


# **Kua Tīmata Te Haerenga** *The Journey Has Begun*

**Mental health and addiction service  
monitoring report 2024: Access and options**





## **Kua Tīmata Te Haerenga | The Journey Has Begun—Mental health and addiction service monitoring report 2024: Access and options**

A report issued by Te Hīringa Mahara—the New Zealand Mental Health and Wellbeing Commission (Te Hīringa Mahara).

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Te Hīringa Mahara—the New Zealand Mental Health and Wellbeing Commission—was set up in February 2021 and works under the Mental Health and Wellbeing Commission Act 2020. Our purpose is to contribute to better and equitable mental health and wellbeing outcomes for people in Aotearoa New Zealand.

For more information, please visit our website:  
[www.mhwc.govt.nz](http://www.mhwc.govt.nz)

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The title of this report has been provided by Ngā Ringa Raupā (the collective of Māori kaimahi within Te Hīringa Mahara). It reflects how the journey to apply He Ara Āwhina as our monitoring framework has begun, which this year has led us to monitor the access and options domain in greater depth.

Published: June 2024.

# Kupu Whakataki

## Foreword

People and whānau have consistently called for timely access to a range of services and supports when needed.

The last five years have seen a welcome increase in access to mental health and addiction services in primary care, but at the same time the number of people accessing specialist services has decreased. We heard the demand for services and complexity of need is increasing. Societal issues, such as the higher cost of living, changes in people's expectations of the health system, and the aftermath of the COVID-19 pandemic, are exacerbating New Zealanders' experience of distress.

The immense pressure on the mental health and addiction workforce, particularly in specialist services, is contributing to a reduction in the number of people who are accessing these services. Staff shortages across specialist services, non-governmental organisations, and general practice mean that services are having to prioritise people with the highest need, referrals are reducing, and more people are being supported in the community while they wait for specialist care. Some urgent issues need to be addressed.

Our monitoring reports consistently point to unacceptable inequities for Māori. Services need to meet the needs of Māori and we want to see continued investment in growing Kaupapa Māori approaches. Rangatahi and youth are a priority and it is promising to see more support available but we must ensure services meet the needs of young people and address the barriers to accessing services.

This report highlights the major shifts in service access over five tumultuous years, from July 2018 to June 2023. Improving a complex system takes time but it is possible and we welcome the Government's focus on timely access to mental health and addiction services. We have made progress and we are optimistic that together the system can shift to better support tāngata whaiora and whānau.



**Hayden Wano**  
Board Chair, Te Hiringa Mahara





# Ngā Ihirangi

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# Ngā Mihi

## *Acknowledgements*

**Te Hiringa Mahara wrote this report with the help and expertise of many people. We thank them all for their valuable contribution.**

Thank you to the members of the mental health and addiction sector and lived experience reference groups. This expert input has guided the development of this report, particularly through the data sense-checking phase once the monitoring story was taking shape. Contributions came from many members across both these reference groups: Margaret Aimer, Ainsleigh Cribb-Su'a, Ross Philips, Darryl Bishop, David Codyre, Hiran Thabrew, Suzette Poole, Jenny Ngarimu, Health Partnerships Team Police, Damien Tomic, Ruth Large, Karla Bergquist, Murray Patton, Lucinda Cassin, Carole Koha, Louise Ihimaera, Tevita Funaki, Theresa Nimarota, Leilani Maraku, Jodi Bennett, Ivan Yeo, Arana Pearson, Jono Selu, Ihorangi Reweti-Peters, Moko Kairua, Tyson Smith and Alexandria Green (and their delegates). Te Kete Pounamu also provided valuable Māori lived experience input.

This monitoring report and the accompanying dashboard drew on quantitative data that many agencies supplied. We thank the staff in these agencies for their timely supply of data and for assisting with technical clarifications. These agencies include Health New Zealand | Te Whatu Ora; Te Aka Whai Ora | Māori Health Authority; Whakarongorau Aotearoa | New Zealand Telehealth Services; Whāraurau; New Zealand Drug Foundation; dapaanz; New Zealand Police; Hato Hone St John; Wellington Free Ambulance; Manatū Hauora | Ministry of Health; Te Pou; Te Tāhū Hauora | Health Quality & Safety Commission; and the

Ministry of Justice. The KPI programme also kindly shared code to support our use of these measures.

We are grateful to the expert reviewers of our report: Margaret Aimer, Ross Phillips, Leilani Maraku, Tyson Smith, Barry Welsh, Murray Patton, and Peter Huskinson. The richness and diversity of your critique enhanced this report. Thank you to the translators who provided the te reo Māori headings and overall summary.

Finally, we acknowledge the people working in mental health and addiction services and the people and whānau who access these services. We particularly thank the hundreds of people who participated in our online forms, focus groups, or direct interviews. You generously shared your experiences and insights to enable us to gain a richer understanding of service access and options. We know there is so much more to your stories than can be captured in this monitoring report, and we hope this and the accompanying **Voices report** does justice to what you shared with us.





# Whakamōhiotanga whānui

## *Overall summary*

This monitoring report focuses on access to mental health and addiction services and options available over the five years from July 2018 to June 2023. In developing this report, we set out to gain a deeper understanding of changing patterns in access to mental health and addiction services and the options available. To do this, we heard from many perspectives in the mental health and addiction sector and communities and triangulated their views with quantitative data.

### **Access to primary and community services has increased and access to specialist services has decreased**

The Access and Choice programme has helped to increase access and expand options for people with mild to moderate distress. The number of people accessing primary and community care<sup>1</sup> has continued to increase over the last five years. While the impact of the Access and Choice programme is positive, we also heard that some people with higher needs (moderate to severe) have not been able to access services in a timely way.

The number of people accessing specialist<sup>2</sup> mental health and addiction services has reduced over the five-year period of our monitoring until it levelled out in the last year. The five-year decrease represents a change in access rate from 3.8 per cent of the total population in 2018/19 to

3.4 per cent in 2022/23. The decrease in access over the five years has been bigger in addiction services (15.9 per cent decrease) than in mental health services (3.1 per cent decrease). Through our qualitative data, we heard from many people about their difficulties with accessing specialist and crisis services.

Whakarongorau Aotearoa | New Zealand Telehealth Services (Whakarongorau) has received fewer people calling/texting mental health and addiction lines over the last year of monitoring. Similarly, after emergency department (ED) presentations for mental health reasons increased steadily over the three years to 2020/21, presentations fell in the following two years. In contrast, the number of calls to Police and Ambulance services (coded as mental health related) has increased, although rates of Police attendance has decreased.

- 1 Primary care services are those provided at initial entry points, usually general practices and other services such as pharmacists. Non-governmental organisations (NGOs), such as Māori and Pacific providers, can also provide primary care services so these have been included as primary and community care services.
- 2 Specialist services are those designed to respond to the needs of people with the most severe and/or complex needs. They usually require a referral or assessment from a primary-level service for a person to enter them but some will accept self-referrals. Providers of specialist services can be hospitals, Health New Zealand community teams, or contracted NGOs.

## Increasing pressure on specialist services due to workforce challenges and needing to focus on those with higher needs

Based on our analysis of data gathered, we conclude that the causes of these changes in service use are the increased pressure on the workforce due to high vacancies, and a focus on caring for those with higher and more severe needs. We also heard that the growth in opportunities to intervene earlier through primary care is having positive effects, which may be contributing to a slight decrease in referrals to specialist services.

While overall the workforce in primary and community care has grown through the Access and Choice programme, significant workforce shortages continue in specialist services, non-governmental organisations (NGOs), and general practice. These shortages have constrained the responses of specialist services, which are needing to prioritise those with the highest needs. We heard about the increasing level of demand for services and people presenting with more complex needs (for example, drug use, neurodiversity, and social issues such as housing instability).


Primary and community providers are changing their behaviour in response to feedback from specialist services. Some perceive that the threshold for acceptance into specialist services has become higher. Some referrers are reducing the number of referrals they make and are supporting people for longer in the community while waiting for access to specialist services. People shared some of the barriers they face in gaining early access to general practice and specialist services, with the result that they were in crisis by the time they received a response.



The decrease in use of specialist services (particularly addiction services) over the five-year period, along with the greater focus of specialist services on people with more complex needs,

may indicate some success of the increase in early intervention through primary and community services. We heard that some people with moderate needs (who would have previously been referred to specialist services) are now receiving support without the need for specialist care.

The New Zealand Health Survey shows that psychological distress has continued to increase. Societal changes, driven by the increased cost of living and changes in people's expectations of the health system (among other factors), have exacerbated that distress. The COVID-19 pandemic is a significant event over the five years of monitoring, which has impacted service use, service delivery models, the workforce, and people's expectations.

### Changing patterns of need and service access

 Representation of the level of mental health and addiction need in the total population, and services designed to respond to need. Mild to moderate needs are at the bottom of the triangle moving up to severe and complex needs at the top of the triangle.

 Previous need  Current need

### Different types of complex needs in population

There are changing mental health and addiction needs in the population, and we have heard about more complex needs.

### Investment to increase options in GPs and NGOs

There has been investment to increase options in GPs and NGOs through the Access and Choice programme. This has improved access for people with mild to moderate needs.

### Need to target limited resource to highest needs

Specialist services are designed for people experiencing more severe mental health and addiction needs. These services are targeting limited resource to people with highest need.

## **The system needs to be strengthened to meet the needs and aspirations of Māori**

The current system does not work well for many Māori. We heard from Māori that different parts of the system lack cohesion. They are calling for the system to be more holistic, culturally appropriate, affordable, and accessible to meet their needs. While many acknowledged pockets of excellence, such as a growth in Kaupapa Māori services, many report these services have a lack of reach across the motu.

We heard high levels of frustration and disappointment after many failed attempts to access services through primary care and then ending up at acute services in crisis. These experiences are reflected in our finding that Māori use of community specialist services has decreased. For many Māori, this has resulted in a loss of faith or trust in the system and difficulties in achieving a sense of wellbeing.

Our monitoring this year has found that Māori admission rates to inpatient services have increased while non-Māori rates have decreased. Over the last five years, Māori rates of mental health presentations to EDs have been higher than those for non-Māori. Māori report higher levels of psychological distress and experiences of mental distress and substance use, which need to be understood in the context of social determinants.

## **Rangatahi and young people need to be a continued focus**

Young people aged 15 to 24 years continue to experience increasing levels of psychological distress. Despite young people having the highest incidence and prevalence of mental illness compared to other age groups, they report the highest rate of unmet need for health services, and they face barriers to accessing appropriate mental health and addiction support. Children and adolescents (aged 0 to 18 years) have the

longest wait times for access to specialist services, and young people (aged 19 to 24 years) have higher ambulance and ED presentations than other age groups. Despite this, there has been a relatively small increase in investment (compared to adult services) in mental health services for this age group.

Options for initial support for young people are improving. They are increasingly using telehealth and Access and Choice programme services, as well as other options available such as school-based services. Young people are now also receiving fewer mental health medications than the year before. This trend in initial dispensings (for antidepressants, antipsychotics, and anxiolytics) for young people increased in the four years to 2021/22, before decreasing in 2022/23. It is also positive to see the number of young people admitted to adult inpatient units has started to decline in the last year of monitoring.

Taking a life-course approach to understanding needs for supports, and planning the collective landscape of services will help to meet the unique needs of young adults, and children and adolescents, in a way that the adult system is not set up to achieve.

## We need to accelerate change

While workforce shortages (particularly in specialist services) are taking their toll, primary and community workforces have grown.

There continues to be pockets of excellence and innovative examples of services that are responsive and mitigate issues. Initiatives such as primary care liaison, co-response teams, and earlier mental health responses for people who call 111 are all making a difference. Acute community options are available in some areas; however, the options that are available vary widely across the country. We are seeing positive changes to address long-term issues and these need to extend across the system. We need continued focused efforts across many agencies, services, and people to ensure a whole-of-system approach.

Further, we need to keep striving for a system in which people have access to mental health and addiction services and supports when they need them, and have genuine choice in what services they use across the full continuum of services. It has been over five years since the landmark inquiry He Ara Oranga, and still more work needs to be done. The recommendations and calls to action set out in this report are our views on the critical areas where accelerating change is most needed.

Having a dedicated Minister for Mental Health presents many opportunities to drive change. We call on the Government to continue to focus on mental health and addiction and to accelerate progress toward a system that has people and whānau at its centre.

## What service access looks like – a visual story

The quantitative data and qualitative voices come together to tell an overall story about access to mental health and addiction services.

**Figure 1** illustrates this story. It is a high-level visual reflection of what we saw and heard from the data we gathered on how the system is working for people currently.





### Growing psychological distress

% of population aged 15 years and over reporting high or very high psychological distress in the previous 4 weeks:



### Overall investment in mental health and addiction services has increased

2018/19  
**\$1.53b**

2022/23  
**\$2.28b↑**



9.5% of total health appropriation

### The Access and Choice programme has improved access for many, but trends for other service types in the last year are mixed

% change between 2021/22 and 2022/23

	National telehealth	66,538 people	↓ 11%
	Access and Choice services	185,632 people	↑ 62%
	Other primary initiatives	116,152 people	↓ 17%
	Specialist services	177,613 people	~ Relatively unchanged
	Police 'mental health' calls	75,759 events	↑ 6%

“

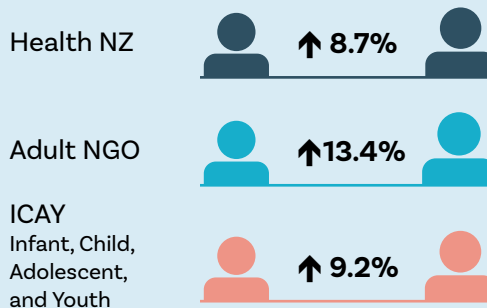
We heard that people across the continuum of services are presenting with more acute distress and more complex needs.

”

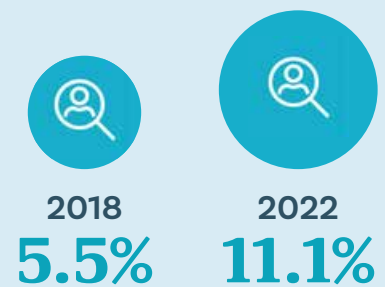
### Workforce is growing, but so are vacancy rates

Total 15,534 full-time equivalent (FTE) staff across mental health and addiction services in 2022/23.

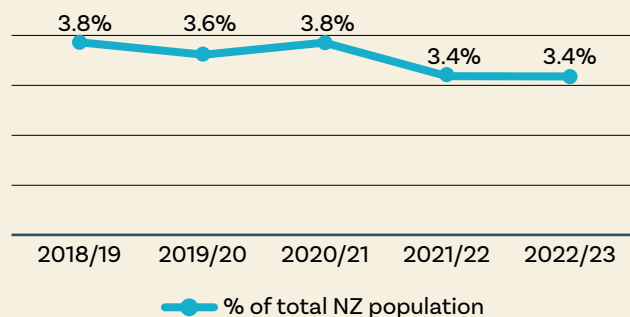
#### FTE growth (employed and vacant) from 2018/19 to 2022/23:



#### Vacancy rates in adult specialist services:



### Specialist service use has decreased over the five years of monitoring



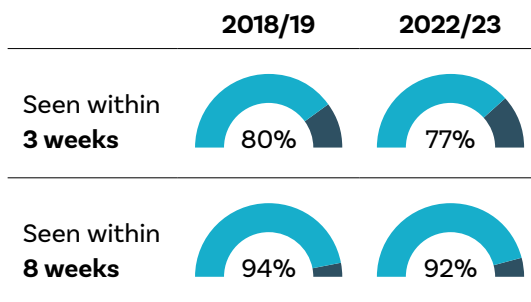
### This decrease is especially marked for addiction services

% decrease over 5 years:

**15.9%↓**  
Addiction  
services

**3.1%↓**  
Mental health  
services

### Wait times have become longer for specialist Health NZ mental health services over the last 5 years but have levelled off over the last year



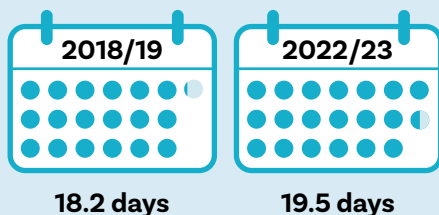
“

Some people with higher needs (moderate to severe) have told us they have not been able to access specialist services in a timely way.

”

### Service access is changing in response to workforce challenges and complex needs

Average length of stay in an inpatient unit has increased:



“

We heard the workforce challenges are constraining the responses of specialist services, which are prioritising those with highest need.

”

### Wait times in other parts of the system have increased



Average wait for ED transfer to mental health bed:

2018/19: 3hrs 46mins  
2022/23: 5hrs 27mins



Average wait for national telehealth services:

2018/19: 1min 20secs  
2022/23: 6mins 6secs





# Ngā huringa e hiahiatia ana

## *The changes we want to see*

In this section, we set out the system changes we want to see from Government and health agencies to accelerate improvement. These calls to action are based on the findings from the monitoring report and describe the changes we consider to be critical to improving the mental health and addiction system for tāngata whaiora and whānau.

### Increase access to services

**Increase access** to address gaps in service, particularly for people with moderate to severe needs (aiming for access rates that match updated prevalence data when available).

Ensure **services are acceptable, appropriate, and welcoming for Māori** and continue to invest in Kaupapa Māori services that are culturally grounded in Mātauranga Māori.

Develop and implement **strategies to reduce workforce vacancy rates**, strengthen clinical workforces, and reduce pressure on the workforce to meet the changing needs of tāngata whaiora (informed by high-quality data and forecasted future capacity requirements).

**Increase and develop the workforce** including through continued growth of the peer and cultural workforces.

### Increase choice of services

**Increase information on available options** so people have the information they need to understand the range of services available (including clear entry criteria), what those services provide, and how to access these.

**Increase acute community options** available for people experiencing acute distress. This includes a specific focus on community acute options for rangatahi and youth.

### Strengthen connections

**Strengthen the interface between specialist and primary services** through primary care liaison functions and other models, and increase opportunities for services to work collaboratively.

**Strengthen cross-agency work** across all levels, from frontline services to government agencies, to enable community and health services to work collaboratively to meet the health and social needs of those experiencing mental distress and harm from substance use.

### Improve data and insights

**Improve the quality of data** about the mental health and addiction system so we can understand if responses, services, and policies are meeting people's needs. Critical data improvements are required in outcome data, experience data, National Health Index (NHI) linking across specialist and primary care, and data to better understand service capacity.

**Work in partnership with Māori** to explore better ways to report on Māori experiences and improve the governance and management of data relevant to Māori.

**Update prevalence data** to determine how this has changed since Te Rau Hinengaro: The New Zealand Mental Health Survey (Oakley Browne et al., 2006) as up-to-date data are needed to inform modelling of current and future demand.



# Ngā Tūtohu

## Recommendations

Based on the changes we want to see, in this section, we set out five recommendations based on the monitoring findings. These recommendations provide more detail about what success looks like so action can be taken and progress monitored.

The recommendations included here are the more specific ‘who needs to do what’ to enable system change. For now, these are the five tangible areas, and we will continue to engage with the sector on how to accelerate progress in the other areas of system change.

