Te Huringa: Change and Transformation

Mental Health Service and Addiction Service Monitoring Report 2022

Mental Health and Wellbeing Commission

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A report issued by the New Zealand Mental Health and Wellbeing Commission

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: https://www.mhwc.govt.nz/

New Zealand Mental Health and Wellbeing Commission (2022). Te Huringa: Change and Transformation. Mental Health Service and Addiction Service Monitoring Report 2022. Wellington: New Zealand.

The mission statement in the Commission's Strategy is "clearing pathways to wellbeing for all." **Te Huringa** acknowledges the current performance of mental health and addictions services: what is working well, what is not, and how this has changed over time. **Te Huringa** also recognises we must create the space to welcome change and transformation of the mental health and addiction system. Transforming the ways people experience support can only be realised when the voices of Māori and people with lived experience of distress and addiction, substance or gambling harm are prioritised.

He whakatakī
Foreword

The Mental Health and Wellbeing Commission's purpose is to contribute to better and more equitable mental health and wellbeing outcomes. We were formed in response to the Government Inquiry – **He Ara Oranga** – with a mandate to improve the effectiveness of mental health services and addiction services and ensure they are targeted towards the areas of greatest need. We are the kaitiaki or guardians of mental health and addiction.

One way we do this is to independently monitor and report on mental health and addiction services. Monitoring is an act of transparency where all people with an interest can see and understand the situation for themselves and identify success and actions for improvement. The intention is not to assign blame or fault, but to identify what needs to be done to accelerate progress.

He Ara Oranga concluded that nothing short of service transformation was necessary to enhance the performance of the sector. This monitoring report is an analysis of the elements of transformation and service delivery processes, to answer the question: how are we doing?

We recognise success will come from a collaborative effort. For that reason, this report is intended for diverse audiences including those with lived experience, decision-makers in government, and practitioners throughout the mental health and addiction system.

In this report we examine the changes we believe are necessary and measure progress on them. For example, we would like to see a decrease in the use of compulsory care and coercive treatment. We would also like to see greater choice around acute and crisis care and expanded use of peer services and community providers who are clearly proving their worth in the delivery of services.

We assess the effectiveness of the services and note what is currently working well, what is not working well, and how this has changed in the last year. Our findings are consistent with much of our other work to date, such as the need to prioritise the development of kaupapa Māori, Pacific, and Youth services and workforce.

Transforming something as big as mental health and addiction services takes time. It also takes conviction and determination. We are concerned that the focus and leadership needed to transform the mental health and addiction system into one that upholds Te Tiriti o Waitangi, respects human rights, and works for all people may get lost in both the COVID-19 response and the broader health reforms. We urge the Government, particularly at this time of transition to Health NZ and the Māori Health Authority, to make sure transforming the mental health and addiction system remains a priority.

Finally, while there is much to do, we acknowledge some examples of genuine progress. There is evidence of growing collaboration between public health services and other community-based organisations. We recognise the enormous effort that is going on to effect changes like this, which we believe will ultimately pay huge dividends in service improvements.

Hayden Wano
Board Chair, Mental Health
and Wellbeing Commision

Ngā Ihirangi
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He Mihi
Acknowledgements

This report was prepared by the Mental Health and Wellbeing Commission using quantitative data provided by the Ministry of Health, Te Pou, the Health Quality & Safety Commission, Te Hiringa Hauora, the Office of the Health and Disability Commissioner, Whakarongorau, and the NZ Drug Foundation.

We are grateful to the exemplar organisations and people who shared their stories with us: Asian Family Services, dapaanz, DRIVE Consumer Direction Counties Manukau, Recovery College NZ, Emerge Aotearoa, the Equally Well collaborative backbone team, Le Va, Ngā Kete Mātauranga Pounamu, Balance Aotearoa, Pathways, Stronger Waitaki Community Coalition, Te Kupenga Net Trust, Te Whare Wānanga o Awanuiārangi, and Zero seclusion – Safety and dignity for all. Thank you – your work is an inspiration to us all.

We acknowledge tāngata whaiora whose experience this report aims to illustrate. We have drawn on data and stories about people's current experiences and will use these to advocate for a better mental health and addiction system. Such a system should meet everyone's needs, particularly those of Māori, and of the communities He Ara Oranga identified as not being served equitably by the current mental health and addiction system. These communities include Pacific people, former refugees and migrants, rainbow communities, trans people, people with variations of sex characteristics, disabled people, rural communities, veterans, prisoners, older people, young people, children in state care, and children experiencing adverse events.

We acknowledge the former Mental Health Commissioner, Kevin Allan, and the Office of the Health and Disability Commissioner who, alongside people with lived experience and the mental health and addiction sector, developed the quality framework on which this report is based.

We thank all those who participated in the co-define phase of the He Ara Āwhina (Pathways to Support) Framework. Their feedback helped us adapt the service quality framework used in this report.

Finally, we are grateful to those who peer reviewed the quality domains used in this report, participated in workshops, and reviewed the draft report (or a combination of these) – Kerri Butler, Johnnie Pōtiki, Sharon Shea, Dr Julie Wharewera-Mika, Pamela Todd, Sandra Baxendine and Mark Smith (Te Pou), Jordan Waiti and Michael Naera (Te Hiringa Hauora), Sal Faid (lived experience), Whāraurau, and the Alcohol and Other Drug Consumer Leadership Group of Te Pou. We also acknowledge our translator Tamahou McGarvey, and Tātou, this report's designers.

Whakarāpopoto whānui
Overall summary

The transformation of the mental health and addiction system must remain a priority for Government

He Ara Oranga: Government Inquiry into mental health and addiction (He Ara Oranga) envisioned a transformed mental health and addiction system that puts people's aspirations first. It proposed that this system should be holistic and focused on what everyone needs to achieve good mental wellbeing. It imagined that people who are experiencing mental distress or addiction have the resilience, tools, and support they need, and a greater choice of supports.

The Government has made a promising start to addressing the recommendations made in **He Ara Oranga**, with the cross-agency $1.9 billion package for mental wellbeing in the 2019 Wellbeing Budget. We commend this investment, particularly the addition of much needed primary and community services, but more is needed to address the pressure on specialist services. We have seen little change in wait times, with continued concerning wait times for young people. Specialist services continue to feel pressured in meeting the

volume of need and in recruiting and retaining the workforce required for current models of care.

Transformation is a complex process of change that includes strong and committed leadership at the highest level. The will for improvement and good intent is not enough – transformation requires strong leadership and a well-managed plan to execute change. There is an opportunity for the health reforms, and the newly-created Health NZ and the Māori Health Authority to enhance the focus on mental health and wellbeing, embed strong leadership in their operating models, and accelerate progress toward realising the vision of **He Ara Oranga**.

Achieving equity for Māori requires Government, service commissioners, and providers to uphold Te Tiriti o Waitangi obligations

Māori are not well served by the mental health and addiction system [1], and there is a persistently higher application of the Mental Health Act to tāngata whaiora [1] Māori. When accessing specialist services, Māori

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[1] Tāngata whaiora is translated as service users / consumers / people seeking wellness. Tāngata whaiora in this report includes individuals and their whānau, hapū, iwi, and communities who experience mental distress and harm from substance use or gambling (or a combination of these) and is defined by the individual. This recognises people as both individuals and a collective.

disproportionately experience higher rates of coercive practices that are restrictive and can cause harm – including community treatment orders and solitary confinement (seclusion).[2]

The Waitangi Tribunal Hauora Report found inequitable outcomes experienced by Māori are due to colonisation and systemic racism, and reflect a persistent disregard of Te Tiriti o Waitangi [2]. Te Tiriti o Waitangi must be explicit and central to mental health and addiction system transformation.

The changes we want to see include:

- the prioritisation of funding for a range of holistic services and supports that reflect whānau, hapū, and iwi aspirations, and acknowledge the interconnection of whakapapa, mātauranga Māori healing and treatment options, and resources developed by Māori

- requiring all mental health, addiction, and wellbeing services are culturally, spiritually, and physically safe for Māori, and acknowledge wairuatanga as a key contributor to mental wellbeing.

Further investment and development is required for peer services, youth services, and other community-based specialist services

Tāngata whaiora have told us they want services to offer genuine choice, including more accessible kaupapa Māori and peer-led options and holistic supports. **He Ara Oranga** found there was an urgent need to provide better access to, and more choice in, mental health services and addiction services – particularly for people with mild to moderate, and moderate to severe, mental health and addiction needs. As noted in our report on the Access and Choice programme, more investment is needed to fully achieve these recommendations in **He Ara Oranga**.

Our measures show use of telehealth and digital supports is increasing as they become more available, and access to primary mental health services (excluding the Access and Choice programme) has increased, particularly for young people. However, access to specialist mental health services and addiction services has not changed over the past five years. Wait times for young people to access specialist mental health services continue to be well below target and wait times for addiction services have increased.

Young people under 20 have had increased access to the DHB funded primary mental health services over the past five years, and there has been large increases in dispensings for antidepressant and antipsychotic medications for this group. Combined with measures showing young people have had

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[2] We advocate using the term solitary confinement in place of 'seclusion' because it more accurately reflects what people experience when they are locked alone into spaces they cannot leave unless let out by another person. This recommendation is in keeping with the practice of the UN Special Rapporteur on Torture, and Other Cruel, Inhuman, or Degrading Treatment or Punishment.

consistently longer wait times for DHB mental health services, these findings reinforce the need to prioritise the rollout of other support options for youth, including peer support services and youth Access and Choice services – a conclusion we emphasised in our recent report on the Access and Choice programme [3].

The changes we want to see include:

- investment in peer support services and workforce across all regions

- investment in services, including, but not limited to, specialist child and adolescent services, and other community-based specialist services.

Services must maximise tāngata whaiora autonomy and uphold rights

Mental health and addiction services must maximise tāngata whaiora autonomy and protect the human rights of tāngata whaiora on an equal basis with other people. The number of community treatment orders is increasing proportionately with specialist mental health service use. While most tāngata whaiora have transition plans when discharged from an inpatient service, a quarter do not, and treatment days involving family and whānau are low.

We call on the Government to be bold in its work to repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992. Restrictive practices should be minimised with a view to elimination. Tāngata whaiora must have autonomy to make decisions about their care and have

these decisions upheld, and have support to make decisions where their decision-making skills may be impaired.

The changes we want to see include:

- 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

- new policy to inform mental health legislation, co-designed with tāngata whaiora, that does not discriminate on the basis of 'mental disorder', so mental distress of any kind is not used as a basis for compulsory treatment

- an increase in treatment days involving family and whānau, and support and acknowledgment of whānau as "first responders" and important carers for tāngata whaiora.

Services must be supported to develop positive risk-taking approaches

Despite calls in 2018 from **He Ara Oranga** to minimise coercive treatment, our measures show an overall increase in the use of solitary confinement.[3] However, some DHBs have made significant progress in reducing solitary confinement, with some eliminating it altogether for a period of time. Other DHBs are starting to see some progress, and a few have made little progress or none at all. We must support DHBs to eliminate solitary confinement and overcome any barriers that are hindering this from happening.

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[3] More recent data from the Health Quality & Safety Commission indicates that solitary confinement rates (events for every 1000 people in inpatient mental health units) appear to have decreased in the first half of 2021.

He Ara Oranga called for a national discussion to reconsider beliefs, evidence, and attitudes about mental health and risk as well as encouraging greater community acceptance and support of people in distress. While there have been discussions across the sector about reframing risk and some efforts to change risk-based practice, a national and public discussion has not occurred. This has, therefore, not led to changes in clinical practice.

The changes we want to see include:

- strong leadership from the Government on the He Ara Oranga recommendation for a national discussion to reconsider beliefs, evidence, and attitudes about mental health and risk, with lived experience leadership central in this work

- positive risk-taking approaches that give tāngata whaiora freedom and supports their wellbeing and recovery

- community-based acute alternatives for people experiencing significant distress.

Measures of service effectiveness should reflect the things most important to tāngata whaiora

Our measures show tāngata whaiora tend to show improvement (rated by their clinician) when using mental health services and recovery (rated by themselves) when using addiction services. While measures of clinical outcomes are generally used to measure how effective a service is (for example, a decrease in the severity of symptoms), we want to see measures of effectiveness, developed with people with lived experience, that measure the things most important to tāngata whaiora.

The changes we want to see include:

- 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

- a continued focus of the holistic health needs of tāngata whaiora, including targeted efforts to ensure tāngata whaiora have access to COVID-19 vaccinations, including boosters.

Improvements are needed to ensure people have access to connected supports

He Ara Oranga noted the mental health and addiction system does not have a full continuum of care and supports, meaning key components of the system are missing. A lot of the pressure falls on the acute end of the system, where people stay longer in inpatient services because there are insufficient community supports and services.

Our measures show additional supports are needed to assist the transition from inpatient to community settings. There has been no change in the average length of people's stay in mental health inpatient units, and 20 % of people are not followed up after discharge, with 1 in 6 readmitted to hospital within 28 days of discharge.

The changes we want to see include:

- additional supports that address the social and economic determinants that impact on people experiencing distress and harm from substance use and gambling

- strengthening the connections between inpatient and community care, and between specialist and primary care.

Kupu whakataki
Introduction

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

The Mental Health and Wellbeing Commission (the Commission) was set up as one of the recommendations of **He Ara Oranga** [1]. One of the Commission's functions is to monitor and report on mental health services and addiction services, and advocate for improvements to those services. This function was transferred to the Commission on 9 February 2021 by the Mental Health and Wellbeing Commission Act 2020.

A new framework, He Ara Āwhina, will be used for future monitoring and reporting

The Initial Mental Health and Wellbeing Commission was told by its priority groups that our new monitoring framework, which is called **He Ara Āwhina (Pathways to Support)**, needs to: prioritise the voices of Māori, people with lived experience of mental distress, and substance or gambling harm, reflect the different ways people experience support (instead of just focusing on services), and include a vision for what a good system looks like.

Expanding our monitoring focus to the mental health and addiction system, rather than just services, will also enable us to shine the light on issues people with lived experience of addiction and gambling harm have told us are important. These issues include prejudice and discrimination, the regulation of alcohol and other drugs, and gambling environments.

The Commission will use **He Ara Āwhina** to monitor the mental health and addiction system (including services) from 2023. We are seeking public feedback on the draft framework in March and April 2022. We will then incorporate feedback and publish **He Ara Āwhina** in June 2022.

This is a transitional report on the performance of mental health and addiction services

This report shows the performance of mental health services and addiction services between 2016 / 17 and 2020 / 21. The report bridges the gap between the former Mental Health Commissioner's 2020 reporting on mental health services and addiction services [4] and our new framework. This report uses an adapted version of the former Mental Health Commissioner's monitoring framework and includes the same measures (see 'Tikanga mahi / Methodology' on page 55). We have

continued the use of the same measures in order to provide continuity of reporting while new measures are developed for **He Ara Āwhina**. All of the data from these measures is included in 'Ngā inega / Measures' on page 57.

We use quantitative data and case studies to assess the performance of publicly funded mental health services and addiction services

This report includes quantitative measures and examples of transformative practice to show what is working, what is not working, and how this has changed over time. We have only reported on national data, although, we know there are regional variations in performance with the diversity of services across Aotearoa. Future reporting through **He Ara Āwhina** will include the experiences of tāngata whaiora, providers, and communities across Aotearoa New Zealand, particularly those who experience higher levels of mental health distress and substance use and gambling harm.

