TE HURINGA

TUARUA 2023

Mental health and addiction service monitoring report

Te Hiringa Mahara

Mental Health and Wellbeing Commission

Te Huringa Tuarua 2023: Mental Health and Addiction Service Monitoring Report

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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

The mission statement in our Strategy is "Whakawāteatia e tātou he ara oranga / clearing pathways to wellbeing for all." Te Hiringa Mahara acknowledges the inequities present in how different communities in Aotearoa experience wellbeing and that we must create the space to welcome change and transformation of the systems that support mental health and wellbeing. Transforming the ways people experience wellbeing can only be realised when the voices of those poorly served communities, including Māori and people with lived experience of distress and addiction, substance harm, or gambling harm, are prioritised.

Te Hiringa Mahara New Zealand Mental Health and Wellbeing Commission (2023). **Te Huringa Tuarua 2023: Mental Health and Addiction Service Monitoring Report.** Wellington: New Zealand.

Kupu whakataki | Foreword

He Ara Oranga (the Government Inquiry into Mental Health and Addiction) was released in late 2018; in 2019 the Government responded with a commitment to transform the mental health and addiction system.

Since then, we have experienced a global pandemic, numerous natural disasters, and consistent calls for a mental health and addiction system that has people and whānau at its heart. This report explores what has changed in the mental health and addiction system over the last five years and what needs to improve.

There has been a substantial investment in mental health and addiction services as well as some new services with the rollout of the Access and Choice programme. Despite these promising trends, fewer people are accessing mental health and addiction services in specialist services, primary mental health initiatives, telehealth, and online platforms. More people are receiving medications. There are persistent workforce shortages, and we are yet to see a clear strategy and roadmap to grow and develop the workforce we so desperately need.

Māori continue to experience significant inequities. Once again, we raise the need for 'by Māori, for Māori' approaches, such as kaupapa Māori services, to support Māori whānau experiencing distress and substance use harm.

Young people continue to experience long wait times to access support. A further concern is the high rates of medicine dispensing for young people experiencing distress.

Yet there is hope. Transforming the mental health and addiction system is a priority. The vision laid out in He Ara Oranga can become a reality when we see strong leadership and investment in more options that meet the needs of all people. That reality also comes closer when we move away from coercive practices and towards choice-based treatment, have supports and services available across all localities, and change commissioning and funding models. Finally, we need to see better data collection by government agencies.

Once again, we lay down the wero (challenge) to the Government—and all parts of the mental health and addiction system—to keep sight of what we are all working towards: a whānau-dynamic mental health and addiction system.

Hayden Wano
Board Chair, Te Hiringa Mahara

Ngā mihi | Acknowledgements

Te Hiringa Mahara wrote this report with the help and expertise of many, without whom this report would not have been possible. We thank all of them for their valuable contribution.

We thank those who provided us with their perspectives during the consultation on the framework He Ara Āwhina in 2021 and 2022. This work laid the foundation for this report, in which we monitor against He Ara Āwhina for the first time.

This report draws on quantitative data from 10 agencies: Manatū Hauora—Ministry of Health (Manatū Hauora); Te Whatu Ora; Te Pou; Health Quality & Safety Commission (HQSC); Whakarongorau Aotearoa; the Health and Disability Commissioner (HDC); Drug Foundation; the Addiction Practitioners' Association Aotearoa New Zealand (dapaanz); the Social Wellbeing Agency, which supplied Integrated Data Infrastructure (IDI) data; and the Ministry of Justice. We are grateful for their timely response to our requests for data and clarifications to ensure we are reporting the data correctly.

We are grateful to the exemplar organisations who generously shared their innovative work with us: Taranaki Retreat, The 502 Rangatahi Ora, and Manaaki Ora. Thank you for sharing a wealth of information about your mahi—your work is an inspiration to us all.

Thank you to all the experts who participated in our data sense-checking workshops in March 2023. These workshops enabled others to review our draft story and interpretation of the data before we wrote the final report. Around 20 experts from different agencies and roles participated in the two workshop streams (shared and Te Ao Māori). They were too many to name here, but we gratefully appreciate all the insight you provided to advance our understanding.

We would like to thank our external expert reviewers, Kerri Butler, Anthony Hill, Dr Margaret Aimer, and Sharon Shea. Your rich critique strengthened this report. We also acknowledge the translation team at the Department of Internal Affairs.

Finally, we acknowledge the workforce who tirelessly provide support, and the people and whānau who need to access mental health and addiction services. This report shines a light on tāngata whaiora and whānau access, experiences, and outcomes, but we know there is so much more to your journey than what data can capture.

Ngā ihirangi | Contents

Whakamōhiotanga whānui | Overall summary

There has been considerable investment in mental health and addiction services

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga) in 2018 laid down the vision for a transformed system and made 40 recommendations to drive this transformation (Government Inquiry into Mental Health and Addiction, 2018a). Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing (Kia Manawanui) built on the themes and recommendations set in He Ara Oranga, and provides the Government's long-term pathway for transforming Aotearoa New Zealand's approach to mental wellbeing (Ministry of Health, 2021a). Almost five years on from the landmark report He Ara Oranga, we are undertaking our monitoring function to shine a light on where progress has occurred and where further work is required.

The Government's increased investment in mental health and addiction services is a promising commitment to this transformed system. Total annual expenditure was $1.95 billion in 2021/22, an increase of 33 per cent since 2017/18.

Transformation needs Te Tiriti o Waitangi as the foundation, and to address system inequities

We elevate Te Tiriti o Waitangi as a platform for mental health and addiction system transformation towards better and equitable outcomes, as the Inquiry into Mental Health and Addiction (2019) called for in Oranga Tāngata, Oranga Whānau: A Kaupapa Māori Analysis of Consultation with Māori for the Government Inquiry into Mental Health and Addiction. In this report we use the framework He Ara Āwhina for the first time, which monitors what an ideal mental health and addiction system looks like from both Te Ao Māori and shared perspectives.

Our findings show that Māori continue to experience significant inequities in the mental health and addiction system; for example, they are subject to higher rates of coercive practices. In response, we need all services to urgently address these inequities, coupled with an increase in kaupapa Māori services, in line with the responsibility under Te Tiriti o Waitangi of tino rangatiratanga—'by Māori, for Māori'.

We are seeing changes in use of mental health and addiction services

Despite the increased investment, service use across many health-funded mental health and addiction services has decreased. In the 2021/22 year, 16,500 fewer

people used specialist mental health and addiction services than in 2020/21—a 8.6 per cent decrease. In primary mental health initiatives,[1] 12,000 fewer people used these services in 2021/22 than the previous year—a decrease of 8.0 per cent. Reduced use of other services, such as national telehealth services and online platforms, was also evident.

The main exception to this trend is the increased use of the Access and Choice programme services, which 114,500 people accessed in 2021/22. Initial dispensings of mental health medications also increased.

The decrease in service use in parts of the system is unexpected given the public reports of increasing levels of distress. The New Zealand Health Survey shows that the proportion of people with high levels of psychological distress has been increasing, from 8.6 per cent of people aged 15 years and over in 2017/18 to 11 per cent in 2021/22 (Ministry of Health, 2022a).

What factors contribute to these changes in service use is a question we will explore and seek to understand in future reports.

We need to address workforce challenges

While the increased investment in services is promising, Aotearoa needs a well-resourced workforce to respond to people experiencing mental distress and substance use harm. Between 2018 and 2022, the number of full-time equivalent (FTE) staff increased in specialist adult services. However, services are hampered by a high rate of workforce vacancies—these rates nearly doubled over the same period.

Services for young people need ongoing focus

Our monitoring report last year called out the longer wait times for young people and noted an increasing rate of medication dispensing. One year on, young people continue to have longer wait times than other age groups to access specialist mental health services. In addition, initial dispensings for antidepressant, antipsychotic, and anxiolytic medications have increased substantially for this age group.

[1] Primary mental health initiatives include services provided in a general practice that come under the devolved primary mental health funding that former district health boards (DHBs) reported against. These services include extended general practitioner or practice nurse consultations, brief interventions, individually tailored packages of care (which cover a variety of services, such as cognitive behavioural therapy, medication reviews, counselling, and other psychosocial interventions), and group therapy.

There are gaps in data about what is important for tāngata whaiora and whānau

In this report we use data from 86 measures to monitor service performance. Yet large data gaps remain for measuring what is important for tāngata whaiora and whānau, particularly from a perspective of Te Ao Māori.

This is a summary report on findings across the breadth of mental health and addiction services, and in some cases, we don't have complete data so can't tell the full story. The purpose of our monitoring role is to make transparent both positive change and issues of concern for the sector. We identify areas that require future examination, and advocate for data improvements to increase understanding of the issues.

System transformation must remain a Government priority

Five years on from He Ara Oranga, we are seeing some signs of progress. But much remains to be done. In some areas we need a paradigm shift to enable choice and respect the rights of people to make decisions about their own care. Transformation requires strong leadership, and we have opportunities through the health reforms, including the establishment of Te Whatu Ora and Te Aka Whai Ora, to accelerate this change.

We acknowledge there will be tension in any complex system change programme, and some areas take longer to transform than many would hope. But with concerted energy, investment, and prioritising the voices of lived experience, we will work together towards the vision of tū tāngata mauri ora, thriving together.

Mental health and addiction services 2021/22

Te Hiringa Mahara
Mental Health and Wellbeing Commission

2017/18 - $1.47b

2021/22- $1.95b

8.0% of total health appropriation

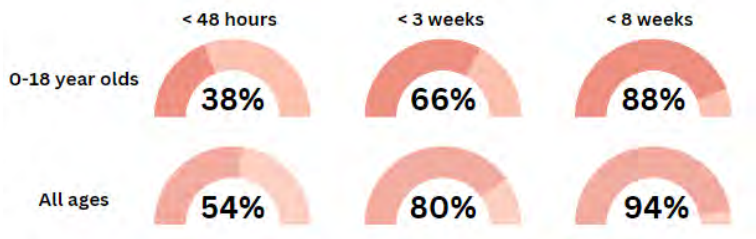
Kaupapa Māori services

		% of total MHA expenditure
2017/18	$151m	10%
2021/22	$212m	11%

Use of services in 2021/22 compared to previous year

	People	% change in use	
National telehealth	74,349	16%	↓
Access and Choice	114,500	25%*	↑
Other Primary initiatives	140,777	8.0%	↓
Specialist services	175,498	8.6%	↓

Young people have the longest wait times for former DHB MH services (2021/22)

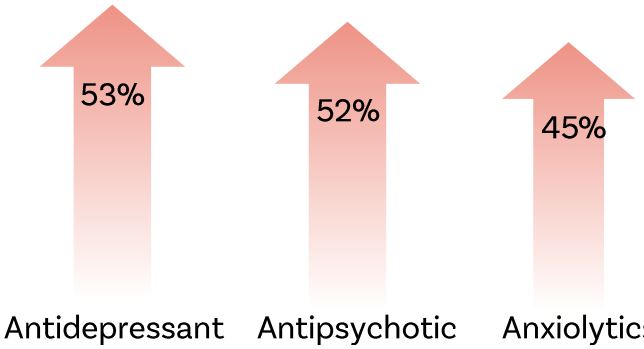


Initial medication dispensing

	2017/18	2021/22
Antidepressants	1.81m	2.18m
Antipsychotics	542,000	702,000
Anxiolytics	409,000	461,000

Young people have had an increases in medication dispensings

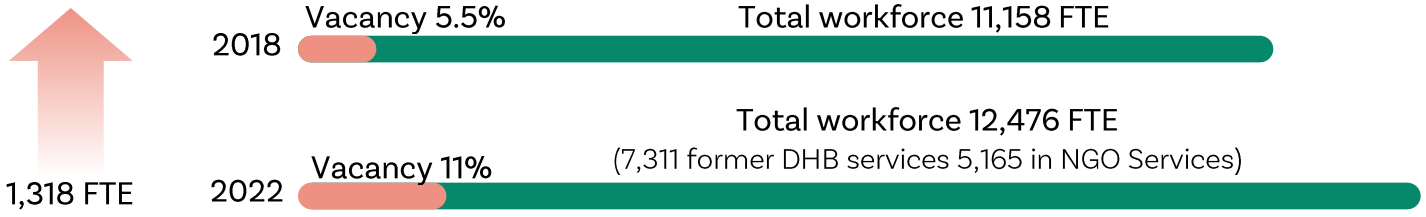
(2017/18 to 2021/22)



Average **inpatient unit stays** have **increased** from **18.0 days** in 2020/21 to **19.6 days** in 2021/22

6,817 people **subject to a compulsory community treatment order** in 2020/21, of which **39%** were **Māori.**

Workforce in adult specialist services



* A unique count of people who used Access and Choice programme services in 2020/21 is not available. The % change in use is calculated from an **estimated** number of 91,674 people in 2020/21.

DHB: District Health Board, MH: Mental health, FTE: Full-Time Equivalent, NGO: Non-government organisation

Ngā huringa e hiahia ana tātau ki te kite | The changes we want to see

In this section we set out the changes that we want the Government and health agencies to accelerate. These changes draw on the findings of this report and our youth focus report (Te Hiringa Mahara, 2023c), and bring forward the calls we made in Te Huringa 2022 (Mental Health and Wellbeing Commission, 2022).

We want to see:

- a comprehensive workforce strategy and roadmap to address the growing workforce vacancy rates
- an increase in funding for kaupapa Māori services, including by allocating a portion of any new mental health and addiction investment to kaupapa Māori services
- the use of commissioning approaches that recognise mana motuhake and tino Rangatiratanga, and enable Māori providers to design and provide services appropriate to their communities
- a decrease in the use of compulsory treatment, particularly for Māori and Pacific peoples, who experience significant inequities in this practice
- an increase in acute community services available for people experiencing acute distress in all districts
- a reduction in the admission of young people into adult inpatient services to zero, which will include an investment in youth-specific acute options in all districts
- initiatives from government agencies to address critical data gaps, which include:
    - collecting Te Ao Māori data on mental health and addiction service access, experience, and outcome measures
    - services reporting accurate data related to the use of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act), which can then be publicly reported within three months of the end of each financial year
    - collecting outcome and experience measurement data that are nationally consistent, reported by tāngata whaiora and whānau, and culturally appropriate
    - priority given to commissioning a comprehensive mental health and addiction prevalence survey
    - collecting more detailed and consistent primary care data that are reported nationally to enable monitoring of tāngata whaiora service access, experience, and outcomes.

Kupu arataki | Introduction

We independently monitor mental health and addiction services in Aotearoa, and advocate for improvement to those services

Te Hiringa Mahara—the Mental Health and Wellbeing Commission (Te Hiringa Mahara) was established in February 2021. One of our mandated functions is to monitor mental health services and addiction services, and to advocate for improvements to those services.

Our purpose is to contribute to better and equitable mental health and wellbeing outcomes. As an independent Crown entity, we scrutinise the Government, wellbeing and mental health and addiction systems, and services. In this and other monitoring reports, we seek to influence decision-makers and service providers at all levels—to shine a light on areas of progress, but also to boldly call out areas where more work is needed.

While this report is written specifically for the people who can bring about change (the leaders within services and Government), at its heart we write it for the people who can benefit from change (tāngata whaiora and whānau[2]).

This summary report is part of a suite of monitoring reports

Te Huringa Tuarua 2023 is a suite of interconnected reports and formats. The purpose of this summary report is to present the change across a breadth of national-level data. It highlights key issues, areas where progress has been made, and areas where we seek to accelerate system and service transformation.

Our new online dashboard will support this report. It will contain data on the suite of service-level quantitative measures that anyone can access to explore, filter, and analyse. We will update the dashboard over time as more recent data and measures become available.

Alongside the summary report and dashboard, this year we have three additional focus reports on selected topics. The 2023 focus reports cover.

1. young people who are admitted to adult inpatient services
2. kaupapa Māori services (to be published in June 2023)
3. compulsory community treatment orders (to be published in July 2023).

We chose this year's topics as areas that are important to people with lived experience, are strongly aligned to our advocacy priorities, and offer timely

[2] This report uses 'tāngata whaiora' to include people of any age or ethnicity and 'whānau' to include people's chosen family. For more detail, see our glossary.

opportunities for us to influence change. In future years we will produce focus reports on other topics.

We are using a new framework, He Ara Āwhina, for the first time

This is our first monitoring report that uses He Ara Āwhina (Pathways to Support) as our framework. We published this framework in June 2022, following a wide consultation process. He Ara Āwhina describes what an ideal mental health and addiction system looks like and links strongly to the vision for system transformation that He Ara Oranga describes. He Ara Āwhina has intentionally been written to amplify the most important voices—tāngata whaiora and whānau as leaders of their wellbeing and recovery, and the system responding to their experiences, needs, and aspirations.

The framework He Ara Āwhina has six system aspirations that describe what an ideal mental health and addiction system looks like for tāngata whaiora and whānau. It expresses each aspiration from both a perspective of Te Ao Māori and a shared perspective,[3] producing the following 12 domains in total.

Te Ao Māori perspective

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

Shared perspective

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

This report is structured around these 12 domains to monitor mental health and addiction services.

For a summary version of He Ara Āwhina, see Appendix 1. For more detail, visit our website.

This is a transitional report focused on health-funded mental health and addiction services

He Ara Āwhina is a system-level framework intended for monitoring a broad range of supports and services in the mental health and addiction system. This transitional report has a narrower focus, on monitoring mental health and addiction services funded through Vote Health.

[3] 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 weave together reflecting the role that tangata whenua and tangata Tiriti have to play – working together to support improving the collective wellbeing of all.

While we remain committed to applying He Ara Āwhina to the system as a whole, the scale of that task is significant. It will take time to develop the suite of methods and measures needed to apply the framework to monitoring at the system level.

Our current scope is mental health and addiction services that receive public funding from the health system

Aotearoa has a broad landscape of mental health and addiction[4] services provided in different settings and funding arrangements. For this transitional report, we cover only those mental health services and addiction services funded under Vote Health (the main source of funding for the health and disability system in Aotearoa) (see below).

Mental health and addiction services in scope for this report

Publicly funded health system mental health and addiction services:

- Former DHB[5] (now Te Whatu Ora) services in inpatient and community settings[6]
- NGOs funded to deliver services
- National telehealth services and online platforms
- Primary care

Mental health and addiction services out of scope for this report
(but may be in scope for future reporting)

- Justice sector services—provided in prison, in the community, or as Police response
- ACC services—related to sensitive claims
- Education sector services—curriculum and school-based services
- Social development services—provided as part of benefits and allowances
- Defence services—provided for veterans
- Privately funded services—e.g. charities, health insurance, self-funded

Note: ACC = Accident Compensation Corporation; DHB = district health board; NGOs = non-governmental organisations.

