Hikaka te Manawa:

Making a difference for rangatahi

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Te Rau Matatini

'Hīkaka te Manawa' (Embracing the Energy)

Whakataukī

Hūtia te rito o te Pā harakeke
Kei whea te korimako e kō
Rere ki uta, rere ki tai
Ūhia mai koe ki a ahau
He aha te mea nui o Te Ao
Mākū koe e kī atu
He taiohi
He Rangatahi
He Tangata

Explanation of Whakataukī

The Pā harakeke is a type of Flax bush and is sometimes used as a metaphor to represent the whānau (family). The new leaf at its centre is the child, and leaves on the outside are older relatives. If you continue to extract the new leaf, eventually the plant will perish. So too will the home of the bellbird disappear. Therefore, I pose this question to you, what is the most significant entity of creation? It is the young shoot, our young children, our youth, it is people!

He Mihi

Tuia i runga tuia i raro
Tuia I roto, tuia I waho
Tuia te muka tangata I take mai
I Hawaiki nui, I Hawaiki roa, I Hawaiki Pāmamao
Te hono ki Wairua, te wahi e whakaputa atu te tangata
Ki te wheiao ki te aomārama!

Tēnei mātou 'Te Hāpai o' e mihi kau atu ki Ngā Amorangi o te kaupapa nei. Nā rātou mātou i ārahi mai kia oti pai tēnei kaupapa ***'Hīkaka te Manawa'***. Mātou Ko te Tākuta Lynne Lane o Te Kaunihera o Te Hauora Hinengaro; ko Ana Sokratov Kaiarahi Te Kaupapa; ko Jarrard O'Brien Kaiwhakahaere Rautaki, rāua ko Fionnuala Followell Ringa Āwhina Tāhūhū, mātou ko Hori Kingi Kaiarahi Te Ara Māori/ Kaumatua; me te kaihautū o Te Rau Matatini ko Trish Davis me ngā poari mema o Te Rau Matatini.

Tuatahi, kia tau tonutia te aroha o te atua ki runga ki a tātou katoa, i roto hoki i te kaupapa Hīkaka te Manawa e horahia nei. Kore e mutu te mihi ki te tangata, nānā hoki te kaupapa I hikitia, I hāpainga I ārahina mai mātou kia whakaputa atu te tuhinga roa nei ki Te Whai Ao ki te Ao Mārama.

Tuarua, Kei te tangi hotu haere tonu mātou ki te hunga wairua kua wehea atu. Ka hoki te mahara ki te tuatahi o te kaupapa Ko Ropata Henare rāua ko Denis Simpson. Ngērā, ērā tangata i pare te huarahi puhi o ngēnei mahi huri haere te motu ki te rapu kōrero. Nō reirā ka tuia i runga ka tuia i raro ka tuia nga mate ki runga I a tātou katoa. Kia mihia, kia tangihia, Haere atu rā koutou ki te pūtahitanga o Pipiri, ki te timatanga, ki te whakamutunga o ngā mea katoa, whetūrangitia! Ka waihotia mātou te pō e tauārai e te hunga wairua.

Ka waiho hoki te hunga ora te ao marama e tītoko ai. Ānō rā te hāpai o ki muri e mihi atu ki nga whare hauora me o rātou ringa raupā ko ngā rangatira, ko ngā kai whakahaere, ko ngā kai kawe i te kaupapa i tuku iho mai ngā taonga kōrero pounamu mō te tuhinga nei. ki a rātou

e awhinatia mai mātou kia oti pai tēnei tuhinga rātou ko Te Ahurei a Rangatahi, Te Utuhina Manaakitanga Trust, Hauora Waikato, Te Roopu Kimiora Whangarei, Te Roopu Kimiora Kaitaia, Tairawhiti District Health Board Child and Adolescent Mental Health Service, Mahitahi Trust, Nelson Marlborough District Health Board Youth Alcohol and Other Drug Services, Nelson Marlborough District Health Board Child and Adolescent Mental Health Service, Nelson Bays Primary Health Organisation, Ngati Koata, Gateway Housing Trust, Southern District Health Board Child and Family Mental Health Service, Adventure Development, Te Oranga Tonu Tanga, Purapura Whetu Trust, Te Korowai Atawhai, Te Korowai Hou Ora, Youth Horizons, He Waka Tapu, Canterbury District Health Board Child and Family Service. Ka hoki atu ahau ki tetehi kōrero ō Tūhoe, ki a Taiarahia Black (2006) hei rāpopoto te korero o runga rā, otirā hei kinaki hoki I taku mihi, ***"A muri a mua ka totika"*** Pai Marire!

The Mental Health Commissioner, the Chief Executive of Te Rau Matatini, the Te Rau Matatini Trust Board, and the members of the project team, would like to recognise the services and everyone within these services who guided us in generating this report: *'Hīkaka te Manawa' (Embracing the Energy).*

First and foremost, acknowledgements to our creator for the hand of peace that descended upon all involved in this project: Hīkaka te Manawa. People were enthusiastic about participating, which allowed us to prepare a meaningful publication.

Secondly, we acknowledge those who have departed. In the context of this project we remind ourselves of the work Bob Henare and Denis Simpson conducted in their time. They were the first group to conduct service interviews for the Mental Health Commission throughout the country. We take this opportunity to acknowledge those who have gone before them and those who have followed in their footsteps and returned to the convergence of time, to the beginning and the end for all things. We leave the world of darkness to those that reside there, and return to uphold the world of light, understanding and enlightenment.

The project team wishes to personally acknowledge the following services, their managers and workers for sharing valuable information and experiences from within their service that has informed this report:

- *Adventure Development*
- *Canterbury District Health Board Child and Family Service*
- *Gateway Housing Trust*
- *Hauora Waikato*
- *He Waka Tapu*
- *Mahitahi Trust*
- *Nelson Bays Primary Health Organisation*
- *Nelson Marlborough District Health Board Child and Adolescent Mental Health Service*
- *Nelson Marlborough District Health Board Youth Alcohol and Other Drug Services*
- *Ngati Koata*
- *Purapura Whetu Trust*
- *Southern District Health Board Child and Family Mental Health Service*
- *Tairawhiti District Health Board Child and Adolescent Mental Health Service*
- *Te Ahurei a Rangatahi*
- *Te Korowai Atawhai*
- *Te Korowai Hou Ora*
- *Te Oranga Tonu Tanga*
- *Te Roopu Kimiora Kaitaia*
- *Te Roopu Kimiora Whangarei*
- *Te Utuhina Manaakitanga Trust*
- *Youth Horizons*

Finally, I return to the oratory of Tūhoe, to known Māori educator Professor Taiārahia Black (2006) to summarise the above acknowledgements in a short sentence, "A muri, a mua, ka tōtika".

Foreword

Hīkaka te Manawa is a collaborative project between our organisations, born out of a shared goal to improve the mental health and wellbeing of rangatahi Māori – one of our most vulnerable groups.

Rangatahi Māori are also the fastest growing population group in Aotearoa, accounting for one quarter of all young people. The factors influencing the wellbeing of rangatahi and their whānau are complex. It is well known that rangatahi are more likely to live in poverty, experience abuse and social isolation, suffer from drug and alcohol related problems, and are at increased risk of mental distress. These young people are our country's future and the fact that many are not able to achieve their full potential is unacceptable.

