Te Kāwanatanga o Aotearoa
New Zealand Government

MANATŪ HAUORA
MINISTRY OF HEALTH

Minister for Mental Health

Mental Health portfolio priorities

17 July 2024

These documents have been proactively released by the Ministry of Health on behalf of the Minister for Mental Health, Hon Matt Doocey.

Title of Cabinet paper: Mental Health portfolio priorities

Titles of minutes:

- Report of the Cabinet Social Outcomes Committee: Period Ended 31 May 2024 (CAB-24-MIN-0191)
- Mental Health Portfolio Priorities (SOU-24-MIN-0054)

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Key to redaction codes:

- Out of scope of this proactive release.
- S 9(2)(f)(iv) to maintain the constitutional conventions that protect the confidentiality of advice tendered by Ministers and officials.

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CAB-24-MIN-0191

Cabinet

Minute of Decision

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Report of the Cabinet Social Outcomes Committee: Period Ended 31 May 2024

On 4 June 2024, Cabinet made the following decisions on the work of the Cabinet Social Outcomes Committee for the period ended 31 May 2024:

Out of Scope		
SOU-24-MIN-0054	**Mental Health Portfolio Priorities** Portfolio: Mental Health	CONFIRMED
Out of Scope		

Rachel Hayward
Secretary of the Cabinet

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SOU-24-MIN-0054

Cabinet Social Outcomes Committee

Minute of Decision

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Mental Health Portfolio Priorities

Portfolio **Mental Health**

On 29 May 2024, the Cabinet Social Outcomes Committee:

1 **noted** that the mental health and addiction system is not delivering the support and services New Zealanders need;

2 **noted** that the Minister for Mental Health (the Minister) has the following priorities for the Mental Health portfolio:

2.1 increase access to mental health and addiction support;

2.2 grow the mental health and addiction workforce;

2.3 strengthen the focus on prevention and early intervention;

2.4 improve the effectiveness of mental health and addiction support;

3 **noted** that further work will be undertaken to develop a more detailed work programme to deliver against the Mental Health portfolio priorities;

4 **invited** the Minister to report to the Cabinet Social Outcomes Committee with more detail about implementation milestones, phasing, and progress delivering against these priorities by June 2025;

5 **noted** that the Minister intends to set the following five mental health and addiction targets as performance measures in the Government Policy Statement on Health 2024–2027 to complement the priorities for the Mental Health portfolio and help drive improvements in the health system:

5.1 faster access to specialist mental health and addiction services – 80 percent of people accessing specialist mental health and addiction services are seen within three weeks of referral;

5.2 faster access to primary mental health and addiction services – 80 percent of people accessing primary mental health and addiction services through the Access and Choice programme are seen within one week of referral;

5.3 shorter mental health and addiction-related stays in emergency departments – 95 percent of mental health and addiction-related emergency department presentations are admitted, discharged, or transferred from an emergency department within six hours of arrival;

5.4 increased mental health and addiction workforce development – train 500 mental health and addiction professionals each year;

5.5 strengthened focus on prevention and early intervention – 25 percent of mental health and addiction investment is allocated towards prevention and early intervention.

Jenny Vickers
Committee Secretary

Present:
Hon Christopher Luxon
Rt Hon Winston Peters (part of item)
Hon David Seymour
Hon Nicola Willis (Chair)
Hon Chris Bishop
Hon Dr Shane Reti
Hon Erica Stanford
Hon Paul Goldsmith
Hon Louise Upston
Hon Mark Mitchell
Hon Tama Potaka
Hon Matt Doocey
Hon Melissa Lee
Hon Nicole McKee
Hon Penny Simmonds
Hon Chris Penk

Officials present from:
Office of the Prime Minister
Officials Committee for SOU

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In Confidence

Office of the Minister for Mental Health

Cabinet Social Outcomes Committee

Mental Health portfolio priorities

Proposal

1 This paper socialises my priorities for the Mental Health portfolio for the parliamentary term and seeks an invitation to report back with more detail about implementation milestones, phasing and progress delivering against these priorities.

Relation to government priorities

2 The proposal in this paper contributes to the Government's priority of delivering better health outcomes, in particular, improving mental health and addiction outcomes.

Executive Summary

3 The establishment of a dedicated ministerial Mental Health portfolio is a critical first step that reflects the importance this Government places on improving mental health and addiction outcomes, and preventing suicide.

4 Despite increasing levels of investment, people with mental health and addiction needs are not receiving the services and support they need in a timely way. This is compounded by increasing workforce vacancies and increasing population mental health and addiction needs.

5 We need a joined-up mental health and addiction system that is adequately staffed and provides people with high-quality, timely support across the continuum of care – from wellbeing promotion, to telehealth, digital and primary-level supports for mild to moderate mental distress, through to specialist services for more complex mental health and addiction needs. We also need to work across government to address the determinants of mental health and addiction to help prevent needs from arising and escalating.

6 I have identified three priority areas where work is required to build an efficient mental health and addiction system that provides access aligned with population needs and growth. They are:

6.1 Increase access to mental health and addiction support

6.2 Grow the mental health and addiction workforce

6.3 Strengthen the focus on prevention and early intervention.

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7 Over this term of Government, I will progress a work programme to support these priorities. I will also progress complementary work to ensure the right system settings are in place to drive improvements in mental health, addiction, and suicide prevention outcomes. This will require cross-government efforts; however, I expect that achieving my priorities will also contribute to improving results in other sectors and achieving broader Government Targets.

8 I intend to introduce five mental health and addiction targets as key measures in the Government Policy Statement on Health 2024–2027. These will support my priorities and help drive improved performance and accountability within the health system. Three of these targets will support increased and more timely access to support, one target will focus on workforce development, and the fifth target will focus on strengthening investment in prevention and early intervention.

9 I intend to report back to Cabinet with more detailed implementation information, including milestones and phasing, and on progress of delivery against my Mental Health portfolio priorities by June 2025.

Significant work is needed to move from a fragmented to a joined-up mental health and addiction system

10 The mental health and addiction system consists of a continuum of mental wellbeing promotion, prevention and early intervention supports, and primary and specialist mental health and addiction services delivered and funded both by government agencies and non-government organisations (NGOs). Currently many of these supports are not joined-up, resulting in a lack of streamlined support and potential duplication and gaps in support.

11 Within Vote Health, ringfenced mental health and addiction funding totals approximately $2.5 billion in 2023/24. Table 1 provides an overview of Vote Health expenditure by Health New Zealand within the ringfence in 2022/23.