[4] Addiction services covered in this report are alcohol or other drug services—services designed to respond to substance harm. Gambling harm services are out of scope for this report, mainly due to data limitations as these services do not report through the PRIMHD national collection.
[5] Throughout the report we have used the term 'former DHB services' rather than 'Te Whatu Ora services' since the entities were DHBs in the period we are monitoring (to 30 June 2022).
[6] We also include a small number of measures outside of mental health and addiction services that are connected to mental health and addiction service performance. For example, we monitor the number of emergency department (ED) presentations related to mental health because EDs can be an entry point for people needing mental health care, often in crisis (Australasian College for Emergency Medicine, 2022).

Most data we use cover the five-year period from 2017/18 to 2021/22

This report provides data on the performance of mental health and addiction services between 2017/18 and 2021/22—financial years that end on 30 June. This is a significant five-year period within the mental health and addiction system, starting with the landmark report, He Ara Oranga, released in December 2018, which led to the Government's response in May 2019 and the substantial investment of $1.9 billion across agencies over four years in the 2019 Wellbeing Budget.

The COVID-19 lockdowns over 2020 and 2021 are important context for monitoring change over time. For the last financial year of our monitoring, 2021/22, lockdowns occurred for the northern regions for long periods, and for the rest of Aotearoa to a lesser extent. These lockdowns, and COVID-19 itself, changed how people access services as well as their experiences of services (Health Quality & Safety Commission, 2022a). As a result, the pandemic impacts many measures used in this report.

This report uses quantitative data, case studies, and published material to monitor mental health and addiction services

This report draws on quantitative data across 86 measures sourced from 10 agencies. This measure set includes:

1. measures we used in the first Te Huringa report (Mental Health and Wellbeing Commission, 2022), remapped to He Ara Āwhina
2. additional measures selected to monitor against He Ara Āwhina.

He Ara Āwhina is an aspirational framework—it describes what an ideal mental health and addiction system looks like. However, most of the available measures are deficit-based, for example, adverse incidents and experiences of coercive practices. Historically, people with lived experience and whānau have not been involved in developing measures that reflect what they most value. The measure set and data sources have a range of data quality limitations. For more information on the measure set and data quality limitations, see Appendix 2.

We monitor national quantitative data: the strength of this report is that it observes the national picture by monitoring across the breadth of measures. Other health entities report by individual services, regions, or localities.

This quantitative measure set is supplemented by other published reports, along with case studies as exemplars of transformative practice. We chose these exemplars based on Māori or lived experience perspectives of excellent work, how well they aligned with our advocacy priorities, and what 'good' looks like in He Ara Āwhina. We acknowledge we include only a few exemplars among the many great services and innovative ways of supporting tāngata whaiora and whānau, and of enabling tāngata whaiora or whānau to support each other, across Aotearoa.

Because of data gaps, we can't measure some important aspects of services, particularly for Māori

A unique feature of He Ara Āwhina is its dual layering—describing what an ideal mental health and addiction system looks like from both Te Ao Māori and shared perspectives. This approach respects the perspectives of both tangata whenua and tangata Tiriti.[7] However, current data systems do not reflect this duality as we continue to have a significant lack of Māori-specific data.

While we can use the Māori 'slice' of data from the shared measures, this does not tell us enough from a perspective of Te Ao Māori. The lack of Te Ao Māori data is a concern given inequities persist for Māori in terms of both the prevalence and treatment of mental distress and substance use harm, as well as the place of Māori as tangata whenua and partners with the Crown. These data gaps significantly limit our ability to monitor the performance of mental health and addiction services, particularly against Te Ao Māori domains of He Ara Āwhina.

See Ngā ngoikoretanga raraunga | Data gaps section for more detail on five critical areas where we need data changes.

This report is structured around the 12 domains of He Ara Āwhina

This report is structured around the 12 He Ara Āwhina domains, which together monitor against both Te Ao Māori and shared perspectives. Within each perspective, each domain section starts with the visionary concept that defines that domain along with a summary table of the measure set and trends, and then discusses key findings.

Detailed data for each domain will be available in the accompanying online dashboard. This online dashboard will include each measure by service type, ethnicity, and age group (where possible), such as data for Asian and Pacific peoples.

How to interpret the domain summary tables

The domain summary tables include the list of measures and how the data for these measures have changed over time.[8] They include all measures for completeness, but those with grey background indicate they are less valid for the domain concept of He Ara Āwhina because they have been carried over from previous monitoring.

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[7] 'Tangata whenua' are Māori as the indigenous people of Aotearoa; 'tangata Tiriti' are all other peoples of Aotearoa.

[8] In some cases, measures relate to more than one domain in the framework. For example, workforce vacancy rates relate to the domains of 'Access and options' and 'Safety and rights'. Where this occurs, we include the measure in one of the domains and cross-reference to it from other domains to avoid duplication.

We take the following approach to show change over time.

- The change over time, signalled through arrows, is colour coded to show whether an increase or decrease is an improvement or going in the wrong direction. In some cases (e.g. a decrease in service use), we cannot judge if the change is an improvement, so we indicate this in grey.

↑ ↓	Measure improving over time
↑ ↓	Unable to determine if change is an improvement
↑ ↓	Measure going in the wrong direction
No/minimal change	Measure hasn't changed over time

- In most cases, the change over time shown in the tables indicates change over the five-year period from 2017/18 to 2021/22.[9] However, when the one-year change differs from the five-year trend, we report the change in the last one year (that is, between 2020/21 and 2021/22). An asterisk (*) signals a one-year change.
- We use an arrow only where the change over time is more than 5 per cent.[10] 'No/minimal change' indicates any change over time that is less than 5 per cent. We use 5 per cent for all measures to provide a consistent threshold, irrespective of whether the measure is expressed as a number, dollars, or a percentage. For measures expressed as percentages, change is calculated in relative terms not absolute.[11]
- The change over time is only based on the total measure at two points in time. The online dashboard will give more complete data over time, and further detail by ethnicity, age groups, and other groups.

All data in this report is presented to two significant figures.

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[9] Some measures use a different time reference period, in which case we use a time that is as close as possible to the five-year period. For example, all workforce data are a comparison between 2018 and 2022.

[10] We use the 5 per cent threshold because, in most cases, this shows a material difference in the measures over the reference period. It also approximately aligns to Aotearoa population growth over the five-year period (Stats NZ 2023a). The exception to this rule is for measures sourced from surveys and the agency supplied confidence intervals. For these measures, we only report change over time that is statistically significant instead of the 5 per cent threshold.

[11] For example, an arrow would be used for a rise from 30 per cent to 34 per cent because this is 13 per cent change. We took this relative change approach rather than percentage point difference (absolute change approach) to recognise improvement for measures of smaller value, such as an improvement in readmission rates.

Ngā kitenga | Findings

Whakataukī/ whakatauākī:

Ko te amorangi ki mua, te hāpai ō ki muri

The leader at the front and the workers behind the scenes

This whakataukī/whakatauākī refers to marae protocol where the speakers are at the front of the meeting house receiving the manuhiri (guests) and the whānau and hapū members are at the back, making sure everything is prepared and that the manuhiri are well looked after. Both jobs are equally important, and manaakitanga is fundamentally reflected throughout the protocol.

Visual collective story

This section presents the overall findings from our service monitoring against He Ara Āwhina.

The infographics on the next two pages summarise the collective story for tāngata whaiora and whānau, which comes from monitoring against Te Ao Māori and shared domains of He Ara Āwhina.

After these visual summaries, we report our findings against each of the 12 domains of He Ara Āwhina in two sections. First, we present the six domains from a shared perspective and then the six domains from a perspective of Te Ao Māori.

Collective story of Māori using mental health and addiction services

Our monitoring uses current state data, while we have significant gaps in Te Ao Māori data. A story from Te Ao Māori would look quite different to that presented here.

We have higher access rates for specialist services but can struggle to get early access through the health system.

Expenditure for kaupapa Māori services increased over the last few years.

The Māori workforce has grown.

Our choice of services and workforce to support us has improved somewhat.

Our inherent right to exercise self-determination continues to be lacking in our experiences receiving care.

Compulsory community treatment has increased.

The use of solitary confinement ('seclusion') has decreased but is still high.

We need a system that prioritises Te Tiriti o Waitangi.

There is limited data to show whether services have improved things for us.

We need data collected through a framework from Te Ao Māori to measure our service outcomes.

We need data collected through a framework from Te Ao Māori that measures our experiences of services.

We need data that show whether we can access supports and services that enable connection to our whānau, whakapapa, hapū, and iwi.

We need data that show how whānau are experiencing tino rangatiratanga.

Collective story for people using mental health and addiction services

We want mental health and addiction services to transform in line with He Ara Āwhina

Fewer of us used most types of mental health and addiction services last year. But more of us are using Access and Choice programme services and are using medications.

Investment has increased but more is needed in areas that He Ara Oranga calls for (e.g. peer services and acute community services).

Many of us have access to new early support services through the Access and Choice programme.

Funding for staff to support us has increased, but vacancy rates have doubled.

We have continued to have similar experiences within services, almost five years on from He Ara Oranga.

Inequalities between groups continue in the way services are provided. E.g. Māori experience more coercive practices, young people experience long wait times.

Too many of us continue to be subject to coercive practices.

A quarter of us leave an inpatient unit or residential facility without a transition plan.

There is limited data to show whether services are working for us.

We need outcome measurement tools that are nationally consistent, culturally appropriate, and reported by tāngata whaiora and whānau.

We need better national data about our experiences of services.

We need more timely data about the use of coercive practices.

We need data on the level of need for services and supports, and use of primary care.

Te aroturuki i te tirohanga ngātahi o He Ara Āwhina | Monitoring against the shared perspective of He Ara Āwhina

Equity

Vision: We (tāngata whaiora) want a mental health and addiction system that supports all of us and our whānau equitably.

This domain is about ensuring an equitable mental health and addiction system for all tāngata whaiora and whānau. This section includes data for specific equity measures, along with key findings from other domains where substantial inequities exist for Māori as tāngata whenua, and for priority population groups, such as Pacific peoples and young people.

Table 1

Measure	Source	Change over time	Selected data
People with/without self-reported long-term mental health condition reporting whether in the last 12 months, there was a time when they wanted health care from a GP or nurse but couldn't get it	HQSC	Trend not available	2021/22 (MHA): 28% 2021/22 (no MHA): 18%
People with/without self-reported long-term mental health condition reporting whether in the last 12 months, they were involved as much as they wanted to be in decisions about the best medicine(s) for them	HQSC	Trend not available	2021/22 (MHA): 83% 2021/22 (no MHA): 85%
Places for Māori and Pacific cultural competency training each year	Te Whatu Ora	↑	2019 (Māori): 80 2022 (Māori): 400 2019 (Pacific): 750 2022 (Pacific): 1200
Scholarships and bursaries for Māori and Pacific students pursuing a career in mental health and addiction services	Te Whatu Ora	↑	2019 (Māori): 80 2022 (Māori): 150 2019 (Pacific): 60 2022 (Pacific): 125
Number of kaupapa Māori NGO mental health and addiction services	Te Pou	↑	2018: 60 2022: 77
Number of Pasifika led NGO mental health and addiction services	Te Pou	Too small to report trend	2018: n/a 2022: 9

Further relevant measures used in another domain:

- Māori, Pacific, Asian population service user profile compared with workforce profile—adult specialist mental health and addiction services (Table 4)

- Māori, Pacific, Asian population service user profile compared with workforce profile—infant, child, and adolescent mental health / alcohol and other drug services (Table 4)
- Mental health and addiction NGOs actively developing Māori cultural roles (Table 9)

The number of kaupapa Māori adult mental health and addiction NGO services has grown

The number of kaupapa Māori non-government organisations (NGOs) contracted to deliver adult mental health and addiction services continues to grow—from 60 in 2018 to 77 in 2022.[12] Kaupapa Māori NGOs are 36 per cent of all NGOs contracted in 2022. In contrast, NGO services led by Pacific peoples have not grown substantially, with 9 NGOs counted in 2022 (the 2018 number was too low to report).

Mental health and addiction services need a more diverse workforce. Later in the report we show the Māori workforce has increased slightly. However, a much greater increase is needed to match the profile of people using these services (2021 data show Māori make up 15 per cent of the adult specialist workforce compared with 29 per cent of tāngata whaiora).

Part of the solution to increasing workforce diversity is to support students to pursue a career working in mental health and addiction services. The number of scholarships and bursaries for Māori and Pacific students has increased steadily through Te Whatu Ora contracts with Massey University. In 2022 there were 150 scholarships for Māori and 125 for Pacific peoples, which in both cases is about double the amount from four years earlier.[13]

He Ara Oranga called out the need to improve cultural competency of staff in mental health and addiction services. Staff in many of these services have access to cultural competency training as part of their ongoing professional development. Te Whatu Ora also contracts Te Rau Ora and Le Va to provide cultural competency training each year. From 2019 to 2022, the number of training places increased from 80 to 400 for Māori training and from 750 to 1,200 for Pacific training.

Tāngata whaiora are less likely to have access to general practice and participate in decision-making

Tāngata whaiora experience poorer general health outcomes and have a higher need for access to general health services than people without a long-term mental health condition (Te Pou, 2020). However, the data show that people with mental health challenges face higher barriers to access a general practitioner (GP) or nurse. In 2021/22, 28 per cent of people with a self-reported long-term mental health

[12] This is a count of kaupapa Māori NGOs. It excludes kaupapa Māori services within mainstream NGOs.
[13] These data do not measure how many people completed the qualifications.

condition could not always get health care when they wanted it from a GP or nurse, compared with 18 per cent of people without a long-term mental health condition.

Tāngata whaiora are also less likely to be involved in medication decisions. In 2021/22, 17 per cent of people with long-term mental health conditions were not involved in decisions about the best medicines as much as they wanted to be, compared with 15 per cent of people without a long-term mental health condition.

Both measures have only been collected consistently for the last two years, so the time series is not yet long enough to draw any conclusions on change over time.

Young people continue to face long wait times and high rates of medication dispensing

Our monitoring report last year drew attention to specific issues that young people face—longer wait times for mental health and addiction services and higher rates of medication (Mental Health and Wellbeing Commission, 2022).

First, we found that, among tāngata whaiora who are seen within three and eight weeks of first referral, the rate was lowest for people aged 0–18 years. One year on, the data in this report show that this issue continues to be a problem for young people and their whānau.

Our 2022 report also highlighted the large increase in initial dispensings for mental health medications for young people, and we can now see this trend is growing over time. From 2017/18, when there were 54,042 initial dispensings of antidepressants to those aged 0–18 years, the number has increased to 82,669 (an increase of 53 per cent) in 2021/22. Similarly, among young people initial dispensings of antipsychotics increased from 21,734 to 33,121 and initial dispensings of anxiolytics increased from 4,787 to 6,925 over this same five-year period.

Many services are working in innovative ways that make a positive difference for young people. 502 Rangatahi Ora, based in Porirua Wellington, is one such example of a services making a difference for young people.

Exemplar: 502 Rangatahi Ora

Named by rangatahi after the Porirua postcode, 502 Rangatahi Ora (The 502) is a youth ‘one-stop shop’ that provides free primary health care and social services, counselling, and other mental health supports for rangatahi aged 10–24 years who are living, working, or studying in the Porirua region.

Nestled among shops in the town centre of Porirua, The 502 was established in 2021 as a collaborative initiative between Te Rūnanga o Toa Rangatira and Partners Porirua, filling a gap in traditional primary and mental health care services. With the voices and leadership of rangatahi at its foundations, The 502 has consistently

involved young people in every decision about the service, down to the artwork that will adorn the walls.

Guided by an 'every door is the right door' philosophy, The 502 provides young people with a safe, trauma-informed, and comfortable space to access a comprehensive range of supports and services. The 502 team is a diverse mix of clinical and non-clinical expertise, with counsellors, social workers, and youth workers working alongside nurses, nurse practitioners, and doctors to deliver high-quality, wrap-around support to rangatahi.

It's not uncommon for young people already using the service to 'bring their mates along' for new assessments. These assessments consider all aspects of a young person's life such as their living situation, family, education, sexual health, employment, and mental health.

Clinical Lead and Registered Nurse Mārama McGhie says it's about "pulling from a young person's kōrero to get to know them as a person. That's the holistic approach. It doesn't matter what they've come in the door for. If there's anything going on, let's talk about it."

The 502 prioritises genuine engagement and connection with rangatahi. Having positive interactions with a young person helps to build trust, which, in turn, 'plants a seed' that empowers rangatahi to make their own decisions about their own lives and bodies.

"We get to rewrite their experiences of health care," says Youth Worker Nella Hakeagaiki.

"We get people coming back again and again and again," says GP Sean Hanna. "It wouldn't be unusual for someone to have used our service six or seven times in six months, but we get funded for one or half a visit. That tells me that young people value continuity of care and they do come back when they make an authentic connection with a service. It's the primary care system that's broken, not young people's health-seeking behaviour."

The referral pathways for Māori and Pacific peoples are different from other population groups

The data on specialist service use and emergency department (ED) presentations show Māori and Pacific peoples have different entry pathways into services.

Māori and Pacific peoples have higher referral rates into specialist mental health and addiction services from the justice sector. In 2021/22, 7.0 per cent of Māori referrals and 5.5 per cent of referrals for Pacific peoples came from courts, compared with 2.6 per cent of non-Māori, non-Pacific referrals. In contrast, in 2021/22 referrals coming from GPs account for 11 per cent of Māori referrals and 10 per cent of Pacific referrals,

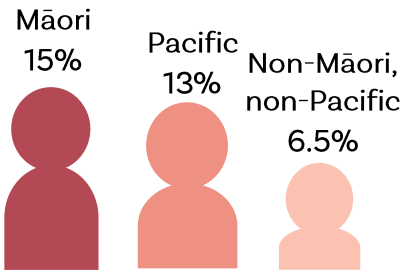
which is about half the rate for non-Māori, non-Pacific peoples (21 per cent). These findings, along with the higher rate of use of specialist services among Māori and Pacific peoples, indicate that Māori and Pacific peoples do not access early intervention supports and services to the same extent as non-Māori, non-Pacific peoples, and are more likely to be referred into specialist services with acute need (Government Inquiry into Mental Health and Addiction, 2018b; Health Quality & Safety Commission, 2019).[14]

EDs are often a default entry point to specialist services for people who do not have their mental health needs met by other services or early support. In 2021/22, EDs had 33,502 mental health presentations.[15] Of these, nearly one-third (31 per cent) were presentations by Māori. More Māori present to ED than other ethnic groups, but this does not explain this high rate because the percentage of Māori ED presentations related to mental health (3.9 per cent) is higher than the percentage of ED presentations related to mental health overall (2.7 per cent). Younger people aged 19–24 years also had a higher proportion of total ED presentations that were related to mental health (6.8 per cent).[16]

Māori and Pacific peoples are more likely to experience coercive practices

There is inequity in the use of coercive practices, including solitary confinement and compulsory community treatment orders. Māori and Pacific peoples are more likely to be subject to solitary confinement ('seclusion') (see infographic). However, in its monthly monitoring of data, the Health Quality & Safety Commission has observed that the equity gap has narrowed in the few months before June 2022 (Health Quality & Safety Commission, 2022b).

