

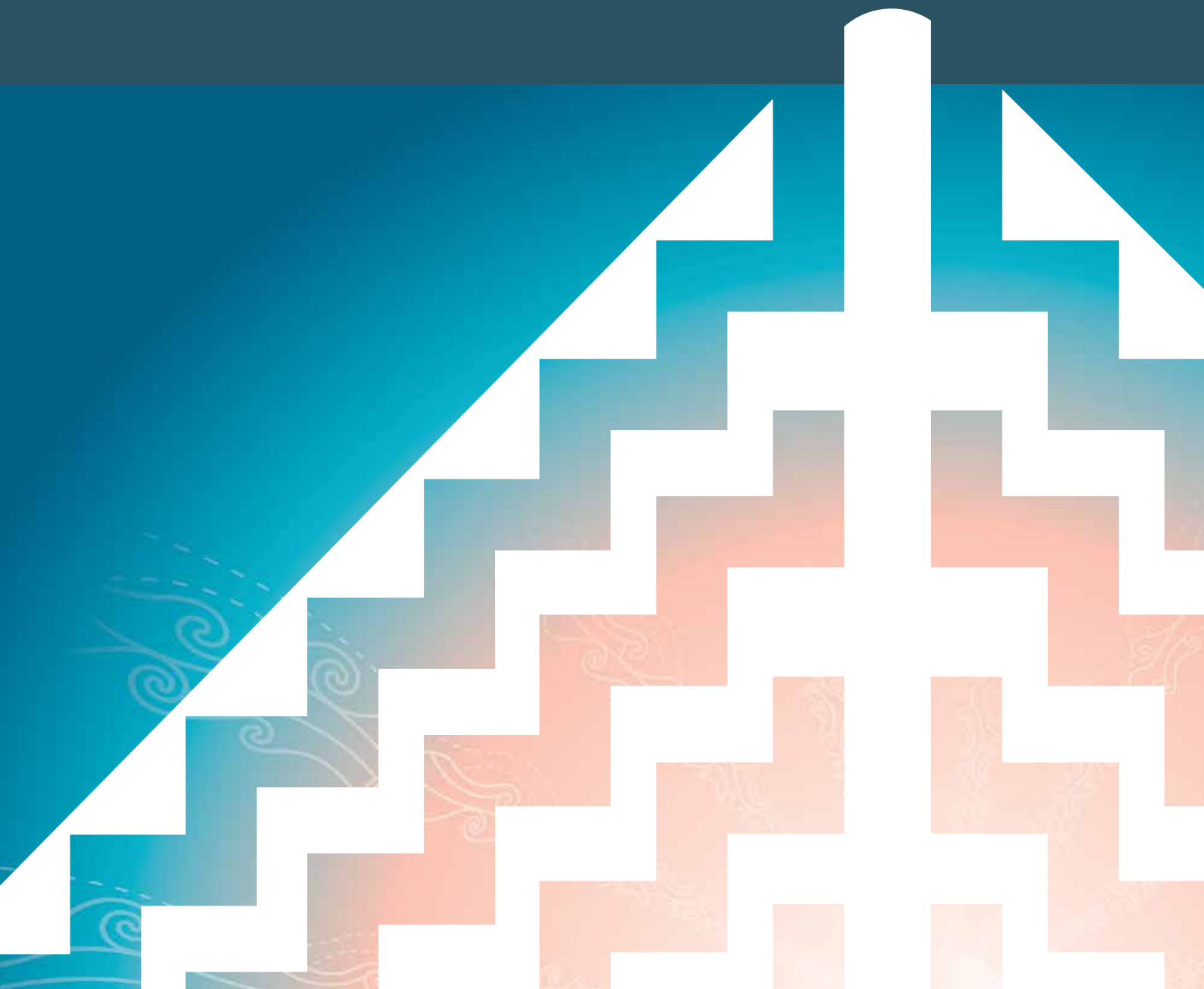


**Te Hīringa
Mahara**

Mental Health and
Wellbeing Commission

Monitoring mental health and addiction system performance in Aotearoa New Zealand

June 2026



Monitoring mental health and addiction system performance in Aotearoa New Zealand

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Te Hiringa 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 orange | clearing pathways to wellbeing for all’. Te Hiringa 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.

Strategic priorities 2025–2029

Over the four years to 2029 Te Hiringa Mahara has three strategic priorities. Each of the priorities is represented by a maunga tietie, as pictured below. This report comes under the first priority.

Read more: www.mhwc.govt.nz/strategy-on-a-page

Mental health and addiction services meet the needs of tāngata whaiora and their whānau.

Waharua Kōpito | A point where people or events cross. The pattern is a reminder that change occurs at such meeting points.

Advancing mental health and wellbeing outcomes for people with lived experience of mental distress and addiction.

Aramoana | ‘Pathway of the sea’. The horizontal zigzags suggest pathways that the ocean and other waterways provide to many destinations.

Improved performance of the mental health and addiction system.

Poutama | A common pattern which symbolises stairways, whakapapa and also the pursuit of knowledge, advancement and growth.



Kupu Whakataki

Foreword

In June 2025 our first system performance report provided a foundation for monitoring system transformation by developing an approach to assess progress towards the vision of He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction. Underpinned by thought leadership from many others prioritising lived experience of mental distress, Te Hiringa Mahara–Mental Health and Wellbeing Commission brought together key ideas, frameworks and strategies to identify six system shifts needed to transform the mental health and addiction system with the aim of improved mental health and wellbeing outcomes for people.

In 2025, we found a system under immense pressure, that was showing very early signs of progress. We used our insights to advise the national Draft Mental Health and Wellbeing Strategy. The Draft Strategy reflects these shifts and that, as a system, we are all working toward the same goals. With a national strategy in progress, now comes the time for action.

This 2026 report shows that, while progress is being made overall, it has been inconsistent across the six shifts, and the benefits are not reaching people with the highest mental health needs. We need progress across all six shifts to see a system that can contribute to improved outcomes for people.

We are concerned about the widening gaps for some, which will ultimately cost everyone. Addressing this requires solutions that work for people with the highest needs, supported by clear and timely actions. We want to see better and equitable outcomes for Māori at all levels of the system, and more focus on supporting the mental health and wellbeing of young people.

Aotearoa New Zealand needs a future where everyone has access to effective mental health and addiction services when they need them, and where policies, strategies and investment are targeted to prevention of mental distress, drivers of good mental health and wellbeing and what we know keeps people well. This requires taking a ‘mental health and wellbeing in all policies’ approach to ensure that there is cross-government contribution to improving mental health and wellbeing.

This year, we are making recommendations for system performance improvement that together with the Mental Health and Wellbeing Strategy and implementation plans will accelerate changes that we collectively want to see to improve mental health and wellbeing outcomes for people.



Hayden Wano

Board Chair, Te Hiringa Mahara–Mental Health and Wellbeing Commission



Ngā mihi

Acknowledgements

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Whakamāramatanga whānui

Overall summary

This 2026 monitoring report shows that, while progress has been made overall, inequity for some groups requires urgent attention.

Since our 2025 reporting, good progress has been made on improving wait times for mental health and addiction services and with government targets being met for the total population. Overall, access has increased to primary mental health and addiction services and better access is available to specialist services that include peer support. Workforce vacancy rates are improving, and workforce diversity is increasing. We have also seen an increase in people entering training to work in the mental health and addiction sector.

These improvements are positive and should be celebrated as significant steps in the right direction. However, a truly transformed mental health and addiction system (MHA system) will support those who need it in a timely, accessible, culturally appropriate way and there are signs that despite these improvements persistent inequities remain.

We are seeing a pattern of systemic disadvantage for Māori across a range of areas. We already know that Māori experience some of the poorest mental health and wellbeing outcomes, so continued focus on improving these outcomes is critical. The level of investment in kaupapa Māori services has not kept up with other mental health investment which means over time we are seeing a decline in the proportion of investment

in kaupapa Māori services. We are also seeing reduced access rates to kaupapa Māori primary mental health services and increased unmet need among Māori. Disparities in coercive practices continue. Māori are subjected to both compulsory community treatment orders and ‘seclusion’¹ at significantly higher rates than non-Māori. Additionally, Māori who are in contact with specialist services have consistently higher rates of homelessness and lower rates of employment, education, or training. This disparity in the drivers of mental health need is growing for Māori.

The needs of young people are not being met by the MHA system. Young people experience persistently high rates of unmet need for professional mental health support, and they are experiencing longer average wait times for specialist services. Access to specialist services has decreased for young people alongside high rates of declined referrals. There has also been an increase in the number of young people admitted to adult inpatient services in the previous year. Across the wider population, nearly a quarter of young people report high or very high levels of psychological distress, and this rate is increasing for young people faster than for any other age group.

1 We use the term ‘seclusion’ because it relates to terminology used in the Mental Health (Compulsory Assessment and Treatment) Act 1992. We use quote marks around the term to indicate this is not our preferred language as 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.

Our findings suggest that urgent work is needed for the MHA system and the wider systems that people journey through when they seek support. We will continue to see increasing rates of distress among young people and Māori if there is no cross-government action on the factors that drive need. MHA system improvement needs to focus on provision of services that address basic human rights such as access to culturally and age-appropriate care, and a real commitment to eliminating 'seclusion'. This needs to be supported with efforts to reduce exposure to the risk factors for distress in the first place. This will require targeted focus on access to appropriate and effective services, as well as prevention efforts

tailored to groups known to have the highest need within and outside the MHA system.

The Draft Mental Health and Wellbeing Strategy (Draft MHWS) aligns with the six shifts for the ideal mental health and addiction system that supports improved mental health and wellbeing outcomes in its vision and actions. Te Hiringa Mahara welcomes this. To achieve the outcomes Aotearoa New Zealand is working toward we want to see implementation plans demonstrate a clear pathway for strengthening the mental health and wellbeing of Māori and young people throughout the MHA system, supported by prioritisation of cross-government contribution to addressing drivers of mental distress.

Recommendations

Based on our monitoring we are making three recommendations for system improvement. We will monitor progress toward these and report back.

New recommendations

We make two new recommendations for action by June 2027.

- That Health New Zealand | Te Whatu Ora publishes a national 'seclusion' plan by June 2027 outlining the pathway to eliminate 'seclusion'.
- That the Ministry of Health includes actions for collection of outcomes and experience data from people engaging with mental health and addiction services in the first three-year implementation plan of the Mental Health and Wellbeing Strategy. Actions should include specific data collection for high-needs populations by June 2027.

Renewed recommendation

Our findings this year show increasing inequity of mental health and wellbeing outcomes for Māori. In 2024 we recommended that Health New Zealand | Te Whatu Ora develop an action plan by June 2025² to meet the needs of Māori and whānau accessing specialist mental health and addiction services.

In our 2025 follow-up report,³ this recommendation had not been realised. Achievement of this recommendation will contribute to addressing the inequities we highlight in this report; therefore, we renew our recommendation.

- That Health New Zealand | Te Whatu Ora develops an action plan by June 2027 to meet the needs of Māori and whānau accessing specialist mental health and addiction services.

2 Te Hiringa Mahara—Mental Health and Wellbeing Commission. 2024. Kua Timata Te Haerenga | the Journey Has Begun recommendations. Wellington: Te Hiringa Mahara.

3 Te Hiringa Mahara—Mental Health and Wellbeing Commission. 2025. Assessment of progress - implementation of Kua Timata Te Haerenga | the Journey Has Begun recommendations. Wellington: Te Hiringa Mahara.

Whakamāramatanga whānui

E whakaatu ana te pūrongo aroturuki 2026, ahakoa ngā kokenga, me wawe tonu te whakatika i te tautika-kore ka pā ki ētahi..

Mai i tā mātou pūrongo i te 2025, kua koke ngā mahi whakapai ake i te wā tatari mō ngā ratonga hauora hinengaro me te waranga, ā, me te whakatutuki i ngā whāinga a te kāwanatanga mā te taupori katoa. I te tirohanga whānui, kua piki ake te āheinga ki ngā ratonga hauora hinengaro me te waranga, ā, he pai ake te āheinga ki ngā ratonga mātanga tae atu ki te tautoko aropā.

Kei te piki ake te pāpātanga o ngā tūranga rāngaimahi wātea, kei te piki ake hoki te kanorau o te rāngaimahi. Kua kite hoki mātou i te pikinga o ngā tāngata e uru atu ana ki te whakangungu ki te mahi i te rāngai hauora hinengaro me te waranga.

He pai ēnei whanaketanga, ā, me whakanui i ēnei ahunga whakamua hira. Engari, ko te pūnaha hauora hinengaro me te waranga (pūnaha MHA) kua āta whakaumutia ka tautoko i ngā matea o te hunga e hiahia ana i taua pūnaha i roto i te wā tika, he wātea, he urupare ahurea, engari ahakoa ēnei whanaketanga, arā ētahi tohu he tautika-kore tonu.

E kite ana mātou i te tauira o te tōhore toronaha o te Māori puta noa i ngā wāhi maha. E mōhio kē ana mātou ka pā ngā hua hauora hinengaro kino rawa atu ki te Māori, nō reira he mea waiwai te arotahi tonu ki te whakapai ake i ēnei hua. Kāore

te taumata o te haumitanga ki ngā ratonga kaupapa Māori i rite ki ō ētahi atu haumitanga hauora hinengaro, ā, ko te tikanga, e kitea ana te hekenga o te nui o te haumitanga ki ngā ratonga kaupapa Māori i roto i te wā. E kitea ana hoki te hekenga o ngā pāpātanga āheinga ki ngā ratonga hauora hinengaro, me te pikinga o ngā matea a te Māori kāore i tautokona. He tautika-kore tonu ngā tikanga uruhi. He nui ake te pānga o ngā ōta whakamaimoatanga ā-hapori whakature me te 'whakataratahi'⁴ ki te Māori tēnā i te tauwiwi. Waihoki, ko ngā Māori e whakapā atu ana ki ngā ratonga mātanga, he auau te pāpātanga nui ake o te kāingakoretanga, ā, he iti ake te pāpātanga whiwhimahi, mātauranga, whakangungu rānei. Kei te tipu haere te tautika-kore o ngā pūtake o ngā matea hauora hinengaro o te Māori.

Kāore te pūnaha MHA i te tautoko i ngā matea a te hunga rangatahi. He auau ngā pāpātanga teitei a te hunga rangatahi o ngā matea tautoko hauora hinengaro ngaio kāore e tautokona ana, ā, he roa rawa te wā tatari ki ngā ratonga mātanga. Kua heke te āheinga ki ngā ratonga mātanga mā te rangatahi, ā, me te pikinga o ngā tonono ratonga i whakakahoretia. Kua piki hoki te nui o te hunga rangatahi e whakaurua ana ki ngā ratonga tūrora tauroto pakeke i tērā tau. Puta noa i te taupori

4 Ka whakamahi mātou i te kupu 'whakataratahi' nā te mea e hāngai ana ki ngā kupu e whakamahia ana i te Mental Health (Compulsory Assessment and Treatment) Act 1992. Ka tuhi i ngā tohukī ki te kupu hei tohu ehara tēnei i te kupu pai ki a mātou nā runga i te mōhio ki ngā wheako whaiaro. I ētahi atu o ā mātou mahi, ka whakamahi i te kīanga 'whakaraunga tōtahi' hei whakakapi, hei tāpirihanga rānei ki te kupu 'whakataratahi' hei whakamana i ngā wheako whaiaro a te tangata o tēnei tikanga.

whānui, tata ki te hauwhā o te hunga rangatahi e pūrongo ana i ngā taumata teitei, teitei rawa rānei o te auhi ā-hinengaro, ā, he tere ake te piki haere o te pāpātanga mā te hunga rangatahi i ō tētahi atu rōpū taipakeke.








E tohu ana ā mātou kitenga he mahi kōhukihuki te whakatikatika i te pūnaha MHA me ngā pūnaha whānui e whai wāhi atu ana te tangata ina rapu tautoko rātou. Ka kite tonu mātou i te piki haere o ngā pāpātanga o te auhi o te hunga rangatahi, te Māori hoki ki te kore he mahi a ngā tari kāwanatanga maha ki te whakatika i ngā āhuatanga e whakaaweawe ana i ngā matea. Me aro ngā whakatikatika ki te pūnaha MHA ki te whakarato ratonga e tautoko ana i ngā mōtika tangata taketake pēnei i te āheinga ki ngā tautiakitanga e hāngai tika ana ki te ahurea me te taipakeke, me te tautoko me te whakaiti i te whakaraerae ki ngā tūraru e pā ai te auhi i te tuatahi. Mā te āta aro ki te āheinga ki ngā ratonga tika, whai hua hoki, e tutuki ai tēnei, ā, me ngā

mahi aukati e hāngai tika ana ki ngā rōpū e mōhiotia ana he matea nui rawa i roto, i waho hoki i te pūnaha MHA.

