Te Hiringa Mahara | Mental Health and Wellbeing Commission

What matters for mental wellbeing:

Analysis of factors related to mental wellbeing for tāngata whaiora

May 2026

What matters for mental wellbeing: analysis of factors related to mental wellbeing for tāngata whaiora

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

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

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Disclaimer

Access to the data used in this study was provided by Stats NZ under conditions designed to give effect to the security and confidentiality provisions of the Data and Statistics Act 2022. The results presented in this study are the work of the author, not Stats NZ or individual data suppliers.

These results are not official statistics. They have been created for research purposes from the Integrated Data Infrastructure (IDI) which is carefully managed by Stats NZ. For more information about the IDI please visit www.stats.govt.nz/integrated-data.

Whakarāpopoto | Summary

Te Hiringa Mahara has a unique role to monitor wellbeing outcomes for people in Aotearoa, NZ which we do using our *He Ara Oranga wellbeing outcomes framework*. Wellbeing outcome monitoring at a population level responds to our priority to monitor cross-government contribution to mental health and wellbeing. We have more recently shifted our focus to monitoring wellbeing outcomes for people with lived experience of mental distress and addiction, or tāngata whaiora. This is the second year we have published monitoring data on outcomes for people with lived experience of mental distress and addiction[1]. We have five years of wellbeing outcome monitoring including for groups with highest mental health need including Pacific peoples (2023) and young people (2024).

For the first time this year, we wanted to gain deeper insights to identify factors that are associated with improved **mental wellbeing**[2] outcomes for tāngata whaiora. Our aim is to focus cross-government action and effort toward tangible improvement in a small number of factors that are strongly associated with mental wellbeing and to proactively improve outcomes.

Key findings from our wellbeing outcome monitoring paint a picture of a lack of improved population level mental health and wellbeing outcomes

- Over the 5 years from 2018, there has been no improvement across a range of wellbeing outcomes for people who interact with mental health and addiction (MHA) services.
- A lack of progress on improved mental health and wellbeing outcomes are especially persistent for Māori, young people, LGBTQIA+ people, Pacific people, people who interact with MHA services and disabled people.
- People who interact with MHA services experience several barriers to improved wellbeing.

This year we have analysed the relationship between a range of factors and overall **mental** wellbeing to inform action.

- Good self-reported health; social connection and whanaungatanga; and material wellbeing are three factors that are most strongly associated with better wellbeing outcomes.
- These findings, coupled with the rising demand for mental health support and persistent inequities in outcomes faced by people who interact with mental health services, show that specific action is needed.
- While our focus is on people who interact with mental health and addiction services in this analysis, the same relationships are evident for the wider population – showing that effort that is good for tāngata whaiora can be expected to be good for the wider population.

[1] In the absence of an adult mental health prevalence survey, health data from government surveys has been used to define people with lived experience of mental distress and addiction for our monitoring. We used data on specialist services, hospitalisations, and pharmaceuticals to flag for interactions with MHA services from the Integrated Data Infrastructure (IDI) to develop a cohort of being who interact with MHA services.

[2] Mental wellbeing, in this analysis, is measured using the WHO-5: an internationally-recognised aggregate measure which is collected in the General Social Survey. It is made up of 5 questions: How often in the last two weeks have you felt: cheerful and in good spirits; calm and relaxed; active and vigorous; woken up feeling fresh and rested, felt your daily life has been filled with things that interest you?

Changes we want to see

Our ongoing work, as outlined in this report, will explore the opportunities to improve mental wellbeing in greater detail, but in short:

- We want to see mental wellbeing outcomes make up part of the decision-making in the systems that support health, social connection, and material wellbeing.
- We also want to see the mental health and addiction system and services better support the health, social and material wellbeing of people who interact with their services.

While examples of cross-sector work exist, and some are highlighted in this report, achieving the vision of 2018's *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* will require greater uptake and system-level support.

To support this, we will convene a cross-government forum, led by people with lived experience, in early 2027 to share and advocate for cross-government action on the wellbeing priorities of people with lived experience.

Takenga | Background

Our wellbeing outcome monitoring

Te Hiringa Mahara | Mental Health and Wellbeing Commission has a legislated role to assess and report on mental health and wellbeing outcomes at a population level and the factors that affect them[3]. Through our ongoing body of work, Te Hiringa Mahara continues to support the vision and intent of the 2018 *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction.* This includes our strategic direction to focus on supporting improved mental health and wellbeing outcomes for tāngata whaiora[4], whose advocacy in the Inquiry called for the establishment of the Mental Health and Wellbeing Commission.

Tāngata whaiora have helped us understand what is most important for wellbeing, through the development of *He Ara Oranga wellbeing outcomes framework*, which was built on the views and input of tāngata whaiora and is the basis for how Te Hiringa Mahara understands wellbeing. This understanding has guided our wellbeing outcomes monitoring work over the 5 years since the Commission's establishment.