Figure 1: Percentage of people admitted to mental health inpatient units who are 'secluded', by ethnic group, 2021/22



Source: Health Quality & Safety Commission mental health and addiction quality improvement programme on zero 'seclusion'.

[14] It is encouraging to see improvement in early access for Māori, with relatively high numbers of Māori accessing some of the Access and Choice programme services, particularly Youth services.
[15] These data do not include people presenting to ED with issues related to substance use.
[16] In a separate report, we assess whether the Access and Choice programme has increased access to and choice of services for youth (12–24 years) (Te Hiringa Mahara, 2022b).

In 2020/21, among people subject to compulsory community treatment orders (CCTOs—that is, compulsory orders for 'outpatient' treatment in the community), 39 per cent were Māori.

Participation and leadership

Vision: We lead and self-determine our pathways through distress, substance, or gambling harm to wellbeing and recovery.

This domain of He Ara Āwhina describes an ideal system where people: use their lived experience in a wide range of leadership roles; lead strategy to address stigma, prejudice, and discrimination; and co-produce policies, supports, and services. Tāngata whaiora also lead their care and decision-making when using supports and services. The data currently available focus on how tāngata whaiora using services participate in their own care and decision-making.

Table 2

Measure	Source	Change over time	Selected data
Tāngata whaiora and whānau reporting they feel involved in decisions about their care	Mārama Real-Time Feedback (Te Pou)	No/minimal change	2017/18: 72% 2021/22: 71%
Tāngata whaiora and whānau reporting that their plan is reviewed regularly	Mārama Real-Time Feedback (Te Pou)	No/minimal change	2017/18: 69% 2021/22: 68%
Complaints about mental health and addiction services related to issues with communication	HDC	↑ As % of complaints	2017/18: 57% 2021/22: 62%

Further relevant measure used in another domain:

- People with self-reported long-term mental health condition reporting whether in the last 12 months, they were involved as much as they wanted to be in decisions about the best medicine(s) for them (Table 1)

Most people with mental health conditions feel involved in decisions about medicine within primary care settings

The primary care sector has limited data about the participation of tāngata whaiora in decisions about their care. One measure available from the primary care patient experience survey indicates 83 per cent of people with a long-term mental health condition in 2021/22 reported they were involved as much as they wanted to be in decisions about the best medicines for them.

Tāngata whaiora participation has not improved in line with vision of He Ara Oranga

In 2021/22, about 68 per cent of tāngata whaiora and whānau agreed their plan is reviewed regularly, and this measure has changed little, if at all, over the last five years. Similarly, the proportion of tāngata whaiora and whānau who feel involved in decisions about their care shows minimal change from 72 per cent in 2017/18 to 71

per cent in 2021/22. From these findings, the participation of tāngata whaiora in their use of supports and services has not improved in line with the vision of He Ara Oranga.

Collection of these experience measures ended on 1 April 2023. This leaves a significant gap in service experience data for mental health and addiction services (see Ngā ngoikoretanga raraunga | Data gaps).

Access and options

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

He Ara Oranga found an urgent need to improve access to, and expand choice in, mental health and addiction services. In this section, we present the level of financial investment in those services, use of the different types of services available,[17] timeliness of services, and the workforce available.

Table 3

Measure	Source	Change over time	Selected data
Expenditure			
Annual expenditure on mental health and addiction services (DHB and Manatū Hauora expenditure)	Manatū Hauora	↑	2017/18: $1.47b 2021/22: $1.95b
People using services			
People using specialist mental health and addiction services	Te Whatu Ora	↓*	See supplementary data table 2
People using primary mental health initiatives	Manatū Hauora	↓*	See supplementary data table 2
People using Access and Choice programme services	Te Whatu Ora	↑	See supplementary data table 2
People using national mental health and addiction telehealth services	Whakarongorau	↓*	See supplementary data table 2
People using national mental health online platforms (depression.org.nz and thelowdown.co.nz)	Te Whatu Ora	↓*	See supplementary data table 2

[17] We acknowledge access to services is broader than use of services. Some barriers to access to service are outside what our measures capture, such as acceptability, affordability, available hours, navigation, referral criteria, and triage.

People using national addiction online platforms (thelevel.org.nz)	Drug Foundation	Not available Platforms changed in 2021	See supplementary data table 2
Emergency department presentations for mental health reasons	Te Whatu Ora	↓*	See supplementary data table 2
People using inpatient mental health services	PRIMHD	↓*	See supplementary data table 2
Other service use / treatment measures			
Treatment days delivered across specialist mental health and addiction services	PRIMHD	↓* Individual treatment sessions	See supplementary data table 8
Bednights across specialist mental health and addiction services	PRIMHD	↓* Total bednights	See supplementary data table 8
Initial dispensings of mental health medications	Te Whatu Ora	↑ Antidepressants, antipsychotics, and anxiolytics	See supplementary data table 6
People receiving opioid substitution treatment (all types of case management)	Manatū Hauora	↓	2017/18: 5,570 2021/22: 5,260
People receiving opioid substitution treatment (GP case management)	Manatū Hauora	↓	2017/18: 1,564 2021/22: 1,405
Average length of stay in an inpatient unit	PRIMHD (Te Pou)	↑*	See supplementary data table 8
Complaints about access to mental health and addiction services	HDC	↓ As % of complaints	2017/18: 18% 2021/22: 11%
Wait times			
Wait times to access DHB mental health services following first referral (within 3 weeks and within 8 weeks)	PRIMHD	No or minimal change	See supplementary data table 7
Wait times to access addiction services following first referral (within 3 weeks and within 8 weeks)	PRIMHD	↑ Within 3 weeks Minimal change within 8 weeks	See supplementary data table 7
Wait times for national mental health and addiction telehealth services	Whakarongorau	↑	See supplementary data table 7
Wait times in emergency departments for an inpatient bed (for presentations related to mental health)	Te Whatu Ora	↑	See supplementary data table 7
Wait list for opioid substitution treatment (transfer from specialist to GP case management)	Manatū Hauora	↑	2017/18: 228 2021/22: 279
Waiting more than 4 weeks from initial contact to first dose of opioid substitution treatment	Manatū Hauora	↓	2017/18: 74 2021/22: 47
Workforce			
Workforce allocated FTE positions	Te Pou	↑ (2018–2022)	See supplementary data table 4
dapaanz-registered addiction practitioners	dapaanz	↑	2017/18: 640 2021/22: 883

NGO adult mental health and addiction services actively developing lived experience roles[18]	Te Pou	↑ (2018–2022)	2018: 57% 2022: 78%

Further relevant measure used in another domain:

- Workforce vacancy rate in adult mental health and addiction specialist services (Table 4)

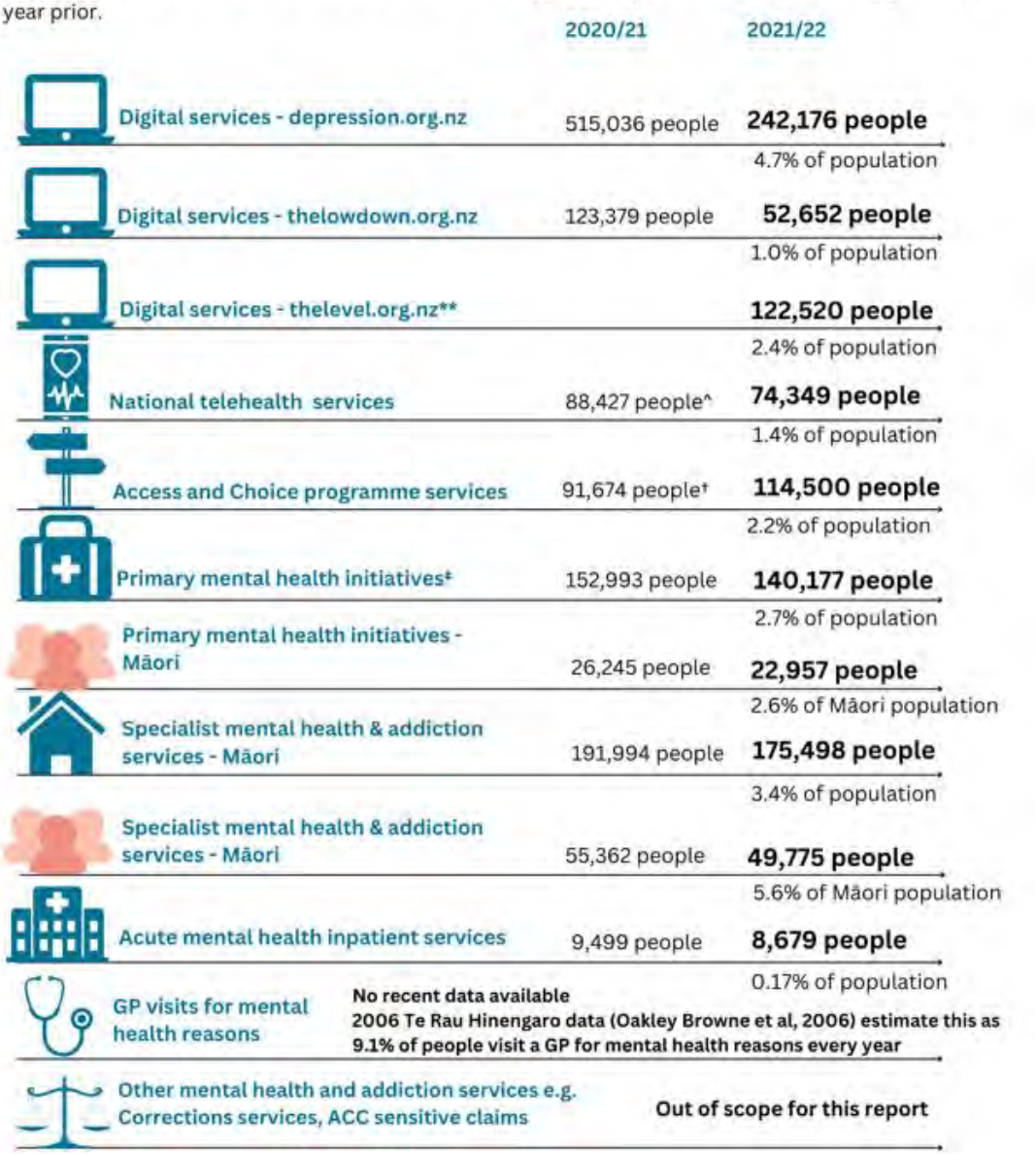
The use of mental health and addiction services has changed in 2021/22

Service use data show service use decreased for most types of mental health and addiction services in 2021/22 (see infographic directly below).

[18] Categorised as 'yes we have these roles' or 'we plan to implement in future'.

Number of people who used mental health and addiction services

Each year, more than 15 per cent of all people in Aotearoa use one or more mental health and addiction service (Social Investment Agency, 2019).* The following infographic shows the percentage and number of people who use mental health and addiction services by service type and how this has changed since the year prior.



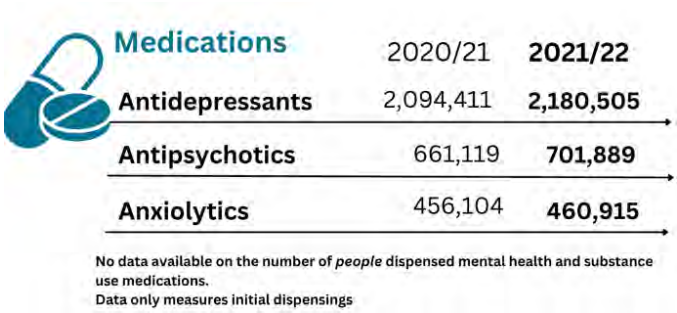
* This figure cannot be exactly quantified due to incomplete national data (particularly for primary care) and the lack of an integrated national dataset. Social Wellbeing Agency (formally Social Investment Agency) analysis established a dataset of 15.5% of the total population who used mental health and addiction services from 5 datasets – pharmaceutical dispensing, specialist mental health and addiction service use, hospital admissions, medical certificates, and laboratory tests (Social Investment Agency, 2019).

** thelevel.org.nz was launched in August 2021.

^ This data differs to what we published in Te Huringa 2022 due to different counting methodologies. In last year's report multiple people who used telehealth services in multiple months in the year were counted more than once. This report contains data using preferred counting rules and only counts a person once each year.

† A unique count of people who used Access and Choice programme services in 2020/21 is not available. The estimated number of people who used these services in 2020/21 was 84,000 in Integrated Primary Mental Health and Addiction services, 913 in Kaupapa Māori services, 3,212 in Pacific services, and 3,549 in Youth services.

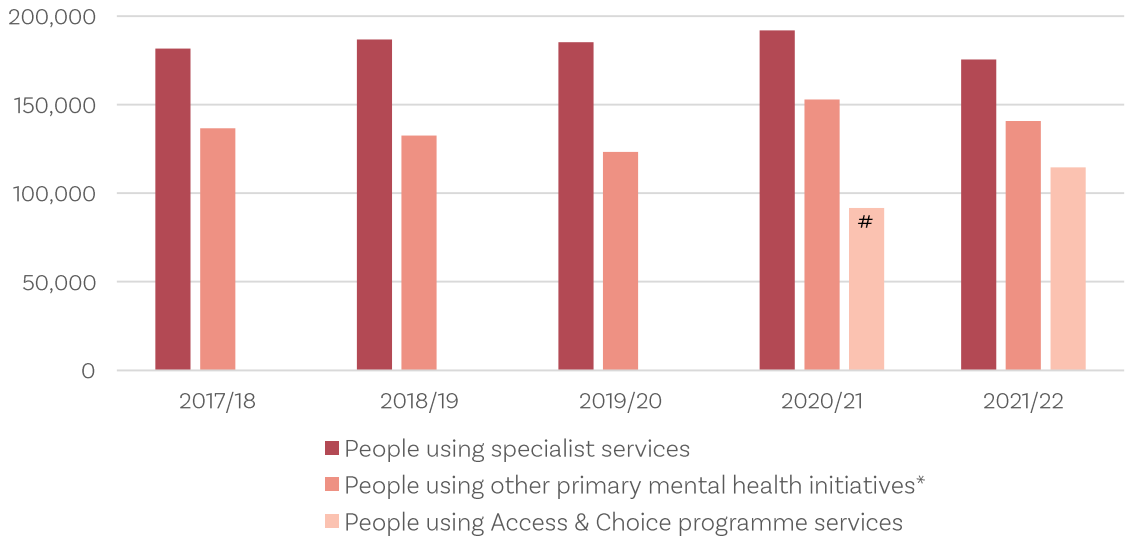
‡ Not an exact count of number of people. This is calculated as the sum of each quarter and the sum of the DHBs, and people seen in multiple quarters or by multiple DHBs will be counted more than once.



Mental health and addiction service use

We can see the decrease in service use in terms of both numbers of people and as a percentage of the population across specialist services,[19] primary mental health initiatives (excluding Access and Choice programme), telehealth services, and online platforms.[20] The only services where use increased are those that are part of the Access and Choice programme (as this is newly established) (see Figure 2). While service use has decreased, medication dispensing has substantially increased.

Figure 2: Number of people using primary and specialist mental health and addiction services, 2017/18 to 2021/22



* Not an exact unique count of people. This is calculated as the sum of each quarter and the sum of the DHBs. People seen in multiple quarters or by multiple DHBs will be counted more than once.
# A unique count of people who used Access and Choice programme services in 2020/21 is not available. The estimated number of people who used these services in 2020/21 was 84,000 in integrated primary mental health and addiction services, 913 in Kaupapa Māori services, 3,212 in Pacific services, and 3,549 in youth services.

[19] Specialist service data (accessed via PRIMHD) does have incompleteness and data quality issues, particularly for the Waikato DHB. However even after removing Waikato from the data analysis, the decline in specialist service use is evident. For more detail, see Appendix 2.
[20] The number of users of mental health online platforms depression.org.nz and thelowdown.co.nz decreased in 2021/22. However, we have limited insight into change in use of addiction online platforms over time because thelevel.org.nz replaced drughelp.org.nz and pothelp.org.nz in August 2021. Further, thelevel.org.nz uses a proactive social media approach so people can access this information without viewing the website. These data do not include use of livingsober.org.nz.

In this report, we focus on change in service use for each service type (e.g. specialist, telehealth). This is because reporting an overall net increase or decrease in use of mental health and addiction services would not be accurate for two reasons. First, some of these data sources are not linked to national health index (NHI) numbers and it is not possible to count the number of unique people overall, because some people will use more than one service. Second, a large part of service increase comes from the Access and Choice programme, which began in 2019/20. The data systems for this programme were in development through 2019/20 and 2020/21; for this reason, data for those years are understandably poor, and the reported annual change between 2020/21 to 2021/22 is only an estimate, not an actual number.

This decrease in service use in parts of the system is unexpected given the public reports of increasing levels of distress. The New Zealand Health Survey shows that the proportion of people with high levels of psychological distress increased from 8.6 per cent of people aged 15 years and over in 2017/18 to 11 per cent in 2021/22 (Ministry of Health, 2022). This increase is higher for some groups, most notably for Māori, young people, and people living in deprived areas. While these data do not tell us how many people need to use mental health and addiction services, they do suggest that the need for support at the very least is not reducing.

Without comprehensive prevalence data, we cannot say whether the decrease in the use of some services reflects less need for services, or whether it reflects greater barriers to accessing some services. Rates of declined referrals to specialist services provide no evidence for greater barriers (as referral declined rates are unchanged). It is possible that the COVID-19 lockdowns from August through to December 2021 had an impact on access to services. Further, people may be getting the support they need earlier through services such as Integrated Primary Mental Health and Addiction services or Access and Choice, Kaupapa Māori, Pacific, or Youth services.

