MANATŪ HAUORA
MINISTRY OF HEALTH

Te Aka Whai Ora
Māori Health Authority

Te Whatu Ora
Health New Zealand

Joint Briefing to the Incoming Minister for Mental Health

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Foreword

Congratulations on your appointment as Minister for Mental Health.

The Ministry of Health | Manatū Hauora, Health New Zealand | Te Whatu Ora, and the Māori Health Authority | Te Aka Whai Ora are committed to working with you to deliver your priorities for mental health and addiction.

Our first priority is to work with you on implementing the Coalition Government s priority commitments in the portfolio:

- establishing and operating the Mental Health Innovation Fund
- funding the Gumboot Friday/I Am Hope charity to $6 million per annum.

Other priority areas we consider warrant early attention include:

- child and youth mental wellbeing, including work across government and potential expansion of services
- supporting suicide prevention, including the development of a new action plan
- options to address the significant pressure on mental health and addiction services and to grow the mental health and addiction workforce
- reforming mental health legislation to support a recovery approach, put people at the centre of their care, and uphold the human rights of people receiving care
- responding better to 111 calls relating to mental distress and ensuring people get the type of help they need
- improving overdose prevention and response, including developing a cross-government plan
- a population prevalence survey to ensure we have up-to-date information to plan and commission services, undertake promotion and prevention, and support communities and whānau to meet their needs.

Our organisations look forward to discussing your priorities and helping you to implement the Government's mental health and addiction policies.

We look forward to working with you as you take up your new portfolio.

Yours sincerely

Dr Diana Sarfati	Margie Apa	Riana Manuel
Director-General of Health	Chief Executive	Chief Executive | Te Aka Matua
Ministry of Health	**Health New Zealand**	**Māori Health Authority**

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Part 1: Coalition Government priorities, key opportunities and upcoming decisions

The current state of the mental health and addiction system in New Zealand presents a range of challenges and opportunities for the Government to deliver its agenda.

This section outlines our initial thinking in response to commitments signalled in the Coalition agreements, as well as some other priority issues and opportunities. We look forward to discussing how we move forward on your priorities.

Coalition Government priorities

Mental Health Innovation Fund

The Mental Health Innovation Fund proposes matching funding for community and non-government organisation (NGO) mental health providers of $20 million over four years to support community providers to scale up already successful operations.

This commitment aligns with the critical role the NGO sector plays in supporting people's mental health and addiction needs in the community. NGOs currently receive significant funding in line with this role. Government agencies and Crown entities are bound by the Government Rules of Procurement, so open procurement processes are used in the allocation of new funding. This helps to ensure services funded meet clinical safety standards and requirements.

Officials can provide further advice on approaches to implement the Mental Health Innovation Fund, including funding criteria and prioritisation mechanisms, as requested.

Funding for Gumboot Friday/I Am Hope Charity

The commitment in the National and New Zealand First Coalition agreement to provide Gumboot Friday/I Am Hope charity funding of $6 million per annum could s 9(2)(f)(iv), s 9(2)(j) [redacted].

The Ministry of Health (the Ministry) has had engagement with representatives of the I Am Hope Charitable Trust, which runs Gumboot Friday, in recent years. The Ministry previously reached out to offer discussions around potential funding options and provided $600,000 of one-off funding to the Trust in 2021 to support the Trust to strengthen its infrastructure.

s 9(2)(g)(i) [redacted] However, a recent evaluation by ImpactLab found benefits from the Trust's activity, which is a positive step towards meeting expectations for receipt of government funding.

We would like to discuss further with you the parameters of this proposed funding arrangement to ensure delivery of Government expe tations and manage any risks.

Priority issues and opportunities

Psychology and psychiatry workforce expansion

We note that the initial National Party manifesto proposed to increase the number of psychiatric registrar places to 50 a year on average (up from about 37) and double the number of clinical psychologists being trained each year from 40 to 80 over the next four years. It is not clear whether this commitment continues to be included within the Coalition agreements under the agreement to the National Party priority to 'cut health waiting times by training more doctors, nurses, and midwives…'

We would welcome a discussion to clarify the status of this commitment, but note that final year internship Clinical Psychology number across all universities is more than the 40 places cited, with approximately 80 in 2024. Of note, clinical psychology interns are employed/placed across a range of agencies including health. There are opportunities to build on initiatives already underway to deliver on this commitment:

- The number of nationally-funded clinical psychology interns within health services has trebled from 12 in 2019 to 38 this year (with 50 planned for 2024). Health New Zealand (HNZ) has established training hubs, and two (of four) training hubs have been established in kaupapa Māori providers. Further increases to the psychology workforce (Clinical Psychology and Health

Psychology (General Scope)) will require university programmes to significantly increase their intake and an associated funding increase.

- Work is underway with the Royal Australian and New Zealand College of Psychiatrists to address issues relating to growing the number of psychiatrist vacancies in New Zealand. Health New Zealand has funded a psychiatry interest forum designed at attracting more medical students and junior doctors into psychiatry. The suggested intake of 50 into first year psychiatry registrar training would represent an increase in intake. Health New Zealand is undertaking work to ensure appropriate funding and service planning can be in place to make sure registrars can complete training and progress into employment within public sector services.

Officials can provide you with further advice on the implementation of this commitment if required, including financial implications, pipeline considerations and wider workforce development activities and opportunities

Addressing significant service and workforce pressures

The mental health and addiction system is under significant pressure, and the capacity of mental health and addiction services and workforce growth have not kept pace with increasing demand. Addre sing these pressures will require a range of approaches including workforce development, changes to models of care and workