Te Pōkai Tara
Universities
New Zealand

Universities New Zealand Submission into the Government Inquiry into Mental Health and Addiction

June 2018

Introduction

This submission is on behalf of all New Zealand universities:

- The University of Auckland
- Auckland University of Technology
- The University of Waikato
- Massey University
- Victoria University of Wellington
- Lincoln University
- University of Canterbury
- University of Otago

New Zealand has an obligation to follow the World Health Organization (WHO) Mental Health Action Plan set out for 2013-2020: The objectives are to:

- strengthen effective leadership and governance for mental health
- provide a comprehensive and integrated response to mental health and social care services in community-based settings
- implement strategies for increasing mental fitness and decreasing or relieving mental distress
- strengthen information systems, evidence and research for mental health.

Within universities, University Health Services are primary health providers that are partly funded by government (and heavily subsidised by universities) and therefore have obligations to provide treatment to patients. University Counselling Services are 100% funded by the university and provisioned as part of the wider university ecosystem of ensuring student academic success. Both are involved in student mental health.

The key points made in this submission are both issues and opportunities for improvement. They are:

1. the recognition of mental health as a **public health** and **society-wide issue**
2. the need for more **clarity of service delivery models** and **investment by government in partnership with education providers** into:
    a. prevention and early-intervention
    b. reducing waiting times, particularly in relation to community services
    c. support for increased facilities and/or staff as appropriate within a framework with clearer service delivery models
    d. evaluating, capturing and sharing best practice (intervention logic)
    e. inter-operability and communications between agencies.
3. Ensure *Vote: Health* is adequately funded to sufficiently support mental health support for youth and adults, so that universities' funds for teaching and research are not side-tracked. Universities are education and research institutions. Noting universities are a microcosm of society, mental health is a public health issue. All NZ university health and counselling services experience unacceptably long waiting times for students in mental distress to access professional care.
4. Universities are education and research institutions. The **roles and responsibilities of universities** regarding mental health assessment, support and treatment require clearer definition, particularly considering the Health and Safety in the Workplace Act 2015. Similarly, health professionals across the

system need to understand that universities' health services staff are professionally competent, while also noting that universities are not a suitable substitute for publicly funded and well-resourced DHB and community mental health services.

5. **Transition from secondary education** (and the NCEA system) into university requires an integrated approach from all parties (government, health and education) to ensure student success. There is international evidence that the biggest barriers to tertiary students' academic success lie in the non-academic areas of personal, emotional and financial stress. Universities should, and do, provide pastoral and support services to address these issues. These are largely funded by compulsory student services levies and frequently provide health services that the primary health sector should fund.
6. There is a need for **more tailored support** to specifically strengthen the wellbeing of minority groups, such as LGBTQ+, Māori, Pasifika, refugees, students with disabilities, and some international groups, whose members may be more vulnerable to exclusion and the negative effects of prejudice on campuses.
7. Acknowledgement of the changing and complex demographics in university communities and the skills and competencies, particularly cultural, required by practitioners to operate effectively. **Bicultural competence and confidence** building needs to be part of any government and organisational strategy to address mental health.

Question 1: What is working well?

We know there are concerns with how we view mental health and addictions, promote mental wellbeing, and provide support and services to those who need it. We also know there are some good things already happening that could be supported and expanded. We want to hear about the good things currently happening.

What do you think is currently working well? Why do you think it is working well? Who is it working well for?

There are several aspects of the current community and university mental health services that are working well. Note however, these do not negate the issues raised in this submission, nor the opportunity for improvement.

Working well within universities:

- a student-centric approach to service design and provision
- the broad skill mix and integrated-holistic/multi-disciplinary provision of health services within a whole-of-wellbeing environment. In universities, this means health services' staff include medical practitioners, nurses, physiotherapists, dietician interns, counsellors, psychologists, psychotherapists and social workers, as well as academic and other advisory services and accommodation support
- a collaborative approach with counselling/dialogue and introduction of case reviews in complex cases where a treatment team has been involved
- the encouragement of self-help interventions
- active communication and the clarification of service expectations and responsibilities between groups / agencies /practitioners
- readily accessible on-campus services for students
- dedicated staff.