What factors contribute to these changes in service use is a question we will explore and seek to understand in future reports. As we have noted in our other reports, there is an urgent need for the Government to commission a prevalence survey of mental distress and substance use harm to understand the level of need and inform service planning and funding.

Primary services

In 2021/22, 140,777 people (2.7 per cent of the population) used primary mental health service initiatives.[21] This was 12,216 fewer people than the previous year.

[21] Primary mental health service initiatives include services provided in a general practice that come under the devolved primary mental health funding that DHBs report against. These services include extended GP or practice nurse consultations, brief interventions, individually tailored packages of care

The rollout of the Access and Choice programme is a significant component of expanding primary mental health and addiction services. The aim of the programme is to provide free and immediate support for people with mild to moderate mental distress or substance use harm needs in a range of settings—Kaupapa Māori, Pacific, and Youth services, as well as in general practice and other community settings. Our separate report on the first three years of the Access and Choice programme shows that Access and Choice services as a whole saw 114,500 people in 2021/22, which is below the aim of seeing 150,000 people in the year to 30 June 2022 (Te Hiringa Mahara, 2022a).

We would not expect to see a reduction of 12,216 people accessing other primary mental health care from the previous year because the Access and Choice programme was designed to provide support to people who had previously not been able to access services—the 'missing middle' (Government of New Zealand, 2019). Although some people use both Access and Choice programme services and services that are part of the primary mental health initiatives, we cannot examine the extent of this overlap because some data sources are not NHI-linked. We need data improvements in this area so that we can examine how the Access and Choice programme is affecting the use of other mental health and addiction services.

Specialist service use

Specialist service use has declined from 3.7 per cent of the population in 2020/21 to 3.4 per cent in 2021/22. This equates to a drop from 191,994 to 175,498 people (a 9.4 per cent reduction). The decrease in specialist service use was greater for younger people (in both age groups of 0–18 and 19–24 years), Māori, Pacific peoples, and people using addiction services.

A range of reasons will help to explain this decrease in specialist service use. One aim of the Access and Choice programme is to provide easy-to-access early intervention to take the pressure off specialist mental health and addiction services in the future (Te Whatu Ora, 2023). However, we consider that it is too soon in the rollout of the Access and Choice programme for its impact to fully explain the substantial decrease in use of specialist services.[22]

Among the other factors that may contribute to the decrease in specialist services is that, while specialist services are seeing fewer people, tāngata whaiora may be

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(which cover a variety of services, such as cognitive behavioural therapy, medication reviews, counselling, and other psychosocial interventions), and group therapy.
The total of 140,777 is not an exact unique client count since the number of clients used in this calculation is the sum of people seen in each quarter and the sum of people seen across the DHBs. Clients seen in multiple quarters or by multiple DHBs will be counted more than once.
[22] As at 30 June 2022, just under 50 per cent of the population enrolled with a general practice had access to Integrated Primary Mental Health and Addiction services, compared with 34 per cent as at June 2021 (Te Hiringa Mahara, 2022a).

experiencing more acute distress and more complex situations. The average length of stay in inpatient units has increased (from 18.0 days in 2020/21 to 19.6 days in 2021/22). The rate of people seen within 48 hours by former DHB mental health services has increased from 50 per cent in 2020/21 to 54 per cent in 2021/22, suggesting people that are seen for the first time are in more acute distress.

Medications

A GP or psychiatrist can prescribe psychiatric medications in primary and specialist services. The total of 2.18 million initial dispensings[23] of antidepressants in 2021/22 continues the trend of a steady increase from 1.81 million in 2017/18. A similar increasing trend is evident for antipsychotics, from about 542,000 to 702,000 dispensings, and for anxiolytics, from about 409,000 to 461,000 dispensings, over this same five-year period. As we noted under the equity domain, young people continue to be dispensed substantially more mental health medications than other age groups.

The data showing that medication dispensing are increasing while access to specialist services is falling indicate that GPs rather than psychiatrists are likely to be prescribing more medications. He Ara Oranga emphasised that while medications are important, they are only part of the approach of mental health and addiction services and need to sit alongside choices from a range of supports and treatments.

Emergency department, Police, and ambulance

When people do not get the mental health and addiction services they need, EDs at times become the default entry point to those services (Australasian College for Emergency Medicine, 2022). While mental health presentations at ED increased steadily over the four-year period to 2020/21, they then fell by 12 per cent from 38,221 presentations in 2020/21 to 33,502 in 2021/22.[24]

There is limited data to monitor whether people have less access to services because of blockages into service pathways, such as into general practices, from general practices into specialist services, or Police triaging to mental health services (or transfer to ED). However, data from New Zealand Police (2023) show that Police call-outs related to mental health increased slightly from about 56,000 in 2020/21 to

[23] An initial dispensing is the first time a prescription is filled. It does not include any repeats. The total of initial dispensings is not the same as the number of people receiving a prescription because a person can get multiple prescriptions across a year that are an initial dispensing. These data only include publicly funded medications. For more detail on the medications data, see Appendix 2.
[24] Manatū Hauora has advised that more people have been presenting to EDs for physical health and medical reasons since the COVID-19 pandemic.

58,000 in 2021/22, while ambulance data show incidents related to mental health fell from 40,915 to 37,025 over this same period (Jones, 2023).[25]

Mental health wait times have barely changed, suggesting limited workforce capacity is not the only reason for changes in specialist service use

Wait times for former DHB mental health services have remained much the same: services saw 80 per cent of people in 2021/22 within three weeks, compared with 79 per cent in 2020/21, and saw 94 per cent of people in both years within eight weeks. Some groups continue to face barriers to timely service access. As we mentioned in the equity domain, young people aged 0–18 years have longer wait times than other age groups.

In contrast to mental health services, wait times for addiction services (from former DHBs and NGOs) are getting longer. In 2021/22, 75 per cent of people were seen within three weeks for addiction services, down from 80 per cent in 2020/21, and 93 per cent were seen within eight weeks, down from 95 per cent in the previous year.

National telehealth services, such as 1737 and the alcohol and drug helpline, have also observed large increases in wait times, from 37 seconds on average in 2017/18 to over 4 minutes in 2021/22. The number of unanswered calls has correspondingly increased (New Zealand Parliament, 2023). These telehealth services were set up to provide brief intervention to people with mild to moderate needs and had a surge of demand over the COVID-19 lockdown periods. Despite the decreasing number of callers in the last year, the complexity of challenges that callers are facing has increased. These national telehealth services define calls that are connected for more than 25 minutes as an indication of 'complexity', and the data show a steady increase in calls lasting for more than 25 minutes, from 5 per cent of answered calls in 2017/18 to 16 per cent in 2021/22.

Financial investment in the mental health and addiction system continues to increase in line with Vote Health

The total annual expenditure on mental health and addiction services has increased by $480 million (33 per cent) over the five years between 2017/18 to 2021/22, from $1.47 billion to $1.95 billion per year. This total annual expenditure on mental health and addiction is 8.0 per cent of the total health appropriation in 2021/22. The 2019 Wellbeing Budget saw substantial investment in mental health and addiction services, and there has been an increase of $420 million since 2018/19, from $1.53 billion to $1.95 billion per year.

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[25] Ambulance data are additional to our measure set and were supplied by Hato Hone St John (Jones, 2023).

We have seen substantial increases in investment for primary-level services and NGO services. Expenditure for primary mental health services (including the Access and Choice programme) increased by $108 million over the last five years – from $33 million in 2017/18 to $141 million in 2021/22. This increase has shifted the allocation of investment to primary-level services from 2.2 per cent of total mental health and addiction expenditure in 2017/18 to 7.3 per cent in 2021/22. This shift is consistent with the call made in He Ara Oranga to improve access to primary mental health and addiction services. Expenditure for NGO services (excluding primary) has increased $175 million over the last five years - from $428 million in 2017/18 to $603 million in 2021/22.

No substantial shift in funding allocation towards some other areas of mental health and addiction services in need of further investment has occurred.

- Addiction services continue to receive a relatively small proportion of health appropriations, at 0.9 per cent of total health appropriation in 2021/22 or 11 per cent of mental health and addiction expenditure. As a proportion, this has remained largely unchanged since 2017/18 but it is increasing in dollar terms, from $161 million in 2017/18 to $211 million in 2021/22. This funding allocated to addiction services is lower than the estimated disability-adjusted life years lost caused by substance abuse disorders (2 per cent of disability-adjusted life years) (Ministry of Health, 2020a).
- Eating disorder[26] and maternal mental health[27] services have received recent public attention for not meeting the needs of tāngata whaiora. However, their funding has decreased in proportional terms (to 0.8 per cent and 1.3 per cent of mental health and addiction expenditure respectively in 2021/22). Moreover, from 2017/18 to 2021/22 their funding has increased only slightly in dollar amounts: from $15 million to $16 million for eating disorders and from $22 million to $25 million for maternal mental health.
- People with lived experience continue to call for funding models to recognise peer support services. The allocation of mental health and addiction funding to peer support services has increased somewhat but it remains a small proportion of overall mental health and addiction expenditure, at 2.4 per cent in 2021/22.

The workforce is the heart of mental health and addiction services

We acknowledge the thousands of staff working in mental health and addiction services who provide care and support to people every day. The Health Quality &

[26] In Budget 2022, eating disorder services received $3.9 million in extra funding over four years (Verrall, 2022a).
[27] In Budget 2022, maternal mental health received an investment of $10.1 million over four years (Verrall, 2022b).

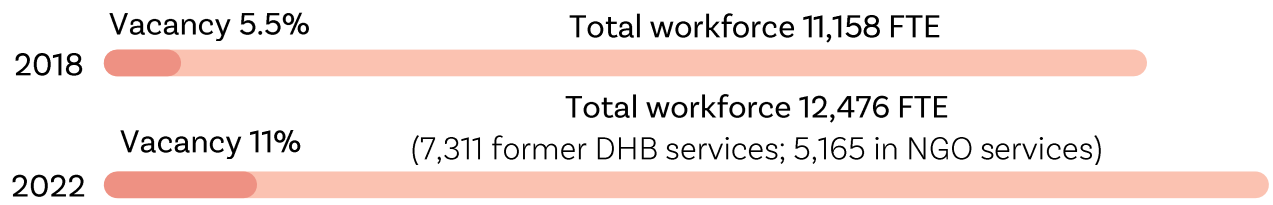
Safety Commission Ngā Poutama staff survey found that over three-quarters of staff said that the service treats tāngata whaiora and whānau with respect (Health Quality & Safety Commission, 2023).

A workforce that is a suitable size and mix of people enables tāngata whaiora to receive access to and have options for different services. Kia Manawanui states the workforce is one of the enablers to change the system, and action is needed to expand and transform the mental health and addiction workforce to be able to respond to people's needs (Ministry of Health, 2021a).

In 2022, there were 12,476 funded full-time equivalent (FTE) staff available in adult specialist services. Of these FTE positions, 7,311 were in former DHB adult services and 5,165 FTE positions in NGO adult services. Furthermore, 9,830 were in mental health services, 1,594 in addiction services, and 1,053 in forensic services. This represents an increase of 13 per cent in adult mental health services, 6.4 per cent in adult addiction services, and 6.5 per cent in adult forensic services between 2018 and 2022. Older data from 2020/21 estimate 1,740 FTE positions in infant, child, and adolescent mental health, alcohol, and other drug services, an overall increase of 2 per cent in this workforce since 2018 (Whāraurau, 2021).

Over this same time, the vacancy rates in adult specialist mental health and addiction services have almost doubled, from 5.5 per cent in 2018 to 11 per cent in 2022.[28] Considering population growth over the same period, the employed FTE[29] per 100,000 adults decreased slightly from 290 FTEs in 2018 to 289 FTEs in 2022.

Figure 3 : Estimated adult mental health and addiction specialist workforce—FTE and vacancy rate



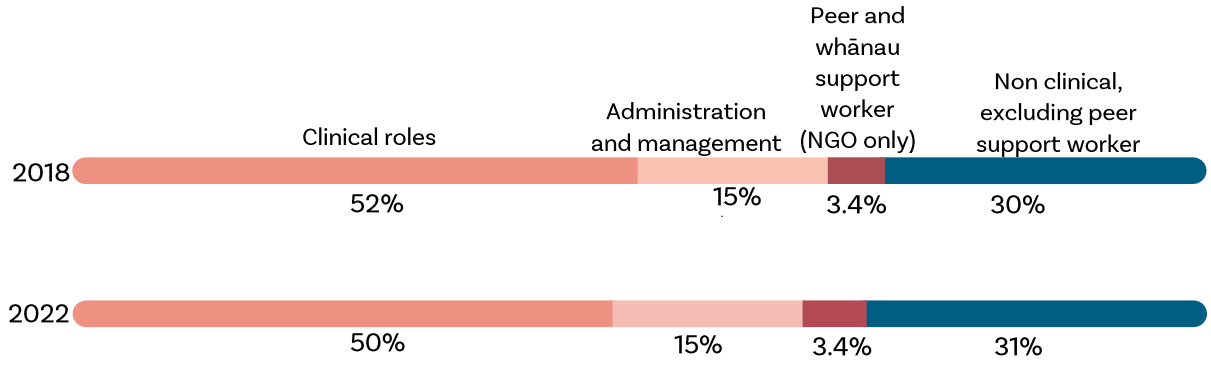
A high rate of staff vacancies impacts the wellbeing of the workforce and increases workforce burnout. The vacancies may also impact service quality and continuity of care (Chambers and Frampton, 2022). These workforce shortages apply across the full remit of services, from specialist through to telehealth services. The vacancy rates in former DHB services have remained high because recruitment barely replaced resignations for the year to 31 March 2022. To lower the vacancy rates, it is necessary

[28] Vacancy rates do vary by role group and region. Medical practitioners, for example, have the highest vacancy rate at 15 per cent. See Appendix 2 for limitations on vacancy rate calculations.
[29] Employed FTE is calculated as the funded FTE minus vacancies.

to both retain existing staff and attract more staff into services. For NGOs, recruitment rates were 50 per cent higher than resignations in the year to 31 March 2022. Workforce development needs to maintain and improve on this trend. One contributing factor driving resignations is staff moving to work in new Integrated Primary Mental Health and Addiction services that are part of the Access and Choice programme.[30]

The workforce data also show how the composition of the specialist adult mental health and addiction workforce is changing. While the FTE workforce size has increased for most roles between 2018 and 2022, the proportion of clinicians has reduced slightly (Figure 4). The number of FTE for peer and whānau support workers has grown, yet in proportional terms it remains at 3.4 per cent of the workforce[31]. These workforces have not grown sufficiently to transform the workforce to the extent He Ara Oranga calls for, and we explore the peer support workforce further in our upcoming insights paper.

Figure 4: Workforce composition (adult specialist services) by role type



Service options available for people to address distress early have increased recently

The COVID-19 pandemic contributed to a large increase in the availability of national telehealth services. Although the number of people using telehealth services decreased in the year ending June 2022, new telehealth options were developed. For example, Whakarongorau together with Emerge Aotearoa stood up a peer support telehealth (phoneline) service. This service has seen the largest month-on-month increase in use, with 24,163 total contacts in 2021/22. However, it has no long-term

[30] Our separate report on the first three years of the Access and Choice programme reports that almost 40 per cent of health coaches and 60 per cent of health improvement practitioners have previously worked in the mental health and addiction sector (Te Hiringa Mahara, 2022a). The peer support and whānau support workforces combined have increased slightly to 3.6 per cent of the total mental health and addiction workforce (from 361 FTEs in 2018 to 452 FTEs in 2022).
[31] Te Pou can only estimate the peer and whānau support workers FTE for NGO services. This is not possible for former DHB services due to peer support workers being categorised with other support workers.

funding in place, which limits the ability of Whakarongorau and Emerge Aotearoa to keep up with the demand and expand the service.

The Access and Choice programme is also providing new options and continues to be rolled out across the country. For more detail about the implementation of the different Access and Choice services, see our separate report on the first three years of the programme (Te Hiringa Mahara, 2022a).

We want to see more kaupapa Māori services and community-based options for tāngata whaiora and whānau

Our separate focus report on kaupapa Māori services, which will be released in June 2023, will shine a light on the investment into kaupapa Māori services. One of our advocacy priorities is to increase and expand kaupapa Māori services so that people have more options for Te Ao Māori healing practices and Māori ways of working in a culturally safe and supportive service.

He Ara Oranga called for growth of different service options, particularly community-based services. In 2022, the Mental Health Act consultation process continued to find that 'there was consensus that there should be a range of settings and options available to tāngata whaiora (and their whānau) that provide the most appropriate treatment support' (Roguski and Chauvel, 2022, p. vi). Despite this, we have seen no evidence that more community-based options are available or provided to tāngata whaiora. The number of people seen in rehabilitation or residential mental health settings has dropped slightly, from 3,060 people in 2020/21 to 2,740 people in 2021/22, consistent with the overall decrease in specialist service use.

There are pockets of excellent work to expand support options for tāngata whaiora

Taranaki Retreat is an exemplar we have selected due to its excellent initiatives as a residential facility and community wellbeing hub.

Exemplar: Taranaki Retreat and Waimanako are championing a community wellbeing initiative

On the rural outskirts of New Plymouth, Taranaki Retreat is a residential service that provides an evidence-based, trauma-informed approach to supporting people experiencing suicidal ideation or mental wellbeing challenges. Since the Retreat opened its doors in 2017, it has provided support to thousands of people through 5- or 10-day stays. The Retreat provides a comprehensive, holistic range of supports, which make up a kete of around 50 elements, such as life coaching, peer support, art therapy, and outreach visits, all tailored for each individual whānau. The Retreat is community-led and relies on a large volunteer workforce. People who stay there have support from a core non-clinical team, which has guidance from a wider clinical support team. Stays at the Taranaki Retreat are free of charge, and

most people who stay have self-referred from anywhere across Aotearoa.

Since 2021, the charity has also opened a community wellbeing initiative—Waimanako Hope Centre, an inner-city hub. The café is in an accessible location where people can have a 'listening ear' when times are tough, or just have a good bowl of kai on a koha basis. Waimanako also has rooms for drop-in support, counselling, workshops, and creative spaces.

Retreat founder and executive officer Jamie Allen says, "The model is a grassroots rebuilding to the village [the community] to do the things it just intuitively does, and doing that really well from the basis of good research, understanding, and intentional peer support."