Table 1. Health New Zealand mental health and addiction ringfence expenditure by service type and organisation, 2022/23

Service type ($m)	Hospital and specialist services	NGO / Primary Health Organisation	Total
Promotion Prevention	0.2	15.1	15.3
Primary Mental Health & Addiction		224.4	224.4
Specialist Alcohol and Other Drug	97.0	114.0	211.0
Specialist Mental Health			
Infant, Child and Youth	166.0	41.2	207.2
Adult Acute Services	384.2	30.5	414.7
Adult Support Services	55.9	286.9	342.8
Adult Treatment Services	422.3	45.6	467.9
Older Person's Mental Health	113.8	2.4	116.2
Forensic Mental Health	212.6	19.2	231.8
Workforce		38.6	38.6
Other		9.5	9.5
Grand Total	**1,452.0**	**827.4**	**2,279.4**

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12 Between 2019/20 and 2022/23, considerable work and investment has gone towards building primary mental health and addiction services for people with mild to moderate needs. While this has resulted in a greater range of services and supports, people requiring specialist services are facing increased wait times. For instance, in 2022/23 only 68% of young people under 25 years of age were seen within three weeks, down from 72% in 2017/18.

13 The mental health and addiction workforce is made up of a diverse range of clinical and non-clinical workers, working across a range of settings. Despite investment in workforce development, mental health and addiction workforce vacancies are growing. For example, as shown in Table 2, vacancy rates increased across almost all mental health and addiction workforce roles between 2018 and 2022.

Table 2. Estimated vacancy rates by roles, 2018 and 2022

Role group	Estimated vacancy rate (%)	
	2018	2022
Registered health professionals		
Addiction practitioners	9.1	10.4
Nurses	5.4	11.7
Occupational therapists	7.0	12.9
Psychologists	7.4	12.1
Social workers	5.9	11.8
Other registered health professionals	2.1	16.7
Medical practitioners		
Psychiatrists	9.3	19.3
Other medical practitioners	13.3	10.4
Support workers	5.3	11.0

Source: Te Pou. More than numbers workforce data. URL: www.tepou.co.nz/initiatives/more-than-numbers-workforce-data (accessed 23 April 2024).
Note: The data depends on the accuracy and completeness of the source information. Vacancy rates are limited to children's and adult services in community and secondary settings and may be underestimated.

14 As illustrated in **Appendix 1**, these increasing system constraints are happening at a time where:

14.1 New Zealanders are experiencing increasing levels of psychological distress, particularly children and young people

14.2 people are reporting increased unmet need for professional help for their mental health

14.3 there are persistent inequitable outcomes for Māori and other population groups (eg, young people, Pacific people, disabled people, and women).

15 This means that despite substantial investment, and mental health and addiction investment overall being higher than it has ever been, the system is not delivering the outcomes we expect. There is significant work to do to improve outcomes and ensure we are getting value for money from current investment.

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The new Mental Health ministerial portfolio will drive a cross-government focus and improve outcomes

16 This Government established New Zealand's first dedicated ministerial Mental Health portfolio in acknowledgement of the need to do more to improve mental health and addiction outcomes and prevent suicide.

17 In line with the scope of the Mental Health portfolio as defined by the Prime Minister, I have responsibility for and oversight of strategic and policy matters within the health system relating to mental health and addiction services and supports. This includes matters and activities relating to alcohol and other drug use, preventing and minimising gambling harm, addiction, and suicide prevention and postvention, as well as mental health and addiction infrastructure and workforce.

18 It also includes oversight of and authority to make policy and priority decisions for mental health and addiction funding within Vote Health. I have responsibility for the gambling and alcohol levies, but the bulk of funding sits within the mental health and addiction ringfence. The Minister of Health retains overall responsibility for Vote Health and its associated appropriations.

19 I am also responsible for progressing a cross-government approach to mental health, to ensure mental health, addiction and suicide prevention is appropriately addressed across all portfolios. As such the Prime Minister has also outlined his expectation that I am consulted on matters in other portfolios that may have mental health and addiction implications. I have been meeting with other portfolio ministers and am keen to continue engaging across portfolios to support consideration of mental health, addiction and suicide prevention across the Government's work.

20 Improving mental health and addiction outcomes will also be an important contributor to better results in other portfolio areas. My officials are engaging with other agencies to support the planning for and achievement of Government Targets, such as:

20.1 Reduced child and youth offending

20.2 Reduced violent crime

20.3 Fewer people on the Jobseeker Support Benefit

20.4 Increased student attendance

20.5 Fewer people in emergency housing

20.6 Shorter stays in emergency departments.

My priorities for the Mental Health portfolio will help deliver the mental health and addiction system that New Zealanders deserve

21 I have three key priorities for the Mental Health portfolio in this parliamentary term to help build the mental health and addiction system that New Zealanders deserve. They are to:

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21.1 increase access to mental health and addiction support

21.2 grow the mental health and addiction workforce

21.3 strengthen the focus on prevention and early intervention.

22 Mental health and addiction services are critical and need to be elevated within the health system; however, we also need to get mental health out of being seen as the sole responsibility of the health system. Mental health and addiction are strongly linked with other factors, including employment, housing, education, and the economy, meaning improvements in these areas will improve mental health and addiction outcomes.

23 The following sections briefly outline my intentions for each priority. An overview of my intended focus areas for a work programme to support my priorities is attached as **Appendix 2**. I intend to report back by June 2025 with progress against these priorities. This will include more detail about implementation milestones and priority cohorts or population groups that have been identified.

Increase access to mental health and addiction support

24 New Zealanders deserve better access to timely mental health and addiction support. This support should be of a high quality and culturally responsive. My goal is that we increase access to match population needs and growth and my focus will be two-fold:

24.1 initially stabilising and then strengthening specialist mental health and addiction services delivered by Health New Zealand; and

24.2 growing community-based supports provided by the NGO sector, to get funding out of Wellington and complement the services delivered by Health New Zealand.

25 This focus will be achieved through:

25.1 ensuring we are utilising existing resources as efficiently and effectively as possible

25.2 identifying opportunities to reprioritise existing funding within the ringfence, to ensure all investment is aligned with our priorities

25.3 seeking new investment over time where needed to address gaps and support achievement of our priorities.

