


Monitoring mental health and addiction system performance in Aotearoa New Zealand: *Our approach and initial findings*

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

For more information, please visit our website: www.mhwc.govt.nz

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

Kupu whakataki

Foreword

This report signals a refreshed direction for Te Hīringa Mahara—Mental Health and Wellbeing Commission (Te Hīringa Mahara). It is the first time we are monitoring how the mental health and addiction system is performing, to show how activities within the system are contributing to overall mental health and wellbeing outcomes.

This report takes us further, providing more accountability of how government is contributing to transformation of the mental health and addiction system and offering key shifts that must be acted on if we want to see improved mental health and wellbeing outcomes for tāngata whaiora and whānau.

Monitoring the performance of the mental health and addiction system is an important area for us. Small changes on their own may not lead to better mental health wellbeing outcomes; we need to see coordinated and significant shifts in the system to realise the vision set out in He Ara Oranga six years ago.

We release this report at a time of opportunity with the current development of a Mental Health and Wellbeing Strategy (the strategy). We have a key opportunity to prioritise mental health and wellbeing in Aotearoa New Zealand and develop a strategy and implementation plan with tangible outcomes and accountabilities.

We expect to see the key system shifts in this report reflected in the strategy so there is a consistent pathway towards improving mental health and wellbeing outcomes for people. It is our expectations that government will act on these key shifts, to relieve pressure on the mental health and addiction system and make He Ara Oranga a reality.

The role of Te Hīringa Mahara is having oversight of the system through our monitoring, advocacy, and leadership roles. We will build on our work to date monitoring the performance of mental health and addiction services, the determinants of health, and their contribution to improved mental health and wellbeing outcomes for people in Aotearoa New Zealand.

This report will be the first of many spotlights on how the mental health and addiction system is performing.

Hayden Wano

Board chair Te Hīringa Mahara—Mental Health and Wellbeing Commission



Ngā ihirangi

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Ngā mihi

Acknowledgements

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We particularly wish to thank our Lived Experience Data Reference Group and expert reviewers Sharon Shea and Amanda Luckman.

Whakamōhiotanga whānui

Overall summary

This report presents a system performance monitoring approach that aims to measure the progress of transformation within the mental health and addiction system.

Our approach is grounded in the vision of He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (2018). It draws a line of sight between government inputs and activities and their contribution to an ideal mental health and addiction system as outlined in the He Ara Āwhina framework. It identifies the changes needed at a system level to contribute to better mental health and wellbeing outcomes for people as described in the He Ara Oranga framework.

Our system monitoring approach is centred around six key system shifts that express the changes that would move the system towards an ideal state. The system shifts were developed through an iterative process, bringing together central government agency plans and strategies, Government priorities, and what we have heard from engaging with people with lived experience and those working in the sector. We also provide initial monitoring results for a small set of system performance and population outcome measures, including the Government's five mental health and addiction targets. Our intent in reproducing targets here is to site the targets within a broader performance story.

Key findings

Population mental wellbeing has decreased since 2018

Indicators at a population level show that since 2018 fewer people are experiencing good mental wellbeing, and this is particularly so for people in contact with mental health and addiction services. The percentage of people experiencing high or very high levels of mental distress has considerably increased since 2019/20, and remains higher among Māori, women, and young people.

When we look at indicators of harm, we see that suicide rates have not decreased despite ongoing interventions, remaining steady since 2018 with Māori and young people experiencing higher rates. Over 700,000 people in Aotearoa New Zealand have hazardous drinking patterns, and fatal accidental drug overdoses have almost doubled in the last nine years.

The mental health and addiction system is under immense pressure

Collectively, the system performance data we have examined paints a picture of a mental health and addiction system under immense pressure.

Unmet need for mental health and addiction services has increased with Māori, Pacific peoples, young people, and disabled people experiencing much higher unmet need. Wait times for telehealth services have increased markedly over the last six years. More than one third of people presenting to emergency departments with mental health and addiction needs wait longer than six hours for admission, discharge or transfer. Workforce shortages continue and vacancy rates for roles in mental health and addiction services increased between 2018 and 2024.

The mental health and addiction system is beginning to reorient in some areas

There are promising signs that the system is beginning to reorient towards the vision described in the He Ara Oranga report. There is evidence of movement towards realising lived and living experience potential and meeting community needs with increased access to services with peer support. Primary prevention and early intervention have been enhanced with the expansion of the Access and Choice programme, and the diversity of the workforce is changing to include more Māori, Pacific peoples, and Asian workers.

Faster progress is needed to realise a transformed system that will achieve better mental health and wellbeing outcomes for people

These early movements are small and not yet extensive enough to realise the system transformation that will drive changes in population-level outcomes. Our monitoring has emphasised areas of concern: for example, access to specialist services has decreased and use of compulsory community treatment orders has increased. Furthermore, there has been no change in the employment or housing status of people in contact with the mental health and addiction system.

The Government's focus on timely access, investment in primary prevention, and improvements to the workforce aligns with what communities and the sector want from services. Increased investment in the Access and Choice programme is improving equity of access to primary and early intervention for populations with higher need, including young people, Pacific peoples, and Māori. There have been modest increases in workforce diversity. We would like to see these improvements continue.

Although these early signs are promising, we would like to see a more comprehensive approach that reflects what people have told us they want and need from a transformed mental health and addiction system. The upcoming Mental Health and Wellbeing Strategy will be an important mechanism to achieve this.

Monitoring system performance is a long-term programme of work for Te Hiringa Mahara

This report is the first step of a long-term, phased approach that will complement our existing service monitoring work. In future we will develop our scope to include a wider range of indicators and measures, and continue our data advocacy to support effective measurement of progress. We also plan to publish a dashboard with a national set of system performance measures, include qualitative approaches informing 'deep dive' reports where data shows more investigation is warranted, and assess the performance of the system from specific perspectives such as sustainability or productivity. Finally, we will consider international benchmarking to better understand the performance of the mental health and addiction system in Aotearoa New Zealand compared with other similar systems overseas. These activities support our role to provide a shared system view for system performance and identify areas for improvement.

We recognise and acknowledge the commitment of people across the mental health and addiction system to strive for better outcomes for tāngata whaiora and whānau, and recognise the considerable pressure the system is under. Working towards the key shifts will support this commitment, and provide a means of understanding how and when system transformation is achieving better mental health and wellbeing for the people of Aotearoa New Zealand.

Whakarāpopoto arowhānui

E whakaatu ana tēnei pūrongo i te huarahi aroturuki i ngā mahi a te rāngai e whai ana ki te ine i te neke whakamua o te whakahoutanga ki roto i te pūnaha hauora hinengaro, waranga hoki.

Ka whakakaupapatia tā mātau huarahi mahi i runga i te whāinga o He Ara Oranga: Pūrongo o te Uiuinga Kāwanatanga ki te Hauora Hinengaro me te Waranga (2018). Ka tirohia te whai pānga o ngā tāuru me ngā mahi a te kāwanatanga me te whai wāhi atu ki tetahi pūnaha hauora hinengaro, waranga hoki e tino pai ana, arā i whakaahuatia ki te pou tarāwaho o He Ara Āwhina. Ka tautohua ngā whakarerekētanga e hiahiatia ana puta noa i te pūnaha kia whai wāhi atu ki ngā hua hauora hinengaro, waranga hoki e pai ake ana mō ngā tāngata ka whakaahuatia i te pou tarāwaho o He Ara Oranga.

E aro ana tā mātau huarahi aroturuki pūnaha ki ngā nekehanga pūnaha matua e ono e whakaatu ana i ngā whakarerekētanga e nekehia ai te pūnaha ki tōna āhua e tino pai ana. Ka waihangatia ngā nekehanga pūnaha i te tukanga tukuru, e whakakotahi ana i ngā mahere me ngā kaupapahere tari kāwanatanga, ngā whāinga matua a te Kāwanatanga, me tā mātau i rongo ai i ngā tāngata e whai wheako ora ana me ngā tāngata e mahi ana i te rāngai. Ka tuku hoki mātau i ngā hua arotake tuatahi mō ētahi inenga ruarua e pā ana ki ngā mahi pūnaha, hua taupori hoki, tae atu ki ngā whāinga e rima a te kāwanatanga mō te hauora hinengaro me te waranga. Ko tā mātau tūmanako i te tāruatanga o ngā whāinga i konei, he whakanoho i ngā whāinga nei ki roto i te rerenga kōrero mahi whānui.

Ngā kitenga matua

Kua heke haere te hauora hinengaro o te taupori whānui mai i 2018

E tohu ana ngā tūtohu taupori whānui, mai i 2018 he iti iho ngā tāngata kei a rātou te hauora hinengaro pai, ā, he tino pēnei te āhua mō ngā

tāngata e whai pānga ana ki ngā ratonga hauora hinengaro, waranga hoki. Kua āta piki haere te ōrau o ngā tāngata e rongo ana, e tino rongo ana rānei i te auhitanga hinengaro mai i 2019/20, ā, he teitei tonu ki waenga i a Ngāi Māori, ngā wāhine me ngā rangatahi.

Ina ka tirohia ngā tūtohu o te tūkinotanga, ka kite atu kāore i heke ngā pāpātanga whakamomori ahakoa ngā mahi e kawea tonu ana, heoi, e mau tonu ana te nui mai i 2018, ko Ngāi Māori me ngā rangatahi kei te nui ake ngā pāpātanga. Neke atu i te 700,000 tāngata i Aotearoa he mōrearea tonu te nui o te inu waipiro, kua tata hoki te pūrua te piki ake o ngā matenga kai tarukino ki roto i ngā tau e iwa kua hori nei.

He tino nui tonu te pēhanga i runga i te pūnaha hauora hinengaro, waranga hoki

Hui katoa, e whakaatu ana ngā raraunga mahi pūnaha kua tirohia e mātau i tētahi pūnaha hauora hinengaro, waranga hoki e tino rongo ana i te pēhanga.

Kua piki haere te hiahia kore tutuki ki ngā ratonga hauora hinengaro, waranga hoki, he nui kē atu te hiahia kore tutuki ki waenga i a Ngāi Māori, ngā iwi o te Moana-nui-a-Kiwa, ngā rangatahi me ngā tāngata hauā. Kua āta piki haere ngā wā tatari ki ngā ratonga hauora ā-waea ki roto i ngā tau e ono kua hori nei. He nui atu i te hauroru tāngata e kuhu atu ana ki ngā tari ohorere me ngā hiahia hauora hinengaro, waranga hoki ka tatari mō te ono hāora, roa atu rānei kia whakaurua atu, kia tukua ki te haere kia whakawhitia rānei. Kei te haere tonu ngā kōpaka kaimahi, i piki haere hoki ngā pāpātanga tūranga wātea i ngā mahi hauora hinengaro, waranga hoki i waenga i 2018 me 2024.

Kua tīmata te pūnaha hauora hinengaro, waranga hoki ki te huri aronga i ētahi wāhi

Tērā ētahi tohu awhero e tīmata ana te pūnaha ki te huri aronga kia whai i te whāinga kei te pūrongo o He Ara Oranga. Tērā ētahi taunakitanga o te neke ki te whakatinana i te pitomata o te wheako ora me te whakatutuki hiahia hapori mā te whai wāhi ki ngā ratonga me te tautoko ā-hoa. Kua whakapikitia te mahi aukati me te kuhu wawe mā te whakawhānui i ngā hōtaka Whai Wāhi me te Kōwhiri, me te rerekē haere o te kanorautanga o te kapa kaimahi, arā he nui ake ngā kaimahi Māori, Moana-nui-a-Kiwa, Āhia hoki.

Me tere ake te neke e whakatinanatia ai tētahi pūnaha whakahou e whakawhiwhi atu ana i ngā hua hauora hinengaro, waiora hoki ki te tāngata

He iti ēnei nekehanga tōmua, kāore anō kia whānui rawa e whakatinanatia ai te whakahoutanga pūnaha hei kōkiri whakarerekētanga ki ngā hua taupori. Kua miramira tā mātau arotake i ngā wāhi māharahara pēnei i – kua iti haere te whai wāhi ki ngā ratonga whāiti, kua piki haere te whakamahitanga i ngā whakahau maimoa hapori. Hei āpiti atu, kāore he rerekētanga i te āhua whai mahi, whai whare rānei o te hunga e whai pānga ana ki te pūnaha hauora hinengaro, waranga hoki.

E hāngai ana tā te kāwanatanga arotahi ki te whai wāhitanga i te wā tika, te tuku haumi ki te aukati i mua i te pānga, me te whakapiki kapa kaimahi ki ngā hiahia o ngā hapori me te rāngai i ngā ratonga. Ko te whakapikitanga haumi ki te hōtaka Whai Wāhi, Kōwhiringa hoki kei te whakapai haere i te ōritetanga o te whai wāhi atu ki ngā mahi hāpaiora matua, wawe hoki mō ngā taupori e nui ake ana ngā hiahia, tae atu ki ngā rangatahi, ngā iwi o te Moana-nui-a-Kiwa me Ngāi Māori. Tērā ngā pikinga iti tonu ki te kanorautanga o te kapa kaimahi. Kei te hiahia mātau kia haere tonu tēnei āhuatanga.

Heoi anō te awhero o ēnei tohu tōmua nei, kei te hiahia tonu mātau kia kite i te huarahi mahi e whānui ake ana, e whakaatu ana i tā mātau i rongo ai i ngā tāngata, arā he aha ō rātau hiahia mō te pūnaha hauora hinengaro, waranga hoki ka whakahotia nei. He taputapu nui te Rautaki Hauora Hinengaro, Waranga hoki e haere mai nei kia whakatutukitia tēnei.

He hōtaka mau roa te aroturuki mahi pūnaha mō Te Hīringa Mahara

He tūāoma tuatahi tēnei pūrongo i te huarahi mahi mau roa, taki mahi hoki e tautoko ana i ā mātau mahi arotake ratonga o te wā. Hei te anamata, ka whakarite mātau i te whānuitanga o ā mātau mahi kia whānui ake ngā tūtohinga me ngā inenga, ka haere tonu hoki tā mātau akiaki i te raraunga kia tautokona te āta ine i te neke whakamua. Kei te whakaaro hoki mātau ki te whakaputa i te papaine e mau ana i ngā inenga mahi pūnaha ā-motu, tae atu ki ngā mahi rangahau hei whakamōhio i ngā pūrongo ‘ruku hōhonu’ i ngā wāhi e tohu ana te raraunga me tiroiro anō, me te aromatawai hoki i ngā mahi a te pūnaha mai i ngā tirohanga whāiti, pēnei i te toitūtanga me te whaihua. Hei whakamutu atu, ka titiro hoki mātau ki ngā taumata nō tāwāhi kia pai ake te mārama ki ngā mahi a te pūnaha hauora hinengaro, waranga hoki i Aotearoa me te whakataurite ki ērā o tāwāhi e hanga ōrite ana. Ka tautoko ēnei mahi i tā mātau kawenga ki te tuku tirohanga pūnaha whānui mō ngā mahi a te pūnaha me te tautohu i ngā āhuatanga me whakapai ake.

