Te Hiringa Mahara | Mental Health and Wellbeing Commission

Voices report: *Accompanying report to Kua Tīmata Te Haerenga*

Mental health and addiction service qualitative report 2024: Access and options

Voices Report: Accompanying report to Kua Tīmata Te Haerenga | The Journey Has Begun—Mental health and addiction service qualitative report 2024: Access and options

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Te Hiringa 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

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Kupu Whakataki

Foreword

We are pleased to present this **Voices Report**, which accompanies our monitoring report **Kua Tīmata Te Haerenga | The Journey Has Begun**. It provides richness and depth to honour what we heard from tāngata whaiora, communities, and the mental health and addiction workforce across Aotearoa New Zealand.

It is crucial that we give people—and their experiences—the space to share the urgency of system changes needed to enable people to access support where and when they need it. It is important to understand why there is a disconnect between an increasing need for mental health and addiction support and a decrease in people accessing specialist services.

We continue to hear about barriers, such as long waiting lists, not knowing how or where to get support, the stigma of asking for help, discrimination, or a lack of suitable options. We have also heard good stories, such as of people getting the support they needed, and the value of being active participants in their own care or with their whānau and family.

We must acknowledge the hard-working mental health and addiction workforce. Working in a field that faces workforce shortages and high vacancies and involves managing more complex issues is not easy. But we have heard about the incredible work going on and staff turning up each day to do their best to support others. We tautoko your calls for more support.

We are pleased that people have noticed a positive difference through providing or accessing services under the Access and Choice programme, which is easing pressure for parts of the workforce while also providing tāngata whaiora with earlier access to supports. We want to harness these changes so that people can continue to access support early in their time of need. As the system changes, we must keep in mind who we are doing this for—people needing support now, and for generations to come.

Karen Orsborn

Tumu Whakarae | Chief Executive, Te Hiringa Mahara

Ngā Mihi
Acknowledgements

Te Hiringa Mahara wrote this report with the help and expertise of countless people, many of whom are from across the mental health and addiction sector. We thank them all for their valuable contribution.

We thank the hundreds of people who shared—via our online forms and focus groups—their experiences of accessing, or trying to access, services. Your experiences have provided us with a deeper understanding of what it is like to access services in Aotearoa. We write this report for you and anyone else who needs to access mental health and addiction services.

We also want to acknowledge everyone who works tirelessly in mental health and addiction services. We appreciate the many people working within the mental health and addiction sector who generously shared with us their experiences of providing services and gave suggestions for change. This enabled us to gain a richer understanding of service access and options beyond what the numbers alone could tell us.

Thank you to the members of the lived experience and mental health and addiction sector reference groups who provided advice and support along the way, including in planning our qualitative data collection and checking our interpretation of data. This meant that our process was safe and respectful, and reached a breadth of perspectives. We are also grateful to Ivan Yeo and LJ Apaipo for facilitating our focus groups for migrants and refugees, and Pacific peoples respectively.

We want to thank everyone who provided expertise for the Māori sections of this report, which ranged from providing guidance on our intended approach, to facilitating interviews and our Māori focus group, to analysing responses from Māori. Thank you to the translators who provided te Reo Māori headings.

Lastly, we want to express our gratitude to Te Kete Pounamu National Māori Lived Experience Leadership who reviewed our initial analysis of the tāngata whaiora Māori and whānau data.

We hope this Voices report provides a deeper and richer understanding of people’s experiences of accessing and providing mental health and addiction services.

Ngā Ihirangi

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Whakamōhiotanga whānui

Overall summary

The **Voices Report** supports our monitoring report Kua Tīmata Te Haerenga | The Journey Has Begun. This report provides richness and depth to the voices we heard from communities and the workforce through our qualitative data collection.

The voices represented in this report include diversity in perspectives from:

- over 300 people with lived experience of mental distress, substance harm, gambling harm, or addiction and whānau, family, and supporters of people with these experiences across the motu (country)
- over 70 staff working across different roles and service types in our mental health and addiction sector.

Te Ao Māori, tikanga, and Mātauranga Māori are valued by Māori and their whānau

Māori and their whānau want an enabling environment for Te Ao Māori, tikanga, and Mātauranga Māori to be respected and trusted. This includes culturally safe and appropriate services and options removed of judgement and stigmatisation. They want to see a workforce that represents them and where kaimahi are culturally knowledgeable and capable.

Māori and whānau want to be actively involved in decision-making and the design and delivery of their care. This would mean services and options with Māori-informed design and delivery are valued and regarded as highly as clinical options. Māori and their whānau told us that when they engaged with people and services that valued Te Ao Māori values and Mātauranga Māori, it was easier to navigate the system, access various services, and be connected to advocates that support them.

Kaimahi Māori [1] told us that the use of applied mātauranga Māori practices or models of care (e.g. Te Whare Tapa Whā and Whānau Ora) leads to improved outcomes for Māori and their whānau. They want to see a focus on further developing Kaupapa Māori services that hold space for tino rangatiratanga and mana motuhake approaches. They told us that pathways need to improve and that we need more Māori practitioners.

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[1] A Māori worker (sometimes means staff or employee).

Perspectives and experiences from tāngata whaiora, whānau, and family

People described being seen by services and receiving prompt support as a positive experience. They shared their experiences of kind, empathetic, and understanding staff who listened to them. We heard about staff keeping people up to date and providing space to participate in their own care. People talked about the benefits of being able to connect with others with lived experience and having access to new roles in primary care.

We heard about barriers to accessing services, particularly specialist services. A key issue described was the wait times to access services—from when people sought help until they received treatment and support. Another barrier was having referrals declined due to people not being 'sick enough'. In some cases, these experiences discouraged them from seeking help again.

Other barriers identified included difficulty navigating the mental health and addiction system and finding out information about services. There were concerns in relation to cultural understanding and enabling access for those with disabilities. We also heard how stigma and fear, level of unwellness, and other factors like service hours, cost of appointments, and transport can add to the challenges of accessing services.

People's choice in service options was limited. Most people told us that they were not offered a choice in what service they accessed, or their choice was constrained by other factors, such as wait times. For some people, choice of service was less important than being able to access the service that best meets their needs.

Perspectives and experiences from staff

Staff generally had positive views of the Access and Choice programme, particularly regarding Integrated Primary Mental Health and Addiction (IPMHA) services. We heard how health improvement practitioners and health coaches were able to provide support for people in addition to the help they gained through their general practitioner (GP) appointment. These roles were able to provide navigation to other options and services, including community and specialist services, which helped reduce GP workloads and provided benefits for tāngata whaiora.

We heard that primary care liaison roles are helping to bridge the gap between primary care and specialist services. Staff from both primary care and specialist services told us that these roles provide specialist advice within primary care settings through direct phonelines, seeing people in general practices, and upskilling staff. Staff identified other initiatives aimed at improving access, such as providing services outside normal hours, offering subsidised transport, and building relationships with other providers and their community.

We heard that workforce shortages are one of the biggest challenges providing services. Staff commented on difficulties recruiting and retaining people and described burnout among staff, which is having further impacts on recruitment and retention.

Staff described the complexity (including neurodiversity, comorbid conditions, and social issues) that tāngata whaiora are presenting with. The current workforce challenges are making it more difficult to meet the needs of tāngata whaiora. Specialist services are managing their limited resources in a range of ways, including by prioritising people with the highest needs and being firm on maintaining their entry criteria.

However, we heard that managing higher-risk caseloads can make it difficult to support tāngata whaiora who are not as acutely unwell. Meanwhile, staff working in primary care and NGO services perceived an increased threshold for access to specialist services and described doing what they could to ensure people get support, whether through the new Access and Choice services or interim supports, or by providing care for longer than they would have otherwise.

Need for increased access and a more sustainable and connected workforce

Tāngata whaiora, Māori and their whānau, and family want clear access pathways to services without long wait times or high access thresholds. This includes more choice of services and better information about how to access them. Improving access to services also means improving people's initial experience. People want service providers to take the time to build trust, and to understand their culture, needs, and preferences.

Staff told us they want to see better access to services for people with moderate to severe needs, and in the areas of maternal mental health, older people's mental health, housing support, attention deficit hyperactivity disorder, and post-traumatic stress disorder. They shared the need to grow and further develop the mental health and addiction workforce. Staff suggested strategies to promote careers in mental health and addiction; improve conditions to retain staff; develop the skills of the wider health workforce; and fill workforce vacancies, such as by employing peer support workers. Ensuring tāngata whaiora were able to access the right services also means giving staff time to work collaboratively and build networks and relationships with other organisations.

Kupu arataki

Introduction

The **Voices Report** accompanies Kua Tīmata Te Haerenga | The Journey Has Begun (Kua Tīmata Te Haerenga), our 2024 mental health and addiction service monitoring report. The purpose of this Voices report is to present a thematic analysis of the qualitative data collection and provides a richer and deeper summary of what we heard. [2]

We seek the views of people with lived experience

Te Hiringa Mahara—the Mental Health and Wellbeing Commission (Te Hiringa Mahara) is mandated under the Mental Health and Wellbeing Commission Act 2020 to monitor mental health and addiction services, and to advocate for improvements to those services. 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 effectively seeking the views of Māori, people who have experienced mental distress and/or addiction, and those supporting them. This includes people who may be at increased risk of experiencing poor mental health and wellbeing outcomes. Hearing these views is extremely important to us, and we strive to do this well.

We uphold a ‘nothing about us, without us’ approach in working together with people who experience mental distress, substance harm, gambling harm, or addiction to transform the mental health and addiction system. We prioritise the voices and interests of people with these experiences in our work as captured in our Lived Experience position statement.

We aim to amplify the voices of people who have experienced or overcome loss, harm, or exclusion because of practices in the system, or through being denied support.

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

We published our He Ara Āwhina (Pathways to Support) framework in June 2022 following a wide co-development phase with the mental health and addiction sector

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[2] Qualitative data’ refers to data that present information and concepts that are descriptive rather than numerical.

and lived experience communities. He Ara Āwhina describes 12 domains that express what an ideal mental health and addiction system looks like from a Te Ao Māori perspective and a shared perspective. [3]

Last year was the first time we applied He Ara Āwhina framework to our system monitoring. In May 2023, we published Te Huringa Tuarua, which monitored measures across the framework to provide a broad overview.

This Voices report has a specific focus on the access and options domain of He Ara Āwhina framework, which states: [4]

> We have the right to choose support and services, when and where we need them, that respond to our experiences, needs and aspirations, and believe in our capacity to thrive.

Using qualitative data collected for monitoring

It was important to us that this year's monitoring report goes beyond the numbers to explore people's experiences in greater depth. We sought the views of people with lived experience of mental distress, substance harm, gambling harm, or addiction, along with the views of whānau, family, and supporters of people with these experiences—whether they had accessed services or not. We also sought the views of people working in the mental health and addiction sector.

We acknowledge the voices that have come before

We acknowledge the voices that have been shared not only for this year's monitoring report, but in previous work to understand people's experiences of the mental health and addiction system and the changes people want to see. As emphasised by members of our lived experience reference group, Te Kete Pounamu National Māori Lived Experience Leadership (Te Kete Pounamu), [5] and people who have shared their experiences with us, what they have told us is nothing new. The consultation for **He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction** (He Ara Oranga) brought a strong understanding of lived experiences into the system

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[3] He Ara Āwhina has two perspectives—a Te Ao Māori and a shared perspective. Each perspective consists of six domains. The shared perspective of He Ara Āwhina applies to everyone in Aotearoa. The two perspectives work together; for instance, the shared perspective also applies to Māori. They are not direct translations of each other, but rather weave together, reflecting the role that tangata whenua and tangata Tiriti have to play—working together to support improving the collective wellbeing of all.

[4] Access and options is one domain from the shared perspective. The shared perspective of He Ara Āwhina applies to everyone in Aotearoa, including Māori.

[5] Te Kete Pounamu is a specialist unit within Te Rau Ora. All members of Te Kete Pounamu are also kaimahi within mental health and addiction services. This includes Kaupapa Māori services.

(Government Inquiry into Mental Health and Addiction, 2018). Further, throughout the consultation period for our He Ara Āwhina framework, we heard people's experiences of accessing services. [6]

> I just really hope that our kōrero today goes somewhere. That we have some kind of result, that it gets into the right hands … and it has an impact.
>
> *Māori focus group*

While people have been asked about their experiences of accessing services and what service options are available to them before, including for He Ara Oranga, our point of difference was to understand what has changed since then. We also wanted to understand service use trends in the last few years. We asked specific questions regarding service access, including about the impact of the Access and Choice programme, [7] which began its roll-out in February 2020, and whether referral pathways and acceptance thresholds have changed.

Our approach represents diverse perspectives

Our approach sought diversity in perspectives and experiences from people with lived experience, whānau, family, priority population groups, [8] mental health and addiction workforces, and other parts of this sector about access to and options for services. We used a two-streamed approach to gather data from the community and the workforce.

The community stream consisted of:

- people with lived experience of mental distress, substance harm, gambling harm, or addiction
- whānau, family, and supporters of people with these experiences.

Online forms were the primary method of collection for the community stream. In addition, we held four online focus groups with Māori, Pacific peoples, refugees and migrants, and Deaf peoples as an accessible way for them to share their perspectives.

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[6] We published four summaries following the co-development phase of He Ara Āwhina, detailing what people told us and the changes we made in responses. These summaries can be found on our website.

[7] The Access and Choice programme set out to provide free and immediate support for people with mild to moderate mental health and addiction needs. The programme consists of four service types— IPMHA services, which are based primarily in general practices and three service types based primarily in NGOs—Kaupapa Māori services, Pacific services, and Youth services. For more information, see our separate report on the Access and Choice programme.

[8] As outlined in our legislation, Mental Health and Wellbeing Commission Act 2020, we have 12 priority population groups. They are Māori, Pacific peoples, refugees and migrants, rainbow communities, rural communities, disabled people, veterans, prisoners, young people, older people, children experiencing adverse childhood events, and children in State care.

The workforce stream involved people working in:

- primary care services [9]
- non-governmental organisation (NGO) services [10]
- specialist services funded by Health New Zealand | Te Whatu Ora (Health New Zealand) [11]
- emergency services.

For the workforce stream, online interviews provided good insights, particularly into the application of referral and triage processes. For those who could not be interviewed, online forms were provided for their feedback.

Our online approach allowed us to hear from hundreds of people for our qualitative data collection that was conducted during November and December of 2023. We acknowledge this approach restricted our reach to those with no access to the internet and presented further limitations in that it did not apply an approach based on kaupapa Māori research, evaluation, and principles that would maximise the opportunity for Māori to fully participate (Community Research, 2019). [12]

300+
online form responses
(lived experience and whānau)

4
focus groups

52
workforce interviews

14
workforce online form responses

This Voices report represents the views and experiences of these people. However, it is not a full representation of all people who access, or try to access, mental health and addiction services and the staff who work for them across the motu.

Please see Appendix B for more information on our methodology and Appendix C for

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[9] Primary care services are services provided at initial entry points. They usually are services provided by general practices.

[10] NGOs are diverse services that span from early intervention to specialist services, such as residential facilities, community support services, and addiction services.

[11] Specialist services are publicly funded services provided by Health New Zealand or NGOs across inpatient and community settings. Most specialist services are community based. In this report, when we refer to specialist services we are referring to those provided by Health New Zealand

[12] Kaupapa Māori principles-based research and evaluation has eight principles: whanaungatanga; manaakitanga; aroha; mahaki; mana; titiro, whakarongo, kōrero; kia tupato, he kanohi kitea. For more information on these eight principles please visit Kaupapa Māori research and evaluation.

data on the demographic characteristics of respondents to our online forms.

The Voices report covers a wider perspective

The purpose of this Voices report is to honour people's experiences and shine a light on what we heard through our qualitative data collection. While the scope of the monitoring report was focused on publicly funded mental health and addiction services as well as emergency services, we also heard about people's experiences with accessing a range of other services, such as those provided by the Accident Compensation Corporation (ACC) and employee assistance programmes (EAP services).

People told us about experiences relating to other domains of He Ara Āwhina framework, such as Connected Care, Manawa ora/Tūmanako, and Kotahitanga. This Voices report, therefore, includes kōrero about access, options, and other experiences related to the wider mental health and addiction system that Kua Tīmata Te Haerenga does not cover.

Structure of this report

This report has four main sections.

1. **Section 1:** What Māori told us about accessing and providing services. This section describes from a Te Ao Māori perspective what works well and what does not work well in current services, and what tāngata whaiora Māori, whānau, and kaimahi Māori want to see moving forward.
2. **Section 2:** What people with lived experience, whānau, and family told us about accessing services. This section covers the experiences of people accessing (or trying to access) services in terms of what is working well, barriers to services, and whether people had any choice of services.
3. **Section 3:** What staff told us about their experiences in providing services. This section discusses initiatives improving access to services, constraints the workforce are facing, and how they are managed, based on the experiences of people working in the mental health and addiction sector.
4. **Section 4:** What tāngata whaiora, whānau and family, and staff told us needs to change. This section sets out suggestions to improve access from Māori, people working in the sector, people with lived experience, as well as whānau and family. These are presented alongside the changes we would like to see from Kua Tīmata Te Haerenga that would improve service access and options.

Throughout this report we have included quotes from the people we heard from during our qualitative data collection. For information on how we have identified the perspective of each of these voices, please see Appendix A.

Please take care when reading this report

This report reflects what we heard and seeks to accurately reflect people's voices, quotes, and experiences related to accessing, or not accessing, mental health and addiction services as well as workforce perspectives on providing them. At times, we reference topics of suicide and self-harm. We appreciate this may be distressing for some readers. Please refer to the list at the end of this report or visit our website to see what support is available.

Ngā Reo

Voices

1. What Māori told us about accessing and providing services

In this section, we highlight voices from those who identified as Māori from all data sources. Themes presented in this section give mana to kaupapa Māori, Mātauranga Māori, and Te Ao Māori perspectives to ensure Māori voices seeking to advocate for culturally appropriate and safe services are heard and understood.

We heard:

- when Māori and whānau have reciprocal trust (both earned and given) with services, then that trusting relationship forms a solid foundation for better engagement and outcomes
- when services give genuine regard to and practise cultural options, Māori and whānau were likely to feel safer
- Māori and whānau who received culturally responsive services were more likely to have a positive experience. Often, these positive experiences were attributed to having trusting relationships with kaimahi Māori, Kaupapa Māori service providers, and Whānau Ora navigators [13]
- when Māori and whānau have mana and rangatiratanga over their own wellbeing pathways and choices, including being listened to, this often resulted in a better outcome and experience, even after they no longer needed the service.

We also heard from Māori and whānau about negative experiences. They described how the system fell short from a Te Ao Māori perspective and lacked manaakitanga and whanaungatanga to support Māori and their whānau to access culturally safe services and options. Māori and whānau reported being offered mostly clinical options and treatments that did not work, or are not working, for them.

Despite the expansion of Kaupapa Māori services through the Access and Choice programme over the past five years, some commented that their preferred services were not considered and Kaupapa Māori services were often offered as a last resort.

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[13] Kaupapa Māori 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). Providers who identify as Māori develop and deliver Kaupapa Māori services. These services include Māori mental health services provided by NGOs and Health New Zealand services that are not Māori-governed organisations. For more information, please see our separate report on Kaupapa Māori services.

> Listened to, great care, wrap around including family and other supports. It is just getting in the door that's the problem for so many.
>
> *Whānau, family, and supporters online form-Māori*
>
> Finding the right person that will be non-judgemental and hold space for culture and talanoa. If we are intending to make safer space for our people … there needs to be a much better system, that acknowledged Te Ao Māori concepts and mātauranga, as well as Pacific, those brothers and sisters need to receive real time care, as and when needed.
>
> *Lived experience online form—Māori*

Māori and whānau want culturally appropriate and responsive services

Some Māori and whānau found it easy to navigate and access various services, including coordination hubs, and connect with advocates where culturally safe practices and options were provided and supported. We heard that when Māori and whānau were able to engage with services and advocates that allowed them to operate and practise their tikanga, their experience of the system was positive.