### We recommend that:

1. **Health NZ** develops a mental health and addiction workforce plan to address service capacity and workforce shortages by June 2025 (inclusive of clinical, peer and cultural workforces, Māori and lived experience leadership, and across primary, community, and specialist services).
2. **Health NZ** develops an action plan by June 2025 to meet the needs of Māori and whānau accessing specialist mental health and addiction services.
3. **Health NZ** provides guidance for the delivery of effective acute community options tailored to meet the needs of rangatahi and youth by June 2025.
4. **Health NZ** develops a mental health and addiction data plan by June 2025 that ensures information systems are integrated and enables collection of quality and timely data.\*
5. **Government** commits to funding a planned programme of work to collect mental health and addiction prevalence data by June 2025, to enable improved services and ensure value for money.

\*The data plan should support collecting data across Te Ao Māori measures, experiences, outcomes, workforce, finance, and activity across primary care, NGOs, and hospital and specialist services. The data plan should ensure that all information systems can be linked to specific mental health and addiction services delivered.

# Ngā whanake

## *Next steps*

Following the publication of this report, our next steps are to:

### Engagement

- Continue to engage with the sector to progress the recommendations set out in this report, and determining the best way to progress the other changes we want to see.
- Continue to engage with the mental health and addiction sector and lived experience communities to better understand the experiences behind the numbers and the challenges they face.

### Advocacy

- Continue advocating for actions, drawing on our monitoring and engagement, that will make a real difference for tāngata whaiora and whānau.

### Monitoring

- Monitor progress of the recommendations set out in this report.
- Produce a monitoring report on the Access and Choice programme implementation over the five-year roll-out to June 2024.
- Advance our dashboard to support its alignment with forthcoming mental health and addiction sector targets where possible. The added value of our dashboard is that it positions targets alongside a broader set of measures to provide important context, interpretation, and balancing measures.
- Improve our measure set for He Ara Āwhina, including working with Māori (people with lived experience and service providers) to improve data to support monitoring Te Ao Māori domains of He Ara Āwhina.

# Kupu arataki

## *Introduction*

The purpose of this report is to monitor mental health and addiction services over the five-year period from July 2018 to June 2023, with a focus on access to services and options available.

### **We independently monitor mental health and addiction services and advocate for improvement**

Te Hīringa Mahara—the Mental Health and Wellbeing Commission (Te Hīringa Mahara) has the mandated function to monitor mental health and addiction services in Aotearoa New Zealand, and to advocate for improvements to those services. As an independent Crown entity, we seek to influence decision-makers and service providers at all levels—to shine a light on areas of progress, but also to identify areas where more work is needed.

We have made a strong commitment to achieving better and equitable mental health and wellbeing outcomes for Māori and our grounding in Te Tiriti o Waitangi is expressed in our **Te Tauāki ki Te Tiriti o Waitangi | Te Tiriti o Waitangi Position Statement**. We are committed to prioritising the voices of people who experience mental distress, substance harm, gambling harm or addiction, and advocating for their needs and aspirations. This is expressed in our **Lived Experience position statement**.

While we have written this report specifically for the people who can bring about change (the leaders within services, organisations, and Government), at its heart it is for the people who can benefit from change—tāngata whaiora and whānau.<sup>3</sup>

### **Our monitoring acknowledges and respects the voices shared, now and in the past**

We acknowledge the voices that have been shared not only for this report, but previously in helping us understand people's experiences of the mental health and wellbeing system and the changes people want to see.

This report is enriched by the voices of people with lived experience, their whānau and supporters, and people working in the sector. We place great value on the insights that people have shared about their experiences. This allows our monitoring role to go beyond measuring change in numbers to understanding changes (or lack of change) in experiences. We call on sector leaders to respect and listen to these voices and deliver change to ensure future experiences are better than those of the past.

3 This report uses 'tāngata whaiora' to include people of any age or ethnicity who are seeking wellbeing or support and 'whānau' to include the chosen family of tāngata whaiora. For more detail, see our Rārangi kupu | Glossary.



“

I just really hope that our kōrero today goes somewhere. I feel that what I've shared today is not new. I've said this so many times and so have our whānau.

”

Māori focus group

### This report focuses on the access and options domain of He Ara Āwhina

We published the framework He Ara Āwhina (Pathways to Support) in June 2022 following a co-development phase with many people in the sector and lived experience communities. He Ara Āwhina describes 12 domains that together express what an ideal mental health and addiction system looks like.

He Ara Āwhina partners with the He Ara Oranga wellbeing outcomes framework. He Ara Oranga shows how wellbeing will be achieved from both a perspective of Te Ao Māori and a shared perspective. For more detail on both frameworks, visit [our website](http://mhwc.govt.nz) (mhwc.govt.nz).

In our previous service monitoring report published in May 2023, Te Huringa Tuarua (Te Hiringa Mahara, 2023c), we applied He Ara Āwhina for the first time. The report provided a broad overview of mental health and addiction services based on monitoring measures across the 12 domains of the framework. As part of this, we identified a decrease in access to most mental health and addiction services in 2021/22. This finding was unexpected alongside the narrative that levels of distress and demand for services were increasing. For this reason, we decided to focus this year's monitoring report specifically on the access and options domain so that we could explore in greater depth what people were experiencing and why changes were occurring.



## He Ara Āwhina (Pathways to Support) framework – Summary

### Te Ao Māori Perspective

Mana Whakahaere	Manawa Ora / Tūmanako	Mana Whānau / Whanaungatanga
Mana Motuhake	Mana Tangata / Tū Tangata Mauri Ora	Kotahitanga

### Shared Perspective

Equity	Access and options	Connected care
Participation and leadership	Safety and rights	Effectiveness

## Achieving equitable outcomes for Māori and whānau

In this report, we provide the Māori slice of data in the access and options domain, as part of the shared perspective in the framework (that is, the perspective that applies to all people). These data are limited from a perspective of Te Ao Māori in that they:

- do not reflect holistic experiences of Māori in the system
- do not accurately capture the work of Kaupapa Māori services with a holistic approach grounded in Mātauranga Māori
- are largely about services provided rather than the causes of the need for those services.

In the future, we plan to monitor Te Ao Māori domains more closely. We discuss this further in Section 4.1: Māori.

## The scope of this monitoring report

The landscape of mental health and addiction<sup>4</sup> services is broad, in that these services are provided in a range of different settings and under diverse funding arrangements.

In scope for this report are:

1. Mental health and addiction services in the publicly funded health system:
  - Health New Zealand | Te Whatu Ora (Health NZ) services in inpatient and community settings
  - NGOs funded to deliver services across the

lifespan and accessed via both primary care and specialist services

- national telehealth services<sup>5</sup>
- national online platforms
- primary care services, including general practice, the Access and Choice programme services, and primary mental health initiatives<sup>6</sup>

2. Emergency responses provided by ambulance services, Police, and emergency departments (EDs).

Services that are out of scope for this report (but that may be in scope for future reporting) are:

- justice sector services—provided in prisons or in the community
- Accident Compensation Corporation services—related to sensitive claims
- education sector services—curriculum- and school-based services
- social development services—provided as part of benefits and allowances
- defence services—provided for veterans
- privately funded services—such as services through charities, health insurance, employee assistance programmes, and self-funding.

We intend to continue expanding the scope of our monitoring across mental health and addiction services that other sectors provide. We will do this progressively over time to maintain the same high standard of monitoring and insight.

We monitor services at a national level. Other health entities report by individual services, districts, or localities.

4. Addiction services covered in this report are alcohol or other drug services—services designed to respond to substance harm. Gambling harm services are out of scope for this report.

5. The scope of our monitoring includes Whakarongorau Aotearoa | New Zealand Telehealth Services. Other telehealth services also provide mental health and addiction support, for example, Youthline.

6. These primary care services are connected but distinct service types that people may access individually or in combination. **General practice** is the well-known model of primary health organisations (PHOs) providing access to health care for their local enrolled population through a general practitioner. PHOs are funded through health appropriations, rather than dedicated mental health and addiction funding.

**Access and Choice programme services** have been rolled-out from 2020 to deliver services to people with mild to moderate needs. Four services types are provided in different settings: Integrated Primary Mental Health and Addiction (IPMHA), and Kaupapa Māori, Pacific, and Youth services. This is discussed later in the report.

**Primary mental health initiatives** include services delivered via PHOs since 2003 that receive dedicated primary mental health funding. These services include extended general practitioner or practice nurse consultations, brief interventions, individually tailored packages of care, and group therapy.

## Significant large-scale shifts have occurred over our five years of monitoring

This report provides information on the performance of mental health and addiction services over the five-year period between July 2018 and June 2023 (in line with public sector financial reporting years, which run July to June).

Three major shifts took place over this period. All three have affected the pattern of New Zealanders' mental health need, as well as the mix, capacity, capability, and performance of services to respond to that need.

### Shift One: The system response to a landmark review of the mental health and addiction system

This is a significant five-year period within the mental health and addiction system, starting with the landmark report, He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga), released in December 2018. The Government responded with the Wellbeing Budget in May 2019, announcing \$1.9 billion would fund the expansion of some services and the establishment of new services and options (Government of New Zealand, 2019).

### Shift Two: The societal impact of a once-in-a-century global pandemic

The COVID-19 lockdowns over 2020 and 2021 are important context for monitoring change over time. The 2019/20 year was impacted by the arrival of COVID-19 and the first lockdown from 23 March to 13 May 2020. Then in 2021/22, lockdowns occurred for the northern regions of Aotearoa for long periods, and for the rest of the country to a lesser extent. These lockdowns, and COVID-19 itself, changed how people accessed services as well as their experiences of services

(Health Quality & Safety Commission, 2022).

More broadly, the pandemic impacted on population wellbeing, the health workforce, and determinants of wellbeing such as education and social cohesion. For these reasons, the pandemic impacts many measures used in our monitoring.

### Shift Three: A fundamental restructure of the publicly funded health services of Aotearoa

The health system has undergone major reforms. Since 1 July 2022, the former district health boards have been replaced by two national organisations: Health NZ and Te Aka Whai Ora | Māori Health Authority (Te Aka Whai Ora).<sup>7</sup> As a result, staff at all levels have been working in an environment of significant and disruptive system change in addition to dealing with the challenges of COVID-19. Responsibility for some data sets and supply of information has transferred to Health NZ and Te Aka Whai Ora. This has created some additional challenges in accessing consistent information for this report.

These three factors have interacted with one another over the period. The most recent financial year of our monitoring (2022/23) represents the second year of the new health structures, the first year following the public health emergency response to COVID-19, and the fourth year since the budget investment in new service options for mental health. This report considers how service patterns are stabilising into 'the new normal' and provides insights into how to meet the evolving needs of the population in the years ahead.

7 At the time of writing this report, legislation was being passed to disestablish Te Aka Whai Ora.



## This report draws on both quantitative and qualitative data

In planning and implementing our monitoring activities for this report, we were particularly focused on the following questions.

1. How has access to mental health and addiction services changed over the last five years?
2. What inequities exist for Māori access to mental health and addiction services, and how has this access changed over time?
3. What inequities exist in access to mental health and addiction services for different population groups, and how has this access changed over time?
4. What factors are contributing to changes in access to mental health and addiction services?
5. What range of service options do people have available to them, and how has this changed over time?

Answers to the first three of these questions were also covered in our previous service monitoring reports and drew on quantitative service performance data. This report uses 40 measures of service access sourced from many different agencies and data sets. Most of the quantitative data used in this report is sourced from supplied data. Other secondary data sources are referenced accordingly.

The greater depth in this report comes through the integration of qualitative data, adding to our understanding of the quantitative data, why service use is changing, and the options people experience. Our approach was designed to obtain diversity in perspectives and experiences from people with lived experience, whānau, priority population groups, and workforces about access to mental health and addiction services. We also sought broad reach across different parts of the mental health and addiction sector. The findings in this report are supported by an analysis of the

qualitative data and we include quotes to illustrate themes from this analysis.

Our role is to monitor services using readily available data. Although there are limitations to the quality and completeness of some data, the monitoring story in this report does not use any measure in isolation. We observe the changes over time across a broad set of measures and triangulating this with what we heard from people working in services and people trying to access services. For further detail on data limitations and methodology, see Appendix B.



**40**  
quantitative  
service measures



**300+**  
online form responses  
(lived experience and whānau)



**4** focus groups



**52** workforce interviews

## A Voices report, a dashboard, and infographics accompany this report

A wide range of data and information was analysed, reviewed, and considered in the development of this report and is shared elsewhere. This report includes the main monitoring story, and specific findings for Māori, and rangatahi and youth. We acknowledge this does not include findings for all priority population groups.

This report is designed to be read alongside the online dashboard, the Voices report, and supplementary infographics.

**Voices report:** The voices that were shared throughout our engagement are included in our qualitative Voices report to give appropriate space for honouring these experiences. This report includes kōrero about access, options, and other experiences that people shared about the wider mental health and addiction system. The Voices report includes a thematic analysis of what we heard from everyone, and a dedicated section of analysis on Māori voices ([mhwc.govt.nz/voices](https://mhwc.govt.nz/voices)).

**Dashboard:** The online dashboard includes updated data on 68 measures across all 12 domains of He Ara Āwhina. We developed this dashboard to publicly report on data in a visual format. The dashboard includes all measures where possible disaggregated by age group and ethnicity. Findings for population groups such as Pacific peoples and Asian populations are available in the dashboard ([mhwc.govt.nz/dashboard](https://mhwc.govt.nz/dashboard)).

**Infographics:** A series of infographics highlights what is happening in our key advocacy areas—Kaupapa Māori services, young people, and coercive practices ([mhwc.govt.nz/monitoring](https://mhwc.govt.nz/monitoring)).





# Ngā Kitenga

## Findings

In this section, we present the key findings in our monitoring of the access and options domain in He Ara Āwhina (Pathways to Support) framework. To arrive at these findings, we have integrated what we have heard from people—tāngata whaiora, whānau, and people working in mental health and addiction services—with quantitative measures and supplementary literature.

This findings section is organised into four parts:

1. what we know about the changing demand for services and the mental health and addiction landscape
2. factors affecting service access—the changes in how services can respond, such as through investment and workforce
3. findings for service types, ranging from telehealth to specialist services
4. findings specifically for Māori, and rangatahi and youth.

### 1. The mental health and addiction landscape

Mental distress and harm from substance use makes up one-tenth of total health loss in Aotearoa (Health NZ, 2024a). The level of need for mental health and addiction services is impacted by wider determinants of health, as well as the public health policy to regulate harms and promote positive mental health and wellbeing. Public health policy settings, such as on prevention and mental health promotion, can help prevent mental distress and harm from substance use, and impact the level of demand for early intervention and in turn other services (Campion, 2017).

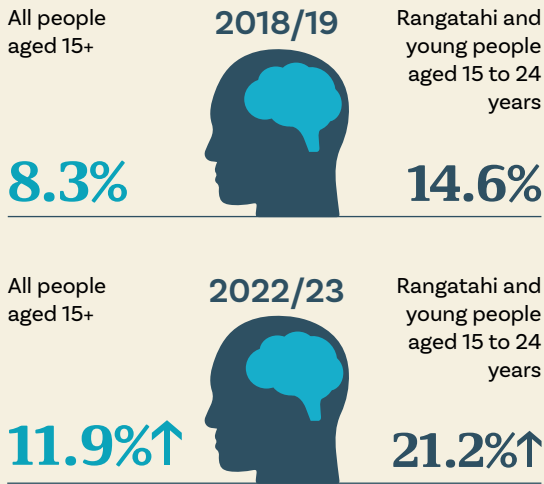
### 1.1 Exploring indicators of the level of need for support

The best source of evidence on the level of need (and subsequent demand) for mental health and addiction services and supports is a population prevalence study. However, the last comprehensive prevalence study was Te Rau Hinengaro, which used data collected in 2003/04 (Oakley Browne et al., 2006). Given those data are now 20 years old, they do not capture substantial changes in population need, generational changes such as the impact of social media, particularly for rangatahi and youth (who were not even born at the time the study gathered those data).

It is urgent and essential to gather prevalence data at regular intervals. Updated data provide an accurate picture of need so that it is possible to align service capacity and future investment in mental health and addiction services.

### High levels of psychological distress in the 4 weeks before survey

% of population aged 15 years and over reporting high or very high psychological distress in the previous 4 weeks:



### 1.2 A diverging picture—growing psychological distress but stable and reducing use of alcohol and other drugs

The New Zealand Health Survey collects population data on levels of psychological distress. While it does not tell us about whether this distress meets diagnostic criteria or levels of service need, it does give us an indication of trends.<sup>8</sup>

The proportion of people aged 15 years and over who reported high levels of psychological distress in the four weeks before the survey continues to increase. In 2022/23, 11.9 per cent of people aged 15 years and over reported high or very high

psychological distress, up from 8.3 per cent in 2018/19. Rangatahi and young people aged 15 to 24 years report the highest levels of psychological distress, and the prevalence among this group has increased from 14.6 per cent in 2018/19 to 21.2 per cent in 2022/23 (Ministry of Health, 2023).

The New Zealand Health Survey reported a slight decrease in rates of hazardous drinking in adults, which fell from 18.7 per cent in 2021/22 to 16.0 per cent in 2022/23. The prevalence of self-reported illicit drug use has remained relatively stable in the last year (Ministry of Health, 2023).<sup>9</sup>

### 1.3 People are presenting with changing needs

Across the mental health and addiction sector, we heard that people are presenting with more acute distress and more complex social needs. Those working in services across the continuum are noticing more people presenting with multiple issues, neurological diversity, and a range of social issues.



“

There are a lot more complex issues ... it’s not within just one area of their life. If we’re thinking Te Whare Tapa Whā, every pou has been affected.

”

Primary sector—Māori

To understand if people are experiencing more complex needs and social situations, we need to rely more strongly on what people have told us in the absence of quantitative measures. We discuss this issue further in Section 3.4: Specialist services.

8 There is not a direct link between experiences of psychological distress or hazardous drinking and need for mental health and addiction services. People receive support in other ways, such as through their whānau, church, or self-help. A comprehensive prevalence study is required to assess whether the level of need aligns to access rates to services.

9 Self-reported drug use is likely to be under-reported (Steinhoff et al., 2023).

## 1.4 Cost of living changes are likely to be impacting access and need

While COVID-19 had an impact on levels of distress and isolation in the population (Every-Palmer et al., 2020; Gasteiger et al., 2021), more recently the effect of inflation relative to income growth means cost of living is having a substantial impact on people. The last three years have seen a rapid increase in household living costs. The cost of living for the average household increased 7.2 per cent in the 12 months to June 2023 (Stats NZ, 2023). While average household incomes also increased over this period, more households were in 'material hardship' compared with the year before (8.5 per cent in 2022/23, up from 7.4 per cent in 2021/22). Further, more households reported that their household income was not enough or only just enough to meet their everyday needs (36.1 per cent in 2022/23, up from 32.3 per cent in 2021/22) (Stats NZ, 2024a).

These financial constraints impact on people's ability to provide for basic family needs and can create additional stress. They also can make it more difficult for people to engage in activities that keep them well and to access services when they need them. Other research shows that progress made to reduce hardship in previous years is not keeping up with additional cost pressures, as the need for food support and other hardship assistance increases (Salvation Army Social Policy and Parliamentary Unit, 2024).



“

We are seeing a gain, an increase, in anxiety and depression ... stress with the increased cost of living. People can't access or do the things that bring meaning into their life or that would've normally been a coping strategy.

”

Primary sector

## 1.5 Some people were not aware of supports, and options were not always accessible

People with lived experience of mental distress and addiction, as well as people working in the sector, told us that knowing what's available and where to go can be the first challenge in getting access to support. Some people with lived experience noted that they were able to use the information available online to navigate their way to the support they needed, while others talked about not knowing where to go for help or being unable to access a mental health advocate in their region.