26 Work to support this priority has already commenced. For example, this Government is:

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26.1 establishing a Mental Health Innovation Fund to deliver more resources to the frontline. Community providers will leverage matched funding to increase access, reduce demand on specialist services, use technology to drive productivity and deliver positive returns on investment

26.2 funding Gumboot Friday $6 million a year to increase access to free mental health counselling for young people. This will enable Gumboot Friday to more than double the number of young New Zealanders able to access counselling services each year. This initiative will also support young people who are waiting to access specialist services

26.3 trialling peer support in emergency departments, which will include partnering with NGO providers of peer services.

27 Work is also underway with New Zealand Police to transition from a Police-led response to a multi-agency response to 111 calls for people in mental distress, to help ensure people have access to the right support. Year one actions have commenced and I will be reporting back with the Minister of Police with more detail on future years of the transition plan by November 2024 [SOU-24-MIN-0039 refers].

28 s 9(2)(f)(iv)

Grow the mental health and addiction workforce

29 Workforce constraints are a key barrier to improving mental health and addiction services. My intention will be to:

29.1 grow and improve mental health and addiction workforce training pipelines, for instance through increasing the number of psychiatrists and psychologists being trained, and by working with the Minister for Tertiary Education and Skills to remove any barriers for growing the workforce

29.2 broaden the range of workforces able to support mental health and addiction. This includes introducing an associate psychologist role, to make better use of the large number of people completing undergraduate psychology degrees each year, many of whom do not go on to work in the mental health and addiction system.

30 This will be supported by the development of a clear mental health and addiction workforce plan. This plan will articulate what we know about our current mental health and addiction workforce composition, future workforce needs, and the plan to get there. The plan will also focus on supporting the development of and embedding the consumer, peer support and lived experience workforce across the continuum of care.

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Strengthen the focus on prevention and early intervention

31 The bulk of ringfenced mental health and addiction funding in Vote Health currently goes towards specialist mental health and addiction services. While some people will always require specialist support, there is evidence that promoting mental wellbeing and intervening early in the life course or when a person starts to experience mental distress can prevent issues from escalating.

32 My priority aligns with this Government's social investment approach as investing in the right prevention and early intervention supports can provide better return on investment in the long run. Work in this area will include:

32.1 looking at how primary and community supports, including digital and telehealth services, can provide better early intervention services to reduce the pressure on specialist mental health and addiction services

32.2 developing and implementing a new suicide prevention action plan. Cabinet recently noted the current action plan is due to end in 2024 [SOU-24-MIN-0038 refers] s 9(2)(f)(iv) expect the final action plan to lay out actions and milestones across government to turn the tide on suicide and suicidal behaviour

32.3 developing the next strategy to prevent problem gambling and minimise harm. s 9(2)(f)(iv)

32.4 progressing work to reduce substance related harms with the development of an Overdose Preparedness Plan. I will also be coming to Cabinet in June 2024 with a new Order for the Alcohol Levy.

33 Ensuring a strong focus on child and youth mental wellbeing will also be key. I expect there to be continued prioritisation of support for maternal mental health, children, and young people. This will include a strong focus on the first 2,000 days to help ensure a healthy start to life.

34 I have an initial focus on responding to the Office of the Auditor General's report, '*Meeting the mental health needs of young New Zealanders*'. Agencies have already begun to prepare a response and implementation plan for the recommendations. s 9(2)(f)(iv)

Bolster system stewardship and settings

35 It is crucial the right system settings (for example, legislative, governance and oversight arrangements) are in place to support mental health, addiction, and suicide prevention, supported by strong system stewardship. These system settings will enable action and drive results against my priorities.

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36 I intend to set five high-level mental health and addiction targets for the health system as key measures within the Government Policy Statement on Health for 2024–2027. These are mapped to my priorities and are reflected in the Minister of Health's paper: *Confirming the Government Policy Statement on Health for 2024–2027*. Following further development, annual milestones will be added to the Government Policy Statement reflecting what I expect be achieved for each of the targets taking into account existing resources.

37 The targets are listed below. Additional information about the rationale for, current performance levels, annual milestones, and approach to establishing and implementing the mental health and addiction health system targets is in **Appendix 3**.

37.1 *Faster access to specialist mental health and addiction services* – 80% of people accessing specialist mental health and addiction services are seen within three weeks.

37.2 *Faster access to primary mental health and addiction services* – 80% of people accessing primary mental health and addiction services through the Access and Choice programme are seen within one week.

37.3 *Shorter mental health and addiction-related stays in emergency departments* – 95% of mental health and addiction-related emergency department presentations are admitted, discharged, or transferred from an emergency department within six hours.

37.4 *Increased mental health and addiction workforce development* – train 500 mental health and addiction professionals each year.

37.5 *Strengthened focus on prevention and early intervention* – 25% of mental health and addiction investment is allocated towards prevention and early intervention.

38 Other work I intend to progress to bolster our system settings includes:

38.1 progressing the repeal and replacement of the Mental Health (Compulsory Assessment and Treatment) Act 1992. It is imperative that we shift compulsory mental health care towards a more modern mental health care approach and minimise the use of restrictive practices. s 9(2)(f)(iv)

38.2 s 9(2)(f)(iv)

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38.3 putting in place an external assurance group, so that we can be sure the way we are doing things will work for the mental health, addiction and suicide prevention sector and the people we serve. This group will comprise a range of experts across the system and will provide advice and assurance to me on implementation progress to ensure delivery

38.4 establishing strong cross-government governance – a Deputy Chief Executive-level group will provide appropriate oversight and mandate for implementing cross-government work. This will ensure that there is a dedicated focus on cross-government efforts and a proactive approach to driving progress.

39 There is also the Pae Ora (Healthy Futures) (Improving Mental Health Outcomes) Amendment Bill currently being considered by the Health Committee, which if enacted will mean the creation of a Mental Health and Wellbeing Strategy that will ensure a targeted implementation focus on mental health and addiction, and further bolster the system settings.

40 To support continued Cabinet oversight of work to implement my mental health and addiction priorities, I intend to provide regular updates to Cabinet on progress with giving effect to the priorities for the Mental Health portfolio.

41 The Mental Health and Wellbeing Commission will also continue to provide independent oversight of mental health and wellbeing in New Zealand. This will provide additional, independent oversight for mental health and addiction work.

Cost-of-living Implications

42 The proposals in this paper do not have any direct cost-of-living implications.

Financial Implications

43 Any financial implications of the Mental Health portfolio work programme and targets will be assessed as implementation progresses and will be subject to future Budget decisions consistent with the Government's Budget Strategy and ongoing fiscal sustainability programme.