> Once the agencies were on board, we were able to let them know (culturally) how we operate (whakamoemiti). Rangatahi were able to ring and there would be action happening almost immediately.
>
> *Whānau, family, and supporters online form—Māori*
>
> What [coordination hub] does do is create wānanga, led by whānau and determine who is filling those spaces in wānanga for whānau, and whānau making the decision of what their journey looks like. … It would be a beautiful thing if we had it everywhere.
>
> *Māori focus group*

Many Māori and whānau reported that they experienced a wide range of barriers preventing them from positively engaging with and navigating the system. Limitations to the cultural capability within the workforce and its ability to use practices informed by tikanga and Mātauranga Māori were significant barriers they experienced. We also heard Māori and their whānau often disengaged from the system because of feelings of whakamā and mamae.

These experiences often played a part in Māori and whānau being left with feelings of not being heard, of burnout, and of being exhausted from trying to support and advocate for themselves, or their loved ones, to access services.

> 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*
>
> It takes courage to walk into a service and ask for help. You're already feeling whakamā about what you're going through. If you are met with hostility or judgement, or even perceived judgement, that can be a huge barrier for our whānau.
>
> *Whānau, family, and supporters online form—Māori*
>
> The clinicians don't look like me, talk like me, walk like me. They often don't understand my needs culturally, so it just doesn't work.
>
> *Lived experience online form—Māori*

Māori and whānau shared that there is a lack of appropriate services that meet their needs. They also reported finding it difficult to access culturally safe and responsive services, and information about available services. We heard that in some regions, Kaupapa Māori services have grown following the roll-out of the Access and Choice programme over the last five years.

> It's become easier because you have … Whānau Ora navigators and mental health support workers and all the different aspects like a wraparound korowai that it's become more accessible for whānau locally to access support if need be.
>
> *Māori focus group*

We heard that cultural disconnection to whakapapa can alienate and stigmatise Māori and whānau. This can create barriers to accessing services and being referred to options that practise and implement kaupapa Māori approaches.

> I was struggling with my identity as Māori. So … I felt more comfortable in the mainstream services. Then there came a time where I really wanted to be able to access Kaupapa Māori services, but I had no idea where they were … but there was that internal stigma … you had to be a certain type of Māori to be able to access these services.
>
> *Māori focus group*
>
> I think the clinical nature of our services, and the language that's used, is just so not fitting with our whānau … huge barrier for our whānau who already have that shame, that fear of judgement, of racism.
>
> *Māori focus group*

Kaimahi Māori want to provide tino rangatiratanga and mana motuhake practices to enable tāngata whaiora to have more timely access to appropriate services

We heard from kaimahi Māori and Kaupapa Māori service providers that they worked hard for those in their care to provide culturally appropriate, safe, strength-based, Whānau Ora, and timely access to services and options underpinned by Te Ao Māori and Mātauranga Māori. Kaimahi Māori reported going above and beyond to manaaki, tautoko, and awhi those in their care.

They also reported providing holistic supports including Mātauranga Māori practices and/or models of care, such as Te Whare Tapa Whā and Whānau Ora. They placed greater value on rongoā, pūrākau, marae, and wairua-based approaches to mental health and wellbeing. Kaimahi Māori reported they did this despite Māori and their whānau previously having poor experiences and subsequently losing trust in the system, and despite the workforce challenges faced by the sector.

> We have Whānau tautoko … we just built a hāngī pit, so we are then trying to weave in the kōrero around hāngī and how you prepare it. We have rangatahi that come in with their parents. … It was about giving whānau a platter of groups … that they wished that they had access to.
>
> *Manager, Kaupapa Māori service*
>
> We take all our whānau to the marae … they're looked after, so we're always off at the marae.
>
> *Manager, NGO service–Māori*
>
> Having a wairua practitioner on hand … ensuring that the wairua is tau in those spaces … healthier and conducive way of healing oneself in the hinengaro. So yeah, that's what it would look like in paradise for me.
>
> *Manager, Kaupapa Māori service*

Kaimahi Māori acknowledged that while there is growing recognition of Kaupapa Māori services and Māori practitioners who support and provide these options, often their use is under-resourced, misunderstood, not widely available, or not regarded as equal by mainstream services.

> Possibly it could have something to do with the salary basis as well in relation to the work we do. Quite often, we do it for the love of the kaupapa, but love don't pay the bills.
>
> *Clinical coordinator, Kaupapa Māori service*

Kaimahi Māori expressed how it is important to draw from tikanga Māori and use manaakitanga and whanaungatanga to build trust and meaningful relationships with Māori and whānau as well as other staff working in the sector. Kaimahi Māori reflected that often implementing these tikanga—where time is essential in building trusting relationships—is constrained by structural barriers of long wait times, costly options, short consultations and appointment times, restrictive assessment criteria, and contract-based arrangements to deliver services.

> Māori vote with their feet. If it doesn't work the first time, they're not going back the second time and then the third and the fourth and the fifth time.
>
> *Clinician, private practice*
>
> Whanaungatanga. Having the time, being able to build relationships with them, being able to relate from a cultural point of view.
>
> *Cultural advisor, Kaupapa Māori service*
>
> When I say whanaungatanga, not just with the whānau that we are working with, but also with the other services, knowing who is the best person for the job, knowing who is going to have the best connection with whānau … knowing our people. That's what gives us the best chance of success.
>
> *Cultural advisor, Kaupapa Māori service*

Kaimahi Māori told us about the workforce challenges involved in recruiting practitioners with the appropriate Mātauranga Māori and who were able and encouraged to hold space for tikanga Māori. Recruiting Māori practitioners who can administer rongoā Māori, and use wairua-based and pūrākau approaches to healing alongside holistic approaches has also been challenging.

2. What people with lived experience, whānau, and family told us about accessing services

In this section, we highlight the voices shared with us from our lived experience online forms; whānau, family, and supporters online form; and focus groups with Māori, Pacific peoples, refugees and migrants, and Deaf peoples. It includes:

- what went well for them
- what they found difficult
- their experience of choice.

People had positive experiences of accessing services

Tāngata whaiora, whānau, and family shared aspects of accessing services that went well. Some people shared that they finally got access to a service and were listened to. Others commented on what helped them to access services, such as having used services previously.

People identified being able to access a service as something that went well

Many people shared that finally accessing a service was something that went well. They said that they had been waiting for a long time to access the service, and some people also commented that they had had difficulty in accessing services previously. Other people were happy that they had finally received the support and care they needed, or they were pleased that the service had contacted them.

> Finally getting to see someone after months.
>
> *Lived experience online form*
>
> When finally seen by psych liaison, care was fantastic. Follow-up care from home-based treatment team was great. Once in the service care was great.
>
> *Whānau, family, and supporters online form*

People appreciated receiving prompt support from services

Some people commented that they were able to access support quickly. This support differed from person to person. For some people, the support was a phone call.

Others shared that an appointment was made quickly after they reached out for support. Because they had received support so quickly, a couple of people said that they, or the person they were supporting, had continued to use the service.

> Fairly smooth and relatively quick start to get an initial assessment and funded support.
>
> *Lived experience online form–Māori*

> The Drs at ED assessed me quickly. I was able to get a bed in the inpatient unit in the end.
>
> *Lived experience online form*
>
> In a crisis moment one morning I rang the service and was very quickly contacted by a senior counsellor. This person was very proactive, spoke to our son that day, and took over his case from then on. Our son has engaged better with this person. I was very pleased with the response in the crisis situation.
>
> *Whānau, family, and supporters online form*

People found it easier to access primary care and community care services

We heard that access to support in primary and community care services has improved. The main reason for this was the roll-out of the Access and Choice programme, which introduced new mental health and addiction roles in the form of health improvement practitioners (HIPs) and health coaches, primarily into general practices. People who had accessed HIPs and health coaches said that they had found them easy to access and appreciated that the services were free.

> I think it has improved in the last five years … there's better access to Kaupapa Māori services … better access to health coaches and health improvement practitioners. So, I would say yes, it is easier to access support.
>
> *Māori focus group*
>
> Sometimes same week, usually the next week. Good thing is that HIP appointment is free.
>
> *Lived experience online form*

Several people also commented that HIPs, health coaches, and other roles established through the Access and Choice programme, such as community support workers, helped them, or the person they were supporting, to access services. They acted as navigational support, providing information on what services tāngata whaiora could access, and also looked into what services would best fit them.

> The health improvement practitioner … asked how my daughter was doing. She found the therapist and arranged funding. She was absolutely fantastic.
>
> *Whānau, family, and supporters online form*
>
> The health coach had plenty of information on what steps to take next, and who I could be referred to easy.
>
> *Lived experience online form*

Previous contact with services made it easier for some people to access services

Though it was not the case for everybody, some respondents to our online forms shared that having previous experiences with services made it easier for them to access services again when they needed to. This could be for one of three reasons: they were known by the service they were accessing, they had a previous history that could help bolster their referral, or they knew where to go to access support and how to navigate the mental health and addiction system.

> There is a previous history so that made the referral easier.
>
> *Whānau, family, and supporters online form—Māori*
>
> Trying to access the services supports were difficult, but once I was under one service, it was easier to access others and things got easier.
>
> *Lived experience online form*

Services that were holistic, well connected, and clear and respectful in their communication created positive experiences for people who accessed services

Tāngata whaiora, whānau, and family commented on their experiences of receiving wrap-around care. They shared how service providers across the sector worked together to provide support. People also described how they, or the person they were supporting, had been referred or connected to other services or supports that were best suited to them. When these transitions were between well-connected teams or services, they enabled a positive experience for people to get the support they needed.

> Was 'wrap around'—in that the therapist also worked with the MHS [mental health service] psychiatrist and GP … also worked with rest of family.
>
> *Lived experience online form*
>
> Listened to, great care, wrap around including family and other supports. It is just getting in the door that's the problem for so many.
>
> *Whānau, family, and supporters online form—Māori*
>
> Good linkage between psychiatrist, psychologist, and inpatient clinic.
>
> *Lived experience online form*
>
> I was supported by my previous inpatient treating team to my first meeting with the new provider.
>
> *Lived experience online form*

The way that services and staff communicated was a major theme for respondents to our online forms. Having clear communication that included relevant information on next steps and what they should do helped to ease stress and anxiety. Many people commented on staff who were kind, friendly, understanding, caring, empathetic, respectful, and 'amazing' in providing them with active support and reassurance. This made them feel safe, heard, taken seriously, and believed.

> I was given approximate wait times to be seen which helped ease my anxiety and ensured I kept informed.
>
> *Lived experience online form*
>
> The intake assessment person was very kind and after that, they got back to me quickly. They were very clear about what the next steps were.
>
> *Lived experience online form*
>
> I felt accepted and not judged. It was the turning point for me and my addictions.
>
> *Lived experience online form*
>
> Great rapport with our son, always warm and friendly, always offered the whole family a hot drink on arrival and biscuits if we wanted them. Always approachable and there for us.
>
> *Whānau, family, and supporters online form*

People appreciated being active participants in their, or their loved one's, care

Tāngata whaiora expressed their gratitude towards service providers who asked them about, and listened to, their needs and wishes for their care. They also appreciated collaborating with service providers about what care they would receive.

> I got bespoke support for my needs. I was empowered to drive things the way I wanted.
>
> *Lived experience online form*
>
> The 0800 crisis team were very empathetic and addressed all my concerns carefully before collaborating with me on a thorough and realistic safety plan.
>
> *Lived experience online form*

Similarly, whānau and family members were greatly appreciative of service providers who listened to what they had to say and who included and involved them in their loved one's care. Respondents also shared experiences where service providers asked them about what support they thought their whānau or family member should receive.

> When we (parents) were fully included and involved, and when whānau voice was fully considered, we did make some positive progress.
>
> *Whānau, family, and supporters online form*

Connecting with other people with lived experience made accessing services more pleasant for tāngata whaiora

Tāngata whaiora shared how seeing others with their own lived experience was helpful and made it easier for them to access services. Some people commented that they met peers within support groups and made connections. Others shared how they saw a peer support worker who supported them to make referrals. Whānau and family members also commented on how seeing others with lived experience helped their loved one.

> Met peers in group and made connections. My counsellor motivated me to become a Peer Support Specialist myself.
>
> *Lived experience online form*
>
> Supportive, understanding peer support worker, counselling co-ordinator, and counsellor, all with their own lived experience, was helpful. The peer support worker was quick to direct me to the referral form for counselling and supported me with what to say/how to fill it out.
>
> *Lived experience online form*
>
> There was a student there who was able to make a mutual connection [via] lived experience, which helped my whānau member open up more where the practitioner was not achieving this.
>
> *Whānau, family, and supporters online form*

People also described difficulties in accessing services

While people shared positive aspects of accessing services, more can be done to further improve people's experiences. Tāngata whaiora, whānau, and family told us they found it difficult to access services, particularly crisis and specialist services, when and where they needed them. People also described the barriers they faced that made accessing services difficult and the impact these difficulties had on their experiences.

Wait times were the main access barrier

Wait times were a major barrier raised by tāngata whaiora, whānau, and family who accessed, or tried to access, services. This was the case for many different services, including helplines, crisis services, general practices, and specialist services. For those who did access services, many respondents noted that they waited a long time to be seen or heard. The length of time people waited varied by the type of service they were accessing. For example, some people noted they were waiting weeks to see their general practitioner (GP) while others said they waited months to access services provided by Health New Zealand or former district health board (DHB) services.

> I texted a national helpline. An automatic response came eight minutes later to say they were busy. A human texted me nearly 90 minutes later. By that stage I had given up on them.
>
> *Lived experience online form*
>
> The wait time was too long, four months in total. Twice the appointment got delayed. … While waiting to be seen by community mental health I had to keep going back to my GP to check in, which meant more medical bills to pay.
>
> *Lived experience online form*

It is important to note that for the tāngata whaiora, whānau, and family we heard from, wait times were not just associated with how long it took for them to receive their first contact with a service. More than that, wait times were associated with how long it took people to receive the support they needed from when they first started seeking help. For example, people mentioned waiting to see their GP to make a referral, waiting for their referral to be accepted, and then waiting to see someone who could provide care. If the service could not provide the help they needed, then people needed to wait longer because they were referred to another service.

> We started with the GP, who sent us to a counsellor. … Then the paediatrician at the hospital, but this took a very long time! Finally got a referral and waited to hear from CAMHS [Child and Adolescent Mental Health Services], this took a very long time too. I had to keep phoning and following up.
>
> *Whānau, family, and supporters online form*
>
> Trying to find a GP or trying to see a GP is a pain at first. You’re waiting probably two to three weeks … which is not helpful especially if you’re in distress. By the time you do see the GP, half of the things that you’re going through are probably out the door or you’ve figured something out … then waiting to be referred is another waiting process.
>
> *Pacific peoples focus group*

People also shared about the impact that wait times had on them or the person they were supporting. This included feeling unable to access services, deteriorating and reaching a crisis point that they felt could have been avoided, additional stress on whānau and family, and deciding to look for support from private or EAP services (although this alternative did not guarantee timely access either).

> I mentioned I felt I was in crisis and needed help. I got told it’s not worth doing a referral because there was such a long waiting list I would not be able to be seen.
>
> *Lived experience online form*
>
> I rang the crisis line and was put on hold for over 20 minutes. I then hung up as I felt I couldn’t wait for help any longer.
>
> *Lived experience online form*
>
> I waited six months and deteriorated so much my whānau wanted to section [me].
>
> *Lived experience online form–Māori*
>
> While we waited to be admitted to eating disorder services, we had to support our son at home. This was so stressful for us as a family as we watched him deteriorate and we didn't know how to help him.
>
> *Whānau, family, and supporters online form*
>
> I tried several private psychology practices after the public service couldn't give me the help I needed, but I was rejected from them all because of no availability to take on new clients, and/or waitlists of between six months to a year.
>
> *Lived experience online form*

We heard that the impact of wait times is particularly significant for young people as well as people who are experiencing substance harm or addiction. People told us that both young people and people experiencing substance harm or addiction need to be seen as soon as possible once they have decided to seek help. If they are not, the window of opportunity may pass, and they could decide against accessing services.

> Services have a huge waitlist, particularly AOD [alcohol and other drug] services. By the time the person was able to access the service, the motivation for change had passed.
>
> *Whānau, family, and supporters online form*
>
> Our young people seek help … when they’re at their worst type of distress … you only come when you’ve had it to the brim. Then when you finally do work up the courage to come through, it’s a whole new process. … I also want to acknowledge that … I have that knowledge of the system … but I am so mindful of the rest of our young Pacific and Māori who don’t and [who] do not come back because either it doesn’t fit, or it took too long.
>
> *Pacific peoples focus group*

Some people told us they called emergency services or visited the emergency department (ED). Often, this was because they, or the person they were supporting, needed immediate help and they felt they could not wait to receive care. Although some people described lengthy wait times in ED, this pathway was often still quicker than waiting for a referral-based entry. However, while some respondents received care quickly in ED, others described poor experiences of waiting in ED and not getting the outcome they were seeking.

> I went to ED with mental health crisis. Took many hours before seeing a psychiatrist and had to wait overnight and until afternoon before being admitted to inpatient unit.
>
> *Lived experience online form*
>
> Incredibly difficult, despite having a crisis plan that talked about admission when suicidal. Waiting in emergency for 7 hours for someone who is suicidal and has autism is terribly triggering. And then to be told there were no beds available was soul destroying.
> *Lived experience online form*

People described being unable to access specialist services because they were considered 'not sick enough'

Tāngata whaiora as well as whānau and family told us that they, or the person they were supporting, were unable to access specialist services because they did not meet service thresholds and criteria. They shared that they, or their loved one, had tried to access services, but their referrals had been declined because they were 'not sick enough'. Other people commented that they decided not to try to access services because they believed they would be declined for that reason. People also shared that their referrals had been declined more than once before they were able to access services.

> Between my GP, midwife and my own self referrals, I had a total of seven rejected referrals before someone from the mental health team agreed to even triage me.
>
> *Lived experience online form*
>
> They said self-referrals were accepted but we did the self-referral process/forms just to be rejected and offered no alternatives. Basically, [they] said I need to be actively having delusions/ hallucinations to be considered.
>
> *Lived experience online form*
>
> People have varying degrees of ability to be able to access services, and it's dependent on how well they know the system, but also how unwell they are. … Our whānau have to get so bad before they actually get support. In my experience, I have gone into services,

> ‘You don’t meet the criteria’. There’s always a criteria to be able to access a service, and there’s never a warm handover either.
>
> *Māori focus group*

This experience was also discussed in the context of trying to access crisis services. Online form respondents told us that because they were not regarded as an immediate risk when they contacted crisis services, they did not get help.

> I rang the crisis team due to feeling suicidal and they didn’t really have any ideas of anything they could do.
>
> *Lived experience online form*
>
> The crisis team told me (as a supporter) to ‘call back when the individual got to the bridge’ they were headed too, as it wasn’t serious enough until he was there.
>
> *Whānau, family, and supporters online form—Māori*

People described the impact of such responses to their attempts to get specialist support. Some tāngata whaiora said that it felt invalidating, and some whānau described being unable to get help as terrifying. Other respondents said they became more unwell and then they met the criteria for specialist services they had previously been unable to access.

> I was told ‘you’re not bad enough to be eligible for public system’. This was highly invalidating. I also couldn’t afford to go private for mental health support.
>
> *Lived experience online form—Māori*
>
> I have never felt so scared, helpless, exhausted, and shocked in my life. To have a child who needs help and not be able to get it is terrifying.
>
> *Whānau, family, and supporters online form*
>
> Not easy until I tried to commit suicide, went to hospital and was referred again through there.
>
> *Lived experience online form*
>
> Inpatient service was accessible only once my daughter was so sick that she could be admitted through ED. Criteria and waiting list for outpatient service made that inaccessible.
>
> *Whānau, family, and supporters online form*

Some people shared that they, or the person they were supporting, decided not to access services because they knew they would not meet service criteria.