Across the sector, staff talked about how professionals vary in their knowledge of what services are available and their entry criteria. Staff also noted that it takes time to become aware of all the services available and ongoing education is needed.

Some people told us they were offered options, which were usually online such as online therapy. Data are not available to quantify service options offered or provided. Some people talked about how some options were not realistic as long wait times for some services limited the support options they could access.



“

I feel like I wasn't given many choices ... I found out what a peer support worker was. They offered that, then they offered a cultural support ... I had already been a service user for at least four or five years at that point.

”

Māori focus group

## 2. Factors affecting service access

Here we cover two key cross-cutting supply-side factors that are affecting the service options available and how people can access them. These factors are investment in mental health and addiction services; and the impact of workforce shortages.

### 2.1 The overall investment in mental health and addiction services has increased

Mental health and addiction expenditure for 2022/23 was about \$2.28 billion. This includes Health NZ and Te Aka Whai Ora expenditure across hospital and specialist services, and primary and community services. This total expenditure on mental health and addiction services is a 17.0 per cent increase on the 2021/22 expenditure of \$1.95 billion.<sup>10</sup>

Mental health and addiction service expenditure in 2022/23 equates to 9.5 per cent of the total health appropriation of \$24.0 billion. This is also proportionately higher than in 2021/22, when the \$1.95 billion expenditure was 8.0 per cent of the total health appropriation.

The increase in expenditure was largely driven by a \$240 million (20.0 per cent) annual increase in expenditure on services delivered through Health NZ. There was also a substantial annual increase in the expenditure on primary mental health services, largely driven by the increase in the Access and Choice service delivery (of \$64.3 million or 64.3 per cent). NGO services (excluding primary) had a smaller increase (of \$17.7 million or 2.9 per cent) (see Table 1).

**Table 1: Expenditure on mental health and addiction services, by selected service types (\$ million), 2018/19–2022/23**

Service type	2018/19	2019/20	2020/21	2021/22	2022/23	1-year increase
<b>Total</b>	<b>\$1,530</b>	<b>\$1,690</b>	<b>\$1,820</b>	<b>\$1,950</b>	<b>\$2,281</b>	<b>17%</b>
Health NZ hospital and specialist services	\$1,050	\$1,120	\$1,190	\$1,210	\$1,452	20%
NGO services <sup>11</sup>	\$445	\$512	\$513	\$603	\$621	3%
Primary mental health initiatives	\$36	\$41	\$39	\$41	\$42	2%
Access and Choice service delivery	\$0	\$20	\$63	\$100	\$164	64%
Kaupapa Māori services	\$151	\$190	\$203	\$212	\$235	11%

<sup>10</sup> Expenditure data provided are for operating expenditure (so they exclude capital investments). They do not provide detail on how much of the expenditure increase was due to increasing costs of providing services and how much was expansion of services. The 17 per cent annual increase is larger than the increase in both the annual Labour Cost Index (which measures growth in salary and wage rates) at 30 June 2023 (4.3 per cent) and the annual Consumer Price Index (which measures change in price of goods and services that households purchase) at 30 June 2023 (6.0 per cent).

<sup>11</sup> These NGO services exclude all primary services and COVID-19 response services.

## 2.2 The overall workforce has grown but so have vacancy rates

In 2022, Aotearoa had a total of 15,534 full-time equivalent (FTE) positions, including employed and vacant roles across mental health and addiction services (Te Pou, 2023a). Just over half (56 per cent) of the workforce deliver Health NZ hospital and specialist services; 37 per cent deliver NGO services; and 7 per cent are in primary care (Te Pou, 2023a).

The mental health and addiction workforce size (employed and vacant) is growing across the range of publicly funded services. The number of positions in Health NZ services has increased by 8.7 per cent (645 FTE) between 2018/19 and 2022/23. The adult NGO workforce has increased by 13.4 per cent (609 FTE) between 2018 and 2022 (Te Pou, 2023b). The infant, child, adolescent, and youth (ICAY) mental health workforce grew by 9.2 per cent (171 FTE) between 2018/19 and 2022/23. These increases in FTE are higher than population growth over this period. We discuss workforce changes in specialist services further in Section 3.4: Specialist services.

A new workforce has also been formed with the 768 total FTE (652 FTE employed) through the Integrated Primary Mental Health and Addiction (IPMHA) programme at 30 June 2023. These new workforces were not a feature of the mental health and addiction system before 2019. We also heard that the peer and cultural workforces have grown but data on the numbers involved were not available.

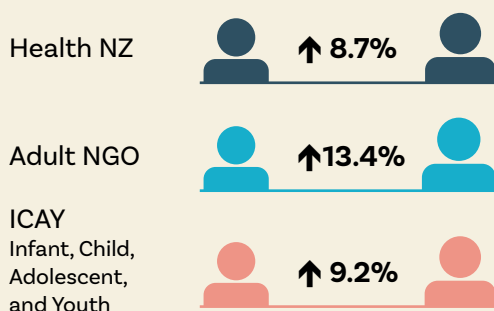
While the workforce has grown, the data and staff experiences are telling us about increasing vacancy rates, higher turnover, and loss of experience within teams. Te Pou's More Than Numbers data provided to us last year show that vacancy rates for the adult mental health and addiction workforce (across Health NZ and NGO services) have doubled from 5.5 per cent in 2018 to 11.1 per cent in 2022.

Workforce data for adult Health NZ services each year are only available for selected professions and is collected by role and not by mental health and addiction service type. Nonetheless, the data show that vacancy rates continue to grow between 2022 and 2023 across all selected roles—psychologists, drug and alcohol counsellors, psychiatrists, and registered nurses.

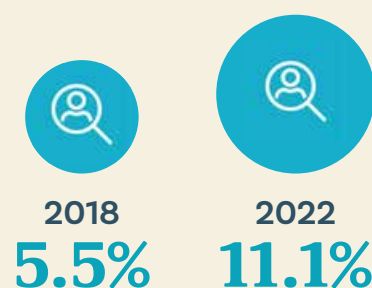
### Workforce is growing, but so are vacancy rates

Total 15,534 full-time equivalent (FTE) staff across mental health and addiction services in 2022/23.

#### FTE growth (employed and vacant) from 2018/19 to 2022/23:



#### Vacancy rates in adult specialist services:



Workforce shortages are evident across many parts of the system. In 2022, the ICAY workforce had a 15.0 per cent vacancy rate. The Access and Choice IPMHA programme has 15.1 per cent of FTE vacant or not yet filled at 30 June 2023. The Royal New Zealand College of General Practitioners report on the future of the workforce estimates a current shortage of 188 general practitioners (GPs). This shortage is forecast to worsen from 74 GPs per 100,000 people in 2021 to 70 GPs per 100,000 in 2031 (Allen & Clarke, 2021).

We heard from many people working in services that vacancies continue to put pressure on service delivery and reduce access to services across different parts of the system. Higher staff turnover also leads to a loss of the knowledge and skills needed to provide the best care to tāngata whaiora.



“

We have a shortage of a workforce ... we've got a nursing workforce shortage, we've got a doctor workforce shortage, we've got a mental health workforce shortage, an urgent care workforce shortage.

”

*Primary sector*

### 3. Findings structured by service type

In this part, we do not report on every individual measure but have structured our monitoring on parts of the system that tāngata whaiora might seek support from at different stages in their journey. We start by discussing early supports (typically for people with mild to moderate needs) in the form of digital and telehealth services and also primary and community services. After that, we look at supports for people with acute or emergency needs in the form of Police, ambulance, and ED services. Finally, we report on access to and options for specialist services.

While we report here on some differences between population groups, we also highlight the different experiences for Māori, and for rangatahi and young people in Part 4.

NGOs are an important part of our mental health and addiction system in providing support to tāngata whaiora within their communities. Their services are diverse, ranging from early intervention services reported in Section 3.2: Primary and community services to services we discuss in Section 3.4: Specialist services, such as residential facilities, community support services, and addiction services.

**Table 2** shows summary data on the number of people using each type of mental health and addiction service. For further detail on these changes, see Appendix A. For the complete time series across the five-year period, disaggregated where available, see the dashboard [mhwc.govt.nz/dashboard](https://mhwc.govt.nz/dashboard).



**Table 2: Summary data on the number of people who used mental health and addiction services, 2021/22–2022/23**

Service type	2021/22	2022/23	2022/23 % of population
<b>Digital and telehealth</b>			
National telehealth services	74,349 people	66,538 people	1.3%
Digital services—depression.org.nz	242,176 people	152,833 people	2.9%
Digital services—thelowdown.org.nz	52,652 people	46,017 people	0.9%
Digital services—thelevel.org.nz <sup>12</sup>	122,520 people	191,972 people	3.7%
<b>Primary care services<sup>13</sup></b>			
Primary mental health initiatives <sup>14</sup>	140,177 people	116,152 people	2.2%
Access and Choice services <sup>15</sup>	114,500 people	185,632 people	3.6%
GP visits for mental health and addiction reasons	No recent data available. Te Rau Hinengaro estimates that 9.1% of people visit a GP for mental health reasons each year (Oakley Browne et al., 2006).		
<b>Emergency services</b>			
Police mental health events <sup>16</sup>	71,626 events	75,759 events	-
Ambulance mental health events <sup>17</sup>	23,261 events	22,966 events	-
Emergency department mental health presentations	33,709 presentations	33,406 presentations	-
<b>Specialist services</b>			
Total specialist services	176,867 people	177,613 people	3.4%
NGO services	73,979 people	74,385 people	1.4%
Health NZ hospital and specialist services	141,228 people	140,416 people	2.7%
Inpatient services	8,722 people	8,598 people	0.2%
Mental health services (Health NZ and NGO)	146,939 people	147,036 people	2.8%
Addiction services (Health NZ and NGO)	42,710 people	43,582 people	0.8%

12 Thelevel.org.nz was launched on 30 August 2021 to replace drughelp.org.nz and pothelp.org.nz, both of which were shut down on 19 August 2022. This launch after the 2021/22 year started may impact user numbers for thelevel.org.nz in that year.

13 It is not possible to calculate the total number of people using all primary care services as not all of the data are NHI-linked. Simply adding together the number of people using Access and Choice programme services and primary mental health initiatives would double-count people who use both services.

14 Health NZ has advised that the 2022/23 data are lower than in previous years due to a change in counting methods (which removed duplicate people), and also because the introduction of other primary mental health programmes lowered activity with these initiatives.

15 Services within this total are IPMHA (136,260 people), Kaupapa Māori (31,677 people), Pacific (10,016 people), and Youth (7,679 people). There may be some duplicates where people have used more than one service type.

16 The total includes both mental health (code 1M) and threatened suicide (code 1X), and represents the number of calls received rather than the number of calls attended.

17 The total includes both Hato Hone St John and Wellington Free Ambulance.

### 3.1 Digital and telehealth services

#### **Aligning demand and capacity of the national telehealth service is vital**

The COVID-19 pandemic led to both increased demand for national telehealth services, and increased funding to provide them. Whakarongorau provides a range of national telehealth services by phone, text, or webchat, which include 1737 Need to Talk among others.

The number of unique people using these national telehealth services increased to a peak around the time of the first COVID-19 lockdowns, and has since returned to pre-COVID levels. Looking at change in the last year, the number of people using one or more of these services fell from about 74,000 in 2021/22 to 67,000 in 2022/23. However, the number of contacts to these telehealth services is similar over these two years (about 200,000 over both years). These differences tell us that those people who use telehealth services are calling or texting more frequently.

The type of needs that telehealth services are dealing with is also changing. The proportion of mental health and addiction ‘complex user’ calls (defined as calls connected for 25 minutes or longer) has increased from 9.3 per cent (8,093 calls) in 2018/19 to 14.5 per cent (16,720 calls) in 2022/23.

The proportion of users making at least one contact where they are at risk of harming themselves or harming others has also increased significantly over five years, from 4.0 per cent (3,424 people) in 2018/19 to 9.7 per cent (6,470 people) in 2022/23.

The number of people with support plans followed at Whakarongorau has increased significantly from 10,510 in 2021/22 to 18,306 in 2022/23. The 2022/23 total represents about 8,000 more people with a support plan from the year before.

These figures paint a picture of an increasing number of callers with high distress and complex needs. On the positive side, they also show that support plans are providing more support to manage ongoing needs that might otherwise result in need for other services.

#### **Wait times and the proportion of unanswered calls are both increasing**

In 2018/19, the average wait time was 1 minute 20 seconds. This has increased to 6 minutes 6 seconds in 2022/23. Unanswered calls have increased from 27 per cent in 2018/19 to 44 per cent in 2022/23.

Whakarongorau has advised that it has minimal vacancy issues so the longer response times reflect how demand is exceeding service capacity.



“

In the past the [telehealth service] has been awesome. This time was very poor and put my life at risk. When you reach out you need someone to respond, not wait two hours, then get told they are too busy and go to somewhere else.

”

*Lived experience online form*

#### **Telehealth services are a safety net**

The sector has told us that staff are using telehealth services as a safety net for tāngata whaiora. Specialist and community services provide 1737 as an alternative point of contact for tāngata whaiora while they are waiting for entry to another service, such as a GP consultation or NGO or specialist services.





“

We hand out the crisis team phone numbers, we give names of other services as well while people wait, we talk to them about the anxiety healthline, and we talk to them about 1737 ... All of that happens at that wait list time, so people know that they can contact [someone].

”

NGO service

### **Telehealth is also supporting those who seek access via 111**

In addition to 1737 telehealth services, an Earlier Mental Health Response (EMHR) phone service has been implemented since 2017 to get faster and more appropriate help to people in psychological distress who call 111 and ask for Police or ambulance services. Call handlers can identify calls that a mental health response would manage and then transfer those calls to the EMHR service. In 2022/23, the EMHR team triaged 8,548 contacts from Police (7,769) and ambulance (779) services to support people in social and psychological distress. Where the EMHR team determines an emergency need, they divert the call back to Police or Ambulance (658 in 2022/23).

The EMHR line is staffed by experienced mental health nurses who can ensure callers get the right help at the right time, either directly on the phone or through advice and navigation support. This service helps to provide people with a mental health response rather than a justice response.

### **Online platforms and apps are evolving and use is changing**

The number of online platforms and apps available to promote mental health and wellbeing is growing in Aotearoa and internationally. Some examples are Groov, Just a Thought, and Aunty Dee.

These tools can provide timely, cost-effective, and discreet ways to support people's mental health (Koh et al., 2022). These digital interventions to support conditions in the mild to moderate range may also reduce the demand on other mental health services, especially among young people. However, research providing evidence for this impact has been limited.

Our monitoring looked at selected online platforms available in Aotearoa. The data show the use of the mental health online platforms 'depression.org.nz' and 'thelowdown.org.nz' has been decreasing since 2020/21 and the number of users (measured by unique NZ IP addresses) has fallen to less than half of the total in 2018/19. These trends warrant further investigation to find out whether the expansion of primary mental health services has seen some people move away from online platforms toward in-person help.

In contrast, use of 'thelevel.org.nz' (the Level) has grown significantly. The Level is the New Zealand Drug Foundation's (Drug Foundation's) online harm reduction platform for people who use drugs, which provides information about what to expect from different drugs and advice on how to stay safer. With The Level, established in August 2021, the Drug Foundation has begun to focus more on delivering information through social media. Since the Level's social platforms have started, 1.6 million people on Facebook and 509,000 people on Instagram have seen their content, and they've had over 1.1 million video views on TikTok. Twice as many people have accessed content on thelevel.org.nz through social media posts compared with the number conducting an organic search using search sites such as Google. This social media approach could be a transferrable strategy to promote use of other online platforms and services more widely.

## 3.2 Primary and community services

### ***There has been significant investment in primary and community care for people with mild to moderate needs***

The 2019 Wellbeing Budget was a key part of the Government's response to He Ara Oranga. One of the recommendations of the inquiry report was to increase access to publicly funded mental health and addiction services for people with mild to moderate and moderate to severe mental health and addiction needs (Government Inquiry into Mental Health and Addiction, 2018).

Following through on this recommendation, the Access and Choice programme was a priority initiative from the Wellbeing Budget that focused on delivering services to people with mild to moderate needs. This investment saw funding of \$664 million allocated for its roll-out over a five-year period from 2019/20 to 2023/24. The programme allocated \$516.4 million for four new service types.

1. **Integrated Primary Mental Health and Addiction (IPMHA)** consists of services people typically access through general practices but also sometimes through NGOs. IPMHA has established the new roles of health improvement practitioner (HIP), health coach, and community support worker.
2. **Kaupapa Māori Primary Mental Health and Addiction Services** are services that are culturally responsive to local Māori communities, delivered by Kaupapa Māori organisations.
3. **Pacific Primary Mental Health and Addiction Services** are services that are culturally responsive to local Pacific communities, delivered by Pacific organisations.

4. **Youth Primary Mental Health and Addiction Services** are services that are youth-friendly and easily accessible to young people, delivered by NGOs.

Additionally, \$99.7 million was allocated for workforce development, and \$48.2 million for system enablers.

We are planning a future monitoring report looking specifically at the Access and Choice programme, with the aim of publishing it by early 2025.

### ***The Access and Choice programme has boosted capacity in primary and community care***

We heard from some people with lived experience and whānau that access to support in primary and community care services<sup>18</sup> has improved, largely because of the roll-out of the Access and Choice programme.

The Access and Choice programme set out to provide free and immediate support for people with mild to moderate mental health and addiction needs. It has boosted the capacity of the primary and community care workforce available to deliver this goal and is now a substantial part of the primary and community mental health and addiction sector. As of 30 June 2023, the Access and Choice programme has contracted funding for 1,275.3 FTE and had employed 1,069.15 FTE.

The Access and Choice programme is starting to see a larger number of people in primary and community care. Our separate report on the first three years of the Access and Choice programme (Te Hiringa Mahara, 2022a) shows the intended and actual reach of this programme part way through its roll-out. In the year to June 2023, IPMHA services saw 136,260 people in total (as distinct from the number of new people seen). This was 2.6 per cent of the estimated total

18 Primary care services are those provided at initial entry points. They are usually services provided by general practices although other organisations such as NGOs also provide primary care services so we describe them collectively here as primary and community care services.

population (see Table 3). Indicative figures for people seen by the other three types of services suggest that the Access and Choice programme as a whole is likely to have seen over 3 per cent of the estimated total population. In the other Access and Choice services, 31,677 people were seen in Kaupapa Māori services in 2022/23, 10,016 in Pacific services, and 7,679 in Youth services<sup>19</sup>.

The Access and Choice programme was intended to provide support for 325,000 people (6.5 per cent of the total population) by 30 June 2024. By June 2023, this is tracking at 57 per cent of what is expected by June 2024. In our separate Access and Choice programme report, we reported that the expectation from the interim Government Policy Statement on Health for July 2022 to June 2024 was 248,000 of these people would be seen by IPMHA services and 77,000 across Kaupapa Māori, Pacific, and Youth services.

The roll out of the Access and Choice programme was over five years and new services are still being rolled out and scaled up through to June 2025. There have been some delays to the roll-out due to the impact of COVID-19 and subsequent lockdowns, particularly impacting Auckland. Health NZ have advised that they are planning to achieve the full access target of 325,000 people per annum in 2024/25.

In addition to the Access and Choice programme, we heard about other forms of support in primary and community care that have improved people's access to services. For example, while outside the scope of our report, the increasing reach of employee assistance programmes (EAPs) appears to be supporting improved access as people who work in an organisation that is signed up to an EAP face no barriers to entry.