An independent evaluation of Taranaki Retreat in 2021 provided strong evidence that it is effective at reducing suicide in the community (Taranaki Retreat Trust, 2021). Data show the Retreat has a notable reach for Māori, with 71 per cent of guests between 2017 and 2020 identifying as Māori.

Funding for this charity comes through fundraising, grants, donations, and goods in-kind. In recent years, the reliance on charitable funding has been challenging, all the more so because of losing corporate funding, COVID-19, and the increasing need. Without sustainable funding streams, the Taranaki Retreat and community wellbeing initiatives are at risk of 'falling over', which would have major implications for the Taranaki community.

Safety and rights

Vision: We want a mental health and addiction system that understands and upholds our cultural, spiritual, relational, and physical safety, and our human rights.

He Ara Āwhina describes holistic safety for tāngata whaiora, whānau, and people working in mental health and addiction services. Safety and rights involves respect, harm reduction, and restorative processes, trauma-responsiveness, and support for the risk taking needed for recovery, as well as elimination of coercive practises.

The use of compulsory treatment currently has legal sanction under the Mental Health Act (Compulsory Assessment and Treatment) Act 1992 and the Substance Addiction (Compulsory Assessment and Treatment) Act 2017. Manatū Hauora is in the process of developing new legislation that 'protects and respects human rights, implements the principles of Te Tiriti o Waitangi and improves equity' (Ministry of

Health, 2021b).[32] In this section, we report safety and rights data relating to current practices.

Table 4

Measure	Source	Change over time	Selected data
Applications made for compulsory treatment orders	Ministry of Justice	↑	See supplementary data table 5
People subject to a compulsory community treatment order under the Mental Health Act	Manatū Hauora	↑ Up to 2020/21	See supplementary data table 5
People detained under the Substance Addiction (Compulsory Assessment and Treatment) Act	Manatū Hauora	Too small to report trend	2018: 25 2021/22: 32
Length of time people are detained under the Substance Addiction (Compulsory Assessment and Treatment) Act	Manatū Hauora	Too small to report trend	2018: 7 weeks 4 days 2021/22: 12 weeks
People in mental health inpatient units subject to 'seclusion'	Manatū Hauora	↓* Comparison between 2020/21 and previous year (not most recent year)	See supplementary data table 5
Average number of events of 'seclusion' per person 'secluded'	Manatū Hauora	No/minimal change*	See supplementary data table 5
Proportion of 'seclusion' events that lasted less than 24 hours out of all 'seclusion' events	Manatū Hauora	No/minimal change*	See supplementary data table 5
Workforce vacancy rate in adult mental health and addiction specialist services	Te Pou	↑	See supplementary data table 4
Māori, Pacific, Asian population service user profile compared with workforce profile—former DHB adult specialist mental health and addiction services	Te Pou	No/minimal change % Māori 2018–2022	2018: 14.0% 2021: 14.6%
Māori, Pacific, Asian population service user profile compared with workforce profile—infant, child, and adolescent mental health / alcohol and other drug services	Whāraurau	No/minimal change % Māori 2018–2020	2018: 20% 2020: 20%
Complaints about inadequate or inappropriate care in mental health and addiction services	HDC	Too small to report trend	-
Serious adverse events (suspected suicide, serious self-harm, and serious adverse behaviour) reported in former DHB mental health and addiction services	HQSC	Differences may be due to change in reporting practices	2017/18: 224 2021/22: 218

[32] We acknowledge that recently Manatū Hauora (2023) revised the Guidelines for reducing and eliminating seclusion and restraint under the Mental Health (Compulsory Assessment and Treatment) Act 1992 to include 'a stronger emphasis on person-centred and culturally appropriate approaches to safely reduce the use of seclusion and restraint in mental health services.' These guidelines come into effect on 1 July 2023.

Many services continue to use coercive practices

Applications for compulsory treatment

The number of applications for compulsory treatment or extensions of compulsory treatment has steadily increased over the last five years. Of the 6,081 applications for compulsory treatment or extensions of compulsory treatment clinicians made in 2021/22, 88 per cent were granted.[33] Of granted applications, 38 per cent were for inpatient orders and 58 per cent were for community orders.[34]

Use of solitary confinement

Solitary confinement ('seclusion') practices mean that a person is placed in a locked room alone and unable to freely exit. They are often harmful and traumatic for tāngata whaiora. Despite focused quality improvement efforts within the sector, services across the country still use these practices.

Former DHBs do vary considerably in how much they use solitary confinement. The national picture obscures district success stories where some inpatient services have reduced solitary confinement or, in some cases, eliminated it entirely for a sustained period (Health Quality & Safety Commission, 2022b).

There are time lags before official data on solitary confinement become available (see Ngā ngoikoretanga raraunga | Data gaps).[35] From the latest year of official data available, across the country in 2020/21, 1,054 people were subject to 'seclusion'. This is a decrease from 1,179 people in the 2020 calendar year.

On average, people who were subject to 'seclusion' in 2020/21 experienced 2.5 events in the year, no change from the previous year. We also monitor the duration of 'seclusion' and observe that 77 per cent of all 'seclusion' events in 2020/21 lasted less than 24 hours, only a slight change from 75 per cent in the previous year.

As we mentioned in the equity domain, considerable inequities still exist with solitary confinement practices. Services are placing Māori and Pacific peoples in solitary confinement at a higher rate. Preliminary data for the latest year show 15 per cent of Māori and 13 per cent of Pacific peoples admitted to inpatient units in 2021/22 were

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[33] The Ministry of Justice could only provide these data disaggregated by age and gender, not ethnicity, which limits our ability to analyse inequity in this data.
[34] Does not add to 100 per cent as a small percentage were categorised as 'other order' or 'no linked order'.
[35] Official data from the Office of the Director of Mental Health and Addiction Services on 'seclusion' are not available for the last year of our monitoring—the year ending 30 June 2022. Instead, we draw from official data from the Office of the Director of Mental Health and Addiction Services up to 2020/21, supplemented with data from the Health Quality & Safety Commission for 2021/22 and for rate measures. These 2021/22 data are preliminary, as the Office of the Director of Mental Health and Addiction Services has not yet put them through a manual validation process.

subject to 'seclusion', compared with 6.5 per cent of non-Māori, non-Pacific peoples.[36]

Use of Compulsory Community Treatment Orders

The number of people subject to Compulsory Community Treatment Orders (CCTOs) has been increasing in Aotearoa, from 6,290 people in 2018 to 6,817 people in 2020/21.[37] People under these orders are required to accept treatment, which typically includes prescribed medication, administered as tablets or intra-muscular injections.

CCTO data show persistent and unacceptable inequity for Māori. Of the 6,817 people subject to CCTOs in 2020/21, 39 per cent were Māori despite Māori representing 17 per cent of the total population. Although the number of people subject to CCTOs is increasing generally, the number of Māori subject to CCTOs is increasing at a faster rate, by 13 per cent from 2018 to 2020/21 compared with 5.8 per cent for non-Māori, non-Pacific peoples.

In processes related to applications (clinical reviews) and granted orders (court hearings), tāngata whaiora are not heard, and whānau are not offered adequate opportunity to be involved. We will provide further information about CCTOs and the changes we want to see in our forthcoming report that focuses on tāngata whaiora and whānau perspectives of the issue.

Building safe and well-resourced workforces is a core part of safety

Eliminating coercive practices, such as solitary confinement, requires both a concerted effort and a workforce that is well-resourced to support alternative practices.

However, workforce data show the vacancy rates have doubled in adult specialist services, from 5.5 per cent in 2018 to 11 per cent in 2022. A 2021 survey of psychiatrists reported that 87 per cent disagreed or strongly disagreed with the statement that they were working in a well-resourced mental health service (Association of Salaried Medical Specialists, 2021). Although resignation rates for psychiatrists over the past year in 2022 (13 per cent) were similar to those in 2018 (12 per cent), recruitment rates of 9.1 per cent did not fully replace those who had resigned. This is contributing to high vacancy rates (15 per cent) for psychiatrists and workforce pressures.

To ensure safety for everyone who uses mental health and addiction services, it is critical that we grow workforce diversity now and into the future as the population

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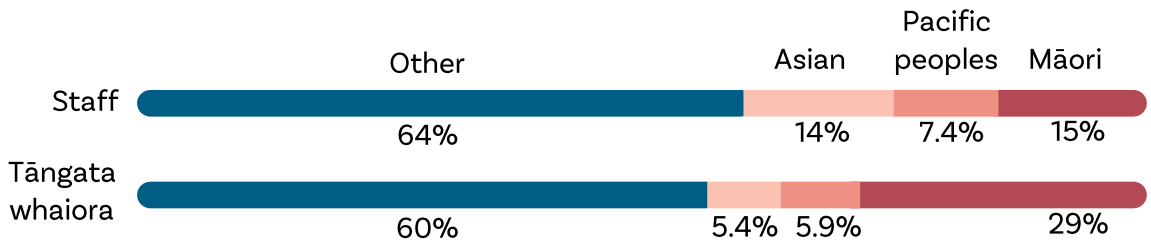
[36] Health Quality & Safety Commission (2022b) and additional supplied data.
[37] Data on CCTOs on the latest year, 2021/22, were not available from Manatū Hauora due to manual data validation processes.

profile of Aotearoa changes. While former DHBs adult services have made some progress in increasing the Māori workforce, this change is slow and has a long way to go (15 per cent of the workforce was Māori in 2021, compared with 29 per cent of tāngata whaiora). In infant, child, and adolescent mental health, and alcohol and other drugs services, 20 per cent of the workforce is Māori, which has not changed between 2018 and 2020.

Figure 5: Ethnic profiles of workforce and tāngata whaiora for former DHB adult specialist mental health and addiction services, 2021



Sources: Te Pou (2022); Te Whatu Ora (2022).

Note: Prioritised ethnicity has been used for both workforce and tāngata whaiora data.

Many initiatives are under way to build workforce capability. For example, Te Rau Ora is providing workforce training (Te Rau Ora, 2022). In addition, Te Manawa Taki has developed a regional framework for lived experience and whānau provision of service and a workforce action plan (Te Manawa Taki Mental Health and Addiction Regional Network, 2021, 2022).

Services need to be culturally safe to improve outcomes

The data in this section relate to cultural safety for Māori in particular. However, cultural safety is important for many communities, including former refugees, migrants, Pacific peoples, and people from other communities who experience mental distress or substance use harm.

Cultural safety can look different for different people. For some, it is having the option to access a kaupapa Māori service that follows Te Ao Māori health practices and Māori ways of working. For others, cultural safety is accessing culturally safe services in a mainstream setting. Of Māori who used specialist mental health and addiction services in 2021/22, 26 per cent had access to a kaupapa Māori service or team, down from 30 per cent in 2017/18. We will explore kaupapa Māori services in a separate focus report specifically on kaupapa Māori services that will be released in June of this year.

The Health Quality & Safety Commission Ngā Poutama survey includes data on cultural competency for staff across different service settings. This survey found that staff access to kaumātua, cultural advisors, and other cultural supervision to support

working with tāngata whaiora Māori has declined from 54 per cent in 2018 to 47 per cent in 2022 (Health Quality & Safety Commission, 2023). More work remains ahead to uphold the cultural safety of all people in mental health and addiction services.

Young people need youth-specific facilities

The service setting and environment are a core element to making people safe in services. Our separate focus report on young people admissions to adult inpatient units shows that over the three-year period from 2019/20 to 2021/22, on average 187 people aged 12 to 17 years were admitted to an adult inpatient unit each year (Te Hiringa Mahara, 2023c). We acknowledge that the reasons for this practice are complex and are inextricably related to available resources. However, the practice is unacceptable, and we want to see a reduction in this practice to zero. To achieve this, all districts must develop alternative, youth-specific acute services.

Connected care

Vision: We want supports and services to work collectively and cohesively for us, and see us as valued members of whānau, communities, and society.

In a good mental health and addiction system, supports and services work collectively together as one system to address the holistic needs of tāngata whaiora, seeing them as valued members of whānau, communities, and society.

Table 5

Measure	Source	Change over time	Selected data
Tāngata whaiora with a transition plan	PRIMHD	↑ From inpatient / residential setting	See supplementary data table 8
Treatment days in specialist services involving family and whānau	PRIMHD	No/minimal change Proportion of treatment days	See supplementary data table 8
Treatment days in specialist services provided to support family and whānau, including children	PRIMHD	↑ Number of days	2017/18: 13,917 2021/22: 16,388
Treatment days in specialist services provided to support tāngata whaiora in their role as parents or caregivers	PRIMHD	↓ Number of days	2017/18: 1,517 2021/22: 1,394
Inpatient stays with recorded NGO activity in the 28 days before an inpatient stay	PRIMHD (Te Pou)	↓	2017/18: 22% 2021/22: 16%
Tāngata whaiora and whānau report that the people they see communicate with each other when they need them to	Mārama Real-Time Feedback (Te Pou)	No/minimal change	2017/18: 63% 2021/22: 64%
Tāngata whaiora followed up within 7 days of leaving inpatient unit	PRIMHD (Te Pou)	No/minimal change	See supplementary data table 8
Complaints about coordination of care between different service providers	HDC	No/minimal change As % of complaints	2017/18: 11% 2021/22: 11%

Complaints about inappropriate follow-up by service providers	HDC	↑ As % of complaints	2017/18: 8% 2021/22: 13%

Further relevant measure used in another domain:

- Average length of stay in an inpatient unit (Table 3)

There has been a reduction in the involvement of family and whānau in care

In the most recent year, 2021/22, the number of treatment days in specialist services that included contact with family or whānau decreased by 42,514 (or 11 per cent) to a total of 348,784 days since the previous year.[38] However this decrease is in line with the reduced number of treatment days overall.

Transition plans are an important tool for connecting services to support tāngata whaiora

Tāngata whaiora may receive support from a collective of different health professionals, clinicians, services, and organisations. These different providers should have cohesion across their approach to deliver the best care that responds to the experiences, needs, and aspirations of tāngata whaiora. This cohesion is needed both where tāngata whaiora have a team of supports wrapped around them and when they are transitioning between supports. This helps to keep people safe and deliver more effective outcomes.

The purpose of transition plans[39] is to document an agreed approach to supporting the recovery of tāngata whaiora, which is informed by and with them. This record can support consistent care across different settings as everyone works towards the same plan. In 2021/22, 73 per cent of people discharged from an inpatient unit or residential setting had a transition plan recorded, up from 61 per cent in 2017/18.[40] However, this means that over one-quarter of people do not have a plan in place when they leave inpatient units or residential facilities.

Follow-up and connection across services have not changed over time

There has been no improvement in the rates of timely follow-up after tāngata whaiora transition out of an inpatient unit. Even though the number of people with an overnight discharge from an inpatient unit has decreased, the proportion of people

[38] Contact with whānau and family is calculated in PRIMHD with the T32 and T36 activity codes. T32 codes include contact with whānau or family when the tāngata whaiora are not present. These data may not collect whānau or family contact accurately, and Manatū Hauora has advised that the reduction may be in part be because of the increased use of telehealth during COVID-19 lockdowns.
[39] PRIMHD data collection covers many settings, which use a range of terms for this documentation, including relapse wellness plan, prevention plan, action plan, personal care plan, continuing or after care plan, or recovery plan. These different terms may vary somewhat in their focus, but all are about documenting a common plan with tāngata whaiora.
[40] This measure is calculated out of people with a known transition plan status. It excludes a significant number of people with an 'unknown plan' (in 2021/22 this was 14 per cent).

with a community service contact within seven days of discharge has remained constant at 80 per cent across the five years from 2017/18 to 2021/22. This means that one in five people are not being followed up in the week following discharge from a mental health inpatient unit.

Further evidence of the lack of progress in connection across services comes from Mārama Real-Time Feedback about mental health and addiction services. The proportion of tāngata whaiora and whānau reporting that the people they see communicate with each other when they need them to has not changed substantially over the past five years (64 per cent in 2021/22 compared with 63 per cent in 2017/18).

Effectiveness

Vision: Supports, services, and policy must make a meaningful difference in our lives, so that we are self-determining and thriving.

In addition to providing people with access to and a positive experience of services, services should contribute to improved wellbeing outcomes for tāngata whaiora.

Table 6

Measure	Source	Change over time	Selected data
Tāngata whaiora who went back into an inpatient unit (readmission) within 28 days of being discharged	PRIMHD (Te Pou)	↓	See supplementary data table 8
Average self-rated increase in tāngata whaiora satisfaction towards achieving recovery goals (addiction services)	PRIMHD (Te Pou)	No/minimal change	2017/18 (start): 3.26 2017/18 (end): 4.04 2021/22 (start): 3.35 2021/22 (end): 4.20
Tāngata whaiora with independent / supported / no accommodation	PRIMHD (Supplementary Consumer Record)	No/minimal change As % independent accommodation, out of SCR	2017/18: 83% 2021/22: 84%
Tāngata whaiora in employment, education, or training	PRIMHD (Supplementary Consumer Record)	No/minimal change	2017/18: 48% 2021/22: 49%
Tāngata whaiora who report feeling lonely a little or none of the time in the last four weeks	General Social Survey (IDI)	No/minimal change	2018: 45% 2021: 64%
Tāngata whaiora who reported experiencing discrimination in the last year	General Social Survey (IDI)	No/minimal change	2018: 39% 2021: 39%
Tāngata whaiora who said it would be 'very easy' or 'easy' to talk to someone if they felt down or a bit depressed	General Social Survey (IDI)	No/minimal change	2018: 49% 2021: 52%
Tāngata whaiora who report life is worthwhile	General Social Survey (IDI)	No/minimal change	2018: 62% 2021: 65%

Tāngata whaiora and whānau reporting they would recommend their service to friends or family if they needed similar care or treatment	Mārama Real-Time Feedback (Te Pou)	No/minimal change	2017/18: 70% 2021/22: 69%

Tāngata whaiora experience more wellbeing challenges

The data available to measure the effectiveness of services are limited. At a population level, the General Social Survey collects data on wellbeing outcomes. From its findings, we can see how wellbeing outcomes differ for tāngata whaiora accessing mental health and addiction services.

The General Social Survey[41] confirms known links between mental health and wellbeing: tāngata whaiora are more likely to experience loneliness, more likely to report experiencing discrimination, less likely to find it easy to talk to someone if they feel down or depressed,[42] and less likely to report that life is worthwhile, compared with other people in Aotearoa. While these wellbeing outcomes are important measures of quality of life, we cannot use these data to infer the effectiveness of service performance as we do not have data on wellbeing outcomes before and after service use that we can compare.

