or expanding their current services. Te Whatu Ora felt these had been quicker to get up and running and that implementation had been smoother. Flexibility in contracting has been the most important thing that has enabled them to acknowledge and recognise the assets that providers bring.

Existing providers who developed new services, were able to build on their existing knowledge about the community and their needs, and what they know works – as well as their existing organisational whakapapa, strategic plans, values, principles, infrastructure, and expertise. They had strong foundations to build from.

Meanwhile, providers with existing services were able to expand and/or extend their offerings (e.g., new support groups for anxiety, parenting, eating disorders, LGBTQI+) and reach by increasing the age band (up to 24). They were also able to increase their reach to more geographic areas, as well as places where young people can be found, such as schools. Further, it allowed better reach to other targeted services (e.g., through collaboratives) that benefit young people including LGBTQI+, Māori and Pacific).

Existing intellectual social and cultural capital have been acknowledged in the development and delivery of services.

There is evidence that providers felt respected, valued, and affirmed in their knowledge and skills. Based on their experience of service provision in their area and knowledge about their population, providers were able to design services that they knew would meet the needs of their community and/or fill gaps in local service offerings. Alternatively, they could choose to expand services they already knew were working.

Kaupapa Māori providers and collective partners have been able to use their cultural capital to inform service design, and most of them felt that their mātauranga was being affirmed and respected by Te Whatu Ora. Some kaupapa Māori providers indicated that the contracts supported them to be creative and build the 'āhua' of their services. Māori models of wellbeing and kaupapa Māori approaches, such as Te Whare Tapa Wha, pūrākau and whakataukī have been incorporated (discussed further below). There is some evidence of mana motuhake – trust in these providers to design services that will best meet the needs of whānau.

Feedback suggests that providers have also been given space to grow organically, to develop processes and refine their services based on what they are learning along the way. An important learning for one provider has been that their experience working with adults in mental health, does not necessarily directly translate to working with young people.

> *A lot of the mahi that we do, we learn that in no way can we compare the mahi we did with our pakeke to our rangatahi and everything needs to just start with them and learn with them on the spot. [Youth PMHA provider]*

One provider questioned whether it might have been more cost-effective to add youth mental health services to existing youth development services, rather than the other way around. Further, providers have acknowledged and valued kaimahi existing skills and knowledge and included them in service design and ongoing service development (both kaimahi employed to deliver the service, and other existing kaimahi who work in the organisation).

Te Whatu Ora noted that the providers have brought innovation and willingness to do things differently – also important intangible assets. This has resulted in services that are more than clinical interventions.

> *The services are more than that - the stuff they do, the activities and how they engage with people and connect with young people Is more creative than I think we've seen before. [Te Whatu Ora]*

Local /community connections, knowledge and skills have been valued and nurtured.

Many providers were already working in a collective – so existing connections, ways of working, experience and knowledge have been utilised to provide more choice and better access for young people. This was particularly so for kaupapa Māori providers but also for some others. In at least one instance, the Youth PMHA services allowed for additional members to come into an existing collective. Further, one collective was established as a result of the Youth PMHA– where providers had been looking for an opportunity to do so.

By contracting collective approaches, different types of expertise, skills and experience have been able to come together in one service, or under one umbrella. There was a sense in some areas that Te Whatu Ora had supported collaborative groups to grow and develop, and it was noted that the variety of philosophies and approaches contribute to increased choice for young people (e.g., faith based, LGBTQI+).

Existing staff are given opportunities to develop their skills and knowledge.

Te Whatu Ora provides free professional development opportunities through Whāraurau[17] as part of contracting for the Access and Choice initiative as a whole. Providers valued these free training opportunities. In particular, they appreciated that Whāraurau tailors the training to their needs, that the training is easily accessible (e.g., online), and that there is variety. Within one provider, this training had inspired some of their staff to undertake further studies.

Meanwhile, the training provided was considered 'entry level' and 'foundational', and did not necessarily offer much for experienced practitioners. Some opportunities for improvement were identified, including:

- Cultural competency training (for mainstream providers not confident in this space),
- More face-to-face engagement,
- More online options to tap into,
- Opportunities to connect more with other regions,
- Training opportunities that better reflect the complexity of the young people they work with, and
- More notice about mandatory training, so they can ensure staff can attend.

[17] Whāraurau is a national centre for Infant, Child and Adolescent Mental Health (ICAMH) workforce development.

Stakeholder interviews did not explicitly explore other professional development that is likely to occur within providers. However, we did hear of a need to provide more explicit clinical opportunities over and above Whāraurau training, and that this had been provided in some instances. Some providers, both kaupapa Māori and others, also talked about providing cultural competency training including te reo Māori and tikanga. Supervision is also provided, including cultural, and can contribute to skills development and increased knowledge.

It is unclear to what extent cultural competency and LGBTQI+ competency trainings are provided to all staff as part of the induction process and as continued professional development.

Kaupapa Māori services have been designed by Māori, in consultation with iwi and rangatahi Māori. However, it is not clear to what extent this has occurred within non-Māori led services.
Kaupapa Māori services are either iwi led, iwi mandated, or have staff who are affiliated with the local iwi/hapū – so naturally have iwi and/or hapū involved in all aspects of design and delivery. Most of the programmes delivered by kaupapa Māori providers are based entirely on rangatahi Māori feedback. Their involvement was considered a key success factor.

However, the inclusion of iwi, hapū, Māori or rangatahi Māori in the service design and ongoing development amongst non-Māori providers varied, and the extent of their involvement was unclear. Nonetheless, it included having kaumātua inform service design, engaging with iwi in early implementation, and having Māori (either as cultural advisors or as Māori led members in a collaborative) involved in the design and ongoing service development. Although the involvement of young people was evident across all non-Māori providers (as per below section), the extent to which these were rangatahi Māori is unknown.

Services have been designed in consultation with young people, who continue to be involved in ongoing service development.
Providers alluded to being keen to hear and take on-board, young people's voices. Feedback indicates that young people, including rangatahi Māori, have been involved in service design, development, and governance in both formal and informal ways such as through Youth Advisory Groups (YAGs), less formal rangatahi rōpū, ad hoc hui, and direct feedback. However, it is not clear from provider feedback to what extent diverse youth have contributed through these forums. This is further discussed in sections exploring a shift in the locus of control (page 77).

Mātauranga Māori underpins the design of kaupapa Māori services and is drawn on in other services.
Kaupapa Māori services have clearly been designed through mātauranga Māori. They are underpinned by values and principles from te ao Māori, such as whakawhanaungatanga, aroha, and kaitiakitanga. Feedback also suggests that mātauranga Māori has been drawn on in the design of other services, through the inclusion of kaupapa Māori models and approaches. The ways in which mātauranga Māori is integrated into practice are illustrated in more detail on page 79.

Performance management and accountability support equitable outcomes

Service providers are required to demonstrate that they meet basic expectations, but the current reporting framework has brought challenges, does not account fully for the work that providers undertake, or for outcomes.

Overall, providers felt that the Youth PMHA contract reporting favours the clinical model of one-to-one counselling, and that other work is not well acknowledged through the current reporting structure. Reporting focuses on consultations and DNA rates but does not show all the work that occurs outside of the counselling session (e.g., texts, phone calls, discussions with whānau), or how the work relates to other contracts. Providers did not feel that this reflected their holistic and integrated approaches, or that it fitted with te ao Māori.

Providers are required to provide monthly and quarterly reports. Monthly reports, which focus on outputs, were considered onerous and "meaningless" by the majority of providers because they can't identify trends through this data, nor does it illustrate change. It was thought to put extra pressure on staff and adds to the administrative workload. Quarterly reports were seen in a more positive light, because they focus on the narrative. This allows providers to illustrate aspects of the young person's journey and was considered a more meaningful exercise. Still, it is not data that can be 'pulled' as part of a package of care and does not provide a full picture or understanding of what it takes to deliver an equitable service.

Further, Te Whatu Ora has allowed for a variety of measures, which has made it difficult to compare data. This has brought particular challenges within collectives, as providers use different data sets. One collective developed their own database, but this has been challenging to implement. There have also been issues associated with reporting when subcontracting (e.g., lead provider having to add sub-contractor's data to theirs), and when holding more than one contract and having to report via different district health boards with different reporting templates.

Providers highlighted the lack of framework, or need, for reporting on outcomes. Te Whatu Ora had intended to give the option of a free to use outcome framework to give consistency around outcome measurements. However, there have been challenges associated with this, and they were still unresolved at the time of the evaluation. In the meantime, it appears that providers are working out their own ways to measure outcomes.

Providers identified a range of opportunities for improvement in regard to reporting, including:

- More consultation and engagement around what would be useful and meaningful data, for both parties, to collect. As alluded to elsewhere, this should include site visits so Te Whatu Ora can get a better understanding of the services and the context in which they operate.
- Acknowledging whānau and non-clinical work in reporting.
- Exploring options for reporting directly, data base to data base (similar to PRIMHD).
- Changing the reporting configuration (e.g., no monthly reporting, or combine with quarterly reports).
- More consistency and integrated reporting across government departments.

Te Whatu Ora demonstrates shifts towards mana whakahaere.

Te Whatu Ora is showing that they are starting to move beyond management of assets or

resources to supporting . For example, their facilitation of three-monthly Zooms for providers to get together and learn from each other was highly valued. Feedback from providers that Te Whatu Ora read their reports and engage with them around the data is also evidence of a shift towards supporting more effective service delivery. Further, Te Whatu Ora's provision of free training opportunities shows an interest to invest in the sector and helps support equity by providing professional development for smaller organisations that may not otherwise have the resource to do their own. Te Whatu Ora staff believed this was a new, valuable approach that had not been used by the department before.

Meanwhile, although the intent to manage things differently is clearly there, feedback suggests that there is still some way to go until Te Whatu Ora fully understands the extent of work needed to design and deliver responsive services. And while individuals within Te Whatu Ora may have a strong desire to do things differently; bureaucracy can be a barrier to making meaningful change, particularly at a systems level.

Delivering Youth PMHA services equitably and efficiently

Equitable and flexible service access

Providers are offering services in multiple settings where young people feel comfortable.
Every provider is conscious that a traditional office setting isn't necessarily going to be the most effective way to engage with young people. Services are being offered in varied settings, for example out in the natural environment, in youth hubs, marae, schools and other community settings where young people are comfortable. Providers who have offices do offer services in those settings, but they also meet young people elsewhere as dictated by their preferences. Some providers also do outreach and satellite clinics to different communities, particularly in rural settings. One provider believed that having a local youth hub would be beneficial and support young people to access and engage with services.

> *So in terms of access, making sure that we're in the right places, making sure we are where young people are, so making sure we're in the schools… …making sure we're in Kaupapa Māori kura, like our mental health team also come to some of our youth development groups, they go out to some of the local community groups as well around workshops, so making sure we're in the right spaces and also making sure we target the right priority groups [Youth PMHA provider]*

Providers recognise that transportation can be a barrier to equitable access. To combat this, some providers offer telehealth and videoconference options for young people who want/need them. These are most commonly used by young people who are particularly isolated, but also some young people may prefer to meet remotely. In addition, some services are able to support young people with transportation, either by picking them up or using the Youth PMHA flexi-fund to provide taxis.

A wide range of services are available for young people through the Youth PMHA initiative.
Across the entire Youth PMHA delivery initiative a huge range of services are being delivered for young people. Some of these services are provided through group work, others are individually focused. Many providers have clinical and non-clinical staff that young people can access to create a more holistic continuum of care. Within kaupapa Māori providers there is also an

emphasis on cultural services/activities and access to tohunga.[18]

Across all these options the choice of the young person is paramount. In all Youth PMHA services young people get to choose what they do and what supports they access. Providers were clear that they adapt and flex their work to meet the needs of young people both in terms of the individual young person and the programme overall.

Within the kaupapa Māori providers, supporting rangatahi Māori and their whānau to access other services is a given. It is part of the whānau centred approach they take. They do not operate as single services or even individual contracts. They take a collective approach, acknowledging that no one programme can offer everything, particularly given the barriers that rangatahi Māori and their whānau experience. For rangatahi Māori and their whānau, when they access Youth PMHA support they become a client of the provider, not the recipient of a single programme or service.

Similarly, within some non-Māori providers, there are often a range of services that young people can access, particularly in larger organisations or collaborations where young people can take advantage of other support opportunities. There are several examples of collaborative offerings funded through Youth PMHA where young people are able to engage with one service and then have supported access to engage in whichever services and programmes match their need and preferences.

> *People walk in the door and there's just this wrap around support and a really clear "what do you need" and then the ability to know all of the services and to know there's usually an option. [Youth PMHA provider]*

> *You don't give up on people because they miss a couple of appointments. [Youth PMHA provider]*

Providers proactively seek to eliminate barriers for young people.

All providers are conscious of the barriers that young people face when trying to access mental health and addiction services and work hard to reduce or eliminate those barriers. The section above discussed how providers reduce physical barriers by supporting easier physical access to services and engaging in more youth friendly settings. Other key barriers that are reduced or eliminated by providers are:

- Taking referrals from a range of sources including self-referral. Providers are present in the community and some have 0800 numbers to access them and others take referrals through social media.
- Having little or no entry criteria for services means it is easier to access services.
- Most providers have no time limit for how long they can support a particular young person, they work hard to keep young people engaged and they welcome young people back whenever it is needed. Providers talked about young people knowing they can come back if they need to and the door is always open.
- The flexi-fund is an essential tool for providers to reduce and eliminate barriers and is well utilised by most providers. Flexi-funds are occasionally used by a few providers to support

[18] Tohunga is defined as a skilled person, chosen expert, priest, healer.

whānau if this will have a direct impact on the wellbeing of the young person.

- Building trust in the sector through trusted relationships with communities, young people and whānau. A barrier for Māori highlighted in the interviews is a historical distrust in services because of institutional racism. All kaupapa Māori providers interviewed and some non-Māori providers are very focused on being seen as an organisation who can help and can be trusted within the community. For kaupapa Māori providers this is about affirming their position as tangata whenua and Te Tiriti partners.

Providers adapt their offerings to meet the needs of young people.

Within most provider offerings there is flexibility to adapt the support to meet the needs of young people. But in addition, providers were clear that they are open to adapting their support to meet the needs of young people, including adapting over time. Some providers use a feedback-informed treatment process and after each session ask the young person how it went and what would improve it. All providers regularly check in with their young people about what support would meet their needs, as well as offering young people different choices about which programmes they enter.

> *We can be like 'Who are you, what do you need, how can we support you?' as a collective. I feel like we do have so much flexibility of what that looks like. [Youth PMHA provider]*

Providers with community connections have indicated that they adapt their offerings if their community identifies a new need. For example, suicide prevention work in schools where a higher risk of suicide has been identified. Finally, as already mentioned, many providers take an open door approach, so young people can come back for more or different support at any time.

Providers seek to meet need in a timely way.

Typically, providers are operating in ways that get young people accessing support straight away rather than having them on a wait list. Some providers have support available outside of business hours for new and existing clients. This could be through their own organisation or linking into another organisation. There are however some providers operating a model of care that has a wait list to see specialist clinical staff, but these young people are still supported with basic wellbeing care while they are waiting.

Shifting the locus of control

Rangatahi voice and lived experience are championed in design and delivery. However, supporting more diverse youth to engage in decision making about design and delivery would be beneficial.

Youth voice is considered in design and ongoing delivery for Youth PMHA providers, as mentioned previously. Typically this takes the form of a youth advisory group (YAG) or rōpū. In some instances organisations employ one or two lived experience partners or a youth consumer advisor. Youth PMHA has been a catalyst for the formation of a YAG for some providers, particularly those who are newer to youth work. In other organisations, the integration of youth voice in design and delivery was already well established.

A YAG member noted that providers and kaimahi actively seek their input and perspectives, advice, and support to advocate for making services more youth focused.

Every [YAG] member has said like how empowering of an opportunity it has been. [YAG member]

Providers report being open to taking on feedback from young people and making changes accordingly. Youth input has influenced aspects of design and delivery initially, for example marketing and language. They also respond on an ongoing basis; for example, one provider reported that their rangatahi rōpū saw a need for a programme in schools about bullying which the provider then delivered. Two of the kaupapa Māori providers indicated that they co-design their programmes with rangatahi Māori.

Some providers felt that their youth voice roles were reflective of the diversity they were serving. For example, some providers, particularly the kaupapa Māori organisations, engaged with rangatahi Māori and one provider who prioritises working with the LGBTQI+ community specified that LGBTQI+ young people were providing advice about programme delivery. Ensuring diversity of youth voice in programme design and delivery should be an area of ongoing focus for providers.

Providers prioritise young people making their own choices about what support they receive, when and from whom.

Providers were clear that young people are the ones making the decisions about what support they receive. These decisions are made about what programme they engage with and then often at each session young people identify what they want to work on. Some providers reported having conversations at every session about what the young person wants to focus on that day, some programmes were completely goal driven so everything is focused on what the rangatahi wants to work on. One provider described their approach as "person centric" even to the point where the young person makes a decision whether or not to be referred to a specialist or remain with the primary provider.

It is choice at the end of the day, cos everything revolves around the young person, what their wants are, what their needs are and getting the best outcomes for them [Youth PMHA provider]

Culturally grounded and culturally responsive programmes are available for rangatahi Māori. However, there are few programmes offering culturally responsive practice for Pacific, LGBTQI+ and refugee/migrant communities.

Findings from provider interviews identify that non-Māori providers have culturally responsive practices to varying degrees. The four kaupapa Māori providers interviewed as part of this evaluation are delivering culturally framed programmes to all their rangatahi Māori and offering culturally grounded therapies, such as traditional healing practices and reconnection to marae and whakapapa. Kaupapa Māori providers also have relations with other providers to enable their rangatahi to receive the support that best meets their needs as well strong connections with community organisations across many sectors including sports, kapa haka etc.

Some non-Māori providers have relationships with local kaupapa Māori organisations or were operating in a collective with a kaupapa Māori organisation. In these instances, rangatahi Māori were offered the choice of mainstream or kaupapa Māori support. In addition, some non-Māori organisations offer cultural supervision to their teams and access external expertise to make their services more responsive to the cultures present in their community. Several providers recognised this was something they needed to do more work on.

Whilst there was a strong focus on supporting the needs of rangatahi Māori there were few other examples of programmes that were responsive to the other priority groups such as Pacific, LGBTQI+ and refugee/migrant populations. There is only one Pacific provider contracted under Youth PMHA, although we acknowledge that there is a Pacific Access and Choice stream. There were a few providers who were intentionally focused on providing support for LGBTQI+ young people and creating relationships with Pacific organisations but these relationships are typically in the early stages. Several interviewees identified that more could be done to tailor their programmes to these population groups and other underserved groups.

Cultural diversity amongst providers.

All providers recognised the value of employing staff that reflected the cultural diversity of the young people they were hoping to serve. Providers reported being able to employ younger people to better support connection and relatability. In some instances these young people were non-clinical staff that walked alongside young people.

Some providers were able to ensure cultural diversity amongst their team, hiring Māori, Pacific and LGBTQI+ staff. Whereas for others this was an ongoing challenge. Two providers mentioned challenges in recruiting male team members.

Recruitment in general was difficult, with a limited pool of workers to draw on particularly in smaller communities. Being able to employ registered NZAC counsellors made a significant difference and eased some providers recruitment challenges.

Providers are seen to be offering evidence and experience based programmes.

All providers indicate they offer programmes that are based in evidence and experience. Some providers spoke of the value of the Youth PMHA clinical roles to enable robust evidence-based programmes. Providers were often providing support for young people through a wide range of clinical and non-clinical roles including registered mental health therapists, social workers, occupational therapists, and peer support workers.

Integration of mātauranga Māori, decolonising practice, upholding mana Motuhake and mana Māori.

Youth PMHA is delivered by Māori and non-Māori providers, and there is also a standalone Kaupapa Māori Access and Choice stream. The kaupapa Māori providers spoken to as part of this evaluation were deeply grounded in te ao Māori. Their practice was based on tikanga principles including tino rangatiratanga, whakapapa (whanaungatanga), kaitiakitanga (aroha) and manaakitanga. Te Tiriti o Waitangi is a foundational document for these providers which underpins the relationships they have with the Crown, and their role to challenge systemic racism and barriers, that hinder whānau from receiving needed services. Kaupapa Māori providers see themselves as partners of the Crown who have the right to exercise tino rangatiratanga, the expression of sovereignty and self-determination. It is the right to participate in decision making and the right to exercise authority by themselves, whānau and young people.

Kaupapa Māori providers had deeply integrated mātauranga Māori in their practice and sought to decolonise and question and address power dynamics, for their organisation as a whole and the whānau.

> *Getting them to take more responsibility cos I think a lot of our rangatahi are sitting in the victim mode and blaming all of them, actually getting them to take more responsibility back and that's where their power is and once they realise that the power was with them all along and that they give it away when they're blaming or relying on other people to make them better [Youth PMHA Kaupapa Māori provider]*

Kaupapa Māori providers act as kaitiaki, guardians and stewards, a collective role to ensure the care of rangatahi and whānau. This role protects and maintains te ao Māori practices and principles, privileging Māori voice and experience. They are committed to delivering what is best for rangatahi Māori and their whānau, even if it fits outside their current contracting structures. Their practice is reflective of mana motuhake in that they are governing themselves and doing what is best for their people.