E hāngai ana te Rautaki Hauora Hinengaro me te Oranga Kōhuikihuki (MHWS) ki ngā nekehanga e ono mō te pūnaha hauora hinengaro me te waranga pai rawa e tautoko ana i ngā hua hauora hinengaro me te oranga pai ake i roto i ana matawhānui, mahi hoki. He pai tēnei ki a Te Hiringa Mahara. E tutuki ai ngā hua e whāia nei e Aotearoa e hiahia ana mātou ki te kite e whakaatu ana ngā mahere whakatinana i te ara wātea hei whakapakari i te hauora hinengaro me te oranga o te Māori me te hunga rangatahi puta noa i te pūnaha MHA, e tautokona ana mā te whakaarotau i te āwhina a ngā tari kāwanatanga maha ki te whakatau i ngā pūtaka o te auhi ā-hinengaro. Hei tāpiri ki tēnei, e hiahia ana mātou ki te kite i te manawanui tūturu ki te whakaiti i ngā tikanga uruhi me te whakakore i te mahi 'whakataratahi'.

Findings at a glance

Table 1: Table showing high level status of outcomes and each system shift.

Area	Progress rating	Findings	What we would like to see next
Population level outcomes		Increased psychological distress. Suicide rates are too high. Some decreases in intentional self-harm measures. Disparities across most measures for Māori, Pacific Peoples, young people, disabled people.	<ul style="list-style-type: none"> • Mental health in all policies. • Cross-government action on drivers of mental distress.
Shift 1 – Realising the potential of lived and living experience		Peer support expanding. Investment trends unclear. Lived experience leadership supporting structures underdeveloped.	<ul style="list-style-type: none"> • Sustained investment in peer support. • More support for lived experience leadership. • Career pathways for lived experience.
Shift 2 – Prioritising effective services for people with the highest needs		High unmet need for Māori. Static funding for kaupapa Māori services.	<ul style="list-style-type: none"> • Increased access to kaupapa Māori services. • Better outcome data to understand effectiveness.
Shift 3 – Effective primary prevention and early interventions		Government focus on early intervention, leaving primary prevention underleveraged.	<ul style="list-style-type: none"> • Increased priority for whole-of-population primary prevention. • Cross-agency commitment to address key risk and protective factors for tāngata whaiora wellbeing. • Co-designed services with young people.
Shift 4 – Equitable access to services and supports that improve outcomes for people		Access improving overall. Inequities for young people in access and timeliness. Increasing unmet need for Māori.	<ul style="list-style-type: none"> • Improved access to services. • Youth-specific solutions.
Shift 5 – Upholding human rights-based practices		Coercive practice too high and inequitable. Human rights for young people need further investigation.	<ul style="list-style-type: none"> • Faster progress to end ‘seclusion’. • No young people admitted into adult inpatient units. • Fewer coercive practices used.
Shift 6 – Workforce with the capability, competencies, and capacity to meet needs now and in the future		Workforce growing and strengthening.	<ul style="list-style-type: none"> • Continued strengthening and growth, especially lived experience.

 Good progress  Some progress  At risk

Recommendations

Based on our monitoring we are making three recommendations for system improvement.

New recommendations

We make two new recommendations for action by June 2027.

- That Health New Zealand | Te Whatu Ora publishes a national 'seclusion' plan by June 2027 outlining the pathway to eliminate 'seclusion'.
- That the Ministry of Health includes actions for collection of outcomes and experience data from people engaging with mental health and addiction services in the first three-year implementation plan of the Mental Health and Wellbeing Strategy. Actions should include specific data collection for high-needs populations by June 2027.

Renewed recommendation

Our findings this year show increasing inequity of mental health and wellbeing outcomes for Māori. In 2024 we recommended that Health New Zealand | Te Whatu Ora develop an action plan by June 2025 to meet the needs of Māori and whānau accessing specialist mental health and addiction services.

In our 2025 follow-up report,⁵ this recommendation had not been realised. Achievement of this recommendation will contribute to addressing the inequities we highlight in this report; therefore, we renew our recommendation.

- That Health New Zealand | Te Whatu Ora develops an action plan by June 2027 to meet the needs of Māori and whānau accessing specialist mental health and addiction services.

Calls to action

A call to action describes the change that we want to see in the system. It speaks to what should look or be different but does not prescribe a pathway to achieve this change or explicitly identify responsible agencies. Calls to action are also made to identify areas needing further evidence as a building block to a recommendation:

Our calls to action:

- Cross-agency commitment to address factors influencing mental wellbeing at a population level, and a stronger focus on primary prevention.
- Strengthening lived experience leadership through support for structures and processes that embed lived experience throughout the system, including formal career pathways and planning for a sustainable workforce.
- Commitment to meeting the higher mental health needs of Māori. Specifically, we want to see increased access to kaupapa Māori options and the systematic national collection of data that provides relevant and meaningful insights into experiences and outcomes for Māori who are in contact with the MHA system.
- A focus on improving access, outcomes and experience for young people experiencing distress, particularly at transition points between child and adolescent mental health and addiction services and adult mental health and addiction services.
- A commitment in the Mental Health and Wellbeing Strategy to uphold human rights-based practices through the elimination of 'seclusion'.

5 Te Hiringa Mahara—Mental Health and Wellbeing Commission. 2025. Assessment of progress - implementation of Kua Timata Te Haerenga | the Journey Has Begun recommendations. Wellington: Te Hiringa Mahara.



Kupu arataki

Introduction

Te Hiringa Mahara–Mental Health and Wellbeing Commission (Te Hiringa Mahara) is an independent Crown entity, established following the report of the 2018 Government Inquiry into Mental Health and Addiction (known as He Ara Oranga⁶).

We assess, report and make recommendations on the mental health and wellbeing of people in Aotearoa New Zealand. This includes assessing the contribution of government actions to improve mental health and addiction (MHA) system performance and therefore outcomes both for people who interact with the system and for people seeking wellness.

Service, system and outcome monitoring undertaken by Te Hiringa Mahara is intended to give effect to its functions as set out in the Mental Health and Wellbeing Commission Act 2020⁷ spanning population-level wellbeing outcomes, factors that affect people's mental health and wellbeing, and services and approaches to support mental health and wellbeing. This includes recommending improvements to effectiveness of mental health approaches, promoting alignment between entities involved in mental health and wellbeing, and advocating for the collective interest of people experiencing mental distress or addiction.

Our MHA system performance monitoring has three objectives, to:

1. Inform shared goals for system performance.
2. Identify opportunities for system improvements.
3. Monitor progress towards addressing the issues identified in the He Ara Oranga report.

In 2025 we developed our approach to system performance monitoring and published our first system performance monitoring report. This established six shifts that would move us towards an ideal MHA system. We also reported on population mental health and wellbeing as further context for people's outcomes and reported against 20 system performance measures. In 2025 we found limited change in MHA system performance and no overall improvement in outcomes at a population level since the 2018 He Ara Oranga inquiry.

This year we have consolidated our approach by continuing to monitor progress against the six shifts and 20 measures identified last year. We identify the changes we want to see and for the first time make recommendations that seek to inform and influence stakeholders with the power to shift the system. In line with our iterative approach to continuous improvement, we also include reporting on population mental health and wellbeing outcomes including suicide and self-harm.

6 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.

7 Mental Health and Wellbeing Commission Act 2020: www.legislation.govt.nz/act/public/2020/32/en/latest/#LMS281163.

Six shifts for system change

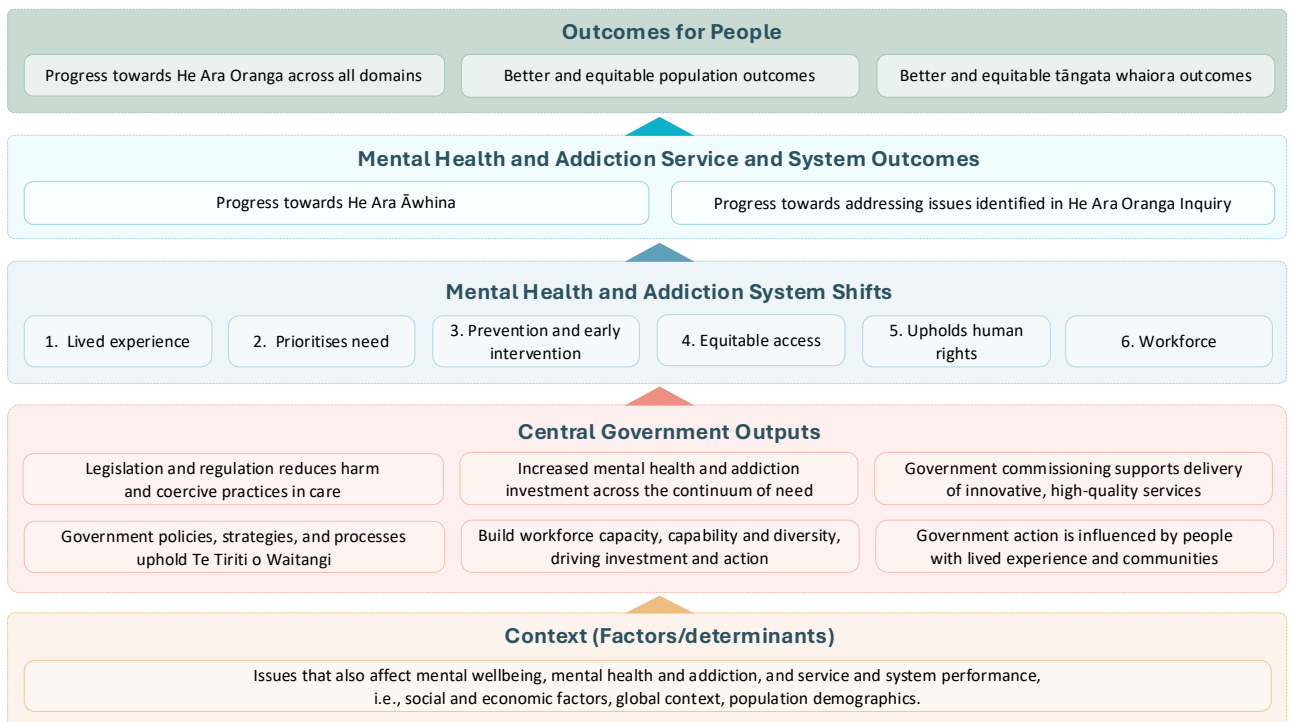
In 2024 we developed a theory of change to provide a line of sight between contextual factors, government inputs, their contribution to the mental health and addiction system performance, and outcomes for people. This report covers monitoring across these layers. See simplified version of the theory of change in Figure 1 below, and the full diagram in Appendix B.

We developed a theory of change to identify the critical actions at a system level that would move the MHA system towards the experience described in the He Ara Āwhina system and services framework⁸ and the outcomes described in the He Ara Oranga wellbeing outcomes framework⁹. This work also brought together findings from government mental health

priorities and targets¹⁰, strategies and policies¹¹, and recommendations and calls to action from our own previous work.

From this we identified six areas where change is expected to bring about system transformation. We developed six ‘shifts’ that the MHA system would need to make to contribute to improved mental health and wellbeing outcomes. We developed our shifts with lived experience and sector leaders to refine what each means in practice, and to establish a measure set to monitor progress towards each shift. We have prioritised measures that are nationally consistent and able to be disaggregated by key demographics, as well as meeting our criteria of validity, availability (frequency and timeliness) and impact.

Figure 1: Simplified theory of change diagram



8 Te Hiringa Mahara – He Ara Āwhina Framework.

9 Te Hiringa Mahara – He Ara Oranga Framework.

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

11 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.

The shifts were developed to be enduring, with the intention to build our ability over time to monitor and hold the system to account. They are expressed in terms of moving towards an ideal MHA system.

Contextual factors matter for mental health

It is well recognised that nothing happens in a vacuum, and many factors influence both individual and population mental health and wellbeing. There is a well-documented link between factors that affect wellbeing and mental distress,¹² and clear evidence of inequitable distribution of these factors between population groups. Our ability to achieve good mental health and wellbeing is influenced by a range of complex factors at an individual, biological, family, and structural level. These factors can be both protective such as good social and emotional skills at the individual level, or present a risk to mental wellbeing, such as poor access to health and social services at the structural level.

Risk and protective factors are not unidirectional but instead have a two-way relationship with mental health outcomes.¹³ For example, material hardship is both a cause of mental distress through a lack of having necessities to live well, and an outcome of mental distress impacting on economic security through loss of employment opportunities or social support systems.

We have heard from lived experience leaders that factors such as income, employment, housing, access to education, experiences of trauma and experiences of discrimination have a significant impact on mental distress for people.

This influences both the likelihood of someone engaging with the MHA system and their mental health experiences and outcomes as they journey through the system. Lived experience leaders have stressed the importance of addressing these factors to improve outcomes for tāngata whaiora.

Research supports this understanding of the contribution of wider life experiences to both risk and protective factors for mental health conditions.¹⁴ These factors can be modified through primary prevention approaches – those that focus on reducing people’s exposure to risk factors or increasing their exposure to protective factors. There is very strong evidence to show that a number of mental health conditions relevant to Aotearoa New Zealand could be prevented or their impact reduced through effective primary prevention. This requires a public and preventative mental health approach to ensure all people have what they need to live well.

This report focuses specifically on the performance of the MHA system within the context of broader factors. We provide reporting on population outcomes in this report as context for people more widely but focus this report specifically on MHA system performance. However, we know that trends such as rising unemployment, increases in unstable housing and rising costs of living, will affect the prevalence of mental distress and the system’s ability to respond to it.

12 Kirkbride JB, Anglin DM, Colman I, Dykxhoorn J, Jones PB, Patalay P, Pitman A, Sonesson E, Steare T, Wright T, Griffiths SL. 2024. **The social determinants of mental health and disorder: evidence, prevention and recommendations.** *World Psychiatry.* 23(1):58-90. doi: 10.1002/wps.21160. PMID: 38214615; PMCID: PMC10786006.

13 Alegría M, NeMoyer A, Falgàs Bagué I, Wang Y, Alvarez K. 2018. **Social Determinants of Mental Health: Where We Are and Where We Need to Go.** *Curr Psychiatry Rep.* 2018 Sep 17;20(11):95.

14 Carbone, S. 2020. **Evidence review: The primary prevention of mental health conditions.** Victorian Health Promotion Foundation, Melbourne.


In the section on prevention and early intervention (Shift 3), we measure two factors that impact tāngata whaiora significantly: housing and employment. We note that the Draft MHWS seeks to identify people who are in contact with services and who lack these basic supports and provide integrated or wraparound support to them. We welcome any increased focus on addressing risk and protective factors for tāngata whaiora.

As part of our role to monitor wellbeing outcomes at a population level, Te Hiringa Mahara has been working to advance wellbeing outcomes for people with lived experience of mental distress and addiction. In 2025, we completed an assessment of wellbeing outcomes for people

who interact with mental health and addiction services which showed disparities in a range of factors of mental health and wellbeing.¹⁵ We built on this monitoring in 2026 and published a wellbeing assessment report as well as a deeper analysis of factors strongly associated with good mental wellbeing for people who interact with the mental health and addiction system to inform priority areas for cross-agency action.^{16,17}

We have a role to promote alignment and collaboration across entities involved in mental health and wellbeing. We will use our wellbeing outcome monitoring as well as what we know from MHA system performance to drive cross-government action toward addressing factors that affect mental health at a structural level.

- 15 Te Hiringa Mahara. 2025a. Assessment of wellbeing outcomes for people who interact with mental health and addiction services. Infographic. Wellington: Te Hiringa Mahara.
- 16 Te Hiringa Mahara. 2026c. Assessment of wellbeing for people who interact with mental health and addiction services. Infographic. Wellington: Te Hiringa Mahara.
- 17 Te Hiringa Mahara. 2026d. What matters for mental wellbeing: analysis of factors related to mental wellbeing for tāngata whaiora. Wellington: Te Hiringa Mahara.



He huanga hauora hinengaro o te taupori whānui

Population mental health and wellbeing outcomes

This section provides insight into population-level mental health and wellbeing-related outcomes as context for understanding MHA system performance.

Mental health and wellbeing are vital components of thriving communities and measuring them is essential to monitor what ultimately matters to people. The He Ara Oranga wellbeing outcomes framework domains outline what wellbeing looks like from the perspective of tāngata whaiora.

The measures we use are mainly from He Ara Oranga wellbeing outcomes framework with additional measures that are more specific to outcomes for people with lived experience of mental distress. These outcomes are the highest-level population monitoring showing contribution from across government and multiple systems. Our focus in this report is on how government policies, strategies and decisions contribute to MHA system performance which in turn contributes to mental health and wellbeing outcomes for people.

It is important to note that the MHA system is only one contributing system alongside other systems such as the social, housing, corrections, education systems that influence what we see at a population level and their mental health outcomes.

Because the factors and systems influencing population-level outcomes are many and varied we would expect changes in outcomes at this level to be slow and incremental. In presenting this data, we are focusing on observing long-term trends rather than highlighting short-term changes.