> I knew from my previous experience that I wouldn't qualify for help and support because I wasn't at crisis point.
>
> *Lived experience online form*

Information and support to help navigate the system were not widely available

Many online form respondents did not access supports such as navigators and peer advocates (who can help people navigate the mental health and addiction system). Some of these respondents said that they were unaware these supports were available to them, noting that no one informed them of, or offered them, these supports. Additionally, some people who did know about these supports were unable to access them despite trying to do so.

> I did not use any supports and had no idea such support existed until after the fact. I feel services like that are not advertised to mainstream society.
>
> *Lived experience online form–Māori*
>
> I tried and tried and tried to access a mental health advocate but there wasn't one available for my region.
>
> *Lived experience online form*

Aside from their GP, we heard that people were largely unaware of what other mental health and addiction staff they could ask about available services or navigational help. However, asking their GP did not necessarily mean that people then got information about what services they could access or that they were referred to a service.

> No idea where to turn for help. Doctor didn't recommend a service. Just meds.
>
> *Lived experience online form*
>
> It's not overly obvious which services provide that support, and I think from what I've seen, whānau will go to their GP. They think their GP is the first port of call, and their GP is the one that will refer them onto all these other services, or it'll be whoever is their firstport of call, they're hoping that if that service isn't the right one for them, that they will be navigated on, but not all services do that.
>
> *Māori focus group*

Some people who had accessed supports that help people to access services found them helpful. However, this was not the case for everyone. For instance, some people found that the supports were unable to help them to access services quickly or at all.

> I did access an advocate service, but it wasn't the best service that I have ever had. The lady that I was dealing with wasn't any help at all, she basically said that she couldn't do anything to help me.
>
> *Lived experience online form*

Other online form respondents said that they themselves searched for information about what services are available. They told us that they found it hard to find information and they spent a lot of time doing so. On the other hand, some people noted they benefited from information available online.

> There was a lot of information online and websites I could navigate to take the easiest path for me. If you are not technology literate it would likely be more difficult.
>
> *Lived experience online form–Māori*
>
> People just actually don't know where to go. When I was a service user, I had no idea that there was all these things out there. I never knew there was peer support workers, or events, things out in the community, like workshops and just things like that. I had no idea, so when I was in my distress, [I] was just medicated, and didn't know where to go, because obviously the GPs don't know where to send you.
>
> *Māori focus group*

People who had more awareness of what mental health and addiction services were available either had previous experience of accessing services or worked within the sector. Generally, these people also found it easier to navigate services. However, this wasn't the experience for everybody in this situation.

> It is worth noting that in our case we weren't new to negotiating mental health services, and this experience is very different from our first year of supporting our whānau member with their mental health and addiction challenges.
>
> *Whānau, family, and supporters online form–Māori*
>
> We feel we are fairly health literate people (as we actually work in health care) yet it was difficult and exhausting trying to find any help. I cannot begin to describe how upsetting it has been to have two children suffering and not being able to find them support when they needed it.
>
> *Whānau, family, and supporters online form*

People also shared that they asked friends with knowledge of the mental health and addiction system about what services they could access. Often, these were friends who worked for mental health and addiction services.

> Easy for me as someone with a lot of colleagues and friends who are rainbow counsellors and could therefore make me aware of the existence of the service.
>
> *Lived experience online form*
>
> I was lucky enough to have friends in the service, so I received support within a short time frame well suited to my needs.
>
> *Lived experience online form*

Poor communication made it difficult for people to access services

Poor communication from services was another barrier that tāngata whaiora and their whānau and family identified as making it difficult to access mental health and addiction services. In the online forms, people shared many examples of poor communication they, or the person they were supporting, had experienced. This includes receiving no response from services, having limited communication with services or a lack of information, and having no follow-up.

> I never heard back from them. (Not blaming them, they are pretty overworked and there isn't great support for the peer support workforce).
>
> *Lived experience online form*
>
> Once in the service there was still several months wait time and counting when being transferred to different pathways with no contact in between so child is left feeling alone and lost.
>
> *Whānau, family, and supporters online form*

Some lived experience respondents commented that when accessing, or trying to access, services, they felt that providers did not listen to or believe them or take them seriously. As a result, they did not get the care they wanted and referrals to further services were not made. Some respondents to our whānau, family, and supporters online form shared that their concerns also weren't listened to, and they had been left out of discussions regarding their loved one's care.

> The GP didn't acknowledge my concerns and dismissed these as lack of sleep.
>
> *Lived experience online form*
>
> There were heaps of questions from the clinical person, but from my end I never had the chance to actually talk as they would keep interrupting me. Sometimes it's frustrating, especially as a young person when you're not felt heard especially around topics such as self-harm.
>
> *Lived experience online form*

> The crisis team tried to manage it at home, but I have been through this with him so many times I wish they just listened to me. I know my husband. I know what his episodes involve. I know when he can avert them, and I know when it has gone too far but the team wouldn't believe me.
>
> *Whānau, family, and supporters online form—Māori*

Services were not always accommodating for people with disabilities

We heard from people that service providers were not necessarily inclusive of other medical conditions or characteristics. Some people (e.g. Deaf or with neurodivergence) shared that services were not set up to accommodate their needs or that they felt discriminated against. Other people shared how they were distressed by the uncertainty around not knowing how services would respond to them, which made it hard to reach out for help.

> Because of my very negative experience last time and the fact they discriminated against me because simply I am autistic. … Communication access needs are [not] met [by] mental health services. They expect us all [to] be able to ring or to have a support person with us 24/7 to ring.
>
> *Lived experience online form*
>
> My GP is good but other services seem to be unable to consider my mental health needs without basically blaming my other disabilities. It undermines the impact of my mental health at the time and means they focus on the wrong issues.
>
> *Lived experience online form*
>
> I don't know what their perspective is on a deaf person. So that's another barrier and creates more anxiety, so this is just an accumulating thing. Will they understand? It's really tough.
>
> *Deaf peoples focus group*

Previous poor experience deterred people from trying to access services again

Respondents to both our online forms shared that they, or the person they were supporting, decided against accessing services due to poor experiences in the past. Most of these poor experiences were associated with being unable to access services previously, so they didn't see the point in trying again. Others were about interpersonal experiences and communication issues.

> 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*

For some people, their off-putting experiences centred on feeling that service providers had been unsupportive or had not listened to, or understood them, or effectively met their needs, so they didn't want to access services again. People were also tired of needing to repeat their story when moving from one service to another.

> Was put off by attitude of one of the telephone support staff at crisis emergency phoneline the previous time I tried calling. She appeared rude and non-caring, and it put me off ringing in for several weeks if not months after this experience.
>
> *Lived experience online form*
>
> I have been treated very poorly by the CAMHS [Child and Adolescent Mental Health Services] services, [so] I didn't want to access the adult services due to the fears that it would be the same.
>
> *Lived experience online form*
>
> Just felt like the service would not help their situation like before, embarrassed to have to go through the whole story again with yet another person that will not be effective in helping them.
>
> *Whānau, family, and supporters online form*

Concerns about stigma and fear prevented people from accessing services

Some people told us that they, or the person they were supporting, did not access services because they did not want to admit they needed help and were scared what others would think of them. They were also worried about the negative consequences that accessing services might have.

> The social stigma surrounding mental health. What would work think? What would the people around me think? Especially as I have previously accessed services before, I didn't want people to think I'd taken a step backward or was back to square one etc. I was definitely in a vastly different place from the first time I accessed services and was needing help on the next step rather than reverting backwards if that makes sense. I was scared of the judgement, the labels, and the pity.
>
> *Lived experience online form*

> Personal connection to the team—thought they would talk about him amongst themselves, and it would affect his career.
>
> *Whānau, family, and supporters online form*
>
> Made to feel by maternity staff that if I continued to seek mental health support, I would be treated like I was crazy and feared my baby being taken off me.
>
> *Lived experience online form*

We heard that there can also be a cultural stigma linked with mental health and addiction issues. This can be a barrier to seeking help or feeling comfortable to approach services.

> I think one of the greatest barriers … is stigmatisation. Especially there are [nationality] who still have the thought that mental health is a dangerous thing. They try to find excuses to say that 'No, my mother or my father or my daughter, they don't have it.' They refuse. Some parents, they refuse the children to seek help.
>
> *Refugees and migrants focus group*

Personal challenges stopped some people from seeking help

People commented on how their health prevented them, or their whānau or family member, from being able to take the action necessary to access services, or it made it more difficult for them to access services. Tāngata whaiora commented that their level of distress and anxiety stopped them from reaching out. Similarly, some whānau and family members said that the person they were supporting did not access services because the person did not believe they needed to or thought services would not be able to help them and might make them worse.

> My anxiety was the main reason, ironically. When I was having the most issues with my mental health to the point that it was significantly impairing me, I was too anxious to self-advocate andtake the necessary steps to find support, so I instead self-medicated as this felt more accessible to me at the time.
>
> *Lived experience online form*
>
> My mental health was so bad that my thinking was that I didn't deserve to access the services—save them for people who would get benefit from them. My GP was also very dismissive of my concerns and prescribed anti-depressants as a first step (which I didn't take).
>
> *Lived experience online form*

> Did not think they needed to. Didn’t think they were ‘that bad’ and thought they could manage on their own.
>
> *Whānau, family, and supporters online form*

Respondents also commented that they, or their whānau and family member, did not want to stop using alcohol or other drugs—which is a requirement for accessing many services.

> Didn’t want to go to AA [Alcoholics Anonymous] or CADs [Community Alcohol and Drug Services]. Not ready to stop drinking.
>
> *Lived experience online form*
>
> The case worker stated they’d need to be sober. [They] chose not to continue from this point onwards.
>
> *Whānau, family, and supporters online form*

Cost, transport, work, childcare, and service hours also affected people’s access to services

The cost of services was a deterrent to some respondents. Often cost was associated with other factors, such as limited services being available, having limited family support, or doubting that services would be useful.

> Cost was the main barrier as I was a student at the time with very limited income.
>
> *Lived experience online form*
>
> One of the main ones was cost. I simply cannot afford the amount of therapy support I need. Another is time. I have to work to keep living but that also means I don’t have that many hours available to access support services, let alone enact the skills and tools I gain in these services.
>
> *Lived experience online form–Māori*

Transport issues, such as the cost of fuel and limited public transport, were another barrier to accessing services that tāngata whaiora, whānau, and family members mentioned. Often, lack of transport was associated with other factors that affected people’s ability to travel, such as service hours, not being able to take time off work, and childcare.

> We live in a rural township about 45 minutes from the service. It required time off work, access to car, cost of fuel.
>
> *Whānau, family, and supporters online form*
>
> No appointments that worked with my job and limited transport options—if you don't drive it is almost a whole day to get to and

> from a one-hour appointment sometimes. No leave at work to take time for appointments.
>
> *Lived experience online form*

Most people did not have a choice of services

We asked people whether they, or the person they were supporting, had any choice with which service they accessed. Some people said they did have a choice. Most people with this experience were people who self-referred, were given options by their GP, or were paying for services privately. Online or phone services provided additional options for people facing barriers such as available hours, timeliness, and distance.

> I was offered a general or a Kaupapa Māori service.
>
> *Lived experience online form—Māori*
>
> In the end yes because I had to go privately. … There are very limited funded options.
>
> *Lived experience online form*
>
> Remote phone/online appointments [are] available more hours of the day including after work. I did have a few options via remote therapy.
>
> *Lived experience online form*

However, most people said they did not choose which service they accessed. Some respondents said their GP offered them only one service or, after calling around, found only one service available that had capacity. Other people said only one service that offered the care they needed was available. For example, there is 'one service offered for eating disorders'. In some instances, potential services were removed as options because the person concerned did not meet conditions, such as service criteria.

> Only one service was offered, and I had the choice to accept or decline.
>
> *Lived experience online form*
>
> No—only one service offered. I later found other services myself after many exhausting weeks researching.
>
> *Whānau, family, and supporters online form*

Online form respondents also shared that they decided not to access services because limited service options were available. For some people, the services that were available to them were not appropriate or the services were not offered in a medium they preferred. For example, some people wanted to access services that were face to face but only phone services were offered. People also commented on how treatment at available services was medication focused, centred on a short-term response to a crisis situation, not holistic, or inappropriate for people with multiple diagnoses.

> [The person we are supporting] wanted a face-to-face engagement with a [service] counsellor rather than a phone call.
>
> *Whānau, family, and supporters online form*
>
> I knew that mental health services here consist of medication and talk therapy. This is a very poor fit for complex trauma. I knew I did not want or need medication. Our services are highly medicalised and geared to short term, symptom relief, crisis situations. This is the exact opposite of what I needed.
>
> *Lived experience online form*

People described how factors other than their preferences determined their 'choice' of service

People told us there was 'sort of' a choice in services. However, often it was other factors, such as service availability, wait times, cost, the location of services, and service criteria, that determined which services they accessed.

> Due to most people being unable to take on new clients, I was unable to have a choice of the place I saw a social worker through, and I was unable to have a choice about the therapist. I just went with the person I was offered as I was unsure how long it would take for another therapist to be available.
>
> *Lived experience online form*
>
> Sort of [there was a choice], but realistically the wait times determined which service was used.
>
> *Lived experience online form*
>
> Other services were offered but none were free, therefore, I had to go with the university counselling.
>
> *Lived experience online form*

For people with disabilities, we heard that services, particularly outside of the main centres, may not be available or accessible, limiting the service options available to them.

> We can’t really pick and choose. It’s very, very limited here in New Zealand. If there are options, then maybe that opportunity is in Auckland … so that’s impossible obviously for me. … But at the same time, I think … lots of providers will provide help online, so face-to-face online.
>
> *Deaf peoples focus group*

Choices available often depended on a health professional’s knowledge

Further, we heard that people’s choice in services also depends on what the person they are asking, such as their GP, knows about available services.

> Now there’re new services and kaupapa popping up, which is amazing. But as before, people don’t know that they’re there. Sometimes the doctors don’t even know, otherwise I feel like they should have referred or sent us or given us the choice.
>
> *Māori focus group*

Having choice was important for some people to access culturally responsive services

Tāngata whaiora, whānau, and family members shared that service providers can lack an understanding of their culture as well as the nuanced differences between similar cultures. For some people, the level of understanding influenced their decision about which services to access or not because having a service grounded in their culture was important to them.

> It’s really got nothing to do with language barriers. It’s more to do with understanding the culture of the person. So, you have Cook Island and then you have Tokelau, Samoa—you have different cultures but that doesn’t mean that you can put together one culture to make it easy for that person.
>
> *Pacific peoples focus group*
>
> I guess the dominant view is that you should act like we act, which is a very westernised way. … I think that actually breaches the cultural safety. … Not often that they do it deliberately, but they don’t know that it’s actually quite impactful in a negative way.
>
> *Refugees and migrants focus group*
>
> I decided not to [access the service] because from experience, they are not that helpful, and people at the other end can be racist, judgmental, or ignorant. I had a counsellor telling me maybe it is my culture that’s the problem.
>
> *Lived experience online form*

However, members of our focus groups told us that people do not necessarily want to access services provided by someone of the same culture or identity as themselves. This may be because they find it easier to relate to mainstream service providers and feel more comfortable with them, or because they do not want to come across someone who knows their family.

> We've had young people come to us and say, 'We don't want a Pasifika counsellor. Can we get a Palagi?' And I ask like, 'Why?' They say, 'Because [that] is the age group from the islands, and they do it different. And this is us'.
>
> *Pacific peoples focus group*
>
> When I was first entering into services, which was about 10 years ago, I was struggling with my identity as Māori. I wasn't brought up in a Māori environment, but because I was Māori, I was referred to Māori services, which didn't make sense to me at the time, and I wasn't supported through that journey. So, a little bit, I'm ashamed to say that I felt more comfortable in the mainstream services. Only because it was a language that I was used to, and it was an environment that I was used to.
>
> *Māori focus group*

Having choice was not a priority for everyone

It is important to note that having a choice of services wasn't the highest priority for some online form respondents. People commented that they were 'just grateful' that services saw them and provided support. Others said that only one service option was offered to them but they were happy to take advice from their GP, or the service they were offered was the best fit for them.

> No, I took advice and asked for guidance from my GP as I was unable to make that decision.
>
> *Lived experience online form—Māori*
>
> I think there was only one service suggested but we were familiar with this service and happy to take our rangatahi there for support.
>
> *Lived experience online form*

We also heard that being presented with many options can be overwhelming for people, particularly when little information is provided to help them discern differences between services or know what to expect. People also told us that although the number of services has increased, these services provide similar support and care, which adds to the difficulty of making choices.

> We have a lot of options, but … there's a lot of similar kaupapa around, so I think it's really difficult for our whānau to actually know which of these services is actually applicable to them.
>
> *Māori focus group*

3. What staff told us about their experiences in providing services

This section focuses on the experiences of people working for mental health and addiction services. These were shared with us during our interviews with (and in a small number of online forms from) staff from across the sector, including general practice, NGO services, Kaupapa Māori providers, specialist services, and an emergency service provider. This section covers:

- positive changes that improve access
- increasing complexity in the presentations staff are seeing
- the significant workforce challenges they identified
- the impact and influence of workforce challenges.

Positive changes are improving access for people

Staff shared positive changes over the last few years that have been improving access to mental health and addiction services. Among these changes were new staff that came with the roll-out of Integrated Primary Health and Addiction (IPMHA) services, [14] primary care liaisons, and initiatives that services introduced to make themselves easier to access. However, work is needed to further improve access to, and choice of, mental health and addiction services.

Staff talked about the benefits of having new staff in the Integrated Primary Mental Health and Addiction programme

Staff, particularly those working for primary care services, generally had positive feedback about IPMHA services, which have become part of the mental health and addiction sector in the last five years.

> I do think it's a very valuable service in and of itself, whether you refer out or they come to you for one or two or three. … Someone said to me last week 'To not ever underestimate the value of what you're doing because you're like a safety valve that's been lifesaving'. … Supportive listening is really important as well as connecting people to options. They're both really important pieces of work.
>
> *Health improvement practitioner, primary care*

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[14] IPMHA services are one of the new service types established through the Access and Choice programme. IPMHA services are primarily based in general practices.

General practice staff, such as GPs and nurses, shared with us that HIPs and health coaches have been beneficial for their team. Clinicians are able to introduce people presenting with mental health and addiction needs to HIPs and health coaches for support beyond what they can provide in a scheduled GP appointment. This has helped provide tāngata whaiora with access to support and has eased GP workloads.

> GPs have said to me, 'I was close to burnout, and this has been helpful.' People come in and go … with a problem or a situation with a GP, and they magically have to fix things. They don't have magic wands. They're all out of wands at the moment, but it's really nice when a GP can say, 'Hey, listen, there's so much here. Would you like to explore this more to the HIP? Can I introduce you to [HIP]? She's just down the hall, she's available and it's free.' Suddenly, the HIP is able to share the load a bit. Package of care has gone from 15 minutes to 45, and that somebody feels really supported in that moment.
>
> *Clinical lead, primary care*

We heard examples of how HIPs have helped to improve referrals to specialist services by including more comprehensive notes. We were also told that where a HIP has seen a person, that demonstrates to specialist services that primary care services have already tried options before making a referral.

> I think HIPs are bringing [these referral skills] to the clinical teams, to GPs and nurses, they'll say, 'Listen, I used to work in the crisis team. Let me help you write some things in the referral that will make it really easy for the triage nurse or whoever's on the team doing the intake to go, "oh, okay, that's why we're going to ring them today or that's why I'll triage this person up".
>
> *Clinical lead, primary care*
>
> [I] ask the GP whether or not somebody's had HIP practitioner and had access to that … it's nice to be able to say, 'have you tried the sessions through the health improvement practitioners?' So, it's one of my regular questions is that what has been tried to date, what are your expectations of this service? And in that respect, people have often and if they have tried, that's great, but if they haven't, I'll say, 'can you go back to your GP and get some of these sessions?'
>
> *Clinician, Health New Zealand service*

We also heard that HIPs are more aware of what services are available and are able to help tāngata whaiora to navigate them. People told us that HIPs can have more time than GPs to discuss with tāngata whaiora what services are available, what type of service they would like to access, and what services they believe would be the best fit for them, as well as any possible barriers to accessing services.