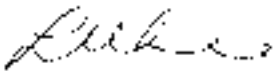
Despite these challenges, rangatahi have an innate strength and aspire to succeed and live meaningful lives. Hīkaka te Manawa celebrates the services throughout the country working with rangatahi and whānau that highlight this strength and support them to achieve positive outcomes. In engaging with these services it identifies the factors that enable them to foster positive outcomes for rangatahi and the common challenges faced by services.

The report advocates for future development of services that builds on their strengths and provides solutions to the common challenges to maximise rangatahi development and whānau inclusion. It also recommends that the lessons learned for improving outcomes for rangatahi are applicable to all youth services and cultures.

The composition of the project team was an intentional effort to work in accordance with Te Tiriti o Waitangi and uphold tikanga and Māori kaupapa. The team was led by Ana Sokratov, Ngāpuhi, Consumer Consultant, and Board member for Te Rau Matatini. Cultural guidance and advice was provided by Kaumātua Hori Kingi, and Jarrard O'Brien provided project support.

We would like to acknowledge and thank everyone who participated in this project. This report is the result of your collective wisdom.

Kura Denness
Chair
Te Rau Matatini



Lynne Lane
Mental Health Commissioner

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Executive summary

In the last decade, we have seen significant positive change in the direction and delivery of mental health and addiction support services to rangatahi in New Zealand.

In 2012, Blueprint II set out a bold transformative vision of how things need to be to improve mental health and addiction support services in New Zealand. As this report demonstrates, this vision is being made a reality by rangatahi mental health and addiction service providers who, by embracing inclusive and collective cultural wisdom and practices are making a real difference for this vulnerable young population.

To date, our knowledge of the good work these services are doing along with the challenges they face has been largely anecdotal. Yet, if we are to capitalise on their strengths and grow and develop the model, evidence is critical.

This report gives us that evidence, born out of the collective desire of rangatahi mental health and addiction services across New Zealand to document their common successes and challenges. It draws on the collective experiences of 21 services across New Zealand, compelling insights from the people who are working at the grass roots and making a difference for rangatahi.

The gathering of information has been done in a partnership between agencies and providers in accordance with Te Tiriti o Waitangi and in keeping with the inclusive spirit underpinning the sector.

Two years on from Blueprint II, we now have valuable insights into what rangatahi mental health and addiction services are doing that is effective along with the constraints at a funding and policy level that need to be addressed to move forward.

On this basis, Hīkaka te Manawa: Making a difference for rangatahi sets out key recommendations for further progressing effectiveness access and outcomes and supporting sustainable funding for services into the future.

Summary of recommendations

Funding and planning

1. Prioritise funding and planning for rangatahi mental health and addiction services that foster growth and development.
2. Increase the capacity of NGOs, particularly kaupapa Māori NGOs in the specialist area as well as improving access to early intervention through primary care.
3. Increase the availability of parenting programmes that work for whānau and rangatahi who are parents.
4. Build the capacity and capability of funding and planning teams to strengthen links within the sector and between providers.
5. Adopt a life-course approach to funding for rangatahi and for consistency in contracting, and close the gaps in service provision due to differing age groups in provider contracts.
6. Adopt a more flexible funding model for contracting and reporting.

Workforce

7. Prioritise activity to address youth workforce shortages to respond to the needs of rangatahi and whānau.
8. Workforce centres must provide development and training solutions to increase competence in both clinical and cultural domains.
9. Professional bodies should also support clinical and cultural competency requirements in the workforce.

A model/philosophy for services for rangatahi

10. Promote a rangatahi development model at the primary care level whereby providers offer a range of services required for rangatahi development.
11. Services must adopt an outward-looking approach in the sector and participate in community forums and networks to support the improved communication and linkages with other relevant services for their populations.
12. Increase accessibility of e-therapies and other self-help options that increase access and positive outcomes for rangatahi.

Conduct disorder

13. Early access to psychological support and therapies.
14. Enable access and availability of psychological therapies or a rangatahi development model of service in primary care settings.

Whiriwhiria ngā toanga tuku iho, e arahina koe i tō mahi

To select unsurpassed treasures of the past, to respond appropriately to circumstances of today.

Introduction

Hīkaka te Manawa: Making a difference for rangatahi has been a collaborative project between the Mental Health Commissioner and Te Rau Matatini, born out of a shared goal to improve the mental health and wellbeing of all New Zealanders, in particular, the most vulnerable.

Māori rangatahi (youth) are at greater risk of mental health problems and substance use than non-Māori. Rangatahi are more likely to come from disadvantaged socioeconomic backgrounds and live with the intergenerational impacts of colonisation; factors which compromise resilience and contribute to poorer mental health outcomes. Access to culturally and clinically competent services needs to be increased for this often hard-to-reach group. However, there is little evidence of which models work best for rangatahi. *Hīkaka te Manawa: Making a difference for rangatahi* was developed to address this.

This report provides the context for the project, highlighting the need for increased advocacy on behalf of rangatahi, their whānau, and the mental health and addiction services supporting them. It sets out the strategic and policy directions toward improving outcomes for young people and for Māori. The report draws on the experiences of a range of services for rangatahi throughout the country, which despite increasing complexity and significant socioeconomic challenges, are engaging with their communities and achieving positive outcomes. This report identifies both their 'keys to success' and their common challenges.

Finally, recommendations are provided to support sustainable funding and inform the future planning and development of these essential services.

Strategic context

To understand this project, and what mental health and addictions services can do to make a difference for rangatahi, it is important to recognise the relevant international and national developments, and the indigenous and cultural factors that contribute to health and wellbeing.

International frameworks

In 1989 the United Nations adopted the **United Nations Convention on the Rights of the Child** (UNROC)[1] which defines universal principles and standards for the status and treatment of children worldwide. New Zealand is a signatory to the Convention and appeared before the UNROC Committee in 2011. It recommended that New Zealand improve access for those most vulnerable and urgently address disparities in access to services for Māori children and their families. Similarly, the 2007 **United Nations Declaration on the Rights of Indigenous Peoples** (UNDRIP) focuses on ensuring parity for indigenous people and maximising their physical and mental health.[2]

In 2013 New Zealand's Mental Health Commissioner signed a promise with the national and state commissioners in Australia, and the Canadian Mental Health Commissioner to support the **Whaerata Declaration**. The Whaerata Declaration[3] provides a framework to improve indigenous mental health through indigenous leadership and values (spirituality, cultural identity as a source of strength, family, and community) that enhance therapeutic work and conventional approaches. It stems from the understanding that a strong sense of cultural identity fosters wellbeing and builds resilience[4].

Kāore te Rino e piri atu ki te uku

Clay does not adhere to iron Clinical and cultural interventions are essential, but from within their own world view dimensions

1 United Nations. 2014. *Children's Rights* [online]. New York: United Nations Convention on the Rights of the Child. Available from http://www.un.org/cyberschoolbus/treaties/child.asp [accessed 23 April 2014]

2 United Nations. 2007. *United Nations Declaration on the Rights of Indigenous Peoples* [online]. Available from http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf [accessed 24 April 2014]

3 Sones, R., Hopkins, C., Manson, S., Watson R., Durie, M. & Naquin V. 2010. The Wharerata Declaration-the development of indigenous leaders in mental health. *The International Journal of Leadership in Public Services*, 6 (1), pp. 53-63

4 Pere, L.M. 2006. Oho Mauri: Cultural Identity, Wellbeing, and Tāngata Whai Ora/Motuhake. PhD, Massey University

The Wharerata Declaration sets out two complimentary approaches:

1. supporting mainstream clinicians to strengthen their cultural competence; and
2. supporting the development of indigenous mental health leaders and policy makers within five key themes: indigeneity; best practice; best evidence; informed, credible, strategic, connected, and sustainable leadership; and influential and networked leadership.