Kei te rāhiri atu mātau, kei te mihi atu ki te manawanui o ngā tāngata puta noa i te pūnaha hauora hinengaro me te waranga arā kia whāia ngā taumata kē mō ngā tāngata whaiora me ngā whānau, me te mārama hoki ki te nui o te pēhanga ki runga i te pūnaha. Ko te whai i ngā nekenekahanga matua ka tautoko i tēnei manawanuitanga, ka whakatakoto huarahi hoki e mārama ai ka pēhea, hei āwhea hoki e whai painga ana te whakahoutanga pūnaha mō te hauora hinengaro me te waiora o ngā tāngata o Aotearoa.

Kupu arataki

Introduction

Te Hiringa Mahara – Mental Health and Wellbeing Commission is an independent Crown entity, established following the 2018 Government Inquiry into Mental Health and Addiction. We assess, report, and make recommendations on the mental health and wellbeing of people in Aotearoa New Zealand.

Our role is to be the eyes and ears of people in Aotearoa New Zealand, amplifying the voices of our communities. We are keeping watch on what is happening in our mental health and addiction system, speaking up and bringing focus to areas where meaningful, long-term transformation can take place. We also have a system leadership role, and monitor service and system performance and wellbeing outcomes for people.

Our work to date has improved our understanding of how mental health and wellbeing is trending over time at a population level and how mental health and addiction services are performing. However, it has been an ongoing challenge to assess the contribution of government actions to improve mental health and addiction system performance and therefore outcomes both for people who interact with the system and for people seeking wellness. Our previous system monitoring report was a deep dive into one system enabler, Lived Experience Leadership¹. It sought to assess actions against Lived Experience Leadership in Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing (Ministry of Health, 2021). This report investigated very early government progress in system transformation, enabled by transformed leadership. This improved our understanding, but only scratched the surface of monitoring progress against the very wide-ranging changes that have been called for.

This system performance monitoring will be complementary to our current service monitoring (He Ara Āwhina) and population outcomes

monitoring (He Ara Oranga) that we already do using a prioritised set of system performance measures. He Ara Āwhina and He Ara Oranga describe aspirations for the mental health and addiction system as a pathway to improving mental health and wellbeing outcomes for people, but they are not intended to be used as tools for monitoring system shifts and government contributions to achieving better and more equitable mental health and wellbeing outcomes.

Service, system, and outcome monitoring undertaken by Te Hiringa Mahara is intended to give effect to our responsibility to undertake system-level monitoring as set out in Kia Manawanui, spanning population-level mental wellbeing, the determinants of mental wellbeing, and services and approaches to support mental wellbeing. This includes recommending improvements to mental health approaches, promoting collaboration in the system, and advocating for people experiencing mental distress or addiction.

This report presents our initial approach to monitoring system shifts within the mental health and addiction system. Our monitoring will be used to measure the progress of change and will support accountability across government in delivering system transformation. Our approach draws from and translates the vision of the He Ara Oranga Report, the Government's mental health and wellbeing strategies and plans, Government priorities, Oranga Hinengaro Service and System Performance Framework², the He Ara Āwhina and

1 Te Hiringa Mahara. 2024a. **Leadership as a Mental Wellbeing System Enabler: Insights on Progress toward Kia Manawanui**.

2 Ministry of Health. 2023. **Oranga Hinengaro System and Service Framework**. Wellington: Ministry of Health.

He Ara Oranga frameworks, our recommendations and calls to action, and the voices of people with lived experience. It brings the key calls for change into a set of key system ‘shifts’ (critical system changes towards improved outcomes) and presents a small initial set of measures we can use to tell an early story of system change.

Purpose and scope

The purpose of this report is to provide our approach to mental health and addiction system performance monitoring and present initial findings on system performance. We also present information on population outcomes that we have not reported on before, namely harm from alcohol and other drugs, and suicide rates. This is the first independent mental health and addiction system performance monitoring report on progress toward system shifts that brings together calls from several key reports, strategies, both our monitoring frameworks, and our recommendations.

Our system performance monitoring has four key objectives.

1. **Provide evidence to hold the system to account** on progress towards the vision of He Ara Oranga. Accountability to people, whānau, and communities with lived experience of mental health challenges and addictions is especially important.
2. **Inform shared goals for good system performance**, enabling strategies to be developed for key measures.
3. **Identify opportunities for system improvements.**
4. **Contribute to the broader evidence base** on the impacts of all-of-government approaches to mental health and wellbeing. This evidence base will remain useful, even as government strategies change over time.

What we did

This report describes the development of our approach to monitoring mental health and addiction system performance. It also provides a quantitative assessment of 20 performance measures and reports on population mental health outcomes. We developed our approach through four phases of work: review and research; engagement; development of key shifts; and measures development.

Phase 1: Review and research

We considered current theory and practice in system performance measurement. Our background research included exploring current system performance theory, looking at other system performance frameworks, and interviewing key people from agencies with roles in system performance monitoring.

To measure system performance from a people-centred perspective, we first needed to understand the relationship between system-level actions and outcomes for people with living and lived experience of mental distress and addiction.

We developed a theory of change to provide a line of sight between government inputs, their impacts and interactions within the system, and how these affect the people moving through the system. This was developed into a logic model diagram. A simplified logic model diagram based on our theory of change is presented as Figure 1. Further details of this are included as Appendix C.

As a result of research, review, and theory of change development, we have chosen to focus on what changes we want to see and, where possible, the progress towards those. In future and as data becomes available, we intend to move towards an integrated approach to monitoring and reporting by assessing system performance against further performance constructs.

Phase 2: Engagement with system leaders

We interviewed representatives from seven agencies with roles in system performance monitoring, and asked them about existing frameworks and the process and approaches they use for system performance monitoring, and how they came to these. They provided advice grounded in practical experience, including identifying challenges and opportunities, and offering guidance and questions that might be useful to our work. Details of this engagement are included in Appendix B.

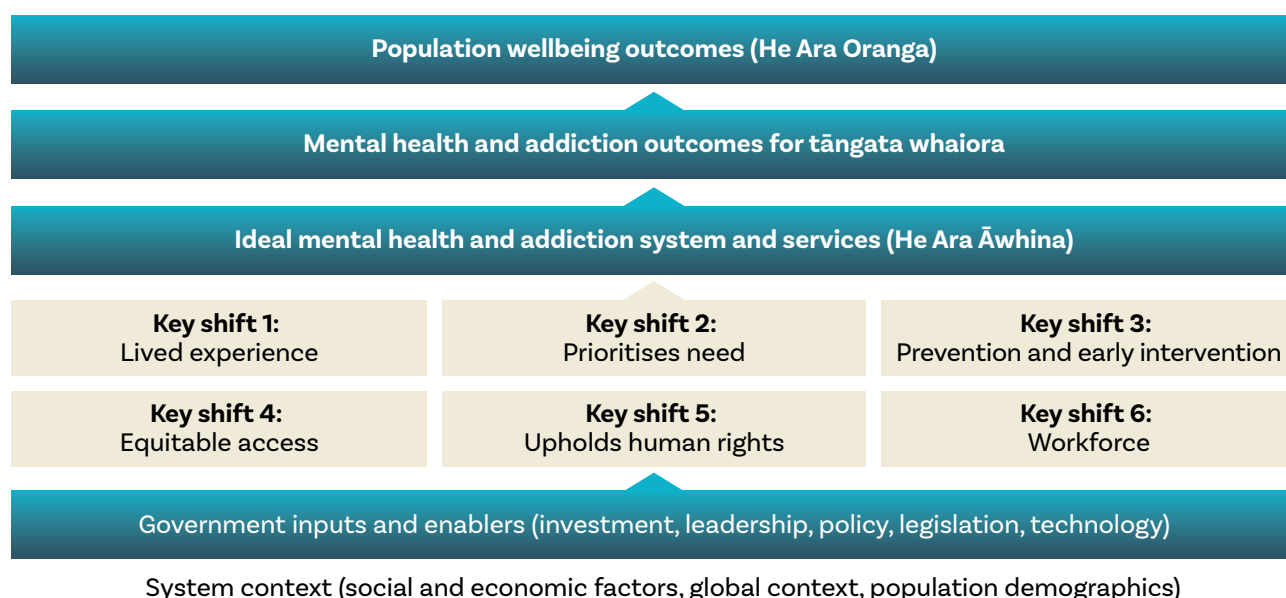
Phase 3: Development of key shifts

Our logic model gave us a clear picture of the critical actions at system level that would move the system towards the outcomes described within the He Ara Oranga framework. We compared the critical actions described in our **logic model**, simplified below as Figure 1, with current recommendations for mental health and addiction system change, using a process of thematic analysis and incorporating:

- Government mental health priorities including mental health and addiction targets³
- strategies and policies⁴
- recommendations and calls to action from our own previous work.

From this we identified six key areas where change is expected to bring about system transformation (key shifts). We tested these shifts with our lived experience and sector reference groups to refine what each shift means in practice.

Figure 1. Cascading simplified logic model from inputs to shifts to outcomes



3 Minister of Health. 2024. **Government Policy Statement on Health 2024–2027**. Wellington: Ministry of Health.

4 Ministry of Health. 2021. **Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing**. Wellington: Ministry of Health.
Ministry of Health. 2023. **Oranga Hinengaro System and Service Framework**. Wellington: Ministry of Health.

Phase 4: System performance measurement prioritisation

To develop our Year One measure set, we worked with a focused group of lived experience data leaders to identify existing measures that reflected the key system shift concepts. We then prioritised these and selected a small set of measures that met our prioritisation criteria of:

- validity
- availability (frequency and timeliness)
- impact.

We prioritised measures that were nationally consistent and were able to be disaggregated by key demographics. We included the Minister for Mental Health's five mental health and addiction targets. Our intent in reproducing targets here is to site these targets within a broader performance story.

Details of the development of the six key shifts and our Year One measures are provided in Appendix C.

System shifts

Our monitoring approach is underpinned by the vision of an ideal mental health and addiction system as described in the He Ara Āwhina framework. An ideal mental health and addiction system contributes to the aspirational outcomes of the He Ara Oranga wellbeing outcome framework.

The shifts are expressed in terms of moving towards an ideal mental health and addiction system. Each shift has a short description of what the shift means. Our measures were mapped against the descriptions and our monitoring aims to measure progress against these shifts.

Figure 2. Six key shifts



Relationship of shifts to Government policies and strategies

Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing (2021)

Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing⁵ was published by the Ministry of Health in 2021. It translates the recommendations of the He Ara Oranga report into a 10-year plan. The plan consists of sequenced actions designed to set the direction for the change needed to promote, protect, and strengthen mental wellbeing in Aotearoa. It outlines key enablers that will support system transformation, and that collectively have contributed to the development of our key shifts. The leadership and workforce enablers align directly with our first and sixth key shifts.

Oranga Hinengaro System and Service Framework (2023)

The Oranga Hinengaro System and Service Framework⁶ was published by the Ministry of Health in 2023. This document sets the direction for the mental health and addiction system and services over the next 10 years. It provides guidance for future policy, design, commissioning, and delivery of mental health and addiction services. Its core principles were developed in partnership with lived experience and its Critical Shift 3 commits to building transformation led by lived experience, aligned with our first key shift to realise the potential of lived and living experience.

Government Policy Statement on Health (2024)

The Government Policy Statement on Health 2024–2027⁷ outlines Government priorities, objectives, and expectations for the health system over the next three years. It has a strong focus on timeliness of access to services, training more mental health and addiction professionals, and increasing investment in prevention and early intervention.

Mental Health Bill (2024)

Since 2019, the Government has been working on policy that aims to reflect a modern human-rights based approach in our mental health law. The Mental Health Bill⁸ aims to follow through on this commitment. The repeal and replacement of the Mental Health (Compulsory Assessment and Treatment) Act 1992⁹ was a recommendation made in the He Ara Oranga report.

Mental health and addiction targets (2024)

In 2024 the Minister for Mental Health announced five mental health and addiction targets which provide expectations for system performance. The focus on faster access to primary and specialist mental health and addiction services, shorter stays in emergency departments, workforce growth, and prevention and early intervention aligns with several of the key shifts. We have reproduced the results of the mental health and addiction targets in this report to reflect this alignment.

5 Ministry of Health. 2021. **Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing**. Wellington: Ministry of Health.

6 Ministry of Health. 2023. **Oranga Hinengaro System and Service Framework**. Wellington: Ministry of Health.

7 Minister of Health. 2024. **Government Policy Statement on Health 2024–2027**. Wellington: Ministry of Health.

8 Mental Health Bill 2024. www.legislation.govt.nz/bill/government/2024/0087/latest/whole.html#LMS994889.

9 Mental Health (Compulsory Assessment and Treatment) Act 1992. www.legislation.govt.nz/act/public/1992/0046/latest/whole.html.

Mental Health and Wellbeing Strategy

The examples above all have aspects that align with the key system shifts. However, the relationship is currently piecemeal, spread across a variety of strategies and frameworks, and lacking the completeness and coherence necessary to bring about system transformation. We would like to see a more comprehensive approach that reflects what people have told us they want and need from a transformed mental health and addiction system. We have previously advocated for a Mental Health and Wellbeing Strategy to be developed and are pleased that this is now being progressed. We see the upcoming Mental Health and Wellbeing Strategy as an important mechanism to achieve this coherence, with this work as a critical input into its development.

Te Hīringa Mahara is shifting its focus from calls to action to being a bolder advocate publicly holding the mental health and addiction system to account. We will do this through building a credible evidence base on trends, insights, and international best practice related to system performance and improvement, promoting system alignment through a shared system view on performance and areas of improvement.

Limitations of our approach

Monitoring a complex system is a very large job and cannot be implemented all at once. There are a number of reasons for this – for some of the changes we would like to monitor, data is simply not available, or it is not consistently or frequently collected or able to be disaggregated. For others, it takes time for the impact of changes to be felt, and it will be some years before we can say for certain that changes are taking place and to what extent.

Quantitative data on its own does not tell a complete story. To get a clear picture of system transformation and its impact on people from the perspective of the He Ara Āwhina and He Ara Oranga frameworks, we will need to understand people's experiences within the system. This would require qualitative research which is outside the scope of this report, but Te Hīringa Mahara is planning to work in partnership with the Health Quality & Safety Commission to include experience data as part of its mental health data collection.

Finally, we recognise that there are aspects of system performance that cannot be easily understood using a goal-oriented approach, such as interactions between functions within the system, more complex aspects of performance such as sustainability or efficiency, and the reasons why changes are or are not taking place. This is why we are taking a phased approach to our monitoring. The first phase, beginning in 2025, includes a small set of quantitative measures focused on data that is currently available and can be analysed and linked to provide initial information on whether system changes are taking place. However, we are taking a long-term, iterative approach to our system performance monitoring and assessment, including consideration of targets and international benchmarking. This report is the first step on a long road towards effective system performance monitoring and there is much work still to do.