> I think what works well is being able to have the time, which of course GPs don't, and we do, to actually finding out what actually is the best service and if there is, what are the barriers? … Is it transport, is it history, is it there's no internet on your phone? What are the things that are actually stopping you engaging or being able to do that? If it went wrong last time, what went wrong?
>
> *Health improvement practitioner, primary care–Māori*
>
> We have more of the knowledge base around what's local in the area that they can just walk into services, the charity organisations, and things that they can use to support or websites they can use to guide them where that's not something that the GPs necessarily have the time to go into.
>
> *Health improvement practitioner, primary care*

However, these positive changes are not yet universal

During our interviews, we heard that primary care staff, including HIPs, are not always aware of what mental health and addiction services are available in their area, what these services offer, and who they can refer to the service. Some primary care staff shared some of their own confusion as well as the lack of awareness they have observed among their colleagues. One example we heard was that some staff at a general practice did not know about HIPs who were based in the same building.

> And yet still there are still members of the team that don't get it, don't know that's available even though again our doors were opposite each other, she would've literally had to walk past me to actually have that patient leave.
>
> *Health improvement practitioner, primary care*
>
> I'm not really sure what, I don't think there's a specific Kaupapa Māori primary mental health and addiction [service]. If there is, I don't know about it.
>
> *Nurse, primary care*

Primary care liaisons are supporting specialist advice within primary care

Primary care liaisons are specialist service roles that predominantly work to support providers and people outside of specialist services.[15] We heard various ways

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[15] Primary care liaison functions are variable around the motu. They can include facilitating access to psychiatrists for advice, providing GP education, and/or supporting consults in primary care. Some may be delivered by specialist roles, e.g. primary care liaison or mental health liaison, while some will be within the existing roles of other specialist clinicians.

primary care liaisons have been used around the motu, including having a direct telephone line for primary care clinicians to call when they need advice, seeing people in primary care settings, and educating staff. Staff from both primary care and specialist services shared with us the skills and knowledge primary care liaisons have brought that have helped to bridge the gap between specialist and community care.

> Our GP lead has just supported a pilot around case conferences with a psychiatrist. So once a week they've got a schedule where they can present for 20 minutes to a psychiatrist … [to] talk about a complex case or [ask for] some recommendations. And so that would help … rather [than] have to refer to secondary services, they can treat them in primary care.
>
> *Manager, primary care*
>
> We have a roving rural mental health specialist or GP liaison covering those [smaller] practices … they actually manage people in the community. … Keep people away from secondary services. It's actually a really good role and the GPs value it.
>
> *Manager, primary care*
>
> Another thing that we offer is every afternoon we have a GP advice line that is manned by a psychiatrist. It means that GPs can call up and seek support from a doctor if they've got concerns or worries that aren't acute, and if they want to talk about a complex prescribing situation or anything [like] that, but also those doctors would then encourage them to refer if they needed to. So, there's access points for other professionals to be able to seek advice and support to make sure that referrals are going in the right place.
>
> *Clinical director, Health New Zealand service*

The mental health and addiction sector is building connections and trying initiatives to improve access to support

The staff we interviewed discussed other initiatives that have been helping to improve access to services for tāngata whaiora. These include new access initiatives within services as well as building relationships and networking across the system and within communities.

Some of the enabling initiatives within services were about making services easier to attend (e.g. by providing or subsidising transport, or offering services at non-standard hours or in a range of places). We heard about such initiatives most often from NGOs and primary care.

> We are looking at how do we improve the patient journey. … One of our most recent initiatives … was opening up some evening sessions

> … because a lot of people that we see are in work
>
> *Manager, primary care*
>
> We can go to their places. We go to parks and cafes and botanic gardens and things like that. Whenever the client feels more comfortable to have conversations.
>
> *Clinician, AOD service*
>
> Where the youth primary service is great is that it's mobile, it goes to where the young people are.
>
> *Team lead, NGO service*

We heard that good relationships with other providers were fundamental to facilitating access to services. Respondents from across the sector commonly remarked on the effectiveness of such connections. Good relationships with other service providers meant people knew which services offered what and who to contact. They could also quickly check on information, discuss situations, be flexible, and work together on a solution.

> We're fortunate to have really good relationships with our community providers. So, when you know them well, you pick up the phone, they know you send a referral, it works quite well. When you've got those relationships and having our triage team is quite helpful in that space, they can hold those relationships with those key providers and then I guess follow up with them as needed and allow the clinicians to do the direct work with people.
>
> *Service manager, primary care*
>
> Everybody knows everybody. It works quite nicely. And there are all these little unofficial connections that get things done when the official response is not what people wanted. So, there's all these workarounds, which as long as you've got the people around who know about them, they work, but they're not written down.
>
> *Community mental health nurse, Health New Zealand service*
>
> Our relationship with our emergency department and police are really good. So, we have monthly meetings with them where we can iron out any kind of process issues. But any issues on the day, I've got a reasonable relationship with [the] senior sergeant and mental health liaison worker at the police, and … our ED charge nurse manager. We can give each other a ring and go, 'Hey, look, we need to come up with a solution here'.
>
> *Clinical coordinator, Health New Zealand service*

We also heard from staff that taking time to build rapport with tāngata whaiora is paramount. Doing so allows them to build trust with tāngata whaiora and find out what they need, and in turn what further services would be beneficial for them. Staff also told us that it is important to be known and create relationships in the community, which allows more people to know about the service and builds trust before they might need those services.

> What works well? If I was to say when I was in the clinical role, it would be creating relationships out there within the community and making sure that I had a face in the community and the presence in the community.
>
> *Clinician, private practice*
>
> Patients need to feel that in a trusting relationship … they can share their thoughts without fear of being judged and can feel that they've got a listening and supportive and empathetic person on the other side that's listening to what they have to say. And so, in that regard, I don't have any issues with providing a patient with the time that they need.
>
> *GP, primary care*

We heard people are presenting with more complex needs

Over the last couple of years, staff have noticed that they are seeing an increase in the number of people presenting with 'complex needs' rather than in the number of people accessing their service. While some staff attributed these changes to the COVID-19 pandemic, others considered they were related to the rising cost of living and social media.

> A lot of the things that continue to come through to me from our health coaches and support workers is that there are a lot more complex issues … and it's not within just one area of their life. If we're thinking about Te Whare Tapa Whā, every pou has been affected. I think there definitely has been an increase [in complex needs].
>
> *Team lead, primary care—Māori*

More people are presenting with 'mental distress' rather than 'mental illness'

We heard from staff that more people in the last year or two have been presenting with 'mental distress' rather than 'mental illness'. They have also seen an increase in the number of people presenting with 'anxiety and psychological distress'. Staff believed this was due to the increasing cost of living as well as the effects of the pandemic and the public health response.

> There hasn't been a change in numbers … not necessarily their level of mental illness needs … but their complexity of social situation, other social indicators of health, the complexity and how hard people are doing, it is higher.
>
> *Clinical director, Health New Zealand service*
>
> A lot of it has had to do with how people have coped with COVID, coped with isolation, coped with job losses, coped with pressure to have the vaccinations, coped with money situations, having to have time away from work.
>
> *Mental health kaihautū, Kaupapa Māori service*
>
> There's definitely been an increase in those presentations coming through and just the generalised 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, and haven't developed alternative coping strategies.
>
> *Health improvement practitioner, primary care*

Some staff shared that they have seen an increase in AOD harm. They commented that people are turning to alcohol and other drugs to help them cope with the pandemic as well as other social stressors. However, staff did also point out that some people do not want to acknowledge that they need support, making it difficult to manage.

> We worked through lockdown, and it was very, very stressful in the clinic because nobody was coping and we saw a lot more of the complexity of people who had been in the service years ago under, say, community mental health and had been okay, but then fell down again or went back to those old self-soothers like addiction. They were also bored cos it was lockdown.
>
> *Health improvement practitioner, primary care—Māori*

People have changed how they have used services since the COVID-19 pandemic

Staff told us that the COVID-19 lockdowns and the other restrictions during the pandemic impacted on the number of people attending their service and their ability to offer face-to-face service. They shared that they knew people were needing help, but they could not provide it. According to the staff, people were more hesitant to approach services when they needed to. Further, although services were offered online rather than through face-to-face contact, people told staff they would rather wait until lockdowns were lifted to re-engage. Subsequently, people's mental health issues escalated.

We also heard that at around the time when COVID-19 restrictions were lifted, staff began to see more people. This caused their service to be overrun with people seeking support. However, staff shared that the pressure has started to ease off.

> COVID had a really big impact on people, the isolation, the uncertainty, and the reduction in face-to-face services. While a lot of things still kept going, it is not the same doing something over the internet like this as it is supporting somebody. So, a lot of people dropped out of their support systems and support networks and isolated themselves even further, which escalated their mental health issues. And now that the country's opened up again, a lot of our services are overrun, and they can't keep up with the number of people coming through.
>
> *Team lead, NGO service*
>
> Over COVID, we did phone sessions, but a lot of people said, 'actually I'll actually wait until I can see a face-to-face' and there's some people that works for, but I was quite surprised actually that not more picked it up.
>
> *Manager, primary care*

On the positive side, people from NGO services, including a Kaupapa Māori service we spoke to, noted that during COVID-related restrictions, some tāngata whaiora had become more independent in that they were managing without daily living supports previously provided. Further, COVID-19 opened up employment opportunities for tāngata whaiora.

> One of the interesting things we found over COVID is that a lot of the not-so-intensive supports that we were providing to whānau, like shopping supports or going to appointments or transport type supports, they were able to do for themselves during that lockdown period, so when we came out of lockdown, we'd done a lot of work with our kaimahi across the organisation to ensure that we didn't strip that away from our whānau again and that if they were able to do those things for themselves during that period, then let's encourage them to continue doing that rather than remaining dependent on services to be there for them, so that's been good.
>
> *Manager, Kaupapa Māori service*
>
> For a lot of people, it was kind of a golden period of getting work because there were a lot of, I suppose, essential roles that other people wouldn't or couldn't do.
>
> *Manager, NGO service*

Diverse presentations include more people with comorbidities, neurodiversity, and intellectual disabilities

Staff told us they are seeing more people with comorbidities, neurodiversity, and intellectual disabilities. They also acknowledge the difficulties in getting diagnosed with conditions such as attention deficit hyperactivity disorder (ADHD), as well as how it can be hard for people who are neurodiverse or have intellectual disabilities to access services.

> I would say 40 per cent probably of our referrals would be for ADHD or potential ADHD assessments, which is massive pieces of work. [We see them but locums from other regions say that their regions] … only see them if they have another coexisting illness. So there seems to be quite a discrepancy nationally about who gets seen around that.
>
> *Clinical coordinator, Health New Zealand service*

> At present there is significant inequality of care experienced by adults with intellectual disability and mental illness. This results in excessive mortality and morbidity that far outstrips the disadvantage described in any other group in Aotearoa.
>
> *Psychiatrist, Health New Zealand service, online form*

Staff have increasing concerns for young people and older adults

We heard of particular concerns for young people. Staff shared that they are seeing more young people experiencing distress, along with a decline in youth resilience. They commented that during the COVID-19 pandemic, young people were isolated and had few social connections, which resulted in distress. Additionally, since restrictions have lifted, according to staff, young people are having difficulty re-engaging in formal education. Further, staff shared how young people are concerned about climate change and wars that are happening around the world. Staff also believe that social media is having an impact on young people's levels of distress as well as contributing to an increase in the number of young people seeking a diagnosis for ADHD.

> It's like this information overload that they actually can't comprehend or process or filter, I guess. We are seeing lots of eco-anxiety. With all that comes a loss of future focus or a loss of an appreciation for authority or adults in ways as well. They feel very let down. That's probably a very general statement around youth mental health, but certainly that has changed over the last couple of years I've noticed.
>
> *Service lead, NGO youth service*

> I think we noticed an increase of referrals for anxiety definitely and psychological distress from young people particularly who have struggled at home or not having the social connections during COVID. That's been quite obvious.
>
> *Clinician, Health New Zealand service*

Staff emphasised that they are seeing more older people due to grief and loss. On top of this, for some older people, the pandemic increased their social isolation and loneliness.

> We see a lot of older people. There's been a huge increase in depression and anxiety and even unresolved grief and loss. And a lot of that is due to the social isolation and the events that occurred due to lockdown in COVID and having people pass away and not having the ability to say goodbye. So that goes unresolved. We had people, older people move into rest homes during lockdown, and they didn't have the ability to form connections and relationships and now they're completely socially isolated and severely depressed.
>
> *Health improvement practitioner, primary care*

Staff working across the mental health and addiction sector highlighted significant workforce challenges

Throughout our interviews, staff commented on workforce challenges, which have worsened over the last couple of years. In particular, staff identified workforce shortages, high vacancy rates, difficulties in recruiting and retaining staff, and the subsequent burnout they and their colleagues have been experiencing.

Staff from across the mental health and addiction sector described workforce shortages and high levels of vacancies as becoming worse over the last couple of years

One of the main themes from our qualitative data collection was that services from across the mental health and addiction sector around the motu are experiencing workforce shortages and high vacancy rates. Most staff we spoke to told us about the challenges their services were having with recruiting and retaining clinical staff in the last couple of years, and workforce shortages they've noticed in other areas of the sector. They observed that these workforce challenges have been worse over the last few years compared with the past. We heard that primary care services are overwhelmed, and some practices have closed their books.

> We've had to close our books this year, because it has been very, very overwhelming, with multiple practices in our area closing or still refusing to see people in person and then social media with my patients posting on social media, 'Come to our doctor, she's

> fantastic,' and then complaining they can't get appointments. … I feel like it's been at least since March since our books have been closed, and we are not in any hurry to open them, because it's just too much.
>
> *GP, primary care–Māori*

NGO staff commented that they are also experiencing a workforce shortage and are finding it difficult to recruit staff.

> We have the pressure of vacancies now. I have a mental health professional vacancy. It hasn't been that long, but prior to that, it was two years because I needed the right person, and I found the right person. We're just stretched, that's all.
>
> *Service manager, NGO service–Māori*

People working for specialist services shared that they are experiencing significant staffing shortages, with some services currently operating at 50 per cent capacity. We heard that staffing shortages are having a flow-on effect, in putting pressure on the rest of the team who are stepping in to fill those gaps.

> Staffing shortages is probably one of the biggest things in terms of being able to provide that response. … That role [psychology brief intervention] has currently been vacant for about a year. We haven't been able to recruit to that. We have four clinicians in the acute team. They are picking up some of that role, which they enjoy and they're actually getting a lot of satisfaction from [it]. But then that does put pressure on that team who are trying to provide that immediate response, or the backfill from that is our case managers then have to step in and provide that work. … So, it's a bit of a flow-on really.
>
> *Clinical coordinator, Health New Zealand service*
>
> Some of our teams had a 48 per cent vacancy rate, so that is basically the number one issue. I mean, in the perfect world we would meet our wait time targets, but I think vacancies have definitely been a massive issue for us. Again, it depends what subset of referrals you are looking at.
>
> *Analyst, Health New Zealand service*

Staff shared that emergency services are also understaffed, leading to long wait times. Furthermore, we heard that ambulance services are likely seeing the consequence of people not being able to access mental health and addiction services when they need them, and they're seeing many people experiencing acute mental health crises.

> The emergency department is pretty much always running understaffed, and the nurses are amazing, but the less staff they have, the more stressful it becomes for the nurses.
>
> *Team lead, NGO service*
>
> I think we're probably the ambulance at the bottom of the cliff for acute mental health crisis. And we're probably, well, we are an acute mental health crisis in the community as opposed to in hospital.
>
> *Manager, emergency service*

Staff shared that services are experiencing high staff turnover

Many staff we spoke to shared that the services where they work have struggled to retain staff over the last couple of years. Some of these services are experiencing higher staff turnover than others.

> In the last 12 months I've probably onboarded nearly 10, 15 staff and all those 10, 15 staff, almost 10 of them are gone. What I'm finding difficult is finding the right people to start working in these spaces and people who aren't just looking for a 9 to 5 but who are passionate about actually supporting people through a wellness journey.
>
> *Manager, Kaupapa Māori service*

Staff offered reasons as to why services are having difficulties retaining staff. One of the reasons was remuneration. We heard that staff are joining government agencies or other services with better pay, or they are moving to Australia. They shared that while they loved the work that they do, it doesn't always pay the bills. Some people commented on how the investment in training skilled staff then makes them more employable elsewhere.

> Funding's always a really big thing because we want a highly skilled workforce. Yet for the pittance that staff are paid, it's really hard to retain people. So, we invest a lot of time and money and energy in training our staff and upskilling our staff.
>
> *Team lead, NGO service*
>
> The problem is we've all got undergraduate degrees, some of us have master's and then we have post-graduate advanced qualifications and AOD [lived experience]. You've got all these qualifications, but you're paid [poorly] … and how do you get people to want to come and work here?
>
> *Manager, AOD service*

> Our vacancy [rate] is really high. The highest it's ever been. Part of that is that people are moving into HIP and health coach roles, but not all of that is [for] that [reason]. … We lose lots and lots of young people to Australia. People who might have done one year with us in their new grad year or two and then going to Aussie. But our vacancy is pretty high.
>
> *Clinical director, Health New Zealand service*

From primary care and NGO services, we heard that they face additional challenges as they are unable to offer remuneration at Health New Zealand rates.

> I know that there are services in our team, in our organisations that have been recruiting for some physicians for ages. I've got a vacancy for a drug and alcohol clinician. We're probably four or five months now, but just no bites on our ad. I know it's because as an NGO, we can't offer, or we can't compete or pull people away from where they're currently working. That's a funding thing. We've got to appeal to the work-life balance. It might be less stressful than your DHB position or we might try and say, 'We will give you a commute vehicle'.
>
> *Manager, NGO service*

We heard how services across the sector are struggling to recruit clinical staff

Many staff shared how their service is struggling to recruit clinical staff, especially over the last couple of years. We heard how some services had clinical positions vacant for several months while other services have had vacancies for several years. Alongside this, staff gave various reasons why they believed it has been difficult to fill these roles. One of these reasons was the shortage of the 'right' people with certain qualifications or specialities to fill these positions.

> Finding Māori registered nurses with addiction support experience is like finding hen's teeth down here. … We've had an addiction nurse vacancy for 12 months.
>
> *Mental health kaihautū, Kaupapa Māori service*
>
> We don't have ready access to medical staff, and we haven't had a psychologist for three years now. So, there are people who need psychological input, but we can't offer that to them. We can't get it, there's a permanent advert on Seek for a psychologist.
>
> *Community mental health nurse, Health New Zealand service*

From specialist services, we heard that having clinical vacancies within the team can make it harder to recruit clinical staff. Respondents shared that clinical staff like to work with other clinical staff and in multidisciplinary teams. On top of this, some staff, like registrars, need supervision but services do not have enough staff to provide this. To overcome staffing shortages, staff told us that specialist services are bringing in clinical staff from overseas periodically on an interim basis, or services have been providing services virtually.

> Doctors and psychologists … prefer to be around other colleagues, the supervision and that whole MDT [multidisciplinary team] type thing. So, the fact that we don't have a permanent psychiatrist means it's less attractive to get somebody else.
>
> *Community mental health nurse, Health New Zealand service*
>
> We don't have a doctor permanently here. … So, it's almost all audiovisual assessments by psychiatrists. No registrars, no house surgeon because we don't have a permanent psychiatrist. You can't have a registrar because they have to be supervised.
>
> *Community mental health nurse, Health New Zealand service*
>
> We don't currently have a psychologist, although we do have a vacancy for a psychologist. Our psychologist is on maternity leave. … A lot of psychologists seem to have basically abandoned the mental health services and gone into private practice. … So, there are vacancies, and it's difficult to find people fill those vacancies or [find] the right person to fill those vacancies.
>
> *Team lead, Health New Zealand service*

Some staff talked that about the stigma that is associated with working in the mental health and addiction sector. They believe this stigma may deter people from wanting to work for mental health and addiction services.