According to the Declaration 'best evidence' means that evaluation is based in the origin of intervention: if an intervention is cultural, then the evaluation methodology must be based in cultural knowledge. Therefore, culturally informed and competent services and practitioners are essential to influencing positive outcomes and wellbeing for indigenous populations.

NEW ZEALANDERS

15–18 year olds

29% of young people are affected by mental health issues

Age group accounts for **7%** of the most serious disorders[5]

The age when mental health issues are most prevalent

18–24 year olds

Over **50%** engage in hazardous drinking

About **40%** use cannabis[6]

15–24 year olds

New Zealand self-harm and suicide rates among highest in OECD

NEW ZEALAND

Youth and mental illness

At least **20%** exhibit challenging behaviours and emotions or had experiences that affect the rest of their lives

High rate of social morbidity compared to developed countries

5 Dunnachie, B. 2007. *Evidence-Based Age Appropriate Interventions: A Guide for Child and Adolescent Mental Health Services* (CAMHS). Auckland: The Werry Centre

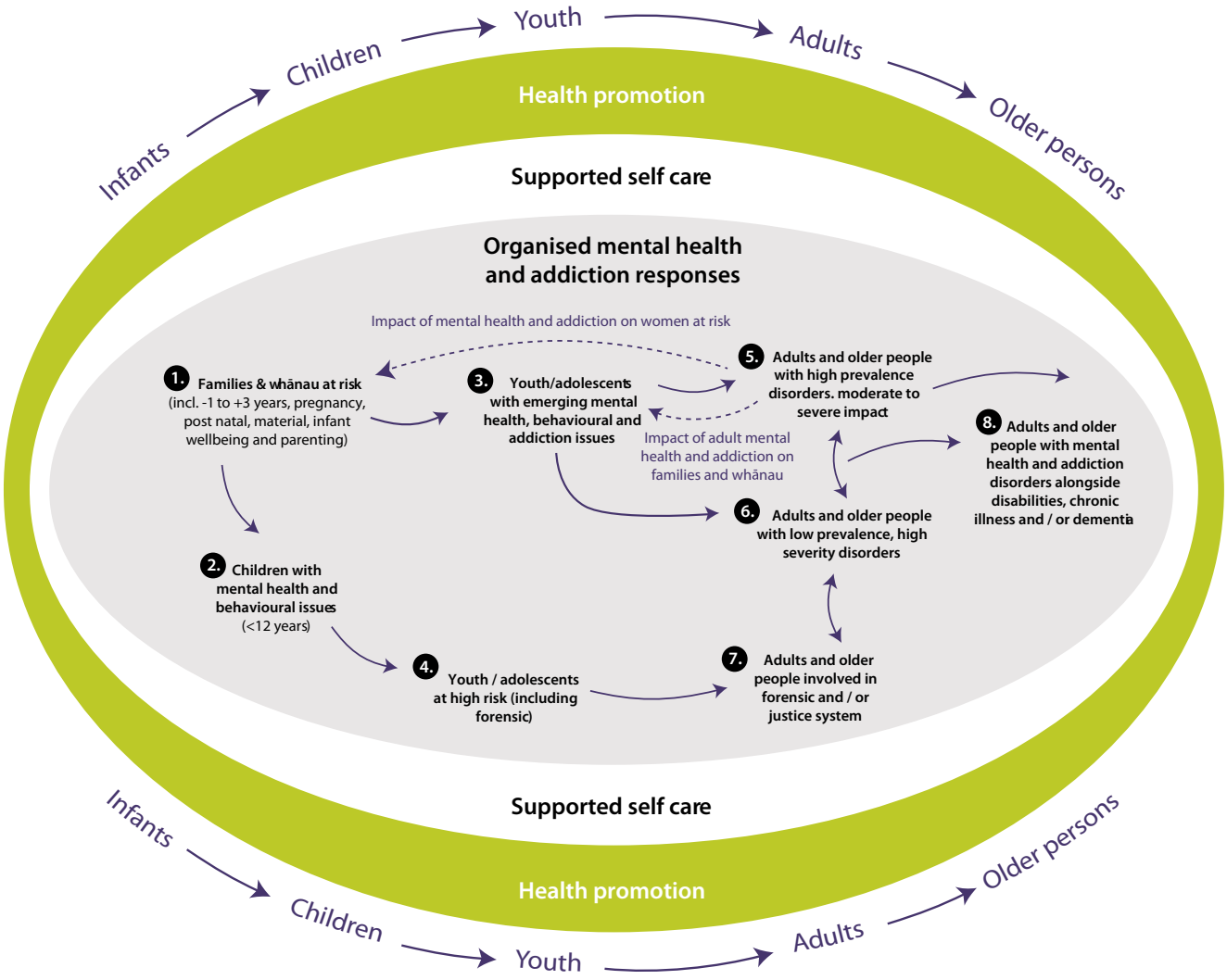
6 Prime Minister's Chief Science Advisor. 2011. *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence.* Auckland: Office of the Prime Minister's Science Advisory Committee

New Zealand strategic plans and priorities

In June 2012 the Mental Health Commission published **Blueprint II**[7]: independent advice to Government that sets out a 10-year programme of sector development. Blueprint II introduced the "life course" approach (see figure 1), which covers the spectrum of developmental stages and promotes early intervention in both the onset and recurrence of mental illness and addiction.

It also identifies eight priority actions, the first of which is "providing a good start"[8] by responding early to young populations in order to reduce the lifetime impacts of mental health and addiction issues.

Figure 1: The life course approach (taken from Mental Health Commission, 2012, p. 14)



7 Mental Health Commission. 2012. *Blueprint II: How things need to be.* Wellington: Mental Health Commission

8 *Ibid.* p. 7

Taking into account the advice in Blueprint II, the Ministry of Health released a service development plan, **"Rising to the Challenge"**[9], which sets out Government priorities and expectations for the mental health and addictions sector over a five-year period. A key policy direction is reprioritising investment within the existing funding to meet the needs of those most at risk, including children, young people and Māori. The expectation is that District Health Boards (DHBs) would provide kaupapa Māori services where needed.[10]

The **Prime Minister's Youth Mental Health Project**[11], led by the Ministry of Health, is a cross-agency initiative based around prevention, improving access to services and involving key people, including whānau, communities, schools, and health services. Other agencies are leading complementary projects. The Ministry of Education is working to improve the accessibility of alcohol and other drug (AOD) education in schools; the Ministry of Social Development is leading the development of social supports for young people, including youth "one-stop shops"; and Te Puni Kōkiri is leading the development of whānau ora programmes in the context of youth mental health.

The Youth Mental Health Project was born out of a report from the Prime Minister's Chief Science Advisor on the health and wellbeing of infants, children and young people in New Zealand.[12] The report adopted a prevention and early intervention focus. Given the high rates of suicide and psychological morbidity in New Zealand, the report recommended that priority be given to addressing this gap. The report also recommended that investment be targeted at improving educational achievement and supporting those areas where there was intergenerational disadvantage. Social investment in New Zealand needed to take account of evidence that prevention and intervention strategies implemented early in life were more effective at improving outcomes and economic returns over the life course than strategies applied later in life.[13]

Some of the other national responses include the **Drivers of Crime Project**, part of a whole-of-government approach to reduce offending, with a particular focus on improving outcomes for Māori. Drivers of Crime looks across the entire life course but has a particular focus on young people 10 to 19 years old. The Ministry of Health has asked workforce centres to scope and develop a project to strengthen the capacity and capability of the mental health and addictions workforce.

