Memorandum

Overview of mental health and addiction system performance

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Overview of mental health and addiction system performance

Purpose

1. This briefing provides further information about mental health and addiction system performance, as signalled in the joint briefing to the incoming Minister for Mental Health. It also responds to your requests for information on the current monitoring and reporting approach and measures used to monitor service, including access and wait times.

There are multiple monitors of the mental health and addiction system

2. Roles and responsibilities for monitoring the mental health and addiction system are spread across a number of organisations. Our collective monitoring approach is evolving as the current health system arrangements embed.
    a. The Ministry of Health | Manatū Hauora has responsibility for monitoring:
        i. health system performance and the health of the population, which is the focus of this briefing
        ii. progress implementing mental health and wellbeing-related strategies, including cross-government contributions
        iii. the performance of the Māori Health Authority | Te Aka Whai Ora and Health New Zealand | Te Whatu Ora in relation to their statutory functions.
    b. The Māori Health Authority and its board monitor the services it commissions and hauora Māori outcomes more broadly.
    c. Health New Zealand and its board monitor the performance of mental health and addiction services it provides and commissions.
    d. The Mental Health and Wellbeing Commission | Te Hiringa Mahara independently monitors, assesses, and reports on mental health and addiction services and approaches that support people's mental health and wellbeing in Aotearoa. Since the Commission was established in 2021, this has typically taken the form of annual monitoring reports on mental health and addiction services and select focus areas.
3. The Suicide Prevention Office, located within the Ministry, also has monitoring responsibilities in relation to suicide prevention efforts. Further information about the Suicide Prevention Office roles and functions can be found in the joint briefing to the incoming Minister for Mental Health.
4. There are additional monitors that sit outside of the main health system organisations. For example:
    a. The Office of the Ombudsman inspects all inpatient facilities where people are detained to check their treatment and conditions.
    b. The Department of the Prime Minister and Cabinet's Implementation Unit has undertaken several reviews of progress with the Budget 2019 mental wellbeing package, the suicide prevention action plan and the mental health infrastructure programme.

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c. An external Mental Health and Addiction Assurance Group comprised of sector experts was established by the Director-General of Health in 2021 to provide assurance of progress against the Government's priorities through the health system reforms.

We draw from a range of data sources to understand system performance

5. The main data source for mental health and addiction is the Programme for Integrated Mental Health Data (PRIMHD, pronounced 'primed'), the single national data collection. PRIMHD captures information related to specialist mental health and addiction services, as well as demographic information related to the people accessing services, such as age and ethnicity.

6. Other data sources that inform our views on system performance include:

   a. quarterly reporting from Health New Zealand and the Māori Health Authority against their accountability documents, such as the interim Government Policy Statement and the New Zealand Health Plan. These include a few mandated mental health and addiction indicators focused on access and wait times for specialist mental health and addiction services, bed nights, the Budget 2019 integrated primary mental health and addiction services rollout, and high-level financial reporting

   b. quarterly reporting from Health New Zealand and the Māori Health Authority about specific services or initiatives funded through recent Budgets. The former Minister of Health reported quarterly to the Cabinet Priorities Committee on key Budget initiatives

   c. self-reported data and information from surveys such as the New Zealand Health Survey, noting that most of these surveys are annual or less frequent

   d. information from regular engagement with national mental health and addiction health sector leaders and groups.

There are a range of measures that provide information about system performance

7. The main measures we look at to understand mental health and addiction system performance can be grouped across the following domains:

   a. population need, unmet need and prevalence

   b. mental health and addiction service metrics including access to services, wait times, and indicators of quality of care/improvement

   c. system indicators including in relation to workforce and expenditure.

8. As noted above, we also monitor performance against expected delivery milestones related to the implementation of priority initiatives funded through recent Budgets. We will provide you with detailed information about the current status of recent Budget initiatives, jointly with Health New Zealand, by the end of December 2023.

9. Additionally, we look at other measures such as substance use hospitalisations, self-harm hospitalisations, poisonings and suicide death rates. These measures provide some insights into system performance. However, they cannot be looked at in isolation of the measures across the domains above, as the circumstances surrounding these measures are complex with multiple contributing factors and are not directly controlled or addressed by mental health and addiction services.

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Population prevalence, needs and unmet needs are increasing

10. Our current understanding of the prevalence of diagnosed mental disorders (including substance use disorders) is limited and outdated. Comprehensive epidemiological data on mental health and addiction was last collected in 2003/04 through *Te Rau Hinengaro: The New Zealand Mental Health Survey*.