44 I expect any costs in the immediate term will be met from within existing funding envelopes. I will be working closely with the Minister of Health, given his overall responsibility for Vote Health, to ensure that Health New Zealand delivers what it can within the mental health and addiction ringfence expectation and the wider funding it receives. This will need to include consideration of ways to generate efficiencies and free up resources to support as much progress towards the priorities as is possible.

Legislative Implications

45 The proposals in this paper do not have any legislative implications.

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Impact Analysis

46 A Regulatory Impact Statement or Climate Implications of Policy Assessment is not required as no regulatory changes are proposed and no substantial changes to greenhouse gas emissions will result from this proposal.

Population Implications

47 People with severe and enduring mental health and addiction conditions experience disproportionately poorer health and social outcomes and a significantly shorter life-expectancy than the general population. Implementing the Mental Health portfolio work programme and mental health and addiction targets will help ensure a stronger focus on mental health and addiction within the wider health system, as well as across government agencies.

48 Within specific work programmes and targets, such as those focused on access, implementation will include consideration of ensuring equitable outcomes for all population groups (eg, across age groups, ethnic groups – including the disproportionate need experienced by Māori, gender identities, sexual orientation, population groups in state care or custody, disability, and location).

Human Rights

49 The proposals in this paper are consistent with the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993.

Use of external Resources

50 No external resources were employed in developing proposals in this paper.

Consultation

51 The following agencies were consulted on this paper:, the Accident Compensation Corporation; the Departments of Conservation, Corrections and Internal Affairs; the Department of the Prime Minister and Cabinet; Health New Zealand | Te Whatu Ora; the Ministries of Business, Innovation and Employment, Education, Housing and Urban Development, Justice, Social Development (including the Child Wellbeing and Poverty Reduction Group) and Youth Development; the Ministries for Culture and Heritage, Ethnic Communities, Pacific Peoples, Primary Industries, and Women; New Zealand Defence Force (Veterans' Affairs); New Zealand Police; the Office for Seniors; Oranga Tamariki; the Social Wellbeing Agency; Sport New Zealand; Te Kawa Mataaho | Public Service Commission; Te Puna Aonui; Te Puni Kōkiri; the Treasury and Whaikaha – Ministry of Disabled People.

Communications

52 I intend to communicate my priorities to the sector and public through my interactions with them.

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Proactive Release

53 This paper and any associated minutes will be proactively released on the Ministry of Health's website following the publication of the Government Policy Statement on Health for 2024–2027, subject to any redactions as appropriate under the Official Information Act 1982.

Recommendations

The Minister for Mental Health recommends that the Committee:

1. **note** that the mental health and addiction system is not delivering the support and services New Zealanders need;

2. **note** that the Minister for Mental Health has the following priorities for the Mental Health portfolio:

   2.1. Increase access to mental health and addiction support;

   2.2. Grow the mental health and addiction workforce;

   2.3. Strengthen the focus on prevention and early intervention;

3. **note** that further work will be undertaken to develop a more detailed work programme to deliver against the Mental Health portfolio priorities;

4. **invite** the Minister for Mental Health to report to Cabinet with more detail about implementation milestones, phasing and progress delivering against these priorities by June 2025;

5. **note** the Minister for Mental Health intends to set the following five mental health and addiction targets as performance measures in the Government Policy Statement on Health 2024–2027 to complement the priorities for the Mental Health portfolio and help drive improvements in the health system:

   5.1. *Faster access to specialist mental health and addiction services* – 80% of people accessing specialist mental health and addiction services are seen within three weeks of referral;

   5.2. *Faster access to primary mental health and addiction services* – 80% of people accessing primary mental health and addiction services through the Access and Choice programme are seen within one week of referral;

   5.3. *Shorter mental health and addiction-related stays in emergency departments* – 95% of mental health and addiction-related emergency department presentations are admitted, discharged, or transferred from an emergency department within six hours of arrival;

   5.4. *Increased mental health and addiction workforce development* – train 500 mental health and addiction professionals each year;

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5.5. *Strengthened focus on prevention and early intervention* – 25% of mental health and addiction investment is allocated towards prevention and early intervention.

Authorised for lodgement

Hon Matt Doocey

Minister for Mental Health

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Appendix 1: High-level overview of current mental health and addiction system pressures

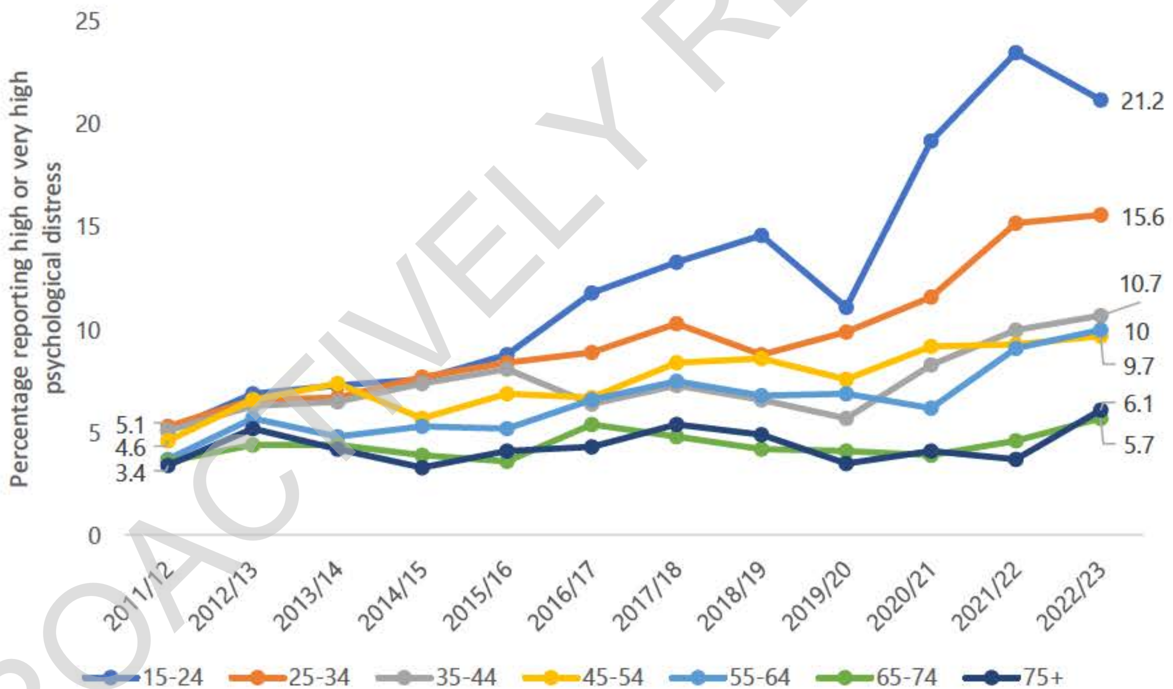
The sections below outline further information as examples of the key pressures on the current mental health and addiction system. Note: there are limitations to all data, however the information below outlines the best available information.