### ***The Access and Choice programme has provided positive experiences for tāngata whaiora***

The qualitative stories show that many tāngata whaiora find it easy to access support through Access and Choice services. NGOs delivering Access and Choice services talked about the benefits of being located in the community where people are, and how it is easy for people to self-present and get rapid support. Locating IPMHA services within general practice also makes it easy for practice staff to introduce people to the HIP, which means that people are getting timely access without additional barriers.

**Table 3: Number of people seen by Access and Choice programme services, 2021/22–2022/23**

Service type	2021/22	2022/23	Expectation by 30 June 2024
Integrated Primary Mental Health and Addiction	95,250 people	136,260 people	248,000 people
Kaupapa Māori, Pacific, and Youth services	19,250 people	49,372 people	77,000 people
<b>Total</b>	<b>114,500 people</b>	<b>185,632 people</b>	<b>325,000 people</b>

<sup>19</sup> Health NZ has advised there is likely under reporting in the youth services data.



“

I accessed a HIP worker and it was very easy—but I did go to the GP first ... after that I was able to contact her directly.

”

*Lived experience online form*

IPMHA can also improve experiences by supporting navigation and awareness of different services and supports from a general practice setting. Throughout our qualitative engagements, we heard about the difficulty in knowing which services exist and which services best fit people's needs. This was a challenge for some people working within the health system in addition to tāngata whaiora. People expect that GPs, as their primary point of care, are knowledgeable about options and have a role in getting people access to the appropriate services. Staff talked about how HIPs, health coaches, and community support workers can all support access to additional community options that GPs do not know about.



“

I think what works well is being able to have the time ... finding out what actually is the best service and if there is, what are the barriers?

”

*Primary sector*

### **Need to raise awareness and expand delivery of IPMHA to make full use of additional capacity**

Some stories indicated the IPMHA programme was not working as well as it could within some practices. Most frequently these stories pointed to the need for general practice staff to have greater education and socialisation related to the new roles. All staff, from GPs to receptionists,

need to be aware of the free service and help introduce it to people.

IPMHA services are not yet available in all practices. As at June 2023, a total of 513 GP sites had IPMHA services, which equates to 47.2 per cent of all GP sites and 63.7 per cent of the population enrolled with a GP.

Practices with IPMHA services also differ in the level of access they offer to the service. Some practices require people to see a GP before they can use the service while others enable direct access to HIPs.

The cost of seeing a GP, wait times, and availability can all be further barriers to access. In the 2022/23 New Zealand Health Survey, cost remained a common reason for unmet need for a GP among adults aged 15 years and over (12.9 per cent). The unmet need for a GP due to wait time almost doubled in the last year when over one in five adults (21.2 per cent) reported unmet need due to wait time, compared with 11.6 per cent in the previous year. While cost is not a major barrier for children (as there are zero fees for under 14s), wait time was reported as a reason for unmet need for a GP among 14.8 per cent of children (Ministry of Health, 2023).

### **The influence of IPMHA goes beyond the direct benefits to tāngata whaiora**

The availability of HIPs can improve the workload for general practice staff. General practice can be a challenging environment, where many staff face long, busy days just to get through their core business. One GP described how much better the day goes when they can introduce patients to a HIP, who can offer support beyond what GPs can provide in a scheduled appointment.



“

Our HIP is amazing ... I can say, ‘Hey, I’m going to introduce you to her.’ And my patients going on my trust, and her ability, that she can provide lots of help.

”

Primary sector – Māori

We also heard examples of HIPs helping to improve referrals to specialist services, such as by providing more comprehensive and articulate notes in referrals.

### **Use of IPMHA may be reducing use of other primary care initiatives**

IPMHA appears to be reducing the number of people who are accessing separate primary mental health initiatives (PMHI). These initiatives can vary but often take the form of four to six sessions of talking therapy or extended mental health consults in general practice. In the 2022/23 year, 116,152 people were supported through the PMHI. Like the Access and Choice programme, experiences and data vary as the use of PMHI varies greatly in some districts.

Unfortunately, the method of collating the PMHI data changed in 2022/23 so these findings cannot be accurately compared with previous years. The new method involved removing duplicate people, which contributed to the substantial decrease in numbers of people using PMHI. Another reason for the decrease, as some people observed, was the introduction of IPMHA. However, PMHI was likely to be more appropriate to the people who continued to use it, while those with mild to moderate needs had other options available.



“

Our referrals to our brief intervention [PMHI] have dropped off significantly ... about 20 to 40 per cent. But the reason for that is we encourage people to see their HIP as a first port of call and then they might have a follow-up session with them, or a couple, and that’s enough.

”

Primary sector

This also illustrates how some people may use both IPMHA services and services that are part of PMHIs. However, we cannot examine the extent of this overlap because some data sources are not NHI-linked. We need improved data so that we can explore how new services are affecting the use of existing mental health and addiction services.

### **Trends for medication dispensing are mixed**

Medications are one option among other supports available for people with mental distress. Data on initial dispensing of medication show that dispensings of antidepressant and antipsychotic medications have increased. Conversely, dispensings of anxiolytics and mood stabilisers have decreased in the most recent year (see [Table 4](#)).

Medication dispensing for young people differs in ways that may indicate promising changes in the range of supports available. After a four-year increase in medication dispensing for those aged 0 to 24 years, the level has decreased in the latest year of monitoring. We discuss these findings further in Section 4.2: Rangatahi and youth.



**Table 4: Initial dispensings of mental health medications, 2021/22–2022/23**

Medication type	2021/22	2022/23	1-year change
Antidepressants	2,113,807	2,154,763	1.9% ↑
Antipsychotics	682,255	699,970	2.6% ↑
Anxiolytics	340,112	337,655	-0.7% ↓
Mood stabilisers	211,395	209,189	-1.0% ↓
<b>Total</b>	<b>3,347,569</b>	<b>3,401,577</b>	<b>1.6% ↑</b>

**Some primary and community care staff perceive specialist service thresholds are becoming firmer**

Staff within general practices and NGOs told us they are finding it more difficult to support people to access specialist services. Although specialist service thresholds have not formally changed, providers noted these have become firmer as capacity is constrained. In a few districts, specialist services had contacted staff in primary care to inform them of the full capacity of specialist services and request that they support people as much as possible within primary and community care services.

We heard that access has improved for people with mild to moderate needs with the Access and Choice programme. However, there is a perception that now a service gap has shifted upwards to more moderate and severe needs, affecting people who don't meet the threshold into specialist services or can't get access in a timely way.



“

I think it's getting harder [to access specialist services as they see we have new resources] ... But I think what they'd neglect to see is that those resources are really targeted for mild to moderate range. And the people we're seeing these days are moderate to severe range that needs psychological help.

”

Primary sector

In general practice, we heard the constraints in specialist services (discussed in Section 3.4: Specialist services) has changed referral behaviour for some (but not all) clinicians in primary care. General practices are also struggling for capacity (Royal New Zealand College of General Practitioners, 2021), and some did not see the value in spending their time doing a referral they thought would be declined.

Conversely, we also heard that more appropriate referrals were being made from general practice into specialist services, and the Access and Choice programme had opened referral pathways. Some HIPs described helping GPs to access specialist support where it was required.

At a national level, the number of referrals for ‘new clients’<sup>20</sup> from GPs that were accepted into specialist services has increased over the last five years—from 32,734 referrals in 2018/19 to 34,982 referrals in 2022/23. After accounting for population change over the five years, this change is slightly higher than population growth.

Within NGOs that provide primary supports, staff were holding a higher level of risk than intended because of the reported difficulty of getting access to specialist services for tāngata whaiora with higher needs. Some described how they were seeing people who were above their

service threshold as they questioned where else these people would be able to get support if they did not provide it. Others, including Kaupapa Māori services, described ‘holding’ people in this situation for longer than they would usually while they waited for them to be able to access specialist support. The change in behaviour from primary and community care providers in response to constrained specialist service resources creates a ‘balancing’ effect to manage the number of people that specialist services are seeing.

### **Primary care liaison can help strengthen connections between general practice and specialist services**

Primary care liaison roles are specialist service roles that primarily work to support providers and tāngata whaiora outside of specialist services. The name of these roles and the activities involved vary across the motu. Activities can range from providing primary care clinicians with direct telephone access to a psychiatrist to get rapid advice, to education with general practices, to seeing people in a primary care setting without a referral to specialist services.

These roles help to bridge the gaps between specialist and community care. They are helpful in bringing specialist advice to increase what can be safely managed in primary care, particularly while general practices are holding people with higher acuity or moderate to severe needs. They also support the transition between services by giving advice on what should be referred and ensuring referrals include good-quality information. Specialist services can then work more efficiently when they have good-quality referral information to support triage decisions.

20 ‘New clients’ for the purpose of this report are defined as people who have had no specialist mental health and addiction service activity in the past 12 months.

### 3.3 Police, ambulance, and emergency departments

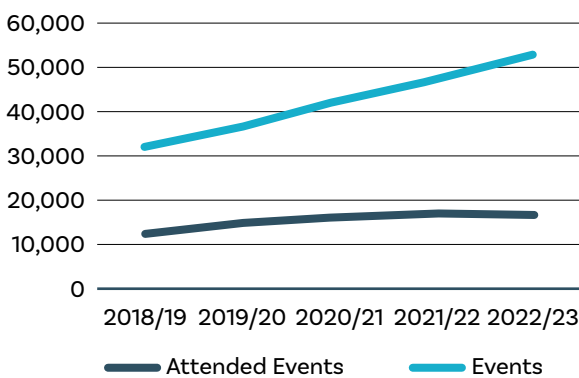
#### More people are looking for mental health support from Police

The number of police events related to ‘mental health’ has increased year on year (noting that mental health police codes may be used in cases of social issues and not a mental health need). Mental health events (code 1M) have increased by 63.6 per cent over five years, from 31,844 in 2018/19 to 52,110 in 2022/23.<sup>21</sup> The number of suicide threats (code 1X) has remained relatively similar over the five-year period (23,649 events in 2022/23). For mental health events, most

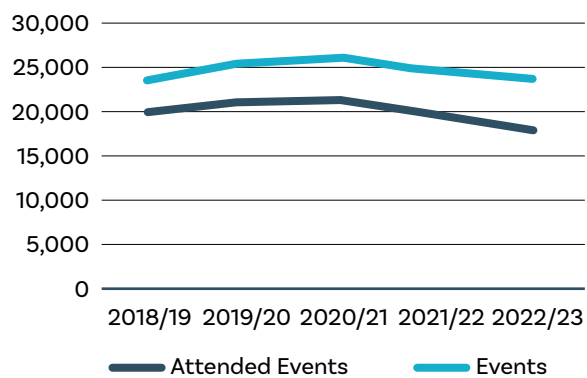
of the increase has been in priority 2<sup>22</sup> events, rising by 79.5 per cent from 24,551 to 44,080. However, priority 1<sup>23</sup> events have also increased substantially, by 52.4 per cent, from 2,741 to 4,178.

The proportion of events that Police have attended has reduced for both mental health and suicide threats. The proportion of mental health events attended has decreased from 38.6 per cent (12,301 attended) in 2018/19 to 31.8 per cent (16,546 attended) in 2022/23 (see Figure 2). The rates of attendance for suicide threats are higher but they have likewise reduced from 85.7 per cent (20,110 attended) in 2018/19 to 75.4 per cent (17,827 attended) in 2022/23 (Figure 3).

**Figure 2: Number of Police calls that were mental health events and number attended (code 1M), 2018/19–2022/23**



**Figure 3: Number of Police calls that were suicide threats or attempts and number attended (code 1X), 2018/19–2022/23**



21 Events are recorded in the Communication and Resource Deployment (CARD) system. CARD events can only have one code type, and Police practice is to code the most serious risk or alleged offence. Therefore, mental health, and potentially threatening suicide, may be a factor in other events but these are not included in these data. Mental health as a code may capture a broad range of events that are not otherwise covered by alleged offences, including social needs. Also, the demographic details of individuals (e.g. ethnicity, age) are not recorded in the CARD system.

22 Priority 2 is defined as ‘offenders present/held but not violent, suspicious activity not involving threat to any person, vehicle crashes but no serious injury, public order disturbance, distressed informant/victim, sudden deaths, evidence present and may be lost’.

23 Priority 1 is defined as ‘actual threat to life or property happening now, violence being used or threatened, serious offence/incident in progress and offenders present or leaving the scene, serious vehicle crashes (persons trapped/seriously injured)’.



As mentioned earlier, Police 111 calls may be coded as 'mental health' but this category is used for a range of social issues and may not require a mental health response. This may partly explain the increase in Police events alongside the stable or declining number of calls attended events, in that the number of calls for social issues that do not require an attendance may have increased. The proportion of attended priority 1 calls (code 1M) is relatively consistent over the five years (small decrease from 90.3 per cent to 87.8 per cent). However, attendance at priority 2 calls, which are more likely to be about social issues, has decreased more substantially, from 39.1 per cent to 28.7 per cent over the same period.

***Ambulance services are responding to more mental health-related incidents that involve more diverse needs***

Both Hato Hone St John and Wellington Free Ambulance provide ambulance services. Like police events, ambulance incidents related to mental health<sup>24</sup> have increased from 19,012 in 2019/20<sup>25</sup> to 22,966 in 2022/23 (a 20.8 per cent increase over four years). This increase is also evident in terms of the proportion of overall ambulance incidents that are related to mental

health, which rose from 4.6 per cent to 5.0 per cent over this period (although the proportion was higher in 2021/22, at 5.2 per cent). In our interviews with ambulance service staff, we heard that ambulance services are receiving more mental health calls and the needs involved are more diverse.

Ambulance services are seeing their role in the system change from being an emergency service to increasingly providing primary care in the community. From a workforce perspective, ambulance services also see an opportunity for paramedics to learn more about working at 'top of scope' to support tāngata whaiora in the community.

A study in 2023 found that both ambulance and Police staff felt ill prepared for incidents related to mental health and felt that mental health services were not easy to work with (Kuehl et al., 2023). A new co-response model aims to improve emergency responses to mental health calls.

24 These include incidents with a clinical impression (primary or secondary) such as anxiety, delirium, dementia, chronic depression, mental health problem, at risk for suicide, or suicidal.

25 2018/19 data have been excluded as industrial action in that year affected electronic Patient Report Form data capture so incident numbers are lower than would be expected.

## Co-response teams are improving outcomes

Improving outcomes for people who are experiencing mental distress is a strategic priority for emergency and health services in Aotearoa. The establishment of multi-agency co-response teams (CRTs) is one initiative to achieve these goals and is an adaptation of similar successful initiatives operating internationally. These teams look different from district to district, with different funding models, and some are in ‘business as usual’ phase while others are at trial stage.

The evaluation of the CRT pilot in the Wellington district (March 2020 to March 2021) found the model contributed positively to callouts related to mental health (Every-Palmer et al., 2021). There was a substantial overlap between 111 calls and people with a history of specialist mental health service use. Almost three-quarters of callouts concerned people currently or previously (in the last five years) using mental health services and around a third were under or had been under the Mental Health (Compulsory Assessment and Treatment) Act 1992 in the last five years.

The evaluation reported better outcomes for tāngata whaiora and whānau as ‘it was viewed as culturally safe, able to provide timely expert advice, and was considered to decrease the risk of violence’. Benefits extended to more effective use of resources as fewer people attended ED when the CRT was available, and those who did attend had their wait in ED shortened by 30 minutes (Every-Palmer et al., 2021).

## Emergency department presentations are decreasing

In 2022/23, a total of 33,406 ED presentations were related to mental health. Presentations in this category increased steadily from 2018/19 to 2020/21 (to reach 38,233) but have since fallen to 33,406 in 2022/23. This is 4.5 per cent lower than five years ago, and an ever-steeper reduction given the population grew over the same time. In contrast, total ED presentations have increased by 1.8 per cent over five years, with the result that mental health presentations as a proportion of overall ED presentations have decreased to 2.6 per cent.

The decrease in mental health presentations is driven by a significant 15.2 per cent decrease in New Zealand Europeans seeking help through ED over the five years. In contrast, presentations among other ethnicities such as Māori, Pacific, Asian, and Middle Eastern, Latin American,

and African have all increased to different degrees. Fewer young people up to 24 years old are presenting to ED for mental health issues, whereas presentations among those aged 25 years and over have increased.

Emergency departments can become the default entry point to mental health and addiction services when people do not get the support they need elsewhere (Australasian College for Emergency Medicine, 2022). The breadth of our monitoring points to a few reasons that could explain these changes. First, a wider range of free service options are available to young people. These include Access and Choice services, school-based health services, and a range of telehealth and online services and platforms. Furthermore, the cost of living and general practice wait times could be disproportionately affecting people under greater financial pressure who see ED as a more accessible entry point or who delay seeking help until they require urgent support.

People's experience of ED is varied. Although it involves a long wait to be seen, many see ED as a sure entry point to the hospital specialist service when people are in crisis.



“

Inpatient service was accessible only once my daughter was so sick that she could be admitted through ED.

”

*Whānau, family, and supporters online form*

### **Wait times in emergency departments continue to be longer**

ED data show that average wait times<sup>26</sup> for ED transfer to mental health inpatient services have risen from 3 hours, 46 minutes in 2018/19 to 5 hours, 27 minutes in 2022/23. Those aged 0–18 years have the shortest wait times (4 hours, 28 minutes in 2022/23).

However, the total ED transfers to mental health inpatient services have fallen by 3.1 per cent over the five-year period (from 7,459 transfers in 2018/19 to 7,229 in 2022/23). The decreasing number of people presenting, fewer people transferring to inpatient services, and longer wait times are all consistent with specialist mental health and addiction services operating under capacity constraints. We explore the circumstances of specialist services in the next section.

## **3.4 Specialist services**

### **Investment is increasing but funding should be based on need**

Specialist mental health and addiction services are funded based on the expectation that 3.0 per cent of the population will need access to these services (Ministry of Health et al., 2023).

Te Rau Hinengaro is the most recent national prevalence survey, and this was conducted in 2003/04 (published in 2006) so its data are now 20 years old. Te Rau Hinengaro estimated that 4.7 per cent of the population will experience a serious mental disorder in a 12-month period (Oakley Browne et al., 2006). As discussed in Section 1.2, the latest New Zealand Health Survey shows increasing levels of psychological distress across the population.

Expenditure on Health NZ specialist services increased by 20.0 per cent from \$1,210 million in 2021/22 to \$1,452 million in 2022/23. This was a significant and necessary increase to respond to community need, population growth, and inflationary pressures. However, the annual increase in NGO (excluding primary) expenditure over this same period has been small at a 2.9 per cent increase (from \$603.0 million in 2021/22 to \$620.7 million in 2022/23).

Overall, expenditure in Māori teams or services across both Health NZ and NGO specialist services has increased from \$212.4 million in 2021/22 to \$235.4 million in 2022/23. As a proportion of total mental health and addiction expenditure, however, this expenditure has decreased from 10.9 per cent of total expenditure in 2021/22 to 10.3 per cent in 2022/23. Over the last year of monitoring, expenditure on Māori teams or services has decreased within Health NZ services but has increased in NGO services.

26 Wait time is calculated as the difference between the date/time of first contact, and the date/time of departure from ED to an inpatient ward.

While the overall expenditure has increased, for some service types the expenditure either decreased, or increased at a relatively low level between 2021/22 and 2022/23. Annual expenditure decreased for Pacific services (down by \$2.8 million or 9.9 per cent) and maternal mental health services (down by \$0.9 million or 3.7 per cent). Increases in annual expenditure were notably low for addiction services (up by \$8.1 million or 3.8 per cent) and for ICAY services (up by \$5.7 million or 2.5 per cent).