Some non-Māori Youth PMHA providers are also integrating mātauranga Māori within the scope of what is possible as a mainstream organisation. This is done through establishing pou whakahaere positions, integrating expertise from local kaumātua, and collaborations with kaupapa Māori providers. Typically, mātauranga in non-Māori providers is expressed through giving effect to tikanga and operating a strengths- based and mana-enhancing approach. Providers are also offering holistic support options, generally based on Te Whare Tapa Wha, that consider the entire wellbeing of young people. In addition, some providers are committed to also supporting the whānau of the young people they are working with. Some providers have a set of te ao Māori framed principles that underpin their practice, but they acknowledge these are not always given effect in their practice.

Manaakitanga and cultural fit

Whānau are nearly always involved in the support of a young person, where permission is given.

All providers are keen to have whānau involved in the support of young people in a number of ways. This recognises the influence whānau have on young peoples' wellbeing. However, permission needs to be given by young people for this to occur. Some providers indicate that young people often give consent for whānau involvement, whereas others say that most young people don't want their whānau involved. Whānau are generally involved through whānau hui and engagement in support sessions both with and without the young person. One provider mentioned that reconnecting young people to their whānau is a focus area.

Several providers mentioned the amount of work they do with the whānau, identifying that this isn't resourced but is important to young peoples' wellbeing. Providers that also offer adult services will do their best to also support whānau with their own wellbeing, recognising that there are often intergenerational behaviours that influence young peoples' wellbeing. This is particularly the case for kaupapa Māori providers, where a young person contacting a service is often a catalyst for the entire whānau to access support.

> *Their families were starting to come in and then the word was getting out and then we were getting older people coming through and yet we weren't funded for it, but we weren't going to turn them away either, because well, we need to wrap around the whole whānau [Kaupapa Māori Youth PMHA provider]*

Two providers mentioned that whānau involvement is enabled through being present in communities because they are a known and trusted organisation.

System connections

Providers believe system connections are important but believe having resource available to do this would enable better connections.

As already mentioned, connections between providers (i.e., system connections) have the potential to significantly benefit young people. Providers identified their links with other providers of youth services as beneficial and valuable. These connections provided more choice for young people as well as supporting learning within the providers about how their Youth PMHA offering could be improved.

An intention of Youth PMHA was for providers to maintain connections with clinical and other local providers, but that this would develop organically. There is a realisation now from Te Whatu Ora and providers that for this to effectively occur it needs to be intentionally resourced. Having resource for people to develop and maintain relationships and then in some instances having ongoing coordination/relationship management roles would likely improve the ability of services to work together efficiently and effectively for the benefit of young people.

Provision of access to other providers and how well it is done.

Providers spoke about the links they had with other providers; for example schools, police, iwi providers and social services. Kaupapa Māori providers spoke of having relationships with other providers, in particular links to Whānau Ora providers were seen as critical. Schools were a key link for providers, although some acknowledged they did not always hear back from schools they tried to engage with. At least two providers have introduced a case management approach as part of Youth PMHA that sees them coordinating between all the services that are supporting a young person to ensure all the services are on the same page.

Some providers identified that they were receiving referrals from the other providers they had links with. All those who referred to other providers identified that they walk alongside the young person to enter and engage in the other service. Kaupapa Māori providers spoke of the historical distrust of services by rangatahi Māori and whānau. These providers saw their role as to help shift this distrust and support engagement.

> *Reassuring our whānau that there are other services that they can tap into, like how you said they may have a bad experience with a counsellor beforehand and it's just introducing them to other counsellors and getting them to come and join one of our sessions and just so then they can have a taste of who the person is, how they work and then have a kōrero afterwards and say did you like that person, do you think that's something you'd like to tap into and usually I find that's worked really well and it's just showing our rangatahi and whānau options of different types of support. [Kaupapa Māori Youth PMHA provider]*

A barrier to collaboration identified by providers was that although providers within Youth PMHA were not acting competitively, there were local providers that did perceive themselves in competition with Youth PMHA providers. This perceived competitiveness meant that providers were resistant to an ongoing relationship. One provider even reported a school they were trying to work with feeling conflicted because they were working with two different providers.

Links between community and clinical settings varied.

There were varied relationships with secondary services. Some providers saw themselves as support for young people who were waiting for secondary care and others identified that they want to "hold the space" for primary mental health and addictions services rather be an add on to an overworked secondary sector.

Most providers however did have a relationship with secondary mental health and addiction services and were committed to working with them to better support young people, such as through being involved in the local CAMHS networks. Some providers identified that they valued the opportunity to support young people when they couldn't be supported by secondary services. The providers acknowledged that it took time to get to a point where appropriate referrals came from clinical settings. One provider identified that they were acting as a 'step down' service to support young people as they were transitioning out of secondary care.

Connections between primary and secondary services are likely to be improved by consult liaison roles and more intentional resourcing of connections to enable trust to grow and develop in the sector. Te Whatu Ora may have a role to play in this to support structures for connection between secondary and primary systems.

Collaboration between providers is adding value.

There are several examples of collectives that have banded together to deliver a suite of Youth PMHA services or provide services over a larger geographic region to better serve young people These examples demonstrate the benefit of groups of providers working together.

> *When we get together there's no competitiveness, like it is very much collaborative and I think what has been really awesome is that each service has been able to support each other to build community connections where we might not have had it before. So (name) and I we have really good successes in some of the schools, so we provide that kind of connection for other kaimahi as well. Some of them have connections elsewhere so it's building those connections up with each other so that we all have access [Youth PMHA provider]*

Young people are able to go to one service for support but have the opportunity to engage with multiple other known services. One collaborative has invested considerable time getting to know and trust each other at all levels of the organisation – kaimahi, management and governance. This means that the providers within the collaborative know and trust each other and are therefore more able to get the right help for the young person. Further, the way the collective model works means that the young person does not have to retell their story or be reassessed as they move between services – something that has been identified as a barrier to engagement.

> *We can all feed off each other and help each other in a sense. And that's the whole fun of it. [Collaborative] is breaking down those barriers as well… …we meet up every month, so we actually get to gain that trust with other people but because we all work together under this collaborative, it's made it easier for us to trust these people we're all doing it for the same reason. [Youth PMHA provider]*

Most providers working as part of a collaborative identified early tensions and conversations around boundaries and how the collective will work together. This is to be expected even when providers within a collaboration are already known to each other. One of the strategies a provider has used to support these conversations is to develop a set of best practice guidelines for how they operate and what is important. This document provides an anchor for conversations around boundaries and scope.

Another key component for the success of collectives is to have a dedicated role for ongoing project management and coordination. This role is critical initially to get everything set up and agreed. But on an ongoing basis there is need for dedicated support to coordinate between the services and ensure communication remains open and constructive.

One provider spoke of the relationship they had with providers from the other Access and Choice streams and identified that these relationships meant they could target support to specific areas and populations more effectively. This is an important area to focus on in the future as the different Access and Choice streams move from an implementation focus to a maintenance focus.

A few providers identified that more could be done to support communication and sharing of models and approaches within the Youth PMHA providers. The quarterly provider hui are useful, but don't really allow providers to have smaller conversations and interactions – they are more about listening to presentations, leaving people to follow up individually later if they are interested. Some opportunities for smaller discussions would be appreciated.

Learning and improving

Learning systems and ongoing adaptation are present, but this requires ongoing focus.
Some, but not all providers spoke of the ways they learn and adapt their programmes to meet the needs of young people. Both formal and informal learning methods were identified and some spoke of an organisation-wide learning focus. Continual adaptation based on youth feedback was a common learning tool as was learning from others with the team. Within collaboratives learning from other provider was also noted as a key tool to support ongoing adaptation.

> *We're sitting all around a table and we can pull from other people in different areas, their expertise in that area and actually say "Oh my gosh that's an awesome way that they delivered that, that's something we can adopt in our own practice." You wouldn't find that anywhere else. [Youth PMHA provider]*

There were three providers who reported having more formal learning systems in place based on their collection and use of output and outcome data. These tools are used to establish areas that may need more attention, and subsequently more training or FTE to address any gaps that may exist. As already mentioned, at least one provider used feedback informed treatment to support improvement at the individual and organisational level. Two of the kaupapa Māori providers spoke of creating a learning and critical reflection space within their organisation and engaging in cycles of continuous improvement. They see this as being accountable to themselves and their whānau.

Generating social value, equitably and effectively

Young people are engaged in the services, with people around them and more active participants in their communities.

A key theme across providers was that the young people they worked with became more engaged in their services, with people around them and more active participants in their communities. In particular providers noted an increased engagement by young people in their programmes and services, such as consistently showing up, taking part in the discussions/kōrero, contacting kaimahi if they can't make it or to ask questions. Providers described a transition amongst young people from being shy and hesitant, to opening up, participating in activities, joking, and laughing and having conversations with others around them. They noticed a growing connection and collaboration between young people, and between young people and kaimahi. Trust in kaimahi has grown over time, in turn supporting more trust and engagement from whānau too.

Providers were also seeing and hearing from principals, teachers, and whānau that young people were becoming more engaged in school, including increased attendance, returning to school after a period of not attending, and transitioning back to school from alternative education. There were also instances of young people having gone on to further education and/or wanting to pursue a profession or go into employment.

> *We see that we're able to actually engage with young people. We see that they're able to move towards where they want to go in their lives. [Youth PMHA provider]*

Services help build skills and confidence for young people to communicate and manage their distress.

Feedback from providers indicates that young people are learning tools and strategies to keep themselves safe in different contexts, building confidence and resilience, and for rangatahi Māori, tino rangatiratanga. This includes breathing exercises and meditation, how to voice their opinions and feelings, how to talk to adults, how to access services and identify people in their lives and/or communities that they can turn to talk. Some rangatahi Māori are also learning how rongoā Māori can help in times of distress.

> *The skills and things that they're learning in group just are setting them up for all of the day-to-day challenges that they've got to face. [Youth PMHA provider]*

Kaupapa Māori providers in particular noted that rangatahi Māori are talking more to adults in their lives, and that they are better able to build relationships with them, including parents, other whānau, and people at school.

> *They always tell me that they feel like lighter and they feel like they have the skills to manage their wellbeing and mental health and that they're growing like capacity to communicate with their whānau about this stuff, cos there's still a lot of stigma around mental health and addictions so our mental health team is really supporting our rangatahi to communicate with their whānau and have them involved in their wellbeing journeys. [Kaupapa Māori Youth PMHA provider]*

Young people are empowered to make good choices.

A key focus for many of the providers is to educate young people about strategies for managing

mental distress. But there is also a lot of other learning that takes place, such as how to stay safe in different environments and the reasons we do certain things (e.g., peer pressure may influence young peoples' choices around vaping/drinking/drugging).

Feedback indicates that as a result of this learning, and the increased confidence gained from their participation overall, young people are making better choices for themselves. Providers noted that they are seeing young people spending less time on social media, delaying, reducing, or stopping alcohol and other drug (AOD) usage, taking up clinical (and other) support, being more engaged in their education and gaining employment.

> *So she was making active changes on her own, and then she ended up getting a full-time job as well until she moves into the course next year, which is a massive change and the school had noticed the change in added student motivation as well, which was really good. [Youth PMHA provider]*

Young people are gaining a better understanding of mental wellbeing, their experiences, and the mental health sector.

A key focus for many of the providers is to educate young people about what might be underlying causes of distress and their experiences generally. There were examples where they'd been able to help young people realise that the trauma they're experiencing is not necessarily 'theirs', in turn enabling the young people to 'move on'.

For kaupapa Māori providers, a core component of this has been to reconnect rangatahi Māori with their culture, so that they can see how other worldviews may have impacted their wellbeing (e.g., being assessed within a western system that does not reflect Māori ways of being). Through kaupapa Māori approaches and models (e.g., use of pūrākau) they have been able to help young people shift and reclaim practices as Māori, and to understand 'ko wai ahau' who they are and how their experiences are intertwined in this.

> *It helps shift their state from te pou, where it's all dark and there's no light to being able to see the light again. [Kaupapa Māori Youth PMHA provider]*

For kaupapa Māori providers, part of the support is also about recognising rangatahi Māori as individuals who sit within a whānau. The whānau centred approach is holistic, addresses the broad wellbeing needs of whānau whanui and focuses on building relationships with groups of people rather than individuals. This has helped rangatahi Māori understand and navigate the contexts they find themselves in.

Providers hoped that their services can contribute to shifting the narrative around mental health, that mental health support is not just about sitting in a room with a psychologist for an hour, to understanding that there are things young people can do every day for their wellbeing and there are people in their everyday lives who can help.

> *Services like ours can reinforce the message that there's lots of help and lots of different ways of helping. [Youth PMHA provider]*

While young people appear to benefit from Youth PMHA services, it is not clear to what extent these benefits are shared equally between different groups.

Young people, including rangatahi Māori who access kaupapa Māori services, appear to be benefiting from the services. However, it is not clear to what extent outcomes are equitable for

rangatahi Māori who access other services or for young people from diverse groups such as LGBTQI+, Pacific, refugees, or migrants. Feedback from young people is collated in other appendices and adds the understanding of how outcomes are distributed.

More efficient and equitable use of health care resources

Youth PMHA services may to contribute to better use of resources across the primary care continuum.

Overall, previous sections have illustrated that Youth PMHA appears to have contributed to increased access to services for young people (e.g., through widened geographic scope, types of services, delivery modes, places of access, etc.). Data also suggest that Youth PMHA has contributed to more collaboration and integration between local providers and services. This indicates better use of scarce resources across the primary care continuum by supporting improved access and greater efficiency in the way services are delivered.

Services established within existing multi service providers have been able to draw on and support other services within the organisation. In particular, having easy and rapid access to social services that can help support young people with practical issues that may be an underlying cause of mental distress (e.g., driver licensing, housing, income, etc.) can help reduce the need for primary care and/or mental health support.

Providers within new collectives have been able to draw on each other's services, come together to plug gaps in the system, offer more diverse services under the banner of one service, and develop more seamless referral pathways.

In either context, kaimahi are able to coordinate and communicate with each other to ensure young people are getting the support they need, that progress is happening, and that any issues that arise are addressed and resolved. For example, one provider noted how GP referrals for psychology input have been appropriately fulfilled through youth worker support, without necessarily having to access the scarcer workforce like psychologists.

Providers also noted that the Youth PMHA is likely to help reduce the need for support over time, and that they are more likely to seek help at the right time, next time they need it.

> *I would like to think that every young person that we have contact with, by definition, we reduce their chances of them needing services later on but I also think, even if they need services, what I want them to experience is a positive impact of 'I sought some help and people cared and so I'm more likely to go and get help' or I've got some language to put towards this' or 'I've got people who are about me, that I can kind of talk to about all of this. [Youth PMHA provider]*

While provider feedback suggests that these positive changes apply to rangatahi Māori and to some extent LGBTQI+ youth, it is less clear to what extent other diverse groups may have benefited. As such, it is difficult at this early stage of implementation to say whether better use of resources also represent equitable use of resources.

Mild to moderate mental health and addiction issues are being identified and addressed at an early stage, and it is likely that this reduces the chances of them becoming more serious.

Feedback indicates that mild to moderate issues are being identified and addressed at an early

stage, before they have time to escalate. The ability to meet young people there and then (i.e., no waiting lists), when they present is key to being able to do so.

Where clinical support is not immediately available, providers are able to hold the young people and/or offer other supports in the meantime through their internal services, or services provided by their collaborative partners (e.g., nurse/GP/youth worker/social support/etc.). Being able to offer young people other types of supports that are not mental health focused can help build independence and address underlying causes of distress as discussed above. This can either help resolve issues or reduce anxiety or concerns that if left unaddressed, may lead to things becoming more serious and requiring higher intensity services.

Further, as illustrated above, providers described how their services focus on building skills and strategies for young people to manage their own wellbeing, thus reducing the risk of mental health issues becoming more serious. The flexi-fund also helps providers to move fast and be agile in their response to young people who may face barriers to accessing support or addressing their needs. This helps with getting things resolved early.

> *I was in the clinical service before this and I don't think I've ever been able to have this kind of immediate, direct impact on youth as I have in this role [Youth PMHA provider]*

Some providers talked about consciously ensuring that priority groups were indeed prioritised in their responses – including Māori men and LGBTQI+ youth. This suggests that the benefits of addressing mental health challenges at an early stage span various groups of young people. However, we can't ascertain from this data whether it is done so more equitably.

As illustrated in previous sections, feedback indicates that rangatahi Māori who access kaupapa Māori Youth PMHA services have wrap around support that affirms them as Māori and are given the opportunity to experience outcomes as Māori. Considering there are well-established links between cultural efficacy and greater psychological resilience amongst Māori,8 it is likely that these services, if sufficiently resourced, could help reduce pressure on other parts of the system over time.

It should be noted also that a key theme that came out of provider feedback was that the complexity of the young people who present, is often higher than mild to moderate. As such, providers - who do not want to turn young people away – are finding that they are addressing more complex needs than what Youth PMHA initiative set out to do.

There is insufficient data to understand the extent to which early intervention is reducing the need for higher intensity services.

The Youth PMHA goal that early intervention reduces the need for higher intensity services – more equitably and in particular for priority groups is a long-term, high level systemic change. As such, providing conclusive evidence of this is beyond the scope of this evaluation. However, the feedback received in the provider interviews is consistent with what was expected given the stage of the programme and the data available. Providers believed in the logic that early intervention reduces need for higher-intensity services. By being able to minimise the anxiety that young people feel about different parts of their lives and being able to walk alongside them

early on, they are less likely to need more intensive support. As already discussed, providers also highlighted the outcomes being achieved by rangatahi Māori, that would hopefully reduce their chances of needing higher intensity services in the future. However, there is minimal data about outcomes for the other priority groups.

Annex 4: Provider survey

Approach

An online survey was sent to providers within the initiative from August to December 2022, following participation in interviews. The intention was to gain reflections from a standardised set of questions, and potentially enable responses from staff unable to take part in interviews. 41 participated in the survey. The survey gathered provider's perceptions and experiences of delivering primary mental health services to young people in their locality, and the utility of delivering their services within the Youth PMHA initiative.

The survey was accessed online and comprised 21 questions using both open-ended and closed-response questions. Questions explored providers perceived equity, flexibility, and design of their services, as well as their ability to reach more young people and their whānau. The survey also explored providers' connections with other organisations and agencies in their communities, any learning and improvements, as well as early or emerging outcomes providers have witnessed while being a part of Youth PMHA. Several demographic questions, including service locality, providers' respective roles within the initiative, and service specifications are summarised later in this section.

Looking after resources, equitably and economically

Design and knowledge base building on existing infrastructure and expertise

Providers were asked to share the ways in which their service seeks to tailor its delivery to the needs of rangatahi from different groups and cultural perspectives. Regardless of whether a provider was a kaupapa Māori or mainstream service provider, all providers appeared to be developing cultural and group gender specific competencies within their workforce and/or utilising consultation from kaupapa Māori organisations.

A majority of providers who do not have a specific cultural or gender/sexuality focus aim to build competencies via training for their staff.
Some providers shared that they were actively seeking to provide training for their staff to address rangatahi in a culturally appropriate way.

> *We have been trained in supporting young people in a culturally appropriate way and the same in supporting young people from different groups. [Youth PMHA provider]*

One provider mentioned that while staff are encouraged to utilise tikanga Māori in their practice, it was unclear to what extent they employ this. Despite this, several providers express that workforce development is a priority to diversify their service delivery.

Some providers are making use of cultural advisors and Māori case review processes to ensure consultation is used when providing care for rangatahi Māori.
One provider, in particular, noted that they see the value of referring rangatahi Māori to a kaupapa Māori service if they feel as though their own service cannot meet their specific needs.

[We are] not being afraid to refer out to more fitting services if we specifically can't meet the cultural needs. Provider survey participant [Youth PMHA provider]

Without referral, providers are leaning on cultural advisors or are offering karakia and kaupapa Māori models of practice for rangatahi Māori. One provider mentioned their clinicians working with rangatahi Māori are required to present Māori case reviews to insure the right cultural competencies are in place.

A cultural advisor has a strong presence in the organisation with a commitment from staff to continue moving forward around cultural knowledge. [Youth PMHA provider]

All clinicians working with Māori rangatahi and or whānau must present Māori case reviews and utilise cultural supervision to support their cultural competency growth. [Youth PMHA provider]

Almost all survey respondents had development, consultation, or referral processes in place to service the needs of their rangatahi Māori.