What we are reporting on in 2026

In 2025, we reported on five population mental health related outcomes. This year we are reporting on 10 outcomes, having added life satisfaction as a summary measure of overall subjective wellbeing. We have also expanded our suicide and intentional self-harm reporting with four additional measures, reflecting our role in having oversight of the Suicide Prevention Action Plan.¹⁸

Outcome measures include accidental overdose, hazardous drinking, suicide and proxy indicators of intentional self-harm. While these are not direct measures of the MHA system, at a population level they are often clustered with risk factors to wellbeing, such as socioeconomic disadvantage and household distress,¹⁹ and can therefore be helpful in gauging overall mental health and wellbeing status.

18 Ministry of Health. 2025. **Suicide Prevention Action Plan 2025–2029**. Wellington: Ministry of Health.

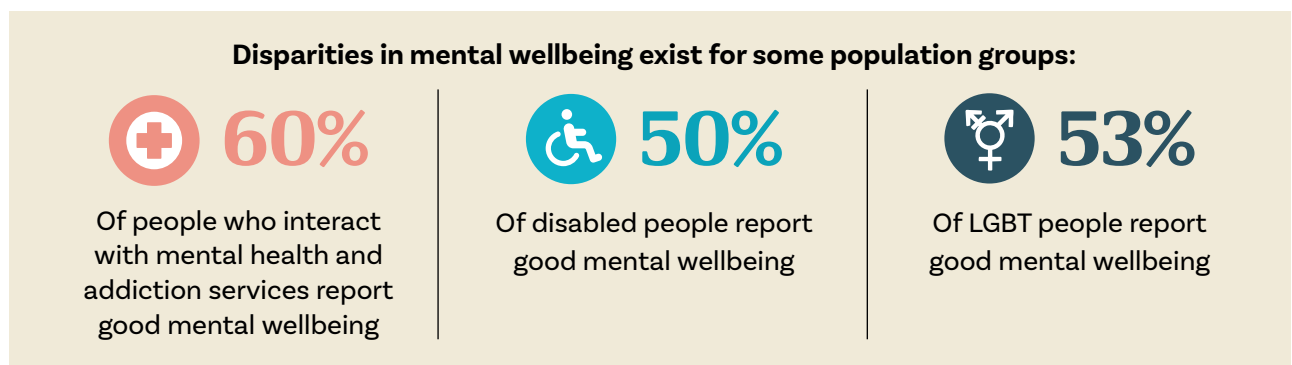
19 Richmond-Rakerd LS, D'Souza S, Milne BJ, Andersen SH. 2024. **Suicides, drug poisonings, and alcohol-related deaths cluster with health and social disadvantage in 4.1 million citizens from two nations**. *Psychol Med*. 54(8):1610-1619.

This facilitates oversight of the broader system as well as monitoring specific plans and strategies such as the Suicide Prevention Action Plan²⁰ and Action Plan to Prevent and Reduce Substance Harm 2026–2029.²¹

We have aligned our measures with those of other countries, where possible, to facilitate future international comparisons and benchmarking.

In the next section we look at changes over time to support analysis of the latest data in the context of longer-term trends. For some of the measures, data for the reporting period (2024/25) is not available. In these cases, the most recently available data is presented. All differences between comparator groups reported here are statistically significant.

Population mental health and wellbeing outcomes at a glance²²



20 Ministry of Health. 2025. **Suicide Prevention Action Plan 2025–2029**. Wellington: Ministry of Health.

21 Ministry of Health. 2026a. **Action Plan to Prevent and Reduce Substance Harm 2026–2029**. Wellington: Ministry of Health.

22 See Appendix A for data sources for this graphic.

Life satisfaction is significantly lower for people who interact with mental health and addiction services

Life satisfaction is a summary measure based on an individual's perspective of their overall life satisfaction, and is useful for providing a high-level overview at a population level. In 2024/25, 83% of adults aged 15 years and older rated their life satisfaction as high or very high (7 out of 10 or higher). Some groups report lower levels of life satisfaction, including Māori (76%), Pacific Peoples (77%), disabled people (64%) and people living in areas of high neighbourhood deprivation (75%). Life satisfaction at a total population level has remained relatively steady over time.

Amongst people who interacted with services, a smaller proportion had good life satisfaction (71%) than for the population who did not interact with services (84%). This was compounded for people who are in more than one underserved population group (Te Hiringa Mahara, 2025).²³

Mental wellbeing is lower for LGBT, disabled people, and people in contact with services

Mental wellbeing is scored by the WHO-5 scale, a widely used self-reported tool reflecting mental wellbeing in the past two weeks. In 2023, 74% of people aged 15 years and older reported good mental wellbeing. Some groups experienced considerably poorer mental wellbeing including disabled people (50%) and people who identified as LGBT (53%). Mental wellbeing decreased in 2021 compared with 2018, but increased again in 2023.²⁴

Among people who interacted with mental health and addiction services, a much smaller proportion had good mental wellbeing (60%), than for the population who did not interact with services (79%).

Psychological distress has increased, especially for disabled people

This measure reflects people's experience of their past four weeks. It is scored using the Kessler Psychological Distress Scale (K10), where high or very high levels of psychological distress are defined as a K10 score of 12 or more out of 40. Prevalence of psychological distress is not the same as the prevalence of mental health conditions because the K10 is not a diagnostic tool and does not provide data on prevalence.

In 2024/25, 14% of people aged 15 years and over experienced high or very high psychological distress, equivalent to 609,000 people. Psychological distress has increased over the last 10 years, up from 6.9% in 2015/16. Some groups experience much higher rates of psychological distress, including Māori (22.5%), Pacific Peoples (24%), young people (23%) and disabled people (35.5%).

Hazardous drinking has reduced, but is higher for Māori, men and disabled people

Hazardous drinking is defined as an established pattern of alcohol use that carries a high risk of future damage to physical or mental health. In 2024/25, 17% of people aged 15 years and over reported hazardous drinking patterns, equivalent to 722,000 people. Men, Māori and disabled people are more likely to report hazardous drinking patterns than other groups. Asian people are much less likely to report hazardous drinking, and alcohol use in general. The overall prevalence of hazardous drinking has decreased over time, and in particular has decreased among men, and young people.

23 Te Hiringa Mahara. 2026c. **Assessment of wellbeing for people who interact with mental health and addiction services.** Infographic. Wellington: Te Hiringa Mahara.

24 Stats NZ. 2023. **Wellbeing statistics: 2023.** Webpage: [Wellbeing statistics: 2023 \(updated\)](#) | Stats NZ Accessed 11 May 2026.

Accidental drug overdose is killing nearly three people per week

This measure shows the number of confirmed and suspected accidental deaths from drug overdose. In 2024, 148 deaths were due to accidental drug overdose. Ninety-five are active cases under coronial enquiry, therefore this may be subject to change. Opioids are responsible for the largest number of accidental overdose deaths. Alcohol was present in around 40% of accidental overdose deaths (suspected or confirmed) in 2024. The number of accidental overdose deaths per year fluctuates over time but appears to have been increasing since 2016.

Overall, what does this tell us?

Most people in Aotearoa New Zealand report good life satisfaction and good mental wellbeing. The average life satisfaction of people in Aotearoa New Zealand of 7.6 out of 10 is relatively high by Organisation for Economic Co-operation

and Development (OECD) standards, at 7.26 averaged across member states. People who are in contact with MHA services consistently report poorer wellbeing. People at the intersections of marginalised communities, such as Māori, Pacific Peoples, disabled people, and people who identify as LGBT, experience much poorer wellbeing.

The increase in levels of psychological distress over the past five years, particularly among young people and Māori, is a significant cause for concern. Large increases in rates of psychological distress may seem contradictory to relatively stable wellbeing at a population level. Wellbeing and psychological distress each have different drivers,²⁵ with protective factors influencing mental wellbeing and risk factors influencing mental distress. This is important for policy and clinical practice, because the same strategies for preventing mental distress might not be sufficient for enhancing positive mental wellbeing, and vice versa.

Monitoring suicide and intentional self-harm rates

Every suicide and intentional self-harm statistic represents a real person. We acknowledge the individuals, families, whānau and communities affected by suicide and intentional self-harm.

The contributing factors for suicide and intentional self-harm are multiple and complex. Prevention requires a whole-of-society response. An effective MHA system is one element in preventing suicide, and in preventing suicidal distress in the first place. Data about deaths

by suicide and incidence of intentional self-harm can provide a better understanding and help inform efforts to address suicide.

Any indicator of suicide and intentional self-harm among Māori must take account of multiple factors. Primarily, they must be based on the recognition that data related to Māori health and wellbeing tend to undercount and miscount Māori.²⁶ Because Māori experience disparities in rates of suicide and intentional self-harm, it is vital that indicators to measure suicide prevention actions do not further exclude and marginalise Māori.

25 OECD. 2023. **Measuring Population Mental Health**. Paris: OECD Publishing. <https://doi.org/10.1787/5171eef8-en>.

26 Theodore, R., Boulton, A. & Sporle, A. 2023. **Māori Linked Administrative Data: Te Hao Nui – A novel Indigenous Data Infrastructure and Longitudinal Study**. The International Indigenous Policy Journal, 14(1), 1–16.

The next section includes statistics on suicide and intentional self-harm. Please proceed with care.

Places to go for support

- Lifeline Suicide Crisis Helpline: free phone 0508 828 865 (0508 TAUTOKO).
- Samaritans crisis helpline: free phone 0800 726 666 if you are experiencing loneliness, depression, despair, distress or suicidal feelings.
- Call or text 1737 or visit the **1737 Digital Hub**

Suicide rates are highest among Māori males

A death is officially confirmed as a suicide if a coroner determines under the Coroners Act 2006 that the person died by suicide. In 2020/21, the most recent year of data available, there were 649 confirmed suicide deaths. This represents an age-standardised rate of 12.2 per 100,000 people. Suicide deaths have been relatively stable over time.

Māori experience disproportionately higher suicide rates than non-Māori (17.3 compared with 11.2 per 100,000 in 2020/21). Males are also much more likely to die from suicide than females (18.3) compared with 6.1 per 100,000 in 2020/21. By age group, age-standardised suicide rates were highest among people aged 25 to 29 years in 2020/21.

There were 630 suspected self-inflicted deaths in 2024/25

Data on suspected self-inflicted deaths is timelier than confirmed suicide deaths but remains provisional while under coronial inquiry and is therefore subject to change. In 2024/25, 630 suspected self-inflicted deaths occurred. The age-standardised rate of suspected self-inflicted deaths was 11 per 100,000 in 2024/25. The rate of suspected self-inflicted deaths for males was much higher than for females (16.2 per 100,000 males, 5.8 per 100,000 females in 2024/25).

Young people experience much higher rates of intentional self-harm requiring hospitalisation

Intentional self-harm does not always have suicidal intent. Some people who intentionally self-harm are at an increased risk of dying by suicide, and there can also be an increased risk of accidental death while intentionally self-harming. Monitoring intentional self-harm can help identify intervention needs and opportunities for targeted prevention approaches. This measure looks at people admitted to a public hospital after an intentional self-harm injury.

Intentional self-harm hospitalisation data does not include all people presenting to hospital emergency departments. This is due to limitations in the collection of data from emergency departments.

In 2024/25 around 6,800 people were hospitalised with intentional self-harm (across around 9,000 events). Young people aged 15 to 24 years had the highest rate of intentional self-harm hospitalisations at 370 young people per 100,000, compared with the overall rate of 128 people per 100,000. The number of people hospitalised with intentional self-harm decreased by 22%, compared with five years ago, and the number of young people aged 15 to 24 years hospitalised decreased by 38% over the same period.

Ambulance attendances for self-harm have been stable over time

In 2024/25, ambulances attended around 1,600 self-harm events. The number of ambulance attendances for self-harm events has been stable over recent years. Young people aged under 25 years make up around half of all ambulance attendances for self-harm. In total, self-harm events comprise around 5% of the mental health incidents responded to by road ambulance services in Aotearoa New Zealand.

Police are receiving fewer calls for threatened²⁷ or attempted suicide

In 2024/25, police received 22,959 calls and attended 14,489 calls where someone had threatened or attempted suicide, attending around two thirds of calls received in 2024/25. The number of calls decreased by 18% between 2020/21 and 2024/25, while the number of attendances decreased by 37%. Recent changes in police triaging may have affected data comparisons in attendance over time, nonetheless, there has been a large decrease in number of calls in 2024/25 compared with 2020/21.

What does this tell us?

Despite an increasing focus and investment in suicide prevention, the age-standardised rate of suicide deaths has remained largely static over the last 15 years and significant disparities by population group exist. While Aotearoa

New Zealand has a similar rate of suicide death as Australia and the OECD average, many countries have much lower rates of suicide death.

The age-standardised rate of suicide deaths is highest among Māori men aged 25 to 44 years (41 per 100,000), indicating the need for further prioritisation of suicide prevention investment to this group.

Proxy measures of self-harm indicate young people experience higher rates of intentional self-harm than older age groups.

While this data provides additional information about suicidality and intentional self-harm, it does not provide a complete picture. Gaps in the data include some presentations to emergency departments, contact with primary care such as general practitioners and those who experience suicidal distress but do not seek health system or emergency services support. This data also does not speak to the personal experiences of people with suicidal distress or those bereaved by suicide.

What we want to see


We acknowledge that the contribution of individual policies and strategies to change at a population level may be small, however in combination, these outputs can add up to real changes for people.

We are pleased to see the Suicide Prevention Action Plan and that the Action Plan to Prevent and Reduce Substance Harm 2026–2029 and Draft MHWS are now underway. Inequities of outcomes across different population groups require urgent attention. Reducing distress and improving wellbeing requires a whole-of-government response to addressing social risk and protective factors alongside and with equal priority to efforts to improve the performance of the MHA system.

We would like to see a government commitment to mental health and wellbeing in every policy to accompany the significant work being done within the MHA system, and the wider health system.

The next section focuses on the six shifts we have identified as critical for mental health and addiction system improvement. It provides insight into how the MHA system is performing to and contributing to improving outcomes for people in contact with it.

27 The term “threatened” reflects language used by the Police when recording callouts.



**Te aroturuki i ngā
tutukinga atu ki ngā
nekehanga pūnaha e ono:
ngā hua matua i waenga
i te 2024 me te 2025**

*Monitoring performance
against the six system shifts:
Results for 2024/2025*

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 and 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.

The He Ara Oranga report emphasised the value of having lived and living²⁸ experience woven through the MHA system. Our consultation with lived experience leaders has identified three ways in which the potential of lived experience can be realised – through partnership, investment, and equal prioritisation of knowledge. To achieve this the system needs to embed lived experience in governance, planning, policy, and service development as well as delivery.

We are encouraged to see that the Draft MHWS recognises this. It aims to embed the infrastructure needed to support lived experience leadership at all levels, “including management, planning, commissioning, delivery, and monitoring²⁹” and value insights from people with lived experience equally alongside clinical expertise. We will be looking for tangible actions to achieve this in the strategy’s first implementation plan.

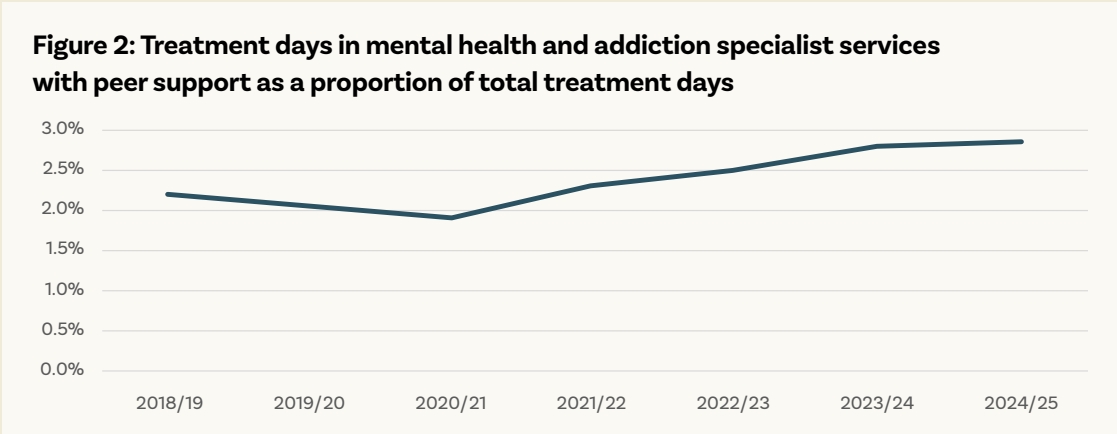
For our first monitoring report we focused on investment in and access to peer support. We heard from our lived experience engagement that this is only one aspect of lived experience potential. However, data on other aspects of lived experience leadership in the MHA system is limited, therefore we have used the same three measures related to peer support in this report.

The Draft MHWS commits to addressing data gaps including measuring the number, distribution and operations of lived experience leadership roles across Health New Zealand. In future years we will include these measures in our monitoring.

28 We include living experience in recognition that people’s experience of mental distress and/or addiction may be current.

29 Ministry of Health. 2026a. **Draft Mental Health and Wellbeing Strategy 2026–2036**. Wellington: Ministry of Health. Page 17.