In 2021, we drew on the He Ara Oranga framework to publish our first wellbeing monitoring report, Te Rau Tira[5], which highlighted that many communities experience significantly poorer wellbeing, and that greater wellbeing will require recognising the causes of poor wellbeing, identifying new ways of working in response, and seeking to implement them.

Between 2022 and 2025 we published a series of wellbeing reports[6], looking at the wellbeing and COVID-19 pandemic experience of priority populations (including Pacific people, rangatahi and young people, older people, Māori, and rural populations). These reports highlighted that more and better cross-agency effort is needed to support mental health and wellbeing and address inequity. They also highlighted examples of effort at a community-level that supports wellbeing.

At the same time, our mental health and addiction service and system monitoring reports have shown the pressure that services face, in line with global trends of increasing levels of distress and growing demand for services, particularly for young people (1).

Across our work we have seen that improving access to effective mental health and addiction services and supports needs to be complemented with action to reduce the demand on the mental health and addiction system and support broader wellbeing of people who interact with those services. Supporting people who interact with mental health and addiction services requires understanding and further support of longer-term wellbeing of people who interact with services.

Last year we published our first wellbeing outcomes monitoring report focused on people who interact with mental health and addiction services[7]. The 2025 report used data from 2018 and 2021

[3] Our legislated functions include the function to assess and report publicly on the mental health and wellbeing of people in New Zealand; on factors that affect people's mental health and wellbeing; and on the effectiveness, efficiency, and adequacy of approaches to mental health and wellbeing.
[4] Tāngata whaiora translates as 'people seeking wellness", and here describes individuals with lived experience of mental distress and/or those using mental health and addiction services
[5] https://www.mhwc.govt.nz/news-and-resources/te-rau-tira-wellbeing-outcomes-report/
[6] https://www.mhwc.govt.nz/our-work/wellbeing/
[7] https://www.mhwc.govt.nz/our-work/wellbeing/wellbeing-assessment-people-who-use-services/

and highlighted that people who interact with mental health and addiction services experience poorer wellbeing outcomes across a range of indicators. For example:

- People who interact with services have lower household income, poorer physical health, and experience higher discrimination.
- They are less likely to have good individual and family wellbeing and access to protective factors such as social connection.
- Inequities are especially pronounced for people who interact with specialist mental health and addiction services, disabled people and people who identify as lesbian, gay or bisexual.

Purpose of this year's monitoring and additional analysis

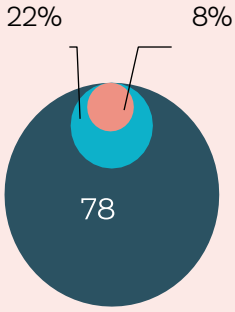
Building on the 2025 analysis, people who interact with services are the focus of two reports published in May 2026:

1. **A monitoring report**[8] that updates our report from 2025, and shows that inequities in outcomes, across a range of measures, persist for people who interact with services.
2. **This factor report**, which seeks to take these insights one step further, highlighting that some factors are more strongly associated to mental wellbeing overall. In doing so, it will help us prioritise our future assessments, reporting, recommendations and advocacy – and will help government agencies and other bodies to prioritise their own efforts.

These reports will be followed by projects to bring together agencies, NGOs, and other stakeholders with tāngata whaiora to shape ongoing effort to support wellbeing and mental health outcomes – and to monitor the results.

Our approach

For our reporting on outcomes for people who interact with services, we analysed wellbeing outcomes for three groups of people. These were:



- The **'specialist services'** group: people who interacted with specialist mental health and addiction services in the five years before their participation in the survey (~8% of respondents – equivalent to 337,000 adults in 2023).
- The **'any services'** group: people who interacted with primary or secondary health care for mental health reasons, and /or interacted with specialist mental health and addiction services in the five years before their participation in the survey (~22% of respondents – equivalent to 894,000 adults in 2023).
- The **'no services'** group: people who didn't interact with any of these specified mental health and addiction services in the five years before their participation in the survey (~78% of respondents – equivalent to 3,081,000 adults in 2023).

[8] http://www.mhwc.govt.nz/wellbeing/improving-wellbeing-outcomes-for-tāngata-whaiora

Ā mātou tātari | Method

We know from our monitoring, research and from what our lived experience communities tell us, that people who experience mental distress and addiction face inequities in wellbeing outcomes. Through the analysis in this report, we have sought to understand which factors related most strongly to overall mental wellbeing, in order to help prioritise cross-government effort to improve outcomes for people with lived experience.

This analysis builds on a range of international and New Zealand research (2) (3) (4) (5), which has tended to use life satisfaction as the outcome measure for a wider population. We have applied this method to understanding wellbeing outcomes for tāngata whaiora, identified here as people who have interacted with specialist mental health and addiction services, using meaningful wellbeing outcomes.