11. *Te Rau Hinengaro* found that about 20.7% of people are estimated to experience a mental disorder within the last 12 months. Of this:

    a. 4.7% of people will experience a serious mental disorder

    b. 9.4% of people will experience a moderate mental disorder

    c. 6.6% of people will experience a mild mental disorder.

12. While this domestic prevalence data is outdated, more recent epidemiological studies in some jurisdiction's (eg, Australia) indicate that prevalence rates overseas have increased only marginally (noting the need for caution in terms of relevance for the New Zealand context). However, we are unsure about the long-term impacts of factors such as COVID-19, climate change and current global political tensions.

13. More recent self-reported data, including from the New Zealand Health Survey and New Zealand's longitudinal studies, suggest psychological distress is increasing, particularly for Māori and young people. For example:

    a. The 2021/22 Health Survey found that nearly one in four young people aged 15–24 years self-reported high or very high levels of psychological distress in the 4 weeks prior to being surveyed in 2021/22, up from 5% in 2011/12.

    b. Levels of mental distress increasing over time are also seen in the 'What About Me" – the Youth Health and Wellbeing Survey, the Youth 2019 survey, and the Growing Up in New Zealand study. 23.6% of young people aged between 15-24 years are reporting high levels of psychological distress, compared with 5.1% 10 years ago.

14. Similarly, self-reported levels of unmet need for professional help for emotions, stress, mental health or substance use has increased from 4.9% of those 15 years and older in 2016/17 to 8.8% in 2021/22. While this is a useful proxy to understand unmet needs for support, it is important to note that it does not indicate whether people reached out for support or what type of support is needed.

15. It is also important to note the difference between mental distress and mental disorder; not everyone experiencing distress will require a mental health and addiction service response. Mental health and addiction services are primarily aimed at supporting people with mental disorders, while a whole-of-government response is needed to respond to increasing levels of distress.

Mental health and addiction service metrics indicate that services are maintaining performance but are under increasing pressure

Overall service access has increased but access to some services has decreased

16. One of the key areas we look at to monitor delivery-related system performance is access to mental health and addiction services. As Figure 1 shows, overall access to mental health and addiction services has increased since 2017/18. This is largely driven by the national expansion of primary mental health and addiction services in recent years.

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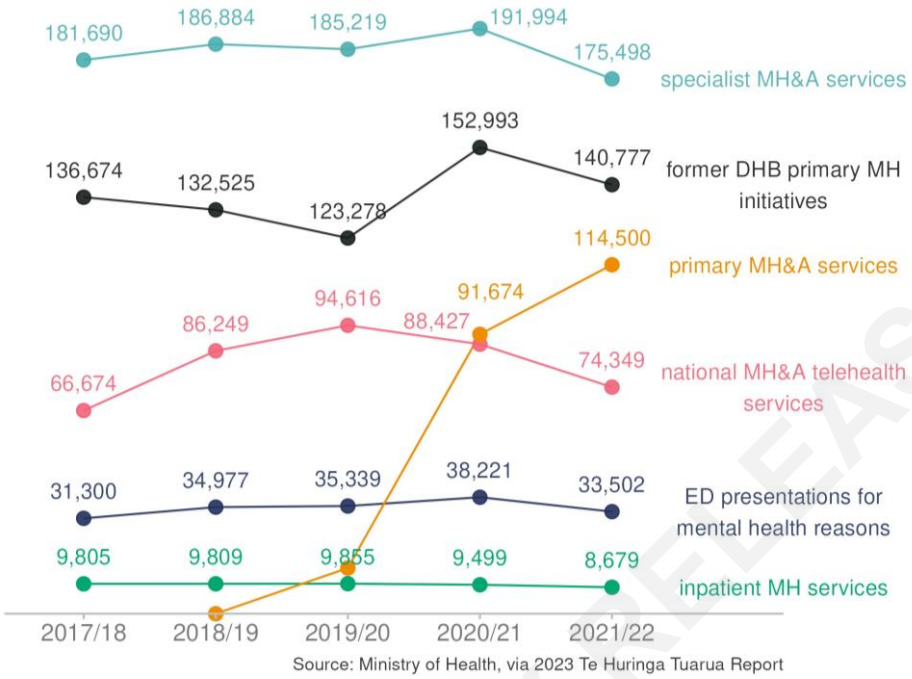
17. However, access to some service types has declined in recent years. This may reflect positive factors such as there being more options available and more people being seen in primary and community services than in inpatient settings, but it may also reflect increasing workforce shortages, different types of engagement and data completeness issues.