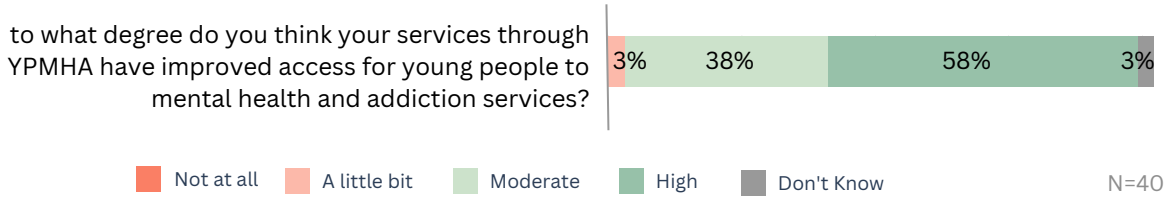
Delivering Youth PMHA services equitably and efficiently

Equitable and flexible service access

Providers were asked to state the extent to which they believe their services through the Youth PMHA have improved access for young people to mental health and addiction services. Respondents were asked to rate the statement from 'Not at all' to 'High'; don't know/not applicable was also an option (Figure 14).

In most cases, providers perceived their services to have highly improved access to mental health and addiction services among young people (58%), while some indicated moderate improvement (38%), while others indicated it had improved a little bit or wasn't sure (3% respectively).

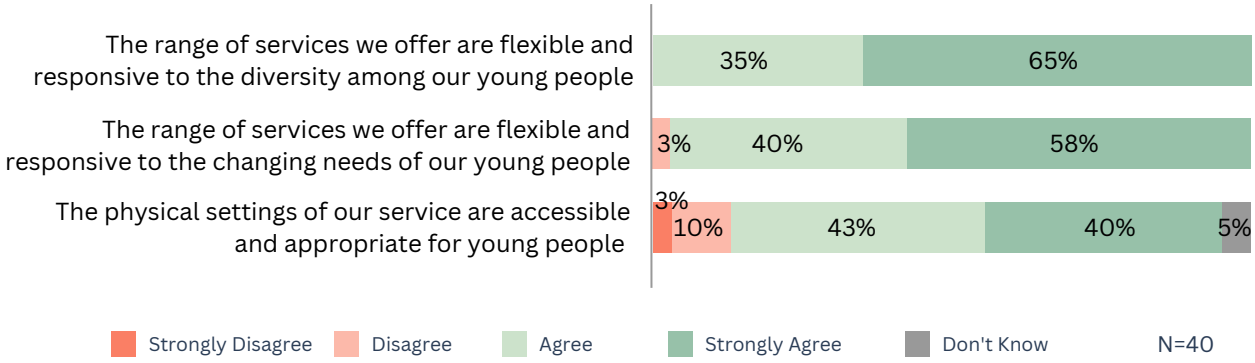
Figure 14: Perceptions of access improvement through Youth PMHA



Providers were asked a series of statements about the degree to which they feel their services are both equitable and flexible for their rangatahi. Respondents were asked to rate the statements from 'strongly disagree' to 'strongly agree'; don't know/not applicable was also an option (Figure 15).

- There was high agreement that the range of services offered by providers was flexible and responsive to the diversity among the rangatahi they support (65% strongly agree and 35% agree).
- There was also general agreement that the services offered were both flexible and responsive to the changing needs of each rangatahi (58% strongly agree and 40% agree).
- While there is also agreement that the physical setting of provider services is both accessible and flexible for the rangatahi they support (43% agree and 40% strongly agree), this was the main area of disagreement.

Figure 15: Perceptions of service flexibility



Providers within the Youth PMHA initiative aim to actively address access barriers to their services, some of which have been mitigated, while others appear to be ongoing among some providers. Respondents were asked to identify any access barriers they have encountered in their service provision, while also mentioning any actions that have since been implemented to overcome access barriers. Several challenges highlighted include:

- Rangatahi transport to and from sessions.
- Poor access and significant wait times for clinical services via primary mental health service referral.
- Rangatahi needing long-term support despite resource constraints reported by providers; we note however that contracts state there are no constraints regarding how long rangatahi can stay within the service.
- Assertive outreach and steady referrals particularly among newly established providers.

Transport is a significant barrier for rangatahi, with variable resources among providers to respond to this challenge.

Several providers mentioned that transport for their rangatahi was challenging, especially when coordinating to assist multiple rangatahi across multiple localities with their transport to and from their sessions. Some providers aim to assist clients by picking them up in a company vehicle or subsidising their transport, which has proven efficient for some while challenging for others.

> *Transport - we assist with picking up clients and returning them after the session. Have a fund available to help with phone top-ups, bus fees, etc to assist with access to service. [Youth PMHA provider]*

> *Transport can become an issue when we have eight rito to pick at the same time for a group. Some could be at different locations, and we have had to try organising two vehicles for our pickups. The transport barrier remains. [Youth PMHA provider]*

Some providers instead have their support persons or clinicians travel to rangatahi in a community setting of their choosing where possible. The trade-off, however, is the allocation of travel time for support persons and the subsequent loss of time and resources to see high volumes of rangatahi on time.

> *We try to be as flexible as possible and have clinics/clinicians drive out to different areas of the city to help make it easier for young people to access services. However, often the travel time means we can see fewer people so it's a balance. [Youth PMHA provider]*

One service provider mentioned they had relocated to central city premises to improve public transport opportunities for their rangatahi. Organisations without the necessary resources to do so, still encounter transport barriers. Some providers have implemented a technology-based intervention within their service offering to improve access for rangatahi who are unable to travel for their treatment or would like to access services outside of normal operating hours.

> *By operating our text, email, and phone services 8am to midnight, have a crisis phone service midnight to 8am and rolling out instant messaging, a medium of support nearly 70% of rangatahi users of a helpline would like to have access to, we can provide support to young people when they most need it with an accessible and free service. [Youth PMHA provider]*

There is a desire from some providers to build out their text and direct message service to reach young people who are unable to travel to the providers offices, with a view to address this in the near future.

Providers experience numerous constraints to the services they can provide due to resource limitations and their understanding of contractual requirements.

Recruitment of and/or access to a clinical FTE resource is a frequently mentioned challenge among providers who feel as though access to clinical resource do not meet increasing demand.

> *We have been able to support more young people with clinical support. There is continual demand, and we still have to fundraise over $1 million a year to stand up our service. [Youth PMHA provider]*

While some providers can subsidise their rangatahi to receive psychological assessments and subsequent treatment, some providers say that the funding allocated is not sufficient for more than two sessions, and rangatahi are unable to complete their assessments due to cost barriers. As a result, rangatahi are left waiting, or without access to clinical support options.

> *Cost is a huge barrier, many of our Rangatahi would benefit from psychology input but this is too expensive. Our service can help fund two sessions, but our rangatahi are requiring more than two sessions. [Youth PMHA provider]*

Providers noted that it is their objective to accept all referrals who approach their services or direct rangatahi to the services that will provide the support that will benefit them the most. Providers noted that they often feel constrained by brief intervention therapy contracts, despite rangatahi clearly needing more long-term or comprehensive forms of support.

Brief intervention has made it possible for young people to access services more regularly,however for those experiencing significant distress, it is very difficult to have them seen forlonger-term counselling.[Youth PMHA provider]

Providers have employed several actions to help overcome the constraints of a brief intervention approach[19] including the option, among some providers, for rangatahi to return to brief intervention counselling an unlimited number of times. Providers also frequently mentioned directing their rangatahi to other alternative therapies within their community such as music therapy and group community sessions to aid long-term support.

We accept pretty much all of our referrals and will offer alternatives if we can't, we do offer clients to access our services more than once as well. [Youth PMHA provider]

Linkages with secondary mental health pathways are sometimes inefficient and ineffective for some providers.

The extent to which more rangatahi presenting with moderate to severe mental distress are being referred to their services appears to be gradually increasing due to resource deficits in secondary services for some providers. Yet, providers seek to remain the 'right door' for every rangatahi. A provider noted they are overdelivering on contract numbers to reduce wait times for their rangatahi that fit the Youth PMHA criteria, which means they are exceeding the negotiated funding provisions available.

We have been asked to deliver to those clients who exceed mild-moderate, who are experiencing severe mental health distress but are unable to access other services. We are over-delivering on the contracted numbers to address the waitlist while not being recognised as working in excess of the negotiated and funded contract both in volume and classification of mental health needs. [Youth PMHA provider]

Another provider felt as though rangatahi were being referred by secondary services without a formal consultation process to discuss the best fit, and rangatahi are instead referred to a primary mental health service without knowing who will be providing their support, or what it might entail.

Our local secondary services are not responsive thus see our service as an alternative to ease their demand rather than fit for taiohi. I note a lot of our referrals are not completed with the taiohi as intended, instead after secondary service presents their assessment to their triage a referral to us is made. Taiohi don't often know who we are or what we do. This is disappointing. We overcome this by introducing ourselves at first contact, reassuring the taiohi there is no expectation and that our first meeting will be a meet and greet where we talk about our service and what we offer and see if we are a 'good fit' for them. [Youth PMHA provider]

[19] Te Whatu Ora has indicated that the Youth PMHA contracts state that the intention is to use brief interventions. However, different to usual brief intervention models, young people can access the service for as long as needed to achieve their goals, with an understanding they can return to the service in the future should the need arise. However, survey responses indicate that this may not be well understood by people delivering Youth PMHA services. Clearing up this misunderstanding could positively influence service delivery in the future.

The rigidity of secondary service criteria also means some rangatahi fall within the catchment of primary mental health services, despite needing treatment for more severe psychological distress. To mitigate the effects of referring rangatahi to a service that does not resonate or will not benefit them, providers indicated that they are working hard to liaise with key secondary mental health services to minimise the need for constant referral and long times and prompt quicker triage and decision making with the young person's interests at the forefront.

Despite access challenges, providers generally feel as though access to primary mental health support has improved.

Providers indicated the ease of access that is afforded by rangatahi self-referral as many rangatahi cannot afford to reach a GP service for a subsequent referral. Instead, rangatahi can access the provider's website to apply for support, or they can be referred by a community organisation.

One provider that is newly established mentioned the process of obtaining referrals is challenging due to a lack of assertive outreach and awareness of their services within the local community. Significant time, and resources are therefore needed to bring awareness to their services within their local youth mental health service networks.

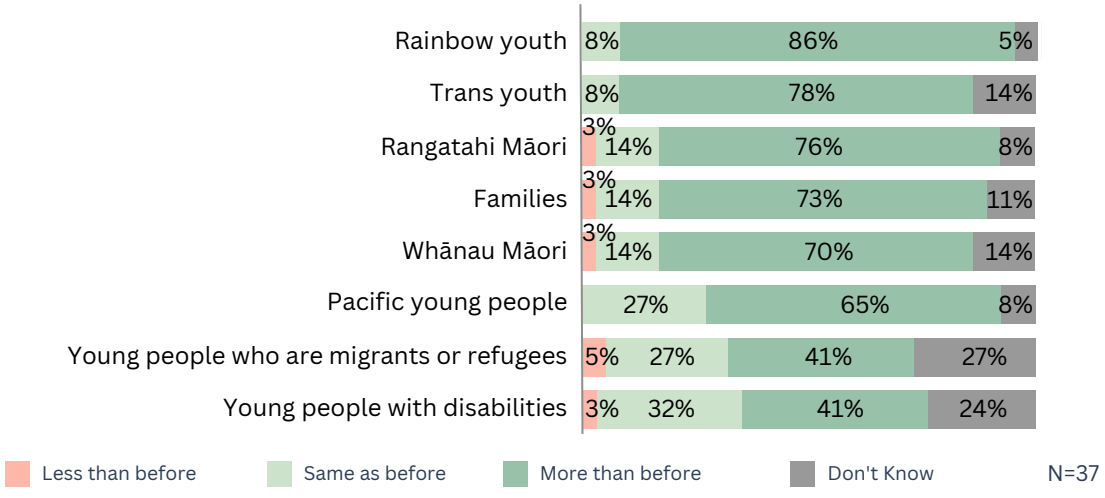
Reaching young people and whānau/family

There is general agreement among providers that services are reaching young people across various groups at higher volumes than before acquiring Youth PMHA funding.

Providers were given a series of groups that are likely to access their services and were asked to rate the extent to which they feel their services are reaching these groups in comparison to previous years before acquiring Youth PMHA funding. Respondents were to rate each group from 'Less than before' through to 'More than before'; don't know/not applicable were also available (Figure 16).

Among the groups listed, all providers believed they were reaching more young people than before Youth PMHA funding was available. Particular areas of growth were seen to be among rangatahi Māori, rainbow and trans youth, whānau Māori and families. Young people with disabilities, and migrant and refugee populations were less likely to be seen as groups that had grown noticeably.

Figure 16: Perceptions of improved access for specific groups of rangatahi and their whānau



Shifting the locus of control

Providers tend to agree that their services are designed to respond to the unique social and cultural contexts of their rangatahi.

All survey participants were asked a series of statements about the extent to which their services are designed for the different contexts their rangatahi present with, their cultural backgrounds, and their lived experiences. Respondents were asked to rate the statements from 'strongly disagree' through to 'strongly agree'; don't know/not applicable was also possible (Figure 17).

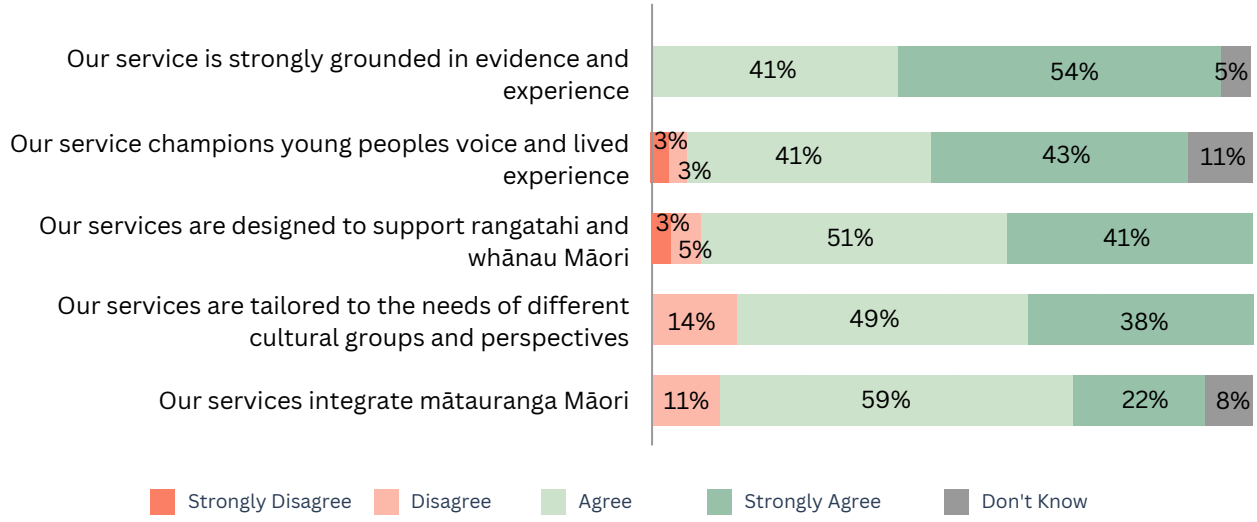
There was general agreement among providers for the following statements:

- With regard to system design, providers tended to agree most that their service offering was grounded in evidence and experience (54% strongly agree and 41% agree).
- Providers also felt that their services were designed to support rangatahi Māori (51% agree and 41% strongly agree), with only minor disagreement.

The following statements had more variable levels of agreement:

- Providers generally felt as though their services were tailored to different cultural groups, needs, and perspectives (49% agree and 38% strongly agree); and that their services championed the voices and lived experiences of their young people (43% strongly agree and 41% agree).
- There was less agreement with the statement that services incorporated mātauranga Māori (59% agree and 22% strongly agree), while some disagreed (11%) or weren't sure (8%).

Figure 17: Perceptions of service design



Survey respondents were asked to comment on how their services are designed to support youngpeople to choose how they receive their support.Responses included:

- Providers employ a strengths-based model of practice using goal setting and flexi-fund capabilities.

- Providers allow rangatahi to choose where and who provides their support, matching counsellors with rangatahi cultural backgrounds where possible.
- Providers are seen to be respecting rangatahi from all cultural and group specific backgrounds.

Some providers operate from a strengths-based and person-centred mode of practice.

A common feature of brief intervention therapy often mentioned by providers is goal setting, of which planning, and progress are determined in consultation with rangatahi across the programme. One provider mentioned that they engage rangatahi in developing a plan to begin working on these goals. Another provider mentioned they utilise vision boards and SMART goals for rangatahi to use outside of their sessions, achieving a noticeable difference in their wellbeing trajectory across the counselling period.

> *Goal setting, we strongly encourage our Rito to set goals for themselves before they leave our programme. Some of our Rito show self-determination, they know what they want for themselves and they set goals and make a plan to achieve what they want to achieve in life. [Youth PMHA provider]*

Some providers mentioned that they often operate from a person-centred and strengths-based approach that allows rangatahi to determine their therapy options. One provider shared that when the co-creation of treatment plans with rangatahi is achieved, rangatahi are known to be more engaged with their treatment and follow through with the actions, tools, and exercises that are recommended by their counsellors.

Providers also draw from the flexi-fund to aid this process, subsidising any activity or resource a rangatahi may need to help achieves these goals.

> *One example is the flexi-fund that can be used for anything that the rangatahi deem most helpful, they can determine when where, and who to meet and what they will discuss, and how best to address the issues. [Youth PMHA provider]*

In initial appointments, rangatahi are encouraged to choose the setting in which they receive their support, including the right to change their support person at any time should they wish to. Rangatahi are also given the option to attend their support as an individual, or with the whānau and friends. As one provider states, services are developed to empower rangatahi to take charge of their wellbeing.

> *We work alongside our youth to empower them in their own journey we actively work to meet the needs of young people without disempowering them by doing all the mahi for them. [Youth PMHA provider]*

Providers strive to acknowledge the lived experiences, world views, and bodies of knowledge of different social and cultural groups.

Some providers noted that they aim to match the culture of their kaimahi with rangatahi where appropriate to ensure support is delivered by Māori for Māori. If this is not possible, training and workforce development is provided for staff in some cases to ensure rangatahi cultural needs are being addressed.

> *[Provider] is a best-fit service, so we can match the culture of our Kamahi to the Rangatahi. Also, as a peer group, we run development sessions to inform the peer group of our cultural perspectives. [Youth PMHA provider]*

Providers also mentioned that they aim to have a culturally diverse workforce, as well as staff that have experienced similar challenges faced by those belonging to the rainbow community. This is however an area that requires ongoing development for those struggling with recruitment.

> *We have advocates and members of the team who are a part of the rainbow community that has lived experience and "inside' knowledge of the challenges rainbow youth face. [Youth PMHA provider]*

Regardless of whether providers have the ability to ensure cultural best fit or group-specific support for their rangatahi, almost all providers acknowledge the unique challenges that these groups face. One provider mentioned they continue to 'learn, listen, observe and encourage rangatahi to be themselves', acknowledging pronouns and any cultural sensitivities that need to be considered in their support provisions. Several providers mentioned asking their young people about their culture within initial consultation, and what it means to them while they are getting to know their clients, without making any assumptions. This is then used to inform the rangatahi treatment plan.

For groups of young people who are marginalised or are less likely to access primary mental health services, sexuality, or gender-specific initiatives have been created in some cases by providers to target these groups.

> *Delivering gender-specific initiatives allow rangatahi tāne or wāhine to feel confident in sharing their hauora journey, and ensure we target specific needs. [Youth PMHA provider]*

Manaakitanga and cultural fit

Providers are increasingly utilising Kaupapa Māori methods in service provision.

When asked to share how providers are attempting to include mātauranga Māori within their service provision, several methods were mentioned. Providers without a Māori specific service, generally report referring rangatahi Māori to the appropriate services, however, some reported incorporating karakia and a Te Whare Tapa Whā framework to support their hauora where possible. Providers also acknowledge the importance of rangatahi whānau, and their integral role in the young person's wellbeing. Rangatahi are given the choice to include their whānau within their support plan in some cases. One provider mentioned highlighted a need within their service for a more ‘holistic whānau based lens’ when approaching their work with rangatahi Māori, addressing the need of the young person’s whānau within the treatment plan of the rangatahi.

> *Whānau are invited to first appointments and can participate throughout the intervention and be involved in planning the transition out of our service. [Youth PMHA provider]*

Kaupapa Māori organisations recognise the value in the integration of Kaupapa Māori approaches to regular service offerings as it allows rangatahi to reconnect with their cultural

identity. For one provider, lived experiences and cultural knowledge has not traditionally been addressed within the context of young people's wellbeing, and the acknowledgment of spiritual influences and other cultural practices should be legitimised methods of support rather than relegated as an 'add on' or specialised service.