For this analysis, we have focused on findings for people who access specialist services. While not representative of the full population of tāngata whaiora, it provides a clearly defined population in the IDI data. As indicated by the findings in our assessment report, the wellbeing experience of the wider 'any services' group sits in-between the 'specialist services' and 'no services groups', and each of the relationships highlighted in this report (except where indicated otherwise) also hold for the wider population who have not interacted with MHA.

Through this analysis, we are seeking to fill three gaps in the existing literature and make available analysis for tāngata whaiora. Objectives of this specific report and analysis includes:

- Deeper insights on wellbeing outcomes from implementation of the He Ara Oranga wellbeing outcomes framework, rather than others such as the Living Standards framework. He Ara Oranga wellbeing outcomes framework was built on the views and input of tāngata whaiora and is the basis for how the Commission understands wellbeing and promotes alignment between entities involved in mental health and wellbeing.
- Analysis focused on the experience and outcomes of tāngata whaiora as the population of interest. This places people with lived experience at the centre of our work.
- Analysis of the relationship between factors and mental wellbeing[9], rather than life satisfaction. This keeps the spotlight on mental health and wellbeing and supports us to promote alignment and influence for positive change.

What we did

Building on our method developed for our 2025 outcomes monitoring report, we looked at three groups of people who completed national surveys, using anonymised linked data in from the Statistics New Zealand Integrated Data Infrastructure (IDI)[10]: those who have interacted with specialist MHA services; those who have interacted with any services for mental health and addiction reasons; and those who have not interacted with any services for mental health or

[9] Mental wellbeing, in this analysis, is measured using the WHO-5: an internationally-recognised aggregate measure which is collected in the General Social Survey. It is made up of 5 questions: How often in the last two weeks have you felt: cheerful and in good spirits; calm and relaxed; active and vigorous; woken up feeling fresh and rested, felt your daily life has been filled with things that interest you?
[10] The Integrated Data Infrastructure (IDI) is a large research database. It holds de-identified microdata about people and households. For this analysis, we drew on anonymised IDI data sourced from surveys and from health records. For more information see our methodology paper linked below.

addiction reasons, as identifiable in the data (as described in the box above). While not representative of the full population of people who are experiencing distress these groups provide the best proxies available to us in the IDI. Because the key data source for this analysis is the General Social Survey, the population in the analysis is aged over 15 years. Outcomes for children are not included in this data. For a fuller description of the methodology please see our related paper[11].

Terminology

Through our reporting, we seek to understand and support the wellbeing of **tāngata whaiora, or people with lived experience** of mental distress.

- In the data available for this analysis, the best way we can identify people with lived experience is by looking at data related to **people who interact with mental health and addiction services**. This is the population of focus of our analysis.

To understand how to support wellbeing, we look at a range of **factors that affect wellbeing**. These are broad, and the overarching factors discussed in this report relate to health, social connection and material wellbeing.

- To identify and analyse these factors that affect wellbeing, we draw on a set of **wellbeing indicators** – these are identifiable data points (such as responses to survey questions), available in the IDI, and represent the factors we are investigating.

In summary, to understand and improve the factors that affect the wellbeing of people with lived experience, we have analysed wellbeing indicators reported or experienced by people who interact with mental health and addiction services.

Using the IDI allows us to access and analyse indicators of a variety of wellbeing factors within our defined groups, forming the basis for our approach and analysis. With a focus on people who have interacted with specialist MHA services, we have analysed the statistical associations between a range of indicators of wellbeing and overall mental wellbeing. Our analysis identifies indicators that are strongly associated with better mental wellbeing for people who interact with services, to guide effort on to support wellbeing.

We report against 17 indicators in this report. Indicators that produced statistically significant results for people who interact with specialist services were included. This means we have reasonable confidence that these indicators have a relationship with mental wellbeing for that group.

The analysis results for each of the groups described, as well as related to different years of survey data, and for Māori only. Unless otherwise specified, the findings presented in this report use data for the 2018, 2021, and 2023 years together, to increase the sample size and therefore our confidence in the results.

[11] *Factors that affect mental wellbeing for people who have interacted with mental health and addiction services Methodology repo rt and data appendices* at www.mhwc.govt.nz/wellbeing/improving-wellbeing-outcomes-for-tāngata-whaiora

We brought together quantitative analysis, our wellbeing outcome findings, literature and published research as well as and the advice of members of the lived experience / tāngata whaiora community, who provided much needed insight and real-world interpretation of our analysis and findings.

Lived Experience Expertise

The indicators analysed in this report are drawn from the He Ara Oranga wellbeing outcomes framework, which was designed in 2020 with lived experience expertise. Indicators were selected for the framework with lived experience expertise, to support monitoring – including our first outcomes monitoring report in 2021, Te Rau Tira (6).