Increasing levels of need

As shown in Figure 1, the proportion of people experiencing high or very high levels of psychological distress has increased over time. Similar to other countries, this increase is particularly noticeable among younger age groups. It is important to note however that psychological distress is not the same as a mental disorder or illness. Psychological distress can be a normal response to life events, whereas mental disorders or illness involve more clinically significant impacts to people's lives. Each requires a different kind of response.

Between 2012/13 and 2022/23 the percentage experiencing high or very high levels of psychological distress increased from 6.9% to 21.2% among 15–24-year-olds and from 6.6% to 15.6% among 25–34-year-olds.

Figure 1: Psychological distress by age group, 2011/12–2022/23



Source: NZ Health Survey

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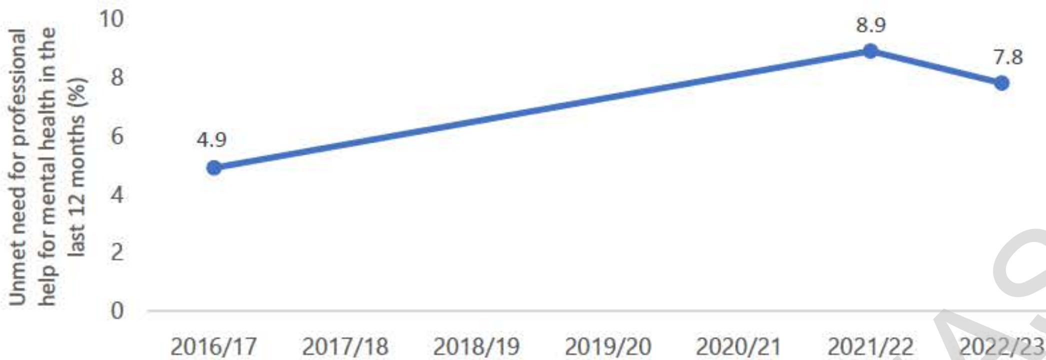
An increasing proportion of people since 2016/17 are also reporting unmet needs for professional health for their emotions, stress, mental health or substance use (see Figure 2).

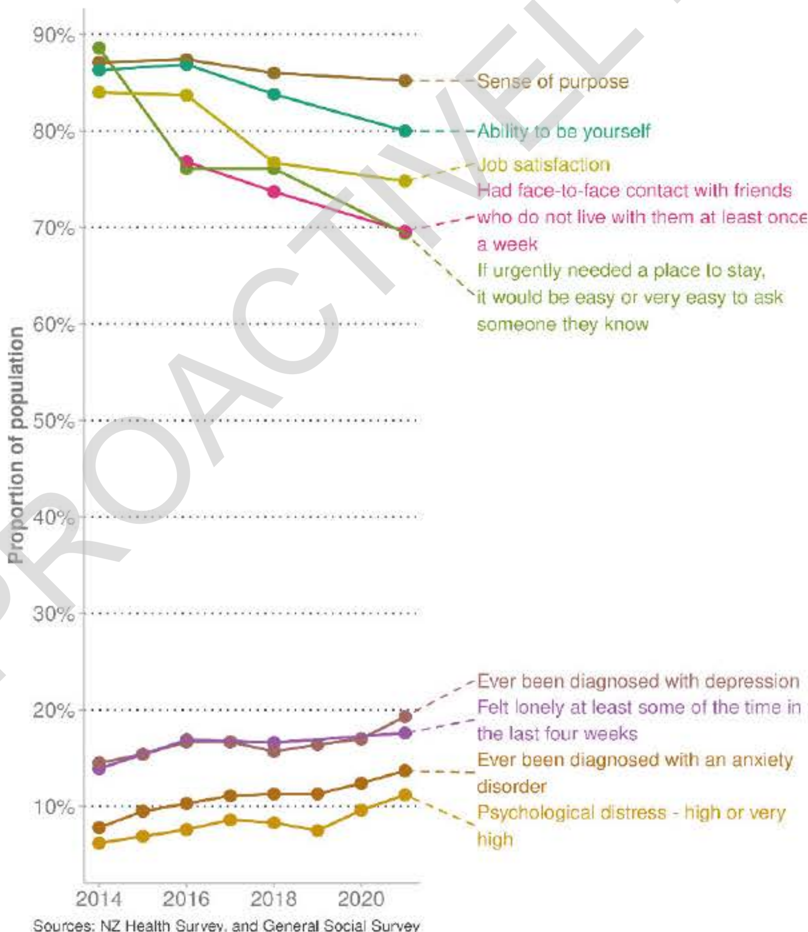
Figure 2: Unmet professional need for mental health in the last 12 months, 2016/17–2022/23



Source: NZ Health Survey

As illustrated by Figure 3, while psychological distress and other mental health and addiction needs have been increasing over time, indicators of protective factors appear to be decreasing. For instance, the percentage of employed people reporting they were very satisfied or satisfied with their job decreased from 84% in 2014 to around 75% in more recent years.