In 2013 Government provided $8m for a four-year programme to strengthen Māori and Pacific communities which have lost a family member to suicide. In February 2014 Rt Hon. Tariana Turia announced a $2m community fund Waka Hourua and new national suicide coordination centres. Developments are also occurring in youth forensics services with the Government in 2011 providing $33m over four years to improve early intervention and treatment services for youth offenders.

9 Ministry of Health. 2012. *Rising to the Challenge: The Mental Health and Addictions Service Development Plan 2012-2017*. Wellington: Ministry of Health

10 *Ibid*. p. 35

11 Ministry of Health. 2014b. *Youth Mental Health Project* [online]. Wellington: Ministry of Health. Available from http://www.health.govt.nz/our-work/mental-health-and-addictions/youth-mental-health-project [accessed April 2014]

12 Prime Minister's Chief Science Advisor. 2011. *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence.* Auckland: Office of the Prime Minister's Advisory Committee.

13 *Ibid*.

Māori health outcomes and socioeconomic factors

The discussion above sets out the strategic direction to intervene early in the life course, and to strengthen mental health and addiction support for young people. It also takes account of the need to direct services to areas with the greatest social and psychological need.

Evidence shows that Māori are the fastest growing young population in the country, live predominantly in poorer areas where there are significant and intergenerational social and economic challenges. Māori also experience a higher prevalence of mental illness and substance use. The early onset of many disorders among Māori suggests preventative early detection is needed. Reducing disparities between Māori and non-Māori is also a priority to enable rangatahi to flourish.

MĀORI

Population[14]

Make up **24%** of all 0–19 year olds

45% of Māori aged between 15 and 24 years

More likely to live in areas of greater deprivation than non-Māori

MĀORI EXPERIENCE OF

Mental illness[15]

3/5 Māori to experience mental illness at some point in their lives

90% higher rate of hospitalisation among 15–24 year olds compared to non-Māori

Disorders are common among women and rangatahi

Mental health and substance disorders commonly coexist

Higher rates of alcohol dependence than non-Māori

14 The Werry Centre. 2013. *2012 Stocktake of Infant, Child and Adolescent Mental Health and Alcohol and Other Drug Services in New Zealand*. Auckland: The Werry Centre for Child & Adolescent Mental Health Workforce Development, The University of Auckland

15 Baxter, J. 2008. *Māori Mental Health Needs Profile Summary: A Review of the Evidence*. Palmerston North: Te Rau Matatini

Families experiencing social inequality and deprivation are likely to experience higher rates of many childhood problems including childhood conduct problems. In addition, conduct disorders are more common among males, Māori, and young people and, based on evidence in the Christchurch longitudinal study, have long-term consequences[16]. Young people with significant conduct problems are at much greater risk of criminality and being imprisoned, substance use, mental health problems, suicidal ideation and attempts, and poor physical health[17].

With young Māori less likely to use mental health and addiction services than their non-Māori peers and most Māori accessing these services via General Practice, there is a need to focus on access to services and the development of primary care.

Suicide rates among young Māori are also comparatively high. **The Suicide Prevention Strategy 2006–2016**[19] and its subsequent action plan[20] emphasise building the evidence base around what works for Māori suicide prevention, engaging Māori communities in suicide prevention and addressing the impact of suicide on whānau, hapū and iwi.

MĀORI

Suicide rates[18]

About

1/2
of suicides among 10–14 year olds are Māori

1/3
of suicides by 15–24 year olds are Māori

Young Māori (especially males) over

2.4 times
more likely to die by suicide

Non-Māori youth suicides rates declined from 1995–2011 but Māori youth suicide rates had not

MĀORI

Access to services

Māori women under 20 years old and males under 15 years are less likely than non-Māori to use mental health service

Most Māori access mental health services through General Practice

16 Prime Minister's Chief Science Advisor. 2011. *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence.* Auckland: Office of the Prime Minister's Advisory Committee.

17 Parsonage, M., Khan, L. and Saunders, A. 2014. *Building a better future: The lifetime costs of childhood behavioural problems and the benefits of early intervention*. London: Centre for Mental Health

18 Ministry of Health. 2014a. Suicide Facts: *Deaths and intentional self-harm hospitalisations 2011. Wellington: Ministry of Health*

19 Associate Minister of Health. 2006. *The New Zealand Suicide Prevention Strategy 2006-2016.* Wellington: Ministry of Health, p. 1

20 Ministry of Health. 2013. *Suicide Prevention Action Plan 2013-2016.* Wellington: Ministry of Health

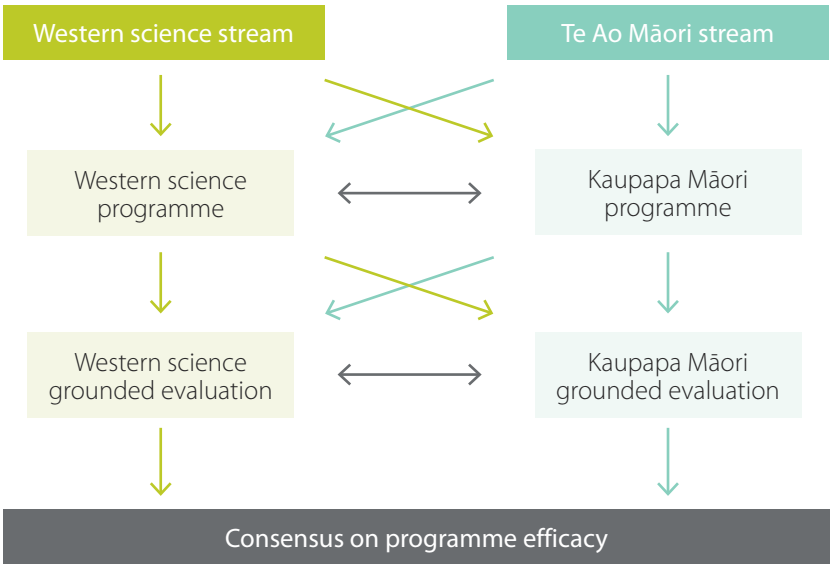
Whānau Ora: Māori health and wellbeing

Culturally competent services

Whānau ora is a Government policy direction[21] which takes a Māori approach to promoting the health and wellbeing of Māori communities. Whānau ora acknowledges the centrality of whānau to Māori social life and works collectively to build the capability of whānau to maintain their own wellbeing. Empowering whānau participation in services provides a solid platform to support positive rangatahi development.

The Chief Science Advisor's report states that the design, development and implementation of culturally-competent and responsive programmes require adoption of Māori concepts, values and world views.[22] Māori processes and practices should also be used to strengthen Māori identity and promote wellness alongside Western biomedical models of care. Kaupapa Māori services have an integral role in promoting wellbeing for Māori at a whānau and population level, and also ensuring that individual care fosters cultural identity. It is important that the relationship between kaupapa Māori and mainstream services is collaborative and partnership-based (see figure 2) to support recovery and resilience for rangatahi.