Peer support access



The number of treatment days in specialist services with peer support has increased as a proportion of total treatment days. This is part of an ongoing trend since 2020/21, and shows a steady growth in the availability of and access to peer support within the system.

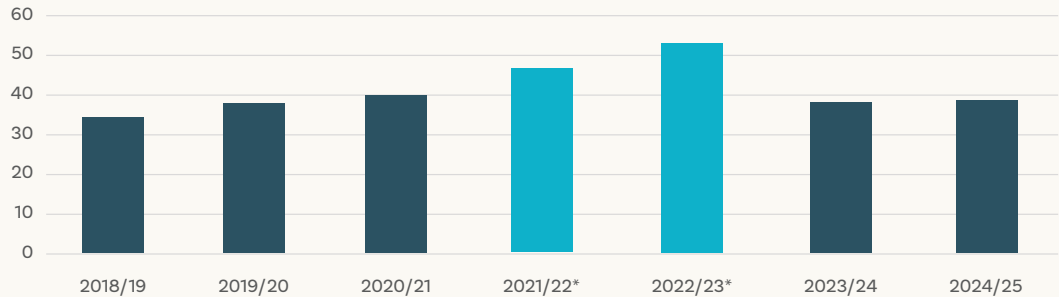
This shows that peer support is becoming embedded as a basic component of MHA specialist services. However, its scope is still small, with fewer than 3% of treatment days taking place in services with peer support. We have also heard that peer support roles can be precarious without lived experience

leadership behind them, and can be deprioritised in budgeting decisions. To grow access to peer support, it must be part of a strong lived experience ecosystem that recognises the value of lived experience and integrates it at all levels. Data that would facilitate understanding of lived experience leadership and infrastructure is not currently available.

Increased peer options in some services and regions are promising. To be sustainable, this needs to be coupled with increased funding, wider reach, and clear governance structures.

Peer support expenditure

Figure 3: Total expenditure in peer support services (\$m)



*2021/22 and 2022/23 should not be compared with previous or subsequent years, see below.

Peer support expenditure has largely remained static in the past year and is currently at similar levels to 2019/20.

Total expenditure on peer support services appears to be much higher in 2021/22 and 2022/23. However, this is likely to reflect changes in the way Health New Zealand counted and reported peer support expenditure during this time.

Peer support has been shown to improve hope, psychosocial outcomes and quality of life for tāngata whaiora,³⁰ and leads to reduced costs associated with ongoing mental health care.³¹ In a system where lived experience is valued, we would expect to see greater clarity on how funding is allocated, and clearly defined funding streams that support lived experience roles in addition to peer support services.

The Draft MHWS commits to a greater range of consumer, peer support, and lived experience roles. It also commits to embedding the infrastructure needed to support meaningful involvement of people with lived experience in the design and delivery of services; however, it does not include detail of how this will be achieved.

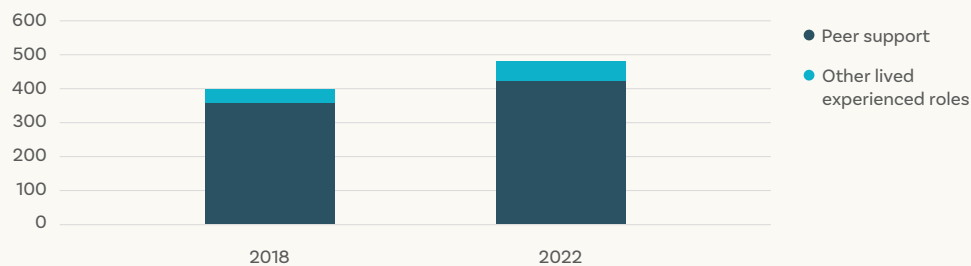
To effectively and sustainably realise the potential of lived and living experience, we would like to see planning that includes growth of the lived experience workforce across all lived experience roles, including but not limited to peer support.

30 Te Hiringa Mahara—Mental Health and Wellbeing Commission. 2023. **Peer Support Workforce Insights Paper**. Wellington: Te Hiringa Mahara—Mental Health and Wellbeing Commission.

31 Cooper, R.E., Saunders, K.R.K., Greenburgh, A. et al. 2024. **The effectiveness, implementation, and experiences of peer support approaches for mental health: a systematic umbrella review**. BMC Med 22, 72 (2024). <https://doi.org/10.1186/s12916-024-03260-y>.

Lived experience workforce

Figure 4: Total FTE lived experience roles in NGO services



Note: FTE – Full-time equivalent; NGO – Non-governmental organisation.

Up to date data on the consumer, peer support, and lived experience (CPSLE) workforce is not available.³² It is likely there has been a further increase in CPSLE full-time equivalent (FTE) in line with the growth of peer support options and the wider mental health and addiction workforce since 2022. This information will next be collated for 2026. Understanding the CPSLE workforce supply is critical for system performance monitoring and must be prioritised.

Workforce development is a vital component to enabling lived and living experience to lead the transformation of the MHA system. The first CPSLE mental health and addiction workforce development strategy and action plan³³ was launched in 2020 and arose from the strong belief that developing the workforce is the fastest way to strengthen the sector. Evaluation found that the action plan has brought structure, increased visibility, and enhanced recognition of the CPSLE workforce.

We also heard from consultation with the CPSLE sector about barriers to realising further and faster progress. Shared responsibility across MHA sector stakeholders and government, resourcing

of lived experience infrastructure and building knowledge about lived experience by non-lived experience workforces were identified as critical enablers. We heard that a lived experience national professional body is needed to uphold the identity and kaupapa of the CPSLE workforce and support development with consistency across regions. Our previous research showed huge potential exists for further development of the Māori lived experience workforce, which brings a te ao Māori perspective that incorporates mātauranga Māori, tikanga, and kawa.³⁴

The 2025 refresh of the Mental Health and Addiction Workforce Plan focuses actions on growing the peer support workforce.³⁵

This cannot be achieved without also improving the infrastructure that supports the CPSLE workforce. The 2026-2029 CPSLE Strategy and Action Plan is currently being developed by Te Pou. It will provide a pathway to strengthening this critical infrastructure, and if accompanied by government commitment, and cross-agency collaboration, could facilitate continued development of the CPSLE workforce beyond peer support.

32 Non-government organization estimates were last made in 2022 and Health New Zealand was unable to supply their CPSLE workforce numbers because the peer workforce is unable to be identified separately from other support workers.

33 Te Pou. 2020. **Mental health & addiction consumer, peer support & lived experience: Workforce development strategy 2020 to 2025**. Auckland: Te Pou.

34 Te Hiringa Mahara—Mental Health and Wellbeing Commission. 2023. **Peer Support Workforce Insights Paper**. Wellington: Te Hiringa Mahara—Mental Health and Wellbeing Commission.

35 Health New Zealand – Te Whatu Ora. 2025. **Mental Health and Addiction Workforce Plan 2024–2027 (2025 refresh)**. Wellington – Te Whatu Ora.

Discussion

The CPSLE workforce has existed for a long time and has intrinsic value to the mental health ecosystem, however, the integration of this valuable workforce has been limited by resourcing and infrastructure challenges.

It is an ongoing challenge to understand how funding is allocated to peer support. Changes over the past few years to the way expenditure is recorded have resulted in an apparent decrease in funding, while in fact investment in new and expanded peer support has increased. The lack of clarity on changes in investment data counting rules and recording of these changes is concerning. We would like to be able to understand and factor such changes into our system performance monitoring. To achieve this, we would like to see processes established within Health New Zealand to enable continuity and transparency in financial data reporting when changes take place so data can be reconciled to provide a clear picture of how money is being spent over time.

We heard from lived experience leaders that with the growth in lived experience roles, there is increasing specialisation within the CPSLE workforce. It is crucial therefore that lived experience integration and leadership are supported at all levels of the system.³⁶

This should include clear governance structures, formal professional development pathways for lived experience workers into leadership and development roles, and training for clinical staff that facilitates the integration of lived experience within practices.

It is currently difficult to understand the extent to which lived experience roles are being supported by structures and processes to grow and sustain this workforce long term. The Draft MHWS makes a commitment to embedding lived experience throughout the system and to supporting lived experience infrastructure and career pathways. To be effective, there must also be explicit support for structures and processes, and in the collection of robust data. This will support evaluation against the strategy's aims and ensure initiatives are working to embed lived experience within the system.

We would like to see lived experience embedded in governance structures, formal professional development pathways to leadership roles, and training for clinical staff. Development of specific lived experience system performance measures, including indicators of effective training and formal career pathways, should also be a priority.

We acknowledge Te Pou's upcoming CPSLE workforce strategy and action plan 2026–2029 as a resource that could be used across agencies for implementation planning. We acknowledge that work is currently underway with lived experience non-government organisations, commissioned by the Ministry of Health, to scope a lived experience national representative body. The work will explore the possible purpose, functions, form, and design features, but will not make decisions about establishing the body, funding arrangements or implementation details.



36 Te Hīringa Mahara. 2024. *Leadership as a mental wellbeing system enabler: Insights on progress toward Kia Manawanui*. Wellington: Te Hīringa Mahara.

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 prioritise decisions.

The 2018 He Ara Oranga report called for a wider variety of service options, co-design, and support for implementation to address disparities in both need and outcomes experienced by different groups of people who interact with the MHA system. While progress has been made,³⁷ inequities experienced by some groups are ongoing.

Investment in kaupapa Māori services is specifically included as part of the vision for effective services for people with the highest need, because we know that inequities in rates of unmet need and in mental health and addiction outcomes persist for Māori³⁸ and that kaupapa Māori services work for Māori. These services not only help individuals but are good for whānau.³⁹ Rangatahi and young people also experience high unmet need alongside ongoing disparities in access.^{40,41}

In 2024 we made a recommendation aimed at addressing the needs of Māori and whānau accessing specialist services.⁴² In our 2025

follow-up report we found that while some progress had been made, this recommendation had not been achieved.⁴³

Our 2025 system performance monitoring focused on access to and investment in services tailored for groups with the highest needs. We measured access rates to primary and specialist services, and investment in kaupapa Māori services as a proportion of total investment. This year we have used the same measures to help establish whether improvements in access and investment are occurring.

We recognise that this shows only part of the picture and that understanding effectiveness for people accessing services will require consistent collection of experience and outcome data to demonstrate whether money spent on service provision is leading to better mental health and wellbeing for people with higher needs.

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

38 Te Hiringa Mahara. 2025c. **Key mental health and addiction findings: NZ Health Survey 2023/24**. Infographic. Wellington: Te Hiringa Mahara.

39 Te Hiringa Mahara. 2025d. **Kaupapa Māori primary mental health and addiction services: Access and Choice programme 2025**. Infographic. Wellington: Te Hiringa Mahara.

40 Te Hiringa Mahara. 2022. **Young people speak out about Wellbeing: An insights report into the Wellbeing of Rangatahi Māori and other Young People in Aotearoa**. Wellington: New Zealand.

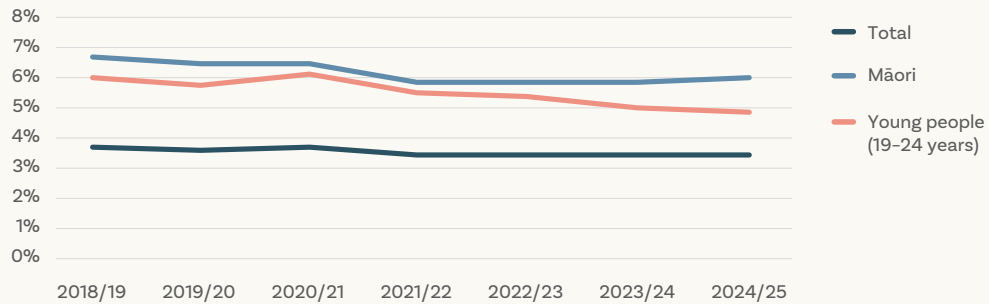
41 Te Hiringa Mahara. 2026. **Access to mental Health and addiction services. Infographic**. Wellington: Te Hiringa Mahara.

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

43 Te Hiringa Mahara—Mental Health and Wellbeing Commission. 2025. **Assessment of progress – implementation of Kua Timata Te Haerenga | the Journey Has Begun recommendations**. Wellington: Te Hiringa Mahara.

Access to specialist mental health and addiction services

Figure 5: Specialist mental health and addiction services access rates as a proportion of the total population



Access to specialist services at a total population level and for Māori increased slightly in 2024/25 compared with the previous year (0.1 percentage points and 0.2 percentage points respectively). Access rates for young people aged 19 to 24 years continued to decrease. Our Access Data Summary showed that young people also experienced the highest rates of declined referrals.⁴⁴ We are concerned about a trend showing a decrease in access among young people given the high prevalence of distress and unmet need among this age group.^{45,46}

Access rates remain below historical levels before the COVID-19 pandemic, the associated lockdowns, and workforce challenges. There is no evidence to indicate that the need for specialist mental health and addiction support has reduced.

Māori access specialist services at consistently higher rates than the total population, which reflects greater need. This sits within a broader context of inequity, where Māori experience

unequal access to protective factors for health and to culturally safe, early support. This leads to higher use of specialist services.⁴⁷

We know that Māori are less likely to access specialist services via a general practitioner (doctor) visit.⁴⁸ Greater rates of access to specialist services may reflect that Māori are waiting longer to seek help and thus having higher needs before coming into contact with services, rather than issues of equitable access or quality of care. It is notable that unmet need for professional help for mental health among Māori has increased from 10% to 16% over the past two years,⁴⁹ while access rates have remained largely static.

Addressing this requires a system response beyond specialist services – it includes accessible primary and community care, social services, and wider policies that enable services to be culturally safe, when people need them, as part of a joined-up and coordinated system.

44 Te Hīringa Mahara. 2026. **Access to mental Health and addiction services. Infographic.** Wellington: Te Hīringa Mahara.

45 See He huanga hauora hinengaro o te taupori whānui | Population mental health and wellbeing outcomes.

46 See unmet need data for SHIFT 4: Towards a mental health and addiction system that provides equitable access to services and supports that improve outcomes for people.

47 Unmet need is a measure against Shift 4: Equitable access to services and supports.

48 Te Hīringa Mahara. 2025c. **Key mental health and addiction findings: NZ Health Survey 2023/24.** Infographic. Wellington: Te Hīringa Mahara.

49 Unmet need is a measure against Shift 4: Equitable access to services and supports.

Primary mental health and addiction services access

Figure 6: IPMHA (people seen)

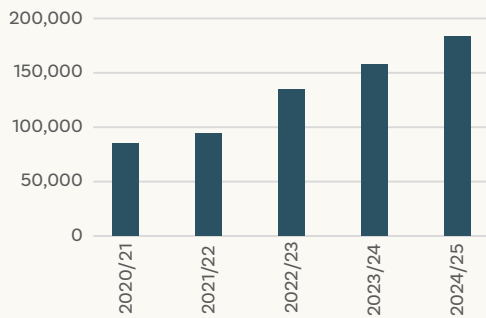


Figure 7: Kaupapa Māori (new people seen)

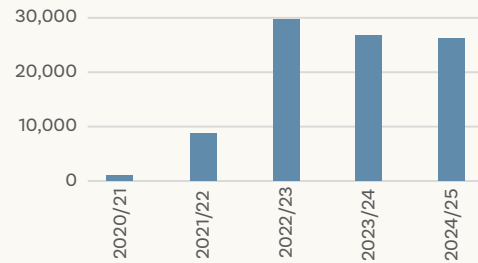


Figure 8: Pacific (new people seen)

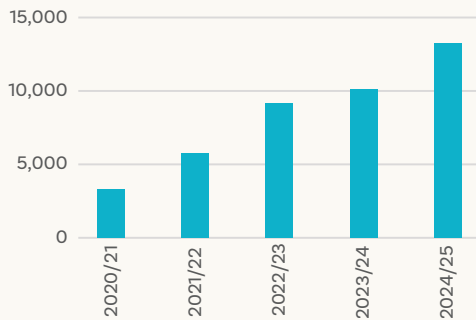
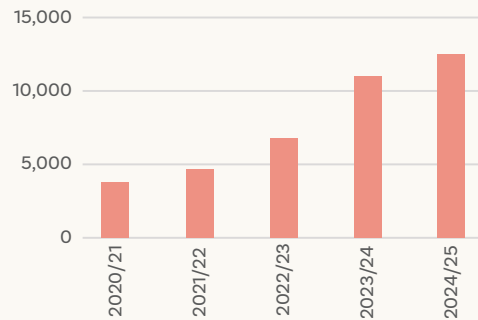


Figure 9: Youth (new people seen)



Note: IPMHA - integrated primary mental health and addiction.

In 2024/25, there was a further 15% increase in the number of people accessing primary mental health services through the Integrated Primary Mental Health and Addiction Access and Choice programme,⁵⁰ compared with 2023/24. While access has also increased among Youth and Pacific Access and Choice services, the number of new people accessing Kaupapa Māori Access and Choice services has decreased since 2022/23.