He huanga hauora hinengaro o te taupori whānui

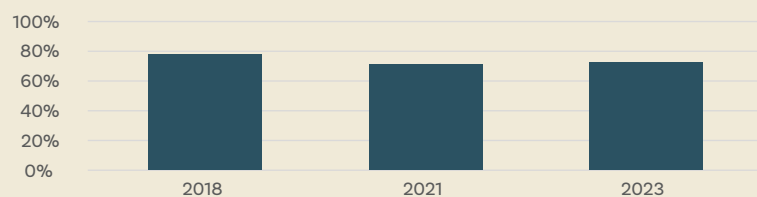
Population mental health outcomes

Here, we present key statistics on the state of population mental health as context for our system performance monitoring. The approach taken by the Government Inquiry into Mental Health and Addiction was “people first”. This is the approach we have also taken, and therefore it makes sense to start by looking at how people are doing. The mental health and addiction system is an important contributor to realising improved mental health and wellbeing outcomes, but other systems and wider social, economic, and environmental factors also influence outcomes.

74%

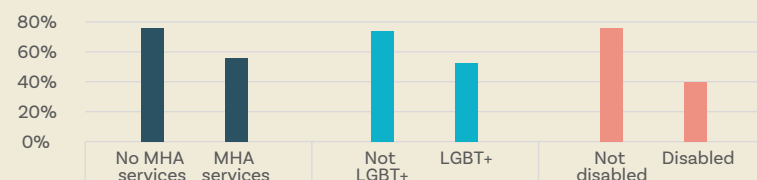
of adults aged 15+
reported good mental
wellbeing in 2023

Proportion of population with good mental wellbeing

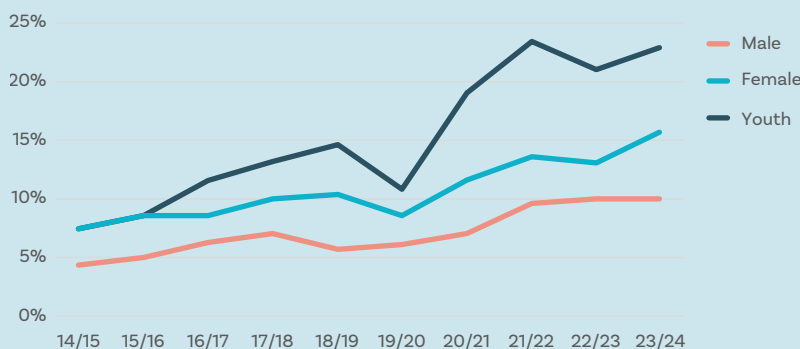


Some groups experience
considerably poorer
mental wellbeing

Proportion of population with good mental wellbeing

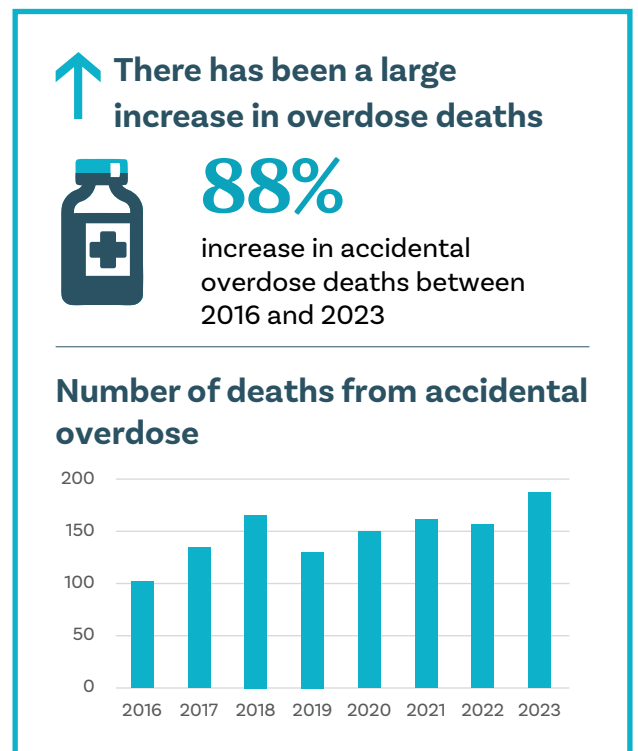
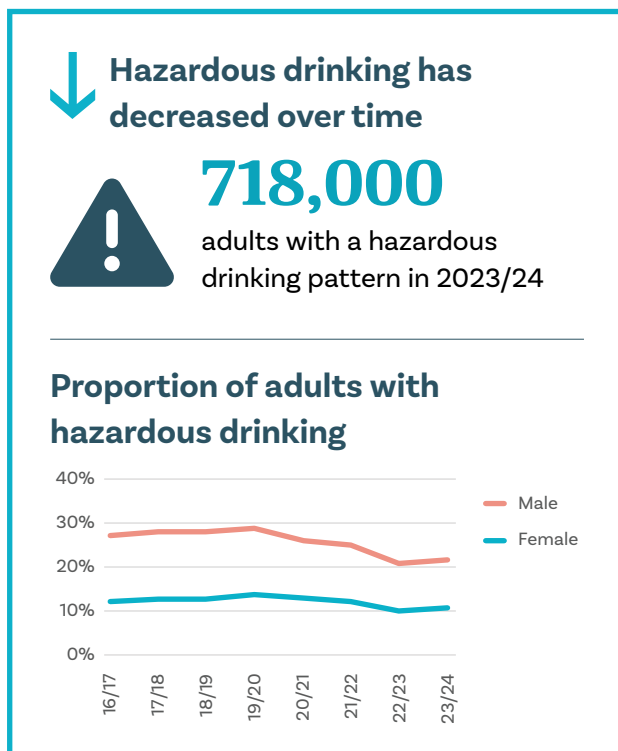
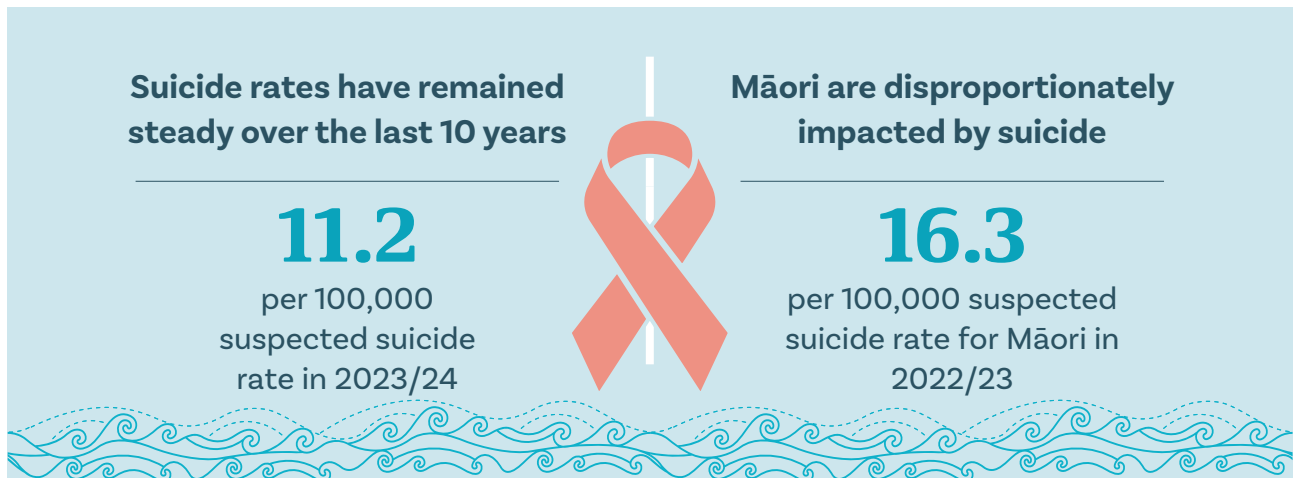


Proportion of population experiencing high or very high
psychological distress in the past four weeks



564,000


adults estimated to
experience high or
very high psychological
distress in the past
four weeks (2023/24)



The statistics paint a confronting picture. These key indicators of population mental health have not improved meaningfully since 2018, and in many cases they have deteriorated. The data also shows the inequity in outcomes experienced by some population groups. This suggests that the issues identified by the Government Inquiry into Mental Health and Addiction have not been alleviated in a way that positively impacts population mental health and wellbeing.

The recent commitment made to undertaking a mental health prevalence study will fill a critical gap in our understanding of mental health needs and will support both our analysis at a population level and our development of system performance measures. We will include this information when it becomes available.

In the next section, we examine the system more closely through the lens of our key shifts.



**Ko te whakamahi i tā mātau
huarahi mahi arotake rāngai:
He aha tā mātau i kite ai**

*Applying our system performance
monitoring approach: What we found*

Shift 1:

Towards a mental health and addiction system that realises the potential of lived and living experience

What this means:

- Partnering with lived experience at all levels including co-creation, delivery, evaluation of programmes, and training/education of clinical teams.
- Investment in a lived experience workforce that includes, but is broader than peer support workers, where all roles are valued and elevated.
- Equal prioritisation and integration of lived experience knowledge with clinical knowledge, including within credentials.

Shift 1 recognises that lived and living experience is deeply woven through and foundational to system transformation. It is based around three key aspects identified through lived experience engagement as vital to realising this potential—partnership, investment, and equal prioritisation of knowledge.

The people-centred approach to mental health and addiction recommended by the He Ara Oranga report¹ called for people with lived experience in governance, planning, policy, and service development. It emphasised the value of a workforce that understands and reflects the communities it serves, and the important counterbalance that lived experience knowledge provides to the medical focus of clinical services.

We have seen in our previous work² that lived experience leadership has been growing in some areas, and as a result trust and genuine engagement have built and are leading to change. However, progress has been mixed, with under-resourcing and stigma still presenting barriers to full realisation of the potential of lived and living experience to transform the system.

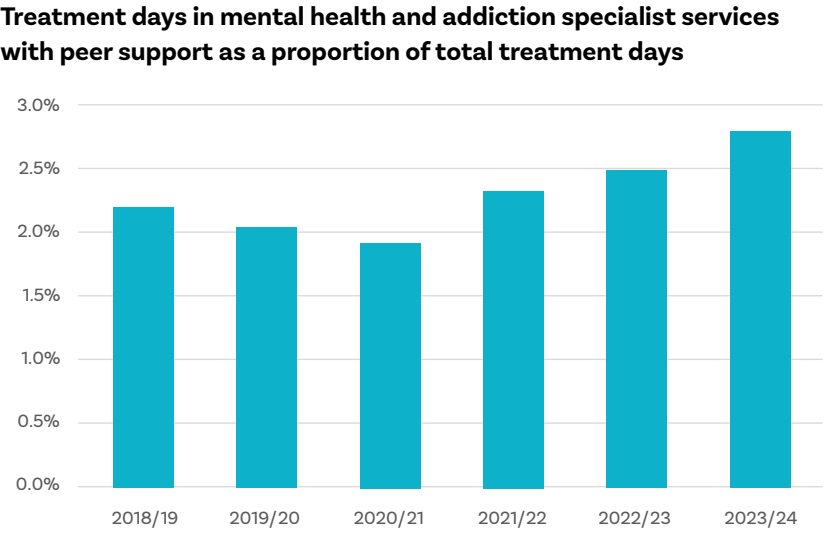
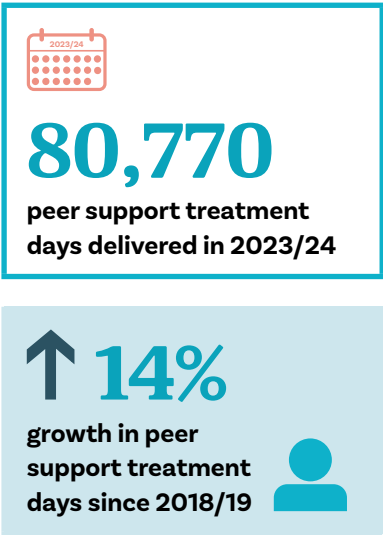
Our initial monitoring focuses on investment in and access to peer support. We intend for future monitoring to widen its scope to include measures of partnership and integration of lived experience knowledge and leadership throughout the mental health and addiction system.

Contribution to system and services		Contribution to population outcomes	
He Ara Āwhina:		He Ara Oranga:	
Te Ao Māori perspective	Shared perspective	Te Ao Māori perspective	Shared perspective
Mana motuhake	Participation and leadership	Whakapuāwaitanga me te pae ora	Having one's rights and dignity fully realised

Measure 1: Peer support access

Treatment days in mental health and addiction specialist services with peer support as a proportion of total treatment days

Rationale	Access to peer support in specialist services shows the extent to which lived experience is becoming embedded as a basic component of the mental health and addiction system.
Commentary	Peer support’s role in specialist mental health and addiction service delivery is increasing. This is shown by the increasing number and proportion of treatment days* in specialist services with peer support. This needs to be coupled with adequate support and investment in this workforce.

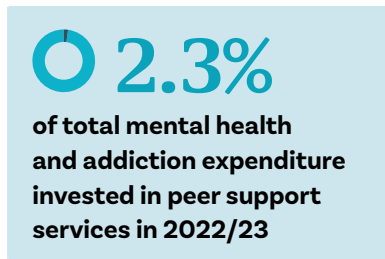
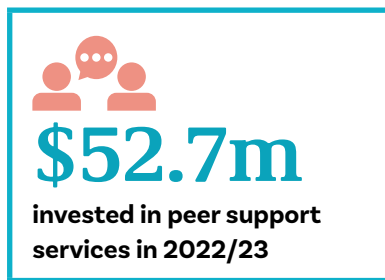


* A ‘treatment day’ is a day in which a service provides a tangata whaiora with one or more activities.

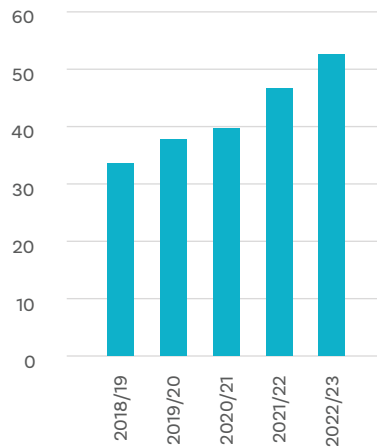
Measure 2: Peer support expenditure

Annual peer support services expenditure as a proportion of total mental health and addiction services expenditures

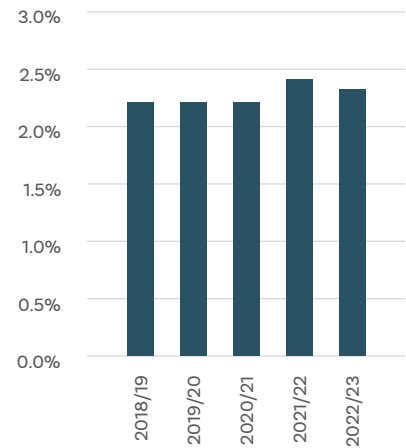
Rationale	Adequate investment in lived experience is vital to the flourishing of lived experience leadership. Peer support is a core part of the lived and living experience workforce.
Commentary	Total investment in peer support has increased since 2018/19. However, the investment share was similar in 2022/23 (2.3%) and 2018/19 (2.2%). Increasing investment to support increased access to peer support is critical for the sustainability of peer support services.