We selected indicators from that list for our 2025 outcome monitoring report, co-designed with a Lived Experience Data Reference Group we convened for that purpose. The indicators selected were reported on in June 2025, and again in May 2026. The Lived Experience Data Reference Group was reconvened in late 2025 to support the design, interpretation and analysis of the findings of this 2026 report. The authors wish to extend their gratitude to this group, for providing analysis and understanding, as well as explanation of the real-world experience of what the data shows us.

We will be convening a cross-government forum, led by people with lived experience, in early 2027 to share this knowledge, with a focus on bringing multiple knowledge streams together to understand what people with lived experience need cross-government action on. This will go on to inform our work to monitoring cross-government contribution to improved mental health and wellbeing.

Interpreting the findings

We present findings from both this analysis and the assessment of wellbeing from the associated report. We also use published literature on mental health and wellbeing and the advice of members of the lived experience / tāngata whaiora community to interpret findings.

In this report, we compare the odds of having good mental wellbeing between groups using odds ratios, making statements like, ‘people with the right amount of contact with whānau had 2 times higher odds of good mental wellbeing compared to people with too much or too little contact’. In this statement, the odds ratio is 2. Odds ratios greater than one show that a group has a higher likelihood of good mental wellbeing than the comparison, while odds ratios less than one show that the group has a lower likelihood.

Our statistical analysis showed that all of the odds ratios in this report were significantly different from 1, meaning that we can be reasonably confident that they demonstrate a relationship between the indicator and mental wellbeing, when other indicators are controlled for. But odds are not the same as proportions. For example, if 4 out of 5 people in a group have good mental wellbeing, the odds of good mental wellbeing is 4 to 1 (or 4), while the proportion is 0.8.

Ngā Kitenga | Findings

Good self-reported health had a very strong relationship with mental wellbeing.

Of people who interact with specialist mental health and addiction services:

People who have good self-rated health had **3.9 times higher odds of good mental wellbeing**, compared to people who interact with specialist services and don't have good self-rated health.	Māori who have good self-rated health had **4.3 times higher odds of good mental wellbeing**, compared to Māori who interact with specialist services and don't have good self-rated health.

The analysis shows that people who interact with specialist services and have good self-reported health had 4 times higher odds of good mental wellbeing.

However, people who interact with specialist services are much less likely to report good health than the wider population. This is consistent with the findings of other research which shows life expectancy gaps for people who experience mental distress and addiction, highlighted in the He Ara Oranga Inquiry, and the work of Equally Well – a collaborative movement focused on physical health equity for people who experience mental health and addiction issues[12].

The proportion of people who report good, very good, or excellent **self-rated health** in 2023

Specialist services	No Service
63%	85%
69% in 2021	86% in 2021
71% in 2018	89% in 2018

We know that inequities in health outcomes for people who interact with services or experience mental health and addiction issues present in a number of ways:

- Internationally, people who access mental health and addiction services have been shown to have more than twice the premature mortality rate of the general population, and their life expectancy can be reduced by up to 15 years (7) (8). Two-thirds of these premature deaths are due to preventable, treatable physical health issues (9).
- We know, from research, that people who experience mental health and addiction issues have significantly higher rates of physical health issues than their counterparts in the general population, including cardiovascular disease, diabetes, oral health problems, and respiratory diseases. Cardiovascular disease is the most common cause of death amongst people who experience mental health issues (10) (11) (12).
- People who experience mental health and addiction issues have worse cancer outcomes than the general population, despite having similar prevalence rates for some cancers. Later diagnosis has been identified as an important contributing factor to worse survival rates (13) (14).

[12] equallywell.co.nz

- ‘Diagnostic overshadowing’, where health providers attribute physical health issues to mental health conditions of tāngata whaiora, affects the quality of physical health support received, as does experience of a range of barriers to accessing quality care, including experiencing discrimination. (15)

Our focus on people who interact with services makes clear the need for action across the mental health and addiction, and wider health systems. Our analysis shows association between self-reported good health and mental wellbeing, not causation, and we know that the link between mental wellbeing and good health is a two-way relationship.

Feedback from people with lived experience underscores the complex nature of this relationship – not only is good health necessary for good mental wellbeing, self-reported health is impacted by many aspects of experiencing mental distress or accessing mental health and addiction services. Examples cited include: the physical health impacts of medications used to treat mental health and addiction symptoms; the effects of substance use or misuse; self-stigma and its impact on how people view their own health; and the physical impacts of specific forms of disorders, including eating disorders.

We recognise that survey respondents’ understanding of ‘good health’ may include elements of mental health, not just physical health. In response to this, we ran the model with, and without, the effects of good health accounted for, in case an overlap in how survey respondents thought of physical health and mental affected the results[13]. The findings of that analysis altered the ‘odds ratio’ value a small amount, but did not affect the overall findings of the analysis.