We describe some innovative services that support tāngata whaiora to thrive, including case studies of transformative practices that are well aligned with the vision of **He Ara Oranga**. We acknowledge these exemplars only profile some of the many excellent initiatives and services being developed across Aotearoa.

We use six domains of quality to assess service performance

The Service Quality Framework we have used in this report includes six domains of service quality (Figure 1):

1. Equity (which covers all domains)
2. Access and options
3. Partnership and leadership
4. Safety
5. Effectiveness
6. Connected care.

This report summarises key findings that signal how services are performing under each of the six domains. The six domains are designed to be read together. Complete data tables and references for all measures can be found in 'Ngā inega / Measures' on page 57.

Access and options
Tāngata whaiora get support for their experiences, needs, and aspirations

Connected care
Services work together for tāngata whaiora

Equity
Services work for all tāngata whaiora

Participation and leadership
Tāngata whaiora are leaders in their care

Effectiveness
Support makes a difference for tāngata whaiora

Safety and rights
Tāngata whaiora are safe in services

Figure 1: Service quality framework

Interpretation
Understanding the visual elements

Equity

The tāniko shown here is a representation of each triangle being different, but all connected at one point.

Access and options

This waharoa acts as the gateway and access to the marae. This suggests the point is being open and welcoming to all.

Participation and leadership

Generally made from flax, the whāriki is a woven mat used to tell stories, share dialogue, sing waiata, and the passing of ones knowledge.

Effectiveness

The poutama represents the journey from one place to another. This gives a feeling of progression, attainment, and growth.

Safety

The korowai representing a cloak that covers all groups of people and ultimately creates a place of safety and security.

Connected care

Native to Aotearoa, the pikoiko is a fern, which as it matures, grows continuous stems of pikopiko into itself. It represents the caring aspect for others.

This report covers mental health services and addiction services funded by the public health system

This report covers specialist mental health services, addiction services, and some primary mental health services and addiction services publicly funded under Vote Health (the main source of funding for New Zealand's Health and Disability System):

- **Specialist mental health services** and addiction services are funded by DHBs or the Ministry of Health, and are provided by DHBs or NGOs. Specialist services can include acute inpatient services, community-based services, talking therapies, and forensic services. Most specialist services are delivered in community settings rather than inpatient or forensic settings.

- **Primary mental health services** includes services provided in a general practice that come under the devolved primary mental health funding that DHBs report 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. These are estimates only as the unique number of clients seen in

Aotearoa is not reported. Clients seen by more than one DHB, or have had an appointment in more than one quarter of the year, or have been seen by more than one service are counted more than once. An estimated 152,993 people (around 3 % of the population) accessed primary mental health services obtained in general practice in 2020 / 21.

This report does not cover:

- other primary health services that address mental health or alcohol and other drug or gambling needs. It is estimated that 30 % of General Practitioner consults have a mental health component [5]

- the access data for the new Integrated Primary Mental Health and Addiction Services and other Access and Choice services – there is no accurate data for the total number of people using the Access and Choice programme for the time period covered in this report. See our report on the Access and Choice programme for an update on the implementation of the Access and Choice programme

- services publicly funded outside of Vote Health, such as services from Department of Corrections, Accident Compensation Corporation (ACC), Ministry of Education, Ministry of Social Development, and Oranga Tamariki.

191,053

people (or 3.7 % of the population) accessed specialist mental health services or addiction services in 2020 / 21

Acute, inpatient, and residential services examples:

	Tāngata whaiora	Bed nights
Acute inpatient care	9,392	238,523
Rehabilitation or residential care	3,046	495,707
Crisis respite care	3,927	36,365
Forensic secure inpatient	520	98,374
Substance use medical withdrawal management (detoxification)	1,746	15,861
Substance use residential treatment	1,707	105,842

Self-care and digital services

In 2020 / 21 there were:

National telehealth mental health and addiction services
110,701 contacts

Depression.org.nz
515,036 visitors

Drughelp.org.nz
27,121 visitors

The Lowdown
126,377 visitors

Primary healthcare services

152,993

people accessed primary mental health services in 2020 / 21. These primarily consist of funded extended GP consultation and talk therapies

$63m

was contracted in 2020 / 21 to increase access to, and choice of, primary mental health and addiction support

$1.82b

was spent in 2020 / 21 on mental health and addiction services by the Ministry of Health and DHBs

Mental health services and addiction community services delivered (total treatment days) in 2020 / 21

1,441,938 Individual treatment sessions

515,087 Coordination of care

381,760 Contacts with family / whānau

496,718 Community support

167,800 Group programmes

121,137 Crisis attendances

92,454 Day programmes

63,602 Māori specific interventions

61,133 Peer support contacts

38,619 Opioid substitution treatment service

2,218 Pacific specific interventions
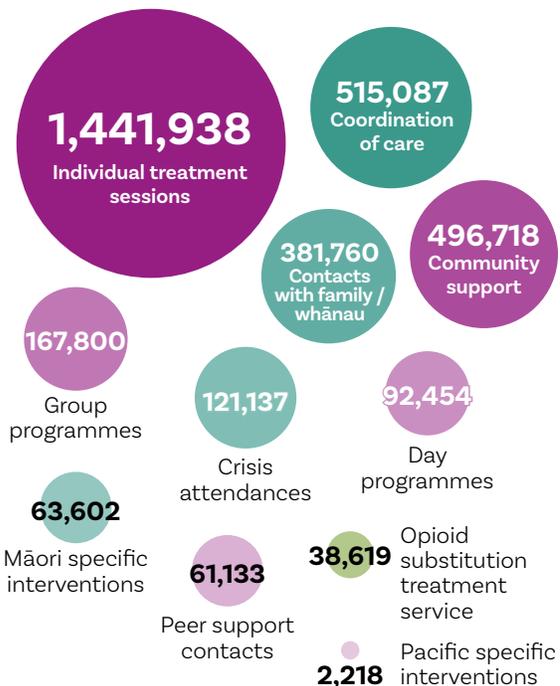
Ngā kimihanga
Findings

The 'Ngā tāpiritanga / Appendix' on page 55 contains the methodology, all measures, and data sources to support this report. This section contains key findings under each domain.

Transforming the mental health and addiction system must remain a priority for Government

He Ara Oranga envisioned a transformed mental health and addiction system that puts the aspirations of people first. It proposed that this system should be holistic and focused on what everyone needs to achieve good mental wellbeing. It imagined people who are experiencing mental distress or addiction have the resilience, tools, and support they need, and a greater choice of supports.

The Government formally responded to the **He Ara Oranga** recommendations in May 2019. Some of the Government's actions to **He Ara Oranga**'s recommendations were in the early stages of development when the Initial Mental Health and Wellbeing Commission reported on progress in **Mā Te Rongo Ake: Through listening and hearing** [6]. Nonetheless, the Commission has high expectations that there will be continual progress on the recommendations and ongoing improvements in service performance.

Transformation is a complex process of change that includes strong and committed leadership at the highest level. The will for improvement and good intent is not enough – transformation requires strong leadership and a well-managed plan to execute change. There is an opportunity for the health reforms, and the newly created Health NZ and the Māori Health Authority, to enhance the focus on mental health and wellbeing, embed strong leadership in their operating models, and accelerate progress toward realising the vision of **He Ara Oranga**.

Despite significant investment in the mental health and addiction system, more is needed to address the pressure on specialist services

The Government has made a promising start to addressing the recommendations made in **He Ara Oranga**, with the cross-agency $1.9 billion package for mental wellbeing in the 2019 Wellbeing Budget. This significant investment includes $883 million over four years from 2019 / 20 to 2022 / 23 for mental health services and addiction services, highlighting the need to monitor whether the performance of services and the system is improving in line with increased spending.

It will take some time for this investment to translate into services in the community. There is an understandable lag between the new services being commissioned and getting up and running, and challenges in recruiting and retaining the workforce required impacts this.

As the Access and Choice programme is rolled out across the country, the relevant data will improve, enabling new methods and measures that better monitor the impact of the investment across the system.

We expect that, in time, the investment in the Access and Choice programme will provide early intervention and support for mental health and addiction needs – with downstream benefits for specialist services that continue to feel pressured in meeting the volume of need. We support the investment in community based early intervention and support. We also want to see improvements in the performance of specialist services and acknowledge that this will require investment in this part of the mental health and addiction system and should be informed by updated prevalence data.

It is important to note that the measures used in this report only provide a partial view of this new investment. This report's measures are largely related to services in which there has not been significant recent investment, particularly specialist mental health services.

Although not a complete picture, investment across service types is shown in the 'access and options' measures on page 58.

Current prevalence data is required to understand unmet need and service pressures

To assess whether services are responsive to population health needs, we need to understand mental health and addiction challenges and how they are changing over time. Our most recent comprehensive data on prevalence of mental distress and addiction is from **Te Rau Hinengaro: The New Zealand Mental Health Survey (Te Rau Hinengaro)** [7], published in 2006 and based on data collected in 2003 and 2004. The age of this information makes it difficult to know whether the number of people currently accessing services is an accurate reflection of how many people need support from services. Furthermore, **Te Rau Hinengaro** excluded children aged under 16 – a priority group experiencing increasing mental distress.

Current prevalence data alone won't tell us the about unmet need for mental health services and addiction services. Whether or not someone needs support from a service depends on many things, including whānau support and other natural or community supports. Aotearoa needs an updated model of supports (including services) that can be used to estimate demand.

Equity
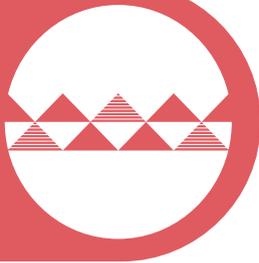
Equity:

Achieving equity for Māori requires Government, service commissioners, and providers to uphold Te Tiriti o Waitangi obligations

Vision: Services work for all tāngata whaiora

Upholding Te Tiriti o Waitangi is the key to ensuring an equitable mental health and addiction system for Māori. The Commission recognises Te Tiriti o Waitangi as the legal instrument that allows Government to exercise kāwanatanga in Aotearoa. We actively support and advocate for more kaupapa Māori choices for whānau accessing mental health and addiction services, and support iwi approaches to service delivery based on their own mātauranga, pūkenga, and tikanga. We expect all mental health and addiction services should be culturally competent.

The essence of Te Ao Māori is relationships, not just between people – whānau, hapū, iwi – but also between the spiritual world and the natural world. These relationships need to be acknowledged and respected in the way services and professionals interact with tāngata whaiora to foster their unique potential and inherent capabilities as Māori (Mana Whakahaere) and to achieve equitable wellbeing outcomes.

The changes we want to see

Achieving equity for Māori as tāngata whenua requires Government, service commissioners, and providers to uphold Te Tiriti o Waitangi obligations. This should include:

- the prioritisation of funding for a range of holistic supports that reflect whānau, hapū, and iwi aspirations, and acknowledge the interconnection of whakapapa, including mātauranga Māori healing and treatment options, and resources developed by Māori

- requiring that all mental health, addiction, and wellbeing services are culturally, spiritually, and physically safe for Māori, and acknowledge wairuatanga as a key contributor to mental wellbeing.

Services do not work as well for Māori, with restrictive practices continuing to cause disproportionate harm

Māori mental health and addiction needs are not being met early enough

While Māori make up 17 % of people in Aotearoa, around 24 % of those who have experienced high levels of psychological distress in the past month are Māori [8]. However, Māori are not accessing primary mental health and addiction services in proportion to this increased distress, with Māori making up only 17 % of the people who access primary services. Given Māori access specialist mental health and addiction services at higher rates than primary services (6 % of Māori access specialist services, compared with approximately 3 % accessing funded mental health services through general practice),[4] it's likely the needs of Māori are not being met early enough.

Māori are also less likely to be prescribed antidepressants compared with non-Māori [9]. While it's not clear if this is because clinicians are less likely to prescribe to Māori, or Māori are less likely to want pharmacological treatment, the Health Quality & Safety Commission concludes that lower use of medication for Māori is not being compensated for with non-medical treatment alternatives [9].

Māori are disproportionally experiencing compulsory treatment and solitary confinement

In 2020, Māori made up 39 % of people subject to a community treatment order, up from 35 % in 2016. Māori were 4.1 times more likely than non-Māori (excluding Pacific peoples) to be subject to a community treatment order. Māori were also 3.5 times more likely to be subject to an inpatient treatment order [10] [11].

Furthermore, Māori were 5.4 times more likely to be subjected to solitary confinement (seclusion – where a person in an inpatient unit is restricted, alone, in an area or room they cannot leave) in adult inpatient services than non-Māori [10] [11]. The total number of Māori who experience solitary confinement within inpatient units increased between 2016 and 2020; 48% of people who experienced solitary confinement in 2020 were Māori, up from 44% in 2016.

In 2020:

48%

of people who experienced solitary confinement were Māori, up from 44 % in 2016.

Source: Ministry of Health

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[4] This figure excludes general primary health services that address mental health or alcohol and other drug or gambling needs, and Access and Choice services.

While there has also been an increase in Māori admitted to inpatient units over this time, the proportion of Māori experiencing solitary confinement is much higher than the proportion of Māori in inpatient units (34 % in 2020).[5] This means Māori had a higher rate of solitary confinement in 2020, not just a higher percentage of the total.

Encouragingly, data from the first half of 2021 show solitary confinement rates (the number of people confined for every 1000 people admitted to inpatient mental health facilities) has decreased [12], and this decline seems to be happening faster for Māori than people who are not Māori or Pacific peoples.

Building the Māori and Pacific mental health and addiction workforce is critical to realising equity

To ensure equity for everyone using mental health services and addiction services, it's critical that we have co-designed services[6] that meet the needs of different populations, with a workforce to match. Below, we have highlighted two initiatives to build the Māori and Pacific mental health and addiction workforce – Pourewa Oranga Hinengaro and Le Va's Rebuilding Wellbeing for Workforce.

Pourewa Oranga Hinengaro is a coming together of two worlds – cultural and clinical – to increase the Māori addiction workforce

Pourewa Oranga Hinengaro is a new Postgraduate Diploma in Applied Mental Health and Addiction Counselling at Te Whare Wānanga o Awanuiārangi (Awanuiārangi) endorsed by the Addiction Practitioners' Association Aotearoa New Zealand (dapaanz). The programme is designed to support the development and training of the addiction workforce within whānau, hapū and iwi, and other communities.

Pourewa Oranga Hinengaro was created by Awanuiārangi staff when the Whakatāne community saw a need for more Māori addiction practitioners in their rohe (region). Lecturer and Programme Lead, Te Rangimaria Warbrick, says the programme teaches tauira (students) to ground their work as addiction practitioners in tikanga.

"[The programme] is designed to give practitioners an extensive knowledge and practice of modern mental health and addiction practice, while at the same time integrating tikanga and ahuatanga Māori into their practice, and ultimately, enabling practitioners to create their own kaupapa practice frameworks," says Mr Warbrick, "the programme is a coming together of two worlds – cultural and clinical."

"Supporting tauira to be trained in their own communities, working alongside their whānau and making a difference for their own communities is the way forward," says Sam White, Executive Director of dapaanz, "it's incumbent on us to support the development and access to high quality kaupapa Māori qualifications wherever we can."

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[5] Supplied by Ministry of Health, November 2021.
[6] Co-design is a process that involves creating something together from the start to the finish, with tāngata whaiora, whānau, service providers, and other stakeholders.