Working well within community services:

- continuity of care, for example, having a lead GP assigned with MedTech notes
- external referral services and resources e.g. 24x7 mental health phone lines, run nationally and locally by District Health Boards (DHBs); the Suicide Postvention service in Wellington (Regional Public Health), which is efficient and effective (it encourages and supports networking to prevent further fatalities); Lifeline; Mental Health Foundation
- increased awareness of mental health through high profile figures e.g. Sir John Kirwan/Mike King.
- victim support—free counselling for families affected by suicide.
- dedicated staff.

Question 2: What isn't working well at the moment?

We know that some things are not working so well at the moment. We want to hear what you think isn't working well, and where there might be gaps or problems — such as the underlying causes of the problems, unmet needs, the way services and support are delivered, the links between services, and the availability of services and resources.

What mental health and addiction needs are not currently being met? Who isn't receiving the support they need and why? What is not being done now that should be?

ROLES AND RESPONSIBILITIES

NZ universities are a unique and discrete education environment, targeting society's most vulnerable age group in terms of development.

Universities are not a suitable substitute for underfunded community mental health. Universities are education and research institutions whose role is to educate students. The role of support services is supporting students to study, persist and achieve their goals. While providing a duty of care and coordination, universities do not have a role as providers of specialist mental health services. Complex cases are not the universities' area of expertise, for example eating disorders, self-harm, ongoing suicide ideation and behaviour, complex post-traumatic stress disorder (PTSD), severe and chronic mental health issues. These need to be managed by external mental health services to free up short-term primary level intervention for less complex cases and to facilitate more expert care.

In particular, there are instances where specialist mental health services return students to the university and university halls of residence because universities offer a supportive environment and provide health and counselling services. University services are not specialist psychiatric services and the practice of returning students poses a risk to the student and the campus community. Further, it detracts from universities' ability to manage mild to moderate cases effectively and can have a significant impact on student academic performance and success, as well as exacerbating mental distress and mental health issues which could be mitigated or contained.

Under-resourced specialist services. Many of the specialist services, including secondary services, are under-resourced, with long wait-times and limited intervention options, and many specialist roles remain unfilled. This means that some people 'fall through the gaps' if they are not high enough acuity to be prioritised. In many of these situations, primary services often end up retaining and holding clients who are beyond the scope the service is designed to manage, negatively affecting wait times. Furthermore, the mental health and addiction (MH&A) sector can be difficult to navigate and engage with for clients who find it difficult to advocate for themselves, and for those who are unaware or misinformed about the range/costs of services available.

Health and Safety in the Workplace Act 2015. There is a lack of clarity and therefore associated risk, attached to obligations and liabilities of universities in relation to mental health, under the Health and Safety in the Workplace Act 2015.

AGENCY INTEROPERABILITY

Universities interact with multiple agencies and are a microcosm of wider society. There is a need:

- **to improve connectivity** between DHBs, university mental health services and other community providers of mental health and addiction services (clarify expectations, referral processes and funding of mental health support and service delivery models)
- to **break down the silos** in which many mental health and associated support agencies work. Communication between departments within DHBs is poor—universities often end up facilitating it. Communication from DHBs to universities in crisis situations often does not occur or is not timely. This is a safety issue; it leaves young people not as supported as they could be at a vulnerable time, when they may have made a suicide attempt or are contemplating one and need ongoing support. Escalation terminology is inconsistent, as is professional respect of universities' referral teams. In other words, when universities refer for help and advice, the matter is urgent; referral is done from a basis of professional expertise and urgency. This needs to be recognised.
- to recognise that while universities are skilled at identifying mental illness and suicidality, **formal diagnosis and treatment is not their role** as education and research institutions
- to improve liaison with individual care/support workers regarding clients—they do not make their direct contact details available.
- to improve feedback from community agencies, which can be slow or missing.
- to update technology. DHBs using faxing as a method of communication is outdated and a more efficient method could be implemented.
- for better education of the counselling and helping professions.

EXTENT OF SERVICE PROVISION

- There are differing understandings of the resourcing levels for community mental health psychology services (specifically to what extent they are funded to asses and treat).
- Police are often called in to a mental health crisis because there is not sufficient resource to bring in anyone else. While police often do a great job of handling these situations, it is not their area of expertise, so their intervention can be inconsistent.
- Community Mental Health teams are not resourced well enough in any area, including in-patient and respite beds. This results in undue risk associated with discharging people back to university care where 24x7 services, crisis service and psychiatrists are not present.
- More tailored support to specifically strengthen the wellbeing of minority groups, such as LGBTQ+, Māori, Pasifika, refugees, students with disabilities, and some international groups, whose members may be more vulnerable to exclusion and the negative effects of prejudice on campuses, and who are disproportionately represented in suicide statistics.
- University counsellors are not diagnosticians and are bound by ethical guidelines to work within their scope of practice. The support of DHB community mental health is therefore critical in assessing students and providing a treatment plan.