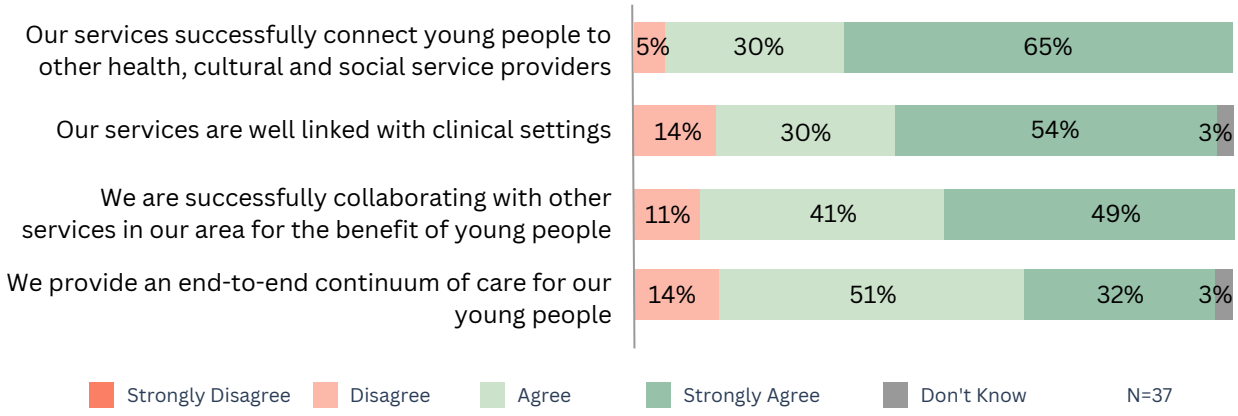
System connections

There is positive consensus among Youth PMHA providers that there are strong and efficient links between their services and other health, cultural and social service providers in their communities.

Respondent providers were given a series of statements about the degree to which they feel their service is successfully linking with other health, cultural and social service supports within their service provision (Figure 18).

There was high agreement among providers that their services worked well when connecting their rangatahi to health, cultural, and social service providers within their network; and that their services were successfully collaborating with other services in a way that is within their young people's best interests. Whilst gaining general agreement, statements of heightened disagreement or uncertainty were that their services are well linked to clinical settings and that they uphold end to end continuum of care for their young people.

Figure 18: Perceptions of Youth PMHA system connectedness



Youth-specific service networks and directories are still largely underutilised and underdeveloped.

Several providers mentioned a lack of awareness or service directories to draw from within their local networks, particularly among those who have recently been established. There appears to be a lack of knowledge of what services can be leveraged for their rangatahi, their access criteria, and the staff who provide these services. With more instances of collaboration, some providers have benefited from increased knowledge of the services they can refer their rangatahi to, and/or receive referrals from. One provider has noted a gradual improvement in the seamlessness of their referral process, knowledge sharing, and further treatment opportunities to offer their young as a result of their active collaboration with other services in their community. The development of a collaborative service directory, therefore, appears to be dynamic and ongoing.

Some providers highlighted an absence of sufficient time to maintain relationships with other organisations. This includes adequate time to collaborate efficiently with warm handover of

clients as well as establishing relationships with new providers in their localities. Staff turnover and limited time for clinicians to adequately collaborate and discuss treatment plans for their rangatahi is a persistent challenge that inhibits organisations from working together effectively.

To overcome this challenge, some providers are leveraging fortnightly interagency discussions about referrals and triage to ensure rangatahi aren't being passed on from service to service without discussing the best fit. These triage liaison meetings ideally should direct rangatahi to the correct service in the first instance and reduce any time delays. For one provider, this includes employing part time triage workers to ensure rangatahi are consulted about their support options.

Despite these challenges, providers have generally reported their relationships with other health, social, and cultural service providers to be beneficial, not only for rangatahi but for service providers to feel as though they have adequately addressed their young people's needs holistically.

Linkages with other social, cultural, and health services have proven beneficial for young people.

Providers commented on the value of being able to offer their rangatahi alternative therapies and pastoral care options to ensure all of the needs of rangatahi are being addressed long after their support contract has ended. Providers have found value in connecting with community organisations to establish a continuum of care for their rangatahi. One provider mentioned that they work to scaffold the process for rangatahi to access these services, establishing a warm-handover and encouraging rangatahi to remain engaged in some form of support beyond their contract.

> *We are able to refer our rito to other services in the collab, that can offer more support after our programme. [Youth PMHA provider]*

> *We are able to transition or refer youngsters to other services either offering more long-term care, or more acute care. However, the transition time is often longer than we can sustain as other organisations' resources are also low and waitlists are endless. [Youth PMHA provider]*

While some providers do not have the authority to refer their rangatahi to other services, they aim to provide information to their rangatahi about the support options available to them or make contact with these services on their behalf. One provider noted that rangatahi are often too anxious to approach other services or aren't aware of other specialist services they are entitled to access.

> *We can help them decide which other services might be helpful and scaffold the process of reaching out and engaging with other services. Often young people have no idea what other services are available or are too anxious to reach out directly. [Youth PMHA provider]*

Providers also frequently noted the value of being able to offer rangatahi alternative services they think they would benefit from that will nurture other aspects of their wellbeing such as arts, music, and sporting groups. According to a provider, staff are working hard to 'fill gaps' in their services with community organisations, leveraging community groups, events, and the

flexi-fund. These relationships with other community organisations are often formed by individual clinicians' relationships within their local community, and there are always new relationships to be leveraged. One provider spoke of collaborating with a local boxing gym to encourage their rangatahi to engage in physical exercise, while another facilitated an interactive multisport day to address the needs identified by their rangatahi for more access to regular exercise and sporting opportunities.

> *We have sought out and nurtured these relationships and can now offer these supports due to individual clinicians' relationships with other clinics in the community using our flexi-fund. Likewise supporting nontalking therapy as such with music, art, and unique therapy has proved to be very beneficial. Again, this relies on individual clinicians' relationships and working hard to foster these. [Youth PMHA provider]*

Linkages within local schools are seen to have lifted providers' profiles within their communities. One provider noted that facilitating groups in schools has increased the awareness of their services and subsequent referrals. Another mentioned the value of forming relationships with school counsellors to ease their student caseloads and provide further support that schools are currently unable to provide.

Another important relationship within communities frequently mentioned by providers is their connection to local marae and Māori organisations.

> *We are collaborating with local Marae and their new programmes - this has meant young people getting mental health and wellbeing support but also support to get into the workforce and connect with whakapapa. [Youth PMHA provider]*

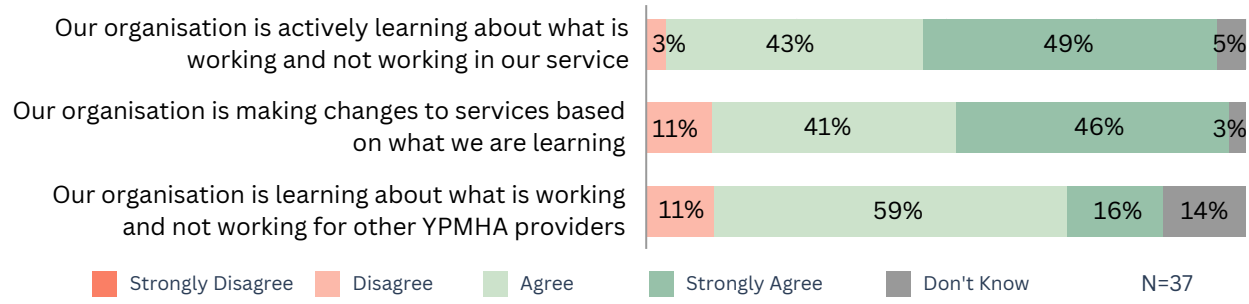
Learning and improving

Providers report early learning and subsequent changes made to their services based on what is being learned.

Survey respondents were given a series of statements about their experience as an organisation learning about their service delivery and how it could improve with subsequent changes (Figure 19).

Providers tended to agree that their organisation was actively learning about the strengths and weaknesses of their services (49% strongly agree and 43% agree). There was higher disagreement and uncertainty with the statement that their organisation was learning about the strengths and weaknesses of other Youth PMHA organisations; and that their organisation was making changes to their services based on what they had learned.

Figure 19: Perceptions of learning and improving within Youth PMHA



Evaluating, reporting, and data collection are systematic among some providers.
Some providers indicated that they aim to continuously evaluate their services, gather feedback from their rangatahi on what they would like to see within their service provision, and gather demographic data of the groups of rangatahi being reached. For one provider, this includes establishing client feedback focus groups and developing in-house quality teams to assess the feasibility and implementation of any suggested changes. For other providers, this involved client exit surveys, and adequate documentation and reporting of rangatahi outcomes after their support contract has ended to locate opportunities for improvement and scalability.

> *We have client and whānau surveys, a YCA that runs client feedback focus groups, and a quality team. We adjust what is learned and or ensure clarity on what we can and can't deliver. [Youth PMHA provider]*

> *We learn from our taiohi and that helps us become more flexible so that we can cater our programme to the young people in our group. Their feedback is really appreciated because we are able to see what works and what does not work. [Youth PMHA provider]*

Some providers, however, mentioned that this is an area which needs active improvement. For example, one provider highlighted a need for more accurate data gathering and reporting of the types of groups currently accessing their services. One provider, in particular, noted their services were disproportionality being accessed by female rangatahi.

> *We are delivering around 75% of service to females - we are about to look at where the young men are. We are also looking at ethnicity data to see if Pacifica and Māori data is being lost in how to collect data. [Youth PMHA provider]*

Some providers are reviewing models of practice based on what is being learned.
Providers also mentioned actively reviewing best practices for various aspects of the primary mental health and brief intervention model; a review that is informed by the advice and learning of other youth practices within their networks. Some providers mentioned their attendance at regular hui with local youth practice leads to discussing needs within their communities and subsequent responses. One provider noted specific utility in reviewing models of practice for telehealth interventions, especially among those who are planning to roll out a text or call support service.

Providers have been broadening their access criteria to accommodate the escalation of rangatahi referrals presenting with high end-moderate mental distress due to resource constraints of secondary mental health services. Despite being constrained by a brief intervention contract, providers are doing the best they can to review their service offering and adjust funding and/or access to a flexi-fund to ensure each rangatahi who approaches their service can access some form of support. One provider mentioned that they encourage their staff to be agile in finding ways around constraints in access criteria. For example, transgender rangatahi may not qualify for funding to attend a women's tramping group, but the staff has to manage to adjust their service offering and funding applications to accommodate this.

Other changes that were mentioned by survey respondents were specific to service delivery. For example, one provider mentioned the value and demand for their wellbeing skill sessions delivered by wellbeing coaches, and, therefore, redefining their roles and provisions to scale the

service. Another spoke of looking into incorporating more te reo Māori in their service provision.

While providers are confident in their ability to review and improve their service offerings based on what they are seeing and experiencing with their rangatahi, one provider acknowledged that these necessary changes aren't always being made due to resource constraints. They spoke of their frustration as service providers in having these requested improvements ignored and disregarded by management within their organisation.

Generating social value, equitably and effectively

Wellbeing outcomes

The initiative is seen to be generating value for young people, not just 'plugging holes' for youth mental health services in each region.

Survey respondents were asked to comment on an important outcome they have witnessed when working with their rangatahi, and the difference their services are making for young people in their regions.

Providers frequently mentioned numerous outcomes that they are seeing amongst the rangatahi they have supported:

- Rangatahi have restored their faith in improving their wellbeing, despite adverse experiences and attempts with other mental health services in the past.
- Rangatahi are connected to, and accessing other social services to address their basic needs, in some cases driven by a non-clinical wellbeing coach.
- Rangatahi are re-engaging in their community networks, including re-engaging with their peers, their studies, and extra circular activities.
- Rangatahi are building their self-confidence and self-efficacy to take control of their lives and make healthy choices.

An important outcome witnessed by providers among the rangatahi who have accessed a service within the Youth PMHA initiative is the improvement in young people's wellbeing, particularly those who have had negative previous experiences with mental health services and 'given up' on their treatment journey. Rangatahi who have previously experienced secondary services have often been surprised by the level of care they experienced by their primary mental health service provider. One provider mentioned that by connecting one of their young people to further social support and psychological assessment and subsequent medications, both the young person and her whānau have been encouraged to re-engage and restore hope in their treatment journey despite previous setbacks and disappointing experiences at other services.

> *A great example is a young wāhine I work with, she was under secondary services for over 4 years. There were lots of gaps as services pushed back on each other to do the work that was needed, and no one really did anything. I have been working with her for a few months, have supported her in education, disability services, and whānau support, and made sense of what is going on for her. With this understanding, she has recommenced medication that is needed (ADHD) she*

previously didn't see the the point. She has also ceased self-harming behaviours by making sense of why she may have felt that was a coping strategy that worked for her. Her mum is re-engaged with service not feeling so hopeless and is active in care for her daughter, where previously she was resentful and had 'given up'. [Youth PMHA provider]

The addition of a non-clinical wellbeing coach appears to be an important resource that has been leveraged amongst some providers to achieve these outcomes, and they have noted a noticeable difference in the rangatahi who have accessed this service. Wellbeing coaches have appeared to have successfully guided rangatahi toward support services that address all aspects of their wellbeing, including helping rangatahi find adequate accommodation or subsidies, food security, and health care to address their basic needs. Once addressed, providers have found a reduction in added stressors has allowed rangatahi to focus on and improve their wellbeing.

Through the use of our wellbeing coach we were able to assist the young person to find accommodation, food parcels, etc therefore once work with a clinician started some of the stress had decreased and their basic needs were being met which improve their ability to focus on wellbeing. [Youth PMHA provider]

As a result of their intervention, providers have witnessed their rangatahi reengage with their community networks including their peers, their studies, and extracurricular activities. One provider shared a story of a rangatahi who had approached their services because they were disengaged from school and their peers due to severe bullying. With the help of kaimahi, the young person was slowly able to reengage in their education and reconnect with their peers resulting in important personal growth.

One of our Rito would refuse to go to school because of bullying. She would not engage with other young people. She would only engage with her family. She came on our programme, and it helped her build confidence. She was engaging with other Rito and it influenced her to return to school the following term. Our programme helped her with her anxiety and depression. It helped her slowly re-engage with people her own age. The personal growth of our Rito is such an important outcome in itself. [Youth PMHA provider]

Providers are seeing their rangatahi build or restore a sense of confidence and control of their life trajectory; as one provider described it, 'shifting young people from a place of helplessness to a place of feeling empowered'. The personal growth of rangatahi who have access to services has been articulated by providers as a common outcome, helping rangatahi to see a way forward and develop a sense of self-efficacy.

For young people to be able to be empowered to take control of their wellness journey is very important as it shows them, they have something to live for. [Youth PMHA provider]

The client was able to learn to accept what she could not change, instead of using a lot of energy and time fighting against it. Instead, she was able to notice and manage her emotions and direct them into the aspects of her life she could develop. It was important to her to move from feeling trapped to recognising her own efficacy. [Youth PMHA provider]

Another provider mentioned an occasion where their services assisted a young woman with her presenting problems, who has since joined the provider on several occasions as a Youth Consumer Representative.

The flexi-fund enables a broad range of wellbeing needs to be addressed.

Another provider spoke of the utility of the flexi-fund within the initiative which has expanded and improved the opportunities they can offer their rangatahi and has made a tangible difference in their treatment journey. Providers note that the ability to address the holistic and basic needs of rangatahi including healthy housing, access to food, alternative education, and medical care has been very beneficial. In addressing these basic needs, rangatahi are able to focus on behavioural activation, and their whānau are relieved of some financial burden. One provider, for example, was able to fund extracurricular activities for one whānau they could otherwise not afford with out-of-school iwi funding of over $750 per child annually.

> *The highlight for me as a clinician is to have the Flexi-fund to support holistic wellbeing, acknowledging socio-economic and socio-environmental, and cultural influences on mental health it really makes a huge difference in terms of behavioural activation and supporting basic needs (Maslow's hierarchy of needs). [Youth PMHA provider]*

The initiative is generating value for providers, expanding, and improving the support they are delivering to their rangatahi.

Survey respondents were also asked to mention their personal highlights from participating in the Youth PMHA initiative and the extent to which they feel it has strengthened the provider's ability to make a difference or address the need in their region.

A highlight acknowledged by providers is the process of establishing a primary mental health service in a region with long-standing deficits and seeing the impact this service is making. As one provider mentions, the service is constantly informed by what they have learned from their rangatahi in the region, and not simply 'plugging holes' in support of other existing services. With previous knowledge and experience of how severe this deficiency in mild to moderate support is available in the region, the difference the service has made has been noticeable.

> *It is an absolute privilege to work with my now-established team. It was also a highlight to start a service from the ground up and learn from our own mistakes, and the community's needs; rather than trying to plug holes in the system. I also strongly believe a mainstream mild to moderate service was lacking in our region (after working in secondary MH locally for the past 6 years prior). [Youth PMHA provider]*

Furthermore, providers have mentioned a marked development in the awareness and utility of their services in their region with a growing profile of trust and reputation amongst their rangatahi and support networks. The processes of assertive outreach within the community and expecting each referral as ‘the right door’ for support were mentioned by one provider as a highlight, making their services known within their community and reaching traditionally underserved or hard-to-reach rangatahi.

> *The reputation we have for excellent work in our communities. Being able to make our door the right door or support to best options. The privilege of being trusted by youth and whānau. [Youth PMHA provider]*

I enjoy reaching out to schools and community services and presenting our service to them. We are still spreading the word about our service to our community. [Youth PMHA provider]

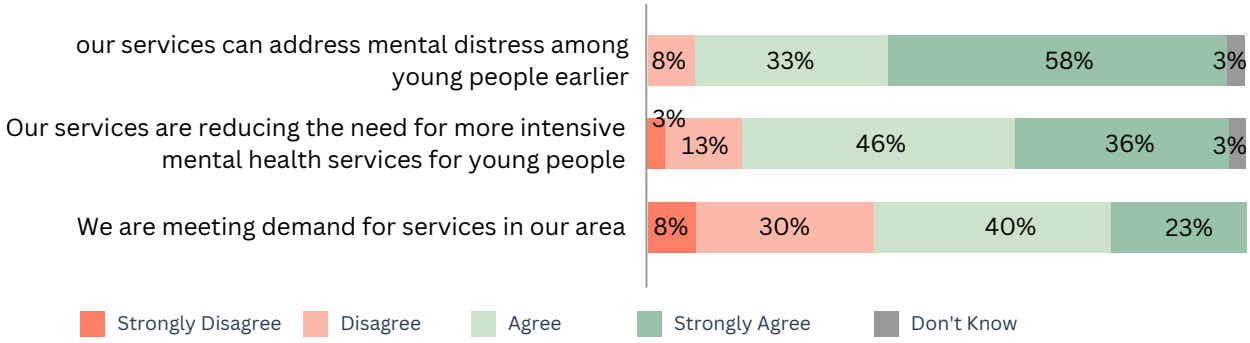
More efficient and equitable use of healthcare resources

There is general agreement among providers that their services are adequately addressing the demand for youth primary mental health services in their region and reducing the burden placed upon secondary mental health services.

All survey participants were asked a series of statements about the extent to which their resources can meet demand, and adequately address the need for primary mental health services in their localities (Figure 20).

There was general agreement among providers that their services are adequately addressing mental distress among young people earlier than previously possible. To a lesser degree, providers felt as though their primary mental health services are reducing the burden placed upon more intensive secondary forms of mental health care for young people; and that services are meeting the demand that is present in their locality. There also appeared to be marked disagreement in this statement.

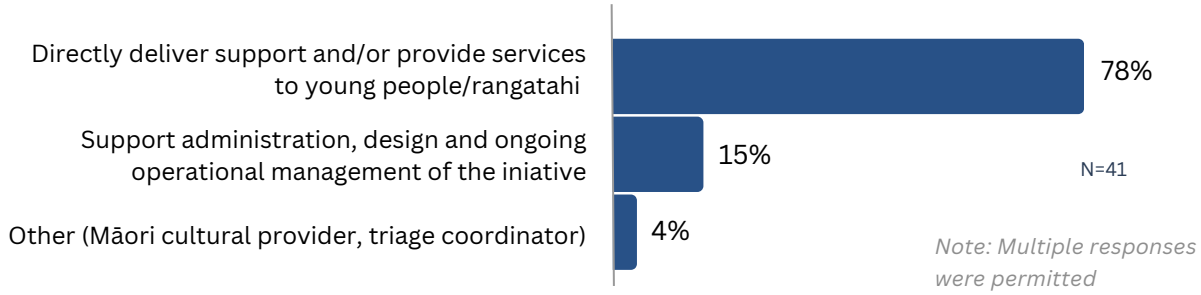
Figure 20: Perceptions of providers' ability to address needs and demand



Participant profiles

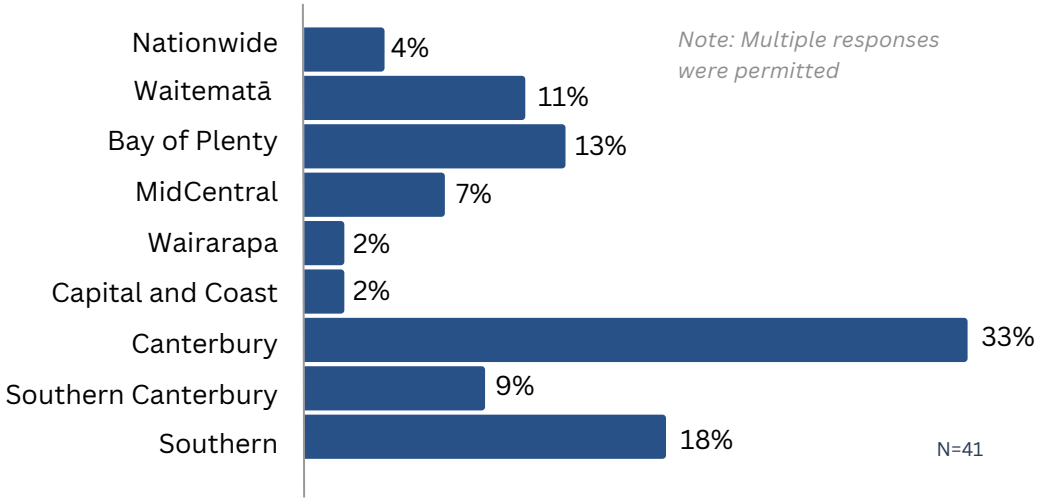
Survey respondents' respective roles within the initiative were to directly deliver support and/or provide services to young people/rangatahi and/or their whānau (88%); and support administration, design, and ongoing operational management of the initiative (17%). Those that responded 'other' (5%) mentioned roles such as Māori cultural advisor, triage coordinator, and clinician (Figure 21).