Le Va is Rebuilding Wellbeing in the Pacific workforce

Le Va assisted the 2020 COVID-19 response by supporting the Pacific health and support workforce through online Rebuilding Wellbeing workshops. These workshops were designed to equip the workforce with the knowledge, skills, and confidence to identify mental distress (particularly anxiety and depression) amongst Pacific people and support them to get the help they need.

Chief Executive of Le Va, Denise Kingi-Uluave, says that the Pasifika health and support workforce play an important role in providing fundamental coping strategies and passing these strategies on to families and communities.

"We need to empower our communities to intervene and support," says Ms Kingi-Uluave, "often we see people who come into specialist services, and we think, 'if only people had recognised these signs earlier on'."

Feedback from participants was overwhelmingly positive, with people recognising the importance of having by Pasifika for Pasifika training. Participants also acknowledged this training is a useful tool for the wider workforce, something Le Va agrees with.

"We see our workforce as families and communities. Pasifika are communal people with all members striving to work together to achieve common goals."

Access and options

Access and options:

Further investment and development is required for peer services, youth services, and other community-based specialist services

Vision: Tāngata whaiora get support for their experiences, needs, and aspirations

He Ara Oranga found there was an urgent need to provide better access to, and more choice in, mental health services and addiction services – particularly for people with mild to moderate, and moderate to severe, mental health and addiction needs. Having better access and options for support[7] is more important now with the increasing pressures of COVID-19 on both people and the health workforce. Budget 2019 invested $664 million over five years for the national roll out of the Access and Choice programme to address these recommendations.

The measures in this section show access to specialist services has not changed since the beginning of the COVID-19 pandemic. However, these measures do not necessarily reflect the need (or demand) for support. The Ministry of Health has reported many people have experienced increased distress during the COVID-19 pandemic, particularly during lockdowns [13]. The workforce is feeling this

pressure too, with recent data showing 45 % of psychiatrists would leave their job if they could [14]. We have also heard from tāngata whaiora that accessing support has been a challenge during the pandemic.

In 2020 / 21, primary care services have been at the forefront of the COVID-19 response. Despite this, they have provided primary mental health services to considerably more people than in the previous year, managed to implement the new Integrated Primary Mental Health and Addiction services, and the rollout of additional psychosocial supports. Specialist mental health services and addiction services have continued performing at pre-pandemic levels, despite the challenges of operating in a pandemic and an increase in the levels of population mental distress.[8] This is a substantial achievement for DHB and NGO specialist services where there has been limited recent investment in new services. These achievements have required huge effort and commitment from across the mental health and addiction sector.

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[7] 'Support' is used to capture the range of offerings from services, including, but not limited to, talk therapies, medication, rongoā Māori and other Māori therapeutic models, supported accommodation, navigation between services, and help into employment.

[8] In 2020 / 21, 9.6 % of people aged 15 years and over had experienced psychological distress in the four weeks prior to taking part in the New Zealand Health Survey, an increase from 7.5 % in 2019 / 20.

Non-government organisations (NGOs), including kaupapa Māori, Pacific, and peer-support services, provided increased support and outreach during COVID-19 lockdowns. These organisations were supported by the Government through faster access to funding and allowing services to act outside the confines of their contracts. This has created an opportunity to provide support to people who may not have received it otherwise. As recommended in Te Rau Tira Wellbeing Outcomes Report 2021 [15], we need to cement the gains Aotearoa has made through its COVID-19 response by adopting high-trust and collaborative community approaches.

The changes we want to see

He Ara Oranga envisioned a holistic system, that recognises the aspirations of Māori and Pacific peoples, and with a greater choice of services and supports for any level of distress or harm from substance use. As noted in our report on the Access and Choice programme [3], more investment is needed to fully achieve these recommendations in **He Ara Oranga**. In particular, there needs to be:

- investment in peer support services and workforce across all regions

- investment in services, including, but not limited to, specialist child and adolescent services, and other community-based specialist services.

Access to specialist services remains stable while access to primary mental health, telehealth, and digital supports is increasing

Use of telehealth and digital supports is increasing as they become more available

In 2020 / 21, 63,275 people used the text service 1737 / need to talk? which provides brief one-on-one counselling support and phone-based peer support. This is almost three times the 21,467 users from the year the service launched in 2017 / 18.

Additionally, 515,036 people (1 in 10 people in Aotearoa) visited depression.org.nz in 2020 / 21, a website that provides ideas for support for people experiencing distress. This was a 68 % increase from the 306,809 people who visited the website in 2016 / 17.

In 2020 / 21:

1 in 10

people in Aotearoa visited depression.org.nz

Source: Te Hiringa Hauora

Access to both the Alcohol and Other Drug helpline and Gambling Helpline has decreased. 14,894 people rang the Alcohol and Other Drug helpline in 2020 / 21, down 13 % from 17,033 people in 2017 / 18. 3,401 people rang the Gambling helpline in 2020 / 21, down from 29 % from 4,785 in 2016 / 17.

These services have freephone 0800 lines and text numbers. Being able to access these supports from home increases the availability of support to those who find it difficult, or prefer not, to access face-to-face services [16].

However, not all people can access these supports easily. Māori, Pacific people, those living in rural areas, and older people over 65 are less likely to have internet access than other groups in Aotearoa [17]. Anecdotally, we have also heard that people seeking support during COVID-19 lockdowns for addiction challenges faced technology and financial barriers.

The estimated number of people accessing primary care has increased

In 2020 / 21, an estimated 152,993 people (around 3 % of the population) accessed DHB funded primary mental health services, which are services available through general practice, such as extended consultations and talk therapy. This is an increase of almost 30,000 people from 2019 / 20 (123,278 people). Young people make up 18 % of those increasing DHB funded primary mental health services, up from 13 % in 2015 / 16.

These services do not include general consultations that involve mental health and addiction issues, and are separate from the new Access and Choice services created through Budget 2019. The Royal New Zealand College of General Practitioners survey estimates that 30 % of General Practitioner consults have a mental health component [5] and the 2020 / 21 New Zealand Health Survey indicates that 9.6 % of adults experienced high or very high levels of psychological distress.

The new Access and Choice primary mental health and addiction support services are intended to address this significant service gap between estimated need and the current access rates. It will be important to monitor these services as the data becomes available under our new **He Ara Āwhina** framework.

Access to specialist mental health services and addiction services has not changed over the past five years

191,053 people accessed specialist mental health services and addiction services. The percentage of the total population accessing these services has remained at 3.7 % from 2016 / 17 to 2020 / 21.

In 2020 / 21, an estimated:

152,933
**people accessed primary mental health services, and**

191,053
**people accessed specialist mental health services and addiction services**

Source: Ministry of Health

## There continue to be challenges with wait times for some mental health services, and addiction services

Wait times for mental health services
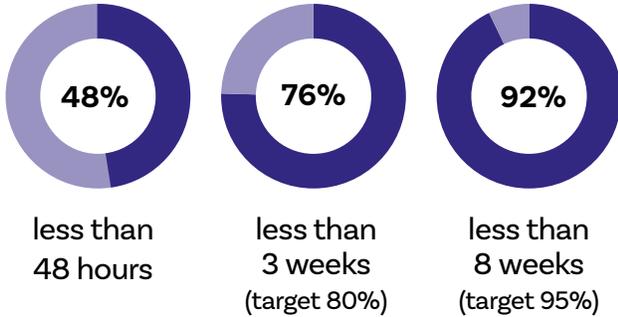
48%	76%	92%
less than 48 hours	less than 3 weeks (target 80%)	less than 8 weeks (target 95%)

Wait times for addiction services

40%	76%	93%
less than 48 hours	less than 3 weeks (target 80%)	less than 8 weeks (target 95%)

Young people wait longer for DHB mental health services

35%	65%	87%
less than 48 hours	less than 3 weeks (target 80%)	less than 8 weeks (target 95%)
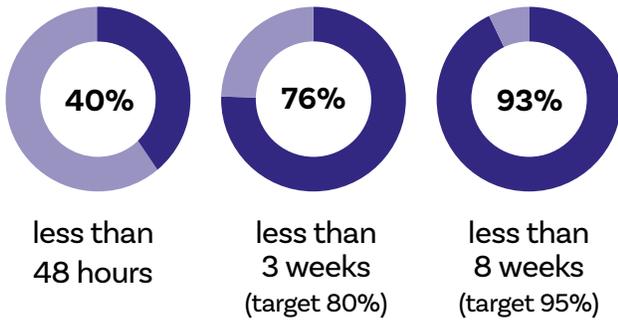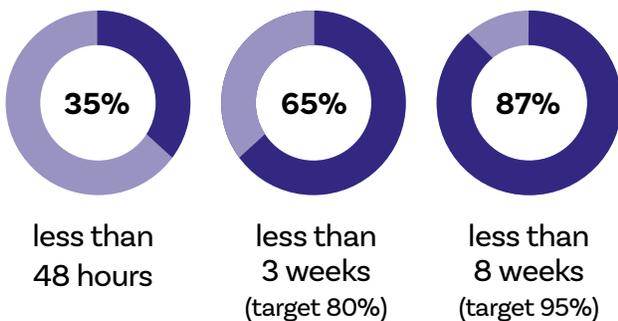
While people called for decreasing wait times[9] in **He Ara Oranga** [1], wait times for mental health services have not decreased over the past five years, and wait times for addiction services have become longer. In 2020 / 21, 40 % of tāngata whaiora referred to addiction services were seen within 48 hours, down from 49 % five years previously, and 76 % are seen within three weeks of referral, down from 82 % five years previously. In 2020 / 21, 76 % of tāngata whaiora accessed mental health services within three weeks of being referred to the services, compared to a target of 80 %, and 92 % accessed treatment within eight weeks compared to the target of 95 %. However, for adults, Māori and Pacific people, the waiting times are just below or better than target. It is encouraging that wait times have not increased for these population groups during the pandemic.

Young people wait longer for DHB mental health services

DHBs are required to meet targets, where 80 % of people referred for non-urgent mental health or addiction services are seen within three weeks, and 95 % are seen within eight weeks.

Unlike other age groups, youth mental health services do not meet wait time targets. In 2020 / 21, only 65 % of young people aged 19 and under were seen in the first three weeks of their referral, and 87 % within eight weeks. Despite the prioritisation of youth in Government policy – including the Child and Youth Wellbeing Strategy, and the focus on increasing access to support for young people – these wait times have gotten worse for young people since 2017 / 18.

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[9] Wait times are the length of time between tāngata whaiora being referred to a mental health or addiction service, and the day when they are first seen by the service.

There are already significant barriers for young people requiring support, including cost of primary care[10] (generally required for referral to specialist services), and are not as involved as they would like to be in decisions about their care.[11]

Over the past year, young people have been accessing more primary mental health services and have been dispensed substantially more psychiatric medications

In the past two years (2019 / 20 to 2020 / 21), young people aged under 20 have shown an increase from 15 % of the total population accessing primary mental health services (excluding Access and Choice services), to 18 %. This increase has been even more marked over the past five years, up from 12 % in 2016 / 17.

There has also been a large increase in mental health related initial dispensings[12] for young people. From 2019 / 20 to 2020 / 21, there was a 21 % increase for initial dispensings of antidepressants for young people (usually a 7 - 9 % increase each year) compared to an 8 % increase for the total population. Over this same period,

antipsychotics initial dispensings have also increased by 18 % for young people compared with smaller increases in previous years – 5 % increase between 2018 / 19 and 2019 / 20, and 11 - 12 % increase in 2016 / 17 and 2018 / 19).[13] The percentage increase for the total population from 2019 / 20 to 2020 / 21 was 6 %. These increases are consistent with an 8 % increase in the prevalence of psychological distress in young people aged 18 – 24 years over the same period, as reported in the 2020 / 21 New Zealand Health Survey [8].

Antipsychotic and antidepressant medicines can be prescribed for several reasons outside of mental health, for example, pain management, sleep, and smoking cessation. However, we don't believe this would explain the recent increases in prescriptions for young people. It's more likely these increases have resulted from increased stress from COVID-19 and a lack of non-medical treatment alternatives.

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[10] 37 % of those aged 15 – 24 years report cost as a barrier to visiting their GP or nurse (New Zealand primary care patient experience survey question 'In the last 12 months was there a time when you did not visit a GP or nurse because of cost?' Health Quality & Safety Commission's Atlas domain 'Health service access', 2018-19).

[11] Younger people reported less involvement, with 30 % of those aged 15 – 24 years being involved either to some extent or not at all in decision about their own care nurse (New Zealand primary care patient experience survey question 'Have you been involved in decisions about your care and treatment as much as you wanted to be?' Health Quality & Safety Commission's Atlas domain 'Health service access', 2018-19).

[12] Initial dispensings include the first time someone goes to a pharmacy to collect a medicine, it does not include any repeats. This data only includes publicly funded medications.

[13] Note, initial dispensings for all medications increased in 2020. Before March 2020, under the Pharmac Schedule, some medicines were dispensed monthly, and others were dispensed three-monthly. In March 2020, Pharmac introduced a change to the Schedule which required pharmacies to move to monthly dispensing, rather than all at once dispensing. This change meant that a person would have to go into a pharmacy three times for a normal 90-day prescription, rather than once. However, the % increase of dispensing of antidepressants overall increased by 8 % over this time (compared to an 3 % increase on average), and antipsychotics went up 6 %, so this does not account for the much larger increases seen in young people.

The Access and Choice programme is providing additional services for tāngata whaiora

The Access and Choice programme was developed in response to **He Ara Oranga**, which found there was an urgent need to provide better access to, and more choice in, services – particularly for people with mild to moderate, and moderate to severe, mental health and addiction needs. The measures in this report related to the existing DHB funded primary mental health services also highlight the significant service gap, with the percentage of the total population accessing these services remaining at 2.7 – 3.0 % over the last five years reported.

Our recent report **Access and Choice Programme: Report on the first two years** found that the Access and Choice programme has put much-needed investment into primary and community care. The programme intends to provide 325,000 people (6.5 % of the total population) with mild to moderate mental health and addiction needs with free and immediate support. The overall programme is being rolled out on schedule, though, we would like to see the rollout of services for Māori, Pacific peoples, and youth accelerated.

We've highlighted two services rolled out through the programme below that are providing holistic support to fit the needs of Māori and young people respectively – Mahana and EaseUP from Emerge Aotearoa.

Mahana is a kaupapa Māori mental health and addiction service offering a range of supports

Wellbeing means something different to everyone, so it's important that people can choose what their wellbeing journey looks like. Mahana, a kaupapa Māori mental health and addiction programme run by Ngā Kete Mātauranga Pounamu in the Southern region, walks alongside tāngata whaiora and whānau to determine what wellbeing looks like, guiding them on their own path embraced in Te Ao Māori, te Reo Māori, and clinical excellence.

Mahana offers an eclectic range of mental health and addiction services, including assessments, interventions, access to cultural wellbeing activities, mobile service options, one-on-one counselling support, a peer support group, creative arts, wānanga-based interventions, Pou Whirinaki cultural advisor support, and experiential learning activities that link tāngata whaiora back to our natural environment.

Chief Executive, Tracey Wright-Tawha, says that there is no one way to wellbeing. People are individuals and have different needs. "We believe people are the experts in their own world and it's up to tāngata whaiora and whānau to be the change they seek. Our role is to provide resources, ideas, energy and sound clinical practice to enable, challenge, and support – it's a journey we take together," says Ms Wright-Tawha.

EaseUp is a peer led service providing holistic support for young people

EaseUp is a mobile community-based service run by Emerge Aotearoa that supports youth and young adults who are experiencing challenges with their mental wellbeing and / or use of alcohol and other drugs. The service is available to young people living in Auckland or Waitematā.