Total expenditure in peer support services (\$m)



Percentage of total expenditure spent on peer support services (%)

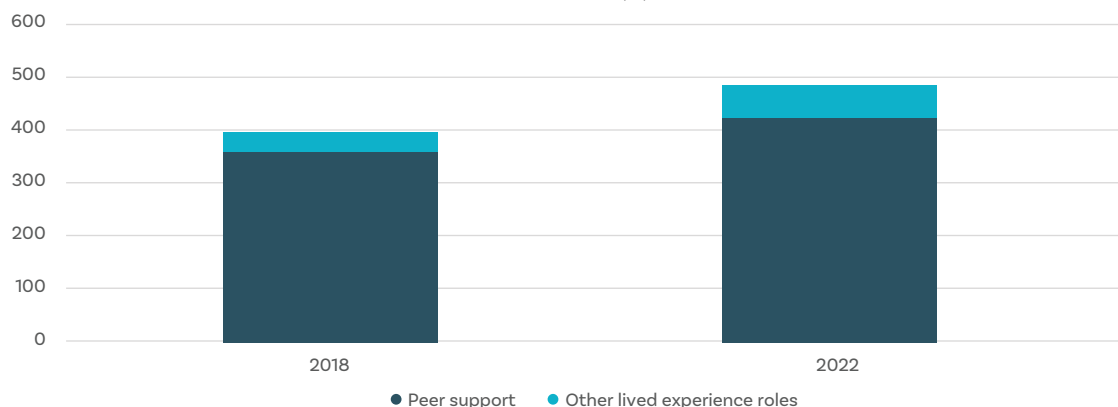


Measure 3: Lived experience workforce

Total Lived Experience Full Time Equivalent (FTE) roles (employed and vacant)

Rationale	Realising the potential of lived and living experience means investment in a lived and living experience workforce. This includes but is not limited to peer support workers. We want to see all lived and living experience roles valued and elevated. The size of the lived and living experience workforce across mental health and addiction services is a measure of the system's investment in lived experience.
Commentary	There was an increase in the size of the lived experience workforce between 2018 and 2022. These figures represent estimates of non-governmental organisation (NGO) services only as Health New Zealand–Te Whatu Ora peer support roles were unable to be identified separately from other workforces.

Total number of FTE lived experience roles in NGO services (n)



Notes Shift 1

- 1 Government Inquiry into Mental Health and Addiction. 2018. **He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction**. Wellington: Government Inquiry into Mental Health and Addiction.
- 2 Te Hiringa Mahara. 2024a. **Leadership as a Mental Wellbeing System Enabler: Insights on Progress toward Kia Manawanui**.

Shift 2:

Towards a mental health and addiction system that prioritises effective services for people with the highest need

What this means:

- Leadership and support by and for those experiencing the highest need within and throughout the mental health and addiction system.
- Commissioning, services, and settings that meet the needs of groups experiencing highest needs, including increased investment in Kaupapa Māori services.
- Collecting data about what services are effective and using it to make prioritising decisions.

Shift 2 aims to address the current disparities in both need and outcomes experienced by different groups of people who interact with the system. Underpinning this shift is a focus on ‘by us, for us’ approaches and improving our understanding of what works for people with the highest needs. A transformed system will recognise, prioritise, and meet the needs of these groups.

There is no ‘one size fits all’ in mental health, and the He Ara Oranga report called for a wider variety of service options, co-design, and support for implementation. Our 2024 report into mental health and addiction service access and options¹ showed that while options have increased, so has demand.

It also showed that inequities experienced by some groups, especially Māori, are ongoing. It identified pockets of excellence in understanding and addressing the needs of these groups.

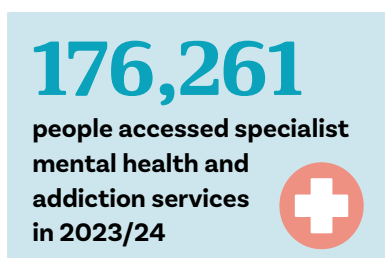
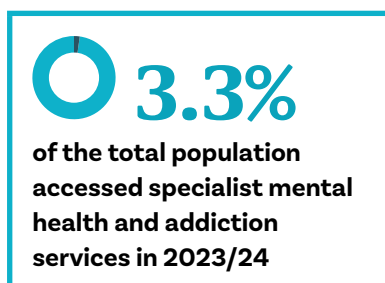
Initially we will monitor investment in and access to services tailored for groups that evidence shows have the highest needs. Future monitoring will work towards including measures of experiences of and outcomes for people with the highest needs who are in contact with the mental health and addiction system.

Contribution to system and services		Contribution to population outcomes	
He Ara Āwhina:		He Ara Oranga:	
Te Ao Māori perspective	Shared perspective	Te Ao Māori perspective	Shared perspective
Manawa Ora / Tūmanako	Access and Options	Whakaora, whakatipu kia manawaroa	Having what is needed
Mana Whānau / Whanaungatanga	Effectiveness	Whakapuāwaitanga me te pae ora	Healing, growth, and being resilient

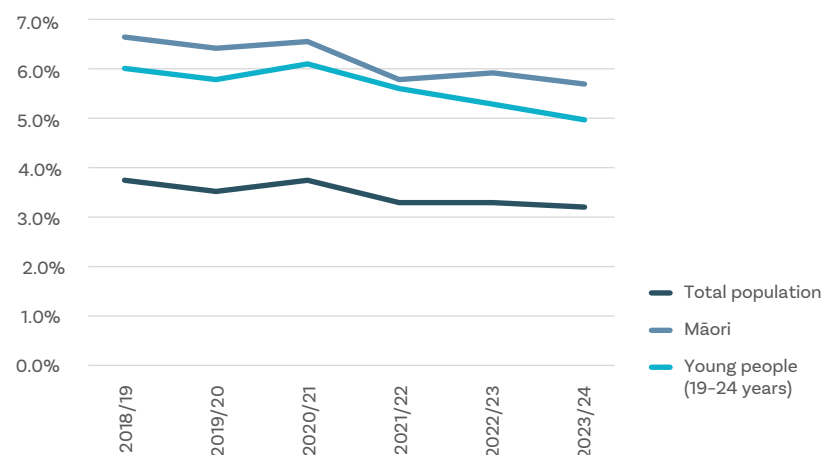
Measure 1: Specialist services access

Number of people who used mental health and addiction services as a percentage of the New Zealand population

Rationale	Mental health and addiction specialist services account for the majority of mental health expenditure. Access to specialist services measures the responsiveness of the system for people with the highest need.
Commentary	Over 16,000 fewer people accessed specialist mental health and addiction services in 2023/24 compared with 2020/21. Young people experienced the largest relative decrease. The reduction in access to specialist services is not due to decreasing need but due to significant workforce shortages in specialist services, and services focusing on caring for those with higher and more severe needs. ¹



Specialist mental health and addiction services access rates as a proportion of the total population (%)



Measure 2: Primary services access

Number of people using Access and Choice mental health and addiction services (at least once per year)

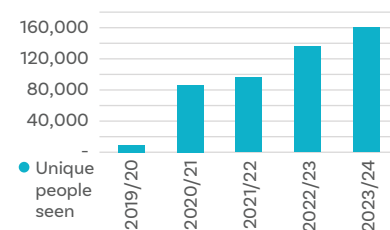
Rationale	Primary mental health services support people with mild to moderate need. Early intervention has the potential to reduce pressure on specialist services. System-level monitoring helps show where the system needs to prioritise resource to meet demand.
Commentary	The Access and Choice programme has considerably increased access to mental health and addiction support. There is increasing uptake of Integrated Primary Mental Health and Addiction (IPMHA) services, as well as Pacific and youth services. There was a decline in the number of new people seen in Kaupapa Māori Access and Choice services in the last year, though this is likely to be due to under-reporting. Increased access to primary mental health services over time is supporting the system to shift focus to prevention and earlier intervention.

Over
207,000
people received support
with mild to moderate
mental health and addiction
needs in 2023/24

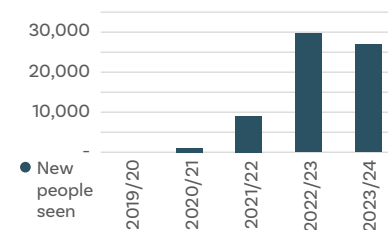
42,000
young people aged
12–24 used Access
and Choice services
in 2023/24



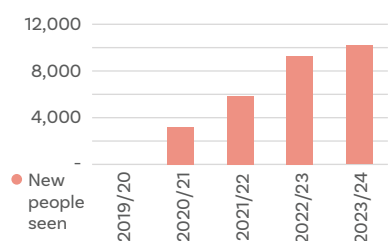
IPMHA



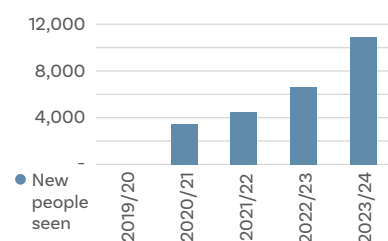
Kaupapa Māori



Pacific peoples



Youth



Measure 3: Kaupapa Māori investment

Total investment and share of investment in kaupapa Māori specialist mental health and addiction services

Rationale

Commissioning, services, and settings must meet the needs of the population groups with the highest need. Having a mental health and addiction system that understands, includes, and protects mātauranga Māori is a critical enabler of improved Māori health and wellbeing outcomes.

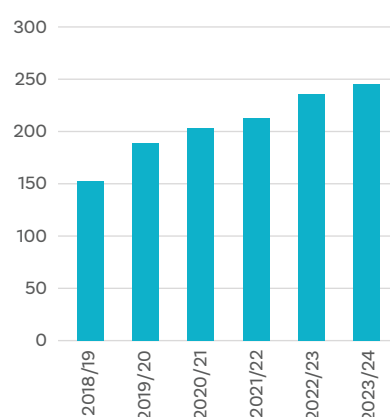
Commentary

There was an increase in total investment in kaupapa Māori specialist mental health and addiction services between 2018/19 and 2023/24. However, the share of investment into kaupapa Māori specialist services remained around 10 per cent of the total mental health and addiction expenditure. Māori represent nearly one third of people accessing specialist services.

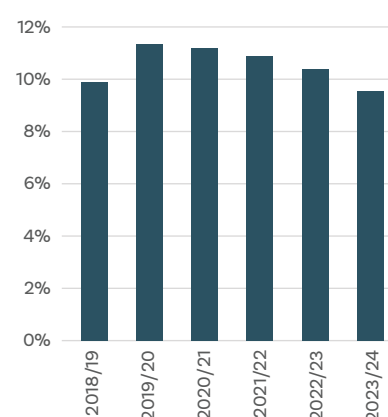
9.5% of total
expenditure was invested in
kaupapa Māori specialist
mental health and addiction
services in 2023/24

30% of people
accessing specialist mental
health and addiction services
in 2023/24 were Māori

Kaupapa Māori specialist services expenditure total (\$m)



Kaupapa Māori specialist services expenditure share (%)



Notes Shift 2

- 1 Te Hiringa Mahara. 2024b. Kua Tīmata Te Haerenga | The Journey Has Begun: Mental health and addiction service monitoring report 2024: Access and options. Wellington: Te Hiringa Mahara.

Shift 3:

Towards a mental health and addiction system that provides effective primary prevention and early interventions

What this means:

- Increased proportion of investment allocated to primary prevention and early intervention, including community-based options.
- Tailored mental health and wellbeing prevention and promotion activities designed and delivered in partnership with priority populations (especially young people and rangatahi).
- Faster access to primary mental health and addiction services.
- Strategies to support families seeking help before reaching crisis point.
- More alternatives to support self-management (e.g. digital and telehealth).
- System contributes to addressing the determinants of mental health and wellbeing for people who interact with services.

Shift 3 focuses on strengthening the factors that promote mental wellbeing, preventing mental health and addiction needs from escalating, and intervening early when needs arise. It acknowledges that supporting good mental health requires a comprehensive approach that helps people to stay well while also offering a spectrum of options to help with mild to moderate need.

The system envisioned by the He Ara Oranga report emphasises wellbeing and community, with more prevention and early intervention, treatment closer to home, whānau- and community-based responses, and cross-government action.¹

The communities we heard from also made it clear that we cannot ignore the factors that affect people's broader wellbeing (determinants). An example is the positive impact that secure housing and employment have on mental health outcomes.

Our initial monitoring will measure investment in and access to primary prevention and early intervention services, alongside early measures of key determinants. In future we will work to develop measures of coverage, effectiveness, and impact, and further develop our monitoring of determinants.

Contribution to system and services		Contribution to population outcomes	
He Ara Āwhina:		He Ara Oranga:	
Te Ao Māori perspective	Shared perspective	Te Ao Māori perspective	Shared perspective
Manawa Ora / Tūmanako	Access and options Effectiveness	Tūmanako me te ngākaupai Whakapuāwaitanga me te pae ora Tūmanako me te ngākaupai	Healing, growth, and being resilient Having what is needed

Measure 1: Telehealth wait times

Average call wait times and number of unique users of national telehealth services

Rationale Access to a range of options for people experiencing distress means people can get the types of support they need when and how they need it. Timely access to telehealth is a measure of a system that provides more alternatives to support self-management.

Commentary Call wait times have increased markedly over time across all telehealth services (360% increase between 2019/20 and 2023/24). The number of unique users has decreased (40% decrease between 2019/20 and 2023/24). Longer response times reflect how much demand is exceeding service capacity.

 **10.27mins**

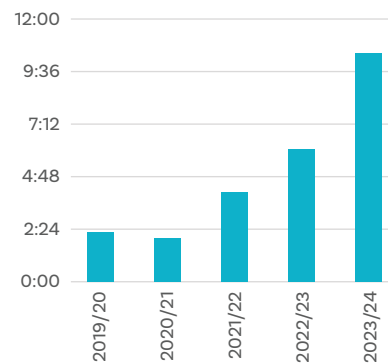
Average wait time for calls to national telehealth services in 2023/24

56,459

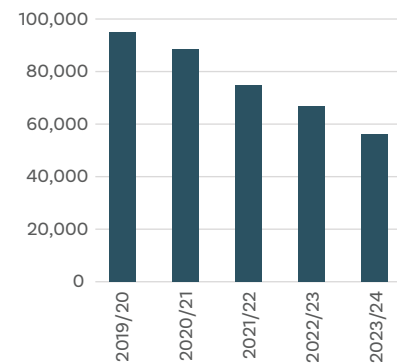
unique service users of national telehealth services in 2023/24



Average call wait times for telehealth services (combined services, minutes)



Number of unique users of telehealth services (combined services)



Measure 2: Access and Choice wait times

Percentage of people accessing primary mental health and addiction services through the Access and Choice programme within one week (mental health and addiction target)

Rationale Timely access to primary mental health and addiction support, consisting of a range of services tailored to population need, is a measure of a mental health and addiction system that provides effective support for people experiencing mild to moderate distress.

