Te Hiringa Mahara | Mental Health and Wellbeing Commission

Evidence Brief: Effective early intervention and secondary prevention approaches for young people experiencing early signs of distress

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This evidence brief presents key findings from a review of research examining effectiveness of early intervention and secondary prevention* approaches for young people aged 12 to 24 years old who experience early signs of distress.

Why this is important:

In Aotearoa New Zealand, distress among young people has increased sharply over the past decade. The research is clear that supporting young people earlier, before distress escalates, can reduce the long-term impacts on their wellbeing, education, employment, and their family. Strengthening prevention and early intervention is a current government mental health priority. This evidence brief provides evidence and insights of effectiveness to inform decisions and investment.

In 2024/25, among young people aged 15 to 24 years:

Source: New Zealand Health Survey, 2025, Ministry of Health[1]

What this review adds:

Young people have told us they need options. This review shows a range of approaches are effective in reducing psychological distress and supporting good mental health and wellbeing, demonstrating the value of investing in a range of services and supports, including light-touch and online options.

Young people have also told us they want their voices heard. This review shows that co-design with youth is a critical driver of effectiveness. Youth co-design should be a minimum standard for service design and evaluation.

* Secondary prevention seeks to reduce the impact of distress or addiction once it is already present. This differs to primary prevention which takes a whole of population focus and aims to prevent distress *before* it occurs.

Introduction

Adolescence and young adulthood is a critical period for development of mental health and wellbeing. Distress in adolescence increases the risk of experiencing one or more mental health conditions later in adulthood.[2]

Early intervention and secondary prevention approaches (e.g. programmes and services) can reduce distress, and have been shown to be effective for helping reduce early signs of distress developing into poorer mental health or diagnosable mental health conditions.[3,4]

Early intervention and secondary prevention programmes and services are increasingly being designed specifically with and for young people to fill a gap in need and help smooth the transition between paediatric and adult services. Research shows that services need to be flexible, targeted towards the individual and whānau, and recognise the broader factors that shape mental health, such as socioeconomic and environmental factors.[5,6]

Context and scope

There are many programmes and services in New Zealand and internationally that provide early intervention and secondary prevention, including Youth One Stop Shops and the Youth Access and Choice Programme. Only programmes and services that had published evidence of effectiveness in improving mental health outcomes for young people experiencing early signs of distress were included in this review.

Programmes and services included were those that had been evaluated in the last 10 years, and where the studies examined whether supports improved distress, anxiety or depressive symptoms, among young people aged 12 to 24 years who were experiencing early signs of mental distress and/or problematic substance use. In total, 20 studies of 16 interventions were identified that met these criteria.

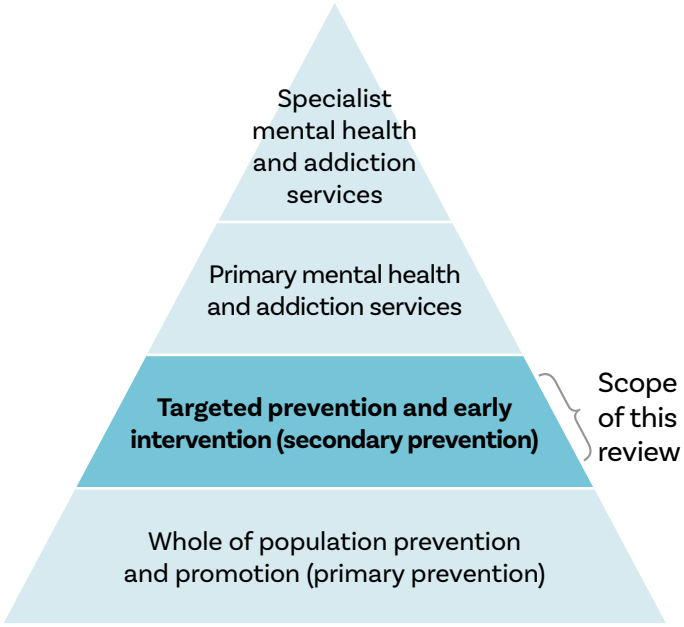

Figure 1. Figure showing the levels of support from primary prevention to specialist mental health and addiction services.