EaseUp is made up of Peer Support Workers and Clinicians who work in partnership with the young person. The service provides holistic support to fit the needs of the young person, which is delivered where they feel most comfortable, for example, their home or a local park.

"Whatever the young person needs," says Emerge Aotearoa District Manager, Simon Hughes, "whether it be support around getting a driving license or help to engage in a college course, or being bullied at school, anything at all that's causing any kind of discomfort to the young person, we can put some supports around."

"Youth who have used our services have shared that they feel empowered and supported to make changes in their lives. They felt listened to, respected, and comfortable to share their emotions and thoughts," says EaseUp Service Manager, Melissa Latimer.
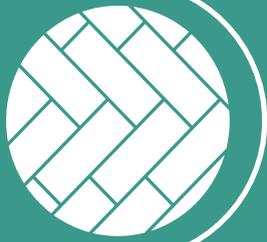
Participation and leadership
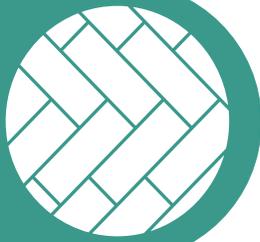
Participation and leadership:

Services must maximise tāngata whaiora autonomy and uphold rights

Vision: Tāngata whaiora are leaders in their care

Mental health and addiction services must maximise tāngata whaiora autonomy and protect the human rights of tāngata whaiora on an equal basis with other people. Aotearoa is on a path to change the legislation that allows for coercive treatment with work underway to repeal and replacement of the Mental Health (Compulsory Assessment and Treatment) Act 1992. People who have been subjected to compulsory treatment have long advocated for the end for such practices. This view is supported internationally, including by the United Nations High Commissioner for Human Rights.[14]

The changes we want to see

The mental health and addiction system must maximise tāngata whaiora autonomy and protect the human rights of tāngata whaiora on an equal basis with other people. The changes we want to see include:

- 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

- new policy to inform mental health legislation, co-designed with tāngata whaiora, that does not discriminate on the basis of 'mental disorder', so mental distress of any kind is not used as a basis for compulsory treatment

- an increase in treatment days involving family and whānau, and support and acknowledgment of whānau as "first responders" and important carers for tāngata whaiora.

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[14] "Forced treatment – including forced medication and forced electro convulsive treatment, as well as forced institutionalisation and segregation – should no longer be practiced." Zeid Ra'ad Al Hussein, UN High Commissioner for Human Rights, 14 May 2018. OHCHR | Consultation on Human Rights and mental health: "Identifying strategies to promote human rights in mental health".

Further work is needed to ensure tāngata whaiora are leaders in their own care

Three quarters of tāngata whaiora have transition plans when discharged from an inpatient unit

Transition plans are an important way for tāngata whaiora to determine what every day supports look like. Services develop transition plans collaboratively to support tāngata whaiora to maintain their mental health and wellbeing after they have moved on from inpatient care. These plans can be shared by tāngata whaiora with other relevant people and services who are involved in supporting them.

Tāngata whaiora with transition plans are less likely to need early re-admission to inpatient units [18]. However, the data we have only captures whether people have a transition plan or not, and does not assess the quality of those plans or whether they have been collaboratively developed.

Three quarters (74 %) of tāngata whaiora have transition plans when discharged from an inpatient service. This means a quarter of tāngata whaiora (26 %) are leaving inpatient units without one.

In 2020 / 21:

74%

of tāngata whaiora had a transition plan upon discharge from an inpatient unit.

Source: Ministry of Health

The proportion of tāngata whaiora with transition plans when discharged from community care is improving, with 64 % of tāngata whaiora having a transition plan in 2020 / 21, up from 57 % in 2017 / 18. This data is not collected by ethnicity or age so we cannot tell if there are any inequities between groups of people.

Treatment days involving family / whānau are low

While suitable levels of family / whānau involvement are different for all tāngata whaiora, many people want whānau involved in their care, and exclusion of family / whānau was a concern highlighted in **He Ara Oranga** [1]. However, treatment days[15] involving family / whānau only made up 12 % of total treatment days in 2020 / 21 with no change across the five years reported. For rangatahi under 20, treatment days involving family / whānau make up 33 % of total treatment days.

The proportion of treatment days for Māori that involve whānau have increased, and are now more in line with rates of tāngata whaiora overall, from 10 % in 2016 / 17, to 11 % in 2020 / 21.

There were only a small number of treatment days (1,430 total compared with 1.4 million individual treatment sessions) provided by services to support tāngata whaiora in their role as parents or caregivers, a decrease from 1,851 days in 2018 / 19.

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[15] Treatment days count as a single contact day, regardless of the number of contacts tāngata whaiora have in a single day. Tāngata whaiora can have multiple treatment days.

The number of community treatment orders is increasing proportionately with specialist mental health service use

A community treatment order means a person experiencing mental distress must receive treatment for up to six months under the Mental Health (Compulsory Assessment and Treatment) Act 1992.[16] Whether tāngata whaiora have the capacity to make decisions is not considered when deciding to put someone under a compulsory treatment order.

In 2020:

6,728

**tāngata whaiora
were subject to a community
treatment order**

Source: Ministry of Health

Use of community treatment orders is coercive, and there is little evidence they reduce frequency and length of admissions to inpatient units for most tāngata whaiora [19]

In 2020, 6,728 people were subject to community treatment orders (4.9 % of people using specialist mental health services). Māori are disproportionately subjected to community treatment orders (39 % of those subject to a community treatment order in 2020 were Māori, up from 35 % in 2016).

There has been a 10 % increase in the number of people subject to a community treatment order since 2016 (6,139 people). While this increase is in line with population increases, we would expect these numbers to decrease over this period, given the calls from communities in 2018 in **He Ara Oranga** to minimise compulsory or coercive treatment and ensure people are leaders in their own care.

The number of people detained under the Substance Addiction Act is low

The decision to detain someone experiencing substance harm under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 is capacity based. This means to be detained under the Act, a person must have reduced decision making capacity and a physical need.

Thirty-seven people were detained under the Act in 2020. While we only have three years' worth of data to assess, this low number suggests the Act is being used as intended, with detention used as a last resort.

Peer led services ensure tāngata whaiora lead their own care

Peer led services, like Recovery College NZ and Te Kupenga Net Trust, work alongside tāngata whaiora and whānau to ensure they are in control of the support they're receiving, whatever that may look like.

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[16] An inpatient treatment order is where a person must remain in an inpatient mental health unit to receive this treatment.

Recovery College NZ provides peer-led education on recovery and wellbeing

Administered by DRIVE Consumer Direction Counties Manukau, Recovery College NZ brings together people with lived experience of mental distress or addiction, tāngata whaiora, and clinicians to co-design and co-facilitate free workshops in Counties Manukau, so that people can learn from each other.

Tāngata whaiora take the lead, with DRIVE coordinators, who are also peers, working alongside and supporting them to build and shape the workshops into something that will work for everyone. "When people come into Recovery College, I like to identify things that I see with them, and strengths that they have, and try to grow their confidence because that's what people did for me," says Troy Guest, one of DRIVE's Coordinators.

Troy and Edith Moore, another DRIVE Coordinator, would both love to see Recovery Colleges running around the motu. "Pull us in, pull in other people who have already done this... Let's all get our heads together and see how we can support this endeavour because it's so important and so worthwhile – so useful for our people," says Edith.

Wānanga support whānau to collaboratively navigate distress

Te Kupenga Net Trust is a mental health and addiction service that provides peer support and advocacy for whānau who are living with distress. In 2017, they partnered with Hauora Tairāwhiti to pilot a model of practice now known as Te Waharoa. This model drew on lived experience expertise, clinical expertise of psychiatrist Dr Diana Kopua, Māori Pūrakau, and belief in the capacity of whānau to lead their own journeys to wellbeing.

For whānau in Tairawhiti, Te Waharoa is the key access point for those in distress and needing guidance to the right support. To respond to whānau, the team organise wānanga (forums for discussion) for whānau to kōrero through their challenges and distress. Whānau have control of the wānanga, deciding who is present, when it will happen, and where. Wānanga can be held once or reconvene over a number of months to meet their unique needs and aspirations. All wānanga are facilitated by Mataora – who can be clinicians, or have expertise in peer support, advocacy and mātauranga Māori (Māori world view).

Te Kupenga Net Trust CEO, Hine Moeke-Murray, sees whakawhanaungatanga (the process of establishing relationships) and being listened to in the wānanga as crucial for whānau, "we can facilitate with them who they want in a wānanga, bringing in other services to sit in that wānanga with them. We explain to the other services that this isn't your wānanga, it belongs to the whānau, and your job is to sit and listen."

For services attending wānaga to offer support, Hine advises, "see where you can lean in and help wrap around this whānau according to what their strength is, according to what their need is – not yours as a service provider." This enables whānau to be the leaders in their own healing.

Safety

Safety:

Services must be supported to develop positive risk-taking approachess

Vision: Tāngata Whaiora are safe in services

Many practices that aim to reduce risk are experienced as harmful by tāngata whaiora. Restrictive practices, such as solitary confinement and restraint are harmful practices. They do not have therapeutic value and violate human and disability rights. These practices are often traumatising for tāngata whaiora and staff, and re-traumatising for people who have experienced inter-personal violence and victimisation [20].

He Ara Oranga called for a national discussion to reconsider beliefs, evidence, and attitudes about mental health and risk as well as encouraging greater community acceptance and support of people in distress. During the development of **He Ara Āwhina**, tāngata whaiora have told us they want services to be well supported to support tāngata whaiora and their whānau, and all risk-taking is seen as essential for recovery.

While there have been discussions across the sector about reframing risk, and some efforts to change risk-based practice, a national and public discussion is yet to occur. Until there is a shift in societal attitudes to people in distress, and a change in the associated expectation that services should take control to eliminate risk, we are unlikely to see a decrease in the use of restrictive practices.

The changes we want to see

The changes we want to to see include:

- strong leadership from the Government on the **He Ara Oranga** recommendation for a national discussion to reconsider beliefs, evidence, and attitudes about mental health and risk, with lived experience leadership central in this work

- positive risk-taking approaches that give tāngata whaiora freedom and supports their wellbeing and recovery

- community-based acute alternatives for people experiencing significant distress.

There has been an overall increase in people being subject to solitary confinement, but elimination is possible

Use of solitary confinement increased nationally between 2016 and 2020

Solitary confinement in this report is analysed at the national level, which combines data across all DHBs. Solitary confinement practices vary significantly by DHB. National-level data is, therefore, limited and does not illustrate the progress many DHBs have made in reducing or eliminating solitary confinement practices. As of November 2021, Te Toka Tumai Auckland DHB had not used solitary confinement since February 2021 [21]. DHB-level reporting is available from Health Quality & Safety Commission (see 'Zero seclusion – Safety and dignity for all' is reducing rates of solitary confinement on page 39).

Nationally, the annual data shows the number of solitary confinement events increased 29 % from 2,279 events in 2016 to 2,934 in 2020, while the number of people admitted in inpatient units over this time has decreased (9,642 people in 2016 to 9,392 people in 2020). The number of people confined increased 19 % from 990 people in 2016 to 1,179 people in 2020 (some people are confined multiple times).

While annual national data supplied from the Ministry of Health shows solitary confinement has increased, reductions have been achieved by many DHBs involved in the Health Quality & Safety Commission's programme Zero seclusion: Safety and dignity for all, which is part of their Mental Health and Addiction Quality Improvement Programme. The Health Quality & Safety Commission data is reported monthly, includes more recent data up to June 2021, and its measures are tailored for the purpose of improving the quality of services [12]. This data shows that by late 2020, the number of people experiencing solitary confinement started to decrease. The decline in solitary confinement events has happened faster for Māori than people who are not Māori or Pacific peoples [12]. This shows promising signs of solitary confinement practices decreasing and the equity gap reducing. However, more work remains to build on these gains and assist the DHBs who are struggling to overcome barriers in eliminating solitary confinement.

In 2020:

25%
of solitary confinement events lasted longer than 24 hours.

Source: Ministry of Health

In 2020:

2,934
solitary confinement events occurred

Source: Ministry of Health

The number of hours spent in solitary confinement is decreasing

The number of hours spent in solitary confinement decreased by 7 % between 2019 and 2020 [10]. A quarter of solitary confinement events in 2020 were longer than 24 hours, which has remained relatively stable since 2016.

A higher proportion of solitary confinement events were longer than 24 hours in 2020 for Māori (31 %) and Pacific peoples (30 %), compared to tāngata whaiora overall.

Increasing the choice of services will help to minimise harm and support recovery

Improving inpatient services is important, but it is only one part of the answer to improving safety for tāngata whaiora. **He Ara Oranga** recommended increasing choice by broadening the types of services available. While there has been some increases in the choice of services available in primary care [3] [6], greater choice is needed for tāngata whaiora experiencing significant distress. Tāngata whaiora across Aotearoa need access to options other than inpatient services, like the peer-led acute service Te Ao Mārama.

Zero seclusion – Safety and dignity for all is reducing rates of solitary confinement[17]

Zero seclusion – Safety and dignity for all is a joint project between the Health Quality & Safety Commission, Te Pou, and the DHBs. The project aims to reduce seclusion rates in all acute mental health wards across Aotearoa by 50 % by 1 June 2022, contributing towards the ultimate goal of zero seclusion.

The project supports DHBs to find alternatives to secluding tāngata whaiora who are experiencing distress. This has proved successful for many DHBs across the motu. Auckland, Waitamatā, Whanganui, South Canterbury, and West Coast DHBs have all seen a reduction in seclusion rates and, at times, have reached and sustained zero seclusion.

Zero seclusion – Safety and dignity for all appears to have impacted seclusion rates for Māori, which have recently been decreasing at a faster pace than that of non-Māori and non-Pacific people.

Work toward zero seclusion begins before a person is admitted to an inpatient unit.

"We have to do better and engage with our tāngata whaiora in their homes and in their communities, not just in our clinics and giving them pills, but actually going out there and working with them, preventing admissions to acute mental health units in the first place," says Wi Keelan, Kaumatua and Māori Cultural Advisor at the Health Quality & Safety Commission for Zero seclusion – Safety and dignity for all.

The DHBs reducing rates of seclusion are also seeing an impact on other measures, including a reduction in calls to crisis teams, use of restraints and sedating medications, and assaults against staff and tāngata whaiora.

"Where you have a reduction in seclusion, you have more compassion, more kindness, more talking, more storytelling," says Matua Keelan.

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[17] This section is taken from a Health Quality and Safety Commission interview that uses the term seclusion to describe solitary confinement.

Te Ao Mārama gives tāngata whaiora meaningful choice in support

Te Ao Mārama is an acute alternative, peer-led service in Ōtautahi (Christchurch), which opened in April 2019 and is run by NGO service provider Pathways. As an acute alternative, Te Ao Mārama gives people meaningful choice in the support they receive when experiencing acute distress.

The house is set up like a home, and peer support specialists, nurses, and an occupational therapist are available to talk with guests. The service caters for seven guests at a time. This allows for different structures, therapeutic supports, and ways of working than inpatient services.

Pathways Crisis Respite manager, Tessa Sturgeon, says that providing peer-led alternatives to inpatient services is a change that **He Ara Oranga** called for, "we know that the existing service model isn't working, it's not meeting people's needs, this is where we want to get to, and part of that was around having peer led services, having community services." NGOs are in a good position to adapt and respond to the needs of communities. "Clinical intervention suits some people, and peer led services suit others," says Tessa.