A bundle of social connection factors are strongly associated with mental wellbeing

Of people who interact with specialist mental health and addiction services:

People who report little or no loneliness had **2.7 times higher odds of good mental wellbeing**, compared to those who do feel more lonely

Those who report high levels of trust in others had over **1.9 times higher odds of good mental wellbeing**, compared to those who don’t report high levels of trust

People who say it would be easy or very easy to talk to someone if they felt down or a bit depressed had **2.2 times higher odds of good mental wellbeing**, compared to those who don’t find it easy

[13] For more detail on the iterations of the model, see our separate methodology paper at www.mhwc.govt.nz/wellbeing/improving-wellbeing-outcomes-for-tāngata-whaiora

However, people who interact with specialist services are more likely to report loneliness, and less likely to report trust and having people to talk to.

The proportion of people **who felt lonely none or a little of the time in the last 4 weeks,** in 2023

65%
Specialist services
68% in 2021
64% in 2018

85%
No Service
85% in 2021
87% in 2018

The proportion of people **who rate general trust in other people as 7 or more out of 10,** in 2023

43%
Specialist services
46% in 2021
48% in 2018

62%
No Service
68% in 2021
68% in 2018

The proportion of people **who feel it would be easy to talk to someone if they felt down,** in 2023

54%
Specialist services
51% in 2021
55% in 2018

69%
No Service
64% in 2021
70% in 2018

Social connection is relevant because it is a protective factor for mental wellbeing:

- International evidence shows that a lack of social connection poses a significant risk for individual health and longevity. Loneliness and social isolation has been shown to increase the risk of premature death by 26% and 29% respectively; and lacking social connection can increase the risk for premature death as much as smoking up to 15 cigarettes a day (16)
- Social support, community belonging, and trust in others have been shown to be significantly associated with mental health outcomes. “Perceived emotional support and family/friend network size were identified as protective factors against common mental health disorders, personality dysfunction, and psychotic experiences [and] may be particularly important for populations such as migrants, refugees, and transgender individuals” (16)
- It is important to distinguish social disconnection from loneliness. Social disconnection is based on the objective quantity of the interactions: people may feel lonely even when surrounded by friends and family. Social disconnection refers to an objective, long-standing lack of social/family relationships and minimal participation in social/family activities. Taken together, loneliness and social disconnection have been a significant and growing concern for a number of years; however, it is now being more widely recognised as a critical public health issue (17).

Again, there is a two-way relationship evident between social connection and mental wellbeing. Evidence shows that loneliness is associated with increased risk for anxiety, depression, and dementia (18).

People with lived experience told us that ‘connection is a prerequisite for wellbeing’, and that trust can underpin much of the success or failure of mental health treatment.

They also identify trust as a key factor in the success of peer support services – where engaging with people with lived experience, who share their own experiences, builds mutual kinship. This can be particularly effective for some tāngata whaiora who have had negative experiences with clinical services in the past. Such peer services build upon the efforts of the lived experience workforce movement, their innovation and their activism, and support effective services through blurring the binary of tāngata whaiora on one side and service providers on the other.

On the other hand, the experience of mental distress or accessing mental health and addiction services can damage or sever social connection. People with lived experience told us about the sense of 'not wanting to be a burden' that can cause people to be less likely to reach out for help when they need it. They told us about the way that accessing mental health and addiction services can disrupt their lives in very real ways, particularly when entering in-patient services – ending employment, accommodation, and personal relationships.

From a Te Ao Māori perspective, whanau-related indicators complement other indicators of social connection

All the findings in this report apply for Māori, but taking a Te Ao Māori view of wellbeing highlights further relationships. Using Te Kupenga data from 2018, for Māori who interact with specialist services:

Those who report having 'the right amount' of contact with whānau had **2 times higher odds of good mental wellbeing**, compared those who have too little or too much contact

Those who report their whānau are doing well had **1.9 times higher odds of good mental wellbeing** as Māori who interact with services but whose whānau aren't doing well

Those who find it easy to find support in times of need had **1.9 times higher odds of good mental wellbeing**, compared to those who do not find it easy to find support

While there is a clear relationship between these whānau and connection factors and mental wellbeing, Māori who interact with specialist services are less likely to report it is easy to find

The proportion of Māori **who report having the right amount of contact with whanau,** in 2018

63% Specialist services

66% No Service

The proportion of Māori **who report their whanau are doing well,** in 2018

64% Specialist services

75% No Service

The proportion of Māori **who find it easy to find support in times of need,** in 2018

61% Specialist services

75% No Service

support, and less likely to report their whānau are doing well, than Māori who don't interact with specialist services[14].

Having strong family relationships, good social support and being able to manaaki others may help protect Māori from social isolation or loneliness (19).

This is reflected in the finding that being involved in iwi environmental planning and decision-making is strongly related to mental wellbeing, though the number of people who are involved in this way is small. This indicator likely reflects a broader set of protective factors relating to social connection, whakapapa, and whanaungatanga.

