Mental Health Social Investment Fund

	Proposal	Description	Approx. cost
Distance and e-therapy			**$10 million**
1	**Enhanced e-therapy options for pre-teens, adolescents and young adults**	This investment will support a package of pilots designed to enhance the effectiveness, responsiveness and reach of e-therapy options for pre-teens, adolescents and young adults, in particular Māori and Pacific youth. Science Advisors and others will undertake an assessment of the current service coverage/gaps and the range of e-therapy approaches and products available to inform the design of a complementary package of e-therapy initiatives. <u>Impact:</u> E-therapy and distance therapy offer the potential to transform mental health services through the delivery of effective services in convenient, easy to access formats, using the Internet and telephone services. The electronic delivery of therapy and other programmes focused on improving mental health has a strong evidence base, particularly delivery of Cognitive Behavioural Therapy (CBT)-based therapies for people experiencing anxiety and depressive disorders. A systematic review of computerised anxiety and depression interventions for young people found that 60 per cent of anxiety and 83 per cent of depression programmes improved at least one outcome measure.[1] Evaluations of SPARX concluded that the programme led to a "…clinically significant reduction in depression, anxiety, and hopelessness and an improvement in quality of life"[2], and found that approximately half of users felt SPARX had helped them improve their wellbeing (54 per cent) and their ability to manage their own wellbeing (62 per cent).[3] In addition to these outcomes, enhancing e-therapy options for young people is expected to impact positively on educational achievement and employment outcomes; to reduce future use of health and social services; and to reduce the likelihood of justice sector interactions.	
2	**E-therapy for young prisoners**	This proposal will provide prisoners under the age of 25, and with a diagnosed mild to moderate mental health need, with access to e-therapies in their cells or in prisons' computer suites. This initiative is intended to provide a more tailored response to the mental health needs of young prisoners by overcoming the traditional barriers to treatment imposed by lengthy periods of cell-time.	

[1] Christensen H et al (2010) *Community-based prevention programmes for anxiety and depression in youth: a systematic review*. Journal of Primary Prevention: 31: 139-170. (cited in D'Arcy and Meng, 2014)
[2] Merry S, Stasiak K, Shepherd M, Frampton C, Fleming T, Lucassen M (2012). The effectiveness of SPARX, a computerised self-help intervention for adolescents seeking help for depression: randomised controlled non-inferiority trial, BMJ 2012;344:e2598.
[3] Malatest International (February 2016). *Evaluation of SPARX.* https://www.health.govt.nz/system/files/documents/publications/evaluation-sparx-dec16.pdf.

	Proposal	Description	Approx. cost
		Impact: There is little evidence around the specific use of e-therapy with young prisoners, but we know for youth in prison to effectively engage in rehabilitation, it is important for them to overcome barriers that could undermine the treatment gains. For a number of these young people, mild to moderate mental health needs are a barrier to effective rehabilitation. By increasing access to services that address mild to moderate mental health needs for this population through e-therapy, it is expected to see an increase in mental well-being and better rehabilitation results, which in turn would contribute to reduced re-offending and improved life outcomes.	
3	**Package of tailored telehealth pilots**	It is proposed to design and pilot innovative, tailored telehealth initiatives for adolescents and adults with mild to moderate mental health needs, with a proposed focus on those who face access barriers to traditional support (e.g. rural communities); follow-up following suicide attempts; and addiction support. The design of the package will need to be considered in the context of the broader package of electronic and distance therapy initiatives, to investigate integrating self-directed help through e-therapy with follow-up via tailored telehealth services. Impact: There is a strong international evidence base for the effectiveness of distance therapy, compared to face-to-face therapy. Research shows that distance therapy reduces financial, physical, geographic and psychological barriers[4]; can improve adherence/completion rates[5]; and results in higher self-disclosure and stronger relationships with therapists.[6] It is expected that this will lead to better overall health and wellbeing outcomes for clients, including greater resilience, coping skills and ability for self-management; with flow-on impacts including reduced acute/unplanned care; improved educational, employment (including productivity) and housing outcomes; and reduced future use of health, social and justice services. Further testing is needed to evaluate the potential impacts of integrating self-directed help through e-therapy with follow-up via tailored telehealth services.	