> I think part of it is the stigma around mental health and addictions. It's really hard mahi.
>
> *Clinical coordinator, Kaupapa Māori service*
>
> If you had a child and they were training to be a doctor, would you really want them to go into mental health when you see the stress they're put under, the workloads that [they] are put under, the consistent, the consistent criticism in the news media that we are failing and failing and failing?
>
> *Team lead, primary care*

Staff shared their experiences of burnout and its impact on staff retention

We heard that a key impact of recruitment and retention challenges was that they put pressure on the existing workforce. Many staff commented that they, and other people they know, are burnt out, stretched, overwhelmed, and exhausted. They're struggling to keep up with demand due to inadequate staffing and high workloads. On top of this, staff shared that their work could take an emotional toll. As a result, some staff told us they had reduced their hours. Others shared that burnout was having an additional impact on staff retention as some of their colleagues had left due to exhaustion.

> I think that we're all stretched, in fairness. Residential is stretched, other clinicians are stretched, our mental health services are stretched. Our professionals, they're moving out because the capacity of the mahi is too much now. They're moving to other careers, so we've lost all that knowledge.
>
> *Manager, NGO service–Māori*
>
> I'm pretty tired in the weekends, and I can't really do much. So, I'm actually dropping a day next year, just to give myself a little bit of space, because I can feel it. It's starting to push me to the edge of my mental health capability.
>
> *GP, primary care–Māori*
>
> We've got high workloads, and it's really emotional work that people do burn out very quickly. … I know ICAMHS [Infant, Child and Adolescent Mental Health Services] has quite a high staff turnover, and I think because it's really [because] there's a lot of pressure, there's a lot of emotion in it, and sometimes the support isn't there for people in their roles.
>
> *Team lead, NGO service*

Some people working for NGO services shared that their employers are focusing on staff wellbeing to help prevent burnout

Some staff working for NGO services described their employer's focus on staff wellbeing to actively prevent burnout and enhance retention and recruitment. This focus ultimately meant people received a better service.

> Definitely a culture of 'look after the staff'. We look after ourselves and the organisation I guess first, and then we can actually look after others, so that philosophy. I've been around the block with different services here and that's consistent in terms of the flexibility and our work arrangements. Our caseloads are good or high, but do-able and so we're not burning out as much some others and we can actually do the quality work.
>
> *Clinician, NGO youth service*
>
> We're always encouraging people to use it and take your leave. We don't want people to get burned out. It's tough on the people that

> take it personally and that are emotionally attached to their clients. We've got values, we want to work with some aroha and manaaki towards clients, but at the same time, keep that professional boundary, that you don't get attached and that it starts to affect you and you're taking things home.
>
> *Manager, NGO service*

Staff members shared how COVID-19 had an impact on staffing levels

Staff shared that the COVID-19 pandemic further reduced staffing levels, primarily because of vaccine mandates. We also heard that since COVID-19, it has been harder to recruit staff.

> There was a whole lot of health people, I lost colleagues, that didn't get vaccinated and lost their jobs, so there's a little bit of anger. There's a little bit of fear, there's shame, there's stigma, there's the, 'I'm not welcome'.
>
> *Clinical lead, primary care*
>
> Attracting people in after the pandemic I think has probably been really hard. I was a clinical nurse manager for a while, and as soon as the pandemic hit, we just couldn't recruit again, hardly any applications.
>
> *Nurse, primary care*

Staff described various impacts of having limited resources to address complex needs

During our interviews, staff pointed to various impacts of their challenging work environment, with its workforce shortages and complex needs. They shared how this environment affected staff, reducing their ability to provide timely access for tāngata whaiora, and the flow-on effects of this for other services, including in limiting their own ability to meet people's needs.

High staff turnover has led to a loss of knowledge, sustainability, and connections

Staff from across the mental health and addiction sector told us that due to high staff turnover, they were experiencing a loss of knowledge within teams. We heard that losing experienced staff limits the ability of the remaining team members to respond as and when needed.

> The main one would be staffing retention. So even if we can staff with some junior staff, we can't respond in the same way as if all our staff were really experienced.
>
> *Clinical director, Health New Zealand service*

Further, staff shared that the workforce is ageing, and they are concerned about what will happen when they retire because new staff are not coming through.

> I think one of the challenges will be for us as well is around an ageing workforce too and how we meet that need for people because there's not a lot of programmes for new staff coming through that I can see in this space.
>
> *Manager, primary care*

Staff also told us about the impacts of high staff turnover on interpersonal relationships between staff across different services. These relationships were described as an enabler for smooth service delivery. However, because of high turnover, staff were needing to build personal relationships again.

> I've heard this phrase from many people while working with clients, 'it's not about what you know, it's about who'. So, we are just finding that one person. But the unfortunate thing again is that we get to know that one person and the person changes. Their job leaves from there. And then again, we are on the ground again looking for someone.
>
> *Clinician, AOD service*
>
> We used to have these cool once-a-quarter networking meetings where we'd all get together. … And they were really needed; they were really important, and they were quite inspirational.
>
> *Manager, AOD service*

Further, we heard that staff turnover is making it more difficult to share information. This applies both at referral stages to support comprehensive handover and in ongoing case management. Turnover can mean that knowledge about tāngata whaiora is lost, while staff shortages can delay handover meetings.

> That also affects the ongoing work because if we need to contact the clinician, oh, they don't have a clinician cos they're short staffed. The last one left and they haven't been replaced yet, so you need to talk to somebody else who doesn't really know that case as well as an allocated clinician would know.
>
> *Manager, NGO service*
>
> I think that short-staffed issue is a major one because we might receive a referral, we'll be ready to start the work with the client, but we need to wait for a clinician to be available to broker a meeting for us. We can't actually start working with the client until we've had a meeting with the clinician there and the client.
>
> *Manager, NGO service*

Specialist services are doing what they can with limited resources

We heard from people working for specialist services that, due to the difficulties in staffing specialist services to their full capacity, they are prioritising those with the highest needs. In addition, specialist service staff told us that they are sticking to their service specifications and not accepting referrals for anyone who does not meet their service criteria. This was also noticed by people working for primary care and NGO services.

> When acuity increases, then you obviously prioritise the acute situations and then people being able to access our services might change because they're not as unwell, and so we might try and divert people through that PCL [primary care liaison] pathway or those kinds of things. The one thing that we have changed is that we've put in criteria for our planned acute care team. Previously that was loose and not formal and so in the last year we've formalised that so people, to receive a period of follow-up acute care, there's some criteria that they have to meet in order to do that.
>
> *Clinical director, Health New Zealand service*
>
> Because we're a specialist service, to stay specialist and to be able to provide care for people that really need our level of input, we can't say yes to everyone. Otherwise, we wouldn't be specialist anymore because we'd have too many clients to follow up and we wouldn't be able to see them as extensively as what we need.
>
> *Clinical coordinator, Health New Zealand service*

Specialist service staff told us that educating and communicating with primary care and NGO services helps them to dedicate their resources to those in greatest need. The education is about specialist services criteria and how to make a good referral that includes the information they require. In addition, specialist staff inform these other services of their own capacity limits and how primary care and NGOs can support tāngata whaiora during this time.

> With primary health and GPs, it's probably an ongoing process of education. As you would expect, some GPs are really good in terms of appropriate referrals and that sort of thing, whereas sometimes there's a degree of confusion as to who they should be referring to.
>
> *Clinical coordinator, Health New Zealand service*

Prioritising the most severe needs means specialist clinicians are increasingly working with higher-risk caseloads

Staff in specialist services talked about how the changing needs of the population were constraining their ability to support tāngata whaiora. People defined as being higher risk need more resources to support them and maintain safety. This has been reducing the resources available in specialist services to support other tāngata whaiora who may not be acutely unwell but would benefit from their services.

> You see what happens is that our whole system starts skewing for people who are at very high risk. We're an outpatient service once again. A predominant grouping of our whaiora in here are all very high risk. A huge amount of work has to go in behind people who are high risk. It takes them a lot longer to be able to access our group treatment programme. Then, our staff get caught up in trying to manage the very high-risk people and keep safety for them. We've got to see them more often. We've got to put different safety around them but, as a result then, our caseload becomes skewed to people who are high risk cos we've triaged them in and therefore the other people who have the equal rights to be able to get service, because they don't have a high risk, they've got to wait then many months. It makes us slower and slower because suddenly … our whole system is weighted towards high risk.
>
> *Director, AOD service*

Limited capacity across the system contributes to increasing wait times and limits the availability of services for tāngata whaiora

One of the main impacts of capacity constraints that staff raised with us was that wait times have been increasing of the last few years for mental health and addiction services across the sector, including for primary care services. For instance, we heard that people are waiting several weeks to months to see their GP.

> At one point, we had over a two-month waiting list in [place] to see a doctor, which is just not acceptable.
>
> *Team lead, primary care*

Another barrier that the staff we interviewed identified is the long wait times for specialist services, sometimes many months. We heard how workforce shortages were increasing wait times for specialist services. Staff working for primary care and NGO services also shared with us their frustrations over the wait times for specialist services.

> It would just be that the wait times are delayed. What those teams tend to say is that you might want to try these other services while you're waiting, and maybe some telehealth services, but I do not believe we are declining referrals because of staff issues if that makes sense? It is just that the actual waits would be longer rather than them being declined.
>
> *Analyst, Health New Zealand service*

> A couple of years ago or more, we would've been like, 'great, you will absolutely get seen by … our local mental health hospital and they'll have outreach clinics'. But now it's pretty much hardly anyone gets through.
>
> *Nurse, primary care*
>
> We've got this suicidal young person who we're struggling to support due to the way that our service functions, but they then need to go on an eight-month wait list.
>
> *Service lead, NGO youth service*

Some staff talked of their difficulties with accessing crisis services. They shared their experiences of calling crisis services to try to get them to assess someone, only to be left on hold or told that crisis staff were too busy to attend. Additionally, a paramedic said that it's so difficult to access the crisis teams that it would be rare to try. As a result, they sometimes have to provide a more restrictive response than what might have otherwise been considered appropriate.

> They [crisis services] do run 24/7, but the average waiting time is 30 minutes, and it cycles. I had been on hold with 'em this week to try and get someone seen and to be told every minute that you're important and we are waiting to get someone to talk to you is very patronising.
>
> *Nurse, primary care*

Staff shared concerns about how delays in access were affecting tāngata whaiora

Staff shared with us their concerns that people were accessing services later than when they needed them. One such concern was that waiting several weeks to see a GP can result in an escalation in distress, which could create further concerns.

> [People] can't get in to see the GP. So, by the time they get to see the GP, they're usually pretty crook … it may have prevented the relationship breakdown … may have prevented the issues at work, which would've prevented the financial hardship that they are now in, the impact that that's had on their children. If they could get into the GP the next day and get some good solid support, then that may have prevented things escalating.
>
> *Clinical coordinator, Health New Zealand service*

Respondents also said that long wait times meant missing the opportunity when people were ready to seek help. This could result in people abandoning their attempt to access services. They mentioned this concern especially in relation to young people, and to those seeking help for alcohol and other drug use.

> When whānau are ready to do something about their addiction, they're ready now. They're ready when they say they're ready. They're not ready in 6 months or 12 months or whatever when a bed comes up, they're ready now.
>
> *Cultural advisor, Kaupapa Māori service*
>
> I think one of the most heartbreaking things that I hear back from our clinicians is when they ring a young person and they go, 'The problem was big. I was miserable, but I've waited so long that the problem's gone away.' We know that the window is open and shut on an opportunity to coach and to teach a young person how to help themselves and it's lost.
>
> *Clinical lead, NGO youth service*
>
> No one's taking neurodiverse clients for testing. The wait list would be months and months to the point where the client just goes, 'no, I can't be bothered'.
>
> *Health improvement practitioner, primary care*

Primary care and NGO service providers have perceived an increase in threshold to access specialist services

Staff views as to whether access thresholds to specialist services have increased differed depending on which area of the mental health and addiction sector they worked in. However, the people we interviewed from primary care and NGO services generally agreed that specialist services had become harder to access over the last two years due to a limited workforce and increased needs in the population. These staff shared their experiences of trying to refer people to specialist services. They told us that they are finding that people need to be acutely unwell (in some cases with multiple suicide attempts) before they are able to access specialist services, something many staff found frustrating and disheartening.

> I think specialist services have increased their threshold … they're down on psychiatrists, they're down on frontline staff, so they've got to do what they've got to do. So, it is hard. … How do you support primary care to see those people?
>
> *Manager, primary care*
>
> I think there's inconsistencies in what the expectation is for access and who should access the service. … It shifted and it seems to be that there has to be an imminent risk or they have to have acted on that risk in order to actually get the support that they need.
>
> *Health improvement practitioner, primary care*

> The bar is continually lifted in terms of who they're willing to provide service to … the reality for us is that when they're busy, it's acute care only. GPs in some areas have just given up referring people to ICAMHS teams.
>
> *Clinical lead, NGO youth service*

People working for specialist services, on the other hand, didn't necessarily believe service thresholds had increased. Rather, they were focusing on people with higher needs and making sure to stick to service criteria. They also shared that some referrals they receive are not of the best quality, which is why they have a focus on education and the primary care liaison role.

> Formally no, but when acuity increases then you obviously prioritise the acute situations and then people being able to access our services might change because they're not as unwell, and so we might try and divert people through that PCL pathway.
>
> *Clinical director, Health New Zealand service*
>
> I do not believe we have changed criteria. … [It's] not a written-down criteria that has changed, but because of the model of care changing … we have got more GP liaison type roles, so more of that advice.
>
> *Analyst, Health New Zealand service*

Primary care and NGOs are changing their delivery due to difficulty in accessing specialist services

People working for primary care and NGO services shared with us that the limited capacity in specialist services is having an impact on how they support people. We heard that they are seeing people for longer, holding greater risk, and offering alternative options while people are waiting.

Primary care and NGO staff told us they are supporting and 'holding' on to people longer than they usually would while they are waiting to access specialist services. To do this, some service providers are checking on tāngata whaiora every week to make sure they remain well and do not deteriorate.

> It's still the same in terms of waiting lists … to be able to get into specialist services. What our teams are finding is that they're holding people before they can get into a specialist service.
>
> *Team lead, primary care—Māori*

> [People] aren't able to access … because the wait list is so long, or they access it and it's a one-off appointment and that's all they can get, and they've waited for four months for that appointment. We are holding those people for longer.
>
> *Counselling coordinator, NGO service*

We also heard that primary care and NGO staff have been suggesting interim services that tāngata whaiora can access while waiting for specialist services. For example, they suggested telehealth services like 1737, provided phone numbers to crisis teams, and referred people to brief intervention services.

> I think there are wait lists with a few places, but the best you can do in terms of a buffer is let people know that and I always give them the 1737, the brief intervention service or let them know they can pop in here to chat through for support while they wait.
>
> *Health improvement practitioner, primary care*

Primary care and NGO staff also told us that they are working outside of their service criteria, and they are seeing people who are higher risk than they are intended to support. Staff were concerned that tāngata whaiora might fall through the service gaps if primary care or NGO staff did not see these people.

> [If] for whatever reason, [people] don't meet the criteria to be supported by secondary services, so secondary services will quite often just refer them on to community-based organisations like ours. But the main concern … is the risk that we carry, and we believe that there should be more of a pushback to secondary services.
>
> *Clinical coordinator, Kaupapa Māori service*
>
> I don't think I've ever seen a mildly distressed person in my HIP role. It's moderate to severe or people who have been discharged back to their GP when they've come out of acute care.
>
> *Health improvement practitioner, primary care–Māori*

Further, general practice and NGO staff described the impact that difficult access to specialist services was having on referral practices. We heard that while some staff are continuing to make referrals to show that the need for specialist services exists, others are making fewer referrals as they do not see the point when they know a referral will be declined. We also were told that some GPs will do a 'scatter-gun approach' and refer people to multiple services in the hope that one service would accept them.

> I'm very much at the mindset of 'refer anyway', so I will keep referring. I have strongly encouraged the referrers, like the GPs and nurses, to refer again even if they feel like it's a pointless exercise, which at times has been their wording. So, I do feel like there was a

> drop-off of referrals and now they're slowly increasing again, although they're still getting the same response.
>
> *Health improvement practitioner, primary care*
>
> I would say more we're having fewer being declined from community mental health, but that's because we're putting less through because the doctors are like, 'Well, there's no point cos it's going to be declined'.
>
> *Health improvement practitioner, Primary care–Māori*
>
> The adult services, I think it's got harder and harder to access … Often GPs will do a scatter gun, which is really poor, but they'll refer to both [specialist services and primary health organisation brief intervention]. … So, those people face months and months delay. They often do not know what's happening with them. They're not informed.
>
> *Programme lead, primary care*

We heard from primary care staff that GPs are introducing people to HIPs and health coaches. Doing so is easy for GPs and takes less time than it does to write a referral to other services. Accessing HIPs also does not involve the same wait times associated with accessing specialist services. This has meant tāngata whaiora gain earlier access to support without any additional barriers.

> They [GPs] talk about how they have to make [fewer] referrals now and it is just that drag and drop into my book, and it's done.
>
> *Health improvement practitioner, primary care*
>
> I think it's changed so they're referring to us more and then I don't seem to be referring to secondary services as much, as my confidence grows and as my skillset grows.
>
> *Health improvement practitioner, primary care*

4. What tāngata whaiora, whānau and family, and staff told us needs to change

This section focuses on what tāngata whaiora, Māori and their whānau, and family, and staff told us needs to change. We have also included the changes that we want to see to improve the mental health and addiction system.

The changes we want to see are based on the findings from Kua Tīmata Te Haerenga, which drew on the themes included in this Voices report, a broad range of quantitative service performance data, and supplementary information. These are the changes we consider to be critical to improving the mental health and addiction system for tāngata whaiora, whānau, and families. Kua Tīmata Te Haerenga includes five recommendations that are more specific on 'who needs to do what' to enable system change.

Many of the suggestions from people as well as the changes we want to see are similar to what He Ara Oranga shared and recommended. However, as we have highlighted throughout this Voices report, new initiatives and changes have been implemented following the inquiry. What we cover in this section builds on He Ara Oranga by focusing on what work still needs to be done.

This section covers improvements for:

- increasing access to services
- increasing choice of services
- strengthening connections
- improving data and insights.

The changes people want to see to increase access to services

Services need to be affordable with clear pathways and without long wait times or high thresholds for access

People want clear and easy pathways when accessing services, and support to navigate the system. Many people asked for a system where services have shorter or no wait times, particularly for people in crisis, and lower thresholds for specialist services that do not require people to be at 'rock bottom'. Affordability also needs to improve.

> More modern ways to make appointments that don't require phone calls which are so difficult for people with anxiety, autism, language disorders etc.
>
> *Whānau, family, and supporters online form*
>
> If it was quicker and easier to get in! If the services were set up to cater for people before they hit absolute rock bottom!
>
> *Whānau, family, and supporters online form*

> Immediate access to psychiatrist appointments for people who are in full blown psychosis. I had to get so bad that I assaulted a family member for the system to sit up and pay attention.
>
> *Lived experience online form*
>
> For patients with previous history of significant mental health issues perhaps a patient fee waiver (Government subsidy) when the visit concerns a relapse. … My sister is now discharged from the community mental health service and encouraged to attend her doctor for her reviews and medications/scripts BUT she won't go as it costs money and she is on a benefit.
>
> *Whānau, family, and supporters online form*
>
> Maybe like a whānau navigator or whānau peer support worker, something like that. A role that would kōrero with the whānau as well with their person's permission and let them involve the whānau more in that process as well if that person wishes.
>
> *Māori focus group*

Tāngata whaiora and staff talked about making services more approachable and available in the places where people live and at flexible times

Staff spoke generally about making care more accessible and approachable for tāngata whaiora. We received a wide range of suggestions, such as to increase the number of navigators, allow for more self-referrals (for services where specialist assessment is required first), offer more community-based services, have longer or more flexible hours, and support people to attend appointments.