Figure 3: Psychological distress and other factors since 2014



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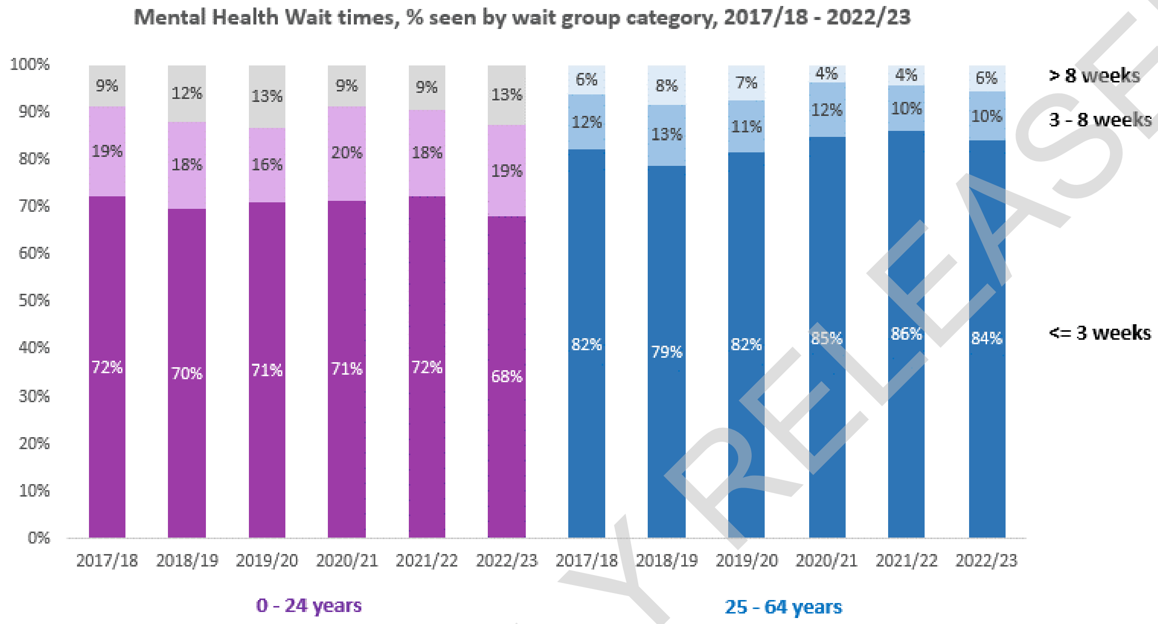
Increasing wait times

As outlined in Figure 4, an increasing proportion of people waiting are longer for specialist mental health and addiction services. For example, among under 25-year-olds the percentage seen by specialist services within three weeks decreased from 72.2% in 2017/18 to 68.3% in 2022/23.

Figure 4: Mental health service wait times for 0–24 and 25–64-year-olds, 2017/18–2022/23



Source: MH03 wait times reports for applicable 12-month periods.

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Inequitable outcomes

There are inequitable outcomes for Māori and other population groups, as well as regional disparities. Examples of these inequities are outlined in Figure 5.

Figure 5: Examples of mental wellbeing inequities across key population groups

EXAMPLES OF MENTAL WELLBEING INEQUITIES ACROSS KEY POPULATION GROUPS

WOMEN are **1.4 times** as likely to have been told by a doctor that they have depression, bipolar and/or anxiety disorder compared to men

YOUNG PEOPLE aged 15–24 years had a suspected self-inflicted death rate of **15.6** per 100,000 population in 2022/23, compared to the age-standardised rate of **10.6**. This is almost **1.5 times** higher

Of young people school years 9-13, **26.6%** of **RAINBOW YOUTH** reported having attempted suicide, compared to **11%** of young people overall

The rates of suicide are higher for people in **RURAL** areas compared to urban areas...

40% higher for men
20% higher for women
20% higher for young people 15-24 years

Mental distress among **MĀORI** is almost **50%** higher than among non-Māori

12.9% of **PACIFIC** people reported an unmet need for professional help for their mental health in the last 12 months

ASIAN people are **9.5** times as likely to develop moderate risk/problem gambling compared to the European/ other population

Psychological distress in the previous 4 weeks...

16.6% of adults in most socioeconomically deprived areas

compared to **9.1%** in least deprived areas

32.8% of **DISABLED ADULTS**

compared to **9.2%** of non-disabled adults

Sources: NZ Health Survey and New Zealand Mortality Collection.

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Appendix 2: Mental Health Portfolio Overview

PORTFOLIO FOCUS

01 SCOPE

- Strategic and policy matters within the health system relating to mental health, alcohol and other drugs, gambling, and suicide prevention
- Oversight and prioritisation of mental health and addiction investment, including $2.5 billon ringfence
- Alcohol Levy and Problem Gambling Levy
- Mental health and addiction system performance, workforce and infrastructure
- Cross-government approach to mental health, addiction and suicide prevention including contribution to the wider Government Targets

02 PRIORITIES

- Increase access to mental health and addiction support
- Grow the mental health and addiction workforce
- Strengthen the focus on prevention and early intervention

03 MENTAL HEALTH TARGETS FOR THE HEALTH SYSTEM

- Faster access to specialist mental health and addiction services
- Faster access to primary mental health and addiction services
- Shorter mental health and addiction-related stays in emergency departments
- Increased mental health and addiction workforce development
- Strengthened focus on prevention and early intervention

PRIORITIES & FOCUS AREAS

ACCESS

Multi-Agency 111 Crisis Response – The crisis system is not always providing the right response to people who call 111 in mental distress. Joint work between Health, Police and other agencies is underway to develop and implement a 5-year transition plan from a Police-led to a multi-agency response

Gumboot Friday – Implement the Government's commitment of funding Gumboot Friday to provide access to free mental health counselling for young people

Mental Health & Addiction Innovation Fund – Implement the Government's commitment to establish the Mental Health Innovation Fund to provide more support for non-governmental organisations to deliver the services their communities need

Implement peer support in emergency departments – Trial peer support in 8 emergency departments to improve support for people presenting in mental distress

WORKFORCE

Workforce Plan – Ensure robust workforce planning, modelling and pipeline development through a focused mental health and addiction workforce plan

Address mental health & addiction vacancies – Work with Tertiary Education Commission and Immigration New Zealand to ensure a good pipeline of qualified and skilled professionals are available to address the mental health and addiction vacancies across the system

Expand training & placements to grow mental health & addiction workforces – Implement a broad programme of work to ensure at least 500 mental health and addiction professionals are trained each year. Includes increased placements across clinical workforces and Assistant Psychology roles, recruitment campaigns and expanded support to develop and embed the consumer, peer support and lived experience workforces

PREVENTION AND EARLY INTERVENTION

Suicide Prevention Action Plan – The current Suicide Prevention Action Plan expires at the end of 2024. The new Action Plan is under development and will lay out the areas of activity across government to prevent suicide over the next 5 years

Prevent & minimise harm from substance use – Develop an Overdose Prevention and Preparedness Plan. The Alcohol Levy will be set by July 2024

Prevent & minimise harm from problem gambling – Develop and release the next three-year Strategy for the Prevention and Minimisation of Gambling Harm

Child & Youth Mental Wellbeing – Ensuring a strong focus on maternal, child and youth mental wellbeing. Will have an initial focus on responding to and implementing the 9 Office of the Auditor-General recommendations to improve understanding of and responsiveness to youth mental health needs, with ongoing work across Children's Agencies