The Access and Choice programme has substantially increased access to services for people seeking support with mild to moderate mental health and harmful substance use or gambling needs. People who interact with

these services report positive benefits. At a system level the programme has alleviated time pressures in primary care and boosted primary care's capability to respond to those with mental health and harmful substance use or gambling needs.⁵¹

In an environment of overall increasing psychological distress any improvement in access is likely to be offset by increasing demand. We do not have consistent data to show whether increased access to primary services is translating to improved outcomes for people using the services. While many services are capturing outcome data, this is not available at a national level.

50 The Access and Choice programme provides support via four types of services: Integrated Primary Mental Health and Addiction (IPMHA) services, kaupapa Māori services, Pacific services, and Youth services.

51 Te Hiringa Mahara. 2025c. **Access and Choice Programme: Monitoring report on progress and achievements at five years.** Wellington: Te Hiringa Mahara.

Investment in specialist kaupapa Māori services

Figure 10: Kaupapa Māori specialist services expenditure (\$m)

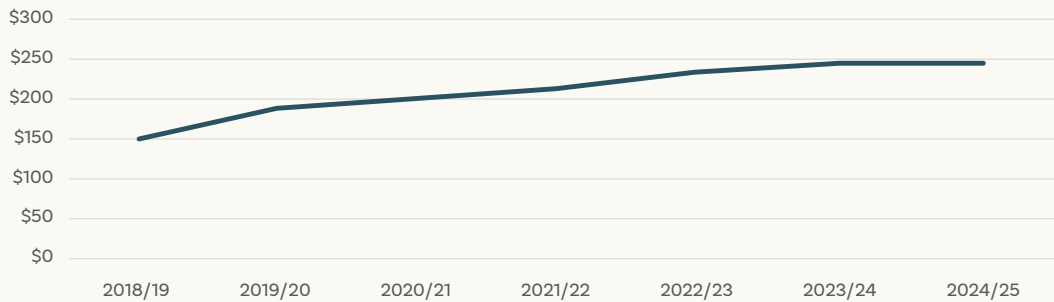
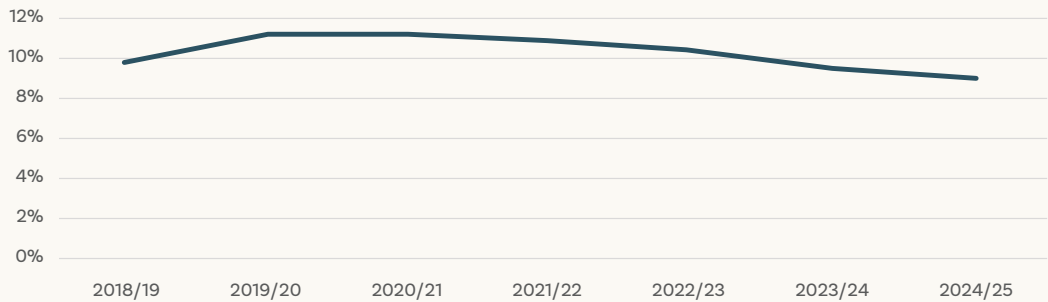


Figure 11: Kaupapa Māori specialist services expenditure share as a percentage of total mental health and addiction expenditure



Although actual funding allocated to kaupapa Māori specialist services has remained static in the last year, the proportion of total mental health and addiction expenditure decreased further in 2024/25 and now accounts for 9.1% of the Mental Health and Addiction ringfenced funding. This is below 2018/19 levels as a share of expenditure. Kaupapa Māori specialist services have not received funding increases in proportion to those provided to other types of mental health and addiction services. If this trend continues, any progress towards improving access and effectiveness for Māori may be compromised.

For many years, Māori have been asking for recognition within the system of the value and importance of kaupapa Māori services in providing effective, culturally responsive mental health care to Māori communities.⁵² These services, where available, are effective in meeting the mental health and wellbeing aspirations of Māori and whānau. When services are commissioned, designed, delivered, and evaluated by Māori for Māori, benefits extend beyond the individual and into the wider community. Only 29% of Māori who access specialist service use kaupapa Māori services. This suggests there is room to improve availability of kaupapa Māori services.

52 Te Huringa Mahara—Mental Health and Wellbeing Commission. 2023b. **Te Huringa Tuarua 2023: Kaupapa Māori services report**. Wellington: Te Huringa Mahara

In 2023 we called for increased investment in kaupapa Māori services and for commissioning approaches that recognise mana motuhake and tino rangatiratanga.⁵³ In 2025, investment appears to have decreased as a proportion of total ringfenced mental health and addiction investment. We need to understand more clearly what is happening to ensure the needs of Māori are being met and appropriate options are available.

The change of service commissioning to a partnership approach has been flagged in the Draft MHWS and we welcome this as a step towards tino rangatiratanga. However, it must be accompanied by adequate investment that enables kaupapa Māori specialist services to increase their reach.

Discussion

Our measures show a significant increase in access to primary services and slight increases in access to specialist services overall. Over the past five years the trend in access rates for 19 to 24 year olds to specialist services has been decreasing. We also see an ongoing trend of reduction in the proportion of investment dedicated to kaupapa Māori services.

We note that ongoing changes have been made in the way funding is administered over the past five years, and that the introduction of new purchase unit codes may have led to changes in the way expenditure is recorded. We expect funding for kaupapa Māori services to keep pace with other areas, and we are calling for action on this issue.

Investing in kaupapa Māori specialist mental health and addiction services is vital given the strong evidence base for kaupapa Māori approaches⁵⁴ and the higher prevalence of mental health needs among Māori relative to other population groups. Due to a lack of data we are unable to ascertain what impact the apparent decrease in the proportion of funding is having on outcomes for tāngata whaiora Māori. We have, however, seen a sharp increase in unmet need among Māori, and, combined with the ongoing inequities in outcomes noted throughout this report, it appears the needs of Māori are not being adequately addressed.

We have heard that commissioning approaches can significantly affect the way services are delivered. Issues include frequent renewal of contracts leading to insecurity of service provision, the siloing of services within contracts limiting how a provider can support tāngata whaiora and whānau needs, and a high reporting burden reducing time available to support tāngata whaiora. We have been told that this approach to commissioning leads to service compartmentalisation, and ultimately a disjointed experience and poorer outcomes for tāngata whaiora. To ensure effective services for those with highest need, we would like to see commissioning approaches that facilitate stability and continuity for tāngata whaiora and their whānau.

53 Te Hiringa Mahara—Mental Health and Wellbeing Commission. 2023d. **More kaupapa Māori services**. Video. www.mhwc.govt.nz/our-work/advocacy/more-kaupapa-maori-services. Accessed 6 March 2026.

54 Te Hiringa Mahara—Mental Health and Wellbeing Commission. 2023b. **Te Huringa Tuarua 2023: Kaupapa Māori services report**. Wellington: Te Hiringa Mahara.

Different agencies have published reports highlighting a system that is not structured to meet the needs of young people.^{55,56} We continue to see young people being expected to fit into models of care designed for older age groups, a lack of cross-agency collaboration, and a lack of youth voice in the design and delivery of services.

The Draft MHWS highlights the higher needs and inequitable outcomes experienced by Māori and young people. It does not set out a path to addressing the underlying drivers of distress, or Māori- and youth-led actions to address these. The Draft MHWS does commit to delivering safe, trauma-informed, responsive, accessible, and age and culturally appropriate services for populations with specific needs. It also commits to improving the availability of population prevalence data to align investment with need. We would expect these actions to include the unmet recommendation from our 2024 report *Kua Tīmata te Haerenga*, and focus on Māori- and youth-specific approaches that prioritise and meet the needs of these groups.

The lack of consistent data to understand effectiveness is an ongoing issue. We note the commitment to improving data quality and completeness and address data gaps in the Draft MHWS, however, what data will be collected and how it will be collected is not clear. Collection of service experience and outcome data through programme evaluation for populations with highest need should be a priority. It is critical that this data is collected to inform understanding of service effectiveness and support better outcomes for groups that are experiencing ongoing inequities. Data collected must also be relevant to the needs of the populations served. Therefore, we have made a specific recommendation to effectively address recognised data gaps.



55 Office of the Auditor-General. 2024. Meeting the mental health needs of young New Zealanders. Wellington: Office of the Auditor General.

56 Cross Party Mental Health and Wellbeing Group. 2023. **Under One Umbrella - A report into integrated mental health, alcohol and other drug use care for young people in New Zealand.** Wellington: Platform Trust.

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 (for example, digital and telehealth).
- The system contributes to addressing the determinants of mental health and wellbeing for people who interact with services.

Supporting good mental health requires a comprehensive approach to help people stay well while also offering a range of options to help with needs as they arise. This shift emphasises wellbeing, treatment closer to home, whānau- and community-based responses, and cross-government action to address the social determinants (risk and protective factors) that influence mental health and wellbeing.

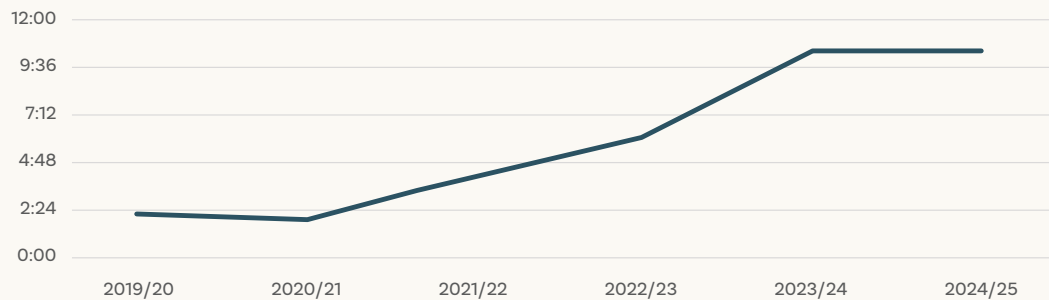
Prevention and early intervention have been topical in the past year, with government targets, strategies and actions making this a primary focus. It is one of four priorities in the Draft MHWS, focusing on addressing the underlying drivers of mental health, intervention early in the life course, and addressing emerging needs early. The Government has set a target of 25% of ringfenced mental health funding to be invested in prevention and early intervention.

Our first system performance monitoring report used measures of investment in and timely access to prevention and early intervention services, along with measures of key risk and protective factors for mental wellbeing among people interacting with specialist services. We have continued to use these measures because together they provide a useful snapshot of the prevention and early intervention system. Our 2026 report on wellbeing outcomes for people who interact with mental health and addiction services⁵⁷ provides deeper insights into the relationship between risk and protective factors and the wellbeing status of people who interact with the system.

57 Te Hiringa Mahara. 2026d. **What matters for mental wellbeing: analysis of factors related to mental wellbeing for tāngata whaiora**. Wellington: Te Hiringa Mahara.

Telehealth wait times

Figure 12: Average call wait times for telehealth services (combined services, minutes)



National telehealth wait times (combined services⁵⁸) remained static between 2023/24 and 2024/25, but are still significantly higher than in previous years.

While it is promising to see the previous four years' sharp increases in wait times level off, a wait of around 10 minutes may mean people do not get access to support when they need it.

Calls to telehealth services are reducing in volume but increasing in complexity. In our 2025 report on crisis response, we noted a sharp increase in unanswered or abandoned calls between 2023 and 2024, with over half of calls being unanswered or abandoned.⁵⁹

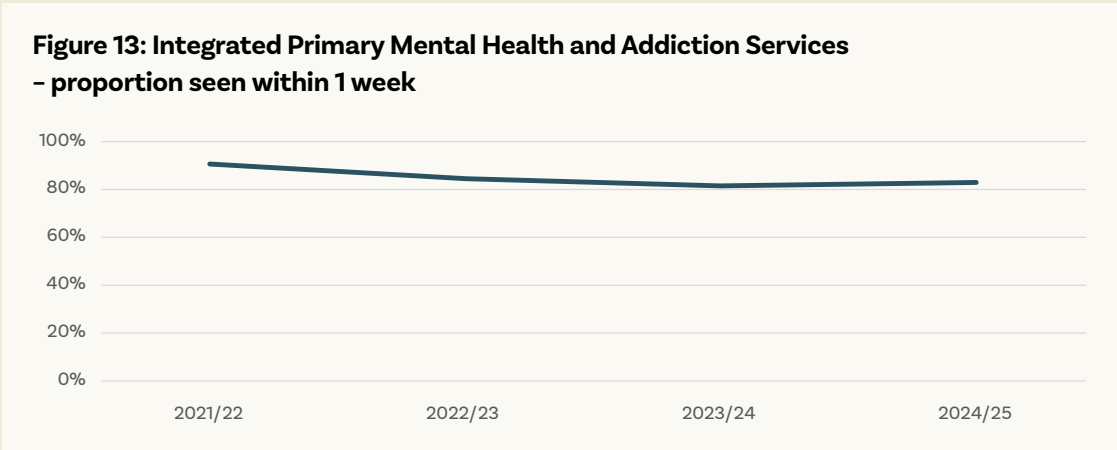
Telehealth as a crisis response is a vital primary service that focuses on de-escalation of distress, assesses needs, and connects people to the most appropriate support. Telehealth is the entry point to services for 51% of people in crisis. Capacity and capability will need to expand to effectively support telehealth services as part of a system of care.

In 2025, we made two recommendations for actions to improve the capacity and capability of crisis response services, including one to enable nationwide access to 24/7 phone-based crisis support. We will follow up on these recommendations in late 2026.

58 National telehealth combined services covers 1737 Need to Talk, AOD, Depression, Gambling, Lowdown and Mind and Body Peer Support.

59 Te Hiringa Mahara. 2025f. **Urupare mōrearea: Crisis responses monitoring report**. Wellington: Te Hiringa Mahara.

Timely access to Access and Choice mental health and addiction services



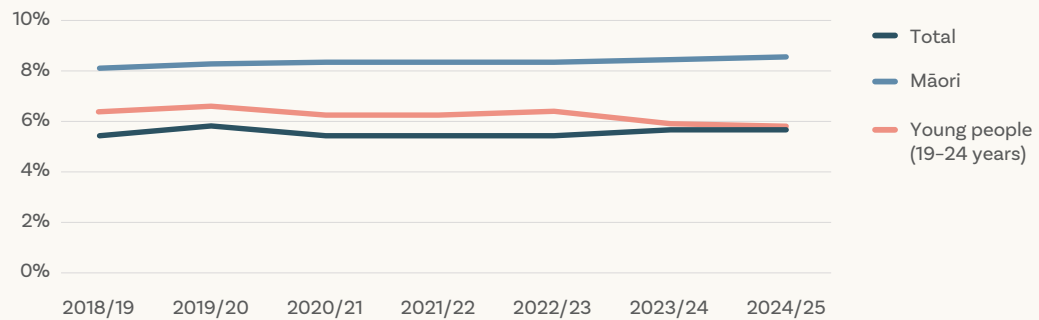
The government target of 80% of people seeking Integrated Primary Mental Health and Addiction Access and Choice services to be seen within one week is being met. In 2024/25, 83% of people were seen within a week, an increase of 1% on the previous year.

This data only covers Integrated Primary Mental Health and Addiction services and we have heard that wait times are longer for youth Access and Choice services. We want to see a continued improvement in timeliness of care, and reporting of wait times across all Access and Choice services.

We would expect any target for timely access to be raised over time as it is met, with the eventual aim of all people receiving primary care within a timeframe that meets their needs. We also note that Access and Choice services are intended to be a same-day service and that timeliness targets should reflect this aim of the programme.

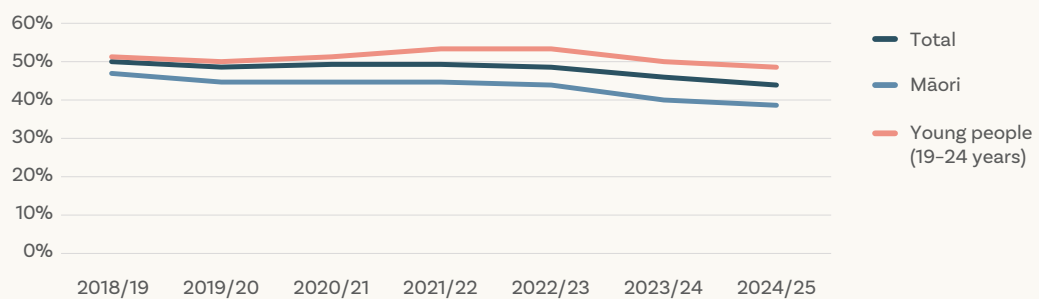
Housing status

Figure 14: Homelessness among people accessing specialist mental health and addiction services



Employment, education, or training

Figure 15: Percentage of people accessing specialist mental health and addiction services who are in employment, education or training



Homelessness⁶⁰ among people interacting with specialist MHA services has remained stable over time, but is 50% higher among Māori compared with the total population. The proportion of people interacting with specialist MHA services who are in employment, education or training has decreased between 2023/24 and 2024/25. The decrease for Māori and young people over the same period has been greater than that of the overall group.

The Draft MHWS focuses on integrated support for tāngata whaiora who lack basic support such as employment and housing and we welcome this. To achieve equitable outcomes for tāngata whaiora, we would also expect to see the needs of Māori and young people specifically prioritised in cross-government actions to address the factors that influence mental health.