PROVISION OF SERVICES

There is inadequate provision or clarity of the service delivery model in four key areas:

1. Acute interventions
2. Interventions for mild-moderate issues on a timely basis (to prevent them becoming worse)
3. Targeted interventions for high risk groups e.g. Māori, Pasifika, LGBTQ+
4. Resilience education for all youth.

Specifically:

- Availability of private psychiatrists and appointments especially for international students
- Long waiting lists to see psychologists and counsellors in the community
- University health services' ethics and services are compromised by the wider mental health system when we refer people to the public services
- The lack of opportunities for ongoing support of young people, and the capacity to offer comprehensive therapeutic process to support them to move on in life
- A need for more services for young people—universal therapeutic services for those in need
- The lack of acknowledgment that students come to university with pre-existing conditions and, though tasked to support academic achievement, it is hard to distinguish between this and pre-existing conditions. Treatment should be paid from the public system, rather than through their fees and student loans.
- The three-month official follow-up time is unacceptably long.
- A lack of availability of moderate to severe services
- Limited access to psychiatrists nationwide
- Lack of community GPs.
- Lack of community-based services which offer no, or low-fee, services for students
- An inadequate number of services to refer students to, particularly in central city Auckland
- Families compensating for poor mental health services
- Inadequate inpatient care
- Acute Care Team (ACT) team, or Assertive Community Treatment teams (for more serious mental health issues needing consistent follow up in the community, are understaffed.
- No counselling services under the DHB/community mental health (CMH).

WAITING TIMES and PHYSICAL SPACES

Current **waiting times** for all MH&A clients are not acceptable. Waiting times for acute assessments and treatment are far too long. Examples include:

- seven-year waiting lists for assessment for Attention Deficit Hyperactivity Disorder—this prevents young people getting treatment when they are in the education system and therefore performing successfully.
- long waiting times for youth with gender dysphoria to be assessed and treated, resulting in severe depression and suicide attempts, directly impacting on their academic achievement.
- mental health clients waiting at the Emergency Department. The experience is variable, for example clients can wait as long as 8-10 hours. We can't be sure they are safe there and the experience is unnecessarily stressful.

There is inadequate **capacity and facilities** in community mental health services. For example:

- There are no spaces for mild-moderate level mental health issues. These issues do not meet the current threshold, so they either fall through gaps, or deteriorate to a point where recovery will be longer, more intense and more expensive.
- Psych wards are full, staff are demoralised and burnt out and they don't allow space for the very severe cases and less severe cases to be separated, thus less severe cases are often traumatised.
- There is a lack of respite facilities, and more spaces are required.

THE PROCESS OF ACCESSING SERVICES

Systemic issues require addressing. Specifically:

- ACC's therapy has a lengthy paperwork process and the waiting times for appointments with ACC registered psychologists can prove detrimental and cause of concern for young people. WINZ funding for mental health appointments has only a fixed amount reimbursed (not full cost) and is paid directly to clients, and could be paid to therapist directly
- Insurance cover /policies for international students with dual diagnosis are inadequate.

NZ CONTEXT

Addressing **practical issues related to poverty** (for example, the affordability of accommodation, financial support, travel costs) will address mental health issues in which poverty is a contributing factor.

Confronting the **lack of community-based services** in places such as central city Auckland will remove the need for universities to provide proxy support, and the subsequent impact on waiting lists and service capacity.

There is a need for improved support for students/youth at all levels to **develop resilience**. There also appears to be a greater gap in expectations between students coming from the NCEA system to more self-directed learning at university. Universities are working to address this, and many universities provide embedded health promotion and resilience education within this environment, but it is a national issue and requires a more integrated solution.

GOVERNMENT TARGETS FOR SERVICES

Government targets for mental health services have unrealistic goals for achieving assessment deadlines, which means assessment takes priority over treatment.

INTERVENTION LOGIC

Current **mental health support services are crisis-focused** rather than providing support to people who are gradually becoming unwell. Future work could include psychoeducation around early warning signs of deteriorating mental health as well as provision of a service for people who are not yet in crisis, but who will likely end up in crisis if left without support or intervention.