Under half of tāngata whaiora were in employment, education, or training

An effective system would help tāngata whaiora gain access to accommodation and employment, education, or training that is conducive to recovery and wellbeing. Data on these measures indicate that the proportion of tāngata whaiora in employment, education, or training over the last five years has been reasonably constant.[43] Under half of tāngata whaiora (49 per cent) were in employment, education, or training in 2021/22, relatively unchanged from 2017/18. The quarterly unemployment rate in Aotearoa in 2021/22 ranged between 3.2 and 3.3 per cent (Stats NZ, 2023b).

The percentage of tāngata whaiora with independent accommodation has remained steady over the past five years (84 per cent in 2021/22). In contrast, the percentage of tāngata whaiora in supported accommodation has fallen from 13 per cent in 2017/18 to 11 per cent in 2021/22. Having fewer tāngata whaiora in supported accommodation is not necessarily negative as it may reflect a change in models of care, in which people access more individualised supports rather than group-based residential supports.

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[41] Using integrated data with PRIMHD via the IDI. See Appendix 2 for limitations of the General Social Survey data.
[42] In 2018 only. In the 2021 General Social Survey, the difference between tāngata whaiora and other people on this measure was not statistically significant.
[43] Measures on employment and accommodation outcomes should be interpreted with caution as the data come from the supplementary consumer record (SCR), which has low levels of compliance. An SCR is available for 33 per cent of tangata whaiora with a PRIMHD record in 2021/22 (and the percentage is similar across the past five years).

Readmission rates have decreased over the five-year period

The rates of readmission to inpatient unit within 28 days of being discharged have improved, falling from 17 per cent in 2017/18 to 15 per cent in 2021/22. This is a positive indication of the system's ability to support tāngata whaiora once they leave an inpatient unit.

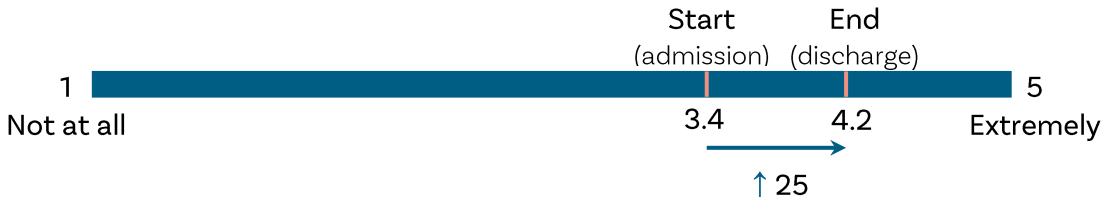
However, declining readmission rates may not indicate an improvement in the short-term effectiveness of the support that people receive from services because numbers of admissions into inpatient services are also lower. Readmission rates may have been particularly impacted during the COVID-19 years as inpatient units were not fully occupied during this time. Changes in capacity or service models may also influence readmission rates so they may not be an accurate indicator of a positive outcome at 28 days post-discharge.

Addiction services continue to support recovery outcomes for tāngata whaiora

The Alcohol and Drug Outcome Measure (ADOM) was developed for use in community-based and outpatient addiction services in Aotearoa for tāngata whaiora to complete at several different timepoints along their journey. This outcome measure includes self-determination of recovery goals and self-rated confidence in progress towards these goals. In this way, the ADOM outcome measure aligns to the aspirations for effectiveness in He Ara Āwhina where it relates to tāngata whaiora experiencing self-defined recovery and holistic wellbeing. These are the types of outcome measures that we want to see consistently used across the mental health and addiction system.

The effectiveness of addiction services in supporting tāngata whaiora to reach their recovery goals has been consistently high across the last five years. At the start of their service use in 2021/22, people rated themselves as just over 'moderately satisfied' on average (3.35 out of 5) with their progress towards their recovery goals. At the end of service use, the average rating of satisfaction with progress was just over 'considerable' (4.2 out of 5).[44]

Figure 6: How satisfied are you with progress towards achieving your recovery goals? (Alcohol and Drug Outcome Measure) 2021/22



[44] See Appendix 2 for data limitations of ADOM.

Te aroturuki i te tirohanga Ao Māori o He Ara Āwhina | Monitoring against Te Ao Māori perspective of He Ara Āwhina

Te Ao Māori perspective in He Ara Āwhina prioritises the voices of Māori. It reframes the status quo into an aspirational view of Māori values, thinking, and ways of being reflected in mental health and addiction services, with the Crown meeting its commitment as a partner of Te Tiriti o Waitangi.

By monitoring progress against Māori aspirations, we can see where we are coming from and where we are now, as well as shine a light on the path forward to achieve aspirations of Māori. In this section, we present data and interpretation for each of the six domains to monitor mental health and addiction services from a Māori experience.

Mana Whakahaere

Vision: We (whānau) experience tino Rangatiratanga and feel that Te Tiriti o Waitangi is actively embedded in the mental health and addiction system and services.

Mana Whakahaere describes a future system where Te Tiriti o Waitangi is embedded throughout all aspects of the system, from legislation and policy and service models designed using mātauranga Māori, to the determination of measures and protection of data. This domain is about fulfilling the promise of Te Tiriti o Waitangi, which means being intentional in collectively addressing institutional racism and shifting from inequity to equity.

Table 7

Measure
No measures suitable for this domain identified

Monitoring progress against Mana Whakahaere is problematic

No measures are currently available for this domain, and more work is required in this area. This is a significant finding in itself. To monitor and apply relevant measures to this domain, we need a system that prioritises Te Tiriti o Waitangi and is committed to having data available to monitor how well this is happening. In particular, we need

data that uphold Māori data sovereignty and are produced by Māori about Māori and the environments they have relationships with (Te Mana Raraunga, 2018).

This reinforces the importance of actively embedding Te Tiriti o Waitangi in the mental health and addiction system. Concerted measurement efforts are required across the mental health and addiction system, in partnership with Māori.

Mana Motuhake

Vision: We lead and self-determine our pathways to pae ora, mauri ora, and whānau ora.

Mana Motuhake prioritises Māori self-determination, placing Māori at the forefront of decision-making on policy and service delivery. This domain describes a future system where Māori have more control over their decisions, their care, and their future. In turn, this will enable whānau to have greater self-determination, autonomy, independence, sovereignty, self-government, authority, and mana.

Table 8

Measure	Source	Change over time	Selected data
Tāngata whaiora and whānau Māori reporting they feel involved in decisions about their care	Mārama Real-Time Feedback (Te Pou)	↓	2017/18: 79% 2021/22: 72%
Tāngata whaiora and whānau Māori reporting that their plan is reviewed regularly	Mārama Real-Time Feedback (Te Pou)	↓	2017/18: 77% 2021/22: 72%
Scholarships and bursaries each year for Māori students pursuing a career in mental health and addiction services	Te Whatu Ora	↑ (2019–2022)	2019: 80 2022: 150
Complaints from Māori about access to mental health and addiction services	HDC	Too small to report trend	-

Support for expanding the Māori workforce is growing

The number of scholarships and bursaries provided each year for Māori students pursuing a career to work in mental health and addiction services has almost doubled from 80 in 2019 to 150 in 2022.[45] This increase is a positive development that reflects a growing awareness and recognition of the importance of a Māori workforce to support whānau participation and self-determination.

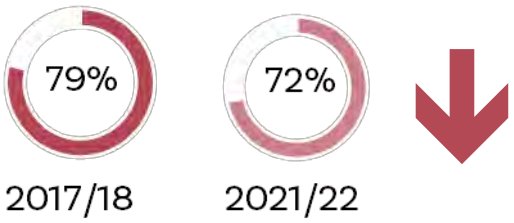
Tāngata whaiora Māori are feeling less involved in decisions about their care

Self-reported data through Mārama Real-Time Feedback show a trend of a decreasing proportion of tāngata whaiora Māori and their whānau who are participating in their care. The proportion of Māori who reported they feel involved in decisions about their care fell from 79 per cent in 2017/18 to 72 per cent in 2021/22.

[45] Te Whatu Ora contracted Massey University to provide these scholarships and bursaries.

Similarly, the proportion of Māori who reported that their plan is reviewed regularly reduced from 77 per cent in 2017/18 to 72 per cent in 2021/22. Regular review of care plans is essential to identify any changes in health status so that services can make appropriate adjustments for Māori to lead and self-determine their own pathways to pae ora, mauri ora, and whānau ora (Ministry of Health, 2020b). Any reduction in the proportion of Māori who have their care plan regularly reviewed consequently makes it less likely that this will happen.

Figure 7: Māori who reported they felt involved in decisions about their care



Manawa Ora / Tūmanako

Vision: We have the right to choose supports and services that respond to our experiences, needs, and aspirations.

Manawa Ora / Tūmanako refers to the inherent right of Māori to exercise choice and self-govern their own wellbeing journey. This domain envisages a system that enables whānau, hapū, and iwi to make decisions about their support and services; responds to needs through providing a wide range of healing interventions, such as rongoā Māori; and recognising and embracing tino rangatiratanga.

Table 9

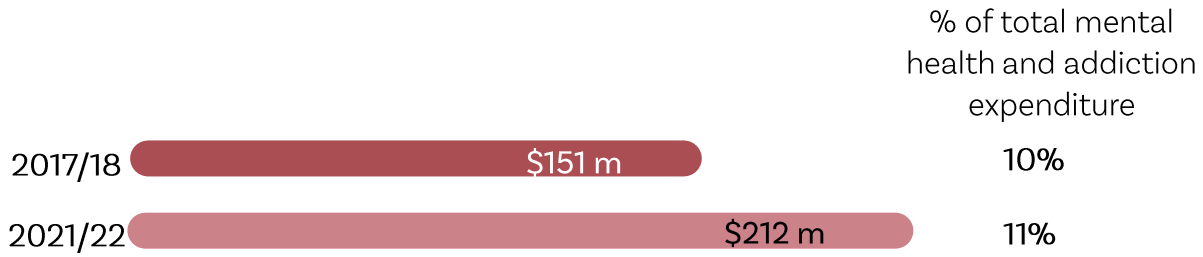
Measure	Source	Change over time	Selected data
Expenditure on kaupapa Māori mental health and addiction services	Manatū Hauora	↑	See supplementary data table 1
FTE rongoā Māori practitioners and Māori cultural roles with a focus on te reo me ōna tikanga employed in NGOs	Te Pou	Only collected in 2022	2022: Rongoā: 3.6 FTE Total Māori cultural roles: 280.2 FTE
Mental health and addiction NGOs actively developing Māori cultural roles	Te Pou	Only collected in 2022	2022: 50% have roles 30% plan to develop

Expenditure on kaupapa Māori services is increasing

An important step in empowering Māori to govern their own affairs is to allocate public funds to kaupapa Māori services. Investment in kaupapa Māori services and teams has increased by $61 million over the five-year period, from $151 million in 2017/18 to $212 million in 2021/22. This increase in investment is promising to support more ‘by Māori, for Māori’ services and tino rangatiratanga.

It is important that increases in the future are significant enough to address the systemic disparities in funding of kaupapa Māori services over many decades. For this to happen, Māori need to be prioritised, and be able to govern their own affairs through a 'by Māori, for Māori' approach, as Nōku te Ao: Sovereignty of the Māori mind outlines (Wikaire et al, 2022).

Figure 8: Expenditure on kaupapa Māori services (DHB and Manatū Hauora expenditure)



Most of kaupapa Māori expenditure on mental health and addiction services occurs within NGO providers, who accounted for 74 per cent of that expenditure in 2021/22, down from 78 per cent in 2017/18.

There are gaps in available information to monitor the size of the workforce delivering rongoā Māori and using te reo me ōna tikanga

Rongoā Māori is a traditional healing practice deeply rooted in Māori culture and spirituality (Wehipeihana et al, 2021).[46] As such, rongoā Māori is considered a taonga that Māori have tino rangatiratanga over under Te Tiriti o Waitangi (Te Aka Whai Ora, 2023; Te Hiringa Mahara, 2023b). Further, because it has many therapeutic and wellbeing benefits, rongoā Māori plays a central role in kaupapa Māori services (Te Hiringa Mahara, 2023b; Wehipeihana et al, 2021).

Monitoring the number of rongoā Māori practitioners is important. In 2022, Te Pou used its NGO workforce survey to estimate the national workforce size, and from the responses found a total of 3.6 FTE rongoā practitioner positions employed and vacant (Te Pou, 2023b). This estimate clearly does not represent the full capacity of the rongoā workforce.[47] The rongoā workforce in former DHB services cannot be

[46] Rongoā Māori is one of many essential healing practices that provides culturally safe and responsive care to tāngata whaiora and whānau. Tāngata whaiora also experience healing environments that enhance their wellbeing when whānau are an integral part of their journey, and they have access to kaumātua, tohunga, karakia, waiata, and other elements that reaffirm cultural identity.
[47] An underestimate is likely because the survey focused on the workforce delivering health contracts from mental health and addiction expenditure that does not fund rongoā Māori roles or services. So, NGOs are more likely to employ these roles under other sector contracts like Whānau Ora that are excluded from the survey. Some NGOs reporting to the survey indicate they want to employ rongoā Māori practitioners but are hampered by contracts specifying health professionals (Te Pou, 2023b).

separately reported.[48] There is a need to improve approaches to data collection and data coding so that monitoring can capture the full diversity of the workforce.

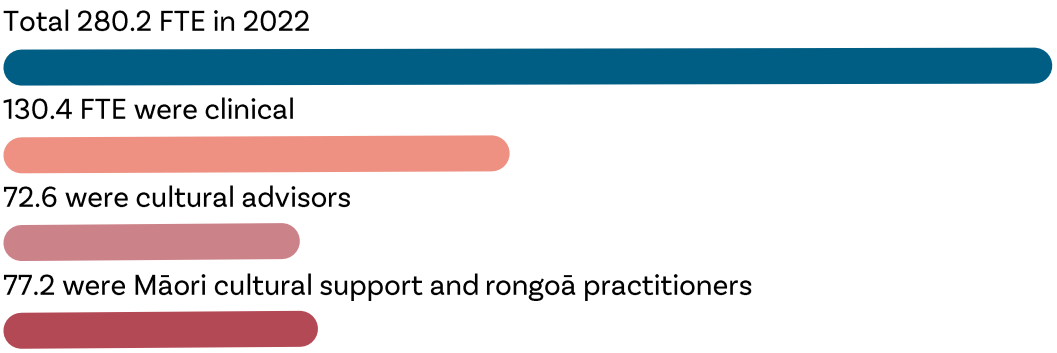
Despite the difficulty of routinely monitoring this workforce, a previous report highlighted the need to make rongoā more accessible (Wehipeihana et al, 2021). The report also identified potential barriers to filling the role of rongoā Māori practitioners in mental health and addiction services, which in turn may hinder that greater accessibility. Among these barriers are:

- no set pathway to become a rongoā Māori practitioner exists
- rongoā-specific training is often unpaid, funding is insufficient to hire new staff, and there is a lack of pay equity
- there is limited recognition for the need to develop and establish Māori practitioners trained and skilled in traditional healing, including rongoā.[49]

Addressing these potential barriers will require a comprehensive and collaborative effort from all stakeholders, including government agencies, health care organisations, training providers, iwi, and Māori communities.

As part of its adult NGO workforce survey, Te Pou collects data on broader Māori cultural roles with a specific focus on te reo me ōna tikanga (Māori language and cultural practices). These roles have unique competencies that support the delivery of kaupapa Māori services (Te Rau Matatini, 2015). Te Pou data show a total of 280.2 (clinical and non-clinical) FTE staff were in Māori cultural roles in 2022. Of these, 130.4 FTE were clinical, 72.6 were cultural advisors, and 77.2 were Māori cultural support (including rongoā practitioners). This 2022 workforce survey also shows that, within mental health and addiction NGOs, 50 per cent have Māori cultural roles, and another 30 per cent have a plan to develop these roles.

Figure 9: NGO workforce Māori cultural roles with a focus on te reo me ōna tikanga



[48] Available information about Te Whatu Ora workforce is coded with the Australian and New Zealand Standard Classification of Occupations (ANZSCO). This does not separately describe the workforce in Māori cultural roles including rongoā Māori practitioners.
[49] This same limitation extends to broader mātauranga Māori about the wellbeing of the whole whānau.

Mana Tangata / Tū Tangata Mauri Ora

Vision: We have a mental health and addiction system that is culturally, spiritually, relationally, and physically safe.

Mana Tangata / Tū Tangata Mauri Ora envisages a system where Te Ao Māori is embedded in services to provide a culturally safe and oranga informed environment without coercive practices and solitary confinement. Services engage in holistic and healing ways using cultural assessments and culturally appropriate approaches that align with cultural values and beliefs.

Table 10

Measure	Source	Change over time	Selected data
Māori subject to a compulsory community treatment order under the Mental Health Act	Manatū Hauora	↑ Up to 2020/21	See supplementary data table 5
Māori detained under the Substance Addiction (Compulsory Assessment and Treatment) Act	Manatū Hauora	Too small to report trend	2018: 4 2021/22: 5
Length of time Māori detained under the Substance Addiction (Compulsory Assessment and Treatment) Act	Manatū Hauora	Too small to report trend	-
'Seclusion' used on Māori in mental health inpatient units	Manatū Hauora	↓* Comparison between 2020/21 and previous year (not most recent year)	See supplementary data table 5
Average number of events of 'seclusion' per person 'secluded' for Māori	Manatū Hauora	No/minimal change*	See supplementary data table 5
Proportion of 'seclusion' events that lasted less than 24 hours out of all 'seclusion' events for Māori	Manatū Hauora	No/minimal change*	See supplementary data table 5
Complaints from Māori about inadequate or inappropriate care in mental health and addiction services	HDC	Too small to report trend	-
Serious adverse events (suspected suicide, serious self-harm, and serious adverse behaviour) involving Māori reported in DHB mental health and addiction services	HQSC	Differences may be due to change in reporting practices	2017/18: 43 2021/22: 53

Use of community compulsory treatment orders and solitary confinement for tāngata whaiora Māori is high

The use of CCTOs conflicts with the aspirations of this domain. The number of Māori subject to a CCTO has risen from 2,361 in 2018 to 2,671 in 2020/21. Accounting for population change over this period, this represents an increase from 289 people per 100,000 in 2018 to 307 per 100,000 in 2020/21. Data were not available for 2021/22.

Detention under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 is rarely used, and the number of Māori detained under this Act is too small

to analyse. Services and courts need to reduce the use of CCTOs and instead use approaches that honour tino rangatiratanga and promote better engagement and experiences for Māori. Taking a holistic approach to care for Māori that comprehensively addresses social, cultural, spiritual, and historical factors would go further towards improving mental health outcomes for Māori.