[4] Bouchard S[1], Paquin B, Payeur R, Allard M, Rivard V, Fournier T, Renaud P, Lapierre J. Delivering cognitive-behavior therapy for panic disorder with agoraphobia in videoconference. Telemed J E Health. 2004 Spring;10(1):13-25.
Swinton JJ[1], Robinson WD, Bischoff RJ. Telehealth and rural depression: physician and patient perspectives. Fam Syst Health. 2009 Jun;27(2):172-82.
Taylor TK[1], Webster-Stratton C, Feil EG, Broadbent B, Widdop CS, Severson HH. Computer-based intervention with coaching: an example using the Incredible Years program. Cogn Behav Ther. 2008;37(4):233-46.
Lingley-Pottie P[1], McGrath PJ. Telehealth: a child and family-friendly approach to mental health-care reform. J Telemed Telecare. 2008;14(5):225-6.
Beattie A[1], Shaw A, Kaur S, Kessler D. Primary-care patients' expectations and experiences of online cognitive behavioural therapy for depression: a qualitative study. Health Expect. 2009 Mar;12(1):45-59.
[5] David C. Mohr, PhD, Joyce Ho, PhD, Jenna Duffecy, PhD, Douglas Reifler, MD, Lesile Sokol, PhD, Nichelle Nicole Burns, PhD, Ling Jin, MS, and Juned Siddique, DrPH. Effect of Telephone-Administered vs Face-to-face Cognitive Behavioral Therapy on Adherence to Therapy and Depression Outcomes Among Primary Care Patients: A Randomized Trial. JAMA. 2012 Jun 6; 307(21): 2278–2285.
[6] Lingley-Pottie, P., Ph.D., & McGrath, P. J., Ph.D. (2013). Barriers to mental health care: Perceived delivery system differences. Advances in Nursing Science, 36(1), 51-61.

	Proposal	Description	Approx. cost
4	**Ensuring support and follow-up for those who attempt suicide**	This proposal is to pilot a package of initiatives to ensure support and follow-up for those who have attempted suicide or are at risk of taking their own lives. People who attempt suicide or are at risk of suicide may present to various services or agencies for reasons unrelated to self-harm or suicide attempts, providing opportunities to improve identification of people at risk of suicide in various settings. There is a range of existing services available that people who have attempted suicide or people who are at risk of taking their own life can be referred to; however, there are some people for whom these services are not accessible or appropriate, and for whom other forms of support may need to be explored. The detailed design of the package of initiatives will consider population groups for whom alternative approaches may need to be trialled, e.g. rural communities, Māori and young people. There is also a gap in follow-up for people who have attempted suicide or are at risk of suicide. In the absence of follow-up support, some may have an increased risk of subsequent suicidal behaviour. This package will consider options to: • improve the identification of people at risk of taking their own life in a range of settings, e.g. general practice, Police, ambulance services and emergency departments; • pilot alternative or additional forms of support for people who have attempted suicide or are at risk of suicide, for whom existing services are not appropriate, acceptable or effective; and • pilot of a range of methods of follow-up to provide ongoing support for people who have attempted suicide or are at risk of suicide (e.g. routine referral following suicide attempts to ongoing support, follow-up phone calls/text messages, app-based follow-up and/or phone-based talking therapies including CBT or brief problem-solving therapy), with ongoing support available for at least one year. <u>Impact:</u> There is evidence to support the benefits of screening for suicide risk, particularly in primary care and emergency department settings.[7] However, more work is needed to identify what method of screening is most effective.[8] There is also evidence that follow-up, particularly after discharge can reduce subsequent suicidal behaviour. [9] Further testing is needed to determine whether and what methods of follow-up is beneficial in a New Zealand context. Being able to identify more people who are at risk of taking their own life, and ensuring people who have attempted suicide or are at risk of taking their own life receive support and follow-up, has the potential to improve the wellbeing of those individuals and prevent suicide. This will also likely have beneficial impacts on those around the person, such as their whānau, friends and colleagues.	$5 million

[7] A rapid review of the suicide prevention literature. 2016. *A report produced for the Ministry of Health*. URL: www.health.govt.nz/system/files/documents/pages/rapid-review-suicide-prevention-literature-dec16.docx.
[8] Zalsman G, Hawton K, Wasserman D, et al. 2016. Suicide prevention strategies revisited: 10-year systematic review. *Lancet Psychiatry*, 3(7), 646-59. doi: 10.1016/S2215-0366(16)30030-X.
[9] A rapid review of the suicide prevention literature. 2016. *A report produced for the Ministry of Health*. URL: www.health.govt.nz/system/files/documents/pages/rapid-review-suicide-prevention-literature-dec16.docx.