60 Homelessness is defined as living situations where people with no other options to acquire safe and secure housing: are without shelter, in temporary accommodation, sharing accommodation with a household or living in uninhabitable housing.

Investment in prevention and early intervention

Of the mental health and addiction ringfenced investment, 24.4% was allocated to prevention and early intervention in 2024/25.⁶¹

Just under a quarter of the MHA ringfenced expenditure was defined as prevention and early intervention in 2024/25, slightly short of the government target of 25%.

In 2024/25, 42% of the ringfenced prevention and early intervention funding was spent on hospital and specialist services such as child and adolescent specialist mental health services.

While improving access to specialist services is important for those who need them, these services are a response to acute mental distress and are designed for people most severely affected by mental distress or addiction. We would like to see a stronger focus on preventing the need for contact with specialist services in the first place.

Discussion

Primary prevention offers an effective, cost-effective way to reduce mental distress and addiction at a population level.^{62,63} Investing sufficiently in primary prevention prevents harm, improves quality of life and societal outcomes, and reduces demand for specialist services.⁶⁴

In 2026, senior sector leaders provided insights on the future of primary and community responses.⁶⁵ They called for accessible, holistic primary support with a wellbeing focus, that is organised with local leadership and flexibility, that empowers people and their whānau, and that is integrated across key boundaries including community and specialist services. It is also important that any primary prevention or early intervention is connected to a focus on addressing risk and protective factors for mental health.

Evaluating the impact of existing and new services and identifying enabling systems will facilitate building on strengths. Importantly, funding and commissioning approaches must support change.

61 Prevention includes mental wellbeing promotion and suicide prevention. Early intervention includes both services that intervene early during distress (such as primary MHA) and services that intervene early in the life course (such as maternal, infant, child and youth specialist services).

62 Mendelson T, Eaton WW. 2018. **Recent advances in the prevention of mental disorders.** Soc Psychiatry Psychiatr Epidemiol. Apr;53(4):325-339. doi: 10.1007/s00127-018-1501-6.

63 Le LK-D, Esturas AC, Mihalopoulos C, Chiotelis O, Bucholz J, Chatterton ML, et al. 2021. **Cost-effectiveness evidence of mental health prevention and promotion interventions: A systematic review of economic evaluations.** PloS Med18(5)

64 Carbone, S. 2020. **Evidence review: The primary prevention of mental health conditions.** Victorian Health Promotion Foundation, Melbourne.

65 Te Hiringa Mahara. 2026b. **The future of primary and community responses to mental health and substance needs.** Wellington: Te Hiringa Mahara.

Realising a MHA system that provides and can support more effective primary prevention and early intervention will require adequate investment in primary prevention. We cannot currently discern the level of investment in primary prevention from the data available, or whether it is changing. We have heard from stakeholders that they consider there is underinvestment in primary prevention.

Measures of factors influencing mental health show significant equity gaps and that more needs to be done to address worsening trends in risk factors over time, with Māori particularly affected by inequity. Our outcome monitoring also shows no improvement over the past five years demonstrating more needs to be done further upstream than specialist services. This suggests the current investment may be too low to resource effective primary prevention and early intervention.

We note that the Draft MHWS focuses on a broad range of actions to strengthen prevention and early intervention, which align with our 'what this means' statements at each key shift. Actions include improving access, tailored mental health and wellbeing promotion activities, supporting families before they reach crisis point, and addressing risk and protective factors for mental health and wellbeing for people in contact with services. We would like to see information on how effort and resources will be allocated between primary prevention and early intervention included in the strategy's first three-year implementation plan.

As part of Health New Zealand Mental Health and Addiction Targets reporting, we would like to see separate reporting of primary prevention investment, distinct from primary mental health and addiction services and specialist mental health and addiction services. This would help us better understand the investment in primary prevention included in the MHA ringfenced funding.



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.

For a system to contribute towards improved mental wellbeing for all, it needs to provide equitable access to mental health and addiction services and supports that improve outcomes. It is about making sure that everyone who needs help can get it in a way that works for them, and that they are better off as a result of that service.

Improved access to services contributes to ensuring mental health and addiction services are meeting the needs of tāngata whaiora and their whānau. While a government focus has been on wait time targets that are presented within this shift, less focus has been given to improving

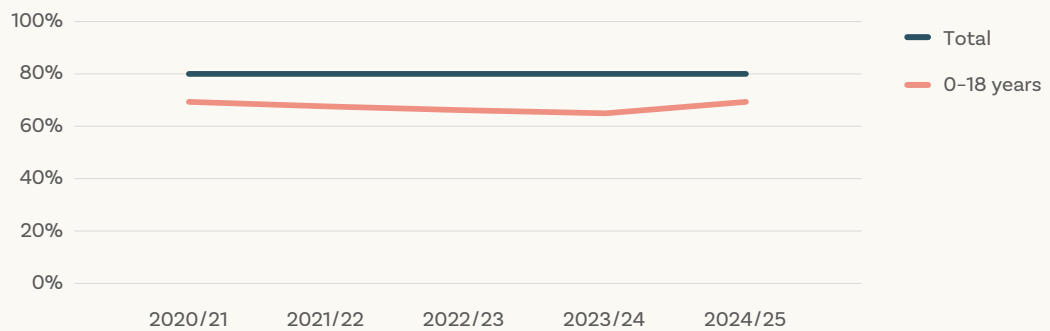
equity for the groups that currently have the greatest unmet need. In our follow up on the recommendations made in Kua Timata Te Haerenga,⁶⁶ we found that a recommendation intended to ensure the needs of Māori and whānau accessing specialist services are met had not yet been achieved.

In our first system performance monitoring report, we focused on equity in measures of access, and we continue to call for measures of experience and outcomes across the MHA system.

66 Te Hīringa Mahara—Mental Health and Wellbeing Commission. 2025. **Assessment of progress – implementation of Kua Timata Te Haerenga | the Journey Has Begun recommendations**. Wellington: Te Hīringa Mahara.

Timely access to specialist mental health and addiction services (3 weeks)

Figure 16: Percentage of people able to access specialist MHA services within 3 weeks



The data shows that the target for faster access to specialist MHA services has been met and more recent Health New Zealand data shows further improvement for the first quarter of 2025/26.

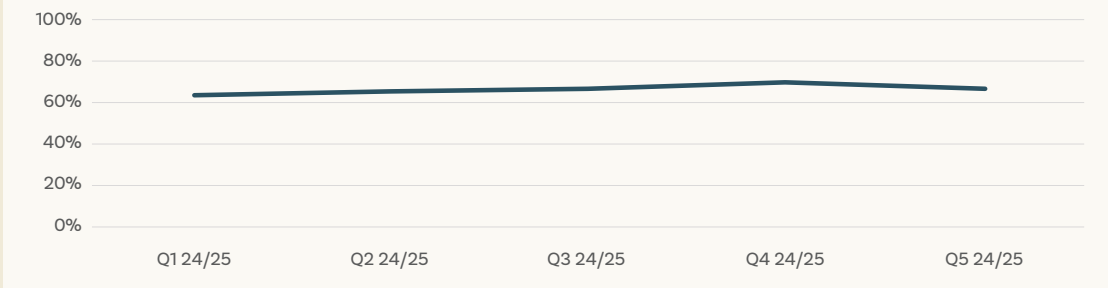
The data also shows that this faster access to specialist MHA services is not being realised

for all people. Large variation occurs by district, and half of all districts did not meet the 80% target.⁶⁷ Average wait times for addiction services and MHA services for children and young people aged 0-18 years are longer and did not meet the 80% target.

67 Health New Zealand | Te Whatu Ora. 2026. **Mental Health and Addiction Targets**. Webpage: **Mental health and addiction targets** | Ministry of Health NZ. Accessed 30 April 2026

Timely access to emergency departments for mental health presentations

Figure 17: Percentage of people presenting to emergency departments for mental health admitted, discharged or transferred within six hours, Q4 24/25

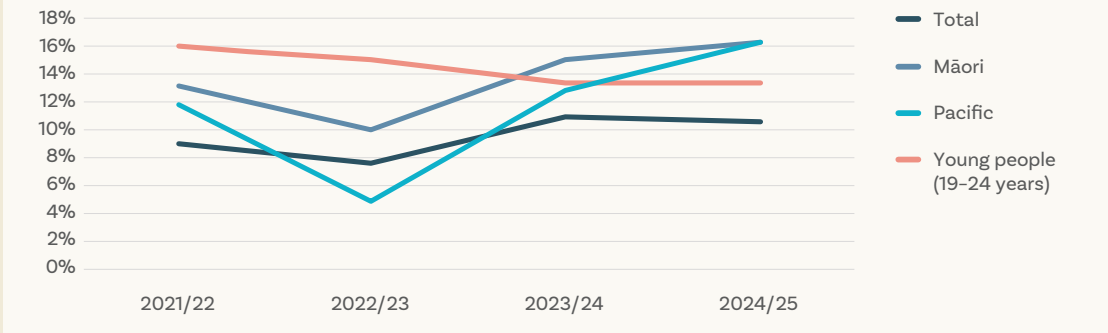


The proportion of people with MHA needs seen in emergency departments within 6 hours was higher than the same quarter last year (an increase from 64% to 67%), but was well below the 2025/26

target milestone of 77%. One region (Te Waipounamu) met the 2025/26 milestone for timely access to emergency departments for mental health presentations.

Rates of unmet need for mental health or addiction services

Figure 18: Percentage of population experiencing unmet need for professional help for mental health in the past 12 months



Self-reported unmet need overall increased sharply between 2022/23 and 2023/24, then stayed stable between 2023/24 and 2024/25. It remains at over 10% of the adult population, equivalent to 456,000 adults. Unmet need has risen from 13% to 16% for Māori, and from 12% to 16% for Pacific Peoples since 2021/22.

The high rates of unmet need show that not everyone is getting access to the services and supports they need. The overall rate of more than 10% of the population experiencing unmet need for professional help is already too high.

Unmet need is higher for people aged 15–24 years (an age group where many major life transitions happen and where the onset of many mental health conditions commonly occurs) and for Māori and

Pacific Peoples. The continued increase in unmet need for Māori in the most recent year shows that the system has not prioritised their needs.

Discussion

In the past year, some improvement has occurred in the timeliness of access to mental health and addiction services overall. This is a positive development and shows the influence of targets; what gets measured gets done. However, one measure does not tell the whole story about people's experiences in accessing timely supports that meet their needs and improve their outcomes. Our access monitoring uses balancing measures to provide a broader view of performance and shows that at the same time as wait times improved last year, the number of declined referrals increased.⁶⁸

Data presented for Shifts 2 and 3 shows the increased availability of early supports through the Access and Choice programme. It is promising to see a greater range of services that can provide timely supports for people with mild to moderate needs. While the increase in provision of early support has the potential to decrease specialist service use in time, it is still too soon to see how this will affect the specialist service demand of intervening earlier in the course of distress.

To realise this shift at a system level, we need more than just targets. Targets must be supported by a comprehensive approach that prioritises those whose needs are not currently being met. The Draft MHWS includes an action to “strengthen access to and options of mental health and addiction services across a comprehensive continuum of care including specialist services, eating disorders services, crisis support services and forensic services”.⁶⁹ However it does not include strategies specific to groups that are currently experiencing disparities in access and outcomes such as young people or Māori.

We would like to see the MHWS and its implementation plan include specific actions and measures that are designed to prioritise and address the disparities experienced by Māori and young people.



68 Te Hiringa Mahara. 2026. **Access to mental Health and addiction services. Infographic.** Wellington: Te Hiringa Mahara.

69 Ministry of Health. 2026. **Draft Mental Health and Wellbeing Strategy 2026–2036.** Wellington: Ministry of Health. Page 14.

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.

Based on our earlier work and discussions with people with lived experience or mental distress and addiction, we recognise that people's rights and agency need to be placed at the centre of legislation, policy and practice. The system must support all people to meaningfully participate in and lead decision-making about their care and treatment, free from harmful practices, and underpinned by a modern human rights framework.

The Mental Health Bill was developed with the intention of repealing and replacing the Mental Health (Compulsory Assessment and Treatment) Act 1992 "so that it reflects a human rights-based approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment."⁷⁰ This was an important recommendation of the 2018 He Ara Oranga report. The Bill passed its first reading in 2024 and the Health Committee reviewed and reported to parliament with changes arising from public consultation in April 2025. However, progress

has been delayed and the Bill has not progressed to second reading as of April 2026. Therefore, the envisioned underpinning legislation has not yet been enacted.

For our first system performance monitoring report, we focused on progress towards human rights-based practices using measures of compulsory community treatment orders (CCTOs), young people admitted to adult inpatient units, and 'seclusion'.⁷¹ We heard from people with lived experience that reducing coercive practice is only one aspect of a human rights-based approach, and that promoting agency, integrating indigenous rights and providing safe alternative pathways are important to establish. However, data that would support monitoring of this wider approach is not currently collected. For this report we have retained the same three measures.

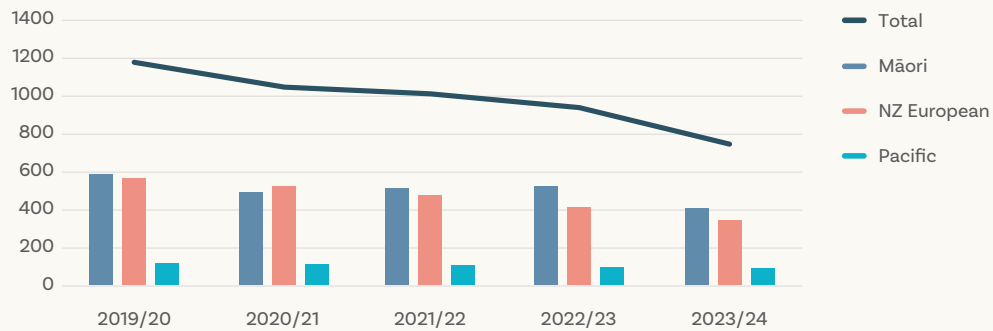
In future years we would like to monitor the use of restraint, as well as explore how human rights, indigenous rights and the agency of tāngata whaiora are upheld within the system.

70 Ministry of Health. 2025a. **Repealing and replacing the Mental Health Act**. Webpage. www.health.govt.nz/regulation-legislation/mental-health-and-addiction/repealing-and-replacing-the-mental-health-act. Accessed 17 February 2026.

71 We use the term 'seclusion' as it relates to terminology used in the Mental Health Act. 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.

‘Seclusion’

Figure 19: Number of people in mental health inpatient services subject to ‘seclusion’ by ethnicity



‘Seclusion’ is a type of restraint where a person is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit.⁷² While not the intended effect, ‘seclusion’ is often a traumatising experience for the ‘secluded’ person, whānau, visitors and health workers. The minimisation of ‘seclusion’ in mental health has been government policy for over a decade with the goal of reducing ‘seclusion’ rates in mental health and addiction adult inpatient settings to less than 3% by 1 June 2025.⁷³

In 2023/24, 755 people in inpatient services were subject to ‘seclusion’.⁷⁴ This includes ‘seclusion’ across adult services, youth services, forensic services and intellectual disability services. Despite decreases in the use

of ‘seclusion’ over time, the number of people subject to ‘seclusion’ remains too high.

The Ministry of Health report that Māori in adult inpatient services were 6.6 times more likely to be ‘secluded’ than non-Māori per 100,000 population. Pacific people were also ‘secluded’ in adult inpatient services at a higher rate per 100,000 population than other ethnic groups.⁷⁵ Inequities in ‘seclusion’ are of significant concern. We expect to see action toward reducing ‘seclusion’ for Māori and Pacific Peoples as a priority.

Significant regional variation in ‘seclusion’, including extended periods of zero ‘seclusion’ in some areas, shows what is possible.⁷⁶

72 Ministry of Health. 2023b. **Guidelines for Reducing and Eliminating Seclusion and Restraint Under the Mental Health (Compulsory Assessment and Treatment) Act 1992**. Wellington: Ministry of Health.

73 Te Tāhū Hauora Health Quality and Safety Commission. 2022. **Zero seclusion: Safety and dignity for all – change package**. Wellington: Te Tāhū Hauora Health Quality and Safety Commission.

74 This measure presents number of people subject to ‘seclusion’ using data manually validated by the Ministry of Health. Manual validation takes time, and as such, the most recent available data is for the 2023/24 year.

75 Ministry of Health. 2026b. **Office of the Director of Mental Health and Addiction Services: Regulatory Report** 1 July 2023 to 30 June 2024. Wellington: Ministry of Health.

76 Ministry of Health. 2026b. **Office of the Director of Mental Health and Addiction Services: Regulatory Report** 1 July 2023 to 30 June 2024. Wellington: Ministry of Health.

We want to see zero 'seclusion' as a reality, and priority given to addressing disparities in use of 'seclusion' on Māori and Pacific Peoples compared with other ethnic groups.