STEWARDSHIP & SYSTEM SETTINGS

Mental Health Bill

Repeal and replace the existing Mental Health Act to shift compulsory mental health care towards a rights and recovery approach and minimise the use of restrictive practices. Includes implementation planning and preparation to support the sector to improve current practice and shift to new ways of working

s 9(2)(f)(iv) [redacted]

Establish an External Assurance Group

Establish an external group of mental health and addiction experts to provide assurance and advice on implementing the priorities across the mental health, addiction and suicide prevention systems

Establish an Implementation Group

A DCE-level implementation group will be established to provide appropriate oversight and mandate for implementing cross-government work. It will initially focus on the OAG's report on the mental health needs of young New Zealanders as the first step towards arrangements across a range of portfolios

Ensure system settings are appropriate across government

Ensure there are strong links between the Mental Health portfolio and others including Employment, Income, Housing, Justice, Family Violence, and Children's and Youth portfolios. Through targeted cross-government engagement, the Mental Health portfolio can help other agencies achieve their targets and demonstrate the Government's commitment to mental health

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Appendix 3: Summary of mental health and addiction targets

1 The five mental health and addiction targets are mapped to the Mental Health portfolio priorities and are intended to be introduced as key measures in the Government Policy Statement on Health 2024–2027 (the GPS). They do not sit at the same level as the Government Targets and have been carefully chosen to provide clear performance expectations and help drive improved performance and accountability within the health system.

2 The first three targets are wait times measures that reflect the crucial importance of improved access to timely support across three different service settings – primary services, emergency departments, and specialist services. Wait times measures have been used as a tool for continuous service quality improvement, benchmarking and learning for many years.

3 The fourth target will drive a focus on growing the mental health and addiction workforce, both a key barrier and an enabler of increasing access to support. There is a substantial existing mental health and addiction workforce development programme supported by dedicated investment which will contribute to achievement of a workforce training target.

4 Lastly, the final target focuses on strengthening investment in prevention and early intervention. We know that investing early can provide substantial return on investment in the long run, but there are risks of investment in this area being deprioritised to support more costly specialist services.

5 The sections below provide further information about the rationale for each of the five mental health and addiction targets within the health system, what is known about current performance, and how they will be established and implemented.

6 Table One outlines the baselines and proposed milestones for each target over the next three years, and the focus for performance improvement for 2024/25. The milestones reflect the improvements I expect can be achieved within existing resources.

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Table One: Baselines and proposed annual milestones for mental health and addiction targets

Target	Current baseline	2024/25 milestone	2025/26 milestone	2026/27 milestone	Performance focus for 2024/25
Faster access to specialist mental health and addiction services: 80% of people accessing specialist mental health and addiction services are seen within three weeks	Mental health (district) baseline as at Quarter 1 2023/24: 78% of all people seen within 3 weeks; 69% of under 25-year-olds; 85% of 20–64-year-olds Alcohol and other drug (district & NGO) baseline as at Quarter 1 2023/24: 81% of all people seen within 3 weeks; 84% of under 25-year-olds; 80% of 20–64-year-olds Baseline for 65+-year-olds to be established	80% overall Increase to 72% for under 25-year-olds accessing mental health services	80% overall Increase to 75% for under 25-year-olds accessing mental health services	80% overall Increase to 78% for under 25-year-olds accessing mental health services	• Actions to target improvement in wait times for mental health services for children and young people • Address variation in performance • Actions to improve PRIMHD data quality and completeness • Quarterly reporting from Quarter 1
Faster access to primary mental health and addiction services: 80% of people accessing primary mental health and addiction services through the Access and Choice programme are seen within one week	Baselines to be established over the first 3 years as indicated in the annual milestones	Establish routine data collection for Integrated Primary Mental Health and Addiction (IPMHA) providers (from October 2024) and youth providers (from January 2025) Set baselines for IPMHA (by February 2025) and youth services (by May 2025)	80% overall or % increase from IPMHA and youth baseline (TBC once baselines are established) Establish routine data collection for Pacific providers (from October 2025) Set baselines for Pacific services (by February 2026)	80% overall or % increase from IPMHA, youth and Pacific baseline (TBC once baselines are established) Establish routine data collection for Kaupapa Māori providers (from July 2026) Set baselines for Kaupapa Māori services (by October 2026)	• Work with providers on consistent and complete reporting and establishing baselines • Provisional quarterly reporting from Quarter 1 with caveats while work progresses to improve consistency and completeness
Shorter mental health and addiction-related stays in emergency departments: 95% of mental health and addiction-related emergency department presentations are admitted, discharged, or transferred from an emergency department within six hours	65% in Quarter 1 of 2023/24, however this includes known data completeness and consistency issues	71%	73%	75%	• Analyse data and confirm baseline • Work with ED staff to ensure accurate and complete SNOMED coding • Address variation in performance and identify opportunities to improve flow across the continuum of care • Provisional quarterly reporting from Quarter 1 with caveats while work progresses to improve consistency and completeness
Increased mental health and addiction workforce development: Train 500 mental health and addiction professionals each year	Baselines to be established, however it is estimated that 428 mental health and addiction professionals started training in the 2023 calendar year Note: this includes psychologists, New Entry to Specialist Practice (NESP) nursing and NESP Allied Health, but excludes the psychiatry registrar intake in 2023 Psychiatry registrars will be included in the 2025 calendar year data, and it is proposed that Level IV Health and Wellbeing (Peer Support) training will be included at the start of the 2026 calendar year (with an upwards revision of the target)	Confirm baseline with 2024 calendar year total (excluding psychiatry registrars and peer support workers)	500 (for 2025 calendar year) excluding peer support Establish (2025 calendar year) baseline for inclusion of Level IV Certificate in Health and Wellbeing (Peer Support) Revise target for 2026 to include Level IV Peer Support	500 (for 2026 calendar year), excluding peer support Target including peer support TBC	• Develop reporting mechanism for psychiatry registrars • Commence capture of data including psychiatric registrars from the first semester 2025 • Improve reporting processes across included professions • Reporting by calendar years
Strengthened focus on prevention and early intervention: 25% of mental health and addiction investment is allocated towards prevention and early intervention	2021/22 baseline is 22.5% or $441.1 million This will be updated to 2022/23 baselines once this has been validated (prior to 1 July 2024)	TBC once 2022/23 baseline is validated Mechanism for extraction of data established by July 2024	TBC once 2022/23 baseline is validated	TBC once 2022/23 baseline is validated	• Improve data extraction and reporting processes • Quarterly reporting from Quarter 1

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Summary information about the mental health and addiction targets

Faster access to specialist mental health and addiction services

> **Target**: 80% of people accessing specialist mental health and addiction services are seen within three weeks of referral

7 Early and timely access to specialist mental health and addiction services for those who need it is crucial to support people's recovery, help them to live well, and prevent further deterioration in their mental health and overall quality of life. Wait times currently vary between services and age groups. Improvements to address variations in wait times between different services and age groups are therefore needed.