Figure 2: Parallel streams of Western science and kaupapa Māori development and evaluation (taken from Prime Minister's Chief Science Advisor, 2011, p. 295)



Ko Te Pā Harakeke

A metaphor representing the whānau (family)

21 Te Puni Kōkiri. 2014. *Whānau Ora* [online]. Wellington: Te Puni Kōkiri. Available from http://www.tpk.govt.nz/en/in-focus/whanau-ora/ [accessed 23 April 2014]

22 Prime Minister's Chief Science Advisor. 2011. *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence.* Auckland: Office of the Prime Minister's Advisory Committee.

Above L–R: Hori Kingi (Cultural Advisor), Eugene Davis (Manager Te Ahurei A Rangatahi), Ana Sokratov (Project Lead and Consumer Consultant), Emanuel Cullingford (Kaimahi Te Auhurei)

Whānau resilience

Blueprint II defines resilience as "the capacity of individuals to cope well under adversity".[23] One of the fundamental building blocks of resilience is supportive relationships. Programmes that support the development of new skills and positive relationships, and that build a strong sense of cultural identity can improve outcomes for rangatahi. These programmes are most successful when they also take account of whānau and community support structures. Evidence shows that the most appropriate rangatahi support services, from the perspectives of both rangatahi and whānau, involve them as partners in service design and delivery.[24] [25] The process for engagement must be clinically and culturally appropriate. Having a strong Māori workforce certainly makes this easier, although mainstream services and non-Māori workers still have a responsibility to ensure their own cultural competence. This includes drawing on Māori models of care and cultural practices such as pōwhiri and whanaungatanga and providing a rangatahi and whānau-friendly environment to support trusting and therapeutic relationships.

23 Mental Health Commission. 2012. *Blueprint II: How things need to be.* Wellington: Mental Health Commission

24 McClintock, K., Moeke-Maxwell, T., and Mellsop, G. 2011. Appropriate Child and Adolescent Mental Health Service (CAMHS): Māori Caregiver's Perspectives. *A Journal of Aboriginal and Indigenous Community Health*, 9 (2), 387-398

25 McClintock, K., Tauroa, R., and Mellsop, G. 2013. Te Tomo Mai. Appropriate Child and Adolescent Mental Health Service (CAMHS): Rangatahi (Youth) Perspectives. *A Journal of Aboriginal and Indigenous Community Health*, 11 (1), 125-131

Project outline

Aim

The project aimed to identify the success factors of services supporting improved outcomes for rangatahi, and share these throughout the sector. It also identified common challenges for rangatahi mental health and addiction services so that the Mental Health Commissioner (MHC) could advocate for necessary change on behalf of services.

Project team

The project team consisted of:

- Ana Sokratov, Consumer Consultant at Waitemata District Health Board and Board member of TRM
- Hori Kingi, Cultural Advisor and Senior Project Manager at TRM, and
- Jarrard O'Brien, Strategic Programme Manager for the MHC.

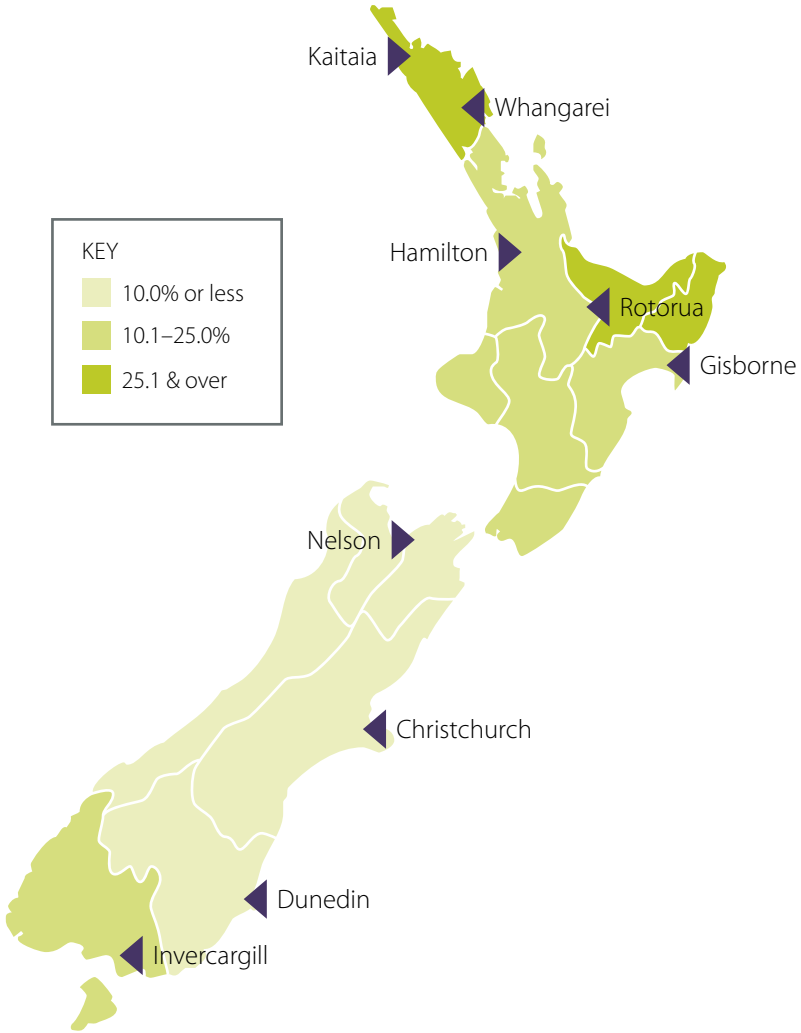
The composition of the project team was a critical consideration in ensuring that the process and resultant conclusions were meaningful and culturally relevant. The project was led by Ana, herself tangata whaiora, supported by Hori who was able to ensure the team navigated cultural pathways and processes during site visits. Jarrard provided administrative/project support and represented the Mental Health Commissioner.

Method

Services were identified through two mechanisms:

- looking at areas with the highest proportion of Māori population (see figure 3 on the next page)
- recommendation from sector networks, which identified services recognised as exemplars of good practice.

Figure 3: Areas visited displayed against Māori population map (adapted from Statistics New Zealand. 2013).[26]



The project team endeavoured to include a cross-section of the types of mental health and addiction services available to rangatahi, including DHB, Non-Government Organisations (NGOs), primary care services, mental health and addiction services (see table 1 on the next page).

26 Statistics New Zealand. 2013. *QuickStats About Māori* [online]. Wellington: Statistics New Zealand. Available from http://www.stats.govt.nz/Census/2006CensusHomePage/QuickStats/quickstats-about-a-subject/Maori/location-te-wahi.aspx [accessed 4 October 2013]

Table 1: Services that participated in the project

	Organisation/Service	Service Type	Location
1	Adventure Development Ltd	Community support NGO	Dunedin
2	Canterbury DHB CAFS	DHB child and family service	Christchurch
3	Gateway Housing Trust	Respite care NGO	Nelson
4	Hauora Waikato	Kaupapa Māori NGO	Hamilton
5	He Waka Tapu	Kaupapa Māori NGO	Christchurch
6	Mahitahi Trust	Kaupapa Māori mental health NGO	Auckland
7	Nelson Bays PHO	Primary care provider	Nelson
8	Nelson Marlborough DHB CAMHS	DHB child and adolescent mental health service	Nelson
9	Nelson Marlborough Youth AOD Service	DHB alcohol and drug service	Nelson
10	Ngāti Kōata	Kaupapa Māori NGO	Nelson
11	Purapura Whetu Trust	Kaupapa Māori mental health NGO	Christchurch
12	Southern DHB CAFMHS	DHB child, adolescent and family mental health service	Dunedin
13	Tairawhiti DHB CAMHS	DHB child and adolescent mental health service	Gisborne
14	Te Ahurei a Rangatahi	Kaupapa Māori health promotion NGO	Hamilton
15	Te Korowai Atawhai	DHB Māori mental health service	Christchurch
16	Te Korowai Hou Ora	Kaupapa Māori mental health NGO	Invercargill
17	Te Oranga Tonu Tanga	DHB Māori health service	Dunedin
18	Te Roopu Kimiora Kaitaia	DHB child and adolescent mental health service	Kaitaia
19	Te Roopu Kimiora Whangarei	DHB child and adolescent mental health service	Whangarei
20	Te Utuhina Manaakitanga Trust	Kaupapa Māori alcohol and drug NGO	Rotorua
21	Youth Horizons	Mental health NGO	Auckland