Māori who interact with specialist services and had been involved in iwi or hapu decision-making or environmental planning had 3.2 times higher odds of good mental wellbeing, compared to Māori who interact with specialist services but had not had that involvement.

Whānau connection is relevant because, like for the social connection under the shared perspective, it is a protective factor for mental health and wellbeing:

The wellbeing of the individual is tied to the wellbeing of whānau: expressing strengths- based whakawhanaungatanga supports positive attachment and belonging, with whānau flourishing in environments of arohatanga and manaaki. Whānau and community relationships are known to be protective for Māori experiencing mental health challenges, and are likely to protect against elements of inequity that affect wellbeing (6).

- Survey data shows Māori were significantly more likely to report higher levels of life satisfaction when they thought their whānau were doing well and getting along with one another compared with those who rated their whānau wellbeing lower (6).
- In the 2018 Te Kupenga survey, over a third of Māori adults reported helping others through a school, church, sports club or organisation, looking after tamariki who lived in their household or another household, and/or helping with cooking, cleaning, gardening, repairs or any other housework for someone who didn't live in the same household (6).

People with lived experience told us about the importance of services that provide connection, and take a broader whānau approach where appropriate.

This included non-clinical approaches, which are welcoming and support connection with marae and whakapapa, or with te taiao (the natural world); services that provide practical skills in a shared setting, encouraging connection, relationship-building, and positive engagement; or services that support maternal mental health and help young people to navigate parenthood, through wānanga that reconnect them with whakapapa, identity and mātauranga Māori.

[14] The Māori wellbeing indicators in our monitoring report have been updated due to methodological improvements; the underlying data has not been updated since the Te Kupenga survey in 2018

Material wellbeing indicators are strongly related to good mental wellbeing

Of people who interact with specialist services:

> Those who do not experience material hardship have **1.5 times higher odds of good mental wellbeing**, compared to those who do experience material hardship.

Material hardship – here a composite measure of material wellbeing drawn from the general social survey – is relevant to mental health and wellbeing for a number of reasons:

- Poverty is consistently associated with increased prevalence of adult common mental health conditions, such as depression and anxiety, in low-income, middle-income, and high-income countries, although the effects of specific aspects of poverty vary. The effects of poverty on mental health are more pronounced among women (particularly during the perinatal period), adolescents, and people with chronic diseases, such as diabetes (20)
- Food insecurity and malnutrition are associated with poorer mental health outcomes among children and teens (21).

People who interact with specialist services are more likely to experience material hardship (or less likely to report not being in hardship).

The proportion of people **who do not experience material hardship,** in 2023

58%
Specialist services

70% in 2021

60% in 2018

78%
No Service

88% in 2021

81% in 2018

The proportion of Māori **who do not experience material hardship,** in 2023

43%
Specialist services

62% in 2021

51% in 2018

65%
No Service

77% in 2021

66% in 2018

People with lived experience told us about a sense of many people in their communities being at a 'tipping point'. For those who are managing, material wellbeing is less important, but many families are struggling, and for them, material wellbeing is a strong contributor to stress and distress.

We also heard about the interconnected nature of material wellbeing with other aspects. While our analysis isolates the different factors, so that they can be examined separately, improved material wellbeing supports connection (through opportunities to spend time or enjoy other activities together), and good health (through diet, housing conditions, and access to health services). This is echoed in literature: "reducing income inequality could improve population mental health and well-being […], and could lead to a virtuous cycle if it leads to improved population mental health and well-being, providing individuals with more psychosocial resources to engage in education and employment, achieving better economic circumstances, and hence further reducing the income inequality gap" (22).

As part of understanding material wellbeing, we looked at indicators related to housing: experiencing less transience (a measure of movement between addresses), and not experiencing household crowding (based on an international measure). These returned interesting results that need further investigation – stability and uncrowded housing are generally considered proxies for appropriate housing that contributes to better outcomes, but these findings showed an association with poorer mental wellbeing.

People who interact with specialist services and are less transient (have greater housing stability), had **one third the odds of good mental wellbeing**, compared with people who interact with specialist services and moved more frequently in previous three years.

Māori who interact with services and don't live in a crowded house are had **half the odds of good mental wellbeing**, compared to Māori who interact with services and do live in a crowded house (2018 Te Kupenga data).

The transience indicator relationship applies only to people who interact with services (not the wider population); the crowding indicator relationship applies only for Māori who interact with specialist services (not to non-Māori who interact with services).

Both relationships are counter to expectations. Published research and advice from people with lived experience offer a range of possible explanations. These include: the role of family and social networks – particularly Māori and Pacific concepts and expectations related to intergenerational living; the value of tāngata whaiora exercising control over living conditions to improve wellbeing; the role of social housing; and needing to move house to access appropriate mental health and addiction services. Further investigation is needed to understand these results better.Six further indicators were associated with mental wellbeing for tāngata whairoa who interact with services.