Figure 1. Number of people accessing mental health and addiction services



Source: Ministry of Health, via 2023 Te Huringa Tuarua Report

18. Figure 1 shows the number of people accessing different mental health and addiction services. It captures the majority of dedicated Vote Health mental health and addiction services, but does not include all mental health and addiction supports. For example, it does not include all school-based supports, uptake of mental wellbeing promotional resources and digital tools, or mental health and addiction-related support provided by General Practitioners.

19. Additionally, some people may have accessed more than one type of service, so summing the figures above could result in double counting. Our data collection systems do not allow for a single comprehensive total access figure.

20. While there are now more services and options available for people to choose from, we know that some people are unable to access mental health and addiction services when they need them. The reasons for this are likely to be multifactorial and could include that:

    a. services are available but people are unable to access them due to workforce vacancies and increased wait times

    b. local and regional inconsistencies mean that services are delivered differently or may not be available in every district

    c. people are not aware of the range of services and supports, and more work needs to be done to promote the services available. There has been progress in relation to this, for example with Health New Zealand's creation of a searchable 'wellbeing support' website.

21. Further information about access rates is included in **Appendix One**.

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Wait times for specialist mental health and addiction services have remained relatively stable

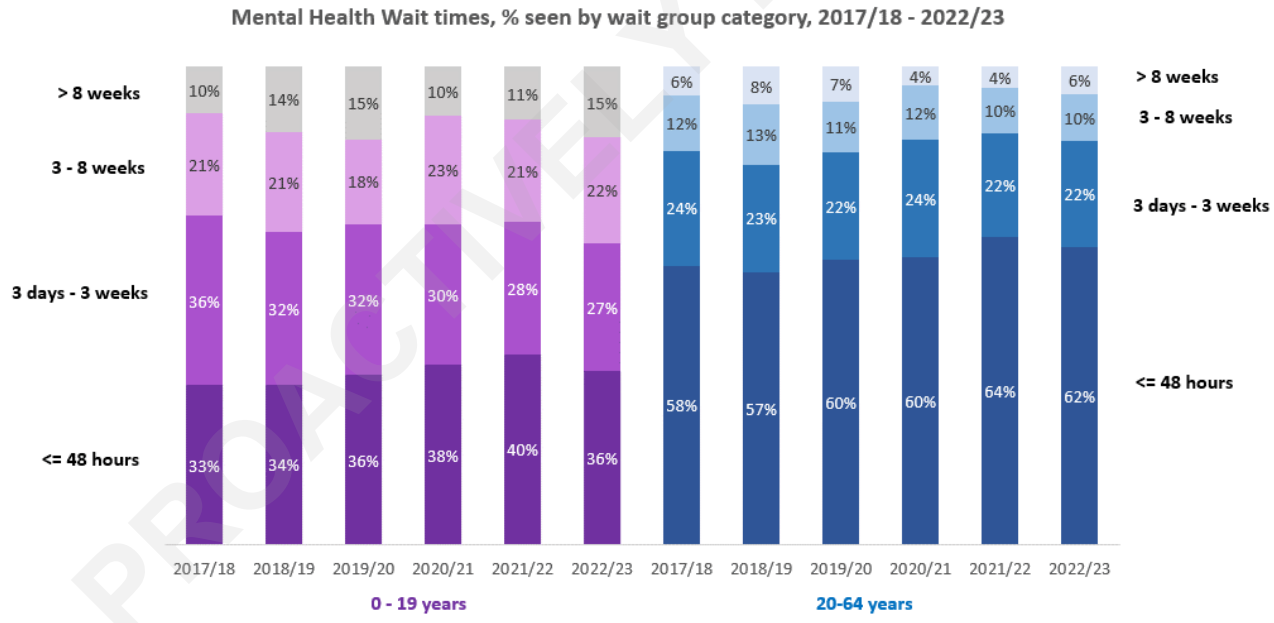
22. We only collect wait times data for specialist mental health and addiction services, and calculating wait times is complex. Mental health and addiction wait times are calculated by identifying how much time has passed between when a referral for a new client was first made, and when the first face-to-face appointment or activities of a clinical nature occurred (note: community support contacts and peer support activities are not counted as a first appointment or activity, as it is expected people are assessed by a clinician first).

23. Mental health and addiction wait times are categorised using age ranges: 0–19 years, 20–64 years and 65+ years; and are divided into three different wait time periods: the percentage of people seen within 48 hours, 3 weeks and 8 weeks.