The project involved visiting (or conducting phone interviews in three cases) a range of services. A template question set was developed (see Appendix 1) to facilitate discussion around five key themes:

1. Service type and socio-demographics
2. Service delivery model (including strengths)
3. Workforce
4. Sustainability, and
5. Challenges

Visits generally lasted around two hours and several services supplemented the discussion with written documents and reports.

Attendance varied between services but included meeting with at least the leadership team and, in most cases, a broader range of staff. Several visits included meeting with tangata whaiora and whānau.

After all site visits were complete templates were used to conduct a thematic analysis of service strengths and common challenges. The results are discussed in the following sections.

Service strengths

The following discussion describes the key strengths identified as facilitating positive outcomes for rangatahi.

Access to appropriate services

Most services had implemented a version of the Choice and Partnership Approach (CAPA), which had increased access and improved the use of resources, especially where those resources were limited. Having a single point of entry was also reported to have had a significant impact on increased access to the appropriate services, particularly in support of early intervention. At the time of the project team visit (in 2013), Hauora Waikato reported only one suicide since 2009, which they believed was due to improved access through their single point of entry.

'single point of entry'

Service philosophy/model based on Māori values

The majority of services incorporated Māori values into their service philosophy and delivery. Unsurprisingly, this was most evident in kaupapa Māori services, which operated from a completely Māori paradigm. However many mainstream services also made significant efforts to incorporate a bicultural framework. This included using Māori cultural processes such as pōwhiri and whānaungatanga, karakia, and waiata as well as working to strengthen the cultural competence of their workforce. Nelson Bays Primary Health Organisation (PHO), a mainstream primary health provider, was developing their cultural responsiveness at all levels of the organisation. At the time of the project team visit (in 2014), they had signed a Memorandum of Understanding with the local iwi and had appointed a cultural advisor.

'cultural resonance, trust'

Incorporation of Māori cultural models and practices was a key strength in building relationships with Māori. Indeed, trust and relationships were identified as of fundamental importance by participating services and the consumers and whānau who provided feedback throughout this project. Rangatahi and their whānau needed time to gain trust and confidence in services which was often facilitated by use of Māori processes and philosophies. Kaumātua and kuia also played an important role. The Child and Adolescent Mental Health Service at Tairawhiti District Health Board ensured that kaumātua and/or kuia were available at initial meetings between clinical staff and rangatahi to help build supportive relationships, which ultimately improve outcomes for rangatahi.

Engagement with rangatahi

Successful engagement with rangatahi is critical to improving outcomes. Many strategies were employed including taking services to rangatahi outside of traditional care settings in locations that were accessible and rangatahi-focussed. Networking through youth forums was a successful way of connecting with rangatahi while offering activities such as kapa haka, waka ama, other sports, arts, and practical life skills helped keep them engaged and build their strengths. Allowing for and supporting rangatahi and whānau choice also helped maintain engagement in services, as did matching case workers to individuals, allowing rangatahi and their whānau to build rapport and supportive relationships.

'going, being, doing rangatahi'

Peer support was a notable strength and several services operated a tuakana/teina (older sibling/younger sibling) model, whereby rangatahi using services were coached to take on peer support roles and support new people coming into the service. Not only was rangatahi peer support achieving positive outcomes for those in services, but the peer supporters themselves found it enhanced their own recovery and resilience.

Whānau engagement/inclusion

All services operated a whānau-inclusive model and were passionate about involving whānau wherever possible, motivated by a holistic understanding that supportive social networks were critical to the recovery and resilience of rangatahi.

Whānau inclusion took multiple forms but generally involved services making efforts to engage with whānau in their own environments and on their terms. This was made easier in cases where Māori workforce was available to build relationships between rangatahi, their whānau, and clinical services. The use of a whānau ora approach was ubiquitous and many services worked with whānau to identify the factors affecting the group more widely, and to set collective goals. Te Korowai Hou Ora in Invercargill was developing a whānau ora assessment tool to determine the non-clinical factors impacting on rangatahi and whānau wellbeing.

'with and within whānau'

Whānau ora was noted by all services as being critical to achieving positive outcomes for rangatahi, although whānau support most often had to be provided over and above contracted services. Mahitahi Trust in South Auckland was the only example of a service funded to provide support to rangatahi, and independent support for whānau – which community feedback saw as a 'necessary and excellent' service model. Youth Horizons offered a combined model of rangatahi/whānau support as part of their intensive treatment programme for rangatahi with conduct disorders.

There was also high value in having a strong Māori workforce to engage with the community in culturally appropriate ways.

It was often reported during visits, that parenting programmes were successful in engaging whānau and improving outcomes for rangatahi. One mother said that while she was initially reticent when invited to participate in a parenting programme, it had helped her to communicate better with her daughter.

Community involvement and collaboration

A number of services mentioned the value of being part of their community. A focus on community involvement and cross-agency collaboration situated services in a wider social network, allowing them to maximise their reach and capacity, while aligning themselves and better coordinating with other supports for rangatahi. This included involvement in sporting and other recreational events where the presence of mental health and addiction services could be normalised and promoted in a context familiar to rangatahi. All services had close links with local schools, (including kura kaupapa and alternative education) and many were working to strengthen links to the youth justice system to promote early intervention and keep rangatahi out of the justice system and in education. Rubicon, an alcohol and other drug (AOD) service in Northland, was noted to have successfully supported the majority of rangatahi using the service to remain in school.

'presence with people'

All services were involved in inter/intra-sectorial networks to facilitate a holistic approach to supporting rangatahi. Te Roopu Kimiora in Kaitaia, for example, showed leadership by bringing together local agencies and businesses to look at sustainable solutions for their community.

Some services were making effective use of social media such as Facebook to communicate with and engage rangatahi. He Waka Tapu in Christchurch, for example, had developed their own online forum, through which rangatahi could network with their peers and support one another.

Workforce

All services noted their workforce as critical to success and had a strong desire to continue to support and develop staff. It was evident that the workforce throughout the country was committed to making a difference for rangatahi, often with very little resource. Visibility in the community was a key workforce strength. As part of their communities, staff understood the socio-economic and cultural dynamics of their areas.

'full heart, full service'

Training and development was a constant focus with services, making the most of available resources and finding innovative ways to maximise opportunities. These included pooling resources and opening training up to other local organisations or utilising online training and development resources. Service managers were supportive of staff enrolling in higher education and, at a minimum, provided support in terms of time and supervision. Staff were encouraged to apply to scholarships and the link to the Te Rau Matatini scholarship programme was promoted.