> I know from experience, especially with our rangatahi services, those who are experiencing suicidal ideation or self-harm, would prefer to come through a self-referral pathway directly … rather than through secondary service.
>
> *Manager, Kaupapa Māori service*
>
> In a perfect world, what I would like to see is a combination of both kaupapa Māori approaches [in a community hub], as well as clinical, because I think they need to work together.
>
> *Clinical coordinator, Kaupapa Māori service*
>
> No services run weekends, but I think that could work for people if you had staff that were willing to do that.
>
> *Manager, primary care*

> We need more checking that the person can either get to the appointment and a reminder that they can attend it. … Taxi chits, health buddies, you name it, agencies, we could all be doing a lot more work to get people to the appointment.
>
> *Clinical lead, primary care*

Similarly, tāngata whaiora want to see coordination hubs where services are all together and are able to manaaki them.

> I don't like the word 'refer' because for me, I think a good example of that is a warm handover. A coordination hub with navigators, with whānau who will walk alongside this person to help them to where they need to go.
>
> *Māori focus group*
>
> Everybody's there in the room, you make a decision together about what's next and you only have to tell your story once. And that gives people options and that gives people choice.
>
> *Māori focus group*

For tāngata whaiora, improving access also includes improving their initial experiences

Tāngata whaiora raised the need to improve the culture of the mental health and addiction system, and the importance of acknowledging trust and relationships. Services need to be acceptable to and welcoming of Māori to better meet their needs. Kaupapa Māori services can provide culturally appropriate and safe support within welcoming spaces to ensure those seeking their services feel safe, cared for, trusted, and understood.

> There is a lot of work that needs to be done around those initial contacts, this may take time as a lot of trust has been lost in mental health services.
>
> *Whānau, family, and supporters online form—Māori*

Suggestions for improving culture and building trust included taking the time to get to know tāngata whaiora, understanding their culture, seeing them holistically, and hearing their preferences.

> People to actually be heard on what they need, instead of being told no. Like they weren't important. No one know what a person needs more than the person themselves.
>
> *Lived experience online form*

> More comprehensive and sensitive triage process and not being so quick to resort to medication.
>
> *Whānau, family, and supporters online form*
>
> A better understanding in NZ Māori health models, gender, and current language etc.
>
> *Lived experience online form–Māori*
>
> A little bit of sign language knowledge, just learning some basics … conversational, sort of an understanding about the language.
>
> *Deaf peoples focus group*

Staff told us there are service gaps that need to be filled

Staff shared that there was a need to look at the gaps for people with moderate to severe needs who require more support than primary care can offer but don't meet the criteria for specialist services. Other specific areas of need identified were maternal mental health, older people's mental health, housing, ADHD, and post-traumatic stress disorder (PTSD). Staff also told us about the need to improve pathways to services for Māori and to increase the number of Māori practitioners.

> Developing a crossover between where our mild to moderate finishes and where the hospital's moderate to high, we need to create a bond there, rather than having a gap.
>
> *Cultural advisor, Kaupapa Māori service*
>
> If we could have people within secondary mental health who do work with ADHD, who do work with PTSD and you can apply support in those spaces and who don't try and separate addiction from mental health, that would be a wonderful situation.
>
> *Director, AOD service*
>
> Different systems for Māori accessing services. I think asking people to phone up or see a GP that you can't get in for six weeks … we're not responding to our responsibilities for Te Tiriti if we are expecting people to jump through all these hoops in order to get to a service.
>
> *Clinical director, Health New Zealand service*

Staff told us that staff recruitment and retention need to be a focus

Staff also shared ways to grow, develop, and further promote the mental health and addiction workforce. Suggestions included promoting working within the mental health and addiction sector by sharing stories of how the work can make a difference and promoting it in schools as a career. Similarly, staff suggested providing additional training on mental health and addiction to doctors and nurses as a way of growing their interest in working with the sector. We also heard that a sector-wide approach to recruitment is needed.

> There's no promotion … about how many people have gone through services and are alive and thriving.
>
> *Team Lead, primary care*
>
> We need a sector approach to recruitment and retention. It feels like everyone's trying to do the same job and struggle with the same pool of people and steal from one another. A national or regional approach to that would be really good.
>
> *Clinical director, Health New Zealand service*
>
> If we could get them [doctors] to train earlier and maybe pathway them into that specialist work earlier … mental health [needs to] really start picking people, paying their training … really pulling them over to our side… and lifting that stigma.
>
> *Team lead, primary care*

Also discussed was the issue of retaining the existing mental health and addiction staff. To improve retention, it is necessary to improve pay and conditions and have a stronger focus on staff wellbeing, such as by providing meaningful clinical supervision.

> How well are we taking care of the workforce genuinely, because it's only a chair away from me becoming the patient and I think that needs to be taken much, much more seriously and then we wouldn't be losing people.
>
> *Health improvement practitioner, primary care*
>
> The biggest factor that I think is impacting us probably at this time is what we are paying our staff because in particular the clinical staff—they're all going overseas.
>
> *Manager, NGO service*

Staff shared how gaps within the workforce can be filled. For instance, it would help to expand peer support and group therapy, increase the number of rainbow-competent counsellors and the number of volunteers, and further develop Kaupapa Māori and NGO services. We heard that more access to and investment in Kaupapa Māori services is essential to provide appropriate support and meet the needs of Māori experiencing distress.

> It would be great to see more Māori practitioners. We are starting to see a massive resurgence in rongoā Māori being identified as an official way of supporting whānau Māori especially.
>
> *Manager, Kaupapa Māori service*
>
> I know we have got locally as well as I think nationally more peer support type services and having those peer support roles in our services, so maybe the model needs to actually shift that.
>
> *Analyst, Health New Zealand service*
>
> Let's talk about communities helping each other … wouldn't it be great to harness the community ethos that we are so good with in New Zealand? I'm a huge fan of peer support … I see a huge opportunity for getting the right people in place to do peer support.
>
> *Clinician, Health New Zealand service*

Staff also gave us suggestions for workforce development

Many people, across the sector, talked about wanting to improve workforce development. Suggestions included more training in mental health and addiction for nurses, paramedics, and GPs; and more education opportunities for existing staff.

Staff also identified specific areas where more training is needed, such as neurodiversity, and the relationship between mental health and addiction.

> GPs need more training in mental health in their training, not just an add-on. It actually should be just part of their standard practice training.
>
> *Team lead, primary care*
>
> Disability providers often know very little about mental health. So, I think more education and training to [disability] providers.
>
> *Team lead, Health New Zealand service*
>
> I think once there's this acknowledgement that mental health and addictions go hand in hand, clients will benefit heaps. … A lot of mental health concerns are leading to addictions and vice versa. So, I think there needs to be more education … stigma is still there.
>
> *Clinician, AOD service*
>
> More recognition around rongoā Māori practitioners, mahi wairua … develop a workforce that incorporates more wairua-specific practitioners as a certified profession.
>
> *Manager, Kaupapa Māori service*

> At the clinician level, we need to work in with the provision of the Bachelor of Health Science paramedicine at that curriculum level to inject that knowledge in there. And then also at the specialist level, perhaps our extended care paramedics or paramedics who want to specialise in that area.
>
> *Manager, emergency service*

In Kua Tīmata Te Haerenga | The Journey Has Begun, we highlight the following changes we want to see.

- **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.

The changes people want to see to increase choice of services

People want more service options

People told us that they want more choice in services in relation to providers, treatment options, and service locations. Expanded choice includes services that are holistic, use treatments beyond medication, are preventative in nature, and offer more proactive care. People want to be able to access more options such as rongoā, pūrākau, marae, and wairua-based approaches to mental health and wellbeing.

> A greater range of support options. E.g., more casual support groups as opposed to straight into counselling sessions.
>
> *Whānau, family, and supporters online form*

> Having flexibility in services and therapy options would have been good … better connection to physical health instead of mental health being totally separate. Can’t address all pillars of Te Whare Tapa Whā if one service is totally siloed from all the others.
>
> *Lived experience online form*
>
> Peer support, group therapy rather than this plodding individualistic approach, more options in services.
>
> *Lived experience online form*
>
> We just need a hub. Let’s take it back, actually the marae is where people gather, that’s the purpose of it. So, let’s create these, let’s have whānau that are in there doing toi Māori, kapa haka, whanaungatanga.
>
> *Māori focus group*

People want better information about services and how to access them

People asked for better information to be provided so that they know what service options are available, where services are, and when and how they can access them. Suggestions included having a database or collection of information on mental health services for people to search, using posters to advertise services in public places, and providing a phone service for people with concerns to call so they can discuss the level of intervention they need as well as service options.

> Giving the individual enough appropriate information to make informed decisions.
>
> *Whānau, family, and supporters online form—Māori*
>
> I’m thinking about all the first places that whānau will go, and those are the services that we need to empower with the information to be able to navigate whānau.
>
> *Māori focus group*

Respondents wanted better, clearer, and more timely information when accessing a service. People told us that they want information on what to expect, what treatment options are available, and how long wait times are.

> More information about wait times, expectations, the referral processes, so the mystery of accessing help is dissolved.
>
> *Whānau, family, and supporters online form—Māori*
>
> More information on guidelines and expectations. More information on what I was getting into.
>
> *Lived experience online form*

Whānau and family members told us they also want to be more informed about their loved one's care and how they can best support them. They wanted a process to be available for when people don't want treatment.

> Treat the person as part of a whānau. Include the whānau. Give whānau information to help them support.
>
> *Whānau, family, and supporters online form*
>
> An obvious improvement is for the system to not pretend someone who stops responding to referrals etc doesn't need help anymore.
>
> *Whānau, family, and supporters online form*

In Kua Tīmata Te Haerenga | The Journey Has Begun, we highlight the following changes we want to see.

- **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.

The changes people want to see to improve experiences through strengthened connections

Staff and people told us about the need for a more connected system and their ideas to enable this

People wanted more seamless transitions between different services. They also want to be provided with options when referral to specialist services is not successful.

> Internal handovers happening so you aren't telling your story and sharing your information over and over again.
>
> *Lived experience online form*
>
> I could have been provided with other community services or peer support avenues to explore on the triage phone call instead of being told I didn't meet severity criteria.
>
> *Lived experience online form–Māori*

Staff told us about the need to improve pathways. Suggestions included improved referral templates, expanding the primary care liaison function, and wraparound support to help people integrate back into their general practice after discharge from specialist services.

> I think we could enhance some of that work and a lot of the GP referrals, as well can we do more work collaboration with GPs around ensuring that when we get a referral it is almost ready to go straight in, so we do not have to do a lot of that almost administrative work upfront around getting good information.
>
> *Analyst, Health New Zealand service*
>
> The primary liaison role … [would have been] good to develop and expand on that.
>
> *Team lead, Health New Zealand service*
>
> So, people coming out of secondary services, they might've had a light touch with crisis services or psych emergencies … so, transition them out of service, walk the journey with them and then make sure integrated back into their service rather than just an electronic referral.
>
> *Manager, primary care*

Staff told us that services need to work more collaboratively with one another

Many staff we spoke to told us that services currently tend to work in silos, and they need to work more collaboratively with one another. This includes services across the sector, such as mental health services and addiction services, as well as beyond the sector to involve disability services and social supports, for example housing supports. Better collaboration, in the view of staff, would improve people's experiences of accessing services and ease some of the pressure that services face. For staff, collaboration meant networking, such as between Kaupapa Māori and Pākehā organisations, building relationships, resource sharing between services, and services working together to do their best for tāngata whaiora.

> I think perhaps if there were more collaborative relationships between, for example, social housing providers, mental health services, [people] have all these complex issues and I feel like it's all compartmentalised.
>
> *Clinical lead, NGO service*
>
> Is there a way to actually have regular meetings between the primary and secondary at the GP level practice with managers or the staff to discuss cases and have that time?
>
> *Health improvement practitioner, primary care*

In Kua Tīmata Te Haerenga | The Journey Has Begun, we highlight the following changes we want to see.

- **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.

The changes people want to see in relation to data and insights

More data sharing and data need to be more accessible

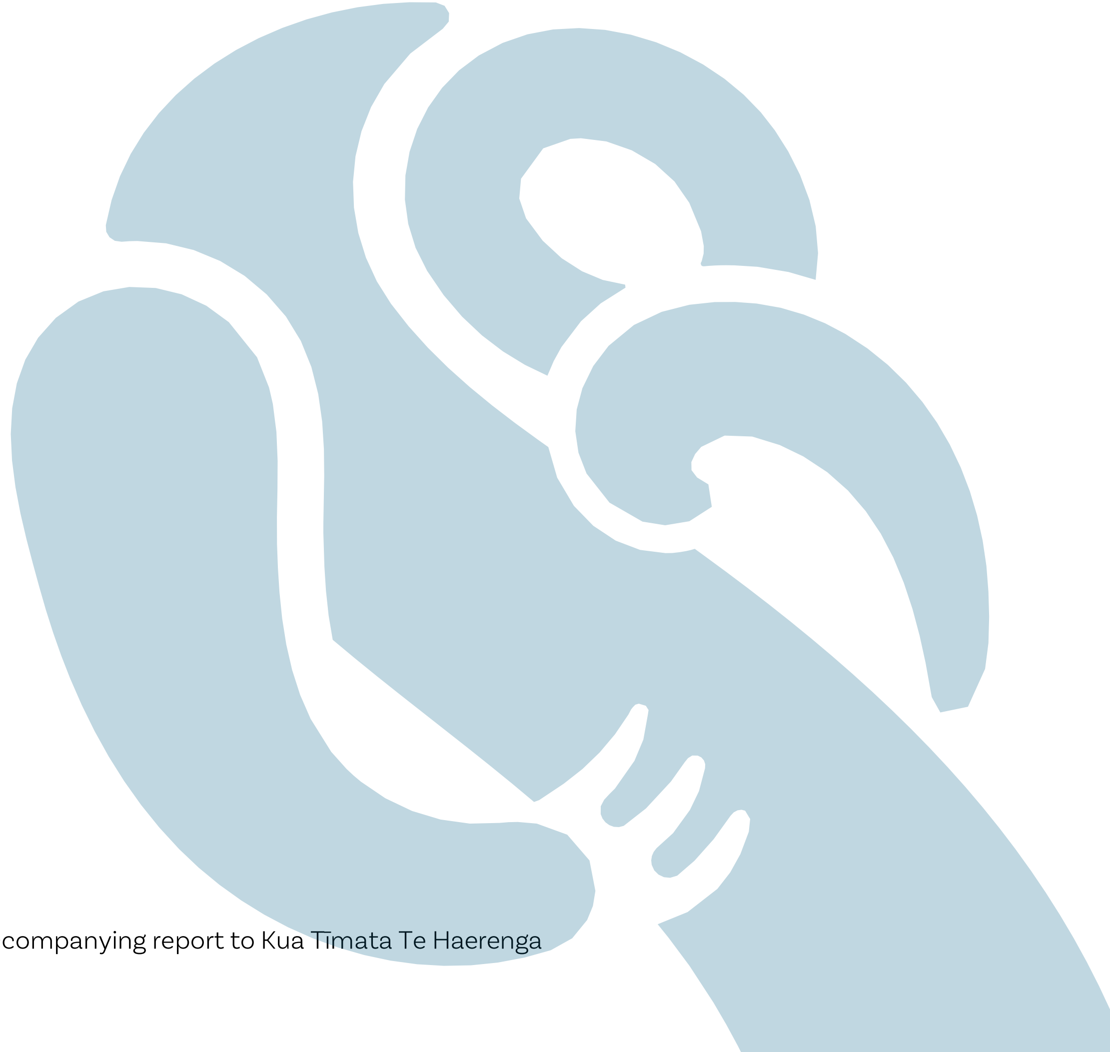
Staff shared that there is a need for more data and resource sharing and better system integration. This includes making information more transparent and visible as well as improving data sharing between services. Staff said better data sharing across districts is also needed. Similarly, staff talked about wanting a better system for searching for and quickly locating appropriate services, such as service directories.

For staff, particularly kaimahi Māori, we heard that it would be beneficial to capture qualitative and experience data, which could be used to recommend services to people.

> We've been having conversations over the last couple of years about pūrākau and more qualitative data depicting or giving a fuller description or reflection of what hauora means for whānau.
>
> *Manager, Kaupapa Māori service*
>
> I think absolutely there is a huge amount that can be improved.
>
> *Analyst, Health New Zealand service*
>
> So what's the quality, the experience of people? How do you capture that? You've got to do it, but have [it] designed by and, like, managed by peer support services, why wouldn't you? They're the experts in that.
>
> *Mental health liaison, Health New Zealand service*

In Kua Tīmata Te Haerenga | The Journey Has Begun, we highlight the following changes we want to see.

- **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 Tohutoro

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Appendix A: Te tūtohu i ngā reo

How we identified voices

To provide context to the quotes, we have provided some details as to where the data were from. For the community stream, we have done this by indicating what online form or focus group the quote was from. For the workforce stream, we included people's roles as well as what area of the sector they work in. This translated to labelling quotes as:

- 'Primary care' for people working for primary care services
- 'NGO service' for people working for NGO services; for specific NGO services, we have used different identifiers, such as 'Kaupapa Māori service', 'AOD service', and 'NGO youth service'
- 'Health New Zealand service' for people working for specialist services provided by Health New Zealand
- 'Emergency service' for people working for emergency services.

Throughout the shared voices, we also indicated whether quotes came from someone working through a kaupapa Māori lens, but they do not necessarily work for Kaupapa Māori services, and also if quotes were from an online form.

Appendix B: Tikanga mahi

Methodology

The purpose of our qualitative data collection was to understand people's experiences of accessing services and what service options are available to them. This information has been asked elsewhere, such as through the Government inquiry He Ara Oranga (Government Inquiry into Mental Health and Addiction, 2018).

However, our point of difference was 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 from people around the motu, and broad reach across different parts of the mental health and addiction sector. We heard from many different perspectives, including lived experience communities, whānau and family, priority population groups, and mental health and addiction workforces.

We had two data collection streams. One was a community stream for people with lived experience of mental distress, substance harm, gambling harm, or addiction and whānau, family, and supporters of people with these experiences as well as whānau, family, and supporters of people with these experiences. The other was a workforce stream for people who work in the mental health and addiction sector who are involved in or closely connected to referral and triage processes. We tailored data collection methods towards the audience of each data collection stream. Data were collected during November and December 2023.

Table 1 shows the number of participants we heard from through our qualitative data collection. [16]

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[16] For details on how we have identified the perspective of voices quoted in this report, please see Appendix A.

Table 1: Number of participants in qualitative data collection, by data collection method

Data collection method	People	Number	Total
Online forms	Lived experience	181 respondents	**317 respondents**
	Family, whānau, and supporters	122 respondents	
	Workforce	14 respondents	
Interviews (workforce)	Primary care	16 interviews, 16 participants [17]	**52 interviews, 61 people**
	NGO service	14 interviews, 19 participants [18]	
	Alcohol and other drug service	3 interviews, 3 participants	
	Gambling harm service	1 interview, 1 participant	
	Kaupapa Māori service	4 interviews, 8 participants	
	Health New Zealand service	12 interviews, 12 participants	
	Private practice [19]	1 interview, 1 participant	
	Emergency service	1 interview, 1 participant	
Focus groups (priority population groups)	Māori	1 group, 6 participants	**4 groups, 18 participants**
	Pacific peoples	1 group, 5 participants	
	Deaf peoples	1 group, 3 participants	
	Refugees and migrants	1 group, 4 participants	

Qualitative data allowed a deeper understanding of service access and availability of options

This report provides a deeper understanding of changes to access and options over the past five years, including the range of service options and inequities for both Māori and other priority populations. By design, the qualitative data and analysis were applied appropriately to reflect both a shared and Te Ao Māori perspectives.

For the community stream, the following questions were used.

1. Are people able to access services when and where they need them?
    a. Do people have access to supports that can help them to access services?

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[17] Four of these participants were Māori and worked for a Māori primary mental health organisation.

[18] One NGO service participant was Māori and included Mātauranga Māori in their practice.

[19] This person was also Māori and included Mātauranga Māori in their practice.

    b. What barriers affect people’s ability to access services?
    c. How has people’s ability to access services changed over time?
    d. What could make it easier for people to access services?
2. Do people have a meaningful choice in services?
    a. Can people choose what services they access?
    b. How have the service options available to people changed over time?
    c. How could people’s choice in services be improved?

For the workforce stream, the following questions were used.