Currently the wider mental health system does no prevention work, or even support work, unless the case is severe, but provides lots of 'bottom of the cliff' work (i.e. reactive rather than preventative).

The dominant system bias is towards a medical model of pathologising mental health, treatment and minimising symptoms; over a psychological and counselling services model which emphasises prevention and addressing underlying causes.

Models of care that place client and whanau at the centre are lacking—care is often institution led. There is little visible support for caregivers of the mentally ill and particularly of the seriously mentally ill.

'At-risk' criteria are inconsistent from agency to agency, for example, in Auckland community mental health insists that unless a student has a current plan, means to suicide, and immediate intent, the university is unable to access services other than one phone call from the crisis team to the student.

There is an acknowledged increase in numbers seeking help for mental distress/health issues. More research is needed to validate the apparent increase in numbers and determine why. Similarly, resourcing is required to evaluate what works—and what doesn't and why—to establish best practice. There is a lack of evidence-based standard operating procedures to effectively identify and treat those at higher risks of developing mental health issues

UNDERLYING CAUSES OF THE PROBLEM

Mental health-related issues have grown significantly in the last five years, possibly in relation to increased population, among other factors. There is a noticeable increase in anxiety disorders, insomnia and depression. Underlying causes include:

- **Drug use:** marijuana is widely seen (in some quarters) as a drug without long-term harms. (See Christchurch Longitudinal Study for clear evidence of harms, especially when used under 18, association with use of other drugs, negative effect on educational achievement, increased likelihood of being on a benefit etc.) Education in schools, where drug habits are starting early, and further education at tertiary level is needed. Increasing ease of availability of other drugs such as Ecstasy has seen growing use on campus. Education linked to meaningful outcomes in youth is much needed in this area also.
- **Alcohol misuse** and related harms remain consistent and highly prevalent. Experience suggests this is starting in secondary school, but it is being treated at the tertiary level where it is strongly linked with poor educational outcomes and high mental health needs. The problem of addiction and abuse of alcohol is compounded exponentially by the open access to alcohol at tertiary level and the high levels of intake/heavy drinking culture. We have been involved in educational programmes of our RAs (residential assistants) around alcohol and drug harm reduction, suicide awareness and sexual assault reduction.
- There is increased awareness and reporting of **sexual assault** particularly with alcohol involved. The experience of sexual assault and harassment is strongly linked to negative mental health and educational outcomes including cessation of current tertiary education. It is apparent that for many young people even a basic 3C approach to healthy sexual relationships (i.e., Caring, Consensual, Contraception) is not present.
- There is less down time due to **technology**; loss of diurnal rhythm and loss of **sleep** are known risk factors for the development of mental health disorders and are increasingly prevalent in a world which is connected 24 hours a day. Resourcing from student health services to students in this area is significant; sleep education is a part of consultations by all practitioners every day.

- The increasing trend toward **deliberate self-harm** (DSH) as a strategy for reducing overwhelming anxiety. Usually separate from suicidal ideation but sometimes overlapping if the mental health problem escalates, DSH is often dismissed by community mental health crisis teams as not mental health related, at the risk of escalation to more serious mental distress, suicide related harm or suicide
- Legislation and awareness of the Rainbow community has increased. The number of gender diverse and transgender students seeking support for coming out, transitioning, or seeking reassignment surgery, has increased rapidly in the past decade. LGBTQ+ present significantly in statistics for alcohol and other drug misuse, homelessness, and as victims of harassment or violence. This places mental health at risk. LGBTQ+ are six times more likely to attempt suicide than any other group.

Overall the education of NZ youth about the risks and consequences of use of drugs, alcohol, technology and sexual activity needs to be improved before and during their transition to tertiary environments, where all these options are widespread.

Question 3: What could be done better?

You've told us what you think is working well, and what isn't working well. In this section we want to hear what you think would make the biggest difference to improve and transform mental health and addiction outcomes in New Zealand. This might include your ideas about how to prevent people from developing mental health or addiction problems, as well as ideas about how to improve the support and treatment given to those who need it.

Your ideas might be focused on specific communities or groups of people, or more general views about what could be done better. We want to hear all ideas — big or small, specific or broad, innovative and new, or building on something that is already happening.

What are your ideas about what could be done better or differently to improve mental health and wellbeing in New Zealand? What could be done better or differently to prevent addiction from occurring? What could be done better or differently to prevent people taking their own lives and support those affected by suicide? How could support be better provided to those who need it? What could be done better?