Figure 21: Roles of Youth PMHA providers



In some cases, participating providers delivered their services in multiple localities under the Youth PMHA initiative including Canterbury (33%), Southern (18%), Bay of Plenty (13%), and Waitemata (11%) regions. A smaller number of participants serviced South Canterbury (9%), Mid Central (7%), Nationwide (4%), Wairarapa (2%), and Capital and Coast (2%) (Figure 22; note the regions displayed below are based on the localities indicated by respondents who completed the provider survey, rather than the actual distribution of providers nationally).

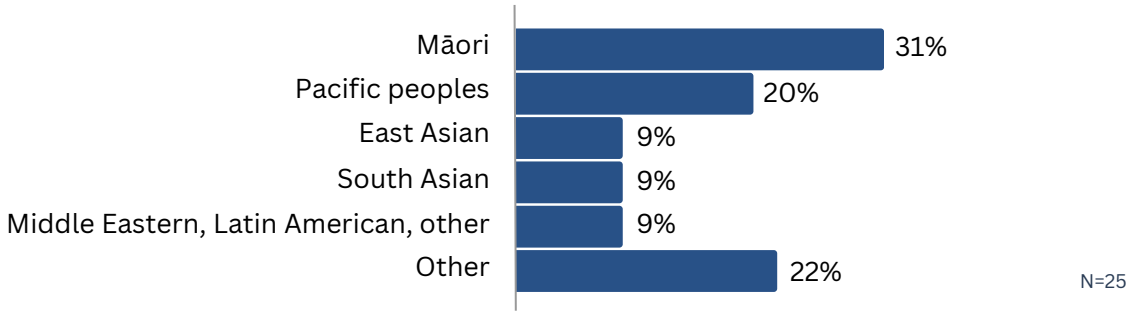
Figure 22: Regions of Youth PMHA provider respondents



Some providers identified themselves as a Kaupapa Māori service (32%), however, a majority did not identify as a Kaupapa Māori service (59%) or they weren't sure (10%).

Of the participating providers, some identified as a service focused on specific ethnic groups including Māori (31%), Pacific (20%), East Asian (9%), South Asian (9%), Middle Eastern, Latin American, and other (9%). Those that responded 'other' mentioned their service was targeted toward African and Filipino rangatahi, while others mentioned they were a nonspecific service (22%) (Figure 23).

Figure 23: Focus of providers towards specific ethnic groups



With regard to a gender or sexuality focus, 23% of providers that participated in the survey identified with a gender or sexuality focus, while 71% were nonspecific and 7% weren’t sure.

Annex 5: Service data analysis

Data overview

Te Whatu Ora provided service and activity data across all contracted service providers for the period from July 2021 to November 2022. Monthly information for individual providers included:

- Total number of people and number of new people seen, including breakdowns by age and ethnicity groups.
- Number of individual and group sessions provided.
- Number of people waiting more than five days to be seen.
- Number of people referred to other services and the number of rejected referrals.
- Actual and contracted clinical and non-clinical workforce (FTE).

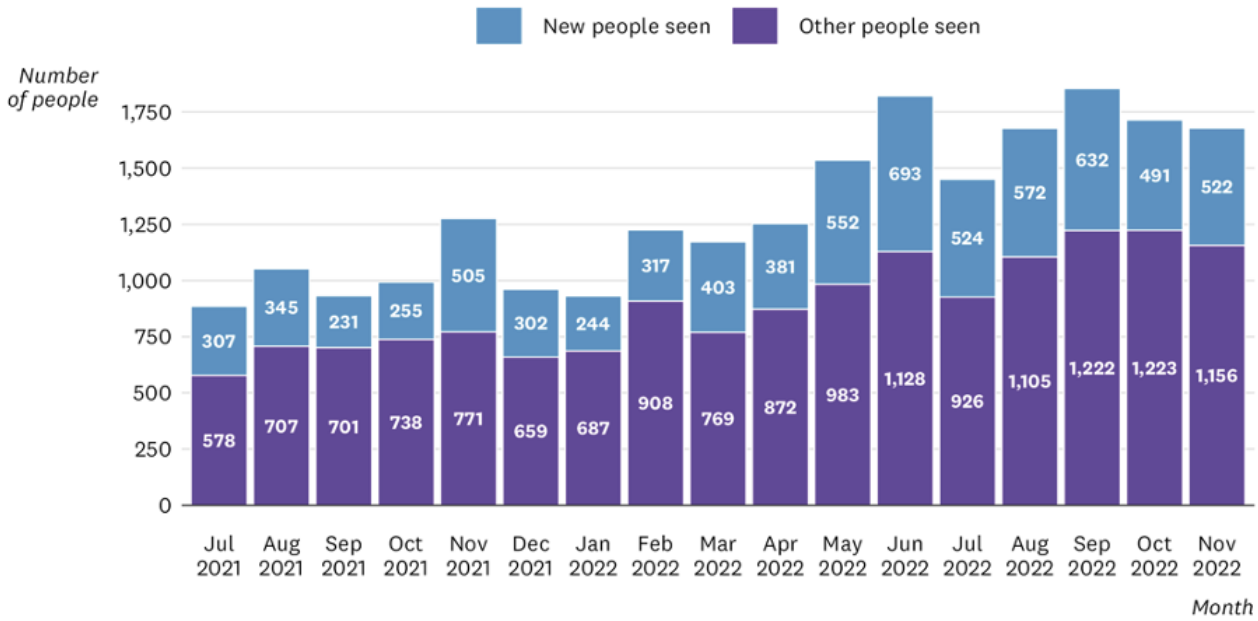
Youthline operates a substantially different model to other providers and its activity levels are not comparable to other providers. For this reason, Youthline's activity levels are not included in the analysis below, but Youthline workforce numbers are included in the workforce analysis except where stated otherwise.

Service activity trends

Number of people seen

Total people seen has increased over time to an average of around 1,700 per month over the last six months of data (June to November 2022). One-third of these were new clients who had not previously been seen during the prior 11 months, and two-thirds were clients who had previously been seen during the prior 11 months (Figure 24).

Figure 24: Total number of people seen per month.

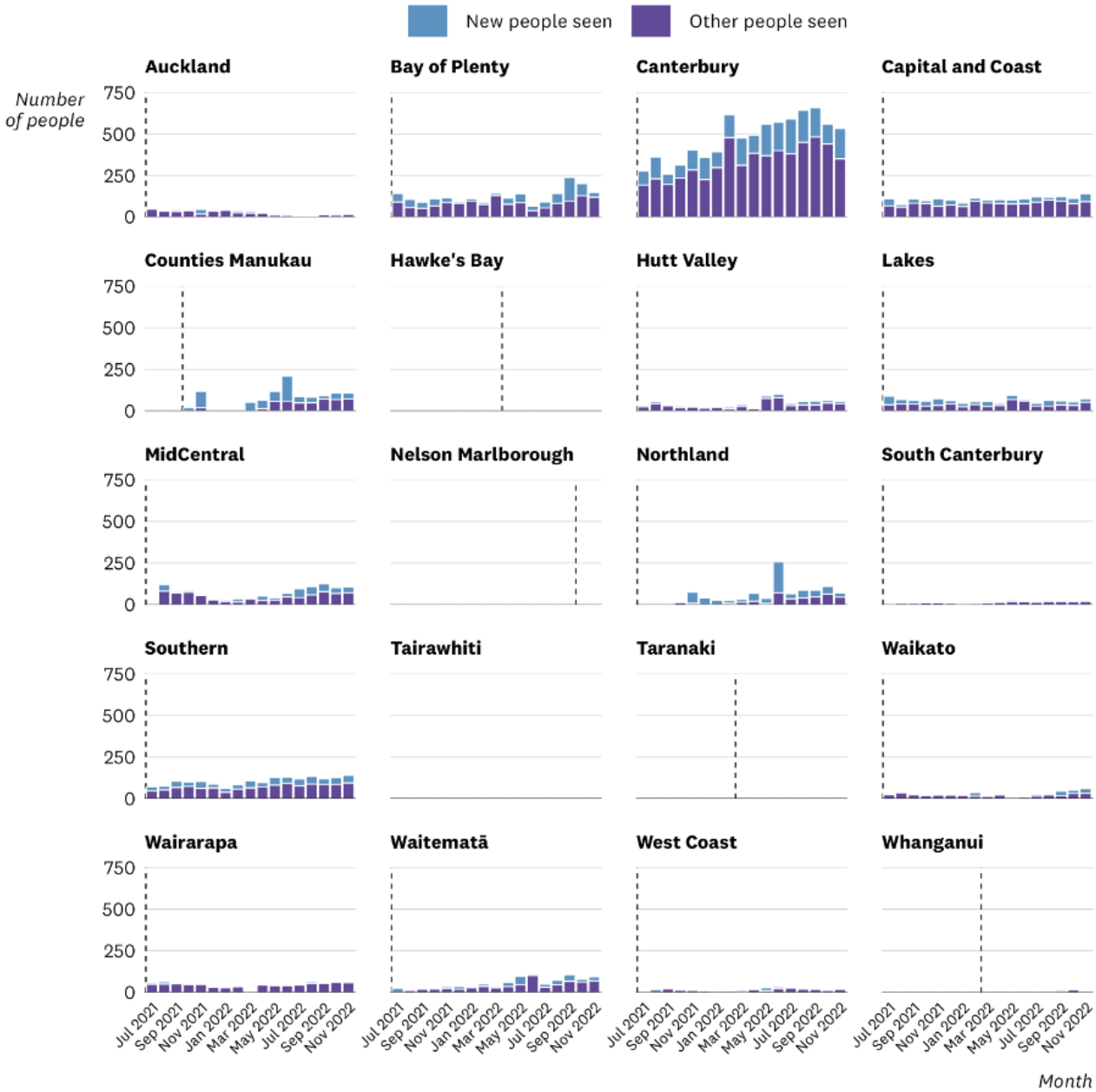


By late 2022, services had been contracted in 19 out of 20 geographic districts (Tairāwhiti being the only exception). Across districts, there is variation in the number of people seen and the trend in activity over time (Figure 25 and Figure 32). Over the last six months of data, around

one-third of people seen were accounted for by Canterbury district, while relatively low numbers or no people seen were recorded in some districts including Auckland, Taranaki, Hawke's Bay, Waitematā and Whanganui. Feedback from Te Whatu Ora indicates that Canterbury services were among the first to be established following the launch of Youth PMHA, compared to services in other areas that are in earlier stages of development.

Figure 25: Total number of people seen per month by district.

Note: Dashed lines show when contracted workforce was first recorded in each district. There is typically a delay between staff employment and service delivery to allow for induction and establishment.

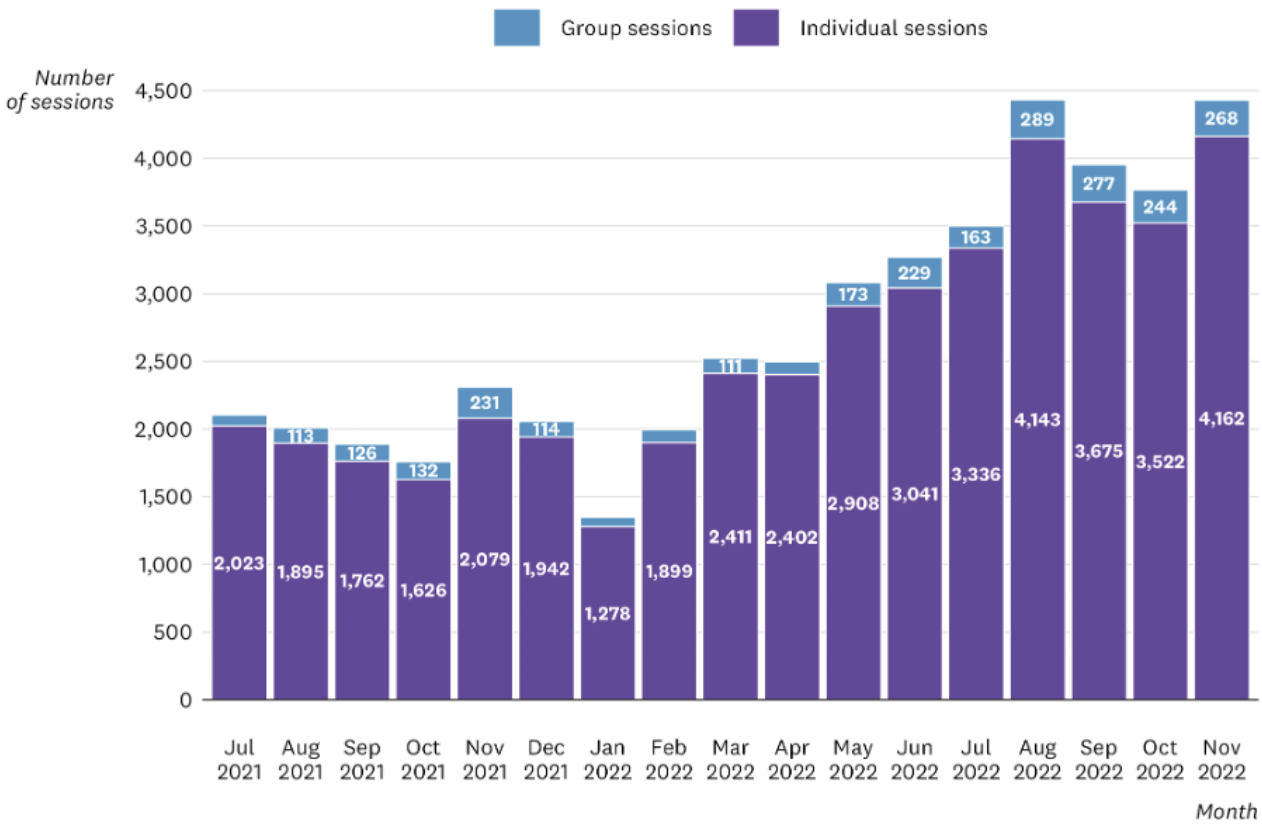


Sessions provided

The total number of sessions provided per month has grown over time in line with client numbers (Figure 27). Over the last six months of data, an average of around 3,900 sessions were provided per month, with around 94% of these being individual sessions.

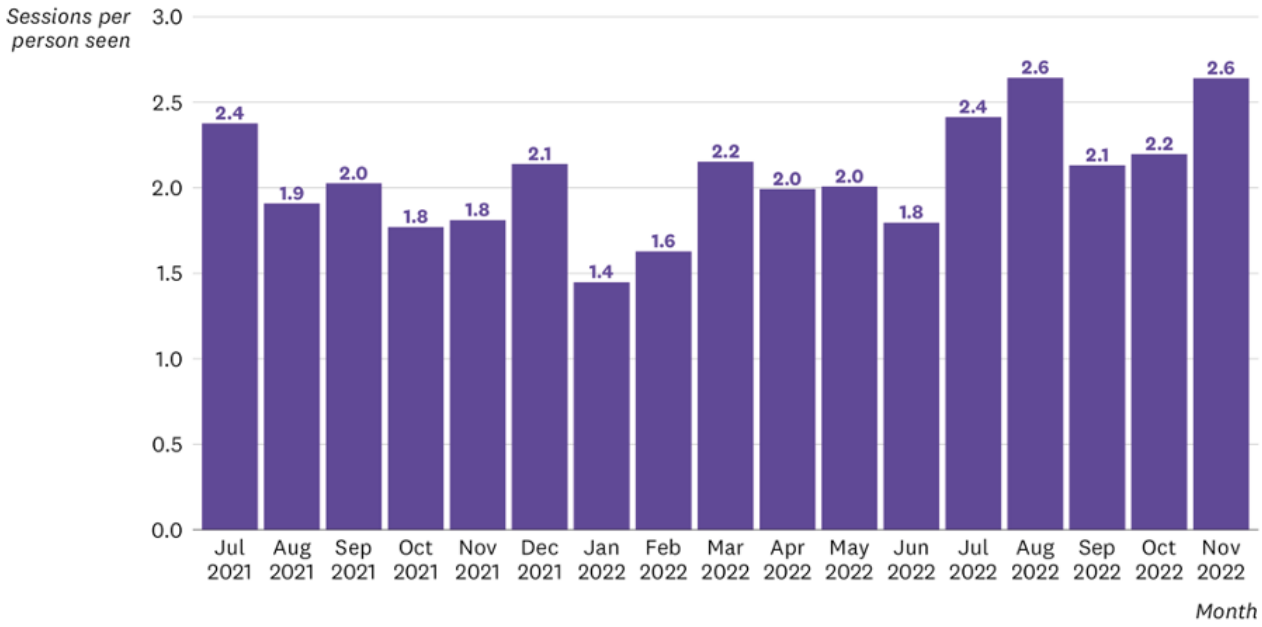
[20] Population data was obtained from the Ministry of Health's Health Service User population data.

Figure 27: Total number of sessions provided per month



The number of sessions provided per person seen appears to have increased slightly over time and averaged around 2.3 sessions per person seen per month over the last six months of available data. Group sessions are understood to be increasing as COVID restrictions have progressively lifted.

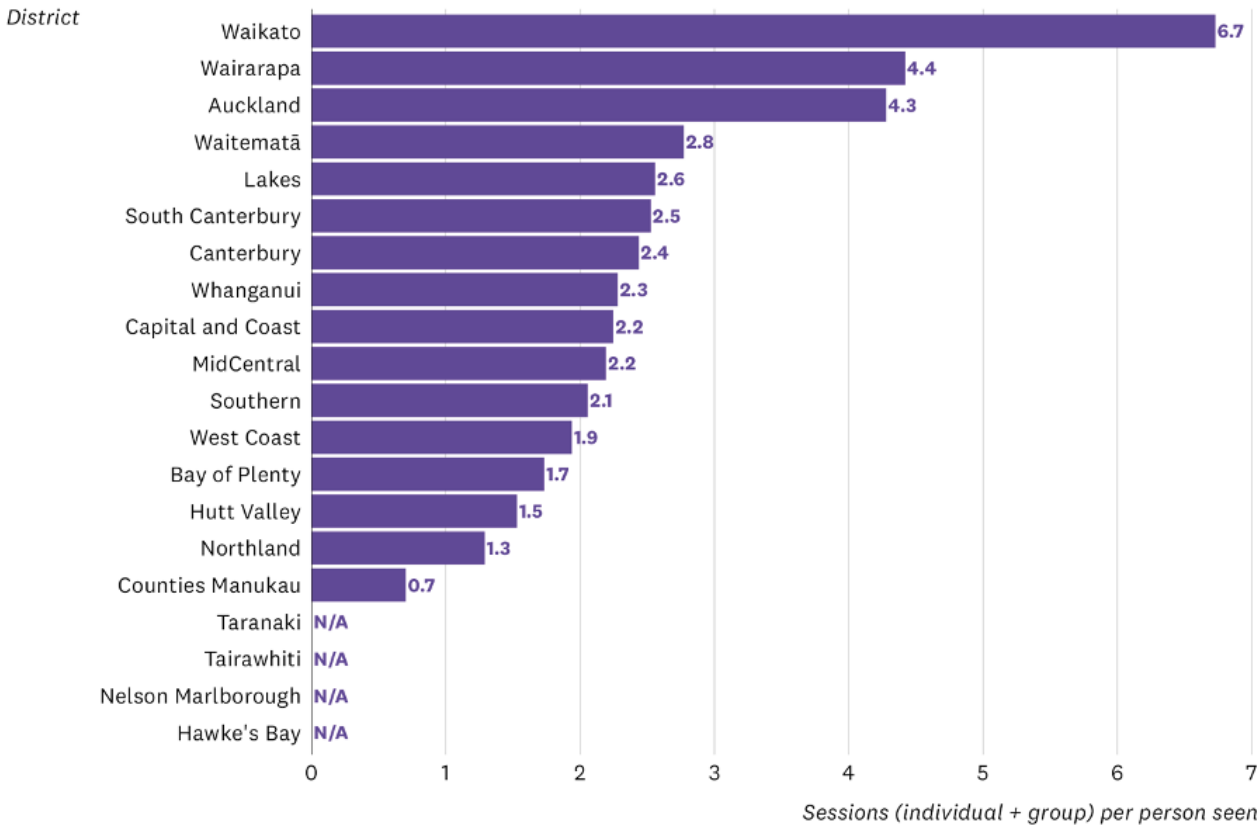
Figure 28: Total sessions provided (individual + group) per person seen per month.