**The number of people using specialist services has decreased**

In 2022/23, a total of 177,613 people used specialist services across the breadth of community and inpatient services, representing an access rate of 3.4 per cent of the population. Of these people, 51,744 people (29.1 per cent) were Māori.

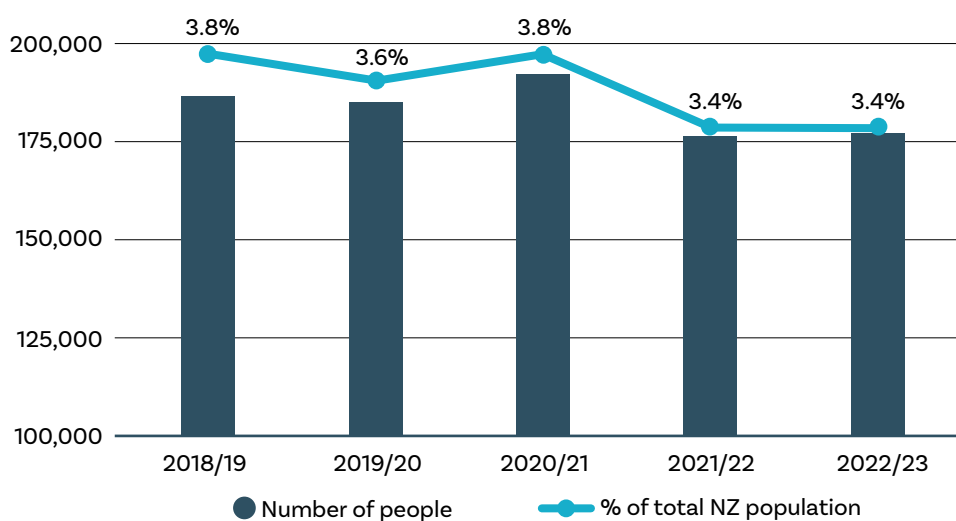
The proportion of people receiving specialist services dropped over the five years of our monitoring. From 3.8 per cent of the population in 2018/19, the proportion in specialist services reduced to 3.4 per cent in 2022/23, which was

similar to the previous year (see **Figure 4**). This represents 9,305 fewer people using specialist services by the end of the five-year period. Accounting for population growth, this change equates to a 9.4 per cent decrease over the five-year period from 3,754 for every 100,000 people in 2018/19 to 3,401 for every 100,000 people in 2022/23.

The decrease is larger for addiction services (15.9 per cent) than for mental health services (3.1 per cent) across the five-year period. We discuss these findings in more detail later in this section.

This decrease is also more significant for some population groups. For Māori, specialist service use (after accounting for population growth per 100,000 people) has dropped by 12.8 per cent and for Pacific peoples by 11.7 per cent over the last five years. The rate for those aged 19 to 24 years has dropped by 12.1 per cent over the same period. Young Māori have the largest decreases: the rate for Māori aged 19–24 years decreased by 20.0 per cent and for Māori aged 0–18 years by 16.1 per cent over five years.

**Figure 4: Number and percentage of people using specialist services, 2018/19 to 2022/23**



A range of reasons may help explain why use of specialist services has decreased. From what we heard from the sector and community, the change is not necessarily due to decreasing demand. We continue to hear that demand is increasing and some people are still reporting difficulties in getting access to specialist services when needed.



“

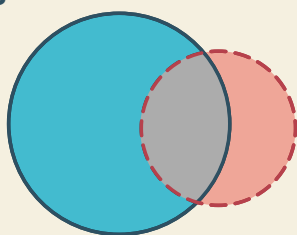
[Access was] very difficult. Many police phone calls, hospital visits, only to be told he did not fit the criteria. Lots of meetings just to get him into a centre.

”

*Whānau, family, and supporters online form*

Later in this section, we discuss how the more complex needs of people presenting to specialist services and workforce vacancies may help to explain the decrease in specialist service use.

### Number of people using specialist mental health and addiction services, by Health NZ and NGO services, 2022/23



- Health NZ services only, **58.1%**
- Both Health NZ and NGO, **20.9%**
- NGO specialist services only, **20.9%**
- 140,416 people received Health NZ specialist services
- - 74,385 people used NGO specialist services

### Fewer referrals but higher acceptance rates

The number of referrals to specialist services has decreased over the last five years. In 2018/19, there were 396,404 referrals made to specialist services, compared with 366,085 referrals in 2022/23.<sup>27</sup> This equates to a decrease of 7.6 per cent over the five years of monitoring.

The main places that referrals come from (which together account for nearly 70 per cent of all referrals) are from self or a relative, from GPs, or from other specialist mental health and addiction services. The number of self or relative referrals has only slightly reduced over the last five years (down by 2.8 per cent), whereas the decrease in referral numbers is more evident in referrals from GPs (down by 10.8 per cent) and other specialist mental health and addiction services (down by 24.6 per cent).

While the number of referrals has reduced, the acceptance rates for referrals have increased across most referral sources. In 2022/23, services accepted 93.1 per cent of referrals, which compares with 91.6 per cent of referrals in 2018/19.



“

I would suggest that we're getting less inappropriate referrals ... more ones that quite clearly meet our complex threshold.

”

*Health NZ service*

We heard from sector interviews that part of the reason for the higher acceptance rates could be that referrers now have a better understanding of appropriateness and the quality of referrals has improved. Roles such as primary care liaisons and improved referral education have supported these improvements.

27 All referrals, irrespective of whether the referral was accepted or not.

**We heard that people accessing specialist services have more complex needs and are receiving more support**

While specialist services are seeing fewer people, we are hearing that those who they do see have more complex needs. The changing needs of people presenting to specialist services could be, in part, offsetting the reduction in number of people being seen. People working in services told us about the increase in multiple issues, such as drug use and social issues, particularly housing.



“

Complexity of social situation, other social indicators of health, the complexity and how hard people are doing it is higher.

”

Health NZ service

From interviews with specialist services, we also heard about increasing neurodiversity in people referred into services.



“

The increase [in referrals] in neurodiversity and the request for ASD ... Is it just because we have more accepting culture of difference or is it because it's socially accepted to be neurodiverse now or has it always been like that and we just haven't noticed?

”

Health NZ service

The quantitative data show that fewer people are being referred into specialist services, and fewer people are receiving more than one contact-related<sup>28</sup> activity. However, for the

smaller group of tāngata whaiora who have received two or more contact-related activities, the average number of treatment days per week has steadily increased from 0.76 average activities per week in 2018/19 to 0.93 activities in 2022/23. This increase is evident particularly in addiction services but also in mental health services. It indicates that specialist services are focusing their resources on providing greater support to those with the highest needs.

Over the five-year period, the average length of stay in an inpatient unit has increased from 18.2 days in 2018/19 to 19.5 days in 2022/23. While average length of stay can be influenced by a range of factors, such as housing and support options for discharge, it can also indicate that people seen in inpatient units may be experiencing more complex or severe needs.

**Services have more 'new clients' and fewer 'long-term clients'**

While the overall number of people using specialist services has decreased over the last five years, the proportion of 'new clients' has increased. These are people who have been referred to specialist services and did not have any mental health and addiction service activity in the past 12 months. In 2018/19, 60.8 per cent of people using specialist services were classified as 'new clients', which has increased to 63.6 per cent in 2022/23. The proportion of declined referrals to specialist services who were 'new clients' also increased over this period, from 54.8 per cent to 61.9 per cent.

This increasing proportion of 'new clients' are being seen by NGO services. The proportion of 'new clients' in Health NZ services has remained relatively similar across the five years, but 'new clients' in NGO services have increased from 37.7 per cent to 45.0 per cent overall.

The specialist services data also show that fewer 'long-term clients' are using services over time.

28 Contact-related activity includes face-to-face and phone contacts.



These are defined as people who have been engaging with specialist services every quarter for the last year or more. In 2018/19, 'long-term clients' made up 21.1 per cent of people using specialist services but this has reduced to 20.3 per cent in 2022/23. This represents 3,298 fewer people over the five years across specialist services both in the community and as inpatients. Given the overall number of people using specialist services reduced by 9,305 people over these five years, this reduction in 'long-term clients' is a considerable driver of overall volume reductions. This finding suggests that people are being kept in services for a shorter period and warrants further investigation to understand whether recovery-oriented care has improved, which would help to explain this change.

**Addiction services have a greater decrease in service use and declining acceptance rates**

Among people accessing specialist services, 24.5 per cent are using addiction services (provided by Health NZ and NGOs).

The decrease in the use of specialist services has been larger for addiction services than mental health services over the five-year period. The number of people using addiction specialist services has reduced by 15.9 per cent (from 51,804 people in 2018/19 to 43,582 in 2022/23). This compares with a decrease of 3.1 per cent in mental health service use over the same period. Part of the decrease in addiction services comes from declining acceptance rates (from 97.4 per cent in 2018/19 to 91.1 per cent in 2022/23).

Workforce shortages are a challenge. However, recent (2022) combined workforce data show that vacancy rates were lower in addiction services. The total FTE vacancy rate was 10.3 per cent in alcohol and drug services compared with 11.7 per cent in mental health services (Te Pou, 2023a).

Māori made up 37.9 per cent of people using addiction services in 2022/23. As the decrease in specialist service use is greater for addiction services, this disproportionately impacts Māori (see Table 5).

**Table 5: Population rate of Māori and total population using specialist services per 100,000 people by service type, 2018/19–2022/23**

Service type	2018/19	2019/20	2020/21	2021/22	2022/23	5-year change
<b>Addiction services</b>						
All people	1,040	973	987	826	835	-19.8%
Māori	2,352	2,200	2,208	1,783	1,819	-22.7%
<b>Mental health services</b>						
All people	3,048	2,971	3,067	2,840	2,815	-7.6%
Māori	4,958	4,855	4,864	4,410	4,433	-10.6%



**Treatment days are decreasing, although services are providing more peer support and Māori-specific interventions**

A ‘treatment day’ is a day in which a service provides a tangata whaiora with one or more activities. Treatment days delivered across specialist mental health and addiction services have decreased over five years by 9.2 per cent. Services provided 3,188,006 treatment days in 2018/19 but this reduced to 2,895,334 treatment days in 2022/23. This decrease over time was greater for Health NZ services (11.3 per cent) than for NGO services (6.3 per cent). The decrease in treatment days occurred across almost all treatment types. The exceptions were ‘peer support’ (up by 2.6 per cent) and ‘Māori specific or integrated interventions’ (up by 3.0 per cent). In terms of expenditure, peer support and Māori services received a smaller increase between 2021/22 and 2022/23 than overall expenditure in mental health and addiction.

**Crisis response**

We heard that it can be very difficult for people to access the support they need from mental health crisis teams. The number of treatment days provided by crisis teams decreased by 13.1 per cent over the five-year period, falling from 111,893 days in 2018/19 to 97,209 days in 2022/23.

**Wait times are a significant issue, especially for young people**

Our primary data collection shows one of the biggest issues that tangata whaiora and whānau experience is long wait times to access specialist services and crisis teams.



“

After multiple calls to [service], I was given an “urgent” appointment 3 months in the future. I deteriorated to crisis point and got committed to hospital long before my “urgent” appointment.

”

*Lived experience online form*

Wait times are one of the few areas in our monitoring where the quantitative data show a different story to what we heard from people. The quantitative measure shows a slight decline over time, whereas people told us waits have become considerably longer. A wait time for tangata whaiora is about how long it takes to get the support they need from when they start seeking help. In contrast, the quantitative wait time measures focus on the time from first referral to specialist services to first contact—which is only one part of the wait that people experience.

Our sector interviews helped to further explain this difference between tangata whaiora experience and the quantitative measures. Some people working in services spoke of using different service models in which services had early ‘initial contact’ with tangata whaiora while there was a second ‘internal wait time’ for people to actually receive treatment.



“

Every district has quite a different model in that space. I know some literally will see you straight away but then you wait for longer to have that second opinion.

”

*Health NZ service*

Based on the limited quantitative measures available for mental health services, it appears that wait times from first referral to Health NZ mental health services have not changed much. The proportion of people seen within three weeks is relatively stable over the last two years of monitoring: 78.0 per cent in 2021/22 and 77.2 per cent in 2022/23 (down from 79.8 per cent in 2018/19). The proportion of people who are seen within eight weeks is also similar at 91.3 per cent in 2021/22 and 91.7 per cent in 2022/23 (down from 93.8 per cent in 2018/19). We do not have data on the overall number of people waiting and the number of weeks they have been waiting in relation to service capacity.

By these measures, Māori have shorter wait times than other ethnic groups: Health NZ mental health services saw 80.8 per cent of Māori within three weeks and 92.8 per cent within eight weeks of first referral in 2022/23.

Across age groups, children and adolescents aged 0 to 18 years are experiencing the longest wait times: Health NZ mental health services saw 60.3 per cent within three weeks and 84.1 per cent within eight weeks of first referral in 2022/23. Within this age group, the wait time is longest for New Zealand Europeans: 57.0 per cent are seen within three weeks and 82.4 per cent within eight weeks of first referral.

These wait times for specialist services have flow-through impacts for primary care, in that primary care services are supporting people for longer.



“

What our teams are finding is that they're holding people before they can get into a specialist service ... trying to keep them well enough or ... at least okay enough before they move up in that waiting list.

”

Primary sector

In contrast to mental health services, wait times for access to addiction services (in both Health NZ and NGOs) did become longer over the four years to 2021/22, but have improved in the last year of monitoring. That is, the proportion of people who accessed addiction services within three weeks improved from 74.9 per cent in 2021/22 to 80.1 per cent in 2022/23, and over the same period the proportion of people seen within eight weeks has improved from 91.4 per cent to 94.9 per cent.

### **Our workforce is growing, but so are vacancy rates**

While the size of the overall workforce has grown with additional roles employed through the Access and Choice programme, many of these roles were filled by people already working in the health sector (Te Hiringa Mahara, 2022a).

Available data suggest that vacancy rates are a significant challenge, making it more difficult for the sector to deliver services. We heard this same message strongly in our interviews with staff working in the sector. To get a clearer picture of workforce challenges, we gathered data from a range of sources: Health NZ workforce 2023 (Health NZ supplied), Te Pou estimates of the 2022 NGO adult workforce (Te Pou, 2023b), and the Whāraurau stocktake of the 2022 ICAY workforce (Whāraurau, 2023). Some of these data are only available up to 2022. There is current work to address vacancies such as the mental health and addiction nursing campaign 'Are You Ready' and the New Entry to Specialist Practice programme.

### Health NZ workforce

The actual contracted workforce<sup>29</sup> in Health NZ has increased from 7,373 FTE in 2018/19 to 8,018 FTE in 2022/23 (up by 8.7 per cent) (see Table 6). In the past year, this workforce has grown by 3.8 per cent.

The ethnic diversity of the workforce is growing. Māori made up 15.5 per cent of the Health NZ mental health and addiction workforce in 2022/23, up from 13.8 per cent in 2018/19. While this proportion has improved, it is still below the estimated 17.4 per cent of Māori in the population of Aotearoa and significantly below the proportion of Māori accessing specialist services, which is 29.1 per cent of all tāngata whaiora using these services.

The workforce data available have some significant limitations. Notably the codes used for the Health NZ workforce do not identify the number of peer support and cultural roles. Health NZ Health Workforce Information Programme (HWIP) data provide vacancies by selected roles (but not by primary area of work) and show that vacancy rates have increased for psychologists, psychiatrists, mental health registered nurses, and drug and alcohol counsellors. Vacancy rates in 2022/23 are highest among psychologists (21.9 per cent) and psychiatrists (19.1 per cent). However, when measured by number, mental health registered nurses have the highest number of vacancies and biggest increase (from 347.7 to 476.5 FTE) in the number of vacancies in Health NZ services.

**Table 6: Number of Health NZ mental health and addiction full-time equivalent staff, 2018/19 and 2022/23**

HWIP occupation group	2018/19 FTE contracted	2022/23 FTE contracted	Share of FTE workforce in 2022/23	5-year change
Allied and scientific	1,327.5	1,477.7	18.4%	11.3%
Care and support	1,247.9	1,436.5	17.9%	15.1%
Corporate and other	777.0	815.4	10.2%	5.0%
Nursing	3,323.4	3,552.6	44.3%	6.9%
Resident medical officer	218.7	272.2	3.4%	24.4%
Senior medical officer	478.8	463.8	5.8%	-3.1%
<b>Total</b>	<b>7,373.3</b>	<b>8,018.2</b>	<b>100.0%</b>	<b>8.7%</b>

29 'Contracted workforce' means the workforce FTE for which funding is allocated. These roles may be filled or vacant. It does not describe the type of employment, i.e. it is not meaning this workforce consists entirely of 'contractors'.

### NGO adult workforce

In its report on NGO workforce estimates in 2022,<sup>30</sup> Te Pou (2023b) estimates that the NGO sector had a total of 5,165 FTE positions (employed and vacant) as of 31 March 2022, which had grown by 13.4 per cent since 2018. However, the report estimates the employed workforce has grown by 5.9 per cent (marginally above population growth) and that the vacancy rate has more than doubled since 2018 to 10.8 per cent. Registered professionals have the highest vacancy rates at 14.0 per cent.

Adult NGO services also include a small but growing peer support workforce. The number of peer support workers increased by 17.7 per cent from 361 FTE in 2018 to 425 FTE in 2022 (8.2 per cent of the adult specialist NGO workforce) (Te Hiringa Mahara, 2023b).

### Infant, child, adolescent, and youth workforce

The Whāraurau stocktake estimates 2,035 FTE (employed and vacant) in the overall ICAY mental health and addiction workforce in 2022/23. This number has grown by 9.2 per cent since 2018/19, when there were 1,864 FTE (Whāraurau, 2023).

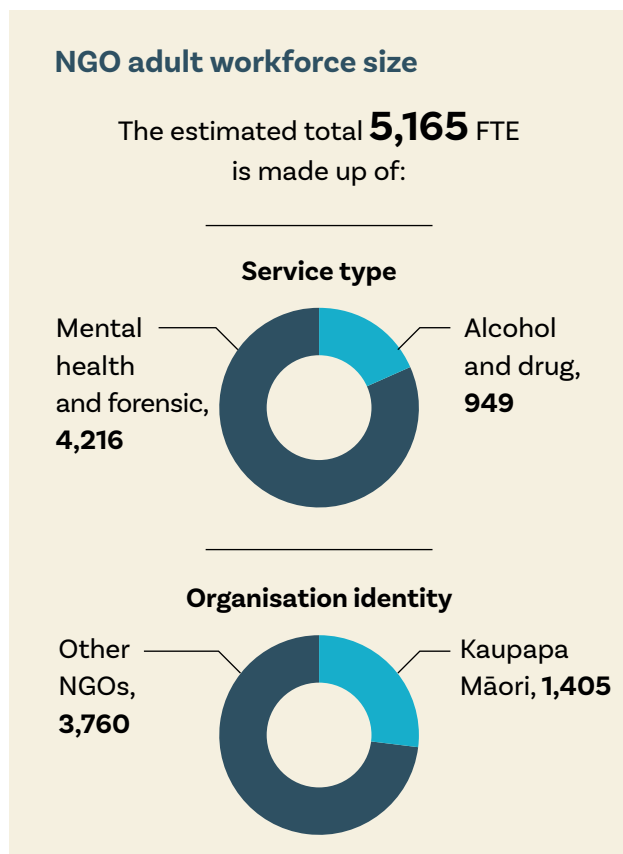
The growth has occurred particularly in the Health NZ ICAY workforce, which increased by 12.1 per cent between 2018/19 and 2022/23, while the NGO/primary care workforce increased by 3.5 per cent. Approximately two-thirds of the ICAY mental health workforce FTE (67.9 per cent) are in Health NZ services.