1. The need for more **clarity of service delivery models and investment by government in partnership with education providers** into:
    a. prevention and early intervention (for example domestic violence child protection, trauma and addiction, funding birth control) programmes, particularly for organisations with a high proportion of young people (e.g. schools, universities, polytechnics)
    b. improving interventions including reducing waiting times, particularly for those with "mild" acuity
    c. support for increased facilities and/or staff as appropriate within a framework with clearer service delivery models
    d. evaluating, capturing and sharing best practice (intervention logic)
    e. inter-operability and communications between agencies
    f. rehabilitation for drugs and alcohol-related mental health
    g. reinstate (at least) six free counselling sessions prescribed by GPs for a larger bracket of society
    h. training medical practitioners to improve mental health assessment, diagnosis, referral and risk assessment skills
    i. providing free psychological assessments for gender diverse and transgender people who are seeking sex reassignment surgeries
    j. increasing the number of sex reassignment surgeries within NZ
    k. resourcing the Rainbow community organisations to provide mental health and counselling support.

2. Ensure *Vote: Health* is sufficiently funded to sufficiently support mental health so that universities' funds for teaching and research are not side-tracked. Universities are education institutions whose focus must be on academic achievement rather than mental health services per se. Mental health is a public health issue.

3. More clearly define the **roles and responsibilities of universities** regarding mental health assessment, support and treatment, particularly considering the Health and Safety in the Workplace Act 2015. Similarly, health professionals across the system need to understand universities are not a suitable proxy in the face of publicly underfunded and under-resourced DHB and community services.

4. **Transition from the NCEA** system into university learning requires an integrated approach from all parties (government, health and education).

5. More **support tailored to particularly vulnerable** groups (and families) in society:
    a. In university environments this includes LGBTQ+ Māori and Pasifika, refugee students and students with disabilities. Higher numbers of Māori and Pasifika students are the first in their whanau to study at university, and they comment that whanau often do not know what they need, to be supported in their studies
    b. In wider society, this tailored support includes ongoing access to Asian mental health services.
    c. Greater outreach to Māori iwi and Māori organisations to educate about suicide and to support culturally appropriate initiatives for prevention and treatment

6. **Facilities** that are appropriate, including:
    a. facilities that reflect reworked service delivery models and are conducive to whole-of-being health, including respite beds, facilities for visiting families, open spaces
    b. Mental Health ER for crisis situations, rather than regular ER Departments
    c. mental health practitioners at universities, funded by government and based in counselling services, not medical. PHO-funded staff are often fully utilised in medical teams and not available for counselling services support.

7. Focus on **inter-agency operability** to overcome silos between services, including built-in system for psychiatrists supporting GPs.

8. Promote **non-medical therapies** (alongside prescription or pharmaceuticals) for mental health, for example, talking therapies, exercise as medicine, nutritional approaches, support groups.

9. Grow **community awareness** of mental distress, health and mental wellbeing so the broader population understands better and knows how to support people.

10. Increase suicidal students' recognition, connection and engagement with services and treatment. Increasing this awareness on campus and in rural communities is essential to reduce the isolation of young rural men and their risk of suicide. Increased depth and understanding of how to engage and positively support a suicidal person is essential across all communities.

11. Move in focus toward **awareness, prevention early intervention, and wellness** in service provision and a holistic view of health.

12. Mental health of youth needs to focus both on negative and positive health outcomes and initiatives. Positive mental health research gives clear evidence-based direction for increasing mental wellbeing.[i]

13. Positive Youth Development is an excellent framework for increasing resiliency and mental fitness in this age group. It focuses on growing the 7Cs of connection, confidence, competence, control, coping, character and contribution, which are evidence-based interventions for increasing resilience in young people.[ii]

14. Positive Education New Zealand is a growing movement bringing wellbeing to life in educational institutions using positive psychology and brain science and elements of mindfulness. At the April 2018 conference, case studies of educational institutions were presented where Positive Education programmes had made significant differences in a number of critical areas such as decrease in bullying and increase in resilience, social connection and tolerance and academic success.[iii] These programmes evaluate and demonstrate positive outcomes for students and staff when there is institution wide application including work for staff on their own wellbeing, with a well-documented flow on effect on the health, wellbeing, and educational engagement and achievement of students.[iv]

15. Small-group workshops with meaningful outcomes for youth are an effective way to reduce harms in the areas of alcohol, suicide awareness, drug use and consent, but they require resourcing beyond the current level to be effective. Programmes like these are used by the NZ Army and universities internationally (see Healthy Universities UK).