There is also variation across districts in the number of sessions per person seen. On average over the last six months of data, Waikato, Wairarapa, and Auckland recorded relatively high

numbers of sessions per person, while Counties Manukau and Northland recorded relatively low sessions per person (Figure 29). This may reflect variations across districts in the needs of clients and service delivery models, or both.

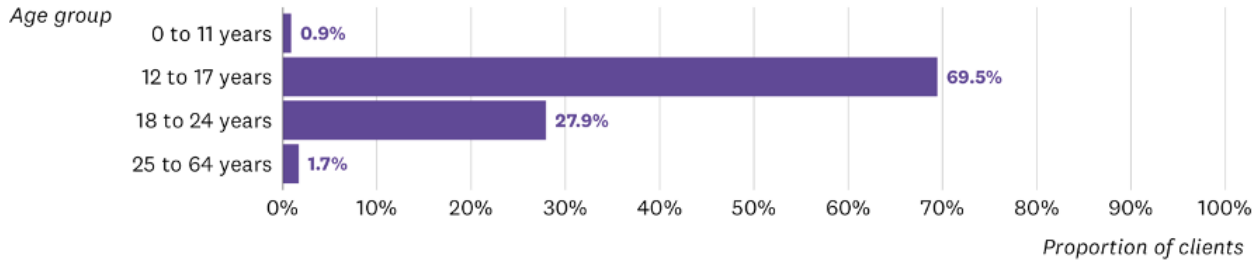
Figure 29: Average total sessions per person seen from June to November 2022 by district.



Client characteristics

As expected, given the age bracket for Youth PMHA is young people aged 12-24 years, almost all clients were between 12 and 24 years old, with the majority between 12 and 17 years old (Figure 30). Given this, the following charts compare the ethnic and geographic characteristics of clients with the population aged 10 to 24 years old in the Health Service User (HSU) dataset.[21]

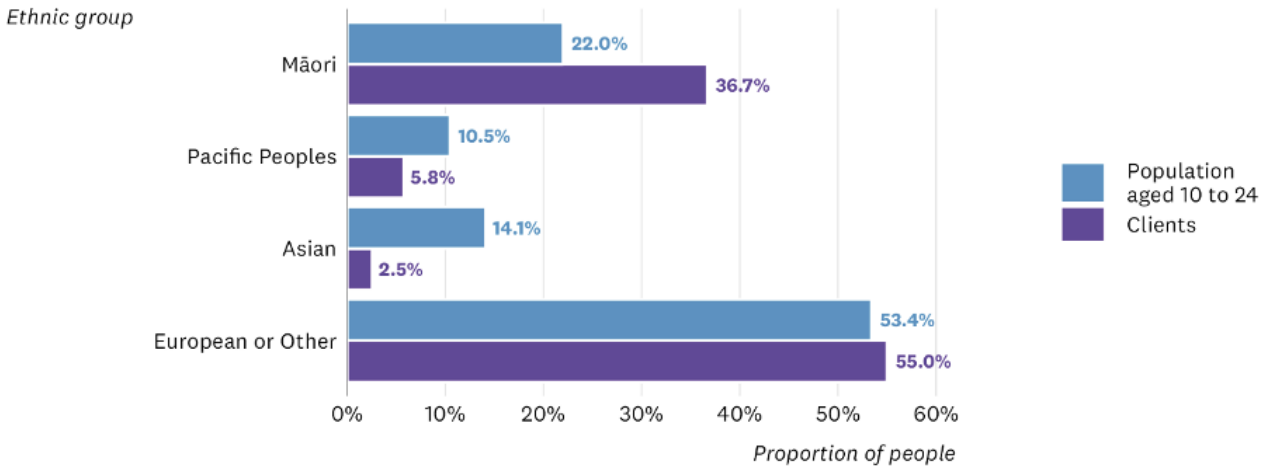
Figure 30: Age of clients.



[21] The HSU population is given for five-year age bands that do not exactly align with those in Figure 30 reported by providers.

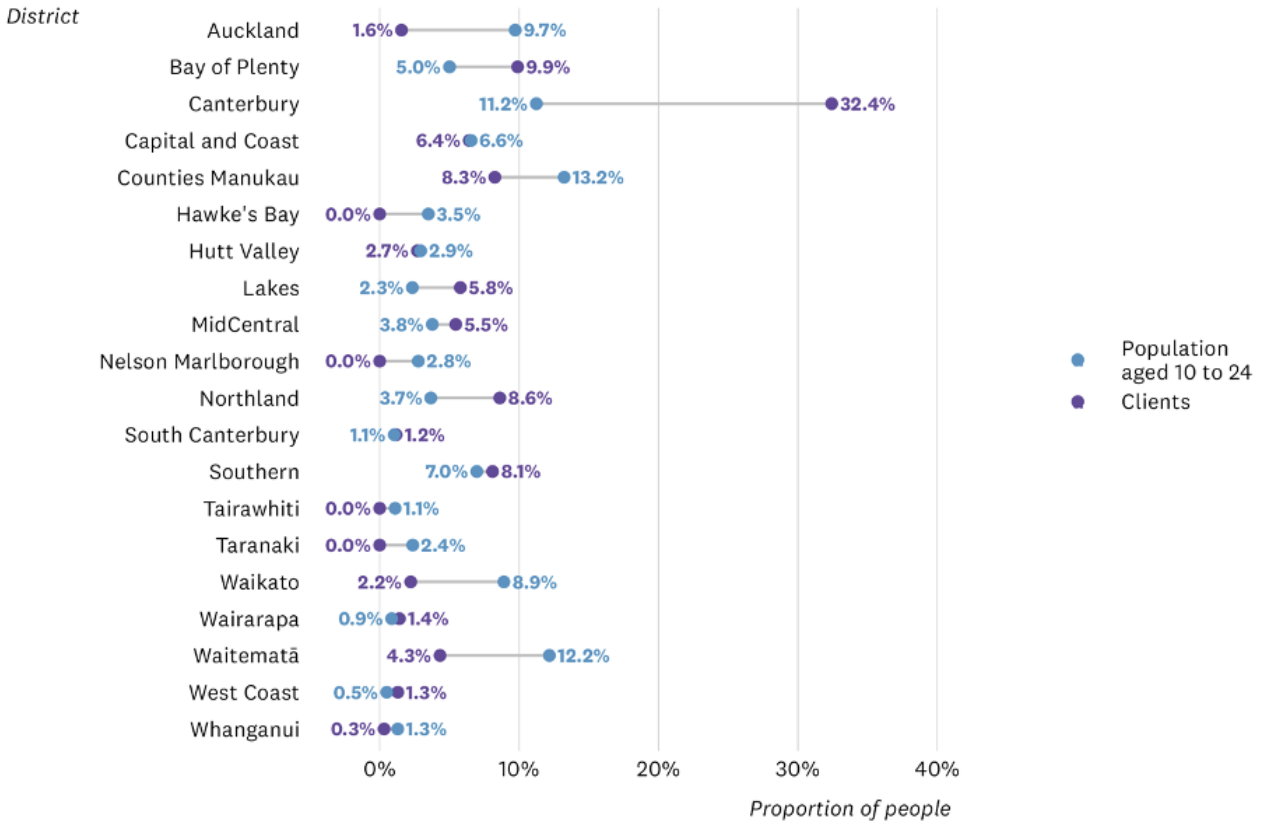
Compared to the population aged 10 to 24 years old, there was a substantially greater proportion ofMāori clients seen by providers but lower proportions of people ofPacificand Asian ethnicities(Figure31). The proportion of people of European and Other ethnicities was similar to that in the10-to 24-year-oldpopulation.

Figure 31: Primary ethnic group of clients compared to the HSU population aged 10 to 24 years old.



A similar comparison reveals substantial differences in the geographic location of clients compared to the 10-to 24-year-old population (Figure 32). Just under one-third of clients were in Canterbury district, compared to 11% of the 10-to 24-year-old population. Similarly, Bay of Plenty and Northland were substantially larger proportions of clients than in the population. Auckland, Waikato and Waitematā districts had substantially smaller proportions of clients compared to the population

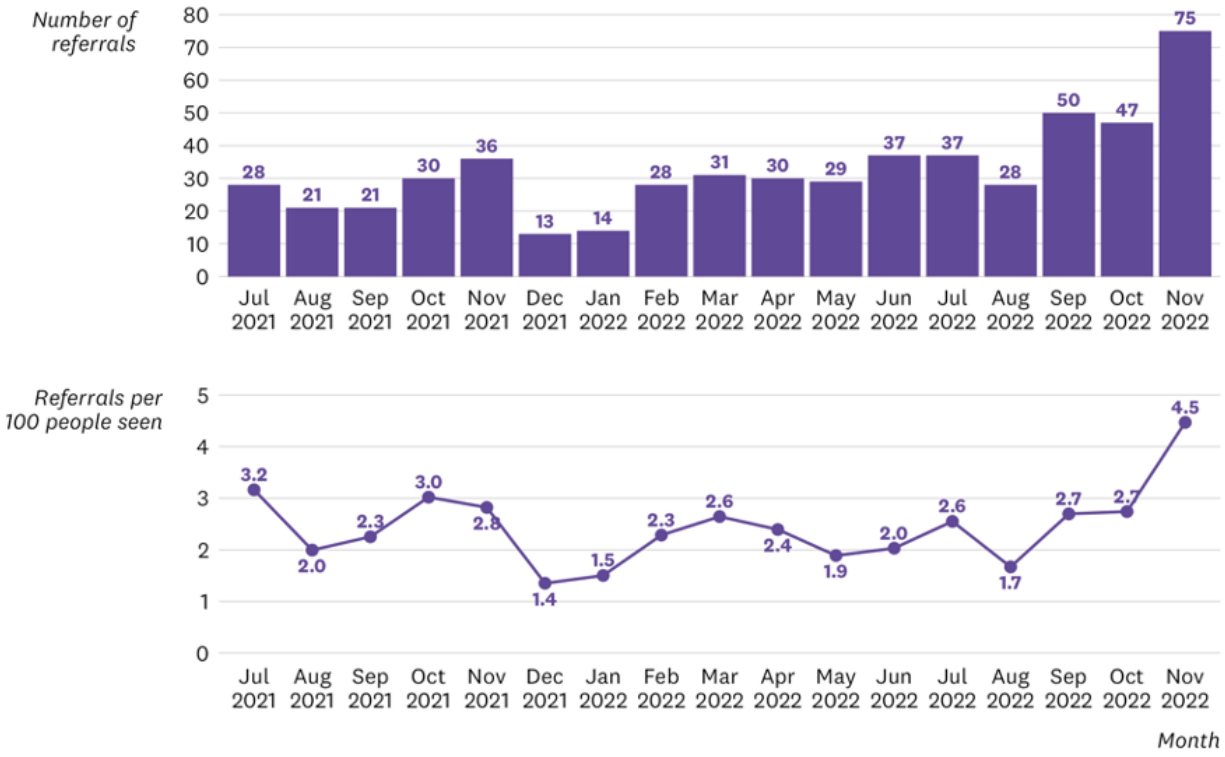
Figure 32: District of clients compared to the HSU population aged 10 to 24 years old.



Referrals

Across all districts, the number of referrals to other services has increased gradually over time (Figure 33 top panel). Relative to the number of people seen, the number of referrals has fluctuated around an average of around 2.5 referrals per 100 people seen per month (Figure 33 bottom panel). The number of outward referrals was relatively high in November 2022 but it is not yet clear whether this represents an increasing trend in referral numbers.

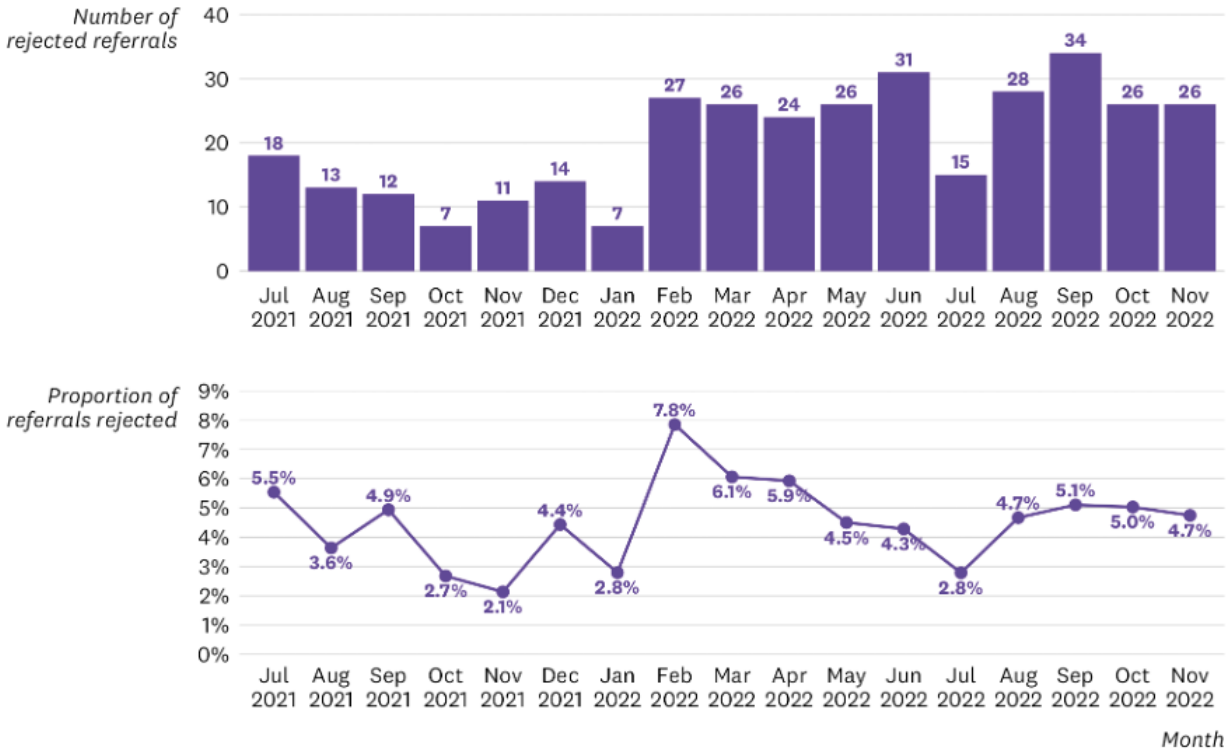
Figure 33: Monthly outward referrals to other services.



The total number of inward referrals rejected by providers appears to have increased over time (Figure 34 top panel) but has remained relatively constant as a proportion of total referrals aside from a spike in early 2022 (Figure 34 bottom panel)[22]. Overall, around 4.5% of inward referrals have been rejected by providers. However, we understand from Te Whatu Ora that most 'rejected referrals' are generally onward referrals (i.e. to other services) and that this is an area that requires more consistent interpretation and data definitions to enable reliable reporting.

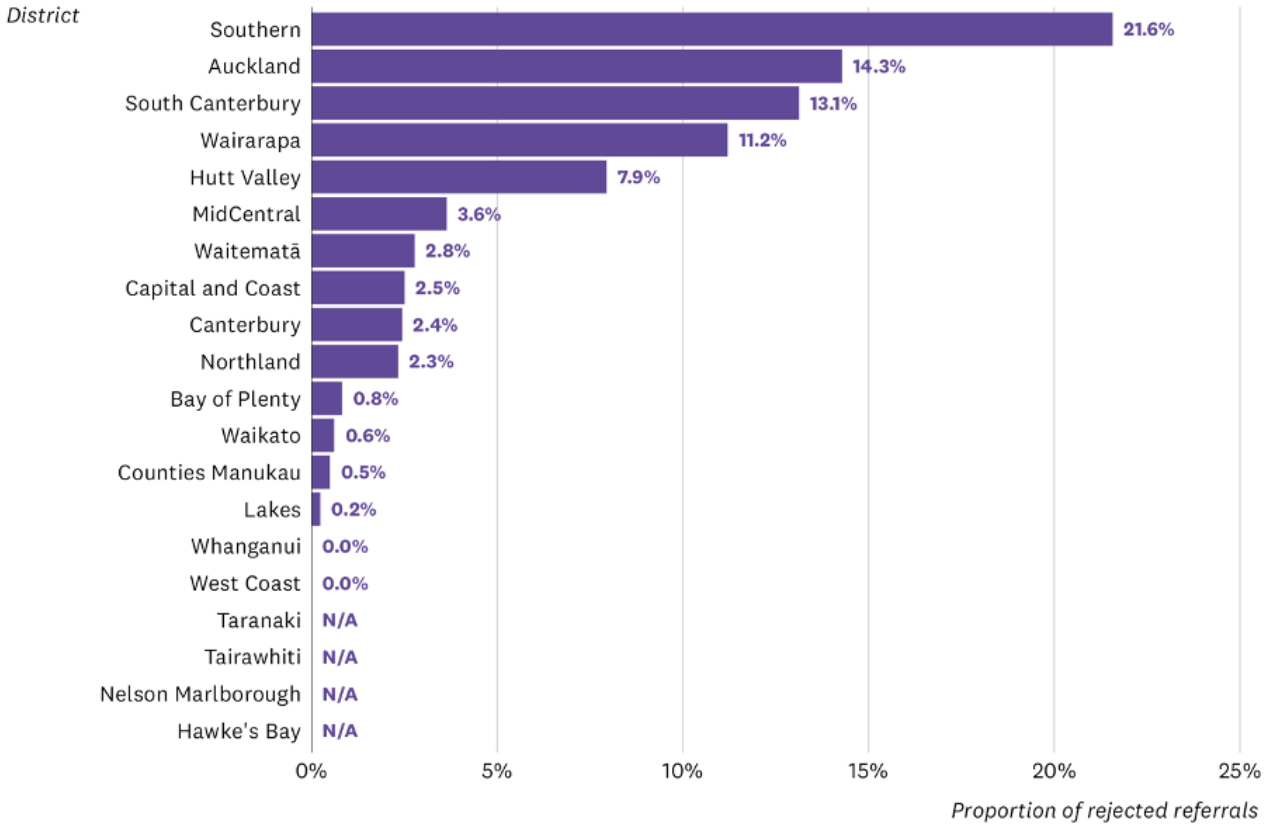
[22] The proportion of referrals rejected is calculated as the number of rejected referrals divided by the number of new people seen plus the number of rejected referrals in each month.

Figure 34: Monthly inward referrals rejected.



Across districts, substantially higher rates of inward referrals rejected were reported for Southern, Auckland, South Canterbury, Wairarapa, and Hutt Valley districts (Figure 35).

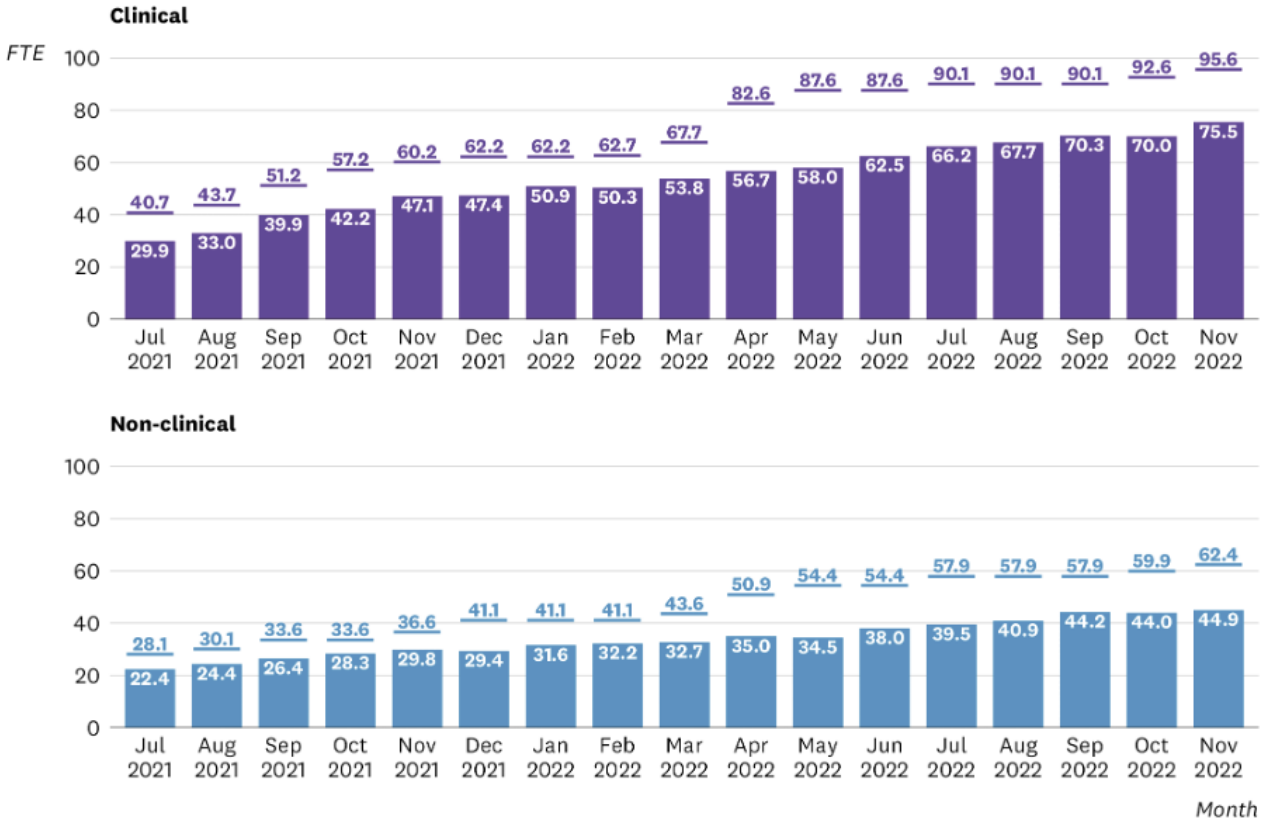
Figure 35: Inward referrals rejected by district.