Vacancies in the ICAY workforce have increased significantly. In 2018/19, Whāraurau reported 168 FTE were vacant, whereas in 2022/23 this had increased to 265 FTE. This 2022/23 vacancy rate is 13.0 per cent of contracted FTE, largely due to vacancies in the Health NZ workforce (which had a 16.8 per cent vacancy rate, compared with 5.0 per cent in NGO/PHO workforce).

### Vacancies are putting additional pressure on the remaining staff

While we are seeing growth in the workforce, vacancy rates are also growing across all parts of the mental health and addiction sector. Services are under constant pressure to cover ongoing vacancies to meet increasing demand. This trend is concerning as evidence shows that a high rate of staff vacancies reduces the wellbeing of the workforce and increases workforce burnout (Chambers and Frampton, 2022).

A survey-based study of psychiatrists in 2021 found that psychiatrists thought specialist mental health and addiction services had been neglected in recent reforms (Every-Palmer et al., 2024). Almost all psychiatrists reported that people needing specialist treatment were unable to access the right care due to resource constraints, either often (according to 85 per cent



30 The estimates are based on a 2022 workforce survey of NGOs with health contracts to deliver alcohol and drug and mental health (including forensic) services to people aged 18 and over. The report also discusses the need to consider other approaches to capture NGO workforce data due to diminishing survey response rates (Te Pou, 2023b).

of psychiatrists) or sometimes (13 per cent of psychiatrists). This lack of access was distressing for psychiatrists where they were unable to do what they knew would be helpful for tāngata whaiora (Every-Palmer et al., 2024).

We heard from interviews with staff that these capacity constraints are leading to a focus on the people with the most severe and complex needs, with the result that staff already working under pressure are put under further pressure due to more complex caseloads. Staff spoke of not being able to meet demand, reduced bed numbers, and closure of units at times due to workforce constraints.



“

We have lots of challenges with staffing around people leaving Auckland because Auckland suffered significantly over COVID ... We lose lots and lots of young people to Australia.

”

Health NZ service

These vacancy rates are compounded by the length of time required to train psychologists, psychiatrists, nurses, and counsellors, and the financial challenges students face to complete their training. We also heard from the sector that remuneration is a reason for leaving roles, and people are leaving to take up jobs with higher pay overseas.

Additional pressures on the workforce constrain their ability to deliver services to tāngata whaiora. The COVID-19 pandemic has contributed to

increased time off due to staff illness and additional workforce stress. Training new recruits into vacant positions, particularly overseas-trained clinicians, takes additional time. Moreover, organisational knowledge is lost when staff leave, and new relationships and networks take time to establish.

### **Capacity constraints are changing whether referrals are made and accepted**

Together the workforce constraints and demand for services are leading, in some cases, to changes in referral pathways as well as in perceptions of thresholds for accepting referrals. We heard that a perception among those in primary and community care is that specialist services are applying a firmer threshold as they prioritise their resource.



“

The bar is continually lifted in terms of who they're [infant, child, and adolescent mental health services] willing to provide service to ... the reality for us is that when they're busy, it's acute care only.

”

NGO youth service provider

People working in specialist services did not mention that any changes had been made to acceptance thresholds over the last five years to focus on helping people with more severe and complex needs.

## The National Workforce Taskforce and the Workforce Development Plan are focused on professions

The National Workforce Taskforce established six professional working groups that are focused on the pipeline for key health professions, including how we recruit, develop, and retain our staff in a health career. Each of these groups—Nursing; Midwifery; Medical; Kaiāwhina; Allied Health, Technical & Scientific; and Clerical and General Management—is undertaking workforce modelling to inform the Workforce Development Plan and the next round of initiatives. Within these are steering groups representing particular professions that will make recommendations to the National Workforce Taskforce to support local growth, and increase the visibility of and interest in these professional pathways.

This national workforce planning needs to provide a clear plan for what the mental health and addiction workforce looks like. This should include models of care that realise the opportunity from the skilled and valuable roles that do not take the form of traditional degree-qualified professions. These roles, such as peer support workers, cultural workers, and rongoā practitioners, provide valuable benefits to tāngata whaiora and can be grown at a much faster rate than the professional pathways we are aware of within the taskforce. Significant inequities remain for Māori, and we need to reconceptualise a workforce and models of care so that they are fit for purpose to better meet the needs of people accessing mental health and addiction services.

### **More people are attending appointments**

High 'did not attend' (DNA)<sup>31</sup> rates can be a sign of disengagement from services. Across all ethnicities and age groups, the number of scheduled specialist appointments that people did not attend has decreased. In 2022/23, the overall DNA rate across specialist community services was 6.2 per cent, a decrease from 7.2 per cent in 2018/19. A reduction in DNA rate indicates that efforts to support engagement with services have increased as well as that use of service capacity has improved.

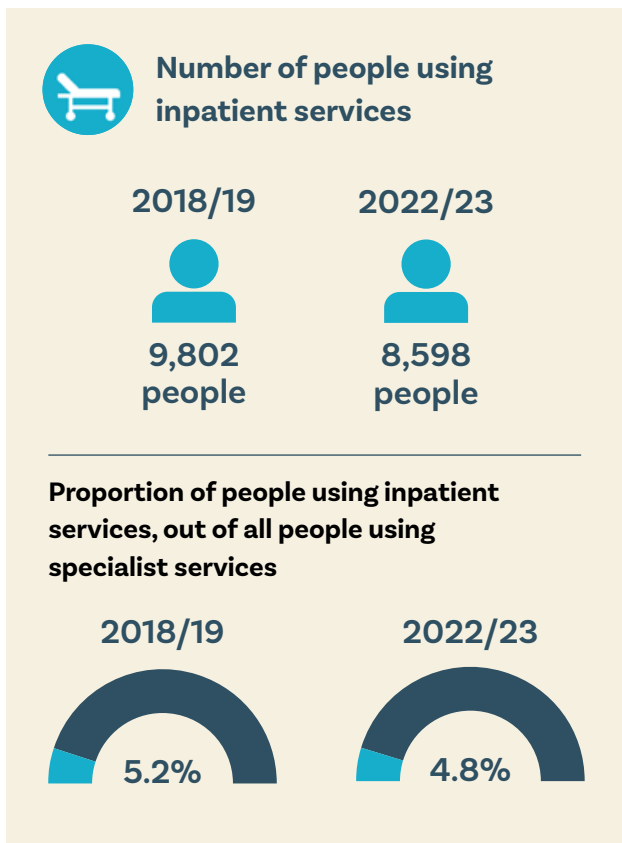
### **Admission to inpatient services has decreased for most people, but not for Māori**

Among all those who use specialist mental health and addiction services, relatively few people will need to be admitted to an acute inpatient service. In 2022/23, 4.8 per cent of people using specialist services were admitted to an inpatient unit once or more in the year, down from 5.2 per cent in 2018/19. In contrast to this overall trend, the proportion of Māori admitted to an inpatient unit has increased, from 5.7 per cent of Māori using specialist services in 2018/19 to 6.0 per cent in 2022/23.

31 Some people have described DNAs as 'did not attract' to illustrate the substantial role that services have to play in enabling engagement, such as by ensuring communication about appointments reaches people and by making appointments at times and locations people are able to attend.



Overall, the number of people using inpatient services has decreased by 12.3 per cent in five years. This reduction is largely driven by an 18.0 per cent decrease in access among New Zealand Europeans. Over the five-year period, use of inpatient services has also decreased among young people: by 22.8 per cent for those aged 0 to 18 years and by 24.5 per cent for those aged 19 to 24 years (while the decrease for people in age groups 25 years or over was 8.2 per cent). Given that the population grew over this period, the reduction in the number of people using inpatient units is even greater, falling from 197 people per 100,000 in 2018/19 to 165 people per 100,000 in 2022/23.



### **The number of bed nights has decreased, except for Māori**

As of November 2023, the data provided show that services have a total of 1,309 mental health and addiction hospital beds. Of these, 607 are in acute adult services and 315 are in forensic services. A further 2,025 contracted mental health and addiction specialist beds were available in 2022/23; of these, 1,441 were in a residential service.

Data on the use of these beds show a consistent pattern with other data. Bed use is measured through the number of bed nights (a count of someone occupying a bed at midnight across inpatient or residential settings). In total, bed nights have dropped by 4.5 per cent over five years. However, bed nights for Māori have increased by 9.7 per cent. Part of the reason for this difference will be related to differences in patterns of inpatient unit use. The disparity warrants further investigation.

### **Readmission rates continue to decrease**

The rates of readmission to an acute inpatient service within 28 days of being discharged have continued to decrease, from 17.0 per cent in 2018/19 to 14.0 per cent in 2022/23. It is not clear why readmission rates are declining. It could be a positive finding that there is focused inpatient care and good handover into community services. Conversely, with service capacity strained due to workforce issues and a shortage of available beds, it may be harder for people to be readmitted when needed.



## 4. Findings on Māori, and rangatahi and youth

While previous sections have touched on data related to Māori, and rangatahi and youth, this section brings together key findings for these groups.

### 4.1 Māori

#### ***Social determinants impact differences in access for tangata whenua***

In the 2022/23 New Zealand Health Survey, 18.2 per cent of Māori aged 15 years and over reported having high or very high levels of psychological distress in the last four weeks, compared with 11.9 per cent of all people aged 15 years and over. Of all those who used specialist mental health and addiction services in 2022/23, 29.1 per cent identify as Māori.

Mental health and wellbeing are strongly influenced by the social determinants of health including low income, unemployment, and a lower standard of living (World Health Organization, 2014). In Aotearoa, Māori are over-represented in the lower socioeconomic deciles and Māori adults have higher rates of unemployment, have lower incomes, are less likely to own their own home, and are more likely to live in a crowded household (Ministry of Health, 2018).

#### ***Current data are limited***

To confidently monitor trends across Te Ao Māori perspective domains of He Ara Āwhina, we need significant improvements to data. It is important for future monitoring and reporting to explore better ways to measure trends that are relevant to Māori and that support Māori experiences within the system accurately and appropriately. For this report, we have used the Māori slice of data from access and options measures as part of the shared perspective in the framework of He Ara Āwhina. We acknowledge the limitations of these data for adequately reporting on Māori experiences and that further work is needed to

improve the data collection, governance, and management of data relevant to Māori.

#### ***Growing the capacity and capability of Kaupapa Māori services***

Expenditure on Māori mental health and addiction services or teams has increased across the last five years: from \$149.6 million in 2018/19 to \$235.4 million in 2022/23. This equates to a 57.3 per cent (\$85.8 million) increase since 2018/19, which is greater than the 49.1 per cent increase in total mental health and addiction expenditure for the same period. Most of this expenditure (86.3 per cent of the \$235.4 million) is for Māori mental health and addiction services and teams that NGOs (including Kaupapa Māori organisations) deliver rather than for Health NZ services.

In 2022/23, this spend on Māori services or teams was 10.3 per cent of total expenditure in mental health and addiction services. This represents an increase over the five-year period from 9.8 per cent in 2018/19; however, it is a decrease from the 10.9 per cent of total expenditure in 2021/22.

The capacity of Kaupapa Māori services to improve early access is growing. A total of 32 Kaupapa Māori services have been established across Aotearoa as part of the Access and Choice programme. These services saw 31,677 people in 2022/23 and have 210 FTE (93.5 per cent of contracted FTE) as of June 2023. These Kaupapa Māori services have the benefit of being culturally appropriate for Māori and being in the community rather than located within a general practice.

We continue to advocate for greater funding to expand Kaupapa Māori services and to build a Kaupapa Māori workforce that better meets and supports Māori needs and aspirations. We also advocate for greater awareness and understanding across the health sector of the value and importance of designing and delivering Kaupapa Māori services. Kaupapa Māori services can provide culturally appropriate and safe support within welcoming spaces that ensures those seeking their services feel safe, cared for, trusted, and understood.



“

The clinical approach can be very sterile and intimidating. Whānau need to feel they are coming into a space that is welcoming, safe and can trust the people there to support their needs.

”

*Māori focus group*

Kaupapa Māori services draw from Te Ao Māori understanding of health and wellbeing and deliver services grounded in Mātauranga Māori. Non-Māori also benefit from these services; about a quarter of people seen by Kaupapa Māori Primary Mental Health and Addiction services funded by the Access and Choice programme were non-Māori.<sup>32</sup>

We have heard that some confusion can arise where services may be perceived as Kaupapa Māori services simply because they have a Māori name. This confusion has the potential to misrepresent and undermine the value of authentic Kaupapa Māori services that are delivering culturally appropriate services to meet the needs of Māori.

### **Accessing parts of the system is proving challenging for Māori**

Workforce capacity issues across the system (see Section 2.2) have increased the pressure on many parts of the system. We heard about long waits at entry points across the system. We also heard about barriers to access, particularly cost (including additional penalties from outstanding fees), time off work, transportation, and childcare. Access is also impacted by demand for primary care; in several areas, GP services have closed their books, meaning they are not accepting any new patients.

Access to early intervention supports a model of care in which tāngata whaiora are treated in the least restrictive setting possible. Māori requiring specialist services have been increasingly using inpatient services, while non-Māori use of inpatient services has decreased. The number of Māori admitted to inpatient units rose from 3,082 people in 2018/19 to 3,112 people in 2022/23. Among Māori using specialist services, 6.0 per cent were admitted to an inpatient in 2022/23, up from 5.7 per cent in 2018/19. Over the same period, inpatient use decreased overall for the total population.

Māori have a shorter length of stay after being admitted to an inpatient unit. The difference is greatest for those aged over 65 years, which may indicate people in this age group have greater whānau support to facilitate discharge.

Over the last five years, Māori rates of mental health presentations to EDs have been higher than other ethnicities. The number of mental health ED presentations for Māori has increased by 5.4 per cent, from 10,310 in 2018/19 to 10,863 in 2022/23. We heard that Māori often use emergency services because they are accessible, affordable, and available outside normal working hours.

Once tāngata whaiora Māori have received appointments, their engagement with services has improved in some ways. One indicator of how well services meet the needs of tāngata whaiora is the rate of ‘did not attend’ appointments. Māori continue to have the highest rates of DNA appointments, but also have the fastest rate of decrease in DNA rates (from 8.8 per cent in 2018/19 to 7.3 per cent in 2022/23). This faster drop may reflect that many services are focusing on ensuring specialist services are culturally safe and trying to address inequitable access barriers.

32 The ethnicity of Kaupapa Māori service users was available for 29,575 ‘new clients’ who were seen in 2022/23 and not seen previously. Among these people, 21,961 (74.3 per cent) were Māori.

### **Previous negative experiences with services are barriers to future access**

Māori with lived experience talked about how previous negative experiences with services deterred them from seeking help later. Some Māori explained they have already experienced discrimination and are sensitive to judgement, stigma, or discrimination based on either their ethnicity or their mental health issue. Many whānau raised this same issue in Oranga Tāngata, Oranga Whānau (Government Inquiry into Mental Health and Addiction, 2019), sharing that they experience fear, distrust, shame, and stigma, which holds them back from seeking help when they needed it. These experiences may be contributing to the finding that Māori present later and require more acute services—because, despite their increasing need for support, they are less likely to seek help.



“

My past experience being turned down when I asked for help has really shaken me and had long term consequences in terms of making me afraid to ask for help again.

”

*Lived experience online form – Māori*

### **We plan to focus on Te Ao Māori domains in future monitoring reports**

There is a lack of data to accurately reflect the experiences of Māori.

Kaupapa Māori epidemiological research principles need to be applied to enable: Māori participation and control at all stages; appropriate collection and classification of ethnicity data to identify and monitor health disparities; and equal explanatory and analytical power for Māori (Paine et al., 2013). We need to improve data collection, management, and governance to ensure data are fit for future monitoring and reporting.

It is our intention to work with Māori (those with lived experience and service providers) to focus on improving data so we can monitor Te Ao Māori domains of He Ara Āwhina in the future. We remain committed to strengthening our monitoring to enable the system to better meet the needs and aspirations of Māori.

## **4.2 Rangatahi and youth**

### **Investment in services for children and young people has not risen at the same level as other parts of the system**

Investment in infant, child and youth services was \$233.8 million in 2022/23. This was 10.3 per cent of the total annual expenditure on mental health and addiction. A comprehensive prevalence study is needed to assess whether this investment is in line with the level of need for services amongst young people. In dollar terms, investment in infant, child and youth services increased by 2.5 per cent since the year before. This increase is considerably lower than the total increase in mental health and addiction expenditure of 17.0 per cent over this same time period.

### **Rangatahi and youth have high distress and need accessible services**

Young people have the highest incidence and prevalence of mental illness across the lifespan and bear a disproportionate share of the burden of disease associated with mental disorder (McGorry et al., 2013). In the 2022/23 New Zealand Health Survey, 21.2 per cent of young people (aged 15 to 24 years) reported psychological distress (Ministry of Health, 2023). This proportion has significantly increased over the last 5 years, from 14.6 per cent in 2018/9. Young people are navigating unique challenges that were unknown to previous generations, notably climate change, a global pandemic, and an increasingly online world with access to information (and misinformation) and social media at their fingertips. They face additional challenges from inequality, discrimination, and

the influence of cost-of-living pressures on their whānau (Te Hiringa Mahara, 2023d).

Young people also experience the highest rates of unmet need for help. In the 2022/23 New Zealand Health Survey, 15.5 per cent of young people aged 15 to 24 years reported they were unable to access professional help for their mental health in the last 12 months when they needed it (Ministry of Health, 2023).

Young adulthood can be a difficult period in the life course as young people are transitioning into adulthood. They may encounter additional challenges to their mental wellbeing as they navigate the adult world, increasing their need for support. At the same time, at an age when many of them have lower economic resources, young people may experience additional barriers to accessing traditional services.

Recent reports have identified that, in their current approach to delivery, mental health and addiction services do not always respond to the unique needs of young people or the contexts in which they live and this can present barriers to access. In a recent report, the Office of the Auditor General (2024) found young people are often expected to fit into services and models of care designed for adults. It recommended that agencies involve young people in the co-design and delivery of services so that those services are tailored to young people.

The cross-party Mental Health and Addiction Wellbeing Group commissioned a report that found many services were not designed for young people (Platform Trust, 2023). It noted some exceptions: Youth One Stop Shops (YOSSs) are valuable services to meet the needs of young people. However, these were inconsistently available across the motu and were struggling to get funding to continue, with some YOSSs having to close due to lack of funding (Platform Trust, 2023).

Our separate report last year (Te Hiringa Mahara, 2023e) shone a light on the need to reduce the number of young people being admitted to adult inpatient services. It is promising to see that the number of young people admitted to adult inpatient services has reduced in the last year. While in 2021/22, 149 young people were admitted to adult inpatient units (representing 25.3 per cent of all young people in inpatient units), this has reduced by 41 per cent to 88 people in 2022/23 (17.0 per cent of all young people in inpatient units).<sup>33</sup>

### ***A wider variety of options for initial support are becoming available***

More self-help tools are becoming available in the form of mental health and wellbeing apps that are particularly suited to young people. Telehealth services appear to be accessible ways of help seeking for many young people. For example, people aged 0 to 24 years make up 42 per cent of known callers to the 1737 telehealth service delivered by Whakarongorau.