What is early intervention?

Early intervention is programmes and services provided when early signs or emerging mental health needs first appear.

These supports aim to prevent mental health conditions from getting worse, as well as promote recovery and wellbeing.

An example of early intervention included in this review are headspace 'one-stop shops' (Australia).

What is secondary prevention?

Secondary prevention is programmes and services for people who are already experiencing distress or early mental health symptoms.

These supports are designed to lower levels of distress, prevent those symptoms from becoming persistent, and stop them from progressing to more serious mental health conditions.

An example of secondary prevention included in this review is the Jigsaw Brief Therapy Clinic (Ireland).

Effective programmes share common characteristics

Although there was diversity in the types of early intervention and secondary prevention programmes and services evaluated, there were commonalities across them that were essential to reducing distress and improving mental health and wellbeing outcomes.

Sustained engagement	Sustained engagement is a critical enabler of effective service design. Evaluations found that young people who attended more sessions or completed more content experienced better mental health and wellbeing.
Accessibility and acceptability	Accessibility and acceptability of supports were important drivers of engagement. This included reducing barriers to entry by allowing self-referral, offering rapid assessment, providing flexible delivery settings, and being free. Making services accessible, youth-friendly, and acceptable to young people is a critical mechanism for generating meaningful improvements in mental health and wellbeing.
Co-design* with young people	Across the programmes reviewed, those that incorporated co-design with young people, particularly digital tools, tended to demonstrate stronger patterns of uptake and continued participation. Co-design influences more than satisfaction alone. It can shape whether young people remain engaged long enough to receive a meaningful intervention, which is critical for achieving mental health benefits. Embedding co-design as an ongoing process is particularly important given how rapidly young people's preferences, digital behaviours, and social contexts evolve. Continuous feedback loops and youth advisory processes can help programmes adapt over time, sustaining both relevance and impact.

Our review found that early intervention and secondary prevention programmes and services designed to support young people experiencing mild to moderate distress are often accessed by young people with higher levels of distress.

These services need effective pathways for referring young people to more intense supports when required. Many programmes purposefully incorporated processes to screen, identify, and refer young people to the right support for their needs.

* Co-design refers to a collaborative approach to developing services or programmes in which the people who are intended to use them partner in shaping the design, delivery, evaluation and refinement.

Indigenous and te ao Māori approaches

Indigenous and te ao Māori approaches recognise that mental health and wellbeing are shaped by culture, identity, whānau, and connection to community. Despite limited studies evaluating programmes and services aimed at indigenous young people and rangatahi Māori, the evidence examined in this review offered some key insights.

While we know from other research that culturally-grounded approaches are valued and engaging for indigenous young people, there is still relatively little evaluation evidence demonstrating their effectiveness for improving mental health outcomes among rangatahi Māori and other indigenous youth, early in the life course of distress and that met the scope of this review.

Within the scope of this review, few evaluations specifically examined programmes designed for indigenous young people or assessed whether culturally-grounded approaches produced stronger mental health outcomes compared with other models of secondary prevention and early intervention. Many studies included small samples, did not compare with other groups, or focused on implementation and acceptability rather than measurable mental health changes.

It is important to understand that a lack of published research evidence on effectiveness for rangatahi Māori or indigenous approaches does not mean that culturally grounded approaches are ineffective. There is a well-established body of kaupapa Māori research and evaluation that demonstrate effectiveness in a range of other settings and services. This is likely to be a reflection of structural issues and barriers for funded and published kaupapa Māori research and evaluation.

Strengthening evaluation capacity in this area, both in terms of resourcing evaluations alongside the development and initiation of early intervention services and investing in Kaupapa Māori researchers, is an important priority for understanding what works best for rangatahi Māori. Where indigenous-focused or culturally grounded approaches were described in the evaluations, some common design elements emerged.

Culturally adapted

Culturally adapted approaches emphasised designing services that reflect indigenous values, practices, and contexts. This included incorporating culturally meaningful activities, using local languages, and delivering services through visible community spaces rather than relying solely on clinic-based counselling. Indigenous young people emphasised the importance of relationship-based care that prioritised trust, consistency, confidentiality, and cultural safety.