24. There is an expectation that approximately 80% of people are seen within 3 weeks and 95% of people are seen within 8 weeks.[1]

25. As Figure 2 shows, wait times for specialist mental health services indicate that there has been little change over the last 6 years, for example with the percentage of people seen within 3 weeks sitting between 63–69% for 0–19 year olds and 80–86% for 20–64 year olds during the 6 years from 2017/18 to 2022/23.

Figure 2. Specialist mental health service wait times: percentage of people seen within 48 hours, 3 weeks, 8 weeks or greater than 8 weeks, 2017/18–2022/23



26. Improving timely access to specialist mental health and addiction services has been a priority within our system performance monitoring approach, particularly for children and young people. The steady rates likely reflect access hitting a capacity ceiling within specialist services. It will be difficult to shift this measure without either introducing additional capacity into existing services or options to support people in other ways.

[1] Note: These were established as benchmarks for performance, rather than targets, to support standardisation.

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27. However, while wait times are longer than desired, the steady rates alongside increasing workforce vacancies (discussed further below) are positive.

28. Further information about wait times is included in **Appendix One**.

Performance against quality improvement measures is steady but could be improved

29. There are a number of measures we previously monitored from district health boards (DHBs) that help support best practice, provide insights into the efficacy of services provided, and focus attention on ensuring people with the highest needs receive follow-up support and high-quality care.

30. These measures are set out below. Health New Zealand does not currently report to us formally on these measures; however, the PRIMHD dataset still includes data inputted by some districts related to these measures. While there are data completeness issues, the most recent information available indicates that:

    a. 7-day post-discharge follow-up: in the quarter ending March 2023, approximately 70% of people were followed up face-to-face within 7 days post-discharge from a mental health inpatient unit

    b. presence of discharge plans from inpatient mental health units: at the end of quarter four 2021/22, DHBs nationally reported that 71% of people discharged had a discharge plan and 82% of plans met a self-assessed quality standard

    c. the 28-day readmission rate to a mental health inpatient unit: the 28-day national readmission rate was 13%, a decrease of approximately 4% over the last 5 years, suggesting an improvement.

31. We continue to advocate for a focus on these measures, as there is good evidence that they improve the quality, safety and outcomes of services provided to people with the highest needs at critical times in their care.

32. In addition to these measures, services also collect information about individual outcomes using tools such as the Health of the Nation Outcome Scale (HoNOS) which measures the health and social functioning of people using specialist services. These results are summarised and published annually by Te Pou (one of the national workforce development centres).

System-level indicators also signal increasing pressure on workforces and capacity constraints

Mental health and addiction workforce vacancies have increased

33. It is difficult to get an accurate picture of the mental health and addiction workforce due to a number of challenges, including:

    a. different processes for counting vacancies across districts, as well as across non-government providers

    b. different data systems for capturing vacancy-related information which means manual collation and consolidation is required to capture national-level vacancy information

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c. the wide range of employers of mental health and addiction professionals. In addition to Vote Health-funded mental health and addiction workforces, there are mental health and addiction professionals working in non-health related agencies such as the Department of Corrections, Ministry of Education, and Ministry for Children | Oranga Tamariki,, as well as those who provide public and private services.

34. There are however a number of different measures related to workforce that we look at such as vacancies, retention and turnover rates. For example, in terms of workforce vacancy rates, Te Pou data indicates that total workforce vacancy rates in 2022 were around 11.4% (in increase of 6.5% from 2018 rates).

35. Vacancy rates differ by roles and settings. For example:

    a. The vacancy rate among medical practitioners was 15.9%, whereas among support workers it was 11.0%.

    b. Vacancy rates in adult mental health and addiction services were 11.1% in 2022, up from 5.5% in 2018, whereas vacancy rates in child and adolescent mental health and addictions services were 13.1% in 2022, up from 9% in 2018.