All services reported that their workforce was well educated, professionally and culturally competent, and worked with compassion and integrity. There were many dynamic teams which came up with creative and innovative ways to engage and support rangatahi with the resources available to them. Many services had strong Māori leadership and a focus on rangatahi development. Te Ahurei a Rangatahi, a kaupapa Māori health promotion agency in Hamilton, employed rangatahi as peer supporters and health promoters. Their service portfolio evolved according to the skills of the workforce, for example, at the time of the project teams visits, Te Ahurei a Rangatahi had implemented a hip-hop dance group as a forum to provide peer support and education.

Many other services ensured that rangatahi were an integral part of the workforce. For example, the Canterbury District Health Board Child and Family Service employed youth and family advisors who informed all policy decisions and were involved in the appointment of all staff.

Discharge/relapse prevention planning

'empowering the future'

Services generally worked with rangatahi and whānau to plan exit strategies from the services. The common approach was goals-focussed and supported rangatahi to identify and develop their strengths. Discharge from services was in line with the CAPA model of "visiting with a purpose" although many services operated an 'open door' policy so that rangatahi and their whānau had a point of contact should they need reassurance or additional support in future.

Common challenges

The following discussion describes the common challenges faced by rangatahi services, as a basis for informing systemic advocacy activities in these areas.

Clinical presentation/complexity

All services reported increasing levels of complexity within their rangatahi populations and their whānau. Issues included rangatahi with coexisting problems (e.g. attention deficit hyperactivity disorder, obsessive-compulsive disorder, post traumatic stress disorder, depression, anxiety, self-harm etc.) leading to high and complex needs. There was a notable increase in substance use (particularly alcohol, cannabis and 'legal highs'), violence, abuse (physical and sexual), neglect, challenges at home and/or school, and issues around self-esteem and confidence. The increase in cyber-bullying (e.g. through Facebook) was noted on several occasions. These problems were compounded by intergenerational socio-economic factors such as poverty, poor housing, and truancy. Many services, particularly those in rural areas, mentioned a general lack of community activities for rangatahi, which was thought to lead to boredom and increased risk of drug and alcohol use. Increasing complexity put pressure on the capacity of services to respond appropriately and many services reported a level of unmet need in their communities.

Other areas that were reported as needing additional focus or resourcing were:

- Primary mental health and AOD services for rangatahi,
- Respite services for rangatahi,
- After-hours CAMHS support, which often had to be provided by adult mental health teams,
- Forensic services for rangatahi in youth justice settings,
- Support for rangatahi with coexisting mental health problems and/or substance use, and intellectual disability,
- Rangatahi and whānau participation in the planning and delivery of services, and
- Inter-agency collaboration to find sustainable solutions to socioeconomic and intergenerational factors affecting rangatahi and whānau wellbeing.

Conduct disorder

Lack of support for rangatahi with conduct disorder was a universal concern. Many rangatahi had a conduct disorder diagnosis but funding models did not

enable access to services, especially specialist services, for support and interventions. Consequently these problems developed into more serious conduct disorders and escalating behaviours, which were not addressed until justice or other incidents occurred.

Contracts and funding models

All NGO services reported challenges around contracting frameworks and funding models. Most had multiple contracts with differing reporting structures which increased the administrative cost for contract maintenance. One service reported a threefold increase in compliance costs in the last four years.

The need to increase back-office functionality was heightened by the general move of funders to shorter-term contracts, generally for two to three years. Short-term contracts limited the ability of services to plan future growth and development, and increased the administrative costs of securing contracts. Several services mentioned that local and regional histories of collaboration and open communication were being undermined by a new ethos of competitive procurement.

Kaupapa Māori NGOs noted that there was a move away from contracting smaller, Māori-specific providers in favour of large mainstream NGOs and this was thought to have damaged the confidence in, and development of, kaupapa Māori services.

A key challenge to service provision noted by almost all services was an apparent inflexibility in the funding models attached to contracts. Services were intimately engaged with their local communities, and responded to need. Often this involved necessary work being undertaken over and above contracted services, such as health promotion and group education sessions, and whānau support. While staff continued to address the needs of their communities, there was risk to sustainability. Contract parameters created gaps in service provision, for example, by restricting availability and access to certain age groups.

Whānau engagement/inclusion

The main challenges to engaging whānau included logistical and economic factors, such as travel distances, costs to whānau of travelling and time away from work. Other factors included liaison with Work and Income New Zealand (WINZ) and issues around the cessation of benefits. These factors often made rangatahi a 'hard-to-reach' population, which was compounded when services failed to take adequate measures to build whānau engagement into their everyday service provision.

There were also significant social challenges, such as broken relationships or the parents of rangatahi themselves having mental health and addiction needs. The pressure on grandmothers caring for mokopuna was raised often.

In some cases 'nannies' had to come out of retirement and work to care for the whānau. Parenting courses were successful in strengthening communication and fostering positive relationships although it was noted that many parents who would benefit had no interest in attending parenting programmes.

Community involvement and collaboration

Services had a strong desire to work collaboratively in order to meet the needs of their communities, and to achieve the national goals for mental health and addictions service development. While there were many examples of successful communication between services, there were instances where relationships had become strained through a lack of open and transparent communication. There was a need for services to work together to ensure a seamless experience for rangatahi and whānau that moved between different services and organisations. This was particularly evident in the transition of rangatahi to adult services, which was identified as a significant challenge.

Good communication and collaboration was seen as pivotal to building rangatahi and whānau trust in services. Conversely, poor communication not only affected the reputation of services within communities (particularly Māori communities) but in doing so, created the risk of adverse outcomes.

One challenge resulted, in fact, from good collaboration between agencies. That was the response to high-risk, high-profile cases such as suicide clusters. The responses to these events could be overwhelming for rangatahi and their whānau. The need to provide a planned and measured approach to these events was highlighted, along with the need to fully engage local communities and take direction from them.

Workforce

The human resource across services was variable although there was a general concern around the difficulty recruiting appropriately trained staff to support rangatahi with mental health and addiction issues. In particular, there was a shortage of specialist psychiatrists and clinicians experienced in a CAMHS environment. Smaller services relied on a roster of clinical support from major centres. There was also a major shortage of a trained Māori workforce nationally, in terms of both clinical and cultural support. Māori health teams were often small and stretched across all mainstream services.

Although training and development was a constant focus for services, there were significant and persistent challenges to staff development due to the direct and associated costs of relevant training and development programmes. There were also concerns, particularly in rural areas, about a lack of necessary infrastructure to allow staff to fully undertake their roles, such as electronic records, mobile phones, video conferencing etc.

Recommendations – a way forward

Funding and planning

1. Prioritisation of funding and planning for rangatahi mental health and addiction services that foster growth and development in the sector is essential to improve access and outcomes. Funding of these services must accommodate responsiveness to, and engagement of rangatahi and whānau. Funding must take a long-term approach to enable sustainable growth.
2. Blueprint I[27] provides resource allocation for youth services that prioritises community-based services and services for Māori. This should include increasing the capacity of NGOs, particularly kaupapa Māori NGOs in the specialist area as well as improving access to early intervention through primary care, especially where psychological therapies are concerned. It may be useful to tag funding for support from primary care for rangatahi and whānau to improve access to psychological therapies and overcome cost barriers.
3. Increase the availability of parenting programmes that work for whānau and rangatahi who are parents, for example, Incredible Years and Triple P-Positive Parenting. The quality of parenting is a critical determinant of rangatahi health and social outcomes. Parenting programmes have proven to be successful in improving parent-child relations and providing parents with skills for managing behaviours[28].
4. Build the capacity and capability of funding and planning teams to strengthen links within the sector and between providers.
5. Adopt a life-course approach to funding for rangatahi and for consistency in contracting, and close the gaps in service provision due to differing age groups in provider contracts. For example, gaps in access to respite and acute residential alternatives and AOD services.
6. Adopt a more flexible funding model for contracting and reporting. The Ministry of Social Development, for example, has adopted a 'high-trust' model whereby providers who have well established accountability and reporting structures are given more flexible funding and reporting frameworks.