	Proposal	Description	Approx. cost

5	**Expanding and enhancing primary and community mental health and addiction care**	We know there are capacity constraints and gaps in services for people with mental health needs, particularly those whose needs are not easily managed by GPs but who do not meet the threshold for specialist services. This can result in mental health needs going unidentified and unaddressed, and eventually escalating to a level that does require specialist intervention. This is supported by anecdotal evidence suggesting that people are sometimes left to wait for issues to worsen before they can get help.
		System transformation is needed to shift more focus to early intervention and prevention to stem the flow of future demand for mental health services, but we also need to improve the way we respond to people who have mental health needs now, particularly in primary and community service settings.
		Responding to current challenges requires a strong and capable primary health workforce and an enhanced community workforce to support the focus on prevention, self-care and care closer to home. The mental health and addiction workforce also includes a diverse range of people working in a number of different settings.
		This investment will enhance and expand primary and community mental health services (with an initial focus on children, adolescents and young people) and will trial new service models for primary and community mental health and addiction care. Design of the package will consider a mix of:
		• Building a diverse workforce who can support delivery of CBT, use of e-therapies and services provided closer to communities (e.g. in Youth One-Stop Shops, Communities of Learning and alongside primary and community care). It is estimated investment of approximately $5 million p.a. will enable:
		  ○ The training of approximately 250 youth peer support workers and approximately 125 community care workers with a focus on young people;
		  ○ Approximately 250 health professionals such as nurses, social workers and other allied health; professionals to train in therapies such as CBT and motivating behaviour change, as well as training to act as supervision to team-based care;
		  ○ An additional approximately 13 clinical psychology intern positions; and
		  ○ Support for the workforce to make the best use of e-therapies.
		• Expanding access to mental health services for children, adolescents and young people, e.g. YOSS and other YOSS-like services and Child and Adolescent Mental Health Services
		• Testing components of an integrated primary, community and multi-disciplinary spectrum of services (e.g. supported self-management options, social interventions to support wellbeing, continued referrals for talking therapies and shared care between primary and secondary care services).
			$25 million

Step/step-down support for people experiencing acute and emergency mental health needs			
6	**Support service for people in acute mental health crisis to sustain tenancies**	The proposal is for people experiencing or at risk of an acute mental health crisis to be supported to establish and sustain tenancies and access appropriate services, with the aim of providing a stable foundation for mental wellness. The initiative will target people who are: • In the private market or in social housing; and • At risk of experiencing an acute mental health crisis and at risk of losing their tenancy; or • Currently in hospital for mental health and in need of safe and stable housing. This service will provide practical support to sustain, retain and establish tenancies which could include things such as liaising with landlords and mediation with neighbours, as well as help to navigate appropriate social services (such as Work and Income and community mental health services). The proposal aligns with the wider mental health strategic approach, by intervening early to avoid potential further escalation of mental health and housing issues. A community based provider(s) will be contracted to deliver this service. <u>Impact:</u> There is New Zealand evidence that sustaining stable housing significantly improves mental health outcomes and reduces hospitalisation rates. A 2010 study found that hospitalisation rates for mental and behavioural disorders for people placed in Housing New Zealand properties declined by approximately 20 per cent following placement in social housing and reduced rates persisted for at least two years. International evidence suggests that the point of discharge from inpatient units can be an effective intervention point for preventing homelessness and that stable tenancies enhance engagement with mental health services, and can lead to a range of positive outcomes, including better physical health and increased social participation.	$4 million
7	**Wraparound and step-up/step-down care trial**	There is an identified need for alternative support options for people experiencing mental health crisis – to make sure we provide timely responses in the most appropriate settings. There is also a known gap in step-down support for people being discharged from in-patient hospital care to return back into the community. Mechanisms for responding more quickly and appropriately to mental health-related emergencies, and for supporting people to return back to the community following in-patient care, may include increased/more effective use of: • Mental health crisis teams; • Home-based treatment teams; • Community respite units; • In-patient units; • Medium-term secure environments; and	$4 million