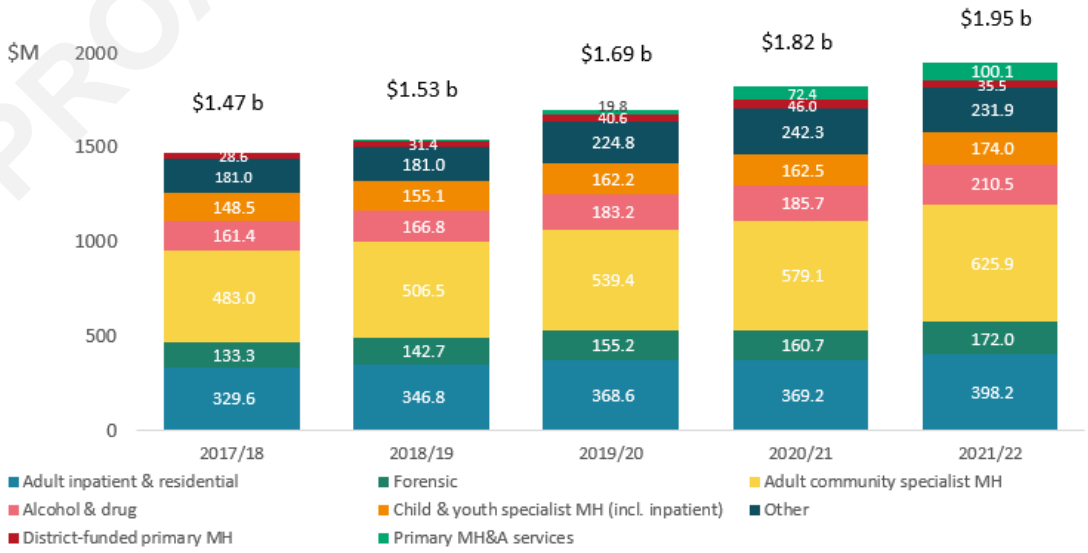
36. It is also possible to look at other metrics such as training places and the number or proportion of people completing training. You have requested further advice related to the mental health and addiction workforce, which we will provide to you by the end of December 2023 jointly with Health New Zealand. This advice will include more detailed information on some of the current workforce data that is available.

Expenditure on mental health and addiction has increased but is largely driven by cost pressures and there are capacity constraints

37. Crown funding for mental health and addiction activities is split across a number of Votes and appropriations, however the majority of Crown funding specifically for mental health and addiction activities sits within Vote Health.

38. Figure 3 shows Vote Health expenditure on mental health and addiction services. Investment has increased, but most of this growth relates to cost pressure uplifts rather than expansion of service capacity.

Figure 3. Vote Health mental health and addiction expenditure, 2017/18 to 2021/22



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39. Our main mechanism to monitor Vote Health mental health and addiction investment is the mental health and addiction ringfence. The Ministry sets the quantum of the ringfence annually, which represents the expectation for the minimum level of expenditure on mental health and addiction that year. The ringfence aims to ensure that the amount spent on mental health and addiction services increases each year at least in line with demographic and cost pressures, and to ensure mental health and addiction expenditure is not reallocated to other service areas.

40. Since the 2022 health system reforms, the ringfence expectation encompasses Health New Zealand and the Māori Health Authority mental health and addiction expenditure across hospital and specialist services and primary and community services. This includes both previously devolved former DHB mental health and addiction funding and funding held nationally prior to the health system reforms (eg, funding allocated through recent Budget processes).

41. Health New Zealand and the Māori Health Authority are each expected to meet or exceed their component of the mental health and addiction ringfence and are required to provide the Ministry with information on their actual expenditure.

42. The ringfence for 2022/23 was set by the Ministry at approximately $2.2 billion. Health New Zealand has reported an actual spend of approximately $2.1 billion against their mental health output class, which largely represents their component of the mental health and addiction ringfence (see below for discussion on limitations of this reporting). The Māori Health Authority has not formally reported the spend against mental health separately, although they have confirmed that their actual spend in this area is approximately $150 million. We will use the 2022/23 spend information to inform the ringfence expectation for 2023/24.

43. We will provide you with further information about mental health and addiction investment, including across government, and current funding arrangements separately.

There are limitations to system performance monitoring

44. There are a number of limitations which impact on our ability to monitor mental health and addiction system performance. These include:

    a. *data availability and consistency* – many existing measures are reliant on data from the PRIMHD national dataset, which has limitations due to data availability, consistency and completeness issues (see below for work underway to address this)

    b. *focus on specialist mental health and addiction services* – several current measures, notably those reliant on PRIMHD data, are limited to the specialist end of the mental health and addiction service continuum. The Budget 2019 national rollout of new primary mental health and addiction services and the establishment of associated data collection processes has helped to build a fuller picture of primary-level services, but we have limited insight at a national level into wellbeing promotion, prevention and early intervention supports

    c. *limited information about outcomes, effectiveness and people's experiences* – most mental health and addiction measures relate to service activities, and there is limited data about the effectiveness of services, outcomes for people or people's experiences accessing services. We also know that people's mental health and addiction outcomes are impacted by factors outside of the health system including education, employment and housing

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d. *there is no single data system across districts* – prior to the health system reforms, DHBs used different electronic systems and processes. With the consolidation of DHBs into Health New Zealand, there is a lack of easily accessible, consolidated information across the system, beyond the information contained within PRIMHD (which as referenced above has its own limitations). While Health New Zealand has work underway to develop integrated systems, this limits our ability to monitor system performance

e. *the Ministry's access to information* – most data required to monitor system performance is held by other health entities. The Ministry is not always given timely access to the data required to fulfil our function effectively, it is unclear what data is available within Health New Zealand, and it is difficult for us to validate what data is provided as most is high-level.