Figure 10: Rate per 100,000 Māori population who were subject to a compulsory community treatment order

2018 – 2,361 Māori, 289 people per 100,000

2020/21 – 2,671 Māori, 307 people per 100,000

Within inpatient units, the number of tāngata whaiora Māori who are put into solitary confinement ('seclusion') is relatively high, but it is reassuring to see a decrease in the most recent year in which official data are available. Namely, in 2020/21, the most recent official data available, there were 482 Māori were subject to 'seclusion', down from 578 in the 2020 calendar year.[50] The average events per person has remained steady (at an average of 2.1 events across both years) and there has been minimal change in the proportion of events that lasted less than 24 hours (from 69 per cent in 2020 to 71 per cent in 2020/21). The Health Quality & Safety Commission monitors these data monthly and noted a statistically significant decrease in the rate of 'seclusion' for Māori in 2020, which has continued to be sustained. This reduced use of solitary confinement in inpatient units is promising.

Mana Whānau / Whanaungatanga

Vision: We have access to supports and services that enable connection to our whānau, whakapapa, hapū, and iwi.

Mana Whānau / Whanaungatanga prioritises strong family connections and relationships to whenua, whakapapa, and ngā atua, promoting holistic wellbeing and whānau-dynamic care. It enables whānau to determine training and resources needed to extend workforce capability and capacity to provide high-quality, culturally appropriate care.

[50] Manatū Hauora provided 'seclusion' data in calendar years except for the most recent data, which covered the 2020/21 financial year.

Table 11

Measure	Source	Change over time	Selected data
Treatment days in specialist services involving Māori whānau provided by services	PRIMHD	No/minimal change* Proportion of treatment days	See supplementary data table 8
Treatment days in specialist services provided by services to support Māori whānau and family, including children	PRIMHD	↓ Number of days	2017/18: 4,095 2021/22: 3,756
Treatment days in specialist services provided to support tāngata whaiora Māori in their role as parents or caregivers	PRIMHD	↓ Number of days	2017/18: 393 2021/22: 350

Further relevant measures used in another domain:

- Tāngata whaiora and whānau Māori reporting they feel involved in decisions about their care (Table 8)
- Tāngata whaiora and whānau Māori reporting that their plan is reviewed regularly (Table 8)

The number of treatment days that enable connection to whānau has fallen slightly

He Ara Oranga called for greater involvement of whānau in care because this is needed for culturally safe and responsive care for Māori. Whānau play an important role in decision-making processes and recognising the importance of family support in health care treatment is a positive step towards improving health care outcomes for Māori.

The number of treatment days provided to Māori in specialist services where whānau were involved had been increasing from 107,971 in 2017/18 to 113,892 in 2020/21. However, these treatment days decreased in 2021/22 to 98,259. Part of the explanation for this is that fewer Māori used specialist services in the last year, and the proportion of treatment days involving whānau has barely changed. The number of treatment days that services provided to support whānau, including children of tāngata whaiora Māori, decreased in the most recent year (from 4,924 in 2020/21 to 3,756 in 2021/22).

Kotahitanga

Vision: We want supports and services to work collectively and cohesively to make a meaningful different for us.

Kotahitanga envisages a system that works together in collaboration with whānau, recognising their unique strengths and aspirations. It incorporates mātauranga Māori into recovery pathways for whānau that are personalised and embedded in Te Ao Māori with a focus on promoting their overall wellbeing.

Table 12

Measure	Source	Change over time	Selected data
Tāngata whaiora Māori who think their whānau are doing well	Te Kupenga (via IDI)	Only collected in 2018	2018: 76%

Tāngata whaiora Māori who felt they had the right amount of whānau contact	Te Kupenga (via IDI)	Only collected in 2018	2018: 60%
Tāngata whaiora Māori who think things are getting better for their whānau than 12 months ago	Te Kupenga (via IDI)	Only collected in 2018	2018: 83%
Complaints from Māori about coordination of care between different service providers	HDC	Too small to report trend	-
Complaints from Māori about inappropriate follow-up by service providers	HDC	Too small to report trend	-

We need wellbeing outcome data to measure what's important for whānau

The survey Te Kupenga provides information about meaningful outcomes for whānau. Results from the 2018 survey indicate that the wellbeing of tāngata whaiora Māori who were referred to specialist mental health and addiction services[51] before the survey differed in only limited ways from the wellbeing of other Māori who had no such referral.[52] The three measures identified:

- an estimated 76 per cent of tāngata whaiora Māori reporting their whānau was doing well (6+ on a 0–10 scale), which was lower than the estimated 84 per cent of other Māori who reported their whānau were doing well
- no statistically significant difference between the percentage of tāngata whaiora Māori reporting their whānau were doing better than or the same as 12 months ago (83 per cent) and other Māori
- no statistically significant difference between the percentage of tāngata whaiora Māori reporting they have an 'about right' level of contact with whānau (60 per cent) and other Māori.

Figure 11

Source: Te Kupenga and PRIMHD, via IDI analysis. This difference is statistically significant. 'Doing well' is where a respondent gives a rating of 6 or higher on a 0–10 scale.

These data from Te Kupenga capture important information on key wellbeing outcomes people with lived experience told us are important. However, they are only useful to measure associations with service use and are not measures of service performance. Services have a role to play in supporting wellbeing outcomes and partnering with others to improve these outcomes. Measuring any contribution

[51] Using integrated data via the IDI linked to PRIMHD.
[52] See Appendix 2 for limitations in using Te Kupenga data.

services make to improving wellbeing outcomes requires improved outcome measurement tools within services (see Ngā ngoikoretanga raraunga | Data gaps).

Across the system, pockets of Kotahitanga and services offer exemplars of how to work collectively and cohesively to make a meaningful difference for Māori. Manaaki Ora, based in Rotorua, is one example of a kaupapa Māori service providing meaningful support for whānau.

Exemplar: Manaaki Ora

Manaaki Ora is a kaupapa Māori health and social service provider based in Rotorua, serving communities across the motu. The vision for Manaaki Ora comes from Te Arawa history and the journey from Hawaiki to Aotearoa. As the waka left the shore, Tipuna (ancestor) Te Tauaki o Houmaitawhiti said in a karakia, "To seek a safe and peaceful future and let old age be our fate." Manaaki Ora uses this aspiration of oranga (wellbeing) to support whānau from the day of conception right through to old age.

Manaaki Ora offers a broad range of trauma-informed services that cover the life continuum. These include (but are not limited to) hapū māmā, tamariki and pēpi services, a perinatal mental health service, services for rangatahi transitioning into adulthood, family harm initiatives, elder abuse services, problem gambling, a youth and adult addictions team, and national drug treatment programmes.

While Manaaki Ora is grounded in a kaupapa Māori approach, it is a service for anybody who 'needs a space to heal'.

A peer and lived experience workforce, particularly in the addiction space, is the backbone of Manaaki Ora.

"In my experience [the typical service model involves] having a peer workforce working alongside and under the guidance of clinicians. In our space, it's the other way around. Because we have to, and because we have deliberately sought out a peer workforce that have other components that we find desirable—te Reo, mātauranga Māori, tikanga, being mana whenua, and connectivity to hapū marae. They are just as important and valuable as anything else," says Group Manager Marita Ranclaud.

During the COVID-19 pandemic, Manaaki Ora teamed up with the other services in Rotorua to respond to the changeable health and economic challenges. When the immediate need for health responses, such as vaccination clinics, fell away, they realised that families and whānau who had been "locked out of general practices for so long, no longer had trust and faith in general practice and were reluctant to see any kind of health care at all," says Marita.

As a result, the community providers continued to work together and organised multiple hauora events aimed at drawing whānau and communities back into conversations about their health and wellbeing, while simultaneously doing health checks that led to referrals and follow-up visits. One of these events attracted over

200 families. The overwhelming feedback from communities was that having difficult conversations felt easier in that setting than with a GP.

"Our true strength lies in our ability to act and respond collectively for the good of our community," says Marita. "If you're thinking Māori, we don't exist without anybody else."

He whakamārama mō ā tātau whakahau o mua | Update on our previous calls to action

Overview of progress

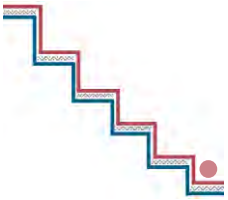
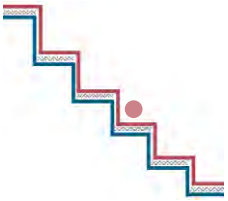
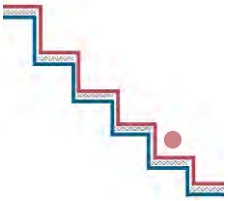
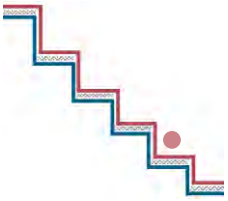
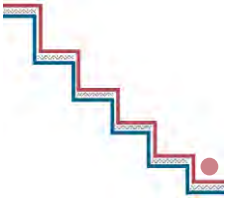
In Te Huringa 2022, we made 14 calls to action about the changes we wanted to see (Mental Health and Wellbeing Commission, 2022). One year on, at 30 June 2022, progress towards making these actions and seeing these changes has been limited. Our assessment is not about how well progress has been delivered or if progress is as fast as we would like it to be, but simply an assessment of what progress has occurred. We acknowledge that one year is a short period to fully implement or complete transformative change in the sector. However, the assessment of progress against steps in our Poutama[53] shows only investment in peer support services has moved past the 'activating' step to the point that discussion and planning are taking place.

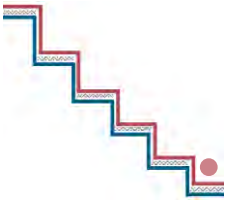
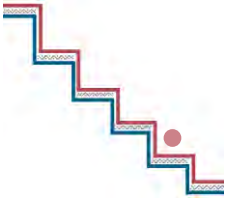
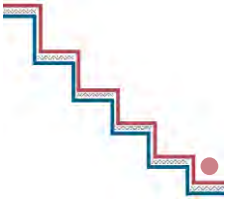
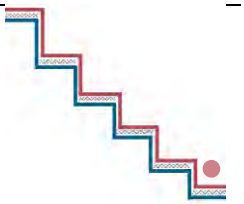
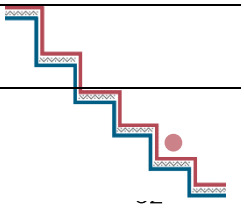
[53] Mā Te Rongo Ake: Through listening and hearing (Initial Mental Health and Wellbeing Commission, 2021) used a Poutama in assessing the Government's progress against the recommendations in He Ara Oranga. We have continued to use this Poutama (with minor refinements to the wording) as a guide to assess progress against our calls to action. For details, see Appendix 2.

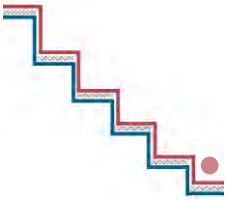
Progress on Te Huringa 2022 calls to action

Table 13

	Call to action	Our assessment
1	Prioritising and funding a range of holistic services and supports that reflect whānau, hapū, and iwi aspirations, and acknowledge whakapapa, mātauranga Māori healing and treatment options, and resources developed by Māori.	**Activating:** Funding for kaupapa Māori mental health and addiction services has increased by about $9 million in the last year (from $203 million in 2020/21 to $212 million in 2021/22).

2	Requiring that all mental health, addiction, and wellbeing services to be culturally, spiritually, relationally, and physically safe for Māori, and acknowledge wairuatanga as a key contributor to mental wellbeing.	**Potential:** There are no strengths-based indictors to show progress. The continuing high and inequitable rates of coercive practices for Māori indicate progress has not occurred.	
3	Investment in peer support services and workforce across all regions.	**Developing:** The investment in peer support services increased by 17 per cent ($6.65 million) from 2020/21 to 2021/22. The proportion of mental health and addiction funding invested in peer support services also increased to 2.4 per cent of mental health and addiction expenditure in 2021/22, from 2.2 per cent in 2020/21.	
4	Acute community-based alternatives for people experiencing distress.	**Activating:** Budget '22 funding announcement included a small investment in community-based crisis services.	
5	Investment in specialist services, including, but not limited to, specialist child and adolescent services, and support in home and community settings for people experiencing significant distress.	**Activating:** As above, discussion and planning informed the Budget '22 funding announcement, which included a small investment for specialist mental health and addiction services, including child and adolescent mental health and addiction services.	
6	A decrease in the use of compulsory treatment, the upholding of treatment decisions made by tāngata whaiora, and support given to tāngata whaiora to make decisions about treatment where needed.	**Potential:** The number and rate of people subject to compulsory treatment have increased. No data are collected about the use of advance directives and whether these are upheld or overridden when people access services	
7	New policy to inform mental health legislation co-designed with tāngata whaiora that does	Currently unable to assess as the new policy on the legislation replacing the Mental Health Act	

	not discriminate on the basis of 'mental disorder', so mental distress of any kind is not used as a basis for compulsory treatment.	has not been announced at the time of writing this report.	
8	An increase in treatment days involving whānau and family, and support and acknowledgment of whānau as "first responders" and important carers for tāngata whaiora.	**Potential:** The data on treatment days that involve family and whānau provide no evidence of an improvement.	
9	Strong leadership from the Government on the recommendation for a national conversation about risk in mental health treatment from He Ara Oranga, with lived experience leadership central in this work.	**Activating:** On 22 December 2022, Manatū Hauora published a discussion document it contracted from authors with a lived experience view.	
10	Positive risk-taking in practice that gives people freedom and supports their wellbeing and recovery.	**Potential:** The use of the Mental Health Act is an important indicator that risk-averse practices continue. We note that this does not indicate a lack of willingness to change but that the broader conditions may not enable changes in practice e.g. through a national conversation that includes participants like the Coroner and Health and Disability Commissioner.	
11	A review of the use of existing outcome tools to ensure they are relevant to tāngata whaiora and whānau, culturally appropriate, nationally consistent, and reliable.	**Potential:** No evidence suggests this has occurred, through either the Health Research Council funding or other mechanisms.	
12	A continued focus on the holistic health needs of tāngata whaiora, including targeted efforts to ensure tāngata whaiora have access to COVID-19 vaccinations, including boosters.	**Not rated:** Funding and local actions gave tāngata whaiora access to vaccinations, but little evidence is available to rate focus on holistic health needs beyond this.	
13	Additional supports that address the social and economic	**Activating:** While no widespread action has happened nationally,	

	determinants that impact on people experiencing distress and harm from substance use and gambling.	some planning and discussion have occurred. This work includes changing the framework used to guide Te Whatu Ora and increasing focus on public health and destigmatising campaigns.	
14	Strengthening the connection between inpatient and community care, and between specialist and primary care.	**Potential:** Indicators of connection between care settings such as transition plans, reviews, and follow-ups have remained stable.	

Ngā ngoikoretanga raraunga | Data gaps

In Te Huringa 2022, we advocated for addressing four critical data gaps (Mental Health and Wellbeing Commission, 2022). Unfortunately, one year on, very little, has changed across these data gaps and in some cases, the data gaps have gotten worse. For example, since 1 April 2023 there is no national survey of tāngata whaiora and whānau experience of mental health and addiction services.

The key data changes we want to see span the following five areas.

We need an urgent valuing of Te Ao Māori data collection

It is crucial to acknowledge and address the data gaps for Māori in the mental health and addiction system. This requires taking steps to improve data quality and representation, which would involve investment in data infrastructure, improving data collection processes, and working with community organisations to better understand the unique experiences of tāngata whaiora and whānau. It is important to incorporate culturally appropriate questions and kaupapa Māori methodologies into data collection to capture the true experiences of Māori in mental health and addiction services. By doing so, the system can develop more effective services and policies to improve outcomes by reducing disparities.

Additionally, it is important tāngata whaiora, whānau, and Māori communities lead in the process of improving data quality. Community engagement and participation can help in collecting data in a way that is culturally sensitive and appropriate, and in using the data to inform culturally appropriate supports and services. Involving Māori

in the process can also help build trust between health care providers and Māori communities, which is essential for improving outcomes.

We want to see government agencies collecting Te Ao Māori data across mental health and addiction service access, experience, and outcome measures. These agencies need to work with Māori to measure what is important for Māori whānau, and to collect these data appropriately.

Mental Health Act data need to be available within three months of financial year end

Considerable time lags in accessing data on coercive practices limit our ability to monitor this important topic. Each year, the Office of the Director of Mental Health and Addiction publishes a regulatory report that contains data on 'seclusion' and compulsory community treatment orders (among other topics). The most recent report was published on 30 September 2022, with data up to the end of 30 June 2021. This involved a 15-month time lag to publish these critical data (Ministry of Health, 2022b).[54] The reported data are often so out of date that they are no longer relevant to current practices and what needs to change.

We want to see services reporting accurate Mental Health Act data, in order that it is publicly reported within three months of financial year end.

We need outcome and experience tools that are nationally consistent, tāngata whaiora and whānau reported, and culturally appropriate

It is critical that our system measures whether:

- mental health and addiction services improve the lives of tāngata whaiora (outcome measures)
- people can use services that are safe, respectful, culturally appropriate, and responding to their needs and preferences (experience measures).

These measures need to be tāngata whaiora and whānau reported. That is, tāngata whaiora and whānau provide their perspective on experiences of using services and on their outcomes of care (Roe et al, 2022).

Despite the long journey Aotearoa has been on towards routine outcome measurement, the Health of the Nation Outcome Scale (HoNOS) and ADOM remain the only outcome tools with any national collection mandate (Smith and Baxendine, 2015). We continue to have no experience or mental wellbeing outcome data that are

[54] This reporting time lag is due to the time it takes to manually validate the data. Former DHBs regularly report data into the national collection, PRIMHD; however, data are often incomplete or inaccurate. The Office of the Director of Mental Health and Addiction Services has a lengthy manual validation process to correct these issues. Compliance on accurate and complete reporting continues to get worse.

nationally consistent, tāngata whaiora and whānau reported, and culturally appropriate.

For experience of service data, the data gap continues to get worse. Since Mārama Real-Time Feedback was discontinued from 1 April 2023, Aotearoa now has no national experience survey of any kind for mental health and addiction services.

For outcome measures, we have decided not to use HoNOS in this report because this is a clinically oriented assessment, which generally does not have support from lived experience communities. Alternative outcome measurement tools exist, such as Hua Oranga, a Māori-specific outcome measurement based on Te Whare Tapa Whā. However, use of this tool is not nationally collected.