16. Strengthen ACC processes and increase the number of providers of ACC counselling for sexual assault cases.

Question 4: From your point of view, what sort of society would be best for the mental health of all our people?

We want to hear what your ideal, healthy New Zealand would look like. What would be the foundations, principles or values that would support positive mental wellbeing for all New Zealanders, and how we might best assist those who need help.

Envision how you could refresh how the system in Aotearoa promotes positive mental wellbeing, and prevents, identifies and responds to mental health and addiction challenges, including suicide.

What would a refreshed system look like, how would it be different from what we have today, where would you start, and where would you focus your efforts?

What this requires is:

1. a holistic vision of physical, mental, social and spiritual wellbeing
2. clarity in responsibilities, processes, systems and funding between universities and DHBs in relation to acute cases, most notably suicide ideation—within six months
3. confirmation of evidence-based intervention models and services available and accessible for mid-moderate mental health cases—within one year
4. an agreed collaborative approach to student groups at risk—Māori, Pasifika, LGBTQ+—within one year.
5. education at all levels to build resilience and coping mechanisms—starting 2019.

A society in which:

- diversity is acknowledged, accepted and embraced.
- stigma around mental health, including in workplaces, is decreased
- mental distress and mental health issues can be spoken about and where seeking help is normal
- workplaces where staff can identify mental distress and know what to do (mental health first aid)
- there is a holistic approach to health care and physical, mental, social and spiritual wellbeing
- Māori concepts of wellbeing and wellbeing through lifestyles are normal
- interventions are provided early on to avoid development of addictions, anxiety, depression and possibly suicide. Young people's resiliency to life's challenges are strengthened.
- It is not implied that services are under threat.

A society in which there is:

- increased social connectedness in communities
- knowledgeable and actively involved parents
- free of abuse, violence, and poverty
- tolerance of difference and respect for individuals
- social justice
- affordable and safe accommodation
- access to support without barriers.

Question 5: Is there anything else you want the Inquiry to know?

- 50% of lifetime mental illness starts by age 14.
- Improve strength-based focus coping skills for all primary and secondary school children. There is a good correlation between childhood trauma and poor coping /resiliency.
- Recognise that the predominant age range of university students is 18 to 25, which coincides with the life stage that significant mental health issues and illnesses are most likely to emerge. Going to university often occurs during the stage in a young person's life where their identity is being (further) developed. Many students are living away from home for the first time. They have access to alcohol and other substances, and do not have the support and guidance of their family. They are attempting to find and fit into a new social group and often they lack the skills to deal with their new environment. Early and timely intervention for mental health presentations amongst young adults is widely recognised as highly evidenced in preventing ongoing mental disorder and associated life burden. This intervention should best take place to allow students to remain within their place of education and belonging and should help minimise interruption to their academic endeavours.
- Psychosocial resiliency. Students who arrive at university pre-disposed to mental illness or managing current diagnoses, need additional support to manage life changes and stress that impacts on their wellbeing. Many students are not equipped to deal with the significant changes in their lives at university. Secondary schools need to have trained mental health practitioners to educate students about managing stress, life changes, relationships, mental health, and equip them to be able to self-care. This preparation for university enables young people to be better resourced to cope and would provide a preventative measure for the mental health of young adults.
- For universities the issue is the **here-and-now tsunami of need that is not being met by providers of care.**

In a perfect world, NZ would have no unemployment; everyone would live in safe and comfortable homes, be actively engaged in lifetime education and physical activity, and nobody's lives would be blighted by drugs/alcohol/smoking.

We all look forward to a day when prevention reduces the need for mental health services.

So right now, what is required is coalface providers who:

- **make it easier and faster to identify when someone is facing mental health or addiction challenges and get them help more quickly.**
- **improve the quality of the support and interventions given to those who need it.**

[i] Drs Lucy Hone and Denise Quinlan, New Zealand institute of Wellbeing and Resilience

[ii] Brainwave Trust Aotearoa Development of the Adolescent Brain Workshop Lincoln University 2017

[iii] Dr Paula Robinson, Positive Psychology Institute Sydney

[iv] Prof Toni Noble, Institute for Positive Psychology and Education, Sydney