45. An example of the impact of these limitations is reporting against the mental health and addiction ringfence. The information the Ministry currently receives about spend against the ringfence is high-level only. Health New Zealand is not currently able to link financial reporting with service delivery reporting consistently. This means we can determine whether the quantum of the ringfence expectation was met or exceeded, but we have limited understanding about what it was spent on.

Work is underway to improve system performance monitoring

46. The Ministry is working with Health New Zealand and the Māori Health Authority to improve mental health and addiction system performance monitoring. This includes:

a. ongoing work to improve data quality and completeness, particularly within PRIMHD. There are longstanding challenges and reporting variations between districts and providers, however we have communicated our expectations that Health New Zealand prioritises improving the completeness, timeliness and accuracy of data inputted into PRIMHD by services

b. focusing on mental health and addiction as part of the enhanced Crown entity monitoring programme underway with Health New Zealand. This work is looking to enhance our understanding of Health New Zealand Board priorities and how mental health and addiction is being managed and monitored within Health New Zealand, and how service level performance is tracking. An initial focus for mental health and addiction is ensuring transparency around mental health and addiction ringfence expenditure

c. ongoing work as part of the Mental Health and Addiction Key Performance Indicator Programme. This national sector-led programme focuses on ongoing quality improvement across all districts and their non-governmental organisation partners via collective data analysis, benchmarking and collective learning and problem solving.

47. Work underway to implement the *Oranga Hinengaro Service and System Framework* will also improve our understanding. The *System and Service Framework*, published by the Ministry in April 2023, sets consistent national expectations for the range of mental health and addiction services that should be available with a 10-year view. Health New Zealand is leading a national investment stocktake to get an accurate picture of current state service investment and delivery (to be completed in early 2024), which will provide a more meaningful baseline for future performance and inform efforts to reduce variation.

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There are opportunities to further enhance the performance monitoring approach

48. The approach to monitoring mental health and addiction system performance will evolve as the work currently underway progresses and as the health system arrangements further embed. There are opportunities for you to set clear expectations for the health entities about the transparency and level of information you expect in relation to mental health and addiction system performance, which we can support you with.

49. Future opportunities to shape and enhance the performance monitoring approach include:

    a. introducing a mental health and addiction target or suite of targets – when appropriately designed, targets can be a good vehicle for public accountability. The introduction of a mental health and addiction target alongside wider health targets could help drive prioritisation of mental health and addiction within the health system

    b. enhancing reporting arrangements to you and across government – as part of the Ministry's monitoring role, we can help make sure that you, your ministerial colleagues and the public have information about how the system is currently performing. This can incorporate reporting on cross-government contributions to mental health and addiction

    c. looking across the range of organisations with monitoring responsibilities for mental health and addiction to ensure complementary approaches. This will help to remove duplication and ensure we are all adding unique value to our collective understanding of system performance.

Equity

50. We know there are inequitable mental health and addiction outcomes for different population groups (eg, Māori when compared to non-Māori) and that some people are less able to access mental health and addiction services than others. Furthermore, people who use specialist mental health and addiction services experience inequitable outcomes in a range of domains such as physical health outcomes, when compared to non-specialist mental health and addiction service users.

51. Enhancing our understanding of mental health and addiction system performance allows us to monitor what's happening in terms of inequities between population groups and access to services. Monitoring can also help encourage and drive work to focus on addressing inequities and increasing access where framed appropriately to prevent reinforcing the status quo.

Next steps

52. We will provide you with regular updates on mental health and addiction system performance, including improvements to monitoring system performance, as work progresses.

53. As signalled above, we will also provide you with a series of further advice before the end of December 2023, which will contain more detailed information relevant to aspects of system performance, including information and advice on:

    a. the mental health and addiction investment landscape within Vote Health and across Votes and current funding arrangements

    b. considerations in relation to a new mental health and addiction epidemiological study

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c. the mental health and addiction workforce, including more information about current workforce data

d. the potential for a mental health and addiction target or suite of targets, for potential engagement with the Minister of Health in relation to wider health system targets

e. a detailed update on the status of Budget 2019 and Budget 2022 mental health and addiction initiatives.