Workforce

The workforce across all districts combined more than doubled between July 2021 and November 2022 for both clinical and non-clinical roles, but actual full-time equivalent (FTE) numbers have remained consistently below the contracted levels (Figure 36). In November 2022 there was a shortfall of around 20 clinical and 17.5 non-clinical FTE, which represent 21% and 28% of the contracted workforces respectively. Given the challenges of growing new capacity in the midst of COVID-19 responses, and a tight labour market, it is perhaps not surprising therefore that a lag in recruitment is occurring, and even in the normal course of events, can be expected in a programme that is steadily gearing up capacity to respond to need. Vacancies are expected in all organisations as a natural part of the programme lifecycle. However, in discussions informing this report, Te Whatu Ora advised that the FTE rate is generally expected to be 60-80% of planned recruitment during implementation, and that this is a new project of work and a significant roll out. A lag between programme funding allocation and recruitment, and then working with rangatahi can therefore be expected, and the FTE levels are thought to be at the high end of what was expected given that timeframe.

Figure 36: Actual (solid bars) and contracted (lines) FTE by type of role.



Across districts, the gap between contracted and actual workforce is variable (Figure 37) and may reflect differing impacts of the COVID-related system challenges noted above and labour market conditions. Many districts have filled all or almost all contracted FTE but in November 2022, actual FTE was less than 80% of contracted FTE in nine districts, although services had only just been established in two of these districts.[23] In addition, actual FTE has fallen as a proportion of contracted FTE over time in Auckland and Waitematā districts.

[23] Auckland (61%), Hawke's Bay (0%), MidCentral (79%), Nelson Marlborough (0%), Taranaki (75%), Waikato (77%), Waitematā (46%), West Coast (67%) and Whanganui (43%). Note that Hawkes Bay and Nelson Marlborough had just been established and no provider has been contracted in Tairāwhiti district.

Figure 37: Proportion of total contracted positions filled, by district. Dashed lines show when contracted workforce was first recorded in each district.

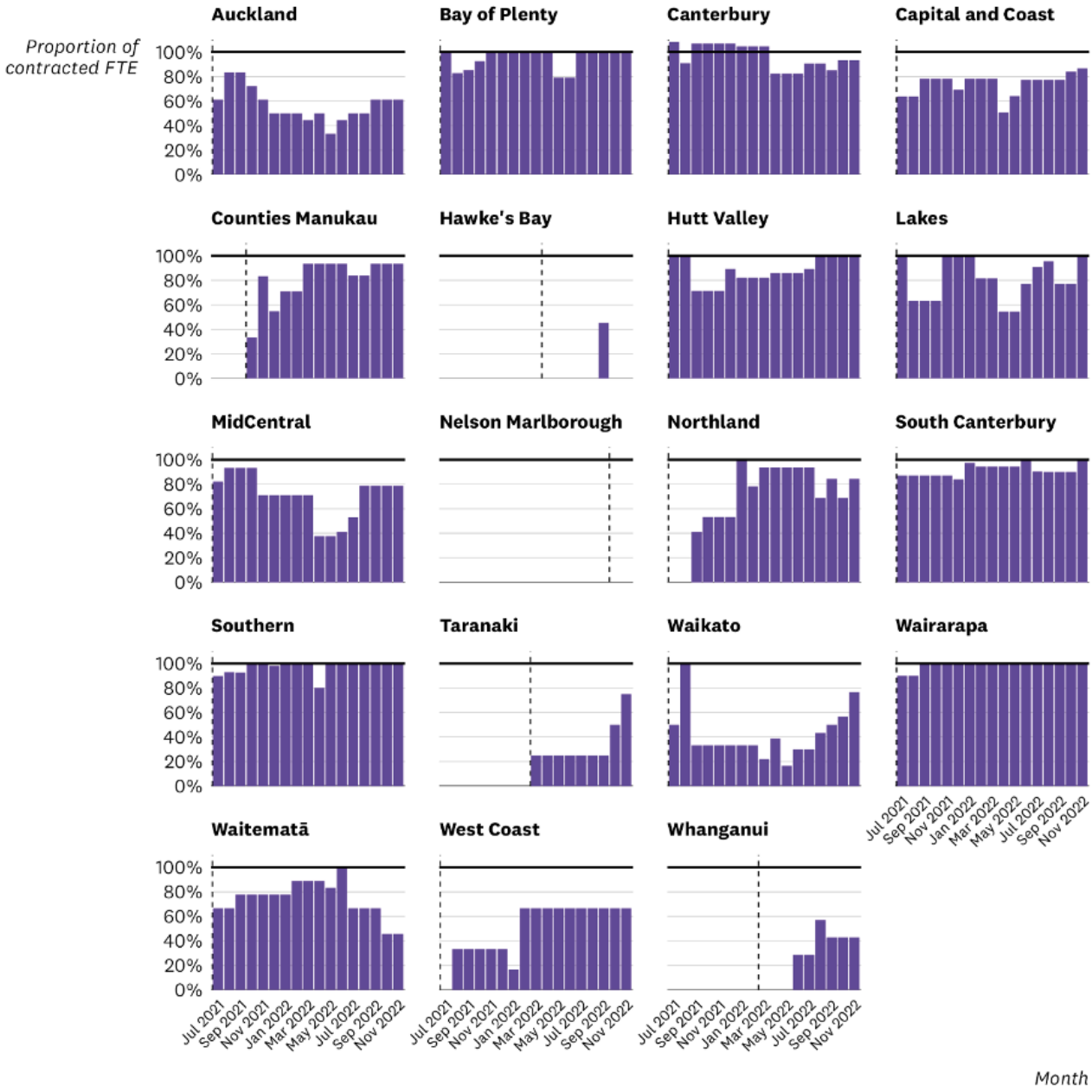
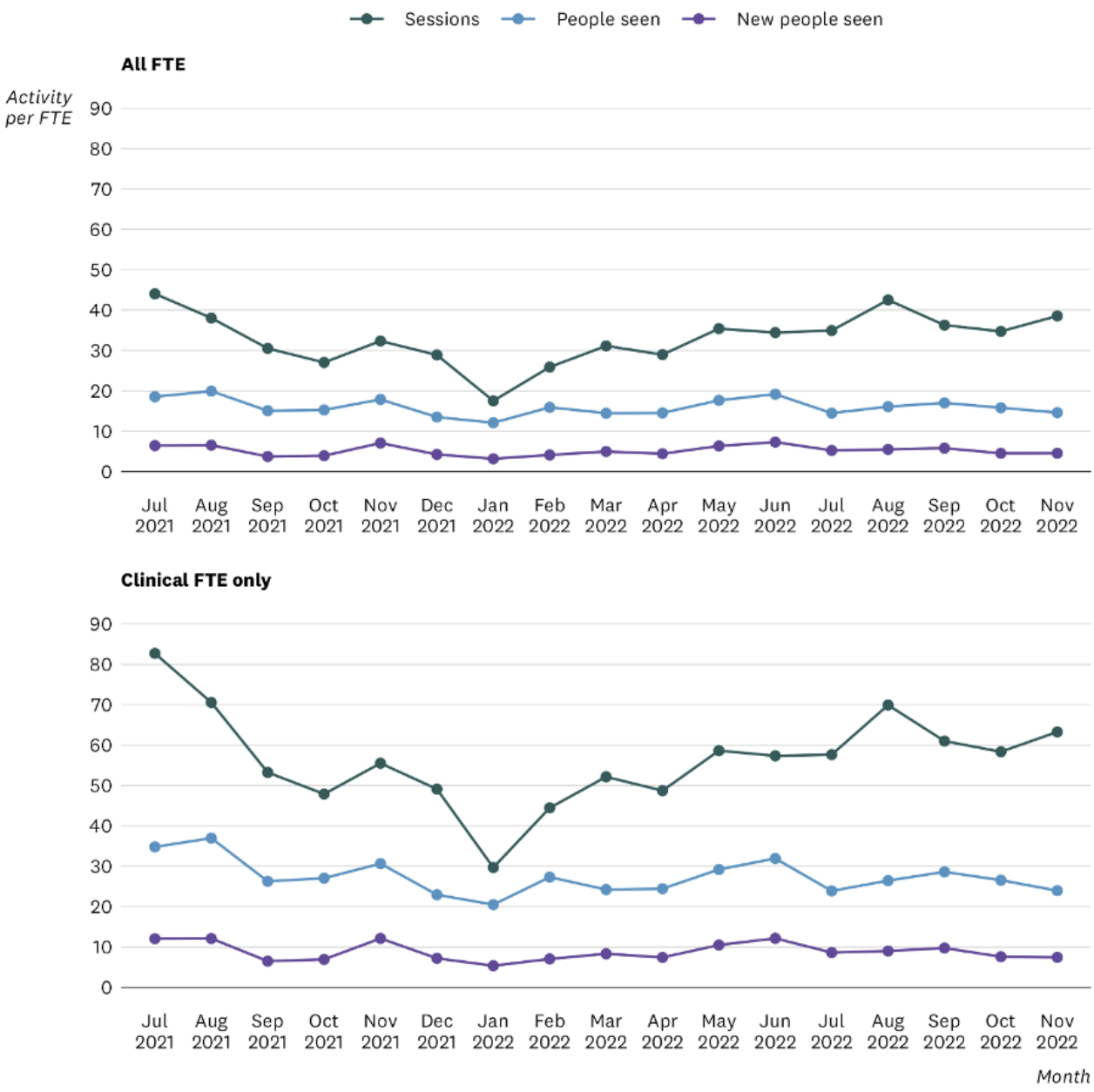


Figure 38 shows activity level per actual FTE across all providers (Youthline is excluded from both activity and FTE measures in this figure), for all roles and clinical roles only. This shows that the number of people seen per FTE per month has remained relatively constant over time, while the number of sessions per FTE initially decreased but has gradually increased during 2022.

Figure 38: Activity rates per actual FTE. Youthline is excluded from these activity and FTE measures.



Excluding the first two months which appear to be different as the service was bedding in (July and August 2021), Table 6 shows average rates of activity per FTE across all providers and months.

Table 17: Average activity per actual FTE between September 2021 and November 2022. Youthline is excluded from these activity and FTE measures.

Activity	All FTE	Clinical FTE only
New people seen	5.0	8.4
People seen	15.6	26.3
Sessions	31.9	53.8

Annex 6: Narrative reporting

Approach

This appendix analyses provider narrative reports produced for the Te Whatu Ora every financial quarter. The reports span 68 documents across the fourth financial quarter of 2020 to the second financial quarter of 2022. Reports were drawn from 16 providers within the Youth PMHA initiative, which operated 23 different services across 16 localities. Of the resources and actions reported on, particular attention was paid to how providers reported their engagement with their local community, the feedback they gathered from their rangatahi, and the linkages they formed with other services within the financial quarter to formulate a narrative of how the service is utilising their Youth PMHA funding. Due to the nature of reporting obligations to funders, reflections on provider services have been mostly positive and should be considered illustrative of providers' success within the initiative.

Delivering Youth PMHA services equitably and efficiently

Equitable and flexible service access

Providers aim to remove any access barriers for rangatahi to receive adequate primary mental health services. As seen frequently within quarterly narrative reports several themes were discussed:

- Providers seek to ensure rangatahi receive immediate support for mild to moderate mental distress and discourage the need for referral.
- Providers have developed telehealth services to alleviate demand and improve access for hard-to-reach rangatahi.
- Providers, in some cases, offer mobile services, traveling to rangatahi in a community setting they are most comfortable in.

Rangatahi feedback revealed primary mental health services enable quick access to support upon referral without the need to approach other services

Evident in provider narrative reports, providers have received feedback from rangatahi that they feel a sense of relief when they receive immediate support upon initial contact without having to approach other services. By offering immediate support, providers make note of higher levels of engagement from rangatahi; a stark to constant referrals and long wait times some rangatahi have experienced from mental health services in the past.

> *Having access to primary mental health support, without having to go through a referral process has improved access. A young person seen by the [services] recently said "she was relieved she didn't have to go anywhere else to get help." [Youth PMHA provider]*

Further client feedback from one provider revealed that rangatahi feel grateful for the ease of their referrals when it was necessary and were able to receive support without having to harm themselves or wait until they had reached a crisis point to be addressed.

Direct feedback from one of our taiohi around the ease of referring to service, feeling that they were able to get support from a preventative approach, rather than harming themself to be able to be heard. [Youth PMHA provider]

Providers are reducing transport barriers for their rangatahi, though it is unclear if this is the case across all providers.

For clients who request in-person services, the initiative's flexi-fund allows some providers to subsidise their client's travel to their premises, supply vehicles to transport their clients, or allow staff to travel to their clients in a venue that has been requested by the rangatahi i.e., their home, school, or community space. Rangatahi, therefore, in some cases are offered flexible and mobile treatment options.

Our Senior Pou Rangatahi Practitioners continue to meet with rangatahi living in rural areas at sites where the rangatahi feel most comfortable; this could be school, community venue, home, or whānau home. Linking with the local organisations within these communities has been essential. [Youth PMHA provider]

In some rural areas whānau spoke of a lack of transportation and limited finances to be able to access counselling services, our team was able to offer wrap-around support to accommodate the whānau so they could proceed toward their wellness plan. [Youth PMHA provider]

For rangatahi and their whānau residing in rural areas, provider feedback frequently notes a lack of transport and financial barriers that hinder rural rangatahi from being able to access counselling services. Teams who can reduce these barriers by offering the necessary resources to travel to the rangatahi or accommodate the young person's travel have found increased access for hard-to-reach rangatahi.

Providers developed telehealth services to improve access and address issues in demand.

A helpful development mentioned by providers, particularly in response to the complications of COVID-19 lockdowns and access barriers, is the expansion of telehealth services. Several providers have found success in being versatile with their approach, engaging with rangatahi beyond face-to-face or group settings and instead using social media or text, email, and phone-based services to their rangatahi as their primary means of communication. This includes a crisis instant messaging service available out of hours. For rangatahi who live rurally or would like to access support discretely due to the stigma they encounter from their family or peers, telehealth interventions ensure support is available to everyone no matter their circumstance.

There were times when this rangatahi would not reply to messages due to being away, however, there have been times when she has confided in me and let me know of some whānau struggles. I think this goes to show how versatile we as mahi whānau can be, in engaging with our rangatahi on a different platform and especially when most use their social media and devices as their primary form of communication. [Youth PMHA provider]

Some providers have encountered rangatahi facing difficult situations at home or with minimal family support systems reaching out anonymously online for support. Staff can build relationships with these rangatahi online to develop their trust and reveal the issues they are struggling with. This case management intervention method improves access to primary

services among rangatahi who often miss their chance due to assumptions, fear, and mistrust of mainstream mental health services.

Many providers express that the COVID-19 lockdowns have enabled the rapid development of this treatment option, and for many, it has remained in the months since in-person sessions have been able to resume for those who prefer a distanced support option. It has been widely seen as a helpful treatment method to keep up with the demand for services.

Shifting the locus of control

Rangatahi determine the timeframe and conditions in which they receive their support within some provider organisations.

Several providers highlighted in narrative reporting the necessity of refraining from allocating any specific number of sessions to tangata whaiora (a person seeking health) and offering to extend their programme of support until the young person's goals have been achieved; we note that contracts allow providers to support rangatahi for as long as required, with no criteria for re-entry. The providers have worked alongside their rangatahi for as long as their services are requested to achieve optimal outcomes and contribute to a comprehensive discharge plan. Offering an unlimited number of sessions to rangatahi, or an open invite to return when needed guarantees they are discharged confidently with the necessary tools they need to cope once their contact has ended.

> *With the tangata whaiora we do not allocate any given number of sessions to our tangata whaiora, we will work with them as long as required to ensure they have the best possible outcomes and contribute to their discharge plan in preparation for closure. Tangata whaiora was extremely thankful sharing this had been weighing on her mind for several weeks and was too whakama to bring it up. [Youth PMHA provider]*

Providers have found success in tailoring their services to the specific needs of their rangatahi. This strengths-based approach allows treatment methods to be determined by the rangatahi, with the treatment journey developed alongside them, and are actively involved in co-creating solutions. Rangatahi retain their sense of agency throughout their treatment journey and are therefore seen as more likely to succeed in their desired outcomes of the intervention.

> *One of our youth workers has been working with an individual who has severe social anxiety. He is resistant to the idea of leaving his house due to fear. At first, the taiohi was reluctant to work with Māori workers and was against the use of Māori kupu due to traumatic experiences in their past. Our youth worker spent months developing a therapeutic relationship and a relationship where the taiohi feels safe and supported. Through a display of manaaki and kaikitanga, they were able to leave the house together and visit a bird sanctuary which was the first big step. This was a meaningful experience for the taiohi.*

> *We pride ourselves in working in a diverse world and love the challenge of being agile to meet the needs of rangatahi and whānau as opposed to our needs. [Youth PMHA provider]*

This tailored approach is best used within the context of high-risk rangatahi, or as one provider persists are wrongfully disregarded as 'too hard or unreachable or unteachable' who have sought help from several service providers in the past.

Iwi organisations are successfully addressing the needs of rangatahi Māori with clear opportunities for further utilisation of their services.

Several iwi-led provider organisations work to ensure that rangatahi Māori and their whānau are in control and set the kaupapa of the support they receive with no ‘boxes to tick’ or process driven systems they must endure. This allows rangatahi to engage with their supports within their own context, and within their own timeframes as opposed to what has been determined in contractual obligations. While programmes can still follow a team practice model to underly their system delivery, a degree of flexibility in their service offering has accommodated for rangatahi to determine what support they receive and how they receive it.

For many Māori primary mental health service providers, their rangatahi have often already pursued several mainstream mental health services and practitioners and have been met with therapeutic interventions that do not resonate with their unique contexts. In quarterly provider reports, these providers maintain that the best and most effective way to engage rangatahi and their whānau is to explore their Māori identity and whakapapa while building on the knowledge they already have. The strategies to do this are informed by the requests of the rangatahi in the setting they choose, indiscriminate of the contract attached to their referral to the provider.

These interventions should champion practical engagement opportunities with an underlying focus on building resiliency within rangatahi and their relationships with their whānau. Practical engagement involves engaging with Māori in relational, familiar, and casual settings such as their marae or local whenua that is safe and familiar. The time used during whakawhanaungatanga and the relationship-building process develops trust and reengages rangatahi with their Māori identity.

> *Rangatahi and whānau also have the chance to be involved in cultural activities, events, and noho, that they may not have necessarily been exposed to previously. As the research continues to tell us, being connected to our culture and identity is paramount to ensuring wellbeing; and for the rangatahi and Whānau that have been referred to us (and will be referred to us), Te Ao Māori and the connection is inherently part of the Tikanga and kawa of our organisation. [Youth PMHA provider]*

For those who wish to develop their rangatahi Māori engagement offerings, providers are liaising with their Māori engagement coordinators, advisors, and cultural leadership teams to drive toward the integration of tikanga Māori into their practices and policies. This role inherently involves building relationships with and learning from iwi and Māori mental health service providers.

> *As Tangata Whenua and an Iwi organisation with a social services arm, it gives us a unique opportunity to work from a different perspective, both collectively and collaboratively within our community. As an Iwi and organisation, we are 'at the table', and can take time to build collaborative relationships and partnerships, which will support the mahi that we are and will be doing with rangatahi, Whānau, hapū, and iwi. [Youth PMHA provider]*

There is a clear opportunity to further leverage iwi organisation's expertise and partnerships with non-specific providers to improve access for rangatahi Māori specific support. Iwi organisations express that they are ready and willing to develop their services further.

Manaakitanga and cultural fit

The use of kaupapa Māori frameworks are an important foundation of activity with rangatahi Māori.

One iwi-led organisation believes practical and interactive engagement with local whenua is the most therapeutic method for rangatahi Māori and is known to have better outcomes for their rangatahi than sitting in a tare and talking.

> *We believe that practical and interactive engagement is more likely to reach our target groups than sitting in the whare and talking. It is about getting them out and experiencing what the world has to offer; with our underlying focus of continuing to tautoko them to build resiliency! [Youth PMHA provider]*

Organising walks for rangatahi amongst their taiao gives the young person the space away from their whare and allows for natural initiation of kōrero surrounding their presenting issues, developing their voice, and initiating their journey toward wellness.