		• Wrap-around support (e.g. development of discharge plans or use of ongoing peer support to engage with appropriate support services). The most appropriate configuration of these options will vary between regions and according to population needs. This funding will enable the local design and trial of innovative wraparound/ step-up/step-down care options, tailored to regional needs. This investment will complement the support service for people in acute mental health crisis to sustain tenancies, as well as the multi-agency co-response service for people who ring 111 for Police or Ambulance requiring a mental health response. <u>Impact:</u> It is expected that improved wraparound/ step-up/step-down care options will lead to more sustainable outcomes for individuals who have experienced a mental health-related emergency or who have been treated in in-patient care. This includes improved mental wellbeing and ability to cope with life's stressors, with flow-on positive impacts in other areas of their lives, including their housing and employment situations.	
8	**Multi agency co-response service for people who ring 111 for Police or Ambulance requiring a mental health response**	It is proposed to operate in three locations, a multi-agency co-response service for people who ring 111 for Police or Ambulance requiring a mental health response. The proposed service will have staff from Police, Ambulance, and Mental Health services deploying together, as a priority emergency response, to events requiring mental health intervention, such as attempted suicides. Whenever possible, the person will be assessed on scene or in the community to ensure they receive a timely and holistic response. Responses could include direct transfer to a community mental health facility, reassurance for family members or the person themselves that they are safe to stay at home, advice on managing the situation and referrals to appropriate follow-up services and support. Transportation to emergency departments will be a last resort response. This initiative covers a 6 month design and implementation period and three years operational delivery in three sites. The three sites would include two metropolitan locations and one provincial/rural location. There will be continual monitoring of delivery in each of the three sites so that the model can be responsively adapted, enabling agile service delivery in response to local circumstances. This initiative is intended to quickly inform future mainstream service design. <u>Impact:</u> The co-response service is a mechanism for improving the service mentally unwell people receive. It will provide more timely and appropriate specialist assessment and care for people, by intervening earlier in the course of a person's illness with treatment in the community or at home rather than at hospital or a police station. This will reduce the number of people being detained by Police or transported to emergency departments; minimise the need for more intensive and expensive health care options, through delivery of the right services at the right time; reduce repeated calls for service; and assist with capacity in DHB crisis services.	$8 million

		There is strong international evidence that a co-response service will be more cost effective than the current operating model, with a lower average cost per event attended. The service will build strong and effective partnerships between agencies and service providers. This will mean a more responsive service, with improved use of referral pathways to link people to appropriate services such as housing and alcohol and drug treatment. These referrals could also be to other services proposed in this package, i.e. Trauma Focused Cognitive Behavioural Therapy, Electronic and Distance Therapy. Providing a coordinated and comprehensive service from the outset means people are more likely to receive the care they require when they need it, reducing repeat demand, and resulting in fewer emergency service calls to Police and Ambulance.	
9	**Strengthening self-regulatory skills in early childhood**	This initiative would seek a provider to deliver a pilot to deliver and evaluate an intervention focused on developing internal self-regulatory skills for 3 and 4 year olds in home and/or ECE settings. A pilot approach is needed because, while some promising age-appropriate interventions to improve self-control in pre-school age children are developing, further evidence of effectiveness is needed before a rollout is advisable. It is expected that a proposed intervention would not only show the ability to improve self-control in young children, but also at a relatively low cost per child and before the cost of adverse outcomes is incurred. <u>Impact</u>: Low levels of self-control appear to be relatively common in early childhood. The Growing Up in New Zealand Study found that just over 25 per cent of children aged four and a half lacked self-control when assessed using a standard test. Higher levels of self-control have been found to predict many important outcomes that extend into adulthood. After accounting for socioeconomic status and IQ, individual differences in children's self-control can predict physical and mental health, criminal behaviour, and wealth in adulthood, as well as better educational outcomes.	$3 million
Schools package			
10	**Pilot frontline mental health provision in schools**	This proposal is for a pilot the provision of frontline mental health services in selected schools to: • Support the development of a universal screening approach/es, to identify mental health issues or issues that left unchecked could manifest as mental health issues later on; • Where mental health issues are identified, provide on-location access to frontline mental health care so that students have fast, easy access to the support they need to address issues as they occur. The objective of universal provision is to identify emerging issues early to reduce this as a barrier to learning, and to build the capability within the Community of Learning to address mild to moderate needs. Screening is likely to be carried out by existing resources, such as nurses, social workers and counsellors, with the oversight and support of a mental health practitioner. When mental health needs are identified, children will be referred to the specialist mental health service.	$11 million