These findings suggest that services that align with indigenous understandings of wellbeing, including community connection and culturally meaningful activities, improve the relevance and accessibility of early intervention supports for indigenous youth.

Co-designed

Co-design with indigenous young people emerged as an important element in developing services that are acceptable and engaging. Programmes that incorporated youth input into the design of content, delivery methods, and programme features often reported higher satisfaction and perceived relevance among participants. For example, digital mental health tools that were co-designed by rangatahi Māori received strong feedback from users, who highlighted the importance of cultural elements in shaping their experience of the intervention.

These findings suggest that co-design involving indigenous young people in the development and refinement of programmes ensures that services better reflect their needs and preferences, leading to better outcomes.

Decolonising

A decolonising approach to youth mental health services involves ensuring that indigenous voices, knowledge systems, and community priorities drive how services are designed and delivered. Examples in these evaluations of decolonishing elements included expanding mental health support beyond clinical therapy, as well as embedding indigenous perspectives into the programme design, including co-design with indigenous youth.

Broader implications of decolonising approaches call for community- and iwi-level leadership, as well as the continued development of Māori mental health practitioners. These approaches reflect a shift away from externally imposed models of care towards a recognition of indigenous definitions of wellbeing and hauora.

Key findings

This section covers different types of approaches and looks at the evidence for effectiveness of programmes across each of these approaches.

Therapy-based brief intervention approaches

Therapy-based brief intervention approaches typically involve a series of therapy session (typically one to eight sessions) delivered quickly after referral or after a young person requests them. These models aim to provide support to reduce distress and build coping skills.

Overall, these supports showed effectiveness in improving mental health conditions, such as levels of anxiety and depressive symptoms and, in particular, levels of distress. These improvements were often achieved within four to six therapy sessions that young people were able to access shortly after being referred or requesting support.

These models demonstrate that relatively low-intensity, timely support can reduce distress and improve functioning for young people.

Programme	About	Outcome	Improvement	Evidence strength
headspace Brief Intervention Clinics (BIC)(Australia)	Brief intervention clinics, small number (4–6) of therapy sessions[7]	Distress	Large	●
		Depressive symptoms	Moderate	
		Anxiety symptoms	Moderate	
		Social functioning	Moderate	
Jigsaw (Ireland)	Brief therapy clinics, small number (average 6) of therapy sessions[8]	Distress (17–25 years)	Large	●
		Distress (12–16 years)	Moderate	
	Goal-based therapy in BIC[9]	Goal achievement	Large	●
Mindspace Mayo (Ireland)	Brief therapy clinics, small number (average 6) of therapy sessions[10]	Distress	Large	●

● Good evidence ● Emerging evidence

Note: Evidence strength refers to the design of the study, and how strong that design suggests the programmes or services "caused" the improvements in mental health.

Community-based approaches

Community-based supports include youth mental health services and programmes that are delivered outside traditional hospital-based specialist mental health settings, and try to meet young people in spaces where they already are. This includes supports such as "one-stop shops," existing youth-facing organisations, or coordinated access models that provide rapid triage, flexible counselling, and connection to additional supports.

Community-based supports were effective in reaching young people with emerging need, rated highly by young people for their accessibility and satisfaction and functioned effectively as entry points into a range of services.

Although reductions in symptoms were sometimes modest, the scale and accessibility of these services make them important components of an early intervention system.

Programme	About	Outcome	Improvement	Evidence strength
headspace one-stop shops (Australia)	One stop-shops with six therapy sessions; highly accessible, community-based centres offering a variety of services[11, 12]	Distress	Large	●
		Social functioning	Moderate	
Your Choice (Aotearoa)	Mental health system navigation; coordinated triage model connecting people to therapy services (average 8 sessions)[13]	Psychological difficulties	Large	●
		Social functioning	Moderate	
		Substance abuse	Large	
RISE (Australia)	Sports-embedded approach; online and in-person delivery, with follow up for those at high risk[14, 15]	Anxiety symptoms	Small to no change	●
		Depressive symptoms	Small	
	RISE programme with at least some content delivered by clinically-trained professionals[16]	Anxiety symptoms	Moderate (among those with elevated symptoms)	●
		Depressive symptoms	Moderate (among those with elevated symptoms)	