However, young people's use of telehealth services has decreased. For example, 12,804 people with a known age between 0 and 24 years used 1737 Need to Talk in 2021/22, but this number fell to 11,286 in 2022/23. This rate of decrease was higher than the fall in use among older age groups. The increasing wait times and higher rates of unanswered calls discourage use—and may lead young people to look for support elsewhere, find other ways of coping, or struggle with their distress. In our interviews, people discussed the wide range of digital tools, online platforms, and social media supports that were available and that young people were using, but we do not capture utilisation data for these services. Examples of youth specific options include Youthline, Headstrong app and digital tools, and Aroā Rangatahi Wellbeing online resource.

33 Noting relatively small numbers so caution in interpreting change over time.



“

There's more ... good, healthy information available online in the proper channels ... people are utilising that and without going to see someone.

”

*NGO youth provider*

The Access and Choice programme has established four new service types that young people may access. Three of them—Youth, Kaupapa Māori, and Pacific Primary Mental Health Services—are often NGO delivered and offer access through schools, marae, community organisations, and other places young people inhabit. The fourth service type, IPMHA services, is usually based in general practices.

The number of young people accessing the Access and Choice programme youth services for the first time has risen from 4,535 in 2021/22 to 6,753 in 2022/23. Including existing people seen by these services, a total of 7,679 people were seen in 2022/23.<sup>34</sup> These services are intended to offer easy and rapid access. However, we have heard that the initial success of some youth-specific services has created unintended access barriers, including the use of wait lists and decisions not to promote awareness of the service in order to manage its capacity.

In addition to accessing new services in the community, young people are accessing new options within general practices: 21,811 people aged 12 to 24 years used IPMHA services in 2022/23. It is expected that 55,000 young people will access all Access and Choice service types by June 2024.<sup>35</sup> However, access rates to IPMHA for young people remain lower than those of older adults (in the age groups of 25 to 64 years and 65 years and over). One reason may be that young people make fewer presentations to general practice for their general health but another may be that they have poorer experiences of the support they access in general practices. Of those aged 15 to 24 years who accessed primary health care, 64.3 per cent reported feeling that their health professional recognised or understood mental health needs they might have (compared with 69.7 per cent for all people aged over 15 years) (Health Quality & Safety Commission, 2023).

34 Health NZ has advised there is likely under reporting in the youth services data.

35 Our earlier report on the Access and Choice programme for youth reported the assumption that 55,000 people aged 12 to 24 years would use Access and Choice programme services by June 2024 (provided that youth use these services at the same rate as other age groups, in line with the total intended reach of 325,000 people) (Te Hiringa Mahara, 2022b). Our forthcoming monitoring report on the Access and Choice programme will report on how many people were seen compared with this expectation.



School-based health services were expanded to all decile 1 to 5 secondary schools following increased funding through the 2019 Wellbeing Budget. These services are now reaching a greater number of young people but limited data on delivery (and impact) are available (Office of the Auditor-General, 2024).

**Trends in medication dispensing for young people have changed**

High rates of medication dispensing for people aged 0 to 24 years have previously raised concerns. In 2022/23, however, dispensing rates have dropped for the first time in five years across all medication categories (see Figure 5).

While we can only draw limited conclusions from medication data alone, these findings may indicate services are relying less on medication and offering more alternative options, such as talking therapies and online tools.

**Wait times to access specialist child and adolescent mental health services remain higher than wait times for adult services**

The time it takes for children and adolescents aged 0 to 18 years to access Health NZ specialist

mental health services is substantially longer than the wait time for adults to access adult mental health services. In 2022/23, 57.0 per cent of children and adolescents are seen within three weeks (relatively similar to the 57.6 per cent in 2021/22) and 82.4 per cent within eight weeks (a slight improvement from 80.9 per cent in 2021/22).

Wait times for addiction services (both Health NZ and NGO services) have slightly improved. In 2022/23, 84.1 per cent of children and adolescents aged 0 to 18 years were seen within 3 weeks (up from 82.1 per cent the year before), and 95.8 per cent were seen within 8 weeks (up from 94.6 per cent the year before).



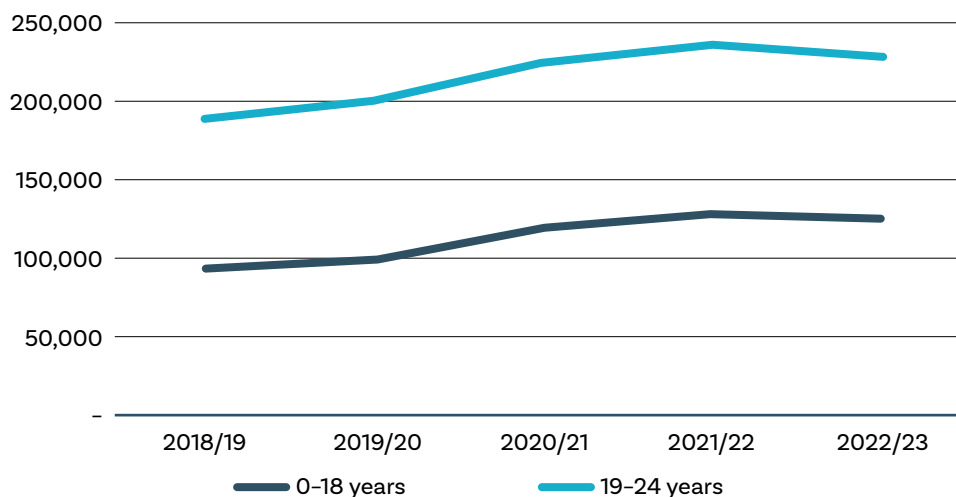
“

It is for us, those really high-end clients that we really need support with, but it’s challenging when that’s met with, ‘We’ve got an eight month wait list.’

”

NGO youth service provider

**Figure 5: Total initial dispensings for mental health medications for young people, 2018/19 to 2022/23**



Young people aged 19 to 24 years have higher rates of accessing specialist mental health and addiction services than those aged over 25 years. In 2022/23, 5.2 per cent of young people were seen by specialist services, compared to 3.4 per cent for all ages.

**Young people have been using emergency services more, but this trend is starting to change**

Young people have high rates of ambulance incidents and ED presentations related to mental health. In 2022/23, there were 614 ambulance incidents related to mental health for every 100,000 young people aged 19 to 24 years. Only older adults aged 65 years or older had higher rates.

In 2022/23 there were in total 33,406 ED presentations that were related to mental health. Around a third of these presentations were for children and young people aged 0 to 24 years. Further, out of total ED presentations, young people aged 19 to 24 years had a higher proportion related to mental health (6.4 per cent compared to 2.5 per cent for people aged 25 years and over).

However, while proportionately higher than other age groups, the total number of ED presentations related to mental health for children and young people aged 0 to 24 years has decreased over the last five years. During this period, the highest number for this age group was in 2020/21, with 15,953 mental health presentations. In 2022/23, this number fell to 11,246 mental health presentations to ED. A similar reduction has not been observed in older adults (in the age groups of 25 to 64 years and 65 years and over). For young people, it is not just the number but also the proportion of ED presentations related to mental health that is decreasing.

Emergency services, such as ED, often become default entry points to services when people do not get their needs met elsewhere. The data reported here may indicate that young people are less likely to have their needs met by the mainstream health system compared with other age groups. However, some signs are suggesting that increased options may be helping to reduce the need to seek mental health support through emergency services, even if young people are still using ED when struggling to access specialist services.



# Whakatepenga

## Conclusion

This monitoring report shines a light on where mental health and addiction services have made progress over the last five years, and where more work is needed. The overall summary and visuals at the start of the report summarise this monitoring story.

The findings of this report underpin the changes we want to see from Government and health agencies to accelerate improvement. We have identified 11 areas of system change under the following categories:

- Increase access to services
- Increase choice of services
- Strengthen connections
- Improve data and insights.

Based on these calls to action, we have made five recommendations as outlined earlier in this report:

1. **Health NZ** develops a mental health and addiction workforce plan to address service capacity and workforce shortages by June 2025 (inclusive of clinical, peer and cultural workforces, Māori and lived experience leadership, and across primary, community, and specialist services).
2. **Health NZ** develops an action plan by June 2025 to meet the needs of Māori and whānau accessing specialist mental health and addiction services.
3. **Health NZ** provides guidance for the delivery of effective acute community options tailored to meet the needs of rangatahi and youth by June 2025.

4. **Health NZ** develops a mental health and addiction data plan by June 2025 that ensures information systems are integrated and enables collection of quality and timely data.
5. **Government** commits to funding a planned programme of work to collect mental health and addiction prevalence data by June 2025, to enable improved services and ensure value for money.

We acknowledge that time and resources are needed to create sustainable system change. However, we call for continued energy, investment, and prioritisation of the voices of lived experience, to accelerate progress toward a system that has people and whānau at its centre.



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# Appendix A: Ngā inenga Measures

This appendix lists the 40 quantitative measures we used to monitor service access and options, and how the measures have changed over time.<sup>36</sup> More detail for most of the measures (including disaggregation by ethnicity, age, and service type where possible) is available in the online dashboard ([mhw.govt.nz/dashboard](https://mhw.govt.nz/dashboard)).

	Measure	Source	Annual change (2021/22 to 2022/23)	5-year change (2018/19 to 2022/23)	Notes and insights
Expenditure	<b>Annual expenditure on mental health and addiction services (Health NZ and Te Aka Whai Ora expenditure)</b>	Health NZ and Te Aka Whai Ora	↑ \$1.95b to \$2.28b (17.0% increase)	↑ (\$1.53b to \$2.28b) (49.1% increase)	Smaller annual increases for expenditure on Māori mental health and addiction services or teams, excluding access and choice (10.8%) and addiction services (3.8%).
People using services	<b>People using national mental health and addiction telehealth services<sup>37</sup></b>	Whakarongorau	↓ 74,349 to 66,538 (-10.5% decrease)	↓ 86,249 to 66,538 (-22.9% decrease)	All telehealth lines dropped across 5 years, except 1737 which has increased 1.3%. Highest during lockdown years.
	<b>People using national mental health online platforms</b>	Health NZ			Highest during lockdown years.
	depression.org.nz		↓ 242,176 to 152,833 (-36.9% decrease)	↓ 415,317 to 152,833 (-63.2% decrease)	
	thelowdown.co.nz		↓ 52,652 to 46,017 (-12.6% decrease)	↓ 98,182 to 46,017 (-53.1% decrease)	

<sup>36</sup> Calculations in this appendix for changes over time do not adjust for population change.

<sup>37</sup> Other telehealth service use measures were also used in this report, e.g., the proportion of 'complex callers' (defined as calls connected for 25 minutes or longer), calls with a risk of harm, use of support plans, and Earlier Mental Health Response calls.



Measure	Source	Annual change (2021/22 to 2022/23)	5-year change (2018/19 to 2022/23)	Notes and insights	
People using services	<b>People using national addiction online platforms</b> thelevel.org.nz	Drug Foundation ↑ 122,520 to 191,972 (56.7% increase)	not applicable	thelevel.org.nz was established in 2021. It has a greater focus on reaching people through social media than drughelp.org.nz and pothelp.org.nz, which were shut down in August 2022 and have not been included in this summary.	
	<b>People using Access and Choice programme services (new and returning)</b> <sup>38</sup>	Health NZ ↑ 114,500 to 185,632 (62.1% increase)	not applicable	Number of people seen for IPMHA, Kaupapa Māori, Pacific and Youth services have been added.	
	<b>People using primary mental health initiatives</b>	Health NZ ↓ 140,777 to 116,152 (-17.5% decrease)*	↓ 132,525 to 116,152 (-12.4% decrease)*	*Some of the reduction in the last year is likely due to a change in counting methods to remove duplicates.	
	<b>Emergency department presentations for mental health reasons</b>	Health NZ ↓ 33,709 to 33,406 (-0.9% decrease)	↓ 34,976 to 33,406 (-4.5% decrease)	Decrease driven by NZ Europeans. Rate has increased for all other ethnic groups.	
	<b>Calls to Police on 111 for mental health reasons</b> (1M) mental health calls   attended events	Police	<b>Calls</b> ↑ 47,064 to 52,110 (10.7% increase) <b>Attended events</b> ↓ 16,806 to 16,546 (-1.5% decrease)	<b>Calls</b> ↑ 31,844 to 52,110 (63.6% increase) <b>Attended events</b> ↑ 12,301 to 16,546 (34.5% increase)	'Mental health' events continue to rise and the proportion of these event types that are attended continues to decrease. Some social issues may be coded as 'mental health'.
	(1X) threats or suicide attempts calls   attended events		<b>Calls</b> ↓ 24,562 to 23,649 (-3.7% decrease) <b>Attended events</b> ↓ 19,417 to 17,827 (-8.2% decrease)	<b>Calls</b> ↑ 23,466 to 23,649 (0.8% increase) <b>Attended events</b> ↓ 20,110 to 17,827 (-11.4% decrease)	

38 Other Access and Choice programme measures, such as workforce size, number of practices, population coverage, etc were used in this report. These will be published in more detail in our forthcoming Access and Choice monitoring report.

	Measure	Source	Annual change (2021/22 to 2022/23)	5-year change (2018/19 to 2022/23)	Notes and insights
People using services	Ambulance incidents related to mental health	Hato Hone St John and Wellington Free Ambulance	↓ 23,261 to 22,966 (-1.3% decrease)	↑ 19,012 to 22,966 (20.8% increase)*	*Change over 4 years as 2018/19 data capture was affected by industrial action.
	People using specialist mental health and addiction services	PRIMHD	↑ 176,867 to 177,613 (0.4% increase)	↓ 186,918 to 177,613 (-5.0% decrease)	Number of people using specialist services appears to have stabilised after the decrease observed in 2021/22.  Addiction services decrease greatest over 5 years (-15.9%).
	People using inpatient mental health services	PRIMHD	↓ 8,722 to 8,598 (-1.4% decrease)	↓ 9,802 to 8,598 (-12.3% decrease)	Decrease is largely driven by NZ European and those aged 0-24 years. Māori use of inpatient mental health services has increased both annually and over 5 years.
Workforce	Contracted adult Health NZ mental health and addiction workforce FTE	Health NZ (HWIP primary area of work)	↑ 7,723 to 8,018 (3.8% increase)	↑ 7,373 to 8,018 (8.7% increase)	
	Contracted adult NGO specialist mental health and addiction workforce FTE	Te Pou More Than Numbers	not available	↑ 4,556 to 5,165 (13.4% increase)*	*For the 4-year period from 2018 to 2022
	Contracted infant, child, adolescent, and youth workforce FTE	Whāraurau	↑ 1,887 to 2,035 (7.9% increase)*	↑ 1,864 to 2,035 (9.2% increase)	*Change between 2020/21 and 2022/23
	Vacancy rates for the adult specialist mental health and addiction workforce	Te Pou More Than Numbers	not available	↑ 5.5% to 11.1%*	*For the 4-year period from 2018 to 2022



Measure	Source	Annual change (2021/22 to 2022/23)	5-year change (2018/19 to 2022/23)	Notes and insights	
<b>Workforce</b>	<b>Vacancy rates for adult Health NZ services (for selected roles)</b>	Health NZ		Vacancies increasing for all selected roles	
	Psychologist		↑ 20.0% to 21.9%	↑ 20.0% to 21.9%	
	Drug and Alcohol Counsellor		↑ 8.6% to 12.8%	↑ 11.2% to 12.8%	
	Psychiatrist		↑ 14.9% to 19.1%	↑ 14.5% to 19.1%	
	Registered Nurse (mental health)		↑ 12.9% to 14.4%	↑ 11.3% to 14.4%	
	<b>Vacancy rates for the infant, child, adolescent, and youth workforce</b>	Whāraurau	↑ 7.8% to 13.0%*	↑ 9.0% to 13.0%	*Change between 2020/21 and 2022/23
<b>Proportion of Health NZ MHA workforce by ethnicity</b>	Health NZ (HWIP primary area of work)			Increasing ethnic diversity in the workforce with Other decreasing as a proportion.	
	Māori		↑ 13.8% to 14.8%	↑ 13.8% to 14.8%	
	Pacific		↑ 7.7% to 8.4%	↑ 6.8% to 8.4%	
	Asian		↑ 13.8% to 15.2%	↑ 11.0% to 15.2%	
	Other		↓ 59.2% to 57.9%	↓ 62.2% to 57.9%	
<b>DAPAANZ registered addiction practitioners</b>	dapaanz	↑ 886 to 944 (6.5% increase)	↑ 681 to 944 (38.6% increase)	Steadily increasing trend.	
<b>Medications</b>	<b>Initial dispensings of mental health medications</b>	Health NZ	↑ 3.35m to 3.40m (1.6% increase)	↑ 2.88m to 3.40m (18.3% increase)	Total mediations of antidepressants, antipsychotics, anxiolytics, and mood stabilisers.  In the past year, initial dispensings decreased for total anxiolytics, and children and young people aged 0–24 years across all categories.
	<b>People receiving opioid substitution treatment (all types of case management)</b>	Ministry of Health	↓ 5,367 to 5,245 (-2.3% decrease)	↓ 5,558 to 5,245 (-5.6% decrease)	Number of people overall has decreased over 5 years but has increased for Māori and Pacific peoples.
	<b>People receiving opioid substitution treatment (OST) (GP case management)</b>	Ministry of Health	↓ 1,409 to 1,333 (-5.4% decrease)	↓ 1,529 to 1,333 (-12.8% decrease)	GP case management decreasing, including as a proportion of total receiving OST (from 27.5% to 25.4%).