The six indicators in this section were identified as statistically significant for people who accessed specialist mental health and addiction services, in different models in our analysis.

One indicator that was collected in the 2021 and 2023 survey years, but not in 2018 shows that a sense of control is an important element of wellbeing, for tāngata whaiora who interact with services.

People who accessed specialist services and report a good sense of control over how their life turns out had **2 times higher odds of good mental wellbeing** compared to those who didn't

As outlined above, as part of conducting the analysis, we ran the model with and without the effects of good health accounted for, in case an overlap in how survey respondents thought of physical health and mental affected the results[15]. The findings of that analysis did not affect the overall findings highlighted above, but it did show a small number of further indicators produced statistically significant results for tāngata whaiora who interact with services, when self-reported health results were excluded from the analysis:

Those who report having the right amount of leisure time had **1.8 times higher odds of good mental wellbeing**, compared to those who do not (2021-23 data only).

Those who report good family wellbeing had **1.5 times higher odds of good mental wellbeing** compared those who did not

Māori who report that their whānau get along had **2.1 times higher odds of good mental wellbeing**, compared to those whose whānau did not get along (2018 TK data)

Those who rated their sense of belonging to New Zealand highly had **1.9 times higher odds of good mental wellbeing**, compared those who did not (2021-23 data only)

These findings further reinforce the overall results relating to material wellbeing and social connection.

Finally, reporting that worrying about crime impacted on quality of life produced a statistically significant result in 2018 only: not worrying about crime had a positive relationship to mental wellbeing for people accessing specialist services.

While the *relationship* may not be statistically significant in more recent years, this does not mean that experience of this indicator has improved.

People who interact with specialist services and did not consider that worrying about crime impacted their quality of life had **1.8 times higher odds of good mental wellbeing**, compared to people who interact with specialist services and consider worrying about crime impacted their quality of life (2018 only)

Across all six of the further indicators in this section of the report, tāngata whaiora who interact with services experience poorer outcomes than the wider population.

[15] For more detail on the iterations of the model, see our separate methodology paper

Ngā Rara | Implications for cross government effort to improve wellbeing outcomes

While this analysis cannot show causation, it shows correlation or strong association between 17 wellbeing factors and the mental wellbeing of people who interact with specialist mental health and addiction services. Published literature and advice of people with lived experience help us understand and explain the relationships between these wellbeing factors and mental wellbeing.

The importance of these relationships as highlighted by this analysis, together with the inequities highlighted in our outcomes monitoring report, underscores the need for action to support the mental wellbeing of all people, and particularly tāngata whaiora and those who interact with services.

Each of the relationships highlighted in this report[16] also hold for the wider population who have not interacted with MHA services (including people who have not needed support, and those experiencing distress but who have not accessed services). ***What is good for tāngata whaiora, under this analysis, is good for everyone***. For tāngata whaiora who interact with services, though, the findings highlight an additional point of leverage or intervention available to government to improve mental wellbeing outcomes: the overlap between the MHA system, and other systems that support wellbeing.

- **The findings of this analysis reinforce the need for mental wellbeing outcomes to be brought into the decision-making for the other systems that support health, social, or material wellbeing.**
- **At the same time, health, social and material wellbeing outcomes should better influence decision-making for the mental health and addiction system, in line with the vision of He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction** (23).

Working towards those shared outcomes would be supported by greater use of He Ara Oranga wellbeing outcomes framework in designing and monitoring the impacts of policy decisions.

Our ongoing work, as outlined in the final section of this report, will highlight areas of intervention in more detail, but action is needed on:

Mental wellbeing and physical health

As people who interact with services are less likely to report being in good health, and being in good health is strongly related to overall mental wellbeing, particularly for Māori, it is clear that action is needed. This reinforces the ongoing advocacy of people with lived experience, and the work and research of groups such as Equally Well[17].

As highlighted in our recent paper on the future of primary mental health care[18], data indicates approximately 30% of GP interactions with patients involve a mental health and/or addiction component (24), and 'a range of personal, social, economic and environmental factors that affect

[16] Except the housing-related measures, as specified above
[17] https://www.equallywell.co.nz/about-the-collab/
[18] https://www.mhwc.govt.nz/our-work/mental-health-and-addiction-system/the-future-of-primary-mental-health-care/

health and wellbeing', accounting for 30% - 80% of health and mental health outcomes, and a greater focus on improving the determinants of health could reduce the need and demand for medical interventions (25).