Effectiveness

Effectiveness:

Measures of service effectiveness should reflect the things most important to tāngata whaiora

Vision: Support makes a difference for tāngata whaiora

Measures of clinical outcomes (such as clinical symptoms) are generally used to measure how effective a service is. Mental health services and addiction services work by supporting tāngata whaiora to improve their clinical outcomes (such as lessening severity of symptoms) while also contributing to broader wellbeing outcomes (such as stable housing).

While services can work with a wide range of partner agencies, and should work alongside tāngata whaiora to support their individual and collective agency for wellbeing, broader wellbeing outcomes are out of scope for this report. Wellbeing outcomes will be reported by the Commission under the He Ara Oranga wellbeing outcomes framework and the upcoming **He Ara Āwhina** framework.

The changes we want to see

We want to see measures of effectiveness developed with people with lived experience that measure the things most important to tāngata whaiora.

The changes we want to see include:

- 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

- a continued focus of the holistic health needs of tāngata whaiora, including targeted efforts to ensure tāngata whaiora have access to COVID-19 vaccinations, including boosters.

Tāngata whaiora tend to show improvement when using mental health services, and recovery when using addiction services

People show clinician-rated improvement when they access mental health services

Health of the Nation Outcome Scale (HoNOS) covers areas including mood, relationships, substance use, and housing. HoNOS measures outcomes (the end result) as opposed to the means to get there. To look at mental health service effectiveness, we've compared the outcomes scores of tāngata whaiora at both service admission and discharge to see if their outcomes have improved as a result of attending the service.

Clinician-rated HoNOS scores of adults for mental distress and social functioning improve[18] by around half between admission to, and discharge from, a mental health inpatient (51 %) or community service (46 %).

In 2020 / 21, the greatest improvements were for tāngata whaiora Pacific adults on discharge from an inpatient unit (58 % improvement).

While HoNOS gives some indication of effectiveness, we have heard feedback from tāngata whaiora that HoNOS is not a good measure of service effectiveness. This is partially because the measures are completed by clinicians, often based on their perspective rather than the views of tāngata whaiora. Furthermore, HoNOS does not measure personal recovery goals or the things that are most important to tāngata whaiora wellbeing. Wellbeing and recovery are different for everyone. They include

finding the right supports to live a satisfying, hopeful, and meaningful life in the presence or absence of mental distress, abstinence, or substance use or problem gambling.

People in addiction services show improvement toward achieving recovery goals

The Alcohol and Drug Outcome Measure (ADOM) is a self-rated tool that measures progress toward recovery goals. ADOM is used by people accessing community outpatient adult addiction services. ADOM allows tāngata whaiora to rate and track key areas of change during their recovery, including changes in use of alcohol and other drugs, lifestyle, wellbeing, and satisfaction with treatment progress and recovery [22]. In this report, we use satisfaction toward achieving recovery goals as a measure of addiction service effectiveness.[19]

In 2020 / 21 tāngata whaiora satisfaction toward achieving their recovery goals showed improvement of around 28 % from the beginning to the end of their treatment at a community Alcohol and Other Drug Service. This is slightly improved compared with previous years.

Compared to tāngata whaiora overall, satisfaction toward achieving recovery goals did not improve as much for tāngata whaiora Māori (21 % increase), or young people (24 % increase). Tāngata whaiora Pacific showed a 10 % improvement in satisfaction toward achieving recovery goals over the last five years to a 29 % increase between 2020 / 21 (compared with a 19 % increase in 2016 / 17).

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[18] HoNOS is a deficit measure so a decrease in score is an improvement e.g. if someone scores 15 on admission, and 7 on discharge, this is a 51 % improvement.
[19] Unlike HoNOS which results in an overall score, ADOM is a goal-based tool – that's why we chose one ADOM measure within the tool rather than averaging out as scores will average out in a meaningless way across the goals.

Services have helped address the physical health needs of tāngata whaiora during COVID-19

It is well documented that the physical health needs of tangata whaiora have not been well addressed by the health system, with tangata whaiora experiencing poorer physical health and shorter life expectancy [23]. Support should be tailored to the needs of tāngata whaiora, whatever those needs may be. This has been more important than ever during the COVID-19 outbreak. The risk of dying from COVID-19 is twice as high for those experiencing mental health or addiction issues compared with the overall population [24].

Vaccinations are one of the best tools we have to reduce the risk of COVID-19 effects.

In January 2022, full COVID-19 vaccination rates for tāngata whaiora in contact with mental health services were 9 % lower than the general population and amongst addiction service users, rates were 19 % lower. In comparison, 93 % of the general population were fully vaccinated. Vaccination rates continue to be lower for tāngata whaiora Māori (76 % fully vaccinated) and tāngata whaiora in contact with alcohol and drug services (67 % fully vaccinated).[20]

Thanks to the efforts of many in the mental health and addiction sector, including those highlighted below, these vaccination rates are moving toward the general population rate; however, there is still need for a targeted focus on tāngata whaiora in the roll out of boosters and COVID-19 treatment.

Equally Well Collaborative is championing equitable physical health for tāngata whaiora

The Equally Well collaborative exists to achieve physical health equity for tāngata whaiora and whānau. Collectively, Equally Well champions from more than 120 organisations conduct research, gather data, influence policy, and enact change.

Equally Well's collaborative efforts recently made a difference at a policy level. Ongoing research and advocacy from many champions meant mental health and addiction issues were formally recognised as health conditions, which increase a person's vulnerability of worse health outcomes if infected with COVID-19. Consequently, tāngata whaiora were included in Group 3 in the national COVID-19 vaccine rollout.

However, without large-scale targeted information and communications for tāngata whaiora or whānau, vaccination rates have continued to be lower than the general population.

Equally Well champions across the whole of the health sector have combined efforts and expertise to proactively reach out and have vaccine conversations with tāngata whai ora. Ongoing visibility of the vaccination rates of tāngata whai ora, through the new data platform, **Tūtohi**, has provided timely and reliable information to champions.

"Everyone has a role to play in achieving physical health equity and our response to COVID-19 has seen so many champions stepping up and taking action in their spheres of influence," says one of Equally Well's strategic leads, Dr Helen Lockett, "now more than ever before it is time for the health system to be equally well."

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20 Data supplied 17 January 2022 by the Ministry of Health.

Ngātahi Ora offers peer support to tāngata whaiora who are thinking of getting their COVID-19 vaccination

Ngātahi Ora, run by Balance Aotearoa, aims to break down barriers, and offers practical solutions to anyone experiencing adversity, addiction, or emotional distress.

Ngātahi Ora have developed partnerships with many peer support services around the country who offer one-on-one support to tāngata whaiora considering vaccinations, and have also established a national free-phone peer support warmline focused on support with vaccination decisions. Ngātahi Ora also offers online forums and hui that contribute towards peoples' awareness and understanding. These forums provide a space for tāngata whaiora to ask questions about the vaccine and talk about how they are feeling.

One of the most valuable things Ngātahi Ora offers is space for tāngata whaiora to be seen, heard, and listened to. Ngātahi Ora co-ordinator, Rana Aston, says that it is most helpful to just listen and "accept what people have to say without needing to give advice, set people straight, or intervene. What's really valuable is just being heard."

While the focus is on supported decision making and informed consent, having peer support through vaccinations is also positively impacting the numbers of people with experiences of distress or addiction getting vaccinated against COVID-19.

Connected care

Connected care:

Improvements are needed to ensure people have access to connected supports

Vision: Services work together for tāngata whaiora

He Ara Oranga noted that the mental health and addiction system does not have a network of mental health, addiction, health, and social services and supports – key components of the system are missing. A lot of the pressure falls on the acute end of the system, with pressures on inpatient services when people are staying longer in these services because there are insufficient community supports and services.

A lack of housing and other supports means some people remain in inpatient units for longer than required for treatment. Around 30 % of beds in mental health units are unavailable for acute use because they are supporting people who could be treated in the community, but don't have appropriate housing or other supports in place. [25]

The changes we want to see

The establishment of 'Collaboratives' for Integrated Primary Mental Health and Addiction Services is a positive step towards improved integration of services across the sector. However, in preparing our report on the Access and Choice programme, we saw little evidence of improvement in the relationships between primary mental health and addiction services and specialist services. This will be particularly important to develop as part of the health reforms that may separate the oversight of community care and inpatient hospital care.

The changes we want to see include:

- additional supports that address the social and economic determinants that impact on people experiencing distress and harm from substance use and gambling

- strengthening the connections between inpatient and community care and between specialist and primary care.

Additional supports are needed to assist the transition from inpatient to community settings

The average stay of 18 days in inpatient units remains unchanged

The average length of stay in inpatient units for tāngata whaiora has remained steady over the past five years at 18 days.

Young people had shorter average stays in inpatient units in 2020 / 21 (13 days). Pacific people had longer average stays in inpatient units (23 days), as did older people aged over 65 years (31 days). Longer inpatient stays for older people may occur because of the more complex circumstances, including co-occurring conditions, that can occur when caring for older people.

In 2020 / 21:

18 days

was the average length of stay in an inpatient unit

Source: KPI Programme

20 % of people are not followed up with after hospital discharge, despite overall follow up rates remaining steady

Making community support available for tāngata whaiora leaving inpatient units is essential and helps prevent re-admission [18]. Follow up refers to community service contact, for example, from a mental health service provider within seven days of a person being discharged from an inpatient unit.

In 2020 / 21:

1 in 5

tāngata whaiora leaving inpatient units were not followed up within 7 days

Source: KPI Programme

7-day follow up has seen little change over the past five years, with 20 % of people not followed up. Follow up rates in 2020 / 21 were lower for older people aged over 65 years (29 % not followed up) and higher for Pacific people (17 % not followed up).

One in six tāngata whaiora are re-admitted to inpatient units within 28 days of discharge

Re-admission rates within 28 days of discharge have decreased slightly over the past five years, from 17 % in 2016 / 17 to 15 % in 2020 / 21. Re-admission can be minimised, and evidence shows re-admission rates decrease with transition care that builds support with community care providers, primary care, and psychosocial supports, including peer support [26].

Services must link up to meet the needs of tāngata whaiora

To best meet the needs of tāngata whaiora, all the supports tāngata whaiora use, including health and social services, must be well connected.

Stronger Waitaki Community Coalition brings together communities to work together for social change

The Stronger Waitaki Community Coalition is a whole-of-community project with a focus on community building. This includes community-wide safety, health, wellbeing, and development.

Stronger Waitaki uses Collective Impact, a model that brings together multiple organisations from across the region to create social change. Government, non-government organisations, community groups, health, and social service agencies work together along with the Waitaki District Council, which provides secretariat support to the Coalition. These groups work collaboratively toward a shared vision. They find consensus, share resources, and work collectively to respond to challenges facing the community.

Youth mental health became one of the Coalition's focus areas after data revealed presentations to Youthline concerning support for moderate to severe mental health concerns have increased 50 % over the past two to three years.

"The coalition decided to respond in a meaningful way to mental health challenges experienced by our young people. That means everything from specialist services to peer support," says Helen Algar, Waitaki District Council's Community Development Manager. For example, the coalition advocated for a provider to tap into support and stimulus funding from Waitaki District Council to provide counselling support to young people in the local intermediate school.

Asian Family Services Gambling Harm Minimisation Programme connects services to provides holistic culturally safe support

Asian Family Services' gambling harm minimisation programme provides Asian communities with a culturally safe and responsive environment for individuals, families, and friends experiencing gambling harm.

National Director at Asian Family Services, Kelly Feng, says the programme recognises that services need to be joined up, so that people can have one point of contact to seek support for wider issues.

"Nobody has one single issue when they present to a service – ever," she says.

"Gambling is not the only issue. Other factors drive people to gamble, and we work with them to explore the root of the problem and look for solutions."

The programme helps Asian people to discover and resolve problems, enabling them to grow stronger, and work towards health and wellbeing.

In addition to a national Asian helpline and clinical support, the service offers facilitation to other services, such as accessing WINZ entitlements, budgeting, and other social and legal services.

Measuring the things most important to people

The voices of Māori and tāngata whaiora need to be paramount in assessing how well services and other approaches to wellbeing are meeting the needs of Māori, people with lived experience of mental distress and / or substance or gambling harm, and those who support them. Data (both quantitative and qualitative) helps us understand whether services and support are making a difference for tāngata whaiora and informs service delivery and planning across the system.

We know there are many data gaps that significantly limit our ability to monitor the performance of mental health and addiction services, and existing data does not measure all that is most important for tāngata whaiora.

In the development of **He Ara Āwhina** – which we'll report against in the future – we are developing methods and measures that will help us assess the things most important to tāngata whaiora. Our application of **He Ara Āwhina** to monitoring, assessment, and advocacy is centred on hearing from people and communities and telling their stories, including where services are doing well. Quantitative data will be part of our storytelling, particularly to track trends over time. **He Ara Āwhina** will include an assessment of data gaps to measure against the framework.

There are, however, some changes to improve mental health service and addiction service data that we are advocating for now, as outlined below.

We reinforce the He Ara Oranga recommendation to undertake and regularly update a comprehensive mental health and addiction survey

As recommended in **He Ara Oranga**, there is a need for an updated and inclusive measurements of mental health prevalence to inform planning and monitor system responsiveness (see 'Current prevalence data is required to understand unmet need and service pressures' on page 17).

In particular, we need better data about communities who are not served equitably by the current mental health and addiction system. More comprehensive data will help us better understand the needs and experiences of people who are not well served by the mental health and addiction system (for example, the rainbow community, the disability community, and people who are former refugees). Currently, ethnicity and age are the only identifiers reliably and routinely collected by services.

Prioritise the collection of Te Ao Māori service quality data and embed Māori data governance

There are significantly fewer data sources that reflect a Te Ao Māori perspective of service quality. Where these data sources do exist, they are collected in far less frequency than data for 'everyone'. While we can 'slice' indicators and measures for Māori using ethnicity data, this does not tell us enough.

The lack of Te Ao Māori service quality data is a concern given persistent inequities in the prevalence of mental distress, substance and gambling harm, and in treatment for Māori and the place of Māori as tāngata whenua (people of the land).

There are major structural challenges to measuring and monitoring Māori wellbeing. Many of the agencies and organisations that collect or steward Māori data lack the capability or capacity to apply a Te Ao Māori lens to their data collection or analysis. More fundamentally, they lack active Māori data governance, and, therefore, a transparent mechanism for Māori influence. The establishment of the Māori Health Authority is a good start.

Both the Commission's monitoring frameworks – the **He Ara Oranga Wellbeing Outcomes Framework** and the draft **He Ara Āwhina Framework** include both Te Ao Māori and shared perspectives, reflecting the role that tangata whenua and tangata tiriti (non-Maori who live in Aotearoa under Te Tiriti of Waitangi) have to play in working together to support improving the collective wellbeing of all.

Amend service data collection to ensure the unit of measurement can include whānau

Most data collected by mental health services and addiction services is about the individual, but there is virtually no quantitative data available about whānau (particularly, as defined by tāngata whaiora). In the absence

of data about whānau, evidence based on New Zealand households and families is used to inform strategy development, planning, priority-setting, decision-making, policy, and delivery. While there is data available on Māori families who live together in the same household level, this data does not equate directly to whānau.