54. Following further engagement with you to better understand your priorities for ongoing system performance monitoring, we will also provide advice in early 2024 on options for enhancing the monitoring and reporting arrangements to support oversight of system performance.

Robyn Shearer

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Clinical, Community and Mental Health | Te Pou Whakakaha

Date: 7 December 2023

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Appendix One: Additional information on mental health and addiction service access and wait times

Access to specialist mental health and addiction services

1. Specialist mental health and addiction services are funded based on a historical expectation that 3% of the population will need to access specialist mental health and addiction services within a 12-month period.

2. Table 1 summarises access rates from 2018 to March 2023, and shows that access to mental health and addiction services has exceeded the 3% threshold (averaging around 3.8% over the past 6 years) except for Pacific children and young people aged 0–19 years whose access rates have never hit the 3% mark and have decreased over this period.

3. We now know that these assumptions about access are lower than known needs. Whilst our current understanding of mental health and addiction prevalence is limited and outdated, our most recent prevalence data estimates that approximately 4.7% of the population may experience a serious mental health disorder in a 12-month period.

Table 1. Access to specialist mental health and addiction services 2018 to March 2023

Age	Year	Proportion of population				Number of service users			
		Total	Māori	Pacific	Other	Total	Māori	Pacific	Other
0–19 years	2018	**3.81%**	4.69%	2.54%	3.65%	**48,154**	15,215	3,036	29,903
	2019	**3.99%**	4.89%	2.64%	3.83%	**50,722**	16,035	3,164	31,523
	2020	**3.85%**	4.33%	2.27%	3.89%	**49,416**	14,760	2,835	31,821
	2021	**3.91%**	4.31%	2.17%	4.02%	**50,306**	14,950	2,766	32,590
	2022	**3.64%**	3.91%	2.09%	3.77%	**46,765**	13,692	2,675	30,398
	Apr22-Mar23	**3.70%**	4.04%	2.17%	3.57%	**47,553**	14,152	2,775	30,626
20–64 years	2018	**3.89%**	8.23%	3.75%	3.16%	**112,960**	32,732	6,684	73,544
	2019	**4.08%**	8.84%	4.01%	3.26%	**120,002**	35,815	7,326	76,861
	2020	**3.90%**	7.62%	3.70%	3.19%	**117,617**	35,175	7,301	75,141
	2021	**3.80%**	7.26%	3.58%	3.12%	**114,863**	34,547	7,229	73,087
	2022	**3.61%**	6.91%	3.43%	2.95%	**109,482**	33,491	7,036	68,955
	Apr22-Mar23	**3.65%**	7.05%	3.49%	3.00%	**110,536**	34,201	7,172	69,163

Access to primary mental health and addiction services

4. Our main insights into access to early intervention and primary-level support is through the Budget 2019 rollout of new primary mental health and addiction services.

5. These services are resourced to see approximately 6.5% of the population, once rollout is completed at the end of June 2024, or an intended capacity of 325,000 people per annum.

    a. As at the end of quarter 4 2022/23, annual access was at approximately 207,800 people. This is approximately 80% of the expected 255,000 people target for the end of that quarter, but overall the programme is on track to achieve the intended capacity of 325,000 people by the end of 2023/24.

    b. The enrolled population coverage for these services was 3.1 million in quarter 4 2022/23. This exceeded the target population coverage for this quarter.

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6. These services are intended to support people with mild and moderate needs. While funding for these new primary mental health and addiction services is based on seeing approximately 6.5% of the population each year, as noted above, our most recent epidemiological data estimates approximately 9.4% of people will experience a moderate mental disorder and 6.6% of people will experience a mild mental disorder in a 12-month period.