● Good evidence ● Emerging evidence

E-therapy and e-screening mental health approaches

E-therapy and e-screening approaches aim to deliver psychological support and/or identify and triage need through online screening and monitoring. These tools support early intervention by being readily accessible online, and provide quick, private, and flexible support. These programmes often combine self-guided digital content (e.g., modules) with some form of professional human support, such as therapist calls.

E-therapy and e-screening approaches were effective in lowering psychological distress as well as alleviating depressive and anxiety symptoms among young people with mild to moderate levels of symptoms. Moreover, they demonstrate examples of scalable models for early intervention. The findings often pointed to the importance of engagement in the supports for their success in supporting young people's mental health, so ensuring content and support is interesting, useful, and acceptable to young people is critical.

Programme	About	Outcome	Improvement	Evidence strength
ENVOY (Netherlands)	Moderated digital platform; 6-month guided therapy programme, social network[17]	Distress	Moderate	●
		Social functioning	Moderate	
AMTE (Spain)	Online CBT with guidance; 7-week self-directed online programme, containing 8 30-minute modules with therapist phone calls[18]	Depressive symptoms	Moderate	●
		Anxiety symptoms	Moderate	
STAND (United States)	Digital stepped care; online screening with digitally delivered CBT content[19]	Anxiety symptoms	Large	●
		Depressive symptoms	Large	

● Good evidence ● Emerging evidence

Digital mental health approaches

Digital mental health approaches include apps, chatbots, websites, and online programmes designed to support young people's wellbeing. Varying widely in their structure and intensity, most are typically able to be accessed quickly, anonymously, and at low cost or free.

Almost all digital supports that were evaluated led to small to moderate improvements across indicators of stress, anxiety and depressive symptoms. Outcome information was typically collected when young people begun the programme and immediately at the completion, which means we do not have evidence of whether the skills and techniques that young people learned while using these supports helped them maintain their wellbeing gains in the longer term.

Programme	About	Outcome	Improvement	Evidence strength
Headstrong: 21-Day Stress Detox (Aotearoa)	Conversational style chatbot on Facebook Messenger; delivers 21 5–7 minute sessions[20]	Perceived stress	Small	Emerging
		Anxiety symptoms	Small	
Headstrong: Aroha Chatbot (Aotearoa)	Conversational style chatbot on Facebook Messenger; user-led chat support in short modules[21]	COVID-19 related anxiety	Small	Emerging
Bite Back (Australia)	Self-guided, web-based positive psychology programme; activities with social online engagement[22]	Depressive symptoms	Moderate	Good
		Anxiety symptoms	Small	
		Perceived stress	Moderate	
Whitu (Aotearoa)	Mobile app grounded in multiple therapeutic approaches; 7 modules[23,24]	Depressive symptoms	Small	Good
		Anxiety symptoms	No change	
		Perceived stress	Small	
SPARX (Aotearoa)	Video-game based unguided CBT programme consisting of 7 modules[25,26]	Depressive symptoms	Moderate	Good
Starship Rescue (Aotearoa)	Video-game based CBT programme for young people with long-term physical conditions; 5 15–30 minute modules	Anxiety symptoms	Large	Emerging

Good evidence Emerging evidence

Family-integrated approaches

Family-integrated approaches include interventions that directly involve parents, caregivers, or whānau and family as part of early intervention for young people's mental health. These approaches recognise that young people's mental health is shaped by their family relationships and support systems and that engaging families early can strengthen and sustain outcomes for young people.

While many interventions include elements of family involvement, just one programme that was evaluated specifically focused on family incorporation as the key aspect of the intervention. This evaluation showed young people and parents reported a small improvement in the young person's social functioning.