Standardised nationally reported data on tāngata whaiora experiences of using services is vital to inform the ways services can improve

A focus on tāngata whaiora experience is key to services becoming culturally safe and responding to the needs and preferences of tāngata whaiora. There needs to be comparable, representative data on tāngata whaiora and whānau experiences using mental health services and addiction services and supports. This data needs to include experiences that encompass a cultural worldview to give an accurate representation of service experience for all communities.

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Ngā tāpiritanga
Appendix

Tikanga mahi / Methodology

Using the former Mental Health Commissioner's measures as starting point

We assessed mental health and addiction services by adapting the former Mental Health Commissioner's monitoring framework. This framework was developed by the former Mental Health Commissioner in consultation with tāngata whaiora, family and whānau, and mental health and addiction sector representatives.[21] This framework is made up of six monitoring questions:

- Can I get help for my needs?
- Am I helped to be well?
- Am I a partner in my care?
- Am I safe in services?
- Do services work well together for me?
- Do services work well for everyone?

These questions show service performance from the perspective of tāngata whaiora with reference to the internationally regarded dimensions of health care quality – access, safety, experience, equity, effectiveness, and efficiency – developed by the National Academy of Medicine (formerly the Institute of Medicine) and adopted in Aotearoa by the Health Quality & Safety Commission.

He Ara Āwhina co-define phase and peer review

To monitor mental health and addiction services, we carried over the former Mental Health Commissioner's mental health and addiction service quality domain categories and adapted the language to reflect feedback from the co-define phase of the **He Ara Āwhina (Pathways to Support)** framework development,[22] and to align with the Commission's **He Ara Oranga Wellbeing Outcomes Framework.**[23]

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[21] Health and Disability Commissioner, New Zealand's Mental Health and Addiction Services — The monitoring and advocacy report of the Mental Health Commissioner (2018), Appendix 2.

[22] He Ara Āwhina (Pathways to Support) Framework co-define phase and a summary of feedback is published on our website.

[23] He Ara Oranga Wellbeing Outcomes Framework is published on our website.

We heard in the co-define phase that monitoring of services is important, and that the former Mental Health Commissioner's monitoring framework is a useful start. However, people want to see the Commission looking holistically at supports for people and whānau who experience mental distress and harm from substance use, gambling, and addiction, including prevention and health promotion, harm reduction, healing, and treatment.

Changes we have introduced in this monitoring report include bringing equity to the front, having aspirational statements rather than questions, moving from 'I' to 'people and whānau / tāngata whaiora', and strengthening autonomy by changing from partnership to leadership in care.

He Ara Āwhina co-design phase

We are co-designing our future monitoring framework, **He Ara Āwhina** from a Te Ao Māori perspective and a shared perspective to look at how the whole mental health and addiction system supports the wellbeing of people and whānau who experience mental distress, substance use harm, or gambling harm (or a combination of these). Between September 2021 and February 2022, we worked with an Expert Advisory Group,[24] held hui and focus groups with lived experience communities, and sought targeted sector feedback to co-design a draft vision of what a

system of services, support, and approaches should look like for tāngata whaiora. We will be seeking public feedback on that draft in March and April 2022.

We have drawn on the feedback gathered so far in the co-design phase to inform our call to action.

Criteria for selecting exemplars

The exemplars we chose to feature had to collectively highlight Māori, Pacific, youth, and peer-led approaches, and demonstrate responses for the Commission's priority groups.[25]

Exemplars were ranked on their ability to:

- clearly relate to a service quality domain
- focus on mental health and addiction services, programmes, and initiatives
- give a sense of what services, programmes, and initiatives might be like if they were transformational, so that others can learn from them.

Making sense of the quantitative data

To understand what the data was telling us about services, we held a workshop with mental health and addiction service data experts, tāngata whaiora, and kaupapa Māori experts.

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[24] Expert Advisory Group members and biographies are available on our website Kāhui Matanga / Expert Advisory Group | Mental Health and Wellbeing Commission (mhwc.govt.nz).
[25] The Commission's priority groups include Māori, Pacific peoples, Asian peoples, migrants, former refugees, rainbow communities, trans people, people with variations of sex characteristics, disabled people, veterans, prisoners, rural communities, young people, older people, children in state care, and children experiencing adverse events.

Ngā inega / Measures

Equity

This domain uses measures from all of the other domains to assess equity in mental health services and addiction services overall. The measures within each domain provide information on priority groups where possible, and within domain 1 we looked for key equity gaps.

The Commission was supplied data by the Ministry of Health, from PRIMHD[26] and other sources, broken down for Māori and Pacific people, young people aged 0 to 19, older people over 65 years, and by service type (Alcohol and Other Drug (AOD) / Mental Health / NGO / DHB). This data contributed to the analysis undertaken for the domain, 'services work for all tāngata whaiora'.

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[26] PRIMHD (Programme for the Integration of Mental Health Data) database is a single collection of national mental health and addiction services information, administered by the Ministry of Health, and includes service activity and outcomes data.

Access and options

Measure	2020 / 21	2019 / 20	2018 / 19	2017 / 18	2016 / 17
How much was spent on mental health and addiction services (DHB and Ministry of Health expenditure)?[27]	$1.82b	$1.69b	$1.53b	$1.47b	$1.44b
COVID-19 psychosocial response services	$10m	$9m	–	–	–
Expanding Access and Choice of Primary Mental Health and Addiction Support – Service Delivery[28] (contracted)	$63m	$14m	–	–	–
Primary mental health services[29]	$39m	$41m	$36m	$33m	$31m
Adult mental health services	$1.5b	$1.4b	$1.3b	$1.2b	$1.2b
Kaupapa Māori services[30]	$203m	$190m	$151m	$151m	$146m
Pacific services[31]	$28m	$21m	$15m	$14m	$14m
Addiction services[32]	$186m	$183m	$162m	$161m	$158m
Infant, child, and youth services[33]	$215m	$212m	$194m	$183m	$184m
Older adult services[34]	$56m	$55m	$54m	$53m	$52m
Forensic services[35]	$161m	$155m	$143m	$133m	$130m
NGO services[36]	$602m	$563m	$477m	$457m	$450m
Peer support services[37]	$40m	$38m	$34m	$32m	$31m

Measure	2020 / 21	2019 / 20	2018 / 19	2017 / 18	2016 / 17
How many people in Aotearoa access primary mental health services? **(% population)** (estimated, this only includes funded primary mental health and addiction services accessed through a general practice. It does not include people who access their General Practice for mental health reasons, nor does it include new Access and Choice services)[38]	152,993	123,278	132,525	136,674	130,663
Māori (% of total access)	17%	17%	17%	17%	18%
Percentage of Māori population	3%	3%	3%	3%	3%
Pacific (% of total access)	6%	7%	8%	9%	8%
Young people 12 – 19 (% of total access)	18%	15%	15%	14%	12%
Adults 20+ (% of total access)[39]	82%	85%	85%	86%	88%
How many people in Aotearoa access specialist mental health and addiction services (% population)?[40]	191,053 (3.7%)	182,232 (3.7%)	184,062 (3.7%)	178,765 (3.7%)	176,994 (3.7%)
Māori (% of total access)	52,729 (28%)	52,460 (29%)	51,720 (28%)	48,936 (27%)	47,360 (27%)
Māori (% of Māori population)	6%	6%	6%	6%	6%
Pacific (% of total access)	11,234 (6%)	10,991 (6%)	11,244 (6%)	10,623 (6%)	10,401 (6%)
Addiction services (% of total access)	48,759 (26%)	49,352 (27%)	52,034 (28%)	52,015 (29%)	51,979 (29%)
Young people 0 – 19 (% total access)	51,947 (28%)	49,051 (27%)	50,329 (27%)	49,480 (28%)	48,564 (27%)
Adults 20 – 64 (% of total access)[41]	123,184 (66%)	120,834 (66%)	120,385 (65%)	116,478 (65%)	115,818 (65%)
Older people (% of total access)[42]	15,481 (8%)	15,304 (8%)	15,012 (8%)	14,399 (8%)	14,226 (8%)
What proportion was with an NGO service? (includes people who saw both an NGO and DHB)[43]	42%	42%	41%	40%	39%

Measure	2020 / 21	2019 / 20	2018 / 19	2017 / 18	2016 / 17
How many people in Aotearoa contact national mental health and addiction telehealth services? (number of unique users)[44]	110,701	118,821	102,970	79,435	50,586
Depression helpline	29,131	33,670	34,131	36,575	31,530
1737 / need to talk[45]	63,275	65,251	48,779	21,467	-
Alcohol and other drug helpline	14,894	16,610	16,555	17,033	14,271
Gambling helpline	3,401	3,290	3,505	4,360	4,785
How many people in Aotearoa used national mental health and addiction online platforms? (number of unique visitors)					
drughelp.org.nz[46]	27,121	29,264	36,745	46,281	33,350
pothelp.org.nz	5,490	4,935	4,179	10,862	12,778
depression.org.nz[47]	515,036	510,589	415,317	290,573	306,809
thelowdown.co.nz	126,377	119,233	98,182	92,515	92,830

Measure	2020 / 21	2019 / 20	2018 / 19	2017 / 18	2016 / 17
How many treatment days were delivered across different specialist mental health and addiction services?[48] (total treatment days)					
Individual treatment sessions	1,441,938	1,420,405	1,391,557	1,401,372	1,401,314
Community support	496,718	508,342	508,586	529,106	554,203
Coordination of care	515,087	488,455	481,967	495,628	531,374
Contacts with family / whānau	381,760	373,057	364,561	365,952	350,002
Group programmes	167,800	149,393	187,187	175,971	174,674
Crisis attendances	121,137	122,086	114,402	108,538	97,814
Day programmes	92,454	102,934	128,101	134,255	146,271
Peer support contacts	61,133	62,358	69,832	70,874	68,120
Māori specific interventions	63,602	67,053	61,567	61,802	57,593
Pacific specific interventions	2,218	2,683	2,290	1,965	1,456
Opioid substitution treatment service	38,619	42,740	40,723	39,330	40,885

Measure	2020 / 21	2019 / 20	2018 / 19	2017 / 18	2016 / 17
What is the number of initial dispensings of mental health and substance use medications?[49]	3,251,352	3,046,269	2,898,750	2,800,942	2,729,268
Number of antidepressants?	2,094,348	1,942,204	1,859,006	1,812,519	1,758,854
Māori	205,116	187,911	168,772	153,569	141,563
Pacific	42,601	38,294	35,079	32,294	30,027
Young people (0 – 19)	99,418	82,195	77,136	70,529	66,004
Adults (20 – 64)	1,390,780	1,289,337	1,230,011	1,204,192	1,168,729
Older people (65+)	604,150	570,672	551,859	537,798	524,121
Number of antipsychotics?	711,004	668,131	623,287	588,912	570,611
Māori	142,490	133,830	119,792	110,144	104,110
Pacific	31,612	29,273	27,081	25,399	24,035
Young people (0 – 19)	38,471	32,643	31,132	28,085	24,980
Adults (20 – 64)	475,647	451,115	419,949	398,867	386,360
Older people (65+)	196,886	184,373	172,206	161,960	159,271

Measure	2020 / 21	2019 / 20	2018 / 19	2017 / 18	2016 / 17
Number of anxiolytics?	446,000	435,934	416,457	399,511	399,803
Māori	48,231	46,609	41,218	37,173	35,490
Pacific	9,200	8,568	7,717	6,824	6,592
Young people (0 – 19)	9,136	8,174	7,614	6,422	6,222
Adults (20 – 64)	301,377	295,237	277,879	264,093	261,786
Older people (65+)	135,487	132,523	130,964	128,996	131,795
What is the number of initial dispensing's of methodone treatment for opioid dependence?[50]	80,875	77,402	74,698	-	-
Māori	14,489	14,261	12,899	-	-
Pacific	635	435	459	-	-
Young people (0 – 19)	184	103	51	-	-
Adults (20 – 64)	76,685	74,120	72,403	-	-
Older people (65+)	4,006	3,179	2,244	-	-
How long do people wait to access DHB mental health services following first referral? (%)[51] ≤48 hours / ≤3 weeks / ≤8 weeks*	48 / 76 / 92	48 / 76 / 91	47 / 75 / 91	46 / 77 / 93	47 / 79 / 94
	Targets are for 80% to be seen within 3 weeks and 95% within 8 weeks.				
Māori	56 / 80 / 93	55 / 79 / 91	54 / 79 / 91	51 / 79 / 93	52 / 80 / 94
Pacific	55 / 82 / 94	57 / 82 / 92	55 / 80 / 90	56 / 85 / 95	55 / 86 / 95
Young people (0 – 19)	35 / 65 / 87	35 / 65 / 85	34 / 65 / 86	34 / 70 / 90	32 / 70 / 92
Adults (20 – 64)	58 / 81 / 93	58 / 81 / 93	58 / 81 / 93	47 / 83 / 94	57 / 83 / 94
Older people (65+)	42 / 84 / 96	43 / 82 / 96	41 / 84 / 95	45 / 86 / 96	45 / 86 / 96

Measure	2020 / 21	2019 / 20	2018 / 19	2017 / 18	2016 / 17
How long do people wait to access addiction services following first referral? (%) ≤48 hours / ≤3 weeks / ≤8 weeks*	40 / 76 / 93	47 / 79 / 92	56 / 85 / 95	49 / 82 / 94	49 / 82 / 94
	Targets are for 80% to be seen within 3 weeks and 95% within 8 weeks.				
Māori	43 / 81 / 96	53 / 82 / 95	52 / 81 / 94	50 / 80 / 93	52 / 80 / 94
Pacific	40 / 75 / 93	71 / 94 / 99	70 / 94 / 99	63 / 92 / 98	55 / 86 / 95
Young people (0 – 19)	40 / 77 / 93	49 / 82 / 94	39 / 87 / 96	51 / 84 / 95	52 / 85 / 96
Adults (20 – 64)	42 / 76 / 93	47 / 79 / 92	48 / 81 / 94	48 / 81 / 94	46 / 80 / 93
Older people (65+)	49 / 82 / 95	44 / 78 / 93	46 / 82 / 94	54 / 77 / 93	47 / 81 / 94
What percent of complaints about mental health and addiction services are about access to those services?[52]	18%	16%	16%	18%	15%

27 Supplied by the Ministry of Health, February 2022. This measure includes expenditure identified in the Ministry of Health's contract and financial systems with a mental health or addiction service-related code: specialist mental health and addiction services, including inpatient, residential, community support, forensic, de-stigmatisation, methadone, alcohol and drug, specialist (e.g. maternal mental health), primary mental health, quality improvements, service & workforce, research and development, pregnancy parenting, Mana Ake, problem gambling, and suicide prevention services.

28 Service delivery only. Excludes workforce development and enablers.

29 DHB funded PU codes PHOMH001 & PHOMH002. Excludes Access and Choice services.

30 This is all services specified as Māori, defined by the GL code, contract or PUC being 'Māori'. Includes relevant primary mental health and Access and Choice.

31 As per above, includes relevant primary mental health and Access and Choice.

32 Includes methadone, and child and youth AOD services.

33 Includes child and youth AOD services and youth forensic services. Includes relevant primary mental health and Access and Choice.

34 Excludes Southern and Central regions as this is funded by DSS.

35 Includes youth forensic (also included in 'infant, child and youth services' above).

36 These figures are also included in other service types. For example, NGO child and youth services are included in both NGO services and infant, child and youth services.

37 Child and youth peer support is also included under "infant, child and youth services" above. Forensic peer support is also included under "Forensic services" above.