27 Mental Health Commission. 1998. *Blueprint for Mental Health Services in New Zealand: How things need to be*. Wellington: Mental Health Commission

28 Parsonage, M., Khan, L. and Saunders, A. 2014. *Building a better future: The lifetime costs of childhood behavioural problems and the benefits of early intervention*. London: Centre for Mental Health

Workforce

7. Services working with rangatahi and whānau must have a strong clinical and cultural foundation. Priority should be given to addressing youth workforce shortages to respond to the needs of rangatahi and whānau. Investment in the workforce should include peer roles.
8. Workforce centres must provide development and training solutions to increase competence in both clinical and cultural domains. It is clear that cultural processes enable rangatahi and whānau participation with services.
9. Professional bodies should also support clinical and cultural competency requirements in the workforce.

A model/philosophy for services for rangatahi

10. Promote a rangatahi development model at the primary care level whereby providers offer a range of services required for rangatahi development. This may include support for general health, mental health, addictions, and access to psychological therapies in primary care environments, as well as social supports needed to foster rangatahi wellbeing and development. Other options could be educational and vocational supports. Such services would be informed by rangatahi, be youth friendly, easily accessible and available in one place. The rangatahi development model fosters an environment where rangatahi and whānau choose to access services, rather than being forced to access services. The model has been endorsed through positive feedback from rangatahi and whānau.
11. Services must adopt an outward-looking approach in the sector and participate in community forums and networks to support the improved communication and linkages with other relevant services for their populations.
12. Increase accessibility of e-therapies and other self-help options that increase access and positive outcomes for rangatahi. For example, the award-winning SPARX[29] programme developed by The Werry Centre has been shown to be a successful tool for supporting rangatahi with depression.

Conduct disorder

13. It is clear that earlier intervention for rangatahi with conduct disorder could reduce the likelihood of higher needs and at risk behaviour for this group. Early access to psychological support and therapies would help to improve outcomes for rangatahi and reduce the long-term impacts (both individual and societal) of conduct disorder.
14. Enabling access and availability of psychological therapies or a rangatahi development model of service in primary care settings would address a significant need, reduce the need for more expensive services and interventions later in life, and make a positive difference in the life trajectory for rangatahi.

29 SPARX. 2014. *What is SPARX?* [online]. Auckland: University of Auckland. Available from https://www.sparx.org.nz/about [accessed May 2014]

References

Baxter, J. 2008. *Māori Mental Health Needs Profile Summary: A Review of the Evidence.* Palmerston North: Te Rau Matatini

Dunnachie, B. 2007. *Evidence-Based Age Appropriate Interventions: A Guide for Child and Adolescent Mental Health Services (CAMHS)*. Auckland: The Werry Centre

Mental Health Commission. 1998. *Blueprint for Mental Health Services in New Zealand: How things need to be*. Wellington: Mental Health Commission

Mental Health Commission. 2012. *Blueprint II: How things need to be.* Wellington: Mental Health Commission

Associate Minister of Health. 2006. *The New Zealand Suicide Prevention Strategy 2006-2016*. Wellington: Ministry of Health

McClintock, K., Moeke-Maxwell, T., and Mellsop, G. 2011. Appropriate Child and Adolescent Mental Health Service (CAMHS): Māori Caregiver's Perspectives. *A Journal of Aboriginal and Indigenous Community Health,* 9 (2), 387-398

McClintock, K., Tauroa, R., and Mellsop, G. 2013. Te Tomo Mai. Appropriate Child and Adolescent Mental Health Service (CAMHS): Rangatahi (Youth) Perspectives. *A Journal of Aboriginal and Indigenous Community Health*, 11 (1), 125-131

Ministry of Health. 2012. *Rising to the Challenge: The Mental Health and Addictions Service Development Plan 2012-2017*. Wellington: Ministry of Health

Ministry of Health. 2013. *Suicide Prevention Action Plan 2013-2016*. Wellington: Ministry of Health

Ministry of Health. 2014a. *Suicide Facts: Deaths and intentional self-harm hospitalisations 2011*. Wellington: Ministry of Health

Ministry of Health. 2014b. *Youth Mental Health Project* [online]. Wellington: Ministry of Health. Available from http://www.health.govt.nz/our-work/mental-health-and-addictions/youth-mental-health-project [accessed April 2014]

Parsonage, M., Khan, L. and Saunders, A. 2014. *Building a better future: The lifetime costs of childhood behavioural problems and the benefits of early intervention.* London: Centre for Mental Health

Pere, L.M. 2006. *Oho Mauri: Cultural Identity, Wellbeing, and Tāngata Whai Ora/ Motuhake*. PhD, Massey University

Prime Minister's Chief Science Advisor. 2011. *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence*. Auckland: Office of the Prime Minister's Science Advisory Committee

Sones, R., Hopkins, C., Manson, S., Watson R., Durie, M. & Naquin V. 2010. The Wharerata Declaration-the development of indigenous leaders in mental health. *The International Journal of Leadership in Public Services*, 6 (1), pp. 53-63

SPARX. 2014. *What is SPARX?* [online]. Auckland: University of Auckland. Available from https://www.sparx.org.nz/about [accessed May 2014]

Statistics New Zealand. 2013. *QuickStats About Māori* [online]. Wellington: Statistics New Zealand. Available from http://www.stats.govt.nz/Census/2006CensusHomePage/QuickStats/quickstats-about-a-subject/Maori/location-te-wahi.aspx [accessed 4 October 2013]

Te Puni Kōkiri. 2014. *Whānau Ora* [online]. Wellington: Te Puni Kōkiri. Available from http://www.tpk.govt.nz/en/in-focus/Whanau-ora/ [accessed 23 April 2014]

The Werry Centre. 2013. *2012 Stocktake of Infant, Child and Adolescent Mental Health and Alcohol and Other Drug Services in New Zealand*. Auckland: The Werry Centre for Child & Adolescent Mental Health Workforce Development, The University of Auckland

United Nations. 2007. *United Nations Declaration on the Rights of Indigenous Peoples* [online]. Available from http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf [accessed 24 April 2014]

United Nations. 2014. *Children's Rights* [online]. New York: United Nations Convention on the Rights of the Child. Available from http://www.un.org/cyberschoolbus/treaties/child.asp [accessed 23 April 2014]

Appendix 1: Rangatahi Project Site Visit Question Template

Socio-demographics
Service Type
Population (numbers & age range)
Ethnicity
Service capacity
Clinical presentation/complexity
Service Delivery
Services provided
Service promotion
Criteria for access
Service philosophy/kaupapa
Service model (Te Whare Tapa Wha etc)
Incorporation of cultural processes
Whānau engagement/participation
Other features
Outcomes
What are the strengths of the service
Example of engaging rangatahi
Workforce
Composition/skill-mix
Strengths of workforce
Training/professional development
Capacity/capability issues
Sustainability
Funding sources
Contract lengths
Ability of service to meet need
Infrastructure (IT etc.)
Governance
Links to other organisations
Comments