A quality improvement approach to eliminating 'seclusion' focuses on transparency and learning. We note the achievements of the Zero Seclusion Programme⁷⁷ coordinated since 2017 by Te Tāhū Hauora Health Quality and Safety Commission, the transfer of this function to Health New Zealand and the establishment of the Always Report and Review⁷⁸ process for reporting 'seclusion' from 1 July 2025.

Decreasing the use of 'seclusion' with the aim of elimination must continue to be a focus for improvement. We noted this in our December 2024 submission on the Mental Health Bill currently before parliament, along with our call for a sunset clause within the Bill with a set date for the elimination of 'seclusion'⁷⁹.

To enable accurate monitoring and reporting of 'seclusion' we need timely, accurate and high-quality data. We have used manually validated data from the Ministry of Health as used by the Office of the Director of Mental Health and Addiction in this report due to significant data quality concerns with seclusion reporting to the PRIMHD national collection. Data quality issues impact the system's ability to monitor and act on trends in seclusion in a timely way. We acknowledge there are several activities already underway with Health New Zealand and the Ministry of Health to address these data quality and timeliness issues in the regions and nationally. We will continue to monitor rates of 'seclusion' in our service and system performance reporting.

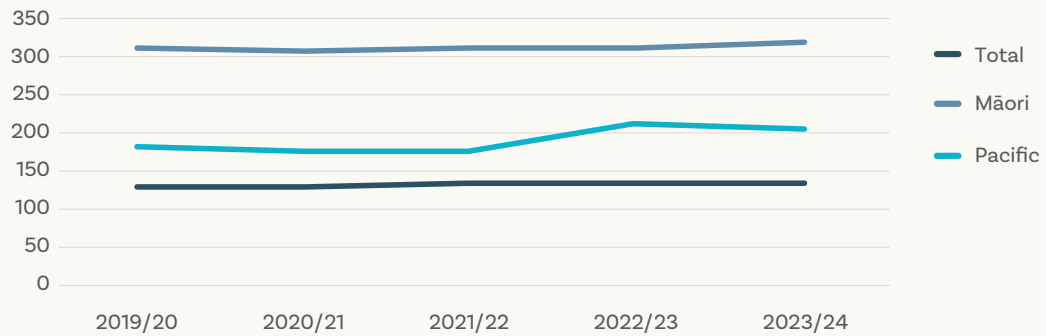
77 Bensemman C, Drummond J, O'Keeffe K, et al. 2025. **Closing the equity gap as we approach zero seclusion: Successes of the quality improvement project some doubted could be done.** *Australasian Psychiatry*. 2025;33(4):669-675

78 Te Tāhū Hauora Health Quality and Safety Commission. 2023. **Always Report and Review list.** Wellington: Te Tāhū Hauora Health Quality and Safety Commission.

79 Te Hiringa Mahara. 2024c. **Submission on the Mental Health Bill.** Submission: Wellington. www.mhwc.govt.nz/our-work/advocacy/our-submissions/. Accessed 13 April 2026.

Compulsory Community Treatment Orders

Figure 20: Rate per 100,000 population subject to a compulsory community treatment order



The number of people subject to a CCTO increased from 6987 to 7173 (a 2.7% increase) between 2022/23 and 2023/24. This equates to an additional person coming under a CCTO nearly every two days. This is part of an ongoing trend that shows a year-on-year increase in the number of people subject to CCTOs. Minimising compulsory treatment in community settings is a long-term goal for the system, yet the use of CCTOs has consistently increased, suggesting influences are at play that are not currently understood. Our previous work describes the impact CCTOs have on tāngata whaiora.⁸⁰

The rate of CCTOs among Māori is more than twice the total population rate. An increase has occurred in the number of Māori subject to CCTOs from 2884 in 2022/23 to 2928 in 2023/24 (a 1.5% increase).

CCTOs are also applied variably across health districts. Their use ranges from 48 per 100,000 to 205 per 100,000.⁸¹ The reasons for this wide

variation are not clear. In-depth analysis of practices and approaches in different districts to explore the factors behind this variation would support sharing of knowledge to address the differences at the local level.

We have heard from lived experience leaders that analysis of performance should also include how CCTOs fit into the wider system. It would be useful to know how well people leaving forensic units⁸² are able to access treatment in their own community, and how CCTOs are being used by practitioners – for example trends in the number of declined applications to end CCTOs, or how many complaints have been received about CCTOs and practices around them. This type of analysis combined with local level knowledge sharing would provide potential avenues for reduction in their use across the country.

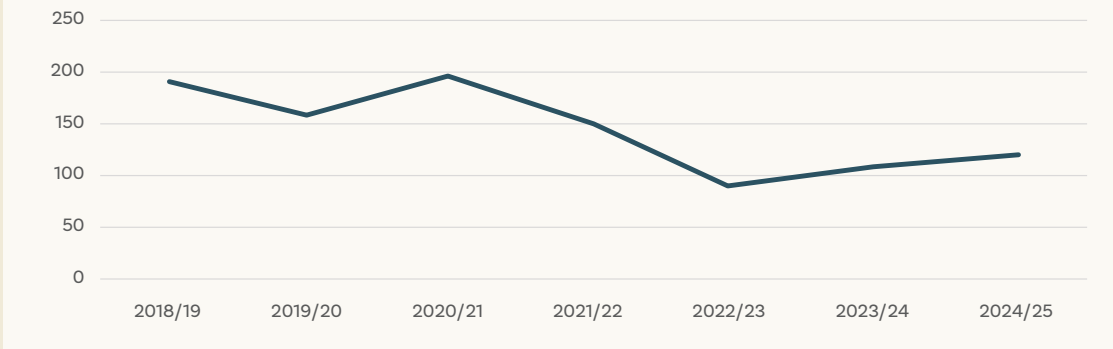
80 Te Hīringa Mahara—Mental Health and Wellbeing Commission (2023). **Lived experiences of compulsory community treatment orders**. Wellington: Te Hīringa Mahara New Zealand Mental Health and Wellbeing Commission.

81 Ministry of Health. 2026b. **Office of the Director of Mental Health and Addiction Services: Regulatory Report 1 July 2023 to 30 June 2024**. Wellington: Ministry of Health.

82 Forensic units are specialised services operating at the intersection of the criminal justice system and the healthcare system. They provide secure assessment, treatment, and rehabilitation for individuals with serious mental health conditions who are involved in or at risk of criminal offending.

Young people in adult inpatient units

Figure 21: Number of young people aged 12–17 years admitted to an adult inpatient service



In 2024/25, 120 young people (aged 12–17 years) were admitted to an adult inpatient service, an increase of 7.1% from 2023/24. This number had been reducing since 2020/21 but the trend appears to have changed. While the number of young people admitted to adult services is lower than previous years it is still concerning, and we advocate for no young people to be admitted to adult inpatient services. We understand it is occasionally necessary, for safety reasons, to briefly accommodate young people in adult units, with appropriate safeguards in place, prior to transfer to a specialist youth service.

We want to see zero admissions of young people to adult inpatient mental health services.⁸³ Youth-specific acute alternatives are lacking

in Aotearoa New Zealand. We have heard that for some young people, being admitted to an adult inpatient unit in their region and close to whānau and support networks is preferable to being moved to another part of the country. This should not be a choice anyone has to make.

Young people have told us they want to see a wider range of options to address youth mental health needs across Aotearoa New Zealand. These include more age-appropriate community-based services and alternatives to hospital-based inpatient mental health care; kaupapa Māori options to meet the needs of rangatahi Māori, and more youth-centric short-term respite services.

83 Te Huringa Mahara—Mental Health and Wellbeing Commission. 2023c. **Te Huringa Tuarua 2023: Youth services focus report - Admission of young people to adult inpatient mental health services | Pūrongo arotahi ratonga taiohi - Te whakauru i ngā taiohi ki ngā ratonga hauora hinengaro pakeke ā-hōhipera**. Wellington: New Zealand.

Discussion

Overall, the data we have measured paints a picture of stated intent to uphold human rights-based practices, which has been delayed by administrative challenges (delays in supporting legislation and changes to the administration of the Zero Seclusion programme). There is a lack of capacity within the system to provide consistent services when and where they are needed. These delays must be addressed urgently.

The ongoing use of coercive practices within the MHA system, and especially the disparities in coercive treatment of Māori and Pacific Peoples, are concerning. We know wide variation occurs in the rates of coercive practices between regions.⁸⁴

Minimising coercive practices requires system-wide change because factors outside the direct control of services influence their use. This includes staff availability (numbers, experience), support for infrastructure (availability and suitability of services and spaces that provide viable alternatives), culture and review practices, and the wider risk and protective factors of mental health that influence individual experiences of mental distress. Analysis of these factors in the context of different uses of coercive practices between regions will provide vital information to support improvement. We would like to see a nationally-coordinated approach informed by local understanding that facilitates knowledge and resource sharing supported by legislation and policy that clearly embeds and enables the goal of minimising coercive practices and eliminating 'seclusion'.



84 Ministry of Health. 2026b. **Office of the Director of Mental Health and Addiction Services: Regulatory Report 1 July 2023 to 30 June 2024**. Wellington: Ministry of Health.

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.

The mental health and addiction workforce is a vital part of the system. This shift focuses on four main areas that will support system transformation – diversity, professional development, sufficient staffing, and planning and investment. Tāngata whaiora tell us the ideal MHA workforce has the capability to understand and meet diverse needs and respond to complex social problems, while engaging with family and whānau.⁸⁵

The MHA workforce is a government focus and has been identified as an important priority in the Draft MHWS. Additionally, we note our 2024 recommendation that Health New Zealand develop a mental health and addiction workforce plan to address service capacity and workforce shortages⁸⁶ has been realised. The Government has set a mental health and addiction target

of 500 professionals per year entering training, with the expectation that this will lead to increased workforce numbers and capability when those people graduate. In our 2025 system performance monitoring, we reported small positive shifts across all workforce measures.

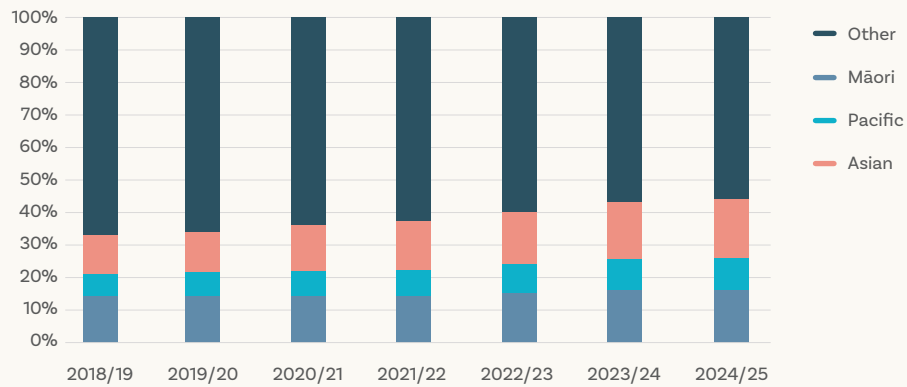
The measures we use to monitor the workforce were selected to reflect as closely as possible the aims of this shift within available data. However, we acknowledge that gaps in data mean aspects of the workforce such as resilience and responsiveness are currently not well measured. We also do not measure investment in training and development. In future we would like to include measures that support analysis of more complex aspects of workforce capacity and capability.

85 Te Hiringa Mahara—Mental Health and Wellbeing Commission. 2025e. **Monitoring mental health and addiction system performance in Aotearoa New Zealand: Our approach and initial findings**. Wellington: Te Hiringa Mahara.

86 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.

Percentage of Health New Zealand employees by ethnic group

Figure 23: Percentage of Health New Zealand employees by ethnic group

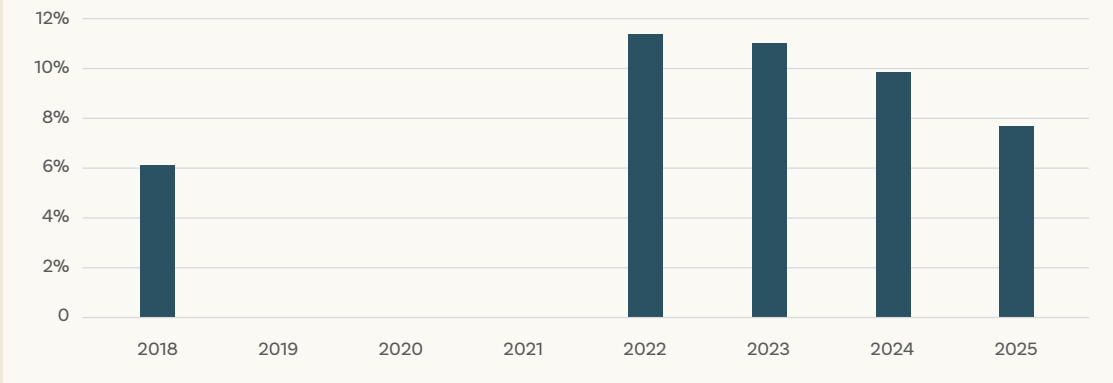


The ethnic diversity in the MHA workforce has been steadily increasing. It is now largely reflective of the wider population's ethnic group proportions, although not of those accessing specialist mental health and addiction services, 30% of whom are Māori. To achieve diversity that reflects the communities served, we would need to see a large increase in the Māori workforce.

Diversity is also not just about ethnicity. The workforce must also reflect gender, age, and other demographics such as sexuality or disability. We are pleased to see composition of the MHA workforces in relation to role type and representativeness, is included as a measure for the workforce priority in the Draft MHWS.

Workforce vacancy rate in mental health and addiction services

Figure 24: Vacancy rate in adult Health New Zealand mental health and addiction workforce



Vacancy rates among the Health New Zealand adult MHA workforce have dropped from a high of 11% in 2022 to 8% in 2025, but are still higher than levels recorded in 2018. The reduction in vacancy rates suggests more professionals are being recruited, however significant shortages still exist in some key roles, and this continues to drive challenges in meeting community needs. The vacancy rate for psychiatrists and senior

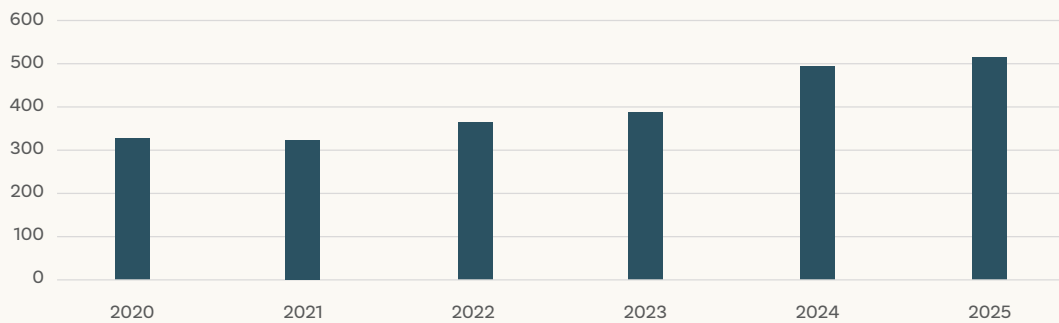
medical officers remained high in 2025 at 19.7%.⁸⁷ The child and adolescent mental health and addiction workforce continues to experience higher vacancy rates than adult services at 11% overall and 24% for psychiatrists in 2024.⁸⁸ Targeted training and support for roles where shortages exist, alongside investment in initiatives to improve attraction and retention of staff, should remain a priority.

87 Te Hiringa Mahara. 2026. **Access to mental Health and addiction services**. Infographic. Wellington: Te Hiringa Mahara.

88 Whāraurau. 2024. Stocktake Dashboard. Webpage: www.wharaurau.org.nz/all-workstreams/stocktake-dashboard accessed 20/2/2026.

Number of new mental health and addiction professionals entering training

Figure 25: Number of new mental health and addiction professionals entering training



The number of mental health and addiction professionals entering training has been increasing since 2021, with 514 people entering in 2025.

This is a positive change. However, the 2024 New Zealand Health Workforce plan acknowledges that people entering training does not equate to qualified people entering the workforce. It notes that in some programmes attrition is over 40%.⁸⁹ Information about how well increased training

is translating to qualified mental health and addiction staff filling vacancies in the workforce is not currently available.

Data that shows the number of people completing training and taking up roles in areas where shortages exist would provide a clearer picture of how this target to grow the mental health and addiction workforce is working.

89 Health NZ. 2024. New Zealand Health Workforce Plan. Wellington: Health NZ

Discussion

This year we have seen modest positive changes in workforce data with increasing ethnic diversity and decreasing vacancy rates, although different patterns are evident for some role types. The Health New Zealand adult MHA workforce (including vacancies) was similar to the total workforce in 2024 (7910 full time equivalent (FTE) in 2024 to 7897 FTE in 2025).⁹⁰ The workforce pipeline is also increasing with more MHA professionals entering training than in previous years.

While the data is positive overall, significant strain points still exist. Two areas of concern are continuing staff shortages in specific roles and retention.