		Screening will build on existing screening tools, such as HEEADSSS, and administration through Communities of Learning enables this pilot to test whether additional screening points and would support earlier identification of issues, monitor children's development, and evaluate the effectiveness of interventions across school years, and at critical transition points. <u>Impact:</u> The Youth'12 survey indicates that over time, the mental wellbeing of students appears to have deteriorated slightly between 2007 and 2012, with small increases in the proportions of students reporting significant depressive symptoms (12.8 per cent up from 9.5 per cent), deliberate self-harming (24 per cent up from 19.4 per cent), and suicidal ideation (15.7 per cent up from 13.1 per cent) (Youth'12 survey). Evidence shows that where young people have access to well resourced, on-site services, the student population experiences lower depression and suicide statistics, decreased visits to emergency departments, and increased educational achievement and engagement. Evidence also shows that young people 'snack' on services as and when need arises and in order for this to occur, services must be easily accessible. Better educational outcomes are associated with better employment outcomes and reduced justice and welfare costs. By increasing accessibility for children and young people to services and improving continuity of care across their whole education pathway, we are increasing the likelihood that they will seek help and support early in the incidence of their issues or illness, which will in turn increase positive life outcomes.	
11	**Improve learning environments and build resilience**	Specific social and emotional skills, including those related to self-control and resilience, can be taught to all young people through school-based programmes. This proposal is aimed at improving the social and emotional learning environment in schools and developing the resilience of children and young people. The proposal is to develop a more evidence-based, effective universal approach building on the capability already in place through PB4L School Wide. This will enable schools to embed a strong foundation of effective systems and processes for positive behaviour, improve the social and emotional learning environment, and develop skills required for resilience. Current evidence suggests this will mean systems and processes for developing leadership strategies to embed a culture to support a positive social and emotional environment, developing the capability to use data and evidence to make decisions, and implementing effective teaching practices across the curriculum to teach students the skills they need to be resilient. In addition, additional targeted interventions, such as an adaptation of the well-researched and well-evidenced Good Behaviour Game will be developed to supplement the universal approach, to address a specific area of need identified by the school or Community of Learning (e.g. anti-social behaviours). This approach will be made accessible to all schools by 2020.	$8 million

		Impact: Building resilience across the school years is a core preventive strategy and to be able to cope with stressors such as bullying. Effective interventions establish a safe, positive physical and emotional school environment for students' achievement and wellbeing. Strategies to improve wellbeing, and critical areas of development known to increase resilience, such as self-control, are most effective when they are part of a whole-school focus on improving the culture and environment, and provide students with the skills they need to face stressors when they arise. Improved resilience is associated with positive social behaviour, reduced emotional distress and mental health issues, and improved academic performance. Targeted interventions such as the Good Behaviour Game have been shown to have widespread effectiveness. Specific impacts include: lowered verbal and physical aggression and oppositional behaviours; greater compliance; reduced hyperactive behaviours; increased pro-social behaviours; self-control; increased engagement in academic tasks; and perseverance. The London School of Economics estimates a significant return on investment for school-based interventions to improve the skills that contribute to resilience, including social and emotional skills.	
12	**Electronic HEEADSSS assessment and brief intervention for young people**	It is proposed to pilot an electronic HEEADSSS (home, education/employment, eating, activities, drugs, sexuality, suicide and depression, and safety from injury and violence) assessment tool with young people within 12 services, focusing on School Based Health Service secondary schools and Youth One-Stop Shop settings. The pilot would reach an estimated 4,000 young people from age 12-24 years per annum. Assessment of workforce capacity to respond to arising need will be considered, and resourcing to ensure appropriate workforce response will be added if required. Impact: Electronic assessment has been shown to improve disclosure of sensitive information and to enhance screening as a pathway to improved support and outcomes. School Based Health Services have been estimated to reduce depression by 3.4 per cent and to impact positively on suicide risk, sexual health, alcohol misuse and school engagement. It is anticipated that use of electronic assessment and brief intervention in these settings would enhance those outcomes. Evaluation of the pilot is essential and should include an annual school health and well-being survey in participating and comparison schools to enable clear measurement of any additional impact of the pilot on these outcomes. Collated data from the assessment tool and the evaluation surveys will also be of significant benefit at the school level enabling school-wide, specific health promotion initiatives to be implemented, and at the area/national level where data from all services can be used in an aggregated format to inform policy and services on levels and areas of youth psychosocial need.	$1 million