Commentary Four out of five people using the Access and Choice programme were seen within 1 week, with no difference by ethnic group. Data by ethnic group is not yet publicly available for quarter 2 2024/25.

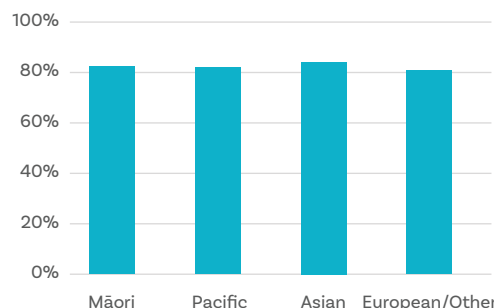
 **83.9%**

of people accessed services within one week in quarter 2 2024/25

676,261

Access and Choice sessions delivered in 2023/24

Percentage of people able to access Access and Choice services within 1 week, quarter 1 2024/25



\$191m

Invested in Access and Choice in 2023/24

Measure 3: Housing

The proportion of people accessing specialist mental health and addiction services by accommodation type

Rationale	Insecure housing has a large impact on people's mental health and wellbeing outcomes. The system has a role in contributing to addressing the determinants of wellbeing for people who interact with services through supported accommodation and linking with housing support services.
Commentary	There has been no change over time in the proportion of people accessing mental health and addiction services who are known to have no accommodation.



6%

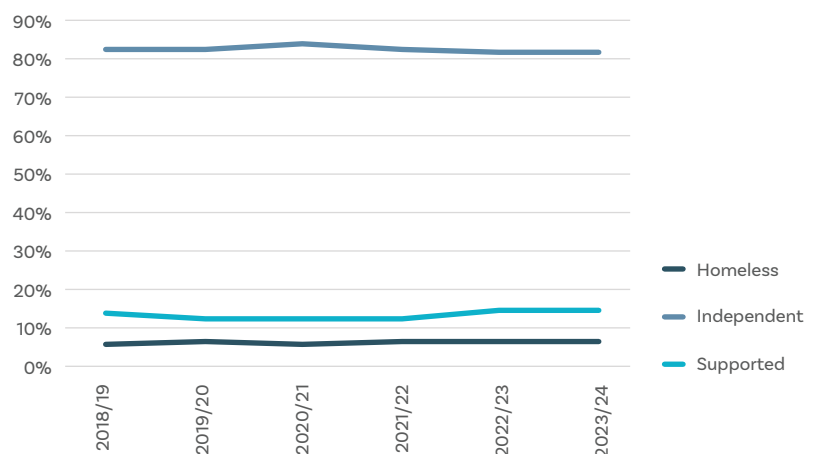
of specialist mental health and addiction service users were homeless in 2023/24



8%

of Māori specialist mental health and addiction service users were homeless in 2023/24

Accommodation types for people accessing specialist mental health and addiction services (%)



Measure 4: Employment, education, and training

The proportion of people accessing specialist mental health and addiction services who were in employment, education or training

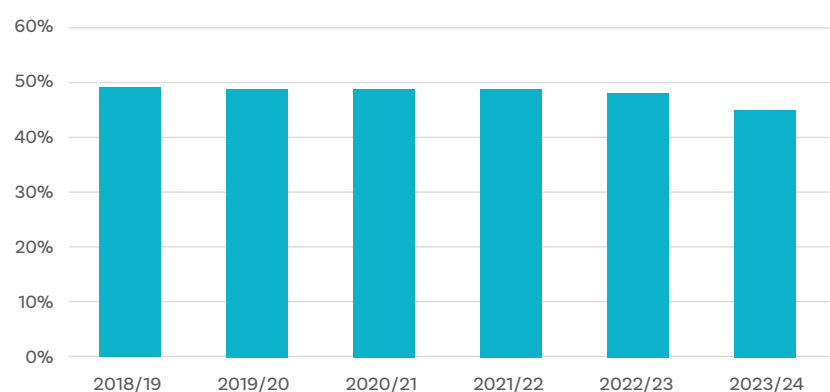
Rationale	Meaningful work contributes to a sense of wellbeing as well as providing income. The system has a role in contributing to addressing the determinants of wellbeing for people who interact with services.
Commentary	In 2023/24, less than half of people who used specialist services were in employment, education, or training. There has been a slight decrease over time in the proportion of people in employment, education, or training since 2018/19.



45%

of specialist mental health and addiction service users were in employment, education, or training in 2023/24

Percentage of people accessing specialist mental health and addiction services who are in employment, education, or training



Measure 5: Investment in prevention and early intervention

The proportion of mental health and addiction investment allocated to prevention and early intervention (mental health and addiction target)

Rationale	Increased investment has the potential to reorient the system towards prevention and early intervention. Population-based approaches help keep people well in their communities and can reduce the pressure on a stretched specialist system.
Commentary	Around one quarter of mental health and addiction investment is allocated to early intervention and prevention. This is the first time this measure has been reported. Further breakdowns and benchmarking data is not available.



24.4%

of annual budgeted investment was allocated to prevention and early intervention as at quarter 2 2024/25

Notes Shift 3

1 Government Inquiry into Mental Health and Addiction. 2018. **He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction**. Wellington: Government Inquiry into Mental Health and Addiction.

Shift 4:

Towards a mental health and addiction system that provides equitable access to services and supports that improve outcomes for people

What this means:

- Mental health and addiction services and supports are available at times and in places where people need them, for the people that need them.
- Provision of services is sufficient, timely, culturally safe, affirming, effective, and welcoming, supported by a coordinated, joined-up system.

Shift 4 is about making sure everyone who needs help can get it in a way that works for them.

There are well-documented inequities in the mental health and addiction system,¹ and it is widely agreed that barriers created by inequity affect tāngata whaiora whether they are in contact with services or not. Equity is considered a fundamental requirement for an effective system—therefore we are focusing on equity of both access and outcomes as a key indicator of system transformation.

We were told that people want to be able to access services where and when they need them. They also want to feel welcome and as if they matter, in environments where they feel comfortable and are understood, accepted, and supported in ways that are meaningful for them. They spoke of the physical environment as well as the emotional and cultural one, and stressed the difference that welcoming surroundings make to a person's experience.

Our initial monitoring will focus on access and investment. In future we will work towards including qualitative understanding of people's experience and outcomes.

Contribution to system and services		Contribution to population outcomes	
He Ara Āwhina:		He Ara Oranga:	
Te Ao Māori perspective	Shared perspective	Te Ao Māori perspective	Shared perspective
Manawa Ora / Tūmanako	Equity	Whakapuāwaitanga me te pae ora	Being connected and valued
Mana Tangata / Tū Tangata Mauri Ora	Access and Options	Whanaungatanga me te arohatanga	Having what is needed
Kotahitanga	Connected care		

Measure 1: Specialist wait times

Proportion of people referred to specialist mental health and addiction services who were seen within three weeks (mental health and addiction target)


Rationale	Timely access is a measure of a system that is structured and resourced to meet need.
Commentary	Specialist services are meeting Government mental health targets for timely access (80%). Supporting timely access to specialist services alongside other measures of service and system performance will ensure people can get the support they need, when and where they need it. Our recent service access reporting shows young people wait much longer for specialist services.

81.9%  of people referred to specialist mental health and addiction services were seen within three weeks in quarter 2 2024/25

Measure 2: Emergency department wait times

Proportion of people with emergency department presentations related to mental health and addiction were admitted, discharged, or transferred from an emergency department within six hours (mental health and addiction target)

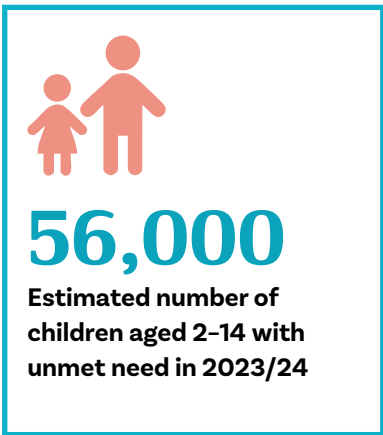
Rationale	Timely access is a measure of a system that is structured and resourced to meet need.
Commentary	Wait times in emergency departments are well below their 95% target. Supporting timely access alongside other measures of service and system performance will ensure people can get the support they need, when and where they need it.

65.0%  of people with emergency department presentations related to mental health and addiction were admitted, discharged, or transferred from an emergency department within six hours in quarter 2 2024/25

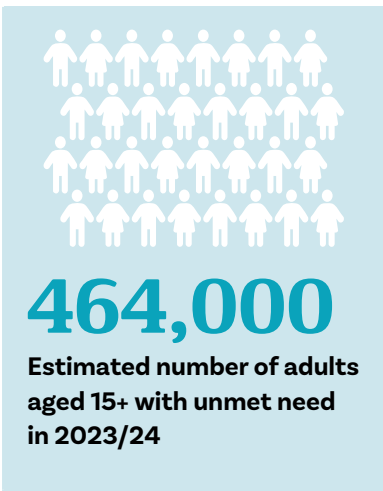
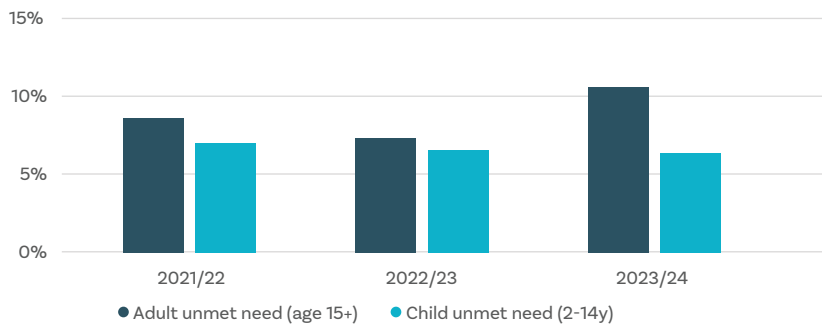
Measure 3: Unmet need

Proportion of people reporting unmet need for professional help for mental health in the past 12 months

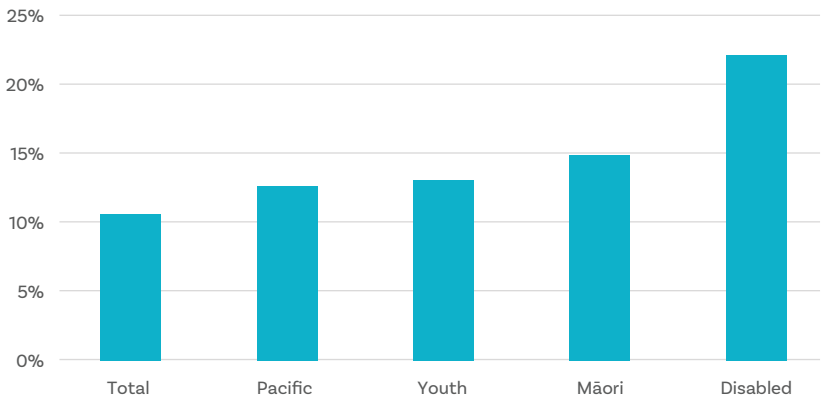
Rationale	Unmet need is a measure of demand for services. Considering patterns of unmet need can help the system reorient to ways to meet demand within service and system constraints.
Commentary	Unmet need has increased among adults, with a statistically significant increase between 2022/23 and 2023/24. The number of people who want support far outpaces the system's current capacity. Young people, Māori and Pacific peoples, and disabled adults were more likely to experience unmet need than older age groups, non-Māori, non-Pacific, and non-disabled adults respectively.



Percentage of population experiencing unmet need for professional help for mental health in the past 12 months



Percentage of population experiencing unmet need for professional help for mental health in the past 12 months, 2023/24



Notes Shift 4

1 Government Inquiry into Mental Health and Addiction. 2018. **He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction**. Wellington: Government Inquiry into Mental Health and Addiction.
Ministry of Health. 2021. **Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing**. Wellington: Ministry of Health.
Ministry of Health. 2023. **Oranga Hinengaro System and Service Framework**. Wellington: Ministry of Health.

Shift 5:

Towards a mental health and addiction system that upholds human rights-based practices

What this means:

- Policy and practice within the system uphold human rights and indigenous rights, along with the agency of tāngata whaiora.
- Legislation to reduce/end coercive practices in care, with clear pathways for safe and rights-based alternatives.

Shift 5 recognises the need for the system to place people's rights and agency at the centre of policy and practice. It calls for the elimination of harmful practices, minimisation of coercive treatment, and for a modern human rights framework to underpin policy and practice.

It has been widely reported that coercive practices such as compulsory community treatment orders (CCTOs) and solitary confinement 'seclusion' can be extremely traumatising.¹ There is also persistent ethnic inequity in how these are applied, with higher use of CCTOs for Māori and Pacific peoples. The envisioned system will support all people to meaningfully participate in and lead their decision-making about care and treatment.

We heard from people with lived experience that reducing coercive practices is not enough: that a truly transformed system will actively seek and provide alternative options that uphold human and indigenous rights. They told us that the system should actively facilitate agency and safety for people in contact with services.

Initially we will monitor progress towards reducing coercive practices. We will work to develop monitoring for human rights- and indigenous rights- based practices and measures of experience, including agency for people in contact with the mental health and addiction system.

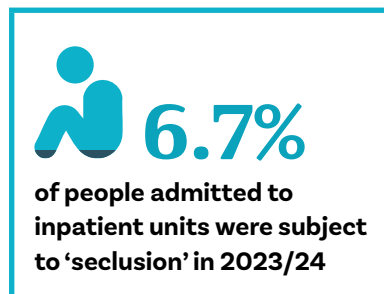
Contribution to system and services		Contribution to population outcomes	
He Ara Āwhina:		He Ara Oranga:	
Te Ao Māori perspective	Shared perspective	Te Ao Māori perspective	Shared perspective
Mana Tangata / Tū	Safety and Rights	Tino rangatiratanga me	Being safe and nurtured
Tangata Mauri Ora	Participation and	te mana motuhake	Having one's rights and
Mana Whānau /	Leadership	Wairuatanga me te	dignity fully realised
Whanaungatanga		manawaroa	
Mana Motuhake			
Mana Whakahaere			

* We use the term 'seclusion' as it relates to Mental Health (Compulsory Assessment and Treatment) Act 1992 data. We use quote marks around the term to indicate this is not our preferred language informed by lived experience. In our other work, we use the term 'solitary confinement' in place of or alongside 'seclusion' to recognise people's lived experience of this practice.