38 Supplied by the Ministry of Health, November 2021. Population group estimates calculated by the Commission. These figures relate only to the devolved primary mental health funding that DHBs report against, and are estimates only as the unique number of clients seen in New Zealand is not reported. Clients seen by more than one DHB and in more than one quarter of the year, or more than one service, are double counted. The figures do not include the new Access and Choice services, which commenced in 2019 / 20, as reporting of Access and Choice volumes is unreliable for this time period. Percentages were calculated by MHWC using the Health Service User population estimates.

39 The Ministry of Health do not collect the 20 - 64 and 65+ age groups separately.

40 PRIMHD database, analysed by the Ministry of Health, November 2021. 2020 / 21 overall data is from a more recent extraction on 19 / 01 / 2022 as previous data included completeness issues with Hawke's Bay data; the decline between 2018 / 19 and 2019 / 20 is due to COVID-19. This includes all specialist mental health and addiction services for all ages, including ICAMHS. This data is different to the PP6 / MH01 data on the NSFL website, which was run at different times, and for 2018 / 19 NSFL data did not include NMDHB data.

41 There is a data quality and completeness issues for Bay of Plenty, Waikato, and Waitemata DHBs, which are currently being resolved.

42 The data on healthcare users aged over 65 (including psychogeriatric services) is incomplete. Mental health and addiction services for older people are funded as mental health and addiction services in the Northern and Midland regions. In the Southern and Central regions, they are funded as disability support services. PRIMHD mainly captures mental health and addiction services, and occasionally captures data on disability support services.

43 Ministry of Health PRIMHD database, analysed by the Ministry of Health, November 2021. Specialist Service use (PRIMHD) Qlik App.

44 Whakarongorau Aotearoa, supplied by Ministry of Health, November 2021. Over the last 18 months, the National Telehealth Service have shifted some of their data onto a new platform (Lightfoot), and the data has been reconciled through that process. This has meant that some of the numbers (user numbers in particular) have changed slightly from that shown in previous Annual Plans. With all data now operating through the Lightfoot platform, there shouldn't be any future discrepancies.

45 1737 / need to talk launched June 2017.

46 Supplied by NZ Drug Foundation, November 2021. New Zealand IP addresses only. Drughelp and Pothelp have been replaced by thelevel.org.nz, which launched August 30, 2021.

47 Supplied by Te Hiringa Hauora, November 2021. New Zealand IP addresses only.

48 Ministry of Health PRIMHD database, analysed by Te Pou, November 2021. Treatment days count as a single contact day, regardless of the number of contacts an individual has in a single day. Tāngata whaiora can have multiple treatment days.

49 Ministry of Health Pharmaceutical Collection, supplied by Ministry of Health, November 2021. The number of times a pharmaceutical product was dispensed from a pharmacy to a named person as initial dispensing's or all at once (i.e. excludes repeat dispensing's).

The Pharmaceutical Collection only counts publicly funded, community dispensed pharmaceuticals; it does not count hospital dispensings, drugs not funded by Pharmac, or prescriptions that were never dispensed. Hence, we have no visibility of the actual number of prescriptions that are written, only those that result in a dispensing. There was an overall increase in dispensings in 2020 seen across all groups of medicines. The total number of dispensings increased from 47.7 million to 56.6 million between 2019 and 2020: an 18.7 % increase. For comparison, dispensings increased from 46.3 million to 47.7 million (3 % increase) between 2018 and 2019, and from 45.9 million to 46.3 million (0.9 % increase) between 2017 and 2018.

These changes reflect the impacts of the COVID-19 pandemic, rather than changes in the actual amount of a pharmaceutical which an individual person received. The reasons for these changes are outlined below:

Prior to March 2020, under the Pharmac Schedule, some medicines were dispensed monthly and others were dispensed thee-monthly. In March 2020, Pharmac introduced a change to the Schedule which required pharmacies to move to monthly dispensing, rather than all at once dispensing. This change meant that a patient would have to go into a pharmacy three times for a normal 90-day prescription, rather than once. This was done to ensure that everyone had access to the medications they needed, to prevent stockpiling, and in response to difficulties in global medicine supply.

New Zealand returned to normal dispensing rules for most medicines on 1 August 2020. It should also be noted that 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, 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.

[50] Ministry of Health Pharmaceutical Collection, supplied by Ministry of Health, November 2021. The Pharmaceutical Collection only counts publicly funded, community dispensed pharmaceuticals; it does not count hospital dispensings, drugs not funded by Pharmac, or prescriptions that were never dispensed. Hence, we have no visibility of the actual number of prescriptions that are written, only those that result in a dispensing. Publicly funded initial dispensing's to patients in the Pharmacy Methadone Service for Opioid Dependence. The reporting of the patient cohort variable (which was used to identify those in the Pharmacy Methadone Service for Opioid Dependence), and the logic behind the cohorts was finalised in January 2018, and as such, the reporting before this point is not consistent with the reporting after. For this reason, we have only included the three latest financial years in which the reporting is consistent and based off the same logic.

[51] Ministry of Health PRIMHD database, supplied by the Ministry of Health, November 2021. 2020 / 21 figure from April 2020 - March 2021 PP8 report.

[52] Supplied by the Office of the Health and Disability Commissioner, November 2021. Issues relating to access include complaints about prioritisation of access.

Participation and Leadership

Measure	2020 / 21	2019 / 20	2018 / 19	2017 / 18	2016 / 17
What percent of tāngata whaiora and whānau report they feel involved in decisions about their care?[53] (agreed / disagreed)					
Tāngata whaiora	76% / 10%	76% / 9%	77% / 9%	77% / 11%	77% / 9%
Māori	76% / 10%	78% / 9%	77% / 9%	79% / 10%	79% / 8%
Pacific	86% / 4%	81% / 7%	79% / 7%	81% / 8%	81% / 8%
Whānau	76% / 10%	81% / 7%	75% / 7%	79% / 7%	80% / 6%
NGO average	75% / 10%	78% / 8%	77% / 9%	78% / 7%	82% / 6%
What percent of complaints about mental health and addiction services include issues with communication?[54]	61%	63%	60%	57%	55%
What percent of tāngata whaiora have a transition plan?[55]					
On discharge from an inpatient unit	74%	75%	90%	–	–
On discharge from community care	64%	62%	64%	57%	–
What percent of tāngata whaiora and whānau report that their plan is reviewed regularly?[56] (agree / disagree)					
Tāngata whaiora	75% / 10%	74% / 9%	75% / 9%	75% / 10%	76% / 8%
Māori	76% / 9%	75% / 10%	76% / 10%	77% / 9%	77% / 7%
Pacific	86% / 4%	79% / 7%	80% / 7%	82% / 7%	82% / 6%
Whānau	76% / 8%	77% / 7%	75% / 7%	76% / 7%	77% / 5%
NGO average	77% / 9%	75% / 8%	75% / 8%	75% / 7%	78% / 7%

Measure	2020 / 21	2019 / 20	2018 / 19	2017 / 18	2016 / 17
How many treatment days involving family and whānau were provided by services?[57] (Percentage of total treatment days)	381,760 (12%)	373,057 (12%)	364,561 (11%)	365,952 (11%)	350,002 (11%)
Māori	109,437 (11%)	109,509 (12%)	111,260 (11%)	106,602 (11%)	99,899 (10%)
Pacific	27,450 (12%)	25,197 (11%)	24,466 (11%)	26,304 (11%)	24,393 (11%)
Young people 0 – 19	204, 967 (33%)	196,748 (33%)	190,371 (32%)	196,318 (32%)	189,082 (32%)
Adults 20 – 64	146,807 (6%)	145,958 (6%)	147,834 (6%)	142,857 (6%)	133,714 (6%)
Older people 65+	29,986 (13%)	30,351 (13%)	26,356 (12%)	26,777 (12%)	27,206 (13%)
Addiction services	26,923 (5%)	28,981 (5%)	29,364 (5%)	27,340 (5%)	26,066 (4%)
NGO services	80,095 (6%)	81,436 (6%)	86,374 (6%)	79,710 (6%)	71,889 (5%)
How many treatment days were provided by services to support family and whānau, including children?[58]	18,122	16,099	15,537	13,919	12,019
Māori	4,410	5,123	5,129	4,060	3,244
Pacific	838	472	466	483	269
Young people 0 – 19	4,265	3,247	5,125	4,911	4,699
Adults 20 – 64	11,432	10,599	8,749	7,676	5,814
Older people 65+	2,425	2,253	1,663	1,332	1,506
Addiction services	1,707	2,503	2,216	1,991	2,327
NGO services	17,609	15,663	14,419	12,955	11,408

Measure	2020 / 21	2019 / 20	2018 / 19	2017 / 18	2016 / 17
How many treatment days were provided to support tāngata whaiora in their role as parents or caregivers?[59]	1,430	1,351	1,851	1,760	1,667
Māori	377	434	534	405	451
Pacific	134	76	141	239	137
Young people 0 – 19	483	228	168	217	269
Adults 20 – 64	944	1,114	1,666	1,523	1,370
Older people 65+	3	9	17	20	28
Addiction services	155	215	363	226	467
NGO services	765	844	953	1,195	1,101
How many people were subject to a compulsory community treatment order under the Mental Health Act?[60] **(calendar year to 2020)** (% of tāngata whaiora using specialist service)	6,728	6,408	6,291	6,092	6,139
Māori (% of community CTOs)	39%	38%	38%	37%	35%
Pacific (% of community CTOs)	9%	9%	10%	10%	9%
Young people 0 – 19 (% of community CTOs)	4%	4%	4%	4%	4%
Adults 20 – 64 (% of community CTOs)	89%	89%	89%	89%	87%
Older people 65+ (% of community CTOs)	7%	7%	7%	7%	6%
How many people were detained under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017?[61] **(calendar year to 2019, then financial year for 2020 / 21)**	37	26	25	-	-
Māori (%)	16%	15%	16%	-	-
Pacific (%)	5%	4%	0%		
Women (%)	57%	46%	48%		
Age range	19 - 74 years	24 – 68 years	23 – 69 years		
How long was the average length of detention under the Substance Addiction Act? **(calendar year to 2019, then financial year for 2020/21)**	12 weeks, 4 days	10 weeks, 6 days	7 weeks, 4 days	-	-

[53] Mārama Real Time Feedback Consumer and Family Experience Survey, analysed by CBG Health Research and Te Pou, November 2021.

[54] Supplied by the Office of the Health and Disability Commissioner, November 2021. These complaints are in reference to communication both with the consumer and their whānau (not just the consumer). There are several reasons for increases in complaints over time, possible reasons may include: an increasing awareness among consumers of their rights, increasing health service activity, the public profile of mental health and addiction services, and overall pressure on services.

[55] Supplied by the Ministry of Health, November 2021. This data is not collected by ethnicity or age. rather it is collected by inpatient, community discharges, and those who have been in the service more than a year (though, this is only available for 2020 / 21). DHB inpatient reporting was relatively new in 2018 / 19. 3 DHBs did not report in the last quarter of 2018 / 19 and two DHBs did not report in the last quarter of 2019 / 20.

[56] Mārama Real Time Feedback Consumer and Family Experience Survey analysed by CBG Health Research and Te Pou, November 2021.

[57] Ministry of Health PRIMHD database, analysed by Te Pou, November 2021. Codes T32 "Contact with family / whānau, tāngata whaiora not present" and T36 "Contact with family / whānau, tāngata whaiora / tāngata whaiora present" combined. Percentage is calculated out of total treatment days including "did not attend".

[58] Ministry of Health PRIMHD database, analysed by Te Pou, November 2021. Codes T47 "Support for family / whānau" and T49 "Support for Children of Parents with Mental Illness and Addictions" combined. This information is not well reported and likely to be underestimated.

[59] Ministry of Health PRIMHD database, analysed by Te Pou, November 2021. Code T50 "Support for Parents with Mental Illness and Addictions". Note that this code has been collected only since 1 July 2016. This code is not embedded into services. It will take a while for people to know this this code is available and to use it properly.

[60] Supplied by Ministry of Health, November 2021. Shown as calendar year not financial year.

[61] Supplied by Ministry of Health, November 2021. Calendar years for 2018 and 2019, and then financial year 2020 / 21 (due to a reporting year adjustment). The Substance Addiction (Compulsory Assessment and Treatment) Act 2017 has been in operation since February 2018.

Safety

Measure	2020 / 21	2019 / 20	2018 / 19	2017 / 18	2016 / 17
What percent of complaints about mental health and addiction services were about inadequate or inappropriate care?[62]	24%	22%	23%	22%	18%
How many serious adverse events (suspected suicide, serious self-harm, and serious adverse behaviour) are reported in mental health and addiction services (DHBs only)? [63]	231	218	232	232	198
How many people in inpatient units were put in solitary confinement (seclusion)?[64] **(calendar year to 2020)**	1,179	1,159	1,066	977	990
Māori adults (% of total confined)	38%	37%	35%	33%	36%
Māori adults (% of adults confined)	48%	47%	44%	41%	44%
Pacific adults (% of total confined)	5%	6%	6%	6%	6%
Pacific adults (% of adults confined)	7%	7%	8%	8%	6%
Young people 0 – 19 (% of total confined)	9%	8%	9%	10%	11%
Adults 20 – 64 (% of total confined)	79%	80%	80%	79%	81%
Older people 65+ (% of total confined)	2%	3%	2%	1%	1%

Measure	2020 / 21	2019 / 20	2018 / 19	2017 / 18	2016 / 17
How many times was solitary confinement used in inpatient units (some people have more than one solitary confinement event)?[65] **(calendar year to 2020)**	2,934	2,507	2,543	2,677	2,279
Māori adults (% of total events)	31%	33%	28%	24%	26%
Māori adults (% of adult events)	44%	47%	43%	40%	40%
Pacific adults (% of total events)	5%	5%	5%	5%	5%
Pacific adults (% of adult events)	7%	8%	7%	8%	5%
Young people 0 – 19 (% of total events)	13%	10%	8%	11%	14%
Adults 20 – 64 (% of total events)	71%	70%	66%	59%	65%
Older people 65+ (% of total events)	1%	2%	1%	1%	1%
What proportion of solitary confinement events in inpatient units last less than 24 hours?[66] **(calendar year to 2020)**	75%	71%	72%	76%	74%
Māori adults (% of events)	69%	66%	62%	75%	69%
Pacific adults (%)	70%	80%	71%	74%	81%
Young people 0 – 19 (%)	74%	78%	71%	83%	87%
Adults 20 – 64 (%)	76%	71%	71%	71%	66%
Older people 65+ (%)[67]	76%	46%	68%	83%	72%

[62] Supplied by the Office of the Health and Disability Commissioner, November 2021.

[63] Supplied by the Health Quality & Safety Commission, November 2021. Adverse events: national quarterly dashboard. Wellington: Health Quality & Safety Commission.

[64] Supplied by Ministry of Health, February 2022. Numbers are calendar year not financial year. Total people confined, and percentage of adults confined is shown for Māori and Pacific adults. Age groups shown do not add to 100 % as the Adult figures exclude forensic.

[65] Supplied by Ministry of Health, February 2022. Numbers are calendar year, show the total confinement events and percentage of adult events for Māori and Pacific. The denominator for young people includes both adult and youth inpatient units. Age groups shown do not add to 100 % as the Adult figures exclude forensic.

[66] Supplied by Ministry of Health, November 2021. Shown as calendar year not financial year.

[67] The drop in the older persons percentage of seclusion events of less than 24 hours in 2018 and 2019 was driven by one DHB who did not raise data quality issues when the Office of the Director of Mental and Addiction Services annual report data was shared with DHBs prior to publishing the reports.