8 Historical data indicates that over the past six years, the proportion of people accessing specialist mental health and addiction services who were seen within three weeks varied between 75.3% and 79.9% for specialist mental health services, and between 75.5% and 81.8% for specialist addiction services. While current performance is close to the target level, there is room for improvement.

9 In particular, wait times vary between different age groups, with data as at Quarter 1 2023/24 showing that for specialist mental health services only 69% of those aged under 25 years were seen within three weeks, compared to 85% of those aged 20 to 64 years and 78% of all people. While the target focuses on wait times for all age groups, improvements in wait times for those aged under 25 years will be closely monitored to ensure this inequitable gap is addressed.

Faster access to primary mental health and addiction services

> **Target**: 80% of people accessing primary mental health and addiction services through the Access and Choice programme[1] are seen within one week of referral

10 As with access to specialist mental health and addiction services, early and timely access to primary services can help support people to live well, reduce the likelihood of becoming more unwell, and prevent people needing more costly specialist services. A target of 80% within a week is based on the same logic in terms of ensuring people are seen promptly and before needs potentially worsen, while acknowledging some people may not need to be seen that quickly or may prefer to be seen at a different time.

[1] The Access and Choice programme provides free mental health and addiction support in general practice, as well as kaupapa Māori, Pacific-led and youth-specific settings.

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11 The expectation of Access and Choice services is to provide rapid support. This is a new measure that will be established to reflect this expectation. Information needed for the measure is currently not mandatory and so not consistently reported by all providers. An initial focus will be on capturing the information from providers of integrated primary mental health and addiction services in general practice, which is the largest Access and Choice service stream, while working to establish reporting from providers of other work streams. This information will help with establishing baselines and setting subsequent annual milestones.

12 The Ministry of Health and Health New Zealand have indicated the need to phase implementation and to start with provisional reporting against this target, with ongoing improvement to increase completeness and establish a comprehensive measure capturing additional service streams.

Shorter mental health and addiction-related stays in emergency departments

Target: 95% of mental health and addiction-related emergency department presentations are admitted, discharged, or transferred from an emergency department within six hours of arrival

13 Some people with mental health and addiction needs, including those in crisis, seek support at emergency departments. While there is work underway to improve outcomes for people seeking crisis support for mental health issues, it is important to ensure people who present to emergency departments are seen in a timely manner.

14 This target aligns to the wider health system target that 95% of people are admitted, discharged, or transferred from an emergency department within six hours. Introducing a specific focus on mental health and addiction will help ensure those with mental health and addiction-related presentations do not experience disproportionately longer stays than those presenting with physical health needs.

15 Initial work indicates that in Quarter 1 of 2023/24, 65% of people presenting with mental health and addiction-related needs were 'seen' within six hours of arrival. There are however known data completeness and consistency issues. This compares to approximately 69% for all emergency department presentations in September 2023.

16 Further work will be undertaken to define mental health and addiction-related presentations for this target, with ongoing improvement in consistency of definitions across emergency departments to increase completeness and robustness of the data. As such, this target will also start with provisional reporting with incremental performance improvement expected year-on-year.

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Increased mental health and addiction workforce development

Target: train 500 mental health and addiction professionals each year

17 There are considerable mental health and addiction workforce shortages. This creates a barrier to improved mental health and addiction services. The proposed target focuses on the number of people trained each academic calendar year to help ensure we continue to grow this crucial workforce.

18 This target would focus on those trained through key workforce training programmes funded through Vote Health, such as the New Entry to Specialist Practice mental health and addiction nursing and allied health programmes, the number of psychiatry registrars, and the number of clinical psychology interns. Noting that there is no one size fits all development model given the diverse nature of the mental health and addiction workforce.

19 In the 2023 academic year, around 428 mental health and addiction professionals were estimated to have started training across these groups; however, this excludes the psychiatry registrar intake in 2023, and there has been growth in training programmes since the 2023 academic year.

Strengthened focus on prevention and early intervention

Target: 25% of mental health and addiction investment is allocated towards prevention and early intervention

20 Prevention and early intervention are important parts of the mental health and addiction continuum, which have historically been underfunded. The proposed target will help ensure that Health New Zealand continues to have a dedicated focus on investing in services and supports aimed at preventing mental health and addiction needs from escalating, and intervening early when needs arise.

21 A dedicated focus will protect against existing funding in this space being diverted to other services. This can help reduce the need for more costly specialist services in the long-term.

22 Around 22.5% of the Vote Health mental health and addiction ringfence investment went towards prevention and early intervention in 2021/22. This is lower than would be expected given the substantial benefits and cost savings in the longer term. These benefits were referenced in *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* released in 2018, with an acknowledgement that governments have faced challenges in shifting this balance of resources, even when evidence about return on investment is strong.

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Establishing and implementing the mental health and addiction targets

23 Phased implementation of the mental health and addiction targets programme is expected to commence from 1 July 2024. Progress towards achieving the targets is likely to be incremental and phased over multiple years, particularly given the current fiscal constraints, work to improve data infrastructure, and the pressures on the system. There is an expectation the targets will be delivered on by 2030.

24 Four out of the five proposed mental health and addiction targets are new measures, and there are known data quality and completeness issues. While this should not prevent or delay the introduction of the targets, it may mean some measures will take longer to implement. Reporting may therefore be initially provisional and become more robust and comprehensive over time.

25 The targets will be reflected in the GPS. The GPS will include clear annual expectations for implementation and performance improvement against each target, as well as the performance framework for monitoring both the mental health and addiction targets and wider health targets. The annual expectations outlined above take into account the resources available, and the time needed to establish data infrastructure and address data quality and completeness issues.

26 Implementation of the targets will also be complemented by:

26.1 monitoring of potential unintended consequences associated with the targets, such as people being seen within the targeted timeframes but not receiving appropriate or timely follow-up appointments or support

26.2 measurement appropriate disaggregation of each targets, for instance by age group and district, to ensure we are not achieving the target at the cost of specific groups or areas.

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