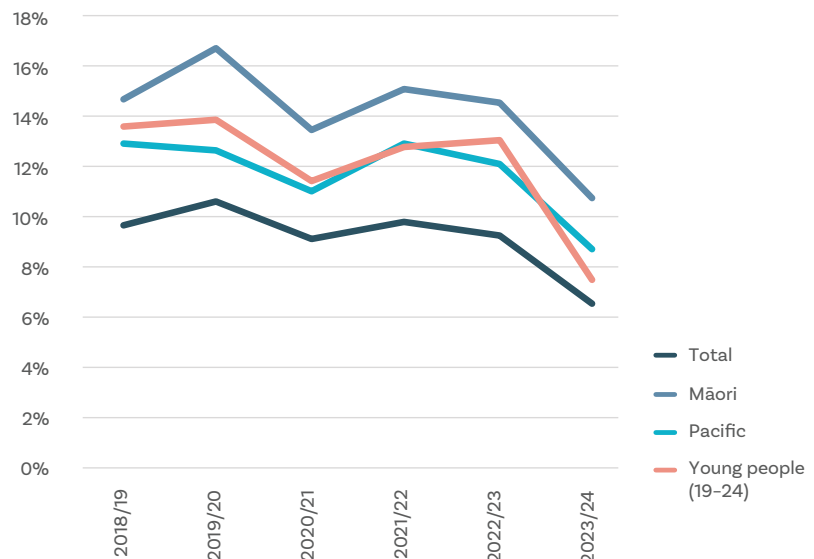
Measure 1: Seclusion

Number of people in mental health inpatient units subject to 'seclusion'

Rationale	'Seclusion' is understood to be an infringement on human rights and can be a traumatising experience for people undergoing treatment.
Commentary	Around 700 people were subject to 'seclusion' in 2023/24. The number and proportion of people subject to 'seclusion' in inpatient units have decreased since 2018/19. The proportion of Māori, Pacific peoples, and young people subject to 'seclusion' is consistently higher than other population groups.



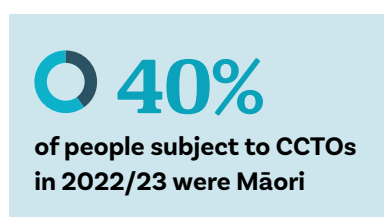
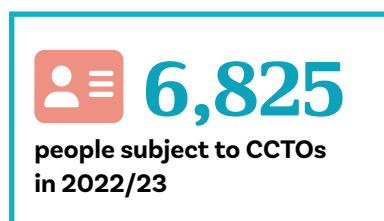
Proportion of people in inpatient units subject to seclusion



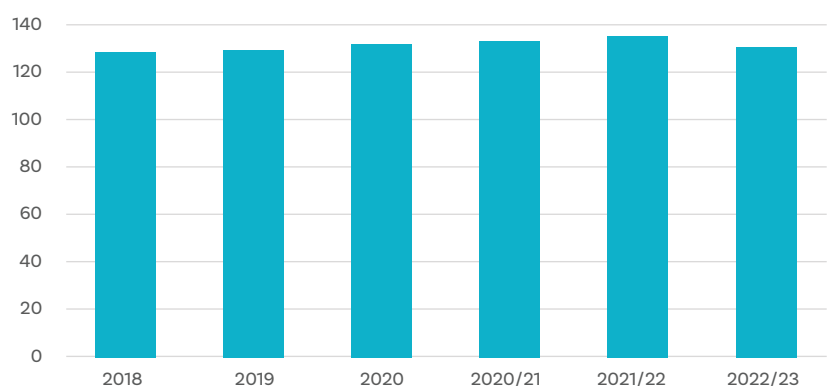
Measure 2: Compulsory community treatment orders

Rate of people subject to a compulsory community treatment order (CCTO) per 100,000 population

Rationale	CCTOs permit clinicians to compel people who are living in the community to be treated without their consent. Evidence shows CCTOs are not effective in reducing inpatient admissions. We want to see the shift from coercive treatment to choice-based treatment.
Commentary	The number and rate of CCTOs have increased over the last six years. There is persistent ethnic inequity with higher use of CCTOs for Māori and Pacific peoples.



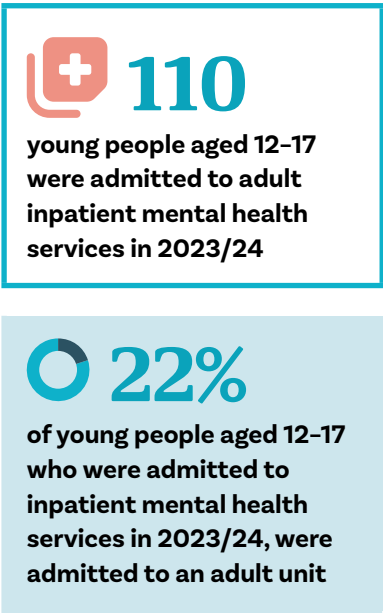
Rate of people subject to a compulsory community treatment order per 100,000 population



Measure 3: Young people in adult inpatient units

Number of young people admitted to adult inpatient mental health services

Rationale	Young people have often been expected to fit into adult services, including inpatient care in adult facilities. Young people, whānau, and families have told us that this practice can be harmful, can cause a loss of hope, and does not uphold the rights of young people.
Commentary	While young people continue to be admitted to adult inpatient units, the number has fallen in the last three years. We want to see zero admissions of young people to adult inpatient mental health services, alongside appropriate alternatives for young people.



Shift 6:

Towards a mental health and addiction system supported by a workforce with the capability, competencies, and capacity to meet needs now and in the future

What this means:

- There is effective planning and investment in workforce resilience and capability.
- The workforce is reflective of and responsive to the needs of the diverse communities it serves.
- There is investment in ongoing training and professional development for the workforce.
- The workforce is well resourced to ensure sufficient staffing levels across the diversity of roles, and levels of need now and in the future.

Shift 6 acknowledges the vital role played by the mental health and addiction workforce and focuses on four key areas that will support system transformation—diversity, professional development, sufficient staffing, and planning and investment.

Our analysis of relevant reports showed that significant challenges affect the mental health and addiction workforce including staffing shortages, a mismatch between required capabilities and available skills, and the need for better support to respond to complex social problems and to engage better with family and whānau.¹ Action is needed at a systemic level to address these challenges.

We learned from our lived experience and sector reference groups that while planning and investment are crucial for an effective workforce, equally important is understanding and meeting the diverse needs of the people the system serves. Therefore, we need to ensure the workforce reflects the wider community and receives appropriate professional development and support across the spectrum of roles.

Our initial monitoring focuses on workforce supply and diversity. In future we will consider measures of workforce sustainability and resilience.

Contribution to system and services		Contribution to population outcomes	
He Ara Āwhina:		He Ara Oranga:	
Te Ao Māori perspective Kotahitanga	Shared perspective Connected care	Te Ao Māori perspective Whakapuāwaitanga me te pae ora	Shared perspective Having what is needed

Measure 1: Workforce diversity

Proportion of mental health and addiction employees by ethnic group

Rationale	Capability and competency are supported by a workforce that is reflective of and responsive to the needs of the diverse communities it serves.
Commentary	The share of the Health New Zealand—Te Whatu Ora (Health NZ) workforce who identify as Māori, Pacific peoples, and Asian has grown since 2018/19. There is still a large gap in the proportion of the workforce who identify as Māori (15%) compared with the proportion of Māori who use specialist services (30%).

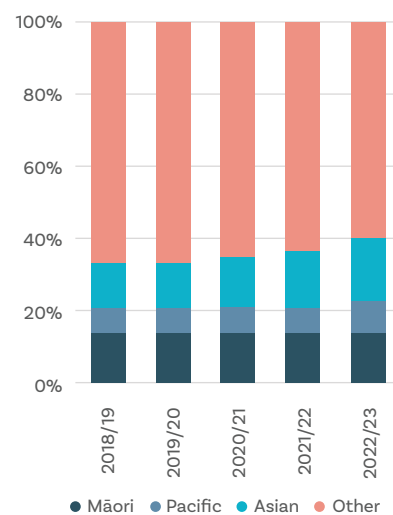
 **15%**

of the Te Whatu Ora Mental Health and Addiction workforce identified as Māori in 2022/23

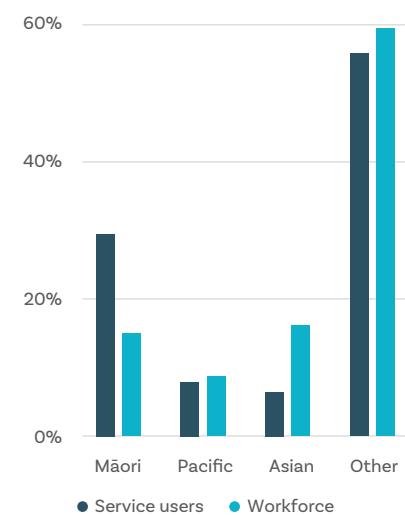
 **30%**

of the people who use specialist mental health and addiction services identified as Māori in 2022/23

Percentage of Health NZ employees by ethnic group



Comparison of service users with workforce by ethnic group 2022/23



Measure 2: Vacancy rate

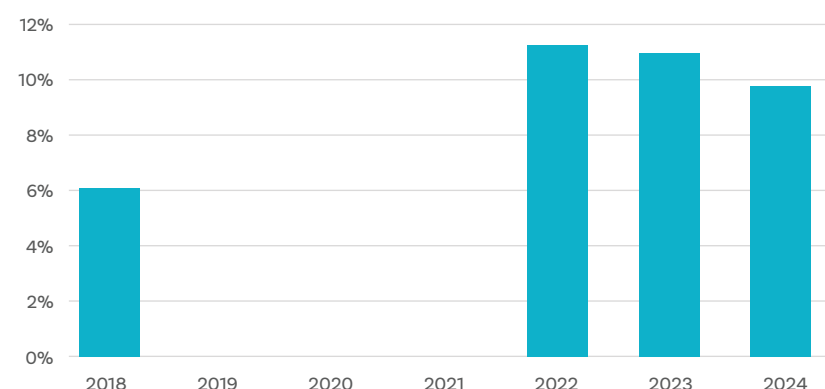
Vacancy rate in adult mental health and addiction specialist services—non-governmental organisations and Health NZ

Rationale	Vacancy rates are a measure of workforce sustainability. High vacancy rates impact the ability of the sector to deliver services and put additional pressure on remaining staff.
Commentary	Vacancy rates continue to be a significant challenge. Vacancy rates increased markedly between 2018 and 2022 and have remained high for the last three years, although there is some positive improvement in 2024. Vacancy rate data is unavailable for the period 2019–2021.

 **9.8%**

vacancy rate across adult Health NZ mental health and addiction services in 2024

Vacancy rate in adult Health NZ specialist services



Measure 3: Workforce development

Number of new mental health and addiction professionals entering training (mental health and addiction target)

Rationale	Increased mental health and addiction workforce development seeks to support system performance by increasing the workforce supply.
Commentary	New training places are expected to support the workforce pipeline. This figure excludes psychiatry registrars and so underestimates the number of training places in this period.



457

mental health professionals entered training in 2024/25*

* Workforce training figures exclude psychiatry training figures in quarter 1. The definition only includes psychology interns, new entry to specialist practice nurses, occupational therapists, social workers, and stage one psychiatry registrars. Other key workforces including support workers and alcohol and drug practitioners cannot be measured at this stage.

Notes Shift 6

1 Government Inquiry into Mental Health and Addiction. 2018. **He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction**. Wellington: Government Inquiry into Mental Health and Addiction.
Ministry of Health. 2021. **Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing**. Wellington: Ministry of Health.
Ministry of Health. 2023. **Oranga Hinengaro System and Service Framework**. Wellington: Ministry of Health.

Whakatepenga

Conclusion

The early signs of change are promising, but there is considerable work still to do to bring about all-of-system transformation.

The small set of quantitative measures presented in this report is focused on data that is currently available and can be analysed and linked to provide initial information on whether system changes are taking place. From this we can see that while the system is still under a great deal of pressure, it is beginning to shift towards the vision of the He Ara Oranga, the strategic direction of Kia Manawanui and the aspirations of the He Ara Āwhina and He Ara Oranga frameworks. This is evident in increased access to services with peer support, the expansion of primary mental health services, and the increase in diversity of the workforce.

The Government has committed to focus on timely access, investment in primary prevention, and improvements to the workforce. This is likely to improve equity of access to primary and early intervention. The increased number of workforce training places is expected to support more people to move into mental health roles. We will continue to monitor the Government's delivery of mental health and addiction targets through our system performance monitoring and through deep-dive analysis.

These early shifts are not yet extensive enough to realise the transformation that will drive changes in population-level outcomes. We also see several areas of concern, such as the decrease in access to specialist services and the increased use of compulsory community treatment orders. The lack of change in the employment or housing status of people in contact with the mental health and addiction system is also a concern.

The upcoming Mental Health and Wellbeing Strategy is a great opportunity to lay out a plan for this work, and to bring about the changes people have told us they want and need from the system. This work will need careful monitoring over time to understand what works, what doesn't, and how these changes are translating into outcomes for people.

Key priorities for the system

Te Hīringa Mahara has a role to broker a shared understanding of how the mental health and addiction system is performing and where improvements could be made.

Key priorities evident from this early work include:

- need for better data including the prevalence of mental health needs across the whole population, outcomes achieved for people from services, and experience of services for people who interact with them
- further investigation to understand the changing patterns of need and service use
- action to reduce wait times across services including emergency departments, specialist services for young people, and telehealth.

We will continue to keep these priorities central to our monitoring and advocacy as we give effect to our system oversight role.

Ngā whanake

Next steps

This report is the first step of a long-term system performance monitoring programme of work.

We will continue to develop our monitoring scope and our measures over time based on access to suitable data and on feedback, which we will actively seek. To assist with this, we will continue our data advocacy, particularly around improving data relating to system performance monitoring gaps such as prevalence, outcomes, and people's experiences of services and the system.

We will make system performance measures data available in the form of a dashboard (currently in development for 2026). This will include measures of determinants, service and system performance, and indicators of wellbeing outcomes.

We will use our monitoring to inform more detailed investigation and advocacy, especially where the data indicates further analysis would be helpful to better understand what we are seeing and to provide advice to support government strategies.

Over time we will work towards taking a broader view of system performance that incorporates not only what is changing and how much, but how well the system is performing. To facilitate this, we intend to develop measures that are appropriate to monitor aspects of the system that we cannot currently measure. This work includes strengthening our quantitative monitoring with qualitative insights.

There are several aspects of system performance that could be considered by analysing combinations of qualitative and quantitative data as outlined in Levesque and Sutherland's (2020) integrated performance framework. We will work to develop our measurement in this area, with a view towards future assessment of system productivity, resilience, and sustainability.