Programme	About	Outcome	Improvement	Evidence strength
headspace (Australia)	Single structured therapy session with young person and their family[27]	Social functioning	Small	●

● Good evidence ● Emerging evidence

Policy implications

Diversity is important, but there are core components that can be shared across all programmes and services when they're being developed

The evidence suggests that an effective secondary prevention and early intervention system for young people should offer a range of support options that reflect the diversity of young people's needs and preferences. No single approach emerged as universally effective. Rather, different models appear to serve complementary roles within an early intervention continuum.

Critical components that can be consistently applied to the development of these different services includes a focus on supporting sustained engagement, ensuring accessibility and acceptability, and utilising youth co-design. These were all factors strongly associated with effective programmes and services and should remain a central focus of service design.

Lived experience commentary:

Diversity in supports is important because young people are not a homogenous group, and accounting for intersectionality is vital. Young people are seeking personalised approaches to their mental wellbeing rather than a one-size-fits-all approach. For example, a youth-friendly environment may look different for rainbow young people than for young people who are straight or cisgender. Creating diverse and accessible youth-friendly services is well suited for co-design with young people who can provide insights that improves their effectiveness. The service landscape should reflect the diversity of young people by actively seeking the expertise of underserved youth communities.

No single service can meet the needs of all young people. However, the mental health ecosystem as a whole should be able to offer something for everyone.

Co-design is a critical component for successful engagement

Co-design is critical for more than simply increasing satisfaction. Co-design was demonstrated to lead to stronger engagement patterns, particularly with digital tools, with increased engagement essential for effectiveness in terms of improvements in young people's mental health and wellbeing.

At a systems level, ensuring that services incorporate youth perspectives and remain responsive to changing preferences may help sustain engagement and effectiveness over time for services. This is especially important because we know young people's preferences, digital behaviours, and social contexts evolve rapidly. Continuous feedback loops, youth advisory groups, and adaptive design processes may therefore be central to sustaining both relevance and impact over time.

Lived experience commentary:

Co-design is a key mechanism for centring lived experience expertise within service design and delivery. It is crucial that co-design approaches are robust and actively share power between service providers and service users. This means that young people are involved in the process from conception to evaluation. A one-off instance of consultation is not sufficient to constitute co-design. It is vital that lived experience partnerships are ongoing, genuinely share decision-making, and actively work to empower the voice of young people.

Co-designing services alongside young people can aid in creating youth-friendly service environments that are accessible and oriented to the youth lifeworld.

Attending to the power dynamics between young people and service providers is a key consideration for effective and ethical co-design. This entails exploring how young people can be fairly compensated for contributing their expertise, and establishing governance systems that balance both service provider and youth perspectives.

Digital and online mental health tools are a lower-cost and scalable area for further intervention development

The digital and online mental health tools all proved to support mental wellbeing, despite often being lighter touch in terms of the overall duration of the programmes and individual modules and exercises. This points to a promising, low-cost and scalable area for further intervention development.

If digital interventions are to work, they need to be designed around youth engagement and usability and are more likely to succeed if co-designed with young people. Research suggests that digital tools may be most effective when paired with some form of human support, such as peer coaching or brief contact with a therapist. This may explain some of the more positive results of these tools, but also impacts cost.

It is important to note that the way young people engage with technology and online is constantly evolving. Research shows young people are moving away from app and website-based engagement and, instead, their online engagement is concentrated on larger online platforms, like TikTok and Youtube.[28] Recent international studies are pointing to how young people are increasingly turning to generative AI tools, such as ChatGPT and Claude, to support their mental health.[29,30] Emerging research suggests that generative AI tools may worsen symptoms.[31,32] Government policy and service providers need to establish clear regulatory standards for safety, privacy, transparency of algorithms, and age-appropriate design for these tools.

Lived experience commentary:

There is scarce research incorporating lived experience perspectives on digital interventions and more work needs to be undertaken in this area. Qualitative studies are particularly rare. Digital interventions should account for inequities of digital access among underserved populations such as Māori, Pasifika, low-income families, and disabled people. These inequities range from unequal ownership of digital devices to digital apps that fail to be comparably accessible and effective for disabled people. For example, ownership of digital devices can vary on socioeconomic lines, with young people from low-income families being less likely to own their own individual device.