1. How have referral pathways and patterns changed, such as triage criteria?
2. Why have referral pathways and patterns changed?
    a. What pressures do mental health and addiction services face? What effect do these challenges have on referral pathway and patterns? What are services doing to help manage the challenges?
    b. How has the level of need changed? What impact does this have on referral pathways and patterns?
    c. How have changes to the mental health and addiction system, such as the introduction of new primary care initiatives, impacted referral pathways and patterns?

Reference groups

Two reference groups were established for our 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 qualitative data component, reviewed our early analysis, and also supported wider engagement of the sector. A couple of members of each reference group reviewed our online forms as well as our focus group and interview questions before our data collection went live.

In addition, Te Kete Pounamu reviewed our early analysis of Māori lived experience and whānau data.

Collecting the views of people with lived experience, whānau, and family

Online forms

We sought the views of people who experience mental distress, substance harm, gambling harm, or addiction as well as the views of their whānau, family, and supporters via two online forms. One of these online forms was for people with lived experience and the other was for whānau, family, and supporters. People could answer the online forms whether they, or the person they were supporting, had accessed services or not.

The online forms were hosted on SurveyMonkey throughout the month of November 2023. Table 2 outlines the eligibility criteria for completing the online forms. We received 181 responses from people with lived experience, and 122 responses from whānau, family, and supporters.

Table 2: Eligibility criteria for completing the online forms

Lived experience	Whānau, family and supporters
People who have experience of mental distress, alcohol or other drug harm, gambling harm, or addiction irrespective of whether they accessed services for this.	Whānau, family, and supporters of people with experience of mental distress, alcohol or other drug harm, gambling harm, or addiction.
Aged 15 years and over	

Recruitment to the online forms

To recruit people to the online from, we used the snowball method. [20]To do this, we:

- advertised the online forms on our website and LinkedIn page
- emailed everyone in our stakeholder and lived experience databases
- informed our media contacts at other organisations
- asked people to forward on the email and to post about the project on social media.

Attached to the emails was a poster that people could print out and pin somewhere if they chose to do so. We also had a social media tile available for people to use. For those completing this online form, we had four Prezzy Virtual cards worth $250 each

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[20] In the online forms, we asked where people had found out about them. Respondents commented that they heard about the online forms in a variety of ways including: via the email we sent to people in our stakeholder and lived experience databases; via an email from other organisations, support groups, friends, or work; through their service provider; on social media, such as in a Facebook support groups, on an organisation's Facebook pages, and on LinkedIn; and through work colleagues.

to give away—two for each online form.

Halfway through the month of November, we reviewed the demographic characteristics of the online form responses we had received so far. In particular, we looked at the priority population groups that people identified with. If a priority population group had low numbers, we then got in touch with organisations we have existing relationships with that either work with or represent that group. We asked them to share the online forms with their networks.

Questions

People could answer whatever questions they wanted in the online forms. Each online form was separated into different sets of open-ended questions that respondents could answer depending on whether they, or the person they were supporting, had accessed services or not. The lived experience online form had three sets of questions concerning:

1. the most recent time the person had accessed a mental health service, alcohol or other drug service, or gambling service
2. a time they tried but had been unable to access a mental health service, alcohol or other drug service, or gambling service
3. a time they considered accessing a mental health service, alcohol or other drug service, or gambling service but decided not to.

The whānau, family, and supporters online form was separated into two sets of questions, which covered:

1. the most recent time they had supported someone to access a mental health service, alcohol or other drug service, or gambling service
2. a time when they supported someone who had not accessed one of these services (for whatever reason).

Table 3 outlines the open-ended questions we asked in each of these online forms.

In both online forms, we also asked a series of quantitative questions. Among these were demographic questions, including which ethic group(s) people belonged to, their age group, gender, what district they live in, and whether any of our priority population groups were relevant to them. For people who identified as Māori, we also asked for the name(s) and region(s) (rohe) of their iwi and whether they lived in the area they whakapapa to. Respondents to the whānau, family, and supporters online form were asked to answer the same demographic questions for the person they were supporting. Additionally, depending on whether people accessed, tried to access, or decided not to access services, people could answer questions about the service or the issue they were seeking help with, including:

- when they, or the person they were supporting last accessed, tried to access, or decided not to access services
- what issue of service it was (what issue they, or the person they were supporting, were seeking help for)
- what type of service provider it was, such as general practice or hospital-based service
- whether it was a mainstream or another type of service, for instance a Kaupapa Māori service, Pacific peoples service, or Youth service)
- how they got, or tried to get, access to the service, such as through a self-referral or general practice referral.

For an analysis of answers to some of these quantitative questions, see Appendix C.

Analysis

To analyse the online forms, we downloaded the SurveyMonkey results into Excel files as well as PDF files. Forms with no response to any open-ended questions were excluded from analysis. Closed questions were analysed with counts. Open-ended questions in each online form were coded and categorised into themes derived from the responses overall and the research questions. We then looked for commonalities and differences in themes across both online forms. For Te Ao Māori perspective, dedicated kaupapa Māori qualitative researchers analysed the Māori responses to the online forms separately.

Table 3: Open-ended questions in the online forms for people with lived experience and for whānau, family, and supporters

Focus	Open-ended questions
Lived experience	
Accessed services	1. How easy was it to access the service? What made it easy or difficult? 2. Were you able to access the service when you needed to? Please tell us about your experience of waiting to access the service, including how long you waited to be seen. 3. Were supports to access the service, such as navigators and peer advocates, available to you? If you used any supports, what supports did you receive, and did they help you to access the service? 4. What went well when accessing the service? 5. Is there anything that could have made your experience accessing the service better? 6. Were you able to choose what service you accessed? Please tell us about this. (For instance, were a range of services offered to you or was only one service offered?) 7. Are there any further comments you would like to make about your experience accessing the service, including what went well, what didn't go well, and what could have been done better?
Tried to access services	8. What barriers did you encounter when you tried to access the service? (For example, the service cost too much or you had no transport to get there.) Please tell us about these barriers and your experience of them. 9. What could have been done to minimise the barriers you faced when trying to access the service? 10. Are there any further comments you would like to make about your experience trying to access the service, including what could be done better to improve access to the service?
Decided not to access services	11. Why did you decide against accessing services? (For example, you got support from friends or family instead, available services did not meet your cultural and language needs, or information on where to get help was hard to find.) 12. What could be done better for you to consider accessing services in the future?

	13. Are there any further comments you would like to make about why you decided not to access services?
Whānau, family, and supporters	
Supported a person and services were accessed	1. How easy was it to access the service? What made it easy or difficult? 2. Were they able to access the services when they needed to? Please tell us about your experience supporting this person whule they waited to access the service, including how long it took for hem to be seen. 3. Were supports to access the service, such as navigators and peer advocates, available to them? If they used any supports, what supports did they receive, and do you think they helped them to access the service? 4. What went well when accessing the service? 5. Is there anything that could have made their experience accessing the service better and, in turn, improved your experience of supporting them? 6. Were they able to choose what service they accessed? Please tell us about this. (For instance, were a range of services offered or was only one service offered?) 7. Are there any further comments you would like to make about your experiences supporting this person to access the service, including what went well, what didn't go well, and what could have been done better?
Supported a person and services were not accessed	8. What reason did they have for not using services? (For instance, they did not think they needed to use services, or they tried to access services but were unable to get in.) 9. What barriers did they encounter if they tried to access the service? (For example, the service cost too much or they had no transport to get there). Please tell us about your experience supporting this person when they encountered these barriers. 10. What could have been done to reduce the barriers they faced when trying to access services and, in turn, make it easier for you to support them?

11. If they did not try to access services, why did they decide not to do so? (For example, they got help from family and friends instead, they did not think their situation was serious enough, or they felt like services would not be able to help them.)
12. What could be done better that would make them consider accessing services in the future?
13. Are there any further comments you would like to make about why they did not access services, whether they tried to do so or not, and your experience supporting them?

Focus group recruitment and facilitation

We held four dedicated focus groups with Māori, Deaf peoples, Pacific peoples, and refugees and migrants to support accessibility with sharing their perspectives.

All focus groups ran for two hours and were held via Microsoft Teams. In recognition of their time, all focus group participants were eligible for a koha if they attended the focus groups during their own time (not during paid work hours). Each focus group had a different recruitment strategy and was also facilitated differently.

For our Māori focus group, we wanted a wide spread of perspectives from around the motu, including Māori with lived experience who are in leadership roles, kaimahi in services with specific lived experience roles, and hau kāinga—those accessing services and living within their rohe. To recruit people to this focus group, we contacted people we already have connections with and reached out to Kaupapa Māori services to see if they knew anybody that might be interested in participating.

Our Māori focus group was facilitated by one Māori staff member, who is a lived experience advisor, and one kaupapa Māori researcher. Within the limitations of online focus groups, Māori tikanga guided this hui. Each hui was opened with Karakia Tīmatanga to initiate a safe space before welcoming everyone with mihimihi. For participants to get to know one another and establish whakapapa connections, the hui included a round of whanaungatanga. Everyone had a kōrero around the questions before the hui was closed with Karakia Whakamutunga.

We worked with external stakeholders—community champions—to recruit and facilitate talanoa for Pacific peoples and a focus group for migrants and refugees. Drawing from, and promoting within, their networks, the champions pulled together groups of up to eight people for two-hour talanoa or focus groups. These were co-facilitated by a champion and a staff member from Te Hiringa Mahara, to ensure that the space was safe and culturally appropriate.

The focus group for Deaf peoples was pulled together from members of previous focus groups, and through recommendations from community leaders and NGOs. A staff member from Te Hiringa Mahara with relationships to focus group members facilitated the focus group with support from two New Zealand Sign Language interpreters. Accessible information, such as New Zealand Sign Language summaries of the focus group questions, was made available to all attendees before the focus group session.

Questions

We asked 10 questions during each focus group session, which were separated into two sets, as shown in Table 4. The first five questions were about people's experiences of accessing services while the last five questions were focused on people's experiences of choosing what service they accessed. Both question sets covered how things have changed over the last five years, what good looks like to them, and what they think needs to happen for this to occur. Focus group attendees were given all of these questions in advance.

Table 4: Focus group questions

Focus	Questions
Accessing mental health and addiction services	1. How easy is it for you to access mental health and addiction services when and where you need to? 2. Are supports that help people to access services available to you? Are they easily accessible? 3. Are there any barriers that have you encountered, or are likely to encounter when trying to access services? 4. Over the past five years, have you found it is getting easier or harder to access services? 5. What would easy access to services look like for you? What changes would you like to see for this to happen?
Choosing mental health and addiction services	6. Are you able to choose what services you access? What choice in services do you have? 7. In the past five years, have you found it easier or harder to choose the services you access? 8. Over the past five years, have you found there are more services available for you to choose from? 9. What does choice mean to you? What changes would you like to see that would make it easier for you to choose the services you access? 10. What changes would you like to see that would improve the range of services for you to choose from?

Analysis

Each focus group was recorded and transcribed for ease of analysis and to accurately capture what people shared with us. The Māori focus group was analysed separately by dedicated kaupapa Māori qualitative researchers for Te Ao Māori perspective as well as analysed as part of the shared perspective. For the shared perspective, transcripts were put into an Excel file while Te Ao Māori perspective was analysed in Word. They were then coded and categorised into themes derived from what was discussed during the focus groups and the research questions. Each focus group discussion was analysed individually before we looked for commonalities and differences across the focus groups.

Collecting the views of people working in the mental health and addiction sector

We conducted 52 interviews with people who worked in the sector in diverse roles in specialist services, NGOs, primary care, and emergency services. We also offered online forms for staff that we were unable to interview. We received five online forms from people working in primary care, five from people working for NGO services, and four from people working for specialist services.

Recruitment

We used the snowball method to recruit interviewees. However, the way we went about this differed slightly depending on the service type.

For primary care services, we sent emails to every primary health organisation across the motu.

For specialist and NGO services, we emailed two members of our sector reference group: one works for Health New Zealand and the other for Pathways, a large mental health and addiction NGO. We asked each of them to forward the emails to their relevant contacts. In these emails, we explained why we were interested in exploring access to mental health and addiction services and noted that we were particularly interested in hearing from people who are involved in or closely connected to the referral and triage processes.

For emergency services, we asked a member of our reference group who works for Hato Hone St John whether they knew anybody who would be interested in being interviewed.

We received an overwhelming amount of interest and requests for an interview from people working across the mental health and addiction sector. To triage these expressions of interests, we looked to see if each person was involved in, or had knowledge of, referral and triage processes, and if we were unsure, we reached out to them to ask. Initially, interview spots were given on a first come, first served basis.

However, because it was important to us to hear from a range of staff working across the mental health and addiction sector around the motu, interviewees were later chosen to fill gaps we were seeing, such as gaps related to location, service type, and role. We had online forms available for people who wanted to be interviewed but did not receive an interview spot.

Interview and online form questions

We had four sets of interview questions: one for primary care services, one of NGO services, one for specialist services, and one for emergency services, as shown in Table 5. All but the emergency services question set covered what interviewees did to ensure people access the services they need or how people access their service, changes in the last two years, the impact of the Access and Choice programme, and ideas or aspirations for improvement. The emergency services questions were based on our research questions for the workforce stream.

The online forms asked similar questions. However, these largely took the form of closed-ended questions with a matrix. The online forms also included space for people to expand on their answers.

Interview facilitation

Interviews were semi-structured and were held via Microsoft Teams. Interviewees were provided with the high-level questions that we would be asking in advance so they could prepare for the interview if they wished. We did not provide interviewees with all interview questions because the questions we asked were dependent on answers they had given previously.

Within the limitations of online interviews, interviews with kaimahi Māori carefully applied kaupapa Māori facilitation tools, techniques, and approaches, including karakia; mihimihi; whanaungatanga; and titiro, whakarongo, and kōrero. Additionally, each interview with kaimahi Māori had at least one Māori interviewer.

Analysis

Like the focus groups, all interviews were transcribed to help with analysis and to accurately capture what was discussed. We then undertook a thematic analysis process. We included the sector online form responses in our analysis.

The Māori responses to the interviews and sector online forms were analysed both as part of a shared perspective, and separately by dedicated kaupapa Māori qualitative researchers. For Te Ao Māori perspective we coded each transcript, either on hard copies or in Word, before looking at themes in each interview and then across service types.

For the shared perspective, once the data were collected, we coded each transcript using NVivo, and then identified key themes. Following this, we looked at differences and commonalities in themes for each service type, and then did the same across all interviews.

Table 5: Sector interview questions

Focus	Open-ended questions
Primary care interview questions	
Introduction / context questions	1. Can you tell me about [the service/organisation] you work for and your role here? 2. What involvement do you have in supporting people to access other services outside of your organisation? (specialist services, primary care, community services)
Getting tāngata whaiora access to the services they need	3. [If involved in making referrals] Can you talk me through your decision-making process when you're considering options for someone with mental health or addiction needs? 4. If not directly involved in referrals] Can you tell me a bit about the process at [the service/organisation] when a person needs referral on to further services, and also referred internally? 5. [Additional part to Q3 or Q4] What influences decisions or patterns about where people are referred to for mental health or addiction support or treatment? 6. In your experience, what works well, or what enables you [or your organisation] to get people access to the services that best meet their needs? 7. In your experience, what could be improved, or what are the barriers to people accessing the services that best meet their needs?
Changes in the past two years	8. Thinking about the last two years (this year and last year), have you noticed any changes in the number of people requiring support for mental distress, substance harm, or addiction? Or is it about the same? 9. Are there any changes in the severity or complexity of presentations or is it about the same? What are these changes? 10. How easy is it for people to access the right level of treatment, assessment, and support? How has this changed over the past two years (this year and last year)? 11. In the past two years, have you noticed any changes in the volume or likelihood of referrals being

	accepted, or is it about the same? 12. In the past two years, have there been any changes in how likely you are to make referrals to different services, or is it about the same?
Impact of the Access and Choice programme	13. If relevant and not already clear from interview] Does your general practice offer the Integrated Primary Mental Health and Addiction service (new wellbeing roles in general practices that include health improvement practitioners and health coaches)? 14. Thinking about the Access and Choice programme, what difference do you think this programme has made on your referrals and utilisation of services outside [your service/organisation]? (thinking particularly about specialist services for mental health, addiction and young people and primary mental health initiatives such as counselling packages of care or group therapies.)
Sector aspirations or ideas for improvement	15. What do you think are the most significant areas where change is needed to better support people to get access to the mental health or addiction services they need? 16. Do you have any other thoughts about understanding the changing patterns in use of mental health and addiction services or is there anything else you want to tell us about mental health and addiction services today?
NGO services interview questions	
Introduction / context questions	1. Can you tell me about your role and the organisation or service you work for? 2. What are the pathways to accessing your service? 3. How do people generally access your service?
Access to services outside of NGO (if applicable)	4. [If make referrals] Can you talk me through the process of making a referral, including what is considered when making a decision about whether a person needs to be referred on to another service? 5. In your experience, what works well, or what enables you [or your organisation] to get people access to the services that best meet their needs? 6. In your experience, what could be improved, or what are the barriers to people accessing the services

	that best meet their needs?
Access to own services (should be applicable to all)	7. Can you tell me a bit about the process that happens when you receive a referral, including what goes into making a decision about whether to accept someone into your service?
	8. In your service, what factors are currently having an impact on your ability to respond to the needs of people in your community?
Changes in the past two years	9. [If relevant] Thinking about the last two years (this year and last year), have you noticed any changes in the number of people requiring support for mental distress, substance harm, or addiction?
	10. [If relevant] How easy is it for you to get your patients access to the right level of treatment, assessment, and support? How has this changed over the past two years (this year or last year)?
	11. [If relevant] In the past two years, have you noticed any changes in the volume or likelihood of referrals being accepted?
	12. [If relevant] In the past two years, have there been any changes in how likely you are to make referrals to different services?
	13. [If relevant] Has there been a change to the people coming into your service over the past two years (this year and last year)? What are these changes and why do you think they have occurred?
Impact of the Access and Choice programme	14. [If not answered in Q1] Do you provide any services that are contracted as part of the Access and Choice programme?
	15. [If Access and Choice provider] How would you consider this/these new Access and Choice service/s has/have supported people to access the support they need?
	16. How effective do you consider these services in: a. reaching the ‘missing middle’? b. providing early intervention?

	c. reducing the need for the people to use specialist services? 17. If Access and Choice provider] Has providing the Access and Choice services impacted, changed, or adapted your delivery of other services you provide? 18. [If not an Access and Choice service] Have you noticed any Access and Choice services in your region? Have they influenced utilisation of different types of services? 19. [If not an Access and Choice service] How have Access and Choice services impacted on the provision of different types of services?
Sector aspirations or ideas for improvement	20. What do you think are the most significant areas where change is needed to better support people to get access to the mental health or addiction services they need? 21. What changes do you think are needed to support the services and workforces? 22. Do you have any other thoughts about understanding the changing patterns in use of mental health and addiction services or is there anything else you want to tell us about mental health and addiction services today?
Specialist services interview questions	
Introduction / context questions	1. Can you tell me about your role and the service you work for? 2. What involvement do you have in the referral and triage process?
Ensuring tāngata whaiora get access to the services they need	3. What are the pathways to accessing your service? 4. How do people generally access your service? 5. What works well in ensuring people get access to the specialist services they need?
Changes in the past two years	6. Has there been a change to the referrals coming into your service over the past two years (this year and last year)? What are these changes and why do you think they have occurred? 7. In the last few years, there have been changes in the wider mental health and addiction sector, such as the development and roll-out of new primary care initiatives. Thinking about the last two years in particular, what impact have these changes at the primary care level had on people's access to your

	service? 8. In your service, what factors are currently having an impact on your ability to respond the specialist needs within your communities? What impact have they had on the referral and triage process? 9. Over the last two years, has your service made any changes to acceptance thresholds or criteria? What are these changes and what impact have they had on access? 10. Has your service made any changes in the last two years to manage service volumes and workloads? What impacts have these had on the referral and triage process?
Sector aspirations or ideas for improvement	11. Thinking towards the future, what changes could help the sector better respond to people and whānau? 12. What changes do you think are needed to support the services and workforces? 13. Is there anything else you would like to tell us about the referral and triage process?
Emergency services	
	1. How have referral pathways and patterns changed, such as triage criteria? 2. Why have referral pathways and patterns changed? 3. What pressures do mental health and addiction services face? What effect do these challenges have on referral pathway and patterns? What are services doing to help manage the challenges? 4. How has the level of need changed? What impact does this have on referral pathways and patterns? 5. How have changes to the mental health and addiction system, such as the introduction of new primary care initiatives, impacted referral pathways and patterns?