The New Zealand Health Workforce Plan also notes that investment in systems infrastructure to support the workforce (such as rostering and payroll) will be vital for ensuring retention of staff. The Draft MHWS includes an action to implement targeted strategies to improve employment conditions and make the mental health and addiction sector an attractive place to work.

The Draft MHWS's priorities and actions for the workforce broadly align with what a transformed MHA workforce looks like. Tangible actions and a specific focus on workforce infrastructure, including systems infrastructure and digital technology, in the first three-year implementation plan from the draft MHWS would implement this strategic direction.



90 Te Hiringa Mahara—Mental Health and Wellbeing Commission. 2026. Access to mental Health and addiction services. Infographic. Wellington: Te Hiringa





Whakatepenga

Conclusion

It has been eight years since the publication of He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction. Over this time, we have seen worsening of some of the main factors that drove the Inquiry. People now report greater unmet need, higher rates of distress and poorer overall mental wellbeing at a population level than eight years ago.

We have, however, also seen significant positive change in the mental health and addiction system since this time, and a system reorienting to meet this need. The Access and Choice Programme, expanded telehealth options, growth of peer support, and progress towards zero 'seclusion' are all significant achievements of the past eight years.

Yet challenges remain. Young people, Māori, and Pacific Peoples continue to experience inequity across access, timeliness, quality, and outcomes. The MHA system remains under significant workforce pressure. Coercive practice continues, while modern legislation lags.⁹¹ Our six shifts, which are grounded in lived experience, guide system transformation by providing touchpoints to gauge progress and ensure strategies and policies remain focused on what is important to people.

Progress is being made towards the realisation of our six shifts, but more has been achieved in some areas than others. The realisation of lived experience potential has progressed with the growth of peer support, but clear pathways for training and professional development into lived experience leadership roles are not evident.

Those with the highest need are not currently being prioritised. The system is not meeting the needs of Māori, Pacific Peoples, and young people despite evidence clearly demonstrating that these groups need a higher level of support. We still lack data to support our understanding of service effectiveness. The government has committed to establishing a prevalence survey to better understand need, however more and better data is required to facilitate understanding of system performance.

Investment in primary prevention and early intervention has been clearly flagged as a government priority. Although improvement has occurred in the availability of supports for people with mild to moderate needs, this is early intervention rather than prevention, and it is unclear what investment in primary prevention is being made. We are also seeing worsening trends in key factors that affect mental health and wellbeing, with significant inequities in their impact on tāngata whaiora.

91 Te Hiringa Mahara. 2024c. **Submission on the Mental Health Bill**. Submission: Wellington. Accessed 13/4/2026 from www.mhwc.govt.nz/our-work/advocacy/our-submissions

In terms of equitable access to services and supports, we have seen improvements in wait times and faster access to services. However, these improvements are again not equitably distributed. Māori and young people continue to experience higher unmet need, and young people under 19 years in particular experience longer wait times, well below government timeliness targets.

In the past year we have seen increases in CCTOs and young people being admitted to adult inpatient units. Coercive practices including 'seclusion' are imposed upon Māori and Pacific Peoples at significantly higher rates than other demographics, and this is an ongoing trend. We currently appear to be moving away from the realisation of a MHA system that upholds human rights-based practices, and this area requires immediate attention.

Work towards realising a workforce with the capability, competencies, and capacity to meet needs now and in the future has been significant, and the MHA workforce is growing and strengthening. Planning and investment in this area are showing results, and we have reported small positive shifts across all of our workforce measures. Although areas of strain and staffing shortages still exist, overall the progress towards this shift is heartening to see.

Our monitoring this year shows progress toward system transformation, but with clear inequities present. Due to limitations in data we are unable to track people's experiences and outcomes at

a system level. This information would support better measurement of system performance and its impact on overall mental health and wellbeing.

In 2025, we called for the development of a national strategy that inspired hope. We are optimistic to see the direction of the Draft MHWS which makes important commitments to lived experience leadership, improved data, and to partnering with communities to meet their specific needs. To prove its worth it needs to be accompanied by a robust, tangible and adequately funded implementation plan. We need to see action and investment in three main areas: cross-agency responses to youth mental health, equity for Māori, and improved data and technology. We will be watching for this.

No system can respond to ever-increasing demand. Alongside transformation of the MHA system, we want to see transformation of the way government addresses the risk and protective factors of mental health and wellbeing. A public mental health approach - mental health and wellbeing in all policies - is vital for reducing the prevalence of distress.

Significant groundwork has been done in the past year, but much is still to be achieved, and progress remains uneven. Now is the moment to act boldly, fund the implementation of the new Mental Health and Wellbeing Strategy sufficiently, and plan effectively to deliver real change for Māori, Pacific Peoples, young people, and everyone who relies on the mental health and addiction system.



Ngā whanake

Next steps

We will be moving our system performance monitoring in-depth reporting to a two-yearly cycle following this report. Our next full report, in June 2028, will facilitate a deeper analysis of the main issues and trends.

We will make relevant wellbeing, mental health and system performance and service measures available annually through our Mental Health and Wellbeing Dashboard which will be released in 2027. This will be accompanied by a shorter infographic on key system performance measures on an annual basis.

We acknowledge the limitations of the data we have access to for system performance monitoring and will continue to work to

expand the way we understand and measure performance, alongside advocacy for better data capture and use.

We will monitor the recommendations we have made in this report along with our previous recommendations. We will make this monitoring information publicly available on our website to provide information for transparency and to hold the system to account.



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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.	PRIMHD	Extract date of 26 October 2025.	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		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 roles.	www.mhwc.govt.nz/our-work/mental-health-and-addiction-system/peer-support-workforce-paper-2023
2	Mental health and addiction specialist services access rates for Māori, Pacific Peoples and youth populations as a proportion of the total population.	PRIMHD	Extract date of 26 October 2025.	Mental health and addiction service monitoring 2026 downloads Te Hiringa Mahara—Mental Health and Wellbeing Commission
	Number of people using Access and Choice mental health and addiction services (IPMHA, Kaupapa Māori, Pacific Peoples and youth services).	Health New Zealand Te Whatu Ora	IPMHA - total people seen. Kaupapa Māori, Pacific Peoples and youth services - 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		Our monitoring dashboard Te Hiringa Mahara—Mental Health and Wellbeing Commission

Shift	Measure	Source	Notes	For more information
3	Wait times for Access and Choice mental health and addiction services (percentage 1 week).	Health New Zealand Te Whatu Ora	IPMHA services only. Does not include Tairāwhiti Access and Choice Services. Reporting referral date prior to 1 October 2024 was not mandatory.	Mental health and addiction service monitoring 2026 downloads Te Hīringa Mahara—Mental Health and Wellbeing Commission
	Wait times for national mental health and addiction telehealth services (minutes).	Whakarongorau	Combines 1737 Need to Talk, Mind and Body Peer Support, Depression, Alcohol and Other Drugs, and Gambling call services.	Our monitoring dashboard Te Hīringa Mahara—Mental Health and Wellbeing Commission
	Tāngata whaiora in independent or supported living.	PRIMHD	This data is sourced from the Supplementary Consumer Record (SCR). SCR reporting compliance is low and affects the accuracy and completeness of this measure.	Our monitoring dashboard Te Hīringa 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 affects the accuracy and completeness of this measure.	Our monitoring dashboard Te Hīringa Mahara—Mental Health and Wellbeing Commission
	Investment in prevention, promotion and early intervention as a proportion of total mental health and addiction expenditure.	Health New Zealand Te Whatu Ora	Prevention includes mental wellbeing promotion and suicide prevention. Early intervention includes both services that intervene early during distress (such as primary MHA) and services that intervene early in the life course (such as maternal, infant, child and youth specialist services). This 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

Shift	Measure	Source	Notes	For more information
4	Wait times for specialist mental health and addiction services (percentage within three weeks).	Health New Zealand Te Whatu Ora	This data may not line up with published target data, because it uses different extraction dates.	Mental health and addiction targets
	Wait times in emergency departments for mental health presentations.	Health New Zealand Te Whatu Ora	Data was extracted on 11 November 2025. Four level 2 Emergency Department facilities (Clutha Health First, Gore Health Limited, Manioto to and Wanaka after hours) are excluded from the result calculation. This data may not line up with published target data, because it uses different extraction dates.	Mental health and addiction targets
	Rates of unmet need for professional mental health help.	Ministry of Health Manatū Hauora	Adult age range is 15+ years. This question was not part of the New Zealand Health Survey between 2017/18 and 2020/21.	NZ Health Survey 2024/25 mental health and substance use data summary downloads Te Hiringa Mahara—Mental Health and Wellbeing Commission
5	Number of people in inpatient units subjected to 'seclusion'.	Ministry of Health Manatū Hauora	This data shows the number 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.	Our monitoring dashboard Te Hiringa Mahara—Mental Health and Wellbeing Commission
	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).	Our monitoring dashboard Te Hiringa Mahara—Mental Health and Wellbeing Commission
	Number of young people admitted to an adult inpatient unit.	PRIMHD	Young people aged 12-17 years.	Youth services focus report Te Hiringa Mahara—Mental Health and Wellbeing Commission

Shift	Measure	Source	Notes	For more information
6	Proportion of Māori, Pacific, Asian and other ethnic groups (including European) in the Health New Zealand Te Whatu Ora adult mental health and addiction services workforce.	Te Pou	Health New Zealand Te Whatu Ora workforce only.	Our monitoring dashboard Te Hiringa 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 Health New Zealand Te Whatu Ora and non-governmental organisation services.	Our monitoring dashboard Te Hiringa Mahara—Mental Health and Wellbeing Commission
	Number of new mental health and addiction workforce training places.	Health New Zealand Te Whatu Ora	The definition ‘Train 500 mental health and addiction professionals each year’ includes clinical psychology interns, new entry to specialist practice nurses, occupational therapists, social workers and stage one psychiatry registrars.	Mental health and addiction targets

Mental Health and Wellbeing Outcome Measures

Mental Health and Wellbeing monitoring

Measure	Source	Notes	For more information
Life satisfaction.	Ministry of Health Manatū Hauora	NZ Health Survey 2024/25.	Annual Update of Key Results 2024/25: New Zealand Health Survey Ministry of Health NZ
Mental wellbeing.	Stats NZ	General Social Survey 2023.	Wellbeing statistics: 2023 (updated) Stats NZ

Measure	Source	Notes	For more information
Psychological distress.	Ministry of Health Manatū Hauora	NZ Health Survey 2024/25: High or very high levels of psychological distress (K10 score 12+ out of 40) in the past 4 weeks.	Annual Update of Key Results 2024/25: New Zealand Health Survey Ministry of Health NZ
Hazardous drinking.	Ministry of Health Manatū Hauora	NZ Health Survey 2024/25: Hazardous drinking pattern (AUDIT score of 8 or higher), among past-year drinkers.	Annual Update of Key Results 2024/25: New Zealand Health Survey Ministry of Health NZ
Accidental drug overdose deaths.	New Zealand Drug Foundation	Reporting is by calendar year, 2024.	Overdose deaths 2016–2024 – New Zealand Drug Foundation

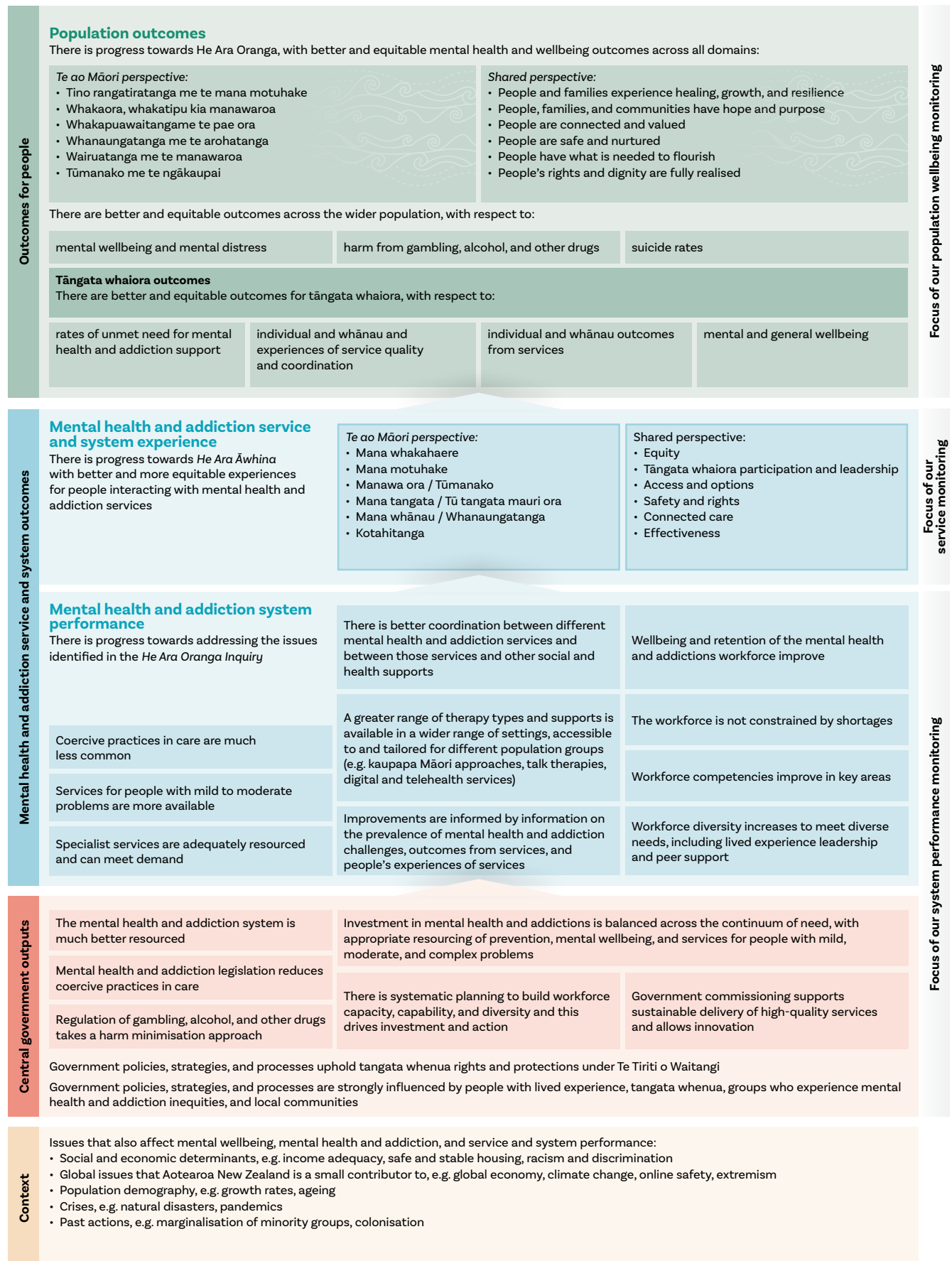
Suicide and self-harm monitoring

Measure	Source	Notes	For more information
Suicide rate.	Health New Zealand Te Whatu Ora	2020/21	Suicide data web tool
Suspected self-inflicted death rate.	Chief Coroner	2024/25	Suicide data web tool
Number and rate of people hospitalised for intentional self-harm.	Health New Zealand Te Whatu Ora	2024/25 Sourced from National Minimum Dataset. Reflects number of people, not number of events.	
Ambulance attendances for self-harm.	Health New Zealand Te Whatu Ora	Data supplied by Hato Hone St John and Wellington Free Ambulance.	
Police attendances for threatened or attempted suicide (1X).	New Zealand Police	2024/25	

Appendix B – Taurira arorau

Line of sight logic model

This logic model outlines the main links between central government actions and their intended mental health and wellbeing outcomes.





Appendix C – Tikanga mahi

Population measures methodology

Currently, no standard international set of population mental health and wellbeing outcome measures exists. We considered 16 population mental health and wellbeing measurement frameworks from six countries, as well as Organisation for Economic Co-operation and Development measures and World Health Organisation reports. These were compared with population mental health and wellbeing

data sources from Aotearoa New Zealand, and the most commonly-reported measures across all of these sources were identified. Life satisfaction was the most commonly-reported measure that was not already included in our existing measure set and for which we could obtain data that met our selection criteria. Thus, we have added it to our population set.



Appendix D – Rārangi kupu

Glossary

A common language is required so we talk with each other, not past each other. Te Hiringa Mahara –Mental Health and Wellbeing Commission seeks to champion a common language across all its 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 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 tāngata whenua and tāngata tiriti as citizens of Aotearoa. The duality of the frameworks reflects the role that tāngata whenua and tāngata Tiriti have in 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 experience can be current, recent, or in the past. For Te Hiringa Mahara, ‘lived experience’ relates to personal experience of distress and/or 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. 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 versus system and/or 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 services 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 (MHA system) – The context within which the range of mental health and addiction services operate – the health structures, strategies and policies, plans, and 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 from gambling (or a combination of these). Tāngata whaiora include people who have accessed or are accessing supports and services, including people who want mental health or addiction support but are not accessing supports or services.

Wellbeing – A holistic and multi-faceted concept to describe peoples' 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.