Effectiveness

Measure		2020 / 21	2019 / 20	2018 / 19	2017 / 18	2016 / 17
What percent of tāngata whaiora and their whānau report they would recommend their service to friends or family if they needed similar care or treatment?[68] (agreed / disagreed)						
Tāngata whaiora		80% / 10%	82% / 7%	82% / 7%	82% / 9%	82% / 8%
Māori		82% / 9%	83% / 8%	84% / 8%	83% / 9%	84% / 8%
Pacific		91% / 2%	85% / 5%	85% / 5%	85% / 8%	86% / 6%
Whānau		83% / 8%	84% / 5%	84% / 5%	83% / 6%	83% / 5%
NGO average		83% / 7%	85% / 5%	84% / 6%	85% / 4%	89% / 4%
Average improvement in clinician-rated scores for the mental health of adult tāngata whaiora of inpatient, community services (admission / discharge)[69]	Inpatient	15 / 7 (51%⇑)	15 / 7 (49%⇑)	15 / 7 (52%⇑)	14 / 7 (53%⇑)	14 / 7 (51%⇑)
	Community	10 / 6 (46%⇑)	10 / 5 (48%⇑)	11 / 6 (48%⇑)	11 / 5 (49%⇑)	11 / 5 (49%⇑)
Māori	Inpatient	15 / 7 (53%⇑)	15 / 8 (51%⇑)	15 / 7 (54%⇑)	15 / 7 (54%⇑)	15 / 7 (52%⇑)
	Community	11 / 6 (42%⇑)	11 / 6 (46%⇑)	11 / 6 (45%⇑)	11 / 6 (46%⇑)	11 / 6 (48%⇑)
Pacific	Inpatient	13 / 5 (58%⇑)	14 / 6 (55%⇑)	14 / 5 (62%⇑)	14 / 5 (61%⇑)	13 / 6 (52%⇑)
	Community	9 / 5 (49%⇑)	10 / 4 (56%⇑)	10 / 4 (56%⇑)	9 / 5 (47%⇑)	9 / 5 (50%⇑)

Measure		2020 / 21	2019 / 20	2018 / 19	2017 / 18	2016 / 17
Average improvement in clinician-rated scores for the mental health of child and youth tāngata whaiora of inpatient, community services (admission / discharge)[70]	Inpatient	17 / 11 (35%↑)	19 / 11 (41%↑)	19 / 11 (42%↑)	19 / 12 (40%↑)	18 / 11 (37%↑)
	Community	15 / 8 (47%↑)	15 / 9 (43%↑)	15 / 9 (43%↑)	15 / 8 (45%↑)	14 / 8 (47%↑)
Māori	Inpatient	19 / 11 (42%↑)	21 / 11 (48%↑)	22 / 12 (45%↑)	21 / 12 (45%↑)	20 / 13 (35%↑)
	Community	16 / 9 (45%↑)	16 / 9 (40%↑)	16 / 10 (39%↑)	15 / 9 (40%↑)	15 / 9 (43%↑)
Pacific	Inpatient	SN[71]	SN[72]	SN	SN	SN
	Community	15 / 7 (55%↑)	15 / 8 (47%↑)	16 / 8 (48%↑)	15 / 8 (46%↑)	14 / 7 (55%↑)
Average improvement in clinician-rated scores for the mental health of tāngata whaiora aged 65+ in inpatient, community services (admission / discharge)[73]	Inpatient	15 / 9 (39%↑)	15 / 9 (42%↑)	16 / 8 (49%↑)	16 / 9 (44%↑)	15 / 8 (43%↑)
	Community	12 / 8 (32%↑)	11 / 8 (32%↑)	11 / 8 (33%↑)	11 / 8 (31%↑)	12 / 8 (33%↑)
Māori	Inpatient	16 / 10 (35%↑)	15 / 10 (36%↑)	15 / 8 (47%↑)	15 / 10 (35%↑)	16 / 10 (37%↑)
	Community	12 / 8 (29%↑)	12 / 8 (33%↑)	11 / 8 (31%↑)	11 / 8 (25%↑)	12 / 8 (34%↑)
Pacific	Inpatient	SN[74]	13 / 7 (50%↑)	14 / 7 (51%↑)	16 / 6 (59%↑)	14 / 8 (48%↑)
	Community	11 / 8 (26%↑)	11 / 7 (32%↑)	11 / 8 (28%↑)	10 / 7 (30%↑)	11 / 8 (24%↑)

Measure		2020 / 21	2019 / 20	2018 / 19	2017 / 18	2016 / 17
Average improvement in clinician-rated scores for the mental health of tāngata whaiora in forensic services (admission / discharge)[75]	Inpatient	13 / 7 (44%↑)	12 / 7 (42%↑)	12 / 7 (41%↑)	12 / 8 (36%↑)	11 / 6 (43%↑)
	Community	9 / 3 (67%↑)	12 / 7 (41%↑)	13 / 8 (35%↑)	12 / 9 (25%↑)	11 / 8 (30%↑)
Māori	Inpatient	13 / 7 (48%↑)	13 / 7 (42%↑)	13 / 7 (48%↑)	13 / 8 (38%↑)	11 / 6 (42%↑)
	Community	9 / 3 (69%↑)	12 / 7 (39%↑)	13 / 9 (36%↑)	12 / 9 (21%↑)	11 / 8 (28%↑)
Pacific	Inpatient	SN	SN	SN	SN	SN
	Community	SN	SN	SN	SN	SN
Average self-rated increase in tāngata whaiora satisfaction towards achieving recovery goals (addiction services)[76]		↑28%	↑26%	↑25%	↑24%	↑25%
Māori		↑21%	↑23%	↑24%	↑23%	↑27%
Pacific		↑29%	↑24%	↑22%	↑16%	↑19%
Young people 18 – 24		↑24%	↑23%	↑27%	↑29%	↑20%
Adults 25 – 64		↑28%	↑26%	↑24%	↑23%	↑25%
Older people 65+		SN	↑31%	↑33%	SN	SN
What percent of tāngata whaiora have independent / supported / no accommodation?[77] (%)		85 / 11 / 4	84 / 11 / 4	84 / 12 / 4	83 / 13 / 4	82 / 14 / 4
Māori		79 / 14 / 7	79 / 15 / 6	78 / 16 / 6	78 / 16 / 6	77 / 17 / 6
Pacific		80 / 14 / 6	81 / 14 / 5	80 / 16 / 4	77 / 18 / 5	77 / 18 / 5
Addiction services		84 / 12 / 4	83 / 13 / 4	81 / 15 / 5	80 / 15 / 5	81 / 14 / 4
Young people 0 – 19		89 / 10 / 1	89 / 10 / 2	87 / 11 / 2	85 / 13 / 1	83 / 15 / 2
Adults 20 – 64		85 / 9 / 6	84 / 10 / 6	84 / 11 / 6	84 / 11 / 6	83 / 11 / 6
Older people 65+		74 / 24 / 1	74 / 25 / 1	74 / 25 / 1	73 / 26 / 1	68 / 31 / 1
NGO services		82 / 12 / 6	82 / 13 / 5	81 / 14 / 5	79 / 15 / 6	79 / 15 / 6

Measure	2020 / 21	2019 / 20	2018 / 19	2017 / 18	2016 / 17
What percent of tāngata whaiora are in employment or in education or in training?[78]	49%	49%	49%	48%	45%
Māori	44%	44%	46%	45%	44%
Pacific	45%	45%	47%	41%	40%
Addiction services	48%	47%	47%	46%	46%
Young people 0 – 19	87%	84%	83%	82%	81%
Adults 20 – 64	40%	40%	41%	40%	38%
Older people 65+	12%	13%	12%	11%	12%
NGO services	41%	39%	40%	38%	36%

[68] Mārama Real Time Feedback Consumer and Family Experience Survey, analysed by CBG Health Research and Te Pou, November 2021.

[69] Ministry of Health PRIMHD database, analysed by Te Pou, November 2021. The measure used is the Health of the Nation Outcome Scale for adults (HoNOS). Twelve items are used for HoNOS, covering areas including mood, relationships, substance use, and housing. Each item is measured out of 4, with a score of 2 or more considered clinically significant. The maximum total score is 48 for adults. Mainly collected by DHB mental health services with very few collections in clinical NGO services. Generally rated over the last two weeks. Tāngata whaiora could have more than one collection. HoNOS is a deficit measure so a decrease in score is an improvement e.g. if someone scores 15 on admission, and 7 on discharge, this is a 51 % improvement.

[70] Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA). Fifteen items are used for HoNOSCA measuring symptom severity and social functioning. Each item is measure out of 4, with a score of 2 or more considered clinically significant. The maximum total score is 60 for children and adolescents.

[71] Small number. Where numbers are under 50, there is a need to suppress to protect the privacy of individuals.

[72] Small number. Where numbers are under 50, there is a need to suppress to protect the privacy of individuals.

[73] Ministry of Health PRIMHD database, analysed by Te Pou, November 2021. The measure used is HoNOS65+, a modified version of HoNOS for people aged 65 years and over.

[74] Small number. Where numbers are under 50, there is a need to suppress to protect the privacy of individuals.

[75] HoNOS Secure first 12 item is used, which is similar to the HoNOS. The main difference with the HoNOS secure tool is the 7-item security scale, which is not included here.

[76] Ministry of Health PRIMHD database, analysed by Te Pou, November 2021. The measure used is from the Alcohol and Drug Outcome Measure (ADOM). Collecting and reporting of ADOM has been mandatory since July 2015, although tāngata whaiora use of ADOM is voluntary. ADOM includes only people seen in community Alcohol and Other Drug Services. The measures analysed are only for people with ADOM matched pairs of treatment start and treatment end, and includes tāngata whaiora aged 18 and over, and excludes ADOM collections with five or more missing items. The measure uses the date of end collection – start collection can be outside the period, but after 1 July 2015. The small numbers and short period of time ADOM has been collected may explain the variation between years.

[77] Ministry of Health PRIMHD database, analysed by Te Pou, November 2021. Includes only tāngata whaiora who have a supplementary tāngata whaiora record.

[78] Ministry of Health PRIMHD database, analysed by Te Pou, November 2021. Includes only tāngata whaiora who have a supplementary tāngata whaiora record.

Connected Care

Measure	2020/21	2019/20	2018/19	2017/18	2016/17
What percent of tāngata whaiora and family and whānau report that the people they see communicate with each other when they need them to?[79] (agree / disagree)					
Tāngata whaiora	81% / 9%	83% / 6%	82% / 6%	82% / 8%	82% / 7%
Māori	81% / 9%	85% / 6%	83% / 6%	83% / 8%	83% / 7%
Pacific	92% / 3%	85% / 5%	85% / 5%	85% / 6%	86% / 6%
Whānau	84% / 7%	86% / 5%	85% / 5%	83% / 7%	84% / 4%
NGO average	82% / 8%	84% / 5%	83% / 7%	84% / 6%	87% / 5%
What percent of complaints were about coordination of care between different service providers?[80]	13%	15%	13%	11%	11%
What percent of complaints were about coordination or inappropriate follow up by service providers?	10%	14%	9%	8%	11%
How many people in Aotearoa used each type of specialist mental health and addiction services?[81]					

		2020/21	2019/20	2018/19	2017/18	2016/17
Acute inpatient care	Tāngata whaiora	9,392	9,788	9,794	9,808	9,642
	Bed nights[82]	238,523	238,259	243,984	241,961	234,682
Rehabilitation or residential care	Tāngata whaiora	3,046	3,006	2,910	2,862	2,950
	Bed nights	495,707	496,400	491,126	486,709	492,966
Crisis respite care[83]	Tāngata whaiora	3,927	4,240	4,207	4,339	4,366
	Bed nights	36,365	40,702	38,776	37,702	37,286
Forensic secure inpatient	Tāngata whaiora	520	521	515	524	498
	Bed nights	98,374	97,346	96,721	92,192	90,727
Substance use medical withdrawal management (detoxification)	Tāngata whaiora	1,746	1,545	1,688	1,674	1,680
	Bed nights	15,861	13,419	15,553	15,222	15,152
Substance use residential treatment	Tāngata whaiora	1,707	1,748	2,021	2,010	2,014
	Bed nights	105,842	110,736	123,628	128,639	132,500

Measure	2020/21	2019/20	2018/19	2017/18	2016/17
Average length of stay in an inpatient unit [84]	18 days	18 days	18 days	19 days	18 days
Māori	17 days	17 days	17 days	18 days	16 days
Pacific	23 days	20 days	25 days	22 days	22 days
Young people 0 – 19	13 days	12 days	13 days	13 days	12 days
Adults 20 – 64	18 days	17 days	18 days	18 days	17 days
Older people 65+	31 days	28 days	30 days	30 days	29 days
How many people were followed up within 7 days of leaving hospital?[85]	80%	79%	80%	80%	80%
Māori	79%	78%	79%	79%	79%
Pacific	83%	82%	82%	84%	85%
Young people 0 – 19	76%	78%	78%	78%	78%
Adults 20 – 64	81%	80%	81%	81%	81%
Older people 65+	71%	72%	73%	73%	72%
How many people went back into an inpatient unit within 28 days of being discharged[86]	15%	16%	17%	17%	17%
Māori	17%	17%	18%	17%	17%
Pacific	14%	14%	13%	16%	14%
Young people 0 – 19	18%	18%	22%	21%	25%
Adults 20 – 64	16%	16%	17%	17%	16%
Older people 65+	8%	10%	12%	11%	11%

[79] Mārama Real Time Feedback Consumer and Family Experience Survey, analysed by CBG Health Research and Te Pou, November 2021.

[80] Supplied by the Office of the Health and Disability Commissioner, November 2021.

[81] Ministry of Health PRIMHD database, analysed by Te Pou, November 2021. Bed nights count the number of nights in the specific category. Tāngata whaiora can have multiple bed nights.

[82] Bed nights refer to people occupying a bed at midnight who were receiving treatment in a mental health inpatient unit.

[83] Ministry of Health PRIMHD database, analysed by Ministry of Health February 2022. Does not include planned crisis respite care.

[84] The KPI Programme Interactive Report sources data from the Ministry of Health PRIMHD database, extracted by Te Pou, November 2021.

[85] The KPI Programme Interactive Report, extracted by Te Pou, November 2021. Percentage of overnight discharges from the mental health and addiction service organisation's inpatient unit(s) where a community service contact was recorded in the seven days immediately following that discharge. This KPI calculates an overall follow up rate, which is the percentage of all acute inpatient discharges that were followed up, regardless of where that follow up occurred (DHB, NGO or both).

[86] The KPI Programme Interactive Report, extracted by Te Pou, November 2021. Issued date of the latest interactive report is 5 May 2021 for PRIMHD. Percentage of overnight discharges from the mental health and addiction service organisation's acute inpatient unit(s) that result in readmission within 28 days of discharge. This KPI calculates an overall readmission rate, which is the percentage of all acute inpatient discharges that were readmitted, regardless of where that readmission occurred (same DHB or different DHB).

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, there is 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 (ED).

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

Phone your local District Health Board (DHB) 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 ring Healthline: **0800 611 116**.

If you need to talk to someone

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

Some other great places to get support include:

- Depression helpline (24 hours a day, 7 days a week): free phone 0800 111 757 or free text 4202.

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

- Lifeline: free phone 0800 543 354 or free text 4357 (HELP).

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

For more information about where to get support, visit the Ministry of Health's website.