	Measure	Source	Annual change (2021/22 to 2022/23)	5-year change (2018/19 to 2022/23)	Notes and insights
Wait times	<b>Wait times to access Health NZ mental health services following first referral.</b>	PRIMHD			This measure is the % seen within 48 hours, 3 weeks, and 8 weeks. In general, an increase in the % would be the desired change as this means more people are being seen within the time threshold.
	<b>Proportion seen within:</b>				
	48 hours		↓ 52.5% to 51.0%	↓ 51.6% to 51.0%	
	3 weeks		↓ 78.0% to 77.2%	↓ 79.8% to 77.2%	
	8 weeks		↑ 91.3% to 91.7%	↓ 93.8% to 91.7%	
	<b>Wait times to access addiction services following first referral – Health NZ and NGO</b>	PRIMHD			Trend for longer wait times changed in most recent year.
	<b>Proportion seen within:</b>				
48 hours		↑ 38.3% to 41.9%	↓ 48.4% to 41.9%		
3 weeks		↑ 74.9% to 80.1%	↓ 81.7% to 80.1%		
8 weeks		↑ 91.4% to 94.9%	↓ 95.2% to 94.9%		
	<b>Wait times for national mental health and addiction telehealth services</b>	Whakarongorau	↑ 4m:11s to 6m:06s	↑ 1m:20s to 6m:06s	Wait times increasing for all telehealth lines.
	<b>Unanswered calls for national mental health and addiction telehealth services</b>	Whakarongorau	↑ 72,181 to 88,355 (22.4% increase)	↑ 32,727 to 88,355 (170.0% increase)	Proportion of unanswered calls has increased over time.
	<b>Average wait times in ED for an inpatient bed (for presentations related to mental health)</b>	Health NZ	↑ 4h:44m to 5h:27m	↑ 3h:46m to 5h:27m	Steadily increasing trend.
	<b>Number of people waiting more than 4 weeks from initial contact to first dose of OST</b>	Ministry of Health	↓ 47 to 45	↓ 61 to 45	Small numbers so we don't report % change.
	<b>Wait list for OST (transfer from specialist to GP case management)</b>	Ministry of Health	↑ 303 to 322 (6.3% increase)	↑ 235 to 322 (37.0% increase)	

Measure	Source	Annual change (2021/22 to 2022/23)	5-year change (2018/19 to 2022/23)	Notes and insights		
Specialist service use and treatment measures	Number of referrals to specialist services	PRIMHD	↓ 366,281 to 366,085 (-0.1% decrease)	↓ 396,404 to 366,085 (-7.6% decrease)	Decrease number of referrals after peak in 2020/21.	
	Bed nights across specialist mental health and addiction services	PRIMHD	↑ 968,602 to 1,007,681 (4.0% increase)	↓ 1,055,163 to 1,007,681 (-4.5% decrease)	Māori have a more significant increase in the last year and their bed nights have increased over the last 5 years.	
	Treatment days delivered across specialist mental health and addiction services	PRIMHD	↓ 3.025m to 2.895m (-4.3% decrease)	↓ 3.188m to 2.895m (-9.2% decrease)	The only contact types with an increase in treatment days across the last 5 years were Māori-specific or integrated Māori interventions (3.0%) and peer support (2.6%).	
	Proportion of treatment days where people did not attend community mental health and addiction services	PRIMHD	↑ 5.8% to 6.2%	↓ 7.2% to 6.2%	The decreasing trend ended in 2022/23.	
	Readmission to an inpatient unit within 28 days of discharge	PRIMHD	↓ 14.6% to 14.0%	↓ 17.0% to 14.0%	Readmission rates are improving over time.	
	Average length of stay in an inpatient unit	PRIMHD	↓ 19.8 to 19.5 bed nights	↑ 18.2 to 19.5 bed nights	Average length of stay is longer over the five years.	
	Average events per week (for specialist service users who have more than one contact-related activity)	PRIMHD	↑ 0.82 to 0.93	↑ 0.76 to 0.93	Steadily increasing trend.	
	Proportion of referrals accepted by source (selected groups)	PRIMHD			Acceptance rate increasing for referrals from Police.	
			Self or relative GP Police	↓ 96.8% to 96.6% ↓ 84.9% to 83.7% ↑ 96.6% to 97.4%	↑ 93.6% to 96.6% ↓ 85.3% to 83.7% ↑ 91.1% to 97.4%	
	Proportion of tāngata whaiora with activity who are 'new clients' (no activity in the last 12 months)	PRIMHD	↑ 58.0% to 63.6%	↑ 60.8% to 63.6%	Increasing proportion of new clients in specialist services	
Number of 'long-term clients' in the community services (with activity in each of the previous 4 quarters)	PRIMHD	↓ 21.2% to 20.3%	↓ 21.1% to 20.3%	Slight decrease		
Number of young people who are admitted to adult inpatient units	PRIMHD	↓ 149 to 88 (-40.9% decrease)	↓ 190 to 88 (-53.7% decrease)	Noting relatively small numbers so caution in interpreting change		

# Appendix B: Tikanga mahi

## Methodology

This appendix outlines how we went about our mahi and describes important limitations for some of the measures used in this report.

### Reference groups

Two reference groups were established for this monitoring project: a sector reference group and a lived experience reference group. Māori perspectives were embedded within both groups.

These two groups provided on-the-ground expert input from start to finish of this work. They provided input into the development of the report and the data we used, and supported sense-making of the data. A subset undertook expert review of the draft report, and members supported wider engagement with the sector.

### Data used

This 2024 report is our third mental health and addiction service monitoring report. The first was Te Huringa published in 2022 (Te Huringa Mahara, 2022c) and the second was Te Huringa Tuarua published in 2023 (Te Huringa Mahara, 2023c). These first two monitoring reports drew largely on a broad range of quantitative service performance data.

This year, we have strengthened our approach, and it is the first time we have collected qualitative data through a primary data collection process for our main service monitoring report. Having a mixed-methods approach enabled us to monitor service access and options in more depth, and to ensure the experiences and voices of people with lived experience are at the centre of our work.

### Primary data collection (mainly qualitative data)

The purpose of our primary data collection was to understand people's experiences of accessing services and what service options are available to them. This information has been sought elsewhere, such as through the Government inquiry He Ara Oranga. However, our point of difference was in aiming to understand what has changed since then, and to ask specific questions such as about the impact of the Access and Choice programme, and whether referral pathways and acceptance thresholds have changed.

Our methodology was designed to obtain diversity in perspectives, and broad reach across different parts of the mental health and addiction sector. We heard from many different perspectives including lived experience communities, whānau, priority population groups, and workforces. For further detail on how we advertised and invited diverse perspectives, see our accompanying **Voices report** ([mhwc.govt.nz/voices](https://mhwc.govt.nz/voices)).

We collected data during November and December 2023, and used different collection methods tailored to the specific audiences.

1. **Online form.** We had two separate online forms: one for people with lived experience, and the other for whānau, family, and supporters. Both were hosted on

SurveyMonkey. We received 181 responses from people with lived experience, and 122 responses from whānau, family, and supporters.

2. **Focus groups.** We held four dedicated focus groups with Māori, deaf people, Pacific peoples, and refugees and migrants as an accessible way for them to share their perspectives.
3. **Workforce interviews.** We conducted 52 interviews with people who worked in the sector in diverse roles, including specialist services, NGO, primary care, and emergency services.
4. **Workforce online form.** For staff that we were unable to interview, we offered an online form as an alternative way for them to contribute. We received 14 online form responses from staff across a variety of services.

Most of the data gathered through these methods were qualitative. However, the online forms asked some quantitative questions, such as demographic questions as well as questions on a Likert scale. Further information on the online forms and interview guides is available in the [Voices report \(mhwc.govt.nz/voices\)](https://mhwc.govt.nz/voices).

After collecting the data, we identified key themes using a thematic analysis process. We coded and generated themes for each data source separately before looking at commonalities and differences between them. We then integrated themes across the online forms, focus groups, and sector interviews.

The Māori responses to the online form, focus groups, and sector interviews were analysed both as part of a shared perspective, and separately by dedicated kaupapa Māori qualitative researchers using a Kaupapa Māori approach.

Our accompanying Voices report includes more detail on the methodology as well as the themes and supporting quotes. The purpose of the Voices report is to honour what we heard from the community and sector, and to provide further detail on the themes provided in this report.

## Quantitative measure set

This report uses 40 quantitative measures relevant to the access and options domain in He Ara Āwhina. We analysed data over time for the five years to June 2023.

We refined some of the measures we used in last year's monitoring such as by expanding how the measures are disaggregated and updating the medication list. We also discontinued some measures from last year's measure set.

For further information about the development of He Ara Āwhina measures, visit [our website](#) (Te Hiringa Mahara, 2023a).

## Data requests and analysis

The 40 quantitative measures relevant to the access and options domain used in this report came from the following sources.

- **Internal PRIMHD analysis:** The Programme for the Integration of Mental Health Data (PRIMHD) is Health NZ's national collection of activity and outcomes data for mental health and addiction specialist services. Te Hiringa Mahara receives a monthly extract of PRIMHD. Some of the measures used in this report, such as wait times and number of people using specialist services, are derived from PRIMHD. This includes both people using Health NZ specialist services, and NGO services (excluding primary care).
- **Data requests:** We submitted data requests to ten agencies—Health NZ; Te Aka Whai Ora; Ministry of Health; Whakarongorau Aotearoa; Whāraurau; Drug Foundation; dapaanz; New Zealand Police; Hato Hone St John; and Wellington Free Ambulance. We requested data from the relevant agencies for the five-year period from 2018/19 to 2022/23 and, where possible, by detailed disaggregation of service type, ethnicity, and broad age groups.

Additionally, we drew on several published sources, which are listed in Ngā tohutoro | References. Our data requests also included measures relevant to the other domains of He Ara Āwhina framework, and these other measures are included in the **accompanying dashboard** ([mhwc.govt.nz/dashboard](https://mhwc.govt.nz/dashboard)). The agencies providing these data were Te Pou; Te Tāhū Hauora | Health Quality & Safety Commission; and the Ministry of Justice. The Mental Health and Addiction KPI programme supplied code to support the output of three dashboard measures.

## Data sense-making and sense-checking

Once agencies had supplied the requested quantitative data, we conducted data cleaning, checking, and collation. We analysed the data first on an individual measure basis, and then combined across measures to make sense of the data. We then triangulated the quantitative data with what we heard in the primary data collection.<sup>39</sup>

When we had a draft story from our interpretation of the data, we ran a series of data sense-checking workshops with the established reference groups. These workshops were an important part of the process to either validate our interpretation or provide feedback on how the data should be interpreted.

Following these data sense-checking workshops, we started to write this report. Our internal team and our expert reviewers reviewed the draft report. The expert reviewers were Margaret Aimer, Ross Phillips, Leilani Maraku, Tyson Smith, Barry Welsh, Murray Patton, and Peter Huskinson. For factual accuracy purposes, we also sent the draft report to Health NZ and the Ministry of Health.

## Measure limitations

All data have their limitations. While we have undertaken a thorough quality assurance process

to ensure the accuracy of data provided in this report, inherent limitations remain. The following data quality issues apply to these selected measures (in alphabetical order).

- **Access and Choice programme data:** Our separate report on the first three years of the programme (Te Hiringa Mahara, 2022a) notes the data quality issues with the Access and Choice programme services. While these issues are improving, an NHI-linked reporting system is not currently in place for the Kaupapa Māori and Pacific services. Work is under way to establish NHI-linked data for Youth primary mental health and addiction services. Earlier data for 2020/21 for the IPMHA services were incomplete, and Health NZ provided estimated annualised access measures at the time.
- **Medication data:** This year we sought pharmaceutical advice to update the medication list of initial dispensings of mental health medications. The data include only publicly funded, community-dispensed medications that are the initial dispensing in a prescription, not repeat dispensings. Some medications can be used for several indications, including indications outside of mental health. For example, antipsychotics are frequently used in palliative care and in older people with dementia for behavioural management, and are also often used for sleep. Similarly, some of the antidepressants are used frequently for pain management, for sleep, for nocturnal enuresis in children, and for smoking cessation. Any differences in prescribing practices will affect the comparability of these data over time.
- **Primary mental health initiatives data:** Data are collected manually from former district health boards (DHBs) and are not NHI-linked. In previous years, the calculations for the number of people who access primary mental health initiative services are the sum of people seen in each quarter and the sum of people seen across the DHBs, rather than a unique people

39 This approach involved bringing individual measures together alongside what we heard in the community and sector. A more sophisticated approach would be to build a systems model with complete integrated data. However, many of the measures are not NHI-linked and not in a form that allows integration.



count. People seen in multiple quarters or by multiple DHBs were counted more than once. For 2022/23, Health NZ was only able to provide the annual count so the figures are significantly lower and unable to be compared with data from previous years.

- **PRIMHD:** Responsibility for this national collection now sits with Health NZ. Health NZ services and NGOs providing specialist mental health and addiction services are mandated to report to PRIMHD.

Some organisations have breaks in reporting and/or incomplete data in PRIMHD for some time periods. PRIMHD is a living data collection, which continues to be revised and updated as data reporting processes are improved. For this reason, previously published data may be liable to amendments, and data will differ based on the PRIMHD extract date. We used an extract of PRIMHD of 25 October 2023 to generate the output used in this report, in line with the best practice of waiting 3 months or more from reference year end for data completeness.

The PRIMHD measures used in this report are impacted by some data quality and/or incompleteness issues. However, our analysis suggests that the overall trends in specialist service use (specifically the decline in number of people using specialist services between 2020/21 and 2021/22 and then a plateau to 2022/23) remain, even when accounting for data quality and incompleteness issues. For example, the overall national trends remain even after removing districts such as Waikato, which has known data issues following a cybersecurity attack in 2021.

- **Wait times:** The wait time measure we report is consistent with the Health NZ definition for calculating wait times (Health NZ, 2024b). There are a range of views about the usefulness and limitations of this technical definition. For example, this measure is the time between referral and when the person is first seen by a service but this may not relate to when the person is receiving treatment. Other parts of health care report wait times calculating forward-load and backlogs. Wait times expressed as a percentage to meet a given

threshold of time do not show the median wait time, or the long tail of wait times. We plan to review the measure set in the future.

- **Workforce data:** Te Pou reported 2022 workforce data for adult specialist mental health and addiction services, using different methods for NGOs and former DHB (now Health NZ) services. For more information, see Te Pou (2023a).

NGO workforce size, composition, and FTE vacancies and turnover are estimated using voluntary survey responses and mental health and addiction expenditure information. Estimates are limited by the accuracy of the information used and assume little difference between reporting and non-reporting NGOs. Workforce vacancy and turnover rates in particular may not account for workers who temporarily deliver other services within NGOs (e.g. for COVID-19 response).

In this report we used Health NZ workforce data for 2023, sourced from the Health Workforce Information Programme (HWIP) data. As noted earlier, this data has significant limitations. HWIP data provides vacancies by selected roles (but not by primary area of work). There are other limitations such as the potential for individuals to be counted more than once if they have roles across multiple groupings.

In addition to data limitations of specific measures, the data included in this report may not be directly comparable with data on the same measure published elsewhere. Various technical reasons limit this comparability, including the following.

- We have used total ethnicity rather than prioritised ethnicity wherever possible. Total ethnicity means that people can be categorised into more than one ethnic group they identify with.
- We have used updated population data sourced from Stats NZ (2024b) as denominators in population rates calculations. These data are retrospectively updated for reference years.

# Rārangi Kupu

## Glossary

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<b>Addiction services</b>	<p>Services that exist to respond to the experiences, needs, and aspirations of tāngata whaiora and whānau who experience harm from substances or substance addiction.</p> <p>Gambling harm services are out of scope for this report.</p> <p>In this report we use the term ‘addiction’ when it relates to services. However, we use the term ‘substance use harm’ when it relates to people.</p>
<b>Districts</b>	<p>The geographical locations consistent with the former district health board boundaries.</p>
<b>He Ara Āwhina framework</b>	<p>He Ara Āwhina means ‘pathways to support’. The framework He Ara Āwhina describes what an ideal mental health and addiction system looks like. For more detail, please visit <a href="https://mhw.govt.nz/our-work/mental-health-and-addiction-system/he-ara-awhina-framework">our website (mhw.govt.nz/our-work/mental-health-and-addiction-system/he-ara-awhina-framework)</a>.</p>
<b>Health NZ services</b>	<p>Services provided currently by Health New Zealand   Te Whatu Ora since it was established 1 July 2022 and prior to this, by district health boards.</p>
<b>Kaupapa Māori services</b>	<p>Kaupapa Māori mental health and addiction services are a tangata whenua response to effectively meeting the mental health and addiction needs of tāngata whaiora and their whānau (Te Rau Matatini, 2015). Kaupapa Māori services are services that providers who identify as Māori develop and deliver. These services include Māori mental health services provided by NGOs and Health NZ services that are not Māori-governed organisations.</p>
<b>Mātauranga Māori</b>	<p>An indigenous knowledge system originating from Māori ancestors that incorporates Māori worldview, philosophical thought, perspectives, and cultural practice.</p>
<b>Measure</b>	<p>A topic of data. For example, ‘workforce vacancy rates’.</p> <p>We use the term ‘measures’ when it relates to people who use services. In our other reports, we use the term ‘indicators’ where it relates to whole populations (consistent with Results Based Accountability terminology).</p>
<b>Mental health and addiction system</b>	<p>All supports and services that respond to the experiences, needs, and aspirations of people and whānau who experience distress, harm from substance use, or harm from gambling (or a combination of these). The mental health and addiction system is part of the wellbeing system.</p>

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<b>Mental health services</b>	Services that exist to respond to the experiences, needs, and aspirations of tāngata whaiora and whānau who experience distress.
<b>Primary care services</b>	Services provided at initial entry points, usually by general practices and other services such as pharmacists. NGOs, such as Māori and Pacific providers, can also provide primary care services so these have been described as primary and community care services.
<b>Specialist services</b>	<p>Specialist mental health and addiction services are also known as secondary care services. Specialist services are designed to respond to the needs of tāngata whaiora with the most severe and/or complex needs. They usually require a referral or assessment for entry.</p> <p>They are publicly funded services provided by Health NZ or NGOs. Specialist services include a range of services across inpatient and community settings. Most specialist services are community based, such as adult community, rehabilitation, alcohol and drug, and other specialist services.</p>
<b>Tāngata whaiora</b>	<p>People of any age or ethnicity who are seeking wellbeing or support, including people who have recent or current experience of distress, harm from substance use, or harm from gambling (or a combination of these).</p> <p>Tāngata whaiora include people who have accessed or are accessing supports and services. They also include people who want mental health or addiction support but are not accessing supports or services.</p>
<b>Te Ao Māori</b>	The Māori world view.
<b>Whānau</b>	<p>Whānau has its whakapapa (history) and origins located in Te Ao Māori (Māori worldview) and refers specifically to blood connections that exist between generations of lineage that descend from atua Māori.</p> <p>In present times, whānau is also commonly used to include people who have close relationships and/or who come together for a common purpose. Tāngata whaiora can determine who their whānau and/or kaupapa whānau are when they are seeking or receiving support. For this reason, we have used 'whānau' in this report to also refer to family.</p>

# Ki hea rapu āwhina ai

## *Where to get support*

Tough times affect each of us differently. It's okay to reach out if you need to, or if you're worried about someone else, encourage them to reach out. We all need a bit of support from time to time. If you or someone you know is struggling, we want you to know that however you, or they, are feeling, there is someone to talk to and free help is available.

People are here for you if you just want to seek advice around how to support people that you're worried about. Whatever support you're looking for, you can choose from a variety of online tools and helplines.

If it is an emergency situation and anyone is in immediate physical danger, phone 111. Alternatively, you can go to your nearest hospital emergency department.

### **For urgent help, mental health crisis services, or medical advice**

Phone your local Mental Health Crisis Assessment Team if you are concerned about a person's immediate safety. Stay with the person and help them to keep safe until support arrives.

To get help from a registered nurse, call Healthline: 0800 611 116.

### **If you need to talk to someone**

Free call or text **1737** any time, 24 hours a day, for support from a trained counsellor, or between 2pm and 10pm for a peer support worker.

Some other great places to get support 24 hours a day, 7 days a week include:

**Are You OK:** 0800 456 450 (family violence help)

**Anxiety NZ:** 0800 269 4389 (0800 ANXIETY)

**Depression Helpline:** free phone 0800 111 757 or free text 4202

**Suicide Crisis Helpline:** free phone 0508 828 865 (0508 TAUTOKO)

**Lifeline Helpline:** free phone 0800 543 354 or free text 4357 (HELP)

**Alcohol Drug Helpline:** free phone 0800 787 797 or free text 8681

**The Lowdown:** for young people, free text 5626

**Youthline:** for young people, free phone 0800 376 633 or free text 234

**Samaritans crisis helpline:** free phone 0800 726 666 if you are experiencing loneliness, depression, despair, distress, or suicidal feelings

**OUTline NZ:** free phone 0800 688 5463 for confidential telephone support for sexuality or gender identity issues

**Ola lelei:** free phone 0800 652 535 is a free national Pacific helpline with Samoan, Tongan, Cook Islands Māori, and English languages available.

For more information about where to get support, please visit the **Health New Zealand website** ([tewhatauora.govt.nz](http://tewhatauora.govt.nz)) or **our website** ([mhwc.govt.nz/where-to-get-support](http://mhwc.govt.nz/where-to-get-support)).