- **Effort is needed to improve health, improve access to high-quality physical health care, and reduce inequities in health outcomes, in order to support better mental wellbeing. This may be through public health and prevention activities, primary care interventions, and or more focused wraparound support, particularly for tāngata whaiora.**
- **For tāngata whaiora who interact with services, targeted effort is needed to support their physical health. This will require a focus on the needs and views of tāngata whaiora, potentially delivered through expansion of holistic care when seeking health services, and greater connection between mental health and addiction services and other primary care providers.**

Mental wellbeing and connection or whanaungatanga

As shown in this report, social connection is important for mental wellbeing, but people who interact with services are less likely to have those connections:

- **Loneliness and social connection need attention and action from government, in partnership with NGOs, schools, iwi, and the myriad social groups, clubs, and third-spaces that support such connection. Support for young people, including connection across generations, is vital; as is support focused on the needs of tāngata whaiora.**
- **Mental health and addiction services need to prioritise ensuring that people who access services can maintain their connections, to support recovery and future wellbeing – this may mean more wraparound support to retain family connections, employment, accommodation, and engagement in society. We have repeatedly called for the expansion of peer services and lived experience leadership in the mental health and addiction system[19]. As a model of care, peer support can foster social connection and trust (both in one-on-one form but also in group peer support communities), and draw on these factors to support mental health and wellbeing outcomes.**

Government action on social connection needs to include actions based on Māori understanding of wellbeing, and focused on addressing inequitable need faced by Māori. Examples which could be built on include the whanau ora programme, with respect to connection and whanaungatanga; and holistic approaches already delivered by Kaupapa Māori mental health and addiction services, and services that support connection to whakapapa, and iwi/hapu. Better data on Māori wellbeing is also needed. The key source of Māori wellbeing outcome data, Te Kupenga, has not been carried out since 2018. Kaupapa Māori service data may hold insights, but was not available to this analysis through the integrated data infrastructure (IDI).

Data that reflects the priorities of tāngata whaiora is also needed, with rangatahi, whānau and lived experience-led collection and insights.

Mental wellbeing and material wellbeing

Inequitable material wellbeing is well recognised, but more action is needed to address this, with a particular focus on tāngata whaiora:

[19] https://www.mhwc.govt.nz/our-work/mental-health-and-addiction-system/system-performance-monitoring-report-june-2025/

- Tāngata whaiora should have a say in and be a focus of government plans and policies that support material wellbeing. This may include more accessible and appropriate housing services, tailored employment assistance, and income support, as well as work to improve the economic and commercial conditions in people's communities. Impacts on mental health and wellbeing should be a factor in all policy decisions that affect peoples' material wellbeing.
- Mental health and addiction services should be supported to help tāngata whaiora and service users access a range of services and resources that support their material wellbeing – including employment, housing, and income support. Mental health and addiction services could be key navigators into broader support for tāngata whaiora, under a 'no wrong door' approach; could expand existing models created with lived experience that provide mental health care embedded within social connection and material realities; or could be fully integrated with services that support material wellbeing.

Mahi i muri mai | Next steps

This report is the second part of a 5-year body of work:

- **Our 2024/25 outcomes report and 2025/26 update**[20] highlight inequities in wellbeing outcomes for people interacting with services, as a proxy for people with lived experience.
- **This current analysis** estimates the associations between different factors and overall mental wellbeing for people who interact with services.
- **In 2026/27**, we will bring together lived experience experts with a range of recent research and data, and key stakeholders, to understand and bring a focus on the areas highlighted by the research, expertise, and our 2025/26 reports.
- **In 2027/28**, we will use the reports and stakeholder engagement information to develop recommendations on cross-government/ cross-sector action and leadership on addressing mental health and wellbeing for people with lived experience.
- **In 2028/29,** we will continue to build our advocacy based on the 2026 report and subsequent work, including submissions on policy/legislation that is expected to impact effort to improve and protect mental health and wellbeing outcomes for people with lived experience.

Alongside advocacy and greater action from government to address the factors that affect mental health and wellbeing, more is needed to understand the experience of tāngata whaiora, and Māori in particular.

- As part of the planned work for 2027/28 outlined above, we expect to carry out deeper analysis within the more limited number of factors focused on. This will likely include conducting the analysis for specific communities and age groups, and will help understand how different communities experience wellbeing, to support fit-for-purpose responses to improve mental health and wellbeing outcomes.
- We are working with others to call for, and support the implementation of, a series of mental health and addiction population prevalence surveys. The last national mental health prevalence survey (Te Rau Hinengaro – New Zealand Mental Health Survey) was carried out in 2003/04, and this has meant a considerable gap in our understanding of mental health and wellbeing in New Zealand in the last twenty years. While we commend investment in a child and youth mental health prevalence survey we need to invest in an adult prevalence survey to understand mental health prevalence across the life course. The collection of prevalence data needs to be a sustainably resourced, ongoing body of work, backed up by a national mental health research and data strategy.
- As raised by the lived experience experts we engaged in this work, better data is needed to understand the experience and outcomes for tāngata whaiora, Māori, and young people. We will continue to advocate for this, including in the design, collection, and analysis of the prevalence surveys.

[20] Both available at http://www.mhwc.govt.nz/wellbeing/improving-wellbeing-outcomes-for-tāngata-whaiora

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