Appendix A – Ngā inenga Measures

Shift	Measure	Source	Notes	For more information
1	Treatment days in mental health and addiction specialist services with peer support as a proportion of total treatment days	PRIMHD	Extract date of 23 October 2024.	Our monitoring dashboard, Te Hiringa Mahara—Mental Health and Wellbeing Commission
	Annual peer support services expenditure as a proportion of total mental health and addiction services expenditure	Health New Zealand Te Whatu Ora	2023/24 peer support service expenditure data is incomplete so is not presented here.	Our monitoring dashboard, Te Hiringa Mahara—Mental Health and Wellbeing Commission
	Total lived experience full time equivalent (FTE) roles	Te Pou	Non-governmental organisation (NGO) services only. Includes employed and vacant.	Peer support workforce paper 2023, Te Hiringa Mahara—Mental Health and Wellbeing Commission
2	Mental health and addiction specialist services access rates for Māori, Pacific and youth populations as a proportion of the total population	PRIMHD	Extract date of 23 October 2024.	Mental health and addiction specialist service access factsheet download, Te Hiringa Mahara—Mental Health and Wellbeing Commission
	Number of people using Access and Choice mental health and addiction services (IPMHA, kaupapa Māori, Pacific, and youth services)	Health New Zealand Te Whatu Ora	New people seen.	Access and Choice Programme 2025 report downloads, Te Hiringa Mahara—Mental Health and Wellbeing Commission
	Investment in specialist kaupapa Māori services as a proportion of total mental health and addiction services expenditure	Health New Zealand Te Whatu Ora	2023/24 kaupapa Māori service expenditure data is incomplete so is not presented here.	Our monitoring dashboard, Te Hiringa Mahara—Mental Health and Wellbeing Commission

Shift	Measure	Source	Notes	For more information
3	Wait times for national mental health and addiction telehealth services (minutes)	Whakarongorau	Combines 1737 Need to Talk, Mind and Body Peer Support, Depression, AOD and Gambling call services.	Our monitoring dashboard, Te Hiringa Mahara—Mental Health and Wellbeing Commission
	Wait times for Access and Choice mental health and addiction services (percentage one week) (mental health and addiction target)	Health New Zealand Te Whatu Ora	<p>Inclusion of referral date was mandated in October 2024. As such, data is incomplete for quarter 2. Data for Tairāwhiti and MidCentral are unavailable for quarter 2.</p> <p>This quarter, youth, Māori, and Pacific providers are not included in the results as they are not yet submitting data at a patient level. These providers represent approximately 30 per cent of activity in the Access and Choice programme. Work is underway to ensure we can include these providers in future quarters.</p>	Mental health and addiction targets performance, Health New Zealand, Te Whatu Ora
	Tāngata whaiora in independent or supported living	PRIMHD	This data is sourced from the Supplementary Consumer Record (SCR). SCR reporting compliance is low and impacts the accuracy and completeness of this measure.	Our monitoring dashboard, Te Hiringa Mahara—Mental Health and Wellbeing Commission
	Tāngata whaiora in employment, education, or training	PRIMHD	This data is sourced from the Supplementary Consumer Record (SCR). SCR reporting compliance is low and impacts the accuracy and completeness of this measure.	Our monitoring dashboard, Te Hiringa Mahara—Mental Health and Wellbeing Commission
	Investment in prevention and early intervention as a proportion of total mental health and addiction expenditure (Mental Health and Addiction Target)	Health New Zealand Te Whatu Ora	This result is the annual budgeted investment; it does not represent the proportion of the mental health and addiction ringfence that has been spent during the quarter.	Mental health and addiction targets performance - Health New Zealand Te Whatu Ora

Shift	Measure	Source	Notes	For more information
4	Wait times for specialist mental health and addiction services (percentage three weeks) (mental health and addiction target)	Health New Zealand Te Whatu Ora	Results for this quarter are estimated to be under-reported by 2 per cent due to delays in the data pipeline.	Mental health and addiction targets performance – Health New Zealand Te Whatu Ora
	Wait times in emergency departments (EDs) for mental health presentations (mental health and addiction target)	Health New Zealand Te Whatu Ora	Reporting is under-estimated due to a high proportion (9 per cent) of ED presentations having no specific presenting complaint recorded. Presenting complaint is required to identify mental health and addiction related presentations. The result excludes three level 2 ED facilities (not publicly funded). This result does not include addiction-related presentations to EDs.	Mental health and addiction targets performance – Health New Zealand Te Whatu Ora
	Rates of unmet need for professional mental health or substance abuse help	Ministry of Health Manatū Hauora	Adult age range is 15+ years, Child age range is 2-14 years. This question was not part of the New Zealand Health Survey between 2017/18 and 2020/21.	minhealthnz.shinyapps.io/nz-health-survey-2023-24-annual-data-explorer/
5	Proportion of people in mental health inpatient units subjected to ‘seclusion’	PRIMHD	This data shows the proportion of people who have experienced at least one ‘seclusion’ event in the year. If they have experienced multiple ‘seclusion’ events in a year, they are only counted once. Data is sourced from PRIMHD using code and methodology supplied by the Health Quality and Safety Commission.	Reducing-coercive-practices-infographic-July-2024.pdf

Shift	Measure	Source	Notes	For more information
5	Rate of compulsory community treatment orders per 100,000 population	Ministry of Health Manatū Hauora, Statistics New Zealand	Population data: Stats NZ, Population projections for end of financial years (used to calculate rates per 100,000).	Reducing-coercive-practices-infographic-July-2024.pdf
	Number of young people admitted to an adult mental health inpatient units	PRIMHD	Young people aged 12–17 years.	Youth services focus report, Te Hīringa Mahara—Mental Health and Wellbeing Commission
6	Proportion of Māori, Pacific peoples, Asian, and other ethnic groups (including European) in the Te Whatu Ora adult mental health and addiction services workforce compared with the proportion of people accessing specialist mental health and addiction services	Te Pou/PRIMHD	Te Whatu Ora workforce only.	Our monitoring dashboard, Te Hīringa Mahara—Mental Health and Wellbeing Commission
	Workforce vacancy rate in mental health and addiction services	Te Pou	Vacancy rates are calculated as the total FTE of vacancies divided by the total number of filled and vacant FTEs. Covers Te Whatu Ora and NGO services.	Our monitoring dashboard, Te Hīringa Mahara—Mental Health and Wellbeing Commission
	Number of new mental health and addiction professionals entering training (mental health and addiction target)	Health New Zealand Te Whatu Ora	Workforce training figures exclude psychiatry training figures. The definition only includes psychology interns, new entry to specialist practice nurses, occupational therapists, social workers, and stage one psychiatry registrars. Other key workforces including support workers and alcohol and drug practitioners cannot be measured at this stage.	Mental health and addiction targets performance - Health New Zealand Te Whatu Ora

Appendix B – Ko ngā kaupapa ariā

Theoretical underpinnings

Our background research was in three parts—current system performance measurement theory, existing system performance measurement approaches, and grounded advice from people with system performance monitoring experience.

Part 1: Current system performance measurement theory

We searched for literature on system performance and system performance measurement in the health sector. We were particularly interested in what aspects of performance monitoring and assessment would be most useful for us to implement in our own approach. In the literature we noted two key means of understanding performance—outcomes-based approaches and the use of performance constructs.

Outcomes-based approaches focus on measuring the results of the activities of a system. This is different from measuring the activities themselves, in that it focuses on the difference the activities and services have made for people (Ministry of Business, Innovation and Employment, 2025) rather than their delivery. Outcomes could include client outcomes, or population-level outcomes—noting that ‘population’ could mean a specific population such as tāngata whaiora.

Population-level outcomes are useful for answering big-picture questions such as “How well is the national system performing as a whole?” However, changes at this level require contributions from multiple activities (Silwal et al, 2025), and therefore it is difficult to attribute these outcomes to specific activities. ‘Intermediate’ outcomes—that is, those outcomes that could be measured before the final impact—can be more useful in understanding how to improve system performance (ibid) if the measures selected are appropriate to the aspects of performance we aim to monitor. In this work we are taking a broad overview of performance, which focuses on actions within the span of control of the system stakeholders. This lends itself to the use of intermediate outcomes as part of our monitoring approach.

The difficulty of controlling overall outcomes in complex adaptive systems such as our mental health and addiction system can lead to ‘directive’ approaches to system change (Newton-Lewis et al, 2021). These involve the use of targets and incentives based around quantitative benchmarks, which are usually easy to measure but are focused on outputs rather than improvements. This can lead to focusing on meeting targets rather than quality of care.

If the aim is people-centred care, directive approaches should be balanced with enabling approaches—which focus on connectedness, relationships, and sharing of knowledge supported by strong data systems and adequate resourcing (ibid). Enabling approaches can be more effective for long-term strategic renewal and change such as the system transformation recommended by the He Ara Oranga report, and thus our monitoring should take these into account.

This balanced approach is supported by the Office of the Auditor General (2021), which notes that successful outcomes are reliant not only on government action but on the buy-in and trust of people, and that means not just delivering services effectively and efficiently but also maintaining a trusted partnership with communities. It suggests that performance monitoring reporting can contribute to this by recognising a wider set of attributes—such as respect, integrity, sustainability, collaboration, participation, and inclusion.

The use of this type of construct or others such as effectiveness, efficiency, and sustainability in system performance measurement provides a lens to gain understanding about a specific aspect of performance. In a complex system such as a national mental health and addiction system, this type of lens is valuable, and performance constructs are already widely used.

An Australian study (Braithwaite et al, 2017) examined the performance frameworks used in health systems in eight Western countries including Aotearoa New Zealand. The researchers found that the most frequently used performance indicators (constructs) were effectiveness, safety, and access. In exploring established performance monitoring, they noted that selected constructs must be supported with a conceptual framework that sets out the rationale and design principles for why certain constructs are used, and links it to the wider health system context. This helps define the scope of measurement and aligns selected measures with other priorities.

Most importantly, it provides a clearly defined vision to encourage buy-in to the design of the framework. “A conceptual framework encompassing multiple domains and with balanced representation across structure, process and outcome indicators is considered to be a key element of health reform over time.” (ibid)

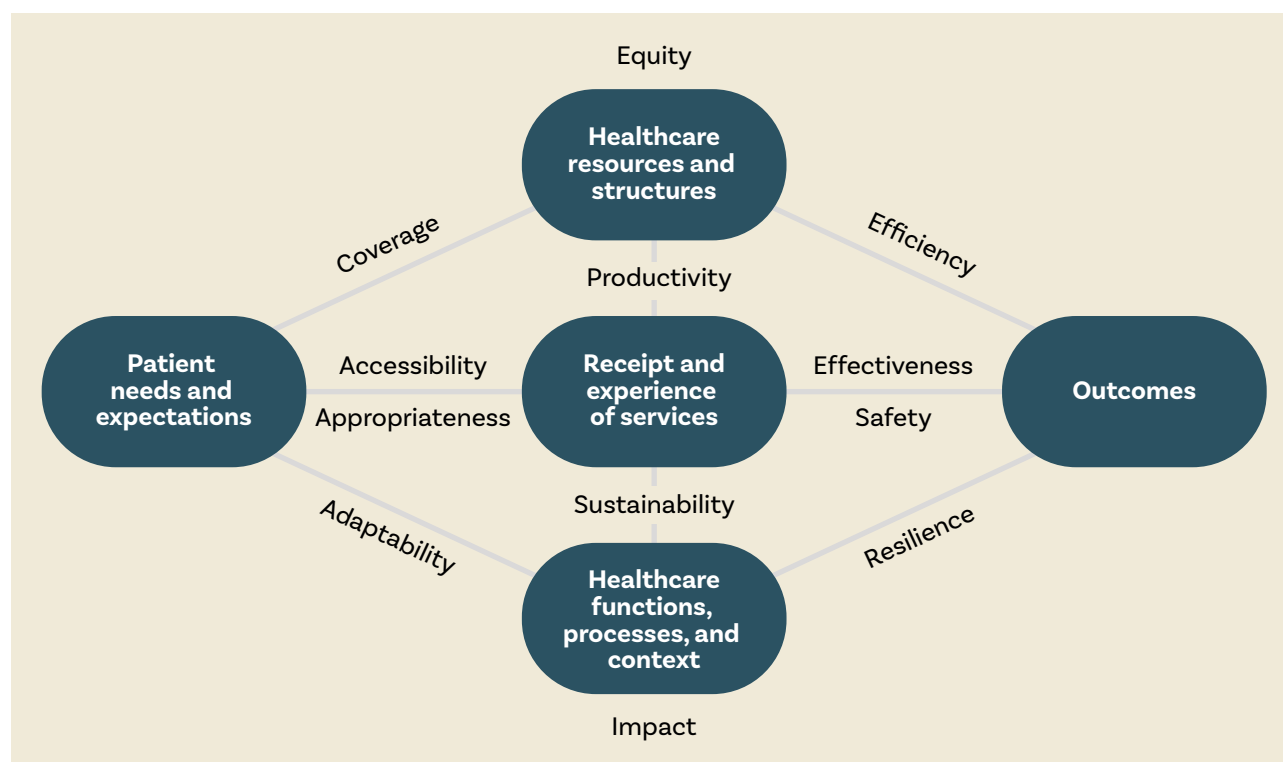
A meta-analysis carried out by Levesque and Sutherland (2020) looked at 19 existing health system performance frameworks and presented an integrated approach that has heavily informed our thinking. In their analysis, they found that there are three main approaches taken to system performance:

- logic model (performance is about relating inputs, outputs and outcomes)
- functional (performance is about the achievement of functions within systems: adaptation, goal attainment, production, values maintenance)
- goal achievement (performance is about achievement of socially determined goals).

They used a mapping process to synthesise these and integrate them into a framework based around 17 broad concept groups. These include five directly measurable performance constructs, and 10 ‘derived’ constructs (see Figure 3). Two further overarching constructs are described—equity (related to population distribution) and impact (determined by the cumulative contribution of all other constructs).

Measurement of these 12 constructs requires combining different aspects of the five directly measurable constructs (e.g. determining cost efficiency requires measuring expenditure in relation to the quantified outcomes achieved).

Figure 3. From Levesque and Sutherland, 2020. The dark circles represent the five directly measurable constructs, and the lighter grey labelled lines represent derived constructs and what combinations of measures can be used to indicate them



This integrated framework provides a useful structure for conceptualising our mental health and addiction system and how its performance might be measured in future. Our initial work has taken an approach based primarily on a logic model; however, our outcomes frameworks are goal oriented, and the use of intermediate outcome measures lends itself to a functional model of the system. Additionally, Levesque and Sutherland's 17 constructs show how existing direct measures such as those related to service delivery may be combined to illustrate new aspects of system performance.

Based on current thinking on system performance measurement in health systems, our approach should:

- make use of carefully selected intermediate outcome data where possible
- consider the balance of directive (targets, incentives) and enabling (relationship-building, connectedness, resourcing) inputs
- include quantitative and qualitative data where possible
- use carefully selected, relevant performance constructs to glean information about specific aspects of performance from existing data.

Part 2: Other monitoring frameworks, what we learned from them

We also looked at other performance monitoring frameworks to ascertain what constructs and methods were already being used and how the information was being presented. We looked at three different approaches.

Domain based

This type of framework organises data under three domains:

- outcomes for people
- social determinants
- system inputs and activities.

Measurement is based on core indicators that collectively provide a snapshot of the current state of that domain. The measures used are primarily quantitative, and derived performance constructs are not explored.

This approach provides valuable information about the challenges and constraints of monitoring system-level performance, and what can and cannot be gleaned from directly measurable data.

Key concepts we can take from this approach:

- transparency about the challenges and constraints of monitoring system-level performance
- starting small, and developing the approach over time
- concise presentation with further detail available for those who want it.

Vision based

This type of framework is designed to show a 'course' for system transformation to achieve a stated vision. It sets out the core principles that should underpin the system and services, the critical shifts required to move towards the

future system, the core components of the future system, the services that should be available and accessible, and the system enablers to operationalise the system.