Bringing the data together for the Voices report

To bring together the perspectives and experiences for this Voices report, we undertook further analysis of the data we had collected using reflexive thematic analysis (Braun and Clarke, 2021). Reflexive thematic analysis offered flexible guidelines for using this approach, rather than a set of rules to follow. It also provided us with a rigorous approach to narrow down what was shared in each data collection stream into the key themes identified in this report.

To do this, we revisited the analysis we had undertaken for the monitoring report from both the shared perspective and Te Ao Māori perspective. We refamiliarised ourselves with the online form responses and focus group transcripts and revisited how we had group together themes. In doing so, we were searching for patterns of meaning. We then generated further initial themes across all data sources in each stream. These themes were refined in writing this report.

After we had revisited our themes for both the shared perspective and Te Ao Māori perspective, we had to bring the data together for this Voices report. To do this, we looked for similarities and differences between the two perspectives. Where we heard themes converge, we have analysed and discussed these as a shared perspective, which includes Māori voices. Where themes were distinctly identified as Māori from all the data sources that gave mana to kaupapa Māori, Mātauranga Māori, and Te Ao Māori perspectives, we have provided a dedicated space for discussion. This analysis approach has been guided by the approach of He Awa Whiria—Braided Rivers (Social Policy Evaluation and Research Unit, 2018).

Ethical considerations

Ethical principles were applied throughout the collection, analysis, and writing of the qualitative data. We obtained informed consent from everyone who participated in our qualitative data collection. We let people know in advance what the project was about and how we would use the data they shared with us for our monitoring project and gave an overview of what questions we would ask them. This information was included in the front first page on the online form, and we sent information sheets to all focus group and interview participants in advance.

We also asked people a series of consent questions, asking them what they would like us to do with their data. These questions were either asked at the end of the online form or in a separate consent form for focus group participants and interviewees. In the consent forms for our interviews and focus groups, we noted that the interviews and focus group discussions would be recorded so we could accurately capture what people shared with us.

We asked people to send through their completed consent forms in advance of the focus group or interview. If any focus group participants did not do this, we asked them to send their consent form through to us afterwards. For the interviews, we either went through the consent questions at the beginning of the interview or asked people to send them through afterwards.

For the Deaf peoples focus group, the information sheet and consent form were translated into accessible formats.

Further, we have ensured that all participants data and personal information is kept confidential and private. All data collected during our qualitative data collection are saved in a secure database that is visible only to people in our project team. We have also de-identified quotes used in this report to ensure that our participants remain anonymous.

Moving forward

We aim to improve the way we design and develop our methods to collect Māori qualitative data. It is our intention to adopt an approach guided by kaupapa Māori theory and practice to ensure the lived experience of Māori voices meets with best practice. We look to improve the way we are guided by kaupapa Māori analytical approaches. For example, we will use He Awa Whiria—Braided Rivers model to amplify the value and integrity of Te Ao Māori perspectives and Mātauranga Māori alongside Western perspectives and science.

Appendix C: Ngā raraunga tatau mō ngā puka tuihono

Quantitative data for online forms

Number of responses

We included online forms in the data analysis if the respondent gave at least one response to an open question. [21] Table 6 shows how many people accessed the online forms and the number of forms we analysed.

Table 6: Number of responses to the online forms, number excluded, and number analysed

	All		Māori	
	Lived experience	Whānau, family, and supporters	Māori lived experience	Māori whānau, family, and supporters
Number accessing the form	257	169	30	34
Number excluded—no open-ended questions answered	76	47	0	0
Number of forms analysed	181	122	30	34

Demographic characteristics

Table 7 shows the demographic characteristics of respondents to the lived experience online form, as well as the demographic characteristics of the people who whānau, family, and supporters were supporting.

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[21] In the total number of responses, SurveyMonkey includes every survey that has one answered question. This includes closed-ended questions. We chose to include only the online form responses that answered at least one open-ended question in our analysis because these questions were designed to give us insight into people’s experiences. The closed-ended questions, on the other hand, were mostly used for other purposes: as a navigation tool to another part of the online form, a way to understand what type of service the respondent was referring to in their open-ended answers, or to gain demographic information.

Table 7: Demographic characteristics of online form responses

Characteristic	Lived experience			Whānau, family, and supporters		
	All		Māori	All		Māori
Age	n	%	n	n	%	n
18 years and under	4	2%	1	27	22%	2
Between 19 and 24 years	21	12%	6	26	21%	11
Between 25 and 64 years	119	66%	22	55	45%	21
65 years and over	9	5%	1	3	2%	–
No response	28	15%	–	11	9%	–
Gender	n	%	n	n	%	n
Male	26	14%	9	46	38%	18
Female	112	62%	18	56	46%	15
Gender diverse	12	7%	3	7	6%	–
Other	1	1%	–	2	2%	1
Prefer not to say	3	2%	–	2	2%	–
No response	27	15%	–	9	7%	–
Ethnicity [22]	n	%	n	n	%	n
New Zealand European	122	67%	15	81	66%	14
Māori	30	17%	30	34	28%	34
Samoan	4	2%	2	5	4%	3
Cook Islands Māori	1	1%	1	–	–	–
Tongan	–	–	–	–	–	–
Niuean	–	–	–	–	–	–
Chinese	1	1%	–	1	1%	–
Indian	1	1%	–	1	1%	–
Other	20	11%	–	9	7%	–
No response	26	14%	–	2	2%	–
Priority population group [23]	n	%	n	n	%	n
None of the priority population groups	49	27%	1	25	20%	–

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[22] Individual respondents could report more than one ethnicity.

[23] People could report more than one priority population group.

	Lived experience			Whānau, family, and supporters		
Characteristic	All		Māori	All		Māori
Māori [24]	32	18%	29	36	30%	34
Pacific peoples	7	4%	4	10	8%	5
Refugees	3	2%	1	2	2%	1
Migrants	9	5%	1	3	2%	1
Rainbow communities (LGBTQIA+)	41	23%	12	14	11%	3
Rural communities	14	8%	4	10	8%	2
Disabled people	45	25%	9	15	12%	4
Veterans	4	2%	2	1	1%	-
Prisoners	3	2%	1	4	3%	2
Young people	29	16%	8	40	33%	8
Older people	15	8%	3	11	9%	3
Children experiencing adverse childhood events	19	10%	5	11	9%	4
Children in State care	6	3%	4	4	3%	3
No response	30	17%	–	10	8%	-
Health New Zealand region	n	%	n	n	%	n
Northern	42	23%	11	25	20%	8
Te Manawa Taki	29	16%	6	24	20%	11
Central	52	29%	10	24	20%	6
Te Waipounamu	32	18%	3	36	30%	6
No response	26	14%	–	13	11%	3

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[24] The difference in the count of responses between Māori ethnicity and Māori as a priority population group is as submitted.

Service access data

Lived experience online forms

Most respondents who answered our lived experience online form had accessed services before. Many of these people had also, at some point, tried unsuccessfully to access services and at another time had considered but decided not to access services, as shown in Table 8.

Table 8: Experiences of accessing services among lived experience respondents

Experience	All (N=181)		Māori (N=30)
	n	%	n
Accessed services	163	90%	27
Tried to access services	129	71%	25
Considered but didn't access services	116	64%	22

The majority of lived experience respondents who accessed services commented on experiences relating to mental health services only. Table 9 and Table 10 list the types of services accessed by respondents (this was a multiple response question). 'Other' services included eating disorder services and private mental health services. Most respondents indicating an 'other' service stated they were also accessing a mental health service.

Table 9: Type of service accessed by lived experience respondents

Service [25]	All		Māori
	n	%	n
Mental health	154	94%	27
Alcohol and other drug	19	12%	3
Gambling	2	1%	1
Opioid substitution therapy	3	2%	–
Other	23	14%	3

Most respondents who accessed services—or tried to—discussed their experiences in relation to crisis services, GP services, and Health New Zealand (DHB) community services (Table 10). 'Other' providers noted were largely private services (counsellors, psychologists, and psychiatrists), including those accessed through ACC. Generally, these were mainstream services (Table 11).

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[25] Multiple responses possible.

Table 10: Services accessed or considered by lived experience respondents

Provider	Accessed services		Tried unsuccessfully to access service	
	n	%	n	%
Crisis or urgent service	34	21%	23	18%
General practice (your community GP)	28	17%	15	12%
Hospital-based service	10	6%	5	4%
Other community service (Health New Zealand/DHB services)	37	23%	31	24%
Other community service (NGO service)	18	11%	11	9%
Phone	2	1%	9	7%
Online	2	1%	–	–
Other	32	20%	17	13%
No response	–	–	18	14%
Total	**163**	**100%**	**129**	**100%**

Table 11: Type of provider accessed or considered by lived experience respondents

Type of provider	Accessed services		Tried unsuccessfully to access service	
	n	%	n	%
Mainstream service	144	88%	93	72%
Kaupapa Māori service	1	1%	1	1%
Rainbow service	4	2%	1	1%
Youth service	6	4%	6	5%
Don’t know	8	5%	11	9%
No response	–	–	17	13%
Total	**163**	**100%**	**129**	**100%**

Whānau, family, and supporters online form

Most respondents to our whānau, family, or supporters online form were supporting someone to access mental health services, or with mental health issues (Table 12). ‘Other’ services or issues included interactions with ACC and Police; helping with drug checking and housing; providing care to a dependent person; and support with autism spectrum disorder, child mental health, eating disorders, severe mental illness, and gender dysphoria.

Table 12: Type of service or issue supported—whānau, family, and supporters

Service or issue [26]	Supported a person when they accessed services			Supported a person when they did not access services		
	All		Māori	All		Māori
	n	%	n	n	%	n
Mental health	101	89%	29	81	83%	25
Alcohol and other drug	29	25%	11	24	24%	12
Gambling	3	3%	1	2	2%	1
Opioid substitution therapy [27]	3	3%	1	–	–	–
Other	11	10%	2	6	6%	3

For respondents supporting a person when they accessed services, the types of service most commonly involved were mainstream Health New Zealand community services, crisis services, or hospital-based services (Table 13 and Table 14). ‘Other’ services included private services (psychologists, rehabilitation services), ACC-related services, school services, a HIP, and a case manager for a person under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Table 13: Services accessed—whānau, family, and supporters

Provider	All		Māori
	n	%	n
Crisis or urgent service	28	25%	10
General practice (your community GP)	7	6%	4
Hospital-based service	19	17%	4
Other community service (Health New Zealand / DHB services)	36	32%	10
Other community service (NGO service)	10	9%	2
Phone	1	1%	-
Other	13	11%	1
Total	**114**	**100%**	**31**

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[26] Multiple responses possible.

[27] This service option was not specified in the question to respondents who supported a person when that person did not access services.

Table 14: Type of provider accessed — whānau, family, and supporters

Type of provider	All		Māori
	n	%	n
Mainstream service	84	74%	25
Kaupapa Māori service	4	4%	2
Pacific peoples service	2	2%	1
Rainbow service	2	2%	–
Youth service	17	15%	1
Don’t know	5	4%	2
Total	**114**	**100%**	**31**

Appendix D: Rārangi Kupu

Glossary

Note: For terms in te Reo Māori (Māori language) in this glossary, the meanings relate directly to the context of this report. We respectfully acknowledge there may be other interpretations and differences.

Access and Choice programme	A programme that set out to provide free and immediate support for people with mild to moderate mental health and addiction needs. It consists of four service types: IPMHA services, which are based primarily in general practices three service types based primarily in NGOs—Kaupapa Māori services, Pacific services, and Youth services. For more information, see our separate report on the Access and Choice programme.
Addiction services	Services that exist to respond to the experiences, needs, and aspirations of tāngata whaiora, whānau, and family who experience harm from substances or substance addiction.
Alcohol and other drug services	A subset of addiction services that provides support to people suffering harm from alcohol and other drug use.
Aroha	An expression of empathy, compassion, and love, which may also be used to give guidance and safety.
Awhi	A positive sense of being embraced (figuratively or physically).
(Infant,) Child and Adolescent Mental Health Services (CAMHS)	Specialist services for young people and their families. In some regions, these services are referred to as Infant, Child, and Adolescent Mental Health Services (ICAMHS). These services are usually for children and young people aged 0–18 years. However, the age range can vary around the motu.
Community support worker	Part of IPMHA services. They are based in the community and can help people with anything that impacts on their wellbeing, such as by connecting people to wider supports in the community. In some

	regions, health coach and community support worker roles are combined.
Comorbidities	Comorbidities are diseases or disorders that exist with other diseases or disorder.
Districts	The geographical locations that have the same boundaries as the former district health boards.
Gambling harm services	Services that provide support for gamblers, whānau and family members, and other people who are negatively affected by someone else's problem gambling.
Hauora	A positive status of health—fit, well, vigorous, and in good spirits.
He Ara Āwhina framework	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 our website.
Health coach	Part of IPMHA services. They help people to gain the confidence, skills, and knowledge they need to better manage their health. Health coaches can also help people to find resources to better support their wellbeing. Unlike HIPs, they are not registered mental health professionals.
Health improvement practitioner (HIP)	Registered mental health clinicians who work with people of all ages and their whānau and family. They help people with any issues that are impacting on their health and wellbeing. HIPs, like health coaches and community support workers, are part of IPMHA services.
Health New Zealand services	Services provided currently by Health New Zealand, and previously by district health boards.
Integrated Primary Mental Health and Addiction (IPMHA) services	IPMHA services are one of the new service types established through the Access and Choice programme. IPMHA services are primarily based in general practices.
Kaimahi Māori	A Māori worker (sometimes means staff or employee).

Kaupapa Māori services	A tangata whenua response to effectively meeting the mental health and addiction needs of tāngata whaiora and their whānau (Te Rau Matatini, 2015). Providers who identify as Māori develop and deliver Kaupapa Māori services. These services include Māori mental health services provided by NGOs and Health New Zealand services that are not Māori-governed organisations. For more information, please see our separate report on Kaupapa Māori services
Titiro, kōrero, and whakarongo	Means to look, listen, then speak.
Lived experience	Having personal experience of an issue or situation. It may be a person or a group that has this personal experience, and it can be current, recent, or in the past. For Te Hiringa Mahara, 'lived experience' relates to personal experiences of distress / mental distress, substance harm, gambling harm, psychiatric diagnosis, addiction, using mental health or addiction supports or services, or experience of barriers to accessing these support and services when someone needs them. Lived experience relates to how people self-identify and share their identity with others, so it is not our role to determine whether people have 'lived experience'—it is each person's decision as to how they identify.
Mātauranga Māori	An indigenous knowledge system originating from Māori ancestors that incorporates Māori worldview, philosophical thought, perspectives, and cultural practice.
Mamae	The experiences (actual or feelings) of hurt, pain, injury being aggrieved.
Mana	A person's status and power accrued through leadership abilities.
Mana motuhake	Māori self-determination, tribal governance, or more simply, autonomy over one's affairs and destiny.
Manaaki	To demonstrate care, respect, and generosity (as being a hospitable host).
Manaakitanga	The process of showing care, respect, and generosity

	to others.
Mental health services	Services that exist to respond to the experiences, needs, and aspirations of tāngata whaiora and whānau who experience distress.
Mental health and addiction system	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.
Mihimihi	Is where all participants at the beginning of any hui or gathering introduce themselves.
Motu	Country.
Navigator	Someone who helps people to be well and works with them to find out how they can be better supported. Navigators can also provide help and guidance with navigating the mental health and addiction system.
Neurodiversity	It is a broad term used to encompass a diverse and wide range of neurological differences, such as ADHD or autism spectrum disorder.
Non-governmental organisation (NGO) services	Diverse services that span from early intervention to specialist services, such as residential facilities, community support services, and addiction services.
Peer advocate	Someone with their own lived experience who works with tāngata whaiora to have their voices heard and can assist them in resolving any issues or problems they may be having in the wider mental health and addiction system. Peer advocates support people to advocate for themselves or can advocate on behalf of tāngata whaiora. They work independently of systems they advocate in.
Peer support	Support provided by someone with their own lived experience of mental health distress and/or addiction. It is an equal relationship where two (or more) people give and receive support. For more information, please

	see our insights paper on the peer support workforce.
Primary care liaison (PCL)	A specialist service role that primarily works to support providers and people outside of specialist services. Primary care liaison functions are variable around the motu. They can include facilitating access to a psychiatrist for advice, providing GP education, and supporting consults in primary care. Some may be delivered by specialist roles, e.g. primary care liaison and mental health liaison, while some will be within the existing roles of other specialist clinicians.
Primary care services	Services provided at initial entry points. They are usually provided by general practices and some other services, such as pharmacists. NGOs, such as Māori and Pacific providers, can also provide primary care services. In this report, we primarily have used primary care services to mean services based in general practices.
Pūrākau	Ancient stories.
Qualitative data	Data that present information and concepts that are descriptive rather than numerical.
Quantitative data	Data that can be counted and measured.
Rangatahi	Young Māori person.
Rangatiratanga	Māori sovereignty.
Rongoā	The many Māori healing remedies and practices of a physical and spiritual nature in achieving a status of health and wellbeing.
Specialist services	Also known as secondary care services. These are publicly funded services provided by Health New Zealand or NGOs across inpatient and community settings. Most specialist services are community based.
Tāngata whaiora	People of any age or ethnicity 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). 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.
Tautoko	To support, advocate and/or endorse including giving comfort and/or encouragement
Te Ao Māori	The Māori world.
Te Whare Tapa Whā	A model developed by leading Māori health advocate Sir Mason Durie in 1984. The model describes health and wellbeing as a wharenui (meeting house) with four walls. These walls represent taha wairua (spiritual wellbeing), taha hinengaro (mental and emotional wellbeing), taha tinana (physical wellbeing) and taha whānau (family and social wellbeing). The connection with the whenua (land) forms the foundation. When all these things are in balance, we thrive (Durie, 2004).
Tikanga	A Māori concept based on customary practices and/or principles. Tikanga is also concerned with safety and protection from harm, both tangible and non-tangible.
Tino rangatiratanga	Absolute Māori sovereignty.
Wairua	Spiritual in nature, spirituality.
Whānau	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. 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.

Whānau Ora	Wellbeing of extended family. It is also a reference to the major Māori health services in Aotearoa.
Whānau Ora navigator	A person who works within a Whānau Ora service and helps and supports whānau to both navigate internal services and access external services needed.
Whakamā	The experiences (actual or feelings) of embarrassment, shame, guilt, or shyness
Whakamoemiti	To praise and express praise, thanks, and appreciation.
Whakapapa	A lineage of descent that gives history of one's genealogy of the human nature, but also to the kinship relationship to the natural elements and environment of ao Māori.
Whanaungatanga	Relationship, kinship, a sense of connection, and belonging.
Youth services	Services specifically for youth. In this report, we have identified quotes from Youth services that are NGOs providing services for people from 12 to 24 years of age.

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:

- Depression Helpline: free phone **0800 111 757** or free text **4202**
- Suicide Crisis Helpline: free phone **0508 828 865** (0508 TAUTOKO)
- Anxiety NZ: free phone **0800 269 4389** (0800 ANXIETY)
- 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 phone **0800 111 757** or free text **5626**
- Youthline: for young people, free phone **0800 376 633** or free text **234**
- Are you OK: free phone 0800 456 450 (family violence help)
- 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**, a free national Pacific helpline with Samoan, Tongan, Cook Islands Māori, and English languages available.

For more information about where to get support, visit the Manatū Hauora website.

Te Hiringa Mahara | Mental Health and Wellbeing Commission

Te Kāwanatanga o Aotearoa
New Zealand Government