> *This is an opportunity for us all to get out and enjoy the moana and be amongst the taiao. I took one of my rangatahi who was not so keen on the walk, however, as time went by, she started to enjoy her time with everyone and being outside. She struggles to get space in her own whare, so I think this was an awesome opportunity for her to be out by the moana where there's fresh air and lots of space to get that feeling of freedom. We had some good kōrero about some of her moemoeā and where she sees herself in years to come. There were lots of laughs, and good kōrero between everybody which I think reminded us all how important it is to sometime have that time away from the realities of life and just be in the moment. [Youth PMHA provider]*

One provider reported working closely with local spiritual healing services that specialised in Māori methods such as wairua (spirituality), mirimiri/romiromi (massage), and healing energies. This intervention has received many referrals that have requested these services including a matakite (spiritual healer) in particular. By using a matakite rangatahi felt a sense of relief when their mental health experiences were recognised and understood from a Māori perspective as a 'gift' rather than pathologised.

One rangatahi in provider quarterly reports provided feedback to their practice that they were expecting normal counselling sessions where they would be assessed and diagnosed when they were referred to a service provider, a system they have typically encountered a negative experience. To be met with understanding and to learn that the mental health experience they spoke of during introductions was viewed differently through a Māori cultural lens brought significant relief for themselves and their whānau members. Thus, they were experiencing a tailored intervention that achieved greater outcomes they would otherwise not be able to access via mainstream primary mental health service avenues.

> *There was a sense of relief from both the wāhine and her mother that she was ok to be her, to speak her truth without judgment. She expressed a desire to learn more about her gifts in terms of why she has them, what is their purpose if any if she can 'control' them or at least find some life balance with them. [Youth PMHA provider]*

Another rangatahi felt understood and validated by their matakite, having found a service that resonated with his lived experience. The matakite was relatable to their rangatahi, reflecting mental health challenges through a Māori cultural lens, and sharing stories of how the practitioner had dealt with similar experiences.

> *During the first hui with the tāne, our Matakite listened to the tāne journey from his and his mother's perspective and then spoke about how we would relate to or view these experiences through the Māori cultural lens. Also importantly, the lens of Matakite who have had to walk the same path and navigate the same challenges. Our Matakite was able to put both the tāne and his mother at ease very quickly by sharing his own stories. Stories which mirrored in many ways the experiences of this Tāne. [Youth PMHA provider]*

> *We saw a change in his demeanour, almost a sense of relief and excitement that he had been recognised for the first time and he could be himself. He said several times at the first meeting with our Matakite, "this is so cool", and "I can finally be myself". [Youth PMHA provider]*

There is growing interest in working with Māori or iwi-led organisations.

Many Māori or iwi-led organisations within the initiative have reported being invited by several organisations both within and outside of their region to discuss the services they offer. Service providers are being more curious about how Māori providers utilise this approach as they have experienced many of their clients requesting it. In some cases, organisations are offering spaces for Māori practitioners to work from, and Māori providers are looking for opportunities to operate beyond their region to deliver to a wider geographical area.

> *[Service] has been invited by several organisations (within and outside of [region]) to discuss our service and introductions of our teams... These organisations have said they have viewed our Facebook page and were interested in our clinical and Te Ao Māori approach as they have whānau that are wanting a holistic approach. [Youth PMHA provider]*

System connections

Providers highlighted a desire to build wider provider networks and a youth-specific service directory.

Providers actively seek to work collaboratively, sharing their expertise, and adding value to each rangatahi presenting to the service who can engage in a range of support options via referral. This often requires weekly, fortnightly, or monthly provider hui bringing together all primary mental health service providers in the local region to discuss how the network can work together effectively, share clients, create referral pathways, co-facilitate workshops, focus groups, and share training. A youth service hui brings together multiple organisations, initiatives, and siloed approaches in each region, creating a forum to better understand each service, and its specifications and improve seamless pathways of care.

For many new or little-known primary mental health service providers in the community, a provider hui is an opportunity to whakawhanaungatanga and claim their position in the local service directory. Each provider can showcase their strengths, specialties, staff capabilities, programmes, and capacities to support rangatahi in their community via referral. These forums and discussions have a youth-specific focus, bringing together in some cases all service providers that engage with youth in the regions, spanning DHBs, NGOs, Rainbow Youth groups, education, employment, Youth justice, and social agencies.

Hui are an opportunity to share triage of rangatahi, discuss areas of collaboration for their support plan and accept referrals. In provider quarterly reports, some providers appreciated the opportunity to seek advice from local clinicians regarding specific rangatahi cases who are presenting with complex needs, utilising other services input and experience from all aspects of the young person's needs including education, mental health, and social service supports. Providers have reported marked improvements in an integrated response for the community and enhancement of their proactive work streams as a result.

> *Attending multidisciplinary team meetings has been good whānaungatanga with local services in the region. [Staff] are happy to host ourselves and other NGOs to encourage a collaborative approach when working with our whānau. This happens once a week when clinicians from [services] present Rangatahi cases they are working with and receive assistance from anyone who is attending the meeting. We also have a psychologist and a psychiatrist present during the meeting who offer their expert options. This time is also used for our service to accept and refer referrals to and from [service], this kanohi ki te kanohi approach with our local services makes it easier for all services to connect and communicate with the services already involved with a whānau we might be working with. [YPMHA provider]*

One provider spoke of developing a helpline collaboration group to facilitate a connection between telehealth services and offer opportunities for shared staff training, resources, advice, networking, and service provision changes. Services were able to refer their rangatahi based on caller needs and service capacity, discuss areas of improvement, access to funding avenues, coordinate a COVID-19 response when it was required, and develop a unified voice for nationwide telehealth leadership and advocacy.

Providers are seeking to engage with community social service arms for wrap-around support. Many service providers have a wide range of services and social support service arms for whānau to access, or to access via referral. This includes whānau ora, kai support packages, home-based support packages, ACC support, employment, housing, and general practice health care services. Some rangatahi require multiple kaimahi in a collaborative impact model that incorporates different fields of expertise and support services for wrap-around care.

> *Rangatahi who come to [service] are able to access various services within our network, such as; Mentoring/advocacy, GP/Nurse consultations (for mental health and primary health needs), Group activities (gym classes, life skills, driver's license, parents group), Alcohol and other drug counselling. [Youth PMHA provider]*

Providers report attending regular hui with community organisations, including Police Youth Aid, Oranga Tamariki, Family violence services, community police, and local charitable organisations. As a result, providers reported receiving more referrals from these agencies. High-risk rangatahi are therefore able to leverage social support, advocacy, and AOD specialist services to support all aspects of their wellbeing.

> *We are increasingly supporting young people in the care of Oranga Tamariki, as well as supporting young people involved in the Youth Justice system where the need for Primary Mental Health intervention supports a young person's reintegration back into their home and community. [Youth PMHA provider]*

In provider quarterly reports, several providers make note of using social housing services to help their rangatahi who do not live with their whānau and are unable to secure a lease on a rental space due to their age. Others report the use of flexi-funding to provide one-off support for rangatahi who need basic amenities such as bedroom furniture to alleviate the financial stress rangatahi and their whānau are experiencing.

Integrating with other social services has been integral to supporting families and addressing every aspect of their wellbeing. By remaining well connected with several service arms, providers report a deepening relationship with their local communities across several demographics as the referral network expands. Providers have noticed an increase in rangatahi approaching the service across the entire 12-24 age range, and a strengthened relationship with Māori organisations to support their rangatahi Māori as a result. This approach is widely seen as an enabler amongst providers to work together, utilising all resources available with their respective community 'eco systems', partners of which are not always necessarily known.

Providers highlighted the necessity of engaging with schools to reach rangatahi.

As mentioned within several provider quarterly reports, many local schools have contacted providers, requesting their counselling and support services. School counsellors are experiencing overwhelming caseloads and require surge support and preventative interventions to alleviate demand.

> *In the past education has, for the most part, kept to themselves and engaged when we have approached them, or it has been certain roles within the kura who have maintained contact. However, this quarter we have seen a huge influx of referrals and contacts from teachers and deans, as opposed to the normal few. In our korero, they have told us that they have never had to deal with the rangatahi needs that they are now… When they give us referrals, we ensure that they are kept informed, and they ensure that any events or relevant information are shared with us about our rangatahi in a timely manner (so that we can tautoko everyone appropriately). [Youth PMHA provider]*

One provider found success in co-facilitating school programmes with existing school youth services, in particular, offering school leadership programmes for high-risk rangatahi. Another spoke of coordinating a student leader mentoring group aimed at developing student leaders' resilience to engage with their learning and understand mental health issues for their peers may be facing and intervene safely. Educating students with coping mechanisms and self-care approaches for dealing with their emotions and behaviour was seen as a helpful brief intervention approach.

We have embedded youth workers as a pilot into one of the secondary schools here and this is working well to create a stepped model of care and reduce barriers to MHA support. [Youth PMHA provider]

Certainly, the repercussions of COVID-19 lockdowns have seen a significant decline in school attendance, an issue several schools have raised amongst primary mental service providers. Schools relay to providers that they have exhausted their capacity internally to make contact with rangatahi and their whānau who have been consistently absent from school and seek further support to address this issue. In quarterly reports, some providers have implemented a support plan to encourage rangatahi to reengage in education, offering an online shared drive of learning materials for students to access and complete from home in the interim.

One provider mentioned their connections with schools a 'pivotal linkage' that has enabled greater access for rangatahi to easily be referred to a primary mental health service.

Learning and improving

Providers are actively seeking to improve rangatahi engagement in their support plan and improving the referral process to other services.

It is a standard practice among some providers to offer an opportunity for their clients to complete a rangatahi and whānau satisfaction survey where feedback is kept both anonymous and confidential and is used to further strengthen provider service delivery. While feedback is often positive and combined with promising engagement statistics, providers on occasion receive feedback that prompts the service to review its delivery and pursue avenues to address these issues.

Some quarterly provider reports draw attention to a sudden dip in rangatahi engagement with the services they initially thought they needed, with reasons for this disengagement largely unknown. Providers would often meet with their practitioners and wider system connections to discuss strategies for re-engagement which lead to several suggested outcomes. One provider, for example, was able to increase their engagement with their rangatahi by liaising with their clinical team who initially referred the rangatahi to the service provider.

Generating social value, equitably and effectively

More efficient and equitable use of healthcare resources

Providers are actively improving their linkages with secondary services; this relationship is however challenged by capacity for rangatahi presenting with top of moderate mental health distress

For many providers, as implied in quarterly provider reports, there has been a marked increase in the number of moderate to severe case referrals, prompting a need for greater flexibility applied across services to accommodate them. Some secondary services have advised that their wait list for key workers is significant. Referring rangatahi to primary service support in the first instance has been identified as a key strategy to reduce the burden currently experienced by secondary mental health services. As expressed by providers, this creates significant challenges for their capacity and referral pathways to support their rangatahi who need more comprehensive and clinical support.

Our connections with secondary services for rangatahi remain a risk as the secondary mental health service lacks the capacity to support rangatahi. This has been raised with DHB contract managers and the services themselves. We currently regularly review higher risk rangatahi as a wider team, with a view to ensuring we provide the best support to rangatahi at the highest risk. [Youth PMHA provider]

All youth primary mental health service providers remain in direct contact with secondary services to escalate their rangatahi who need further support beyond primary capabilities for moderate to severe mental health issues. For many providers, working closely with the rangatahi they refer to secondary services, and remaining involved where appropriate is still imperative. Providers highlight the importance of ensuring rangatahi are supported during the referral process, working collaboratively with secondary services while rangatahi are on the waiting list. Offering counselling support to rangatahi before referring them to secondary services and supporting them in the interim has been noted as a helpful solution.

Annex 7: Detailed value criteria

Looking after resources, equitably and economically

Procurement and funding processes			
[below the level outlined in the criterion for 'just good enough']	**Just good enough**	*[between the levels outlined in the criterion for 'just good enough' and 'excellent']*	**Excellent**
	Procurement process is transparent and results in a national network of services being established		Procurement process is part of an ongoing dialogue with service providers Procurement provides opportunity for Māori service providers to access funding in a way that best fits their kaupapa Procurement actively seeks to partner with local iwi/hapū to guide the procurement process
	Equitable funding for Māori providers (proportionate to need)		Māori providers are resourced in recognition of the additional work/burden they carry Funding decisions carefully weigh up and are clear about trade-offs Funding recognises the cultural capital of Māori providers and their ability to recognise the diverse realities of Māori

Design and knowledge base – building on existing infrastructure and expertise			
[below the level outlined in the criterion for 'just good enough']	**Just good enough**	*[between the levels outlined in the criterion for 'just good enough' and 'excellent']*	**Excellent**
	Existing intellectual, social and cultural capital of the sector (know-how, networks, values, ways of working, etc) are used appropriately to develop and provide services Existing staff are given opportunities to develop their skills and knowledge to better provide youth services		Local/community connections, knowledge and skills are valued and nurtured Existing staff are provided in-depth development opportunities and supported to develop their skills and knowledge to better provide youth services. This includes regular cultural and rainbow competency training.

	Just good enough		Excellent
	Cultural competency and rainbow competency trainings are provided to all staff as part of the induction process and as continued professional development.		
	Services are designed in consultation with iwi Māori/hapū/whānau and rangatahi Māori		A supportive relationship is co-created/mutually negotiated between rangatahi Māori and providers to support ongoing service design and delivery.
	Services are designed in consultation with rangatahi (including diverse youth)		Services are co-designed with iwi Māori/hapū/whānau and rangatahi Māori leading the design Services are designed using mātauranga Māori (including rongoā Māori)

Performance management and accountability			
[below the level outlined in the criterion for 'just good enough']	**Just good enough**	*[between the levels outlined in the criterion for 'just good enough' and 'excellent']*	**Excellent**
	Service providers are required to demonstrate that they meet basic expectations for stewardship of resources and accountability to funders (e.g. financial budgeting and reporting, progress and performance reporting, risk management)		Service providers are supported to be exemplary stewards of resources (e.g. supported to establish, use and refine outcome monitoring systems) and are accountable to all kaupapa partners including iwi/hapū. **Mana whakahaere** is demonstrated by the Ministry as funder through kaitiakitanga over the system (moving beyond management of assets or resources, to supporting a system to thrive)

Delivering Youth PMHA services equitably and efficiently

Equitable and flexible service access			
[below the level outlined in the criterion for 'just good enough']	**Just good enough**	*[between the levels outlined in the criterion for 'just good enough' and 'excellent']*	**Excellent**
	Services are delivered in settings that are accessible and acceptable to rangatahi		Services are delivered in a range of settings and are flexible and mobile, allowing rangatahi to be in the setting of their choice, where they feel the most comfortable Services are accessible within a Māori community setting
	Rangatahi can access a range of support options Rangatahi can access services with low or no barriers to access		Rangatahi and their whānau/family feel that the service is there for them whenever they need them Services work to actively remove barriers to access - both on a systems level and working with individual rangatahi and their whānau to remove their personal barriers to access
	Rangatahi from diverse backgrounds can access services (including Māori, Pacific, refugee/migrant and LGBTQI+)		Large flexibility in service - when and where to meet, who to meet, with the option to try and then change to something that works better (self-directed) Services are responsive to the changing needs of young people
	Services are delivered in a way that generally meets demand		Service delivery is calibrated so that all rangatahi can receive services appropriate to their needs and are not left isolated and waiting

Reaching young people and whānau/family			
[below the level outlined in the criterion for 'just good enough']	**Just good enough**	*[between the levels outlined in the criterion for 'just good enough' and 'excellent']*	**Excellent**
	Service volumes meet minimum expectations.		Services are well utilised, providing an efficient volume of support at an efficient cost (e.g. further increases in utilisation would not significantly reduce unit costs of delivering services)

	Just good enough		Excellent
	Increasing numbers of rangatahi in priority groups (Pacific, Māori, Refugee/migrant LGBTQI+, and other young people known to experience inequities) are accessing the help they need		Services are successfully reaching significantly increased numbers of rangatahi in priority groups including people who were previously under-served or hardly reached
	Wait times are reduced for rangatahi to access appropriate services, and are making progress towards initial contact within 3-5 days where contracted		Services are consistently meeting 3-5 day waiting times for initial contact.

Shifting the locus of control			
[below the level outlined in the criterion for 'just good enough']	**Just good enough**	*[between the levels outlined in the criterion for 'just good enough' and 'excellent']*	**Excellent**
	Rangatahi voice and lived experience (including Māori, Pacific, refugee/migrant and LGBTQI+) is championed and respected in service development and delivery		Rangatahi voice and lived experience is championed and respected, alongside inclusivity/openness to multiple worldviews/bodies of knowledge Services prioritise self-determination by rangatahi in the support they receive and how they receive it
	Services are tailored to different cultural groups/perspectives		There is a wide choice of services available to meet the needs of different population groups, and there is representation of these different groups in the service provider A service seeks to decolonise and is mindful of/actively seeks to address and question power dynamics Services uphold **Mana motuhake**: Māori self-determination, Māori authority over their lives, according to Māori philosophies, values and practices including tikanga Māori
	Services are based on evidence and experience of what is known to work well and incorporate mātauranga Māori		Services uphold **Mana Māori** - enable Ritenga Māori, are framed by te ao Māori, enacted through tikanga Māori and encapsulated within mātauranga Māori

Manaakitanga and cultural fit			
[below the level outlined in the criterion for 'just good enough']	**Just good enough**	*[between the levels outlined in the criterion for 'just good enough' and 'excellent']*	**Excellent**
	Rangatahi from all cultures and backgrounds experience services and staff as warm and friendly		Services feel human and relatable; as rangatahi, with rangatahi
	Rangatahi from all cultures and backgrounds feel comfortable in the services being delivered and intend to continue to make use of the services		Rangatahi experience services as mana enhancing and reflective of their own world view
	Whānau/family are included in support provision		Whānau are welcomed and encouraged into the support experience, with links available to support services for whānau

System connections			
[below the level outlined in the criterion for 'just good enough']	**Just good enough**	*[between the levels outlined in the criterion for 'just good enough' and 'excellent']*	**Excellent**
	Services provide access to a range of other health, cultural and social service providers		Services provide seamless and timely access to a range of other health, cultural and social service providers
	Effective links in place between community and clinical settings		There is a continuum of care between community-basedprogrammes and clinical settings that is mutually supportive and enables positive outcomes for rangatahi and their whānau/family
	Collaboration is evident between YPMHA service providers and other local services, as well as between YPMHA service providers across the country.		Collaboration is evident between service providers and is adding value to the services being delivered

Learning and improving			
[below the level outlined in the criterion for 'just good enough']	**Just good enough**	*[between the levels outlined in the criterion for 'just good enough' and 'excellent']*	**Excellent**
	Services and funder have systems in place to support learning and improvement		Services and funder are demonstrably working as a 'learning system', collecting and reviewing evidence and feedback, reflecting on performance, and adapting to become more efficient, equitable and effective over time.

Generating social value, equitably and effectively

Wellbeing outcomes for rangatahi and whānau/family			
[below the level outlined in the criterion for 'just good enough']	**Just good enough**	*[between the levels outlined in the criterion for 'just good enough' and 'excellent']*	**Excellent**
	Rangatahi feel the service helped them and their whānau/family		Rangatahi feel the service helped them to reach their potential and has given skills for ongoing support/resilience
	Rangatahi have developed some skills, and are building confidence and ability to draw on them outside of the support context Rangatahi develop skills and confidence to communicate and manage their distress in effective ways that support their wellbeing Rangatahi feel resourced to live with mental distress		Rangatahi feel resourced to navigate the inevitable ebbs and flows in their experiences/wellbeing – building resilience, acceptance, and confidence to draw on internal and external resources Rangatahi feel empowered and are provided the opportunity to take up leadership positions Some rangatahi who accessed services go on to have a role in holistic youth mental health spaces themselves in a way that feels meaningful for them
	Community-based programmes/services achieve their stated goals		Support encourages/facilitates the strengthening in rangatahi of community networks/resilience as well as internal skills Rangatahi Māori feel that they are contributing to thriving whānau/hapū/iwi and communities Rangatahi Māori feel the service affirms their identity as Māori
	Positive outcomes as defined by the service are reached		Positive outcomes as defined by the rangatahi and the service are reached Rangatahi are reaching their full potential, as defined by rangatahi Rangatahi confidently explore and affirm their identity
	Service is responsive to the needs of Māori, Pacific, refugee/migrant, LGBTQI+ and other groups		**Mana tangata** – For those who access services, outcomes experienced are equally good for Māori and other traditionally underserved groups, and contribute to population wellness

More efficient and equitable use of health care resources			
[below the level outlined in the criterion for 'just good enough']	**Just good enough**	*[between the levels outlined in the criterion for 'just good enough' and 'excellent']*	**Excellent**
	Youth primary mental health and addiction services contribute to better use of scarce resources across the primary care continuum (e.g. reduced pressure on other parts of the system)		Mild to moderate mental health and addiction issues are being identified and addressed at an early stage, before they become more serious - more equitably and in particular for priority groups Early intervention is reducing need for higher-intensity services – more equitably and in particular for priority groups