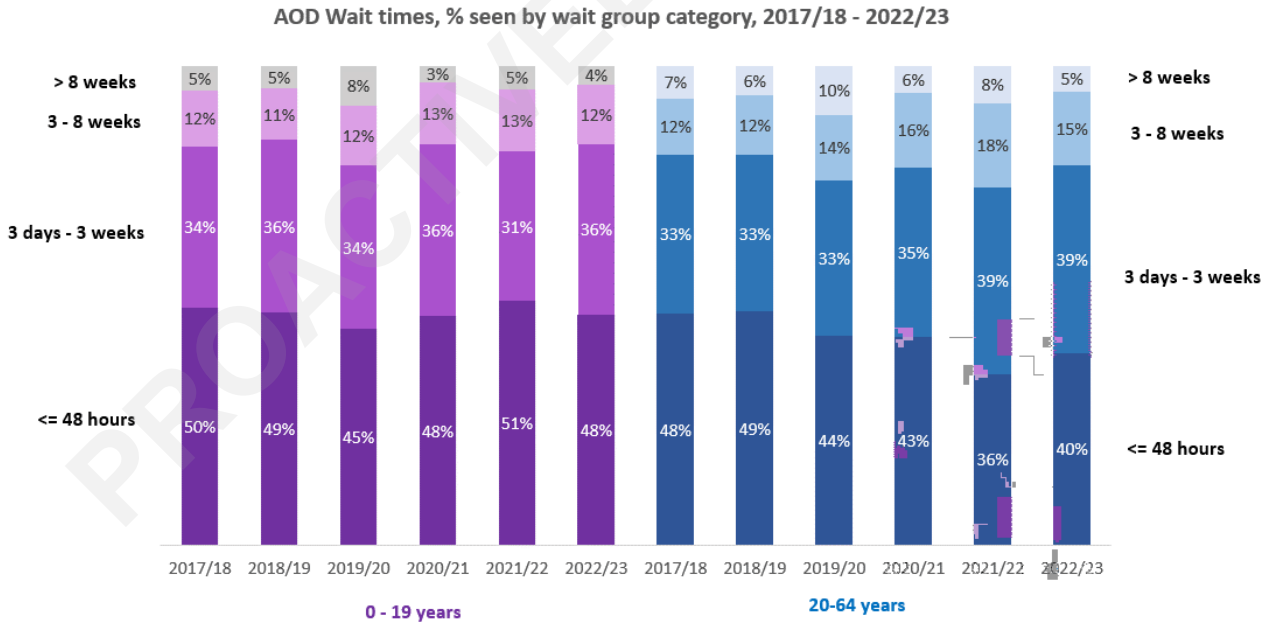
Specialist mental health and addiction service wait times

7. As noted above, we collect wait time data for specialist mental health and addiction services which measure the time between a new client referral and the first face-to-face clinical interaction with a client.

8. It is important to look at measures in the context of a wider set of metrics. For instance, wait time data needs to be looked at in the context of the number of referrals received and the percentage of people accessing services, as this helps provide a more fulsome picture of what may be happening, and therefore what may be needed to address any issues. Though this still provides a limited picture as it does not include any information related to the severity of need or presenting issues which can tell us more about the complexity of demand.

9. Data about wait times for specialist mental health services is included in the body of this briefing. We also have separate information about wait times for specialist alcohol and other drug (AOD) services. These have also remained reasonably consistent over recent years.

Figure 4. Specialist AOD service wait times: percentage of people seen within 48 hours, 3 weeks, 8 weeks or greater than 8 weeks, 2017/18–2022/23



10. Across both specialist mental health and AOD services, while national rates have remained relatively stable, there is significant variation between districts. For example:

    a. Hawkes Bay saw 65% of young people within 48 hours and 95% within 3 weeks, compared to 37.2% and 64.2% respectively for the national average.

    b. Lakes specialist AOD services see nearly 85% of adults and children and young people within 48 hours while Nelson Marlborough only sees 10% of adults.

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11. It is important to note that whilst access to services within a 48-hour time frame may be appropriate for some presentations such as overdose, severe self-harm attempt, symptoms of psychosis, hypermania or an eating disorder, most people do not need to be seen within 48 hours. We monitor this indicator because if the percentage of people seen within the 48 hour wait time changes over time or at specific times, it can indicate:

    a. a service or system under pressure, which if unresolved could result in pressures on other services (eg, if people have been waiting too long to be seen, they may present to emergency departments)

    b. people are genuinely presenting in crisis and may not have been able to access timely support earlier, for instance through primary care services or care from their family or community

    c. changes to who is being prioritised for access, for instance in child and adolescent specialist mental health and addiction services, young people may be prioritised over children, resulting in delays to children waiting for routine planned assessments for neurodevelopmental disorders.

12. The sector-led Key Performance Indicator Programme has recently introduced a measure which focuses on the length of time from the point of referral to the third face-to-face appointment. This is a potentially useful metric, particularly within child and adolescent mental health services, to help monitor whether people are receiving timely interventions/ support after their first appointment.

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Minister's Notes

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