Co-design engagement in this area should aim to work alongside a broad spectrum of young people from different social contexts. This will increase the potential for digital tools to work effectively for underserved communities. Digital tools should be treated as a supplement for, rather than a replacement of, human interaction. Protecting data, particularly due to the sensitive nature of mental health challenges, is paramount – especially when situated in a broader digital landscape where data privacy has become increasingly eroded.

More evaluative research is needed for us to better understand what works and for whom

There is a lack of evaluative research on what works. Many evaluations did not follow up with young people in the longer term to understand if the benefits that they gained from using these supports persisted. Strengthening the quality and consistency of evaluation, through clearer reporting of baseline need and longer follow-up, would help clarify whether programmes are preventing escalation and reducing symptoms.

Many of the studies either did not have sufficient statistical power or did not focus on potential heterogeneity in their findings. It is likely that some interventions work better for certain groups, such as young people with disabilities or across different gender and sexual identities.

Future research should examine whether impacts differ by age, gender, ethnicity, disability status, and socioeconomic context, and whether particular delivery models, such as brief interventions, family-inclusive approaches, or digitally supported stepped care, are more effective for specific groups of young people.

Finally, while the findings highlighted the importance of continued investment in evaluation and culturally responsive approaches, particularly for rangatahi Māori and other indigenous young people, none of the evaluations in this review had rigorously assessed their effectiveness in improving mental health outcomes for rangatahi Māori. Strengthening evaluation capacity alongside service development will be important for understanding which approaches work best, for whom, and under what conditions.

Continued development of culturally responsive, youth-centred services will be critical to ensuring early intervention systems are equitable and effective for all young people in Aotearoa New Zealand.

Lived experience commentary:

Lived experience services, such as peer support, have a developing body of evaluative evidence. Early indications suggest that these services can have positive psycho-social impacts and are particularly well-suited for fostering self-empowerment and hope among service users. Further research should evaluate lived experience services using methodological approaches that are purpose-built for lived experience epistemologies. For example, work has been done in international contexts to develop an evaluative framework for peer support that is built upon the principles of peer support practice. Rigour may look different depending on whether traditional Western, Kaupapa Māori, or lived experience methodologies have been deployed.

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Our purpose

Te Hiringa Mahara – Mental Health and Wellbeing Commission is a kaitiaki (guardian) of mental health and wellbeing in Aotearoa New Zealand.

What we do

We contribute to better and equitable mental health and wellbeing outcomes for all people in Aotearoa New Zealand.

Related work

This work contributes to our priority to advance mental health and wellbeing outcomes for people with lived experience of mental distress and addiction. Te Hiringa Mahara published **insights into rangatahi and youth wellbeing** in 2023 and an assessment of **rangatahi and youth wellbeing and access to services** in 2024. In 2026, Te Hiringa Mahara will publish an in-depth monitoring report on access to mental health and addiction services for rangatahi and young people.

Need support?

Free call or text 1737 any time for support from a trained counsellor.
Some other great places to get support include:

National helplines

- **Depression helpline** (24 hours a day, 7 days a week): free phone 0800 111 757 or free text 4202.
- **Suicide Crisis Helpline:** free phone 0508 828 865 (0508 TAUTOKO).
- **Lifeline:** free phone 0800 543 354 or free text 4357 (HELP).
- **Samaritans crisis helpline:** free phone 0800 726 666 if you are experiencing loneliness, depression, despair, distress or suicidal feelings.

Child and youth helplines

- **Youthline:** free phone 0800 376 633 or free text 234, email **talk@youthline.co.nz** or **online chat**.
- thelowdown.co.nz or email **team@thelowdown.co.nz** or free text 5626.
- **Kidsline:** free phone 0800 543 754. Talk to a trained Kidsline buddy from 4pm–9pm weekdays.
- **What's Up** (for 5 to 18-year olds): free phone 0800 942 8787. Phone counselling is available Monday to Friday, 1pm–10pm and weekends, 3pm–10pm. Online chat is available 7pm–10pm daily.

Compiled by Te Hiringa Mahara – Mental Health and Wellbeing Commission. April 2026.
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