We want to see health agencies collecting outcome and experience measurement data that are nationally consistent, tāngata whaiora and whānau reported, and culturally appropriate.

We continue to reinforce the He Ara Oranga recommendation for a comprehensive mental distress and substance use harm survey

The last comprehensive prevalence survey on mental health and substance use conducted in Aotearoa was Te Rau Hinengaro, published in 2006 using data collected in 2003/04 (Oakley Browne et al, 2006). Because these data are now significantly out of date, we can no longer rely on them for robust information on prevalence of mental distress and substance use harm and the level of need for services. The New Zealand Health Survey gives us part of the picture, such as trends in experiences of psychological distress, but it does not tell us about whether conditions met diagnostic criteria or about level of service need.

In 2018, He Ara Oranga recommended to 'undertake and regularly update a comprehensive mental health and addiction survey' (recommendation 11). The Government accepted this recommendation in principle. However, an in-depth epidemiological survey has yet to be implemented.

We want to see a comprehensive mental health and substance use prevalence survey.

We need better data about how people access and use primary care for mental health and substance use reasons

Significant data gaps limit our understanding of how people are using primary care services for mental health and substance use reasons. General practices provide most primary mental health services. Additional services are available from funded primary mental health initiatives and, since 2020, as part of the Access and Choice programme.

An estimated 30 per cent of general practice consults have a mental health component (Royal New Zealand College of General Practitioners, 2021). However, we have no nationally collected, NHI-linked data to understand the number of people involved and their reasons for visiting a general practice. Some service use data are available for primary mental health initiatives, but these are manually collected and not NHI-linked. As a result, it is not possible to integrate data from different sources and the data available give us limited insight into how priority population groups use these services. While the Access and Choice programme has made some improvements in the quality and availability of data, particularly for Integrated Primary Mental Health and Addiction Services, there continues to be no NHI-linked reporting system for Kaupapa Māori, Pacific, and Youth primary mental health and addiction services. For more information on this issue, see our separate report on the first three years of the Access and Choice programme (Te Hiringa Mahara, 2022a).

We want to see more detailed and consistent primary care data that are reported nationally to enable monitoring of tāngata whaiora service access, experience, and outcomes.

Many other data gaps also limit our ability to monitor mental health and addiction services. For more detail on our measure selection process and data gaps, see our data phase summary report (Te Hiringa Mahara, 2023a).

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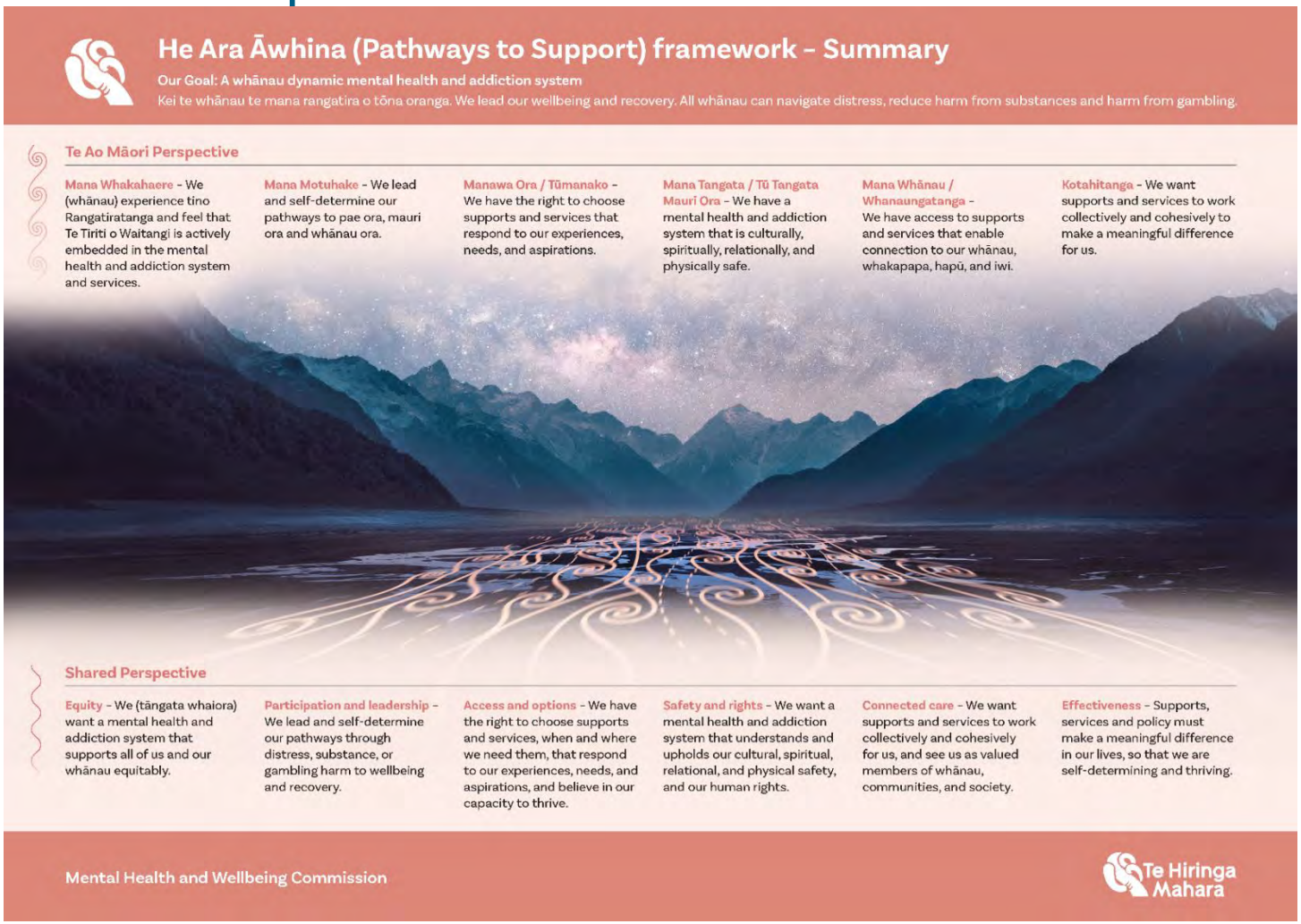
Appendix 1: He Ara Āwhina (Ngā ara Tautoko) te tarāwaho | He Ara Āwhina framework



A detailed version of He Ara Āwhina is available on our website as well as summary and detailed versions of the framework in te Reo.

Appendix 2: Tikanga mahi | Methodology

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

Measure set

This report uses 86 quantitative measures drawn from two sets:

1. **carried-over measures:** measures we used in our first monitoring report, Te Huringa 2022 (Mental Health and Wellbeing Commission, 2022), remapped to the framework He Ara Āwhina (with exception of HoNOS and did not attend (DNA) measures[55])
2. **additional existing measures:** measures we selected from existing sources to monitor against He Ara Āwhina.

The carried-over measures originally came from the former Mental Health Commissioner's monitoring reports and were re-mapped to the domains of He Ara Āwhina. About 56 measures were carried over.

We supplemented this measure set with other existing measures aligned to He Ara Āwhina. The framework He Ara Āwhina has a broad scope covering services and the wider system. Phase 1 of the measure development process focused on service data within Vote Health funded services currently available at a national level (rather than regionally specific measures). Specialist advice from a technical advisory network informed this phase. This work resulted in approximately 30 additional measures.

For more detail about this project on He Ara Āwhina methods and measures, see our separate report (Te Hiringa Mahara, 2023a).

Data requests

The 86 measures used in this report were sourced from 10 agencies: Manatū Hauora; Te Whatu Ora; Te Pou; Health Quality & Safety Commission; Whakarongorau; the Health and Disability Commissioner; Drug Foundation; dapaanz; the Social Wellbeing Agency, which supplied Integrated Data Infrastructure (IDI) data; and the Ministry of Justice. We requested data from the relevant agencies for the five-year period from 2017/18 to 2021/22 and, where possible, by detailed disaggregation of service type, ethnicity, and broad age groups.

[55] See 'Ngā ngoikoretanga raraunga | Data gaps' for our rationale for excluding HoNOS. The DNA measure was removed due to calculation issues.

We output Programme for the Integration of Mental Health Data (PRIMHD) for some measures. (PRIMHD is the national collection for specialist mental health and addiction services. We receive monthly PRIMHD extracts from Manatū Hauora.) Additionally, we drew on several published sources.

Data sense-making and sense-checking

Once agencies had supplied the requested data, we conducted data cleaning, checking, and collation. We analysed the data first on an individual measure basis, and then combined across measures to make sense of the data. When we had a draft story from our interpretation of the data, we ran a series of data sense-checking workshops with a range of experts from different agencies and roles. These workshops were an important part of the process to either validate our interpretation or provide feedback on how the data should be interpreted.

Following these data sense-checking workshops, we started to write this report. Our internal team, and our expert reviewers, Kerri Butler, Anthony Hill, Dr Margaret Aimer, and Sharon Shea, reviewed the draft report. For factual accuracy purposes, we also sent the draft report, or the relevant parts of it, to agencies that had provided a significant amount of the data.

Measure limitations

All data have their limitations. While we have undertaken a thorough quality assurance process to ensure the accuracy of data provided in this report, inherent limitations remain. The following data quality issues apply to these selected measures (in alphabetical order).

- **Access and Choice programme data:** Our separate report on the first three years of the programme (Te Hiringa Mahara, 2022a) notes the data quality issues with the Access and Choice programme services. While these issues are improving, an NHI-linked reporting system is not currently in place for the Kaupapa Māori, Pacific, and Youth primary mental health and addiction services. Earlier data for 2020/21 for the Integrated Primary Mental Health and Addiction services were incomplete, and Manatū Hauora provided estimated annualised access measures at the time.
- **Alcohol and Drug Outcome Measure (ADOM):** Practitioners must offer tāngata whaiora the opportunity to complete ADOM. It is intended that practitioners and tāngata whaiora will complete it in partnership and using a collaborative approach. While offering ADOM is mandated, some tāngata whaiora choose not to participate in the process. However, when they do complete ADOM, the scoring is reliable, as a number of research studies indicate (Deering et al, 2009; Jury and Smith, 2016).

Manatū Hauora has not set a compliance level for the collection of ADOM. Te Pou regularly publishes completion data for ADOM that Te Whatu Ora district services and NGOs have collected. Services vary considerably in their collection rates, but average completion rates are in the 30–35 per cent range for both Te Whatu Ora and NGOs. For this reason, the ADOM data may not be representative of all tāngata whaiora.

- **Complaints data:** Tāngata whaiora and whānau can send complaints about any health or disability service to the Health and Disability Commissioner. While this provides some measure of quality issues with services, the complaint process itself is often a last resort and different population groups do not use it equally. Māori and Pacific peoples, for example, are less likely to make complaints through this formal route. Any comparison of complaints data between groups needs to consider this limitation.
- **General Social Survey (GSS) and Te Kupenga:** Data from these surveys were linked to the PRIMHD national collection, via the IDI by the Social Wellbeing Agency.[56] Confidence intervals are wider for people who had a PRIMHD referral in the reference period. The 2021 GSS has a reduced sample size because data collection stopped during the survey period due to COVID-19 lockdowns. As a result, the data have wide confidence intervals, so caution is needed when interpreting differences in the data. (The online dashboard will provide confidence intervals for these survey estimates. This report only refers to statistically significant differences.)

  Non-response bias also affects all survey results. That is, people who respond to the survey may differ from non-responding people. The Social Wellbeing Agency estimates that non-response bias for tāngata whaiora is particularly high, and this will impact the accuracy of these measures (but it is not possible to quantify the extent of this impact).
- **Mārama Real-Time Feedback:** As this survey was discontinued on 1 April 2023, 2021/22 is the last year when we can monitor these measures. In 2021/22, a total of 6,445 tāngata whaiora and whānau responded to Mārama Real-Time Feedback, which was a similar number to previous years. Most services that were using Mārama only discontinued their use when the service was finished on 1 April 2023. Mārama was a voluntary measure for tāngata whaiora and

[56] **IDI disclaimer:** These results are not official statistics. They have been created for research purposes from the IDI, which Stats NZ carefully manages. For more information about the IDI, please visit www.stats.govt.nz/integrated-data/. Access to the data used in this study was provided by Stats NZ under conditions designed to give effect to the security and confidentiality provisions of the Data and Statistics Act 2022. The results presented in this study are the work of the author, not Stats NZ or individual data suppliers.

whānau to complete, and some services decided not to use Márama as their feedback mechanism.

- **Medication data:** Te Whatu Ora defined and supplied data on initial dispensings of mental health medications. The data include only publicly funded medications that are the initial dispensing in a prescription, not repeat dispensings. Antipsychotic and antidepressant medicines can be used for several indications, including indications outside of mental health. For example, antipsychotics are frequently used in palliative care and in older people with dementia for behavioural management, and are often used for sleep. Similarly, some of the antidepressants are used frequently for pain management, for sleep, for nocturnal enuresis in children, and for smoking cessation. Any differences in prescribing practices will affect the comparability of these data over time.
- **Primary mental health initiatives data:** Data are collected manually from former DHBs and are not NHI-linked. The calculations for the number of people who access primary mental health initiative services are the sum of people seen in each quarter and the sum of people seen across the DHBs, rather than a unique people count. People seen in multiple quarters or by multiple DHBs will be counted more than once.
- **PRIMHD:** Responsibility for this national collection now sits with Te Whatu Ora. Te Whatu Ora services (former DHBs) and NGOs providing specialist mental health and addiction services are mandated to report to PRIMHD (Ministry of Health—Manatū Hauora). For more information, see Manatū Hauora (2023).

  Some organisations have breaks in reporting and/or incomplete data in PRIMHD for some time periods. PRIMHD is a living data collection, which continues to be revised and updated as data reporting processes are improved. For this reason, previously published data may be liable to amendments, and data will differ based on the PRIMHD extract date.

  There are known data quality issues with PRIMHD reporting in the last year that this report covers, such as the May 2021 cyber-attack, which impacted Waikato data. Analysis has been undertaken to confirm overall service use patterns remain even after removing Waikato DHB.
- **Supplementary Consumer Record (SCR)**: The SCR is collected as part of PRIMHD. It includes data on accommodation status, employment status, education and training status, and transition plans. This has been a mandatory collection for all referrals since July 2016. There are some exceptions including family and whānau supported by services, telehealth, consult liaison and respite services, and those with brief services (one or two face-to-face activities). However, compliance rates are low and impact the accuracy and

completeness of these measures. Data for 2021/22 show that 33 per cent of people had a SCR recorded for one or more of their referrals in the reference year. For more information, see Te Pou (2019).

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

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

  The estimated data on the former DHB workforce are based on information from the Health Workforce Information Programme data set and mental health and addiction expenditure. Workforce vacancy rates are estimated from available information across all Te Whatu Ora services as specific service vacancies are not identifiable for most occupation groups. Vacancy rates for psychiatrists and addiction practitioners are based on all reported FTEs vacant as most of these will be in mental health and addiction services. Vacancies for consumer and whānau advisors were provided by relevant national networks. Te Pou estimates that this method likely under-reports vacancy rates specific to mental health and addiction services.

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

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

Poutama for assessing progress against 2022 calls to action

The Initial Mental Health and Wellbeing Commission co-designed a Poutama, a type of rubric, for assessing the Government's response to He Ara Oranga recommendations. The Initial Mental Health and Wellbeing Commission (Initial Commission) used this tool in its Mā Te Rongo Ake: Through listening and hearing

report (Mā Te Rongo Ake), which details how the Poutama was developed and used (Initial Mental Health and Wellbeing Commission, 2021, p. 133).

This Poutama provides a consistent and transparent way of assessing progress. The intent of the Poutama in Mā Te Rongo Ake was to 'reflect a journey towards system transformation rather than a judgement of outcomes at this initial stage of the journey'. The Initial Commission received positive feedback that the rubric provided an easier way for people to understand our assessment of progress.

We adapted the Poutama for use in this mahi to assess the calls to action we made in our 2022 Te Huringa report to show what has changed one year on (Mental Health and Wellbeing Commission, 2022). We made some minor refinements to the wording in the Poutama to reflect the different focus of its application. Further, we greyed out the highest step of 'Thriving together', while keeping the Poutama intact, because the Te Huringa reports are about monitoring mental health and addiction services, not linked to wellbeing benefits.

Evidence to inform assessment against each call to action was sourced from: quantitative data included in Te Huringa Tuarua monitoring, publicly available data, documents, and announcements. It was supplemented with two brief interviews, which provided addiction system knowledge and specialist clinical mental health knowledge that was useful in making an assessment where there were gaps in other evidence available. The Poutama was then collectively applied to our last year's calls to action by experts from within Te Hiringa Mahara, with strong Māori and lived experience perspectives. This involved individual assessments followed by a hui to come to a collective consensus on the final assessment.

Rārangi kupu | Glossary

Addiction services	Services that exist to respond to the experiences, needs, and aspirations of tāngata whaiora and whānau who experience harm from substances or substance addiction. Gambling harm services are out of scope for this report. In this report we use the term 'addiction' when it relates to services. However, we use the term 'substance use harm' when it relates to people.
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.
Measure	A topic of data. For example, 'workforce vacancy rates'. We use the term 'measures' when it relates to people who use services. In our other reports, we use the term 'indicators' where it relates to whole populations (consistent with Results Based Accountability terminology).
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.
Mental health services	Services that exist to respond to the experiences, needs, and aspirations of tāngata whaiora and whānau who experience distress.
Solitary confinement ('seclusion')	As defined in Ngā Paerewa, the 2021 Health and Disability Services Standard, 'seclusion' is 'a type of restraint where a person is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit' (Standards New Zealand, 2021, p. 10). In this report we use the term 'seclusion' when it relates to the Mental Health Act data. However, in all other places we use the term 'solitary confinement' in place of or alongside 'seclusion' to recognise

	people's lived experience of this practice, which is often traumatising and harmful. Where we do use 'seclusion', we use quote marks around the term to indicate this is not our preferred language informed by lived experience.
Specialist services	Specialist mental health and addiction services are also known as secondary care services. They are publicly funded services provided by former DHBs or NGOs. Specialist services include a range of services across inpatient and community settings. Most specialist services are community based, such as adult community, rehabilitation, alcohol and drug, and other specialty services.
Tāngata whaiora	Tāngata whaiora can be 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.
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. For this reason, we have used 'whānau' in this report to also refer to family.

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

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