The detailed description of an ideal state for the system aligns closely with the "clearly defined vision" described by Braithwaite et al (2017) as a necessary component of system monitoring. The critical shifts can be used as a basis for understanding how system transformation can be measured, and the principles can guide prioritisation of measurement

Key concepts we can take from this approach:

- a clearly described vision
- outlining critical changes that drive system transformation
- underpinning principles that can guide performance constructs.

Outcomes based

This type of framework is designed to measure progress towards outcomes. It is centred around key strategic shifts that are expected to lead to a set of outcomes. The framework outlines the way in which each outcome will be achieved, and what a shift towards it would look like.

Measures that show the desired changes are categorised as 'Measure now' and 'Measure next' –recognising that implementing monitoring at system level is a process and that not every aspect of monitoring can be implemented immediately.

There are many parallels between the goals of this type of framework and our own aims, and much of our approach is based on the concepts presented, with particular regard to:

- presenting key shifts that will demonstrate change
- defining what can be measured now and what will be measured later.

Part 3: Advice from key people

We interviewed representatives from seven agencies with roles in system performance monitoring, and asked them about their process, what approaches they take, and how they came to these. They provided grounded advice based in practical experience, including challenges, opportunities, guidance, and questions that might be useful to our work.

Challenges—All interviewees spoke of the challenge presented by the lack of regularly available, up-to-date, consistent data. Additional challenges include the complexity of the system, difficulty in effective consultation, and the high potential for overlap with other monitoring.

Opportunities—The overlap across current monitoring is especially evident with aspects of performance such as access and coverage, which are already reported on regularly. However, there are gaps in long-term monitoring, and a focus on long-term trends that informs government of potential needs for intervention could be valuable. Additionally there are opportunities to look at system performance in terms of outcomes, effectiveness, and impact. There are also opportunities for asking questions that cannot necessarily be answered with data alone—providing rich narratives and diagnostic analysis.

Guidance—We were advised to start small and concise, and expand our monitoring based on feedback. Even when monitoring against a long-term plan, we should begin with a short-term focus that indicates whether the system is shifting towards the desired outcome rather than attempting to assess against performance constructs immediately. It is likely that appropriate performance constructs will emerge more strongly over time. Additionally, we should allow time for the shifts to take place within the system, and for them to have measurable impact.

Where possible we may be able to use ‘diagnostic indicators’—combinations of measures that can provide more information about context, influences, or balances to the main direct

indicator. This can support narrative approaches and understanding of the causes of change (or lack of change) in directly measurable data.

It is also important to ensure our terminology is clearly defined. For that purpose we have included a glossary as Appendix D.

Questions—Alongside the broader guidance, stakeholders shared the questions they found useful to ask when developing an approach to monitoring. These are listed below.

- Are the services there, are people using them, are they working, how well are they working?
- What is working, what is not working, how do we know it is or is not working?
- What is an action in the system intended to achieve, what did it actually achieve, what is the relationship between the intentions and achievements?
- Has a change taken place and if so, what contribution has an enabler or intervention made to that change?
- What action can/will be taken based on this data?

We will not be able to answer all these questions with our initial monitoring, and our intention in this report is to focus on the first and second questions. However, keeping these in mind as we develop our approach will provide framing for how we develop our monitoring in future.

Appendix C – Tikanga mahi

Methodology

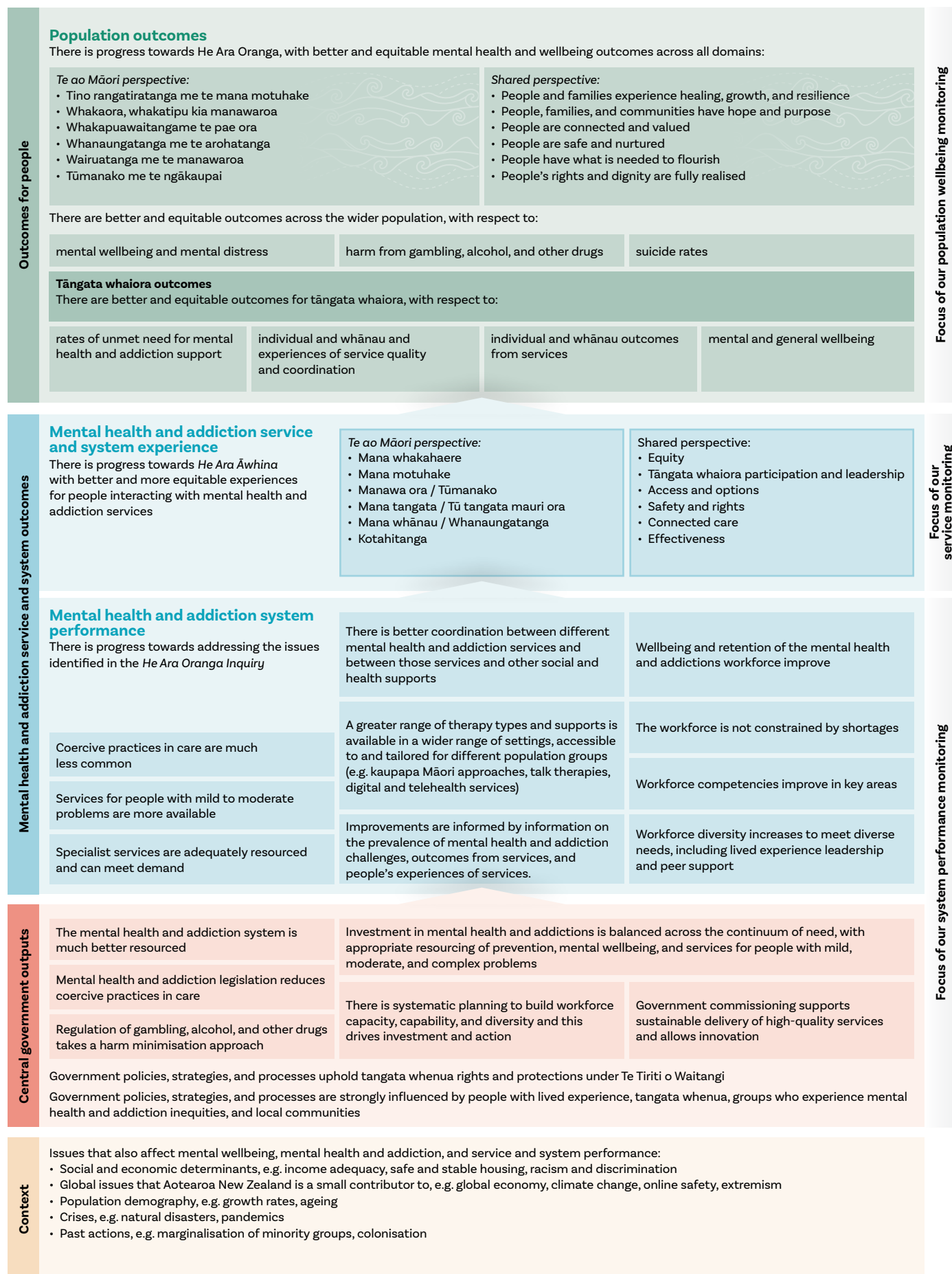
This appendix outlines how we developed the key shifts and measures.

In 2024 Te Hīringa Mahara developed a theory of change and logic model as a tool for how we might assess progress against the recommendations of the He Ara Oranga report. This outlines key links between central government actions and their intended mental health and wellbeing outcomes. The model, as presented in Figure 4, illustrates a theory of change for the mental health and addiction system that incorporates:

- the wider context, including external influences on outcomes—in yellow
- a wide range of central government outputs that can influence outcomes—in orange
- the longstanding problems within the system that the government outputs will contribute to addressing, and the expected outcomes for people interacting with mental health and addiction services—in blue
- the expected improved outcomes for people interacting with mental health and addiction services and overall population as a result of improved system performance—in green.

If the intended system improvement outcomes are achieved, progress will be made towards the ideal mental health and addiction system described in the He Ara Oranga report, Kia Manawanui, and our He Ara Āwhina and He Ara Oranga frameworks. An improved mental health and addiction system will contribute to improved outcomes for people interacting with the system, including better mental and general wellbeing as described by the domains of the He Ara Oranga framework.

Figure 4. Logic model outlining key links between central government actions and their intended mental health and wellbeing outcomes



To effectively monitor system performance, we need measures that consider both government actions and their impact within the system. The logic model outlines a ‘roadmap’ for how to get to the outcomes we are seeking, involving government actions and key issues within the system, which when collectively addressed are expected to lead to system transformation.

Development of the key shifts

We wanted to identify what critical changes would indicate that system transformation is taking place, and thus what can be monitored to track its progress. Many shifts have already been identified through:

- He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction
- Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing
- Oranga Hinengaro System and Service Framework
- the recommendations and calls to action that Te Hīringa Mahara has made to date
- Government priorities.

Comprehensively measuring system performance against all the possible shifts that have been previously identified is a long-term project. While we intend to increase the scope of our monitoring over time, we have initially prioritised a small set of key shifts that we have distilled and summarised to more easily track progress. To do this we compared the 22 shifts in our logic model with recommendations made in four other relevant reports¹⁰ and our own recommendations and calls to action. From this we identified the changes considered most relevant to system transformation and grouped them together under broad themes.

We identified six main themes. Underpinning all of these were themes of equity and inclusion, with a strong focus on the participation of priority populations in decision-making and provision of services, particularly people with lived experience and tangata whenua.

We also asked lived experience leaders to tell us what they considered to be the most important shifts they would like to see occur within the mental health and addiction system.

The views of the lived experience leaders were compared with the themes from our analysis, to identify where lived experience priorities aligned with other identified shifts and integrate the lived experience perspective. These were then further tested with expert advisors working in the mental health and addictions sector, and synthesised to outline our final six key shifts.

The six key shifts express the priorities of lived experience, the He Ara Oranga report, the government, and the mental health and addiction sector.

10 Ministry of Health. 2021. **Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing**. Wellington: Ministry of Health.
Te Hīringa Mahara. 2021. **Te Rau Tira: Wellbeing Outcomes Report 2021**. Wellington: New Zealand.
Minister of Health. 2024. **Government Policy Statement on Health 2024–2027**. Wellington: Ministry of Health.
Ministry of Health. 2023. **Oranga Hinengaro System and Service Framework**. Wellington: Ministry of Health.

Choice and development of system performance measures

We took a phased approach to the development of measures. For this report (Year One), we selected a small number of quantitative measures to demonstrate how we applied our key shifts approach to monitoring system performance.

To develop our Year One measure set, we worked with lived experience leaders to identify existing measures that reflected the key shift concepts.

We then prioritised these and selected a small set of measures that met our evaluation criteria of validity, availability (frequency and timeliness), and impact. We also prioritised measures that were nationally consistent and were able to be disaggregated by key demographics.

Many of these measures are part of our He Ara Āwhina dashboard or are areas we have focused on in our previous monitoring reports. This report brings these measures together in one place and applies a system lens to their interpretation.

We faced significant limitations in data availability for the system performance concepts we sought to monitor. The system currently produces good metrics of access and investment but has very limited existing and available quantitative data on outcomes at a system level.

Collection and analysis of qualitative insights to complement quantitative data was out of scope for this first year of our system performance monitoring. However, it is an important area for us to build into monitoring in future years.

Appendix D – Rārangi kupu

Glossary

A common language is required so we talk with each other, not past each other. Te Hīringa Mahara seeks to champion a common language across all our work.

Coercive practices—Practices where people are forced or pressured to do something. This can include forced medication, solitary confinement, forced electroconvulsive therapy, physical restraint, mechanical restraint, and environmental restraint such as locked units. Coercive practices also include influencing decision-making in a particular direction and denying fully informed consent.

Dual perspective—The He Ara Oranga wellbeing outcomes framework and He Ara Āwhina system and service framework comprise a vision for all people in Aotearoa New Zealand. They include a dual perspective—a shared perspective, for all people in Aotearoa New Zealand, and a te ao Māori perspective, for Māori as tāngata whenua. A te ao Māori worldview acknowledges the unique position of Māori as tāngata whenua and as partners with the Crown through Te Tiriti o Waitangi. The shared perspective acknowledges the role of both tangata whenua and tangata Tiriti as citizens of Aotearoa. The duality of the frameworks reflects the role that tāngata whenua and tāngata Tiriti have to play, working together to improve the collective wellbeing of all people in Aotearoa. The ‘shared perspective’ and ‘te ao Māori perspective’ should not be read as direct translations. They represent related concepts from different worldviews. The ‘shared perspective’ also applies to Māori.

Lived experience—Lived experience refers to a person or group of people who have personal experience of an issue or situation. This personal experience can be current, recent, or in the past. For Te Hīringa Mahara, ‘lived experience’ relates to personal experiences of distress / mental distress, substance harm, gambling harm, psychiatric diagnosis, addiction, using mental health or addiction supports or services, or experience of barriers to accessing these support and services when they are needed. Lived experience relates to how people self-identify, and share their identity with others, so it is not our role to determine whether people have ‘lived experience’— it is each person’s decision how they identify.

Measures—A topic of data. For example, ‘workforce vacancy rates’. We use the term ‘measures’ when it relates to people who use services. In our other reports, we use the term ‘indicators’ where it relates to whole populations (consistent with Results Based Accountability terminology). At a population level, measures are described as indicators to distinguish between population-level versus system-/service-level data.

Mental health and addiction services—All publicly funded services and options that support and respond to the experiences, needs, and aspirations of people and whānau who experience distress, harm from substance use, or harm from gambling (or a combination of these). These range from promotion, prevention, and early intervention supports, as well as primary and specialist mental health and addiction services including services delivered by non-governmental organisations.

Mental health and addiction system—The context within which the range of mental health and addiction services operate—the health structures, strategies and policies, plans, workforce settings—that together make it possible to deliver services that improve mental health and reduce harm from alcohol and other drugs. Mental health and addiction services are a subset of the mental health and addiction system.

Outcomes (or conceptual outcomes)—Narrative statements of wellbeing for people, whānau, and/or communities. Distinct from processes—activities, steps, or outputs.

Outcomes framework—A framework that defines the outcomes (end states) for a defined group of people and a range of data that will be used to measure success. Some outcome frameworks also have outcomes linked to a system (e.g. mental health system).

People interacting with mental health and addiction services—This is a subset of tāngata whaiora who seek wellness through interacting with publicly funded mental health and addiction services. This includes but is not limited to specialist services.

Tāngata whaiora—Tāngata whaiora can be people of any age or ethnicity seeking wellbeing or support, including people who have recent or current experience of distress, harm from substance use, or harm from gambling (or a combination of these). Tāngata whaiora include people who have accessed or are accessing supports and services, and also include people who want mental health or addiction support but are not accessing supports or services.

Wellbeing—A holistic and multi-faceted concept to describe people's overall quality of life. Wellbeing is defined here via the 12 conceptual outcomes in the He Ara Oranga wellbeing outcomes framework from tāngata whenua and shared perspectives.

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