13	**Supportive housing models for youth with a mental health condition**	This proposal would provide accommodation support with wraparound services for young people aged 16-24 who are at risk of developing a mental health disorder or who have one diagnosed already; and are living in insecure housing situations. A community based provider(s) could be contracted to provide the housing and wrap around support services for the young person. Wraparound support will focus on: • Mental health support (diagnosis, medication, counselling, engagement in activities that support wellness); • Housing support (learning rights and responsibilities of tenants and landlords); and • Life skills support (support in cooking and cleaning, house activities and working towards education and/or employment goals). The initiative would support up to 30-40 young people per year, with on average three-four young people per house, in up to ten houses. This would enable a number of locations around the country to test this intervention, with locations to be determined by level of need and provider interest and capability. The initiative would operate as a pilot to test this type of support and its effectiveness in improving mental health and achieving positive outcomes for young people. <u>Impact:</u> We know that there is a significant association between poor mental health and a need for housing support and there is New Zealand evidence that sustaining stable housing significantly improves mental health outcomes and reduces hospitalization rates. We know that young people with mild to moderate mental health issues are three times more likely to be benefit dependent. International supportive housing models that take an integrated approach to housing, education and employment outcomes for young people who are at risk of homelessness suggests that a high proportion of residents move onto stable housing and some form of employment and education upon exiting (an Australian study showed that 81per cent of ex-residents were in recognised and on-going permanent housing and 52 per cent of ex-residents were in education and training a year after leaving).	$5 million
14	**Strongest Families pilot**	This investment will support a pilot based on the Canadian programme ‘Strongest Families’ that delivers Cognitive Behavioural Therapy via telephone conferences for whānau with children experiencing anxiety or moderate mental health or behavioural problems. The programme teaches whānau skills to better manage their child’s behavioural problems, and teaches children how to manage their symptoms of anxiety. It is proposed to test and evaluate the initiative with up to 1,000 children aged between 3-12 and their whānau. <u>Impact:</u> The Canadian programme on which this pilot is based has been evaluated to improve behaviour modification (approximately 25 per cent of participants successfully managed behavioural problems to extent they avoided	$6 million

		diagnosis), educational outcomes and whānau relationships/functioning[10,11]; and to reduce treatment barriers, strengthen therapeutic alliance and result in higher self-disclosure than usual treatment.[12] It is expected that these impacts will lead to improved future outcomes for the children involved (including being better able to cope with their symptoms, reduced acute/unplanned care, reduced likelihood of offending and improved employment outcomes) as well as their whānau (including creating safer and supportive home environments, improved health literacy and improved mental wellbeing, resulting in a reduction of the intergenerational impacts of poor mental health)	
15	**Culturally responsive trauma-focused CBT for children following experiences of family and/or sexual violence**	Trauma-focused Cognitive-Behavioural Therapy (TF-CBT) is a conjoint parent-child treatment that uses cognitive-behavioural principles and exposure techniques to prevent post-traumatic stress disorder, depression and behavioural problems as a result of the trauma. The initiative is to pilot a culturally responsive TF-CBT service for children aged 5-12 years that have experienced or been exposed to family and/or sexual violence in the New Zealand context. The pilot is estimated to reach up to 270 children over two years across three locations. <u>Impact:</u> There is a considerable body of evidence that has documented the relationship between childhood trauma associated with family and/or sexual violence and subsequent aggression and criminality. Child abuse as a result of family and/or sexual violence or witnessing violence is the most common risk factor for post-traumatic stress and associated behavioural problems (including aggression, antisocial behaviour and inappropriate sexual behaviours) as a result of such trauma. In the long-term, across the child's life course, sexual and/or family violence trauma is associated with a wide range of negative outcomes including increased mental health issues, substance abuse and involvement with the criminal justice system. Through early identification, TF-CBT has been proven to decrease and prevent symptoms of post-traumatic stress disorder which are associated with, in the short-term and long-term: • Improved social adjustment; • Improved educational achievement; • Reduced likelihood of offending; • Reduced likelihood of mental health escalation; • Improved ability to recognise and respond to abusive situations; • Improved family communication and connectedness;	$4 million

[10] McGrath, P. J., PH.D., Lingley-Pottie, P., Ph.D., Thurston, C., M.A., MacLean, C., M.D., Cunningham, C., Ph.D., Waschbusch, D. A., Ph.D., . . . Chaplin, W., Ph.D. (2011). Telephone-based mental health interventions for child disruptive behavior or anxiety disorders: Randomized trials and overall analysis. Journal of the American Academy of Child and Adolescent Psychiatry, 50(11), 1162-1172.

[11] Removing the barriers to care. (n.d.). Retrieved from http://strongestfamilies.com/wp-content/uploads/2012/11/Insert_BusinessPortfolio_01June15.pdf

[12] Lingley-Pottie, P., Ph.D., & McGrath, P. J., Ph.D. (2013). Barriers to mental health care: Perceived delivery system differences. Advances in Nursing Science, 36(1), 51-61.

		• Decreased behavioural and conduct problems; • Decreased anxiety and depression; • Decreased substance abuse; and • Reduced likelihood of welfare receipt and therefore increased likelihood of employment opportunities and earnings.	
16	**Enhancing mental health and neurodevelopmental capacity in Gateway assessment teams and associated service pathways**	Within this initiative, Health will enhance the capacity and capability of Gateway assessment teams by including mental health specialists, to improve responses to the mental health and neurodevelopmental needs of children and young people (aged 0 – 18 years) who are engaged with the statutory care system. It is proposed to pilot this initiative in three DHBs alongside MVCOT's Access to Services trial sites, through which MVCOT will direct purchase responses to needs identified through Gateway assessments when those services are not available through the public system i.e. the service doesn't exist or there is a waiting list for an existing service. This Health-led initiative has been designed to align with MVCOT's Access to Services trials, and will share governance arrangements to ensure the systems to strengthen assessment, referral and therapeutic responses are integrated. Collecting the evidence on the impact of this enhancement will help inform how Health and MVCOT can better invest in future services to support the mental health needs of this population coming into statutory care. <u>Impact:</u> Engagement with the sector has informed this proposal – Gateway assessments tend to focus on physical health needs and reports from paediatricians administering assessments that they don't feel they have the skills to properly assess and respond to mental health and neurodevelopmental needs. There is substantial evidence that exposure to Adverse Childhood Experiences (ACEs) has a dose-response relationship to poor outcomes in early adulthood. Prolonged exposure to adversity and trauma (toxic stress) can affect the development of the brain and the foundations for good mental health. If these issues remain unidentified and unaddressed they can increase in severity and contribute to a range of negative outcomes, including poor educational attainment, benefit dependence, offending behaviour, risky sexual behaviour and teen pregnancy, substance misuse, mental health issues, poor parenting behaviours, physical health issues and increased mortality. The risk of negative outcomes can be increased by the introduction of well-intentioned yet uninformed interventions. This initiative targets a population of vulnerable children and young people who have some of the highest exposures to ACE's and toxic stress in New Zealand and who are therefore likely to have a high prevalence of mental health and neurodevelopmental issues - often in combination. At present, these issues are not always identified for a range of systemic reasons, and opportunities to intervene early and effectively are lost. Increasing the mental health and neurodevelopmental capacity of	$4 million

		Gateway teams will support the implementation of effective and child-centred intervention, and increase the capacity of those working with or caring for these children to adapt their approach to best suit their needs. We expect that this will improve outcomes for this cohort and their whānau. This initiative has also been designed to collect data on the incidence and severity of mental health and neurodevelopmental need, and to identify barriers and service gaps for responding to that need effectively. Increasing the health system's responsiveness will also have benefits for a broader population of children and young people.	
17	**Improving the evidence base about New Zealanders' mental health and interventions that work**	Our understanding of mental health and mental disorder (including addiction) in present-day New Zealand is limited. As there are indications that rates of mental disorder are increasing, establishing this with precision is important for understanding who is at risk, for measuring changes since the last research was undertaken, for planning prevention, and for organising services. To build our understanding, this funding will support a programme of extended semi-structured interviews ensuring the inclusion of young people, the hard-to-find, the transient, the homeless, and migrant populations, among others. This would enable us to get a reliable estimate of unmet need and provide an accurate baseline against which to measure progress as we transform our approach to mental health/resilience and the better prevention and management of mental disorder (including addiction). More detailed work, including privacy and ethical considerations, needs to be done. <u>Impact:</u> Data and information is an important enabler that will support the ongoing transformation of mental health and related services in New Zealand. It is vital that we have a clear picture of the nature and prevalence of mental disorders in New Zealand, helping us to understand who is at risk, to develop prevention strategies and to plan and organise services. Collecting and collating data in a way that allows for international comparisons and benchmarking is also important, enriching our understanding of the New Zealand situation. Building the evidence base is a critical element of a social investment approach – we need to understand where to target investment to have the greatest positive impact for New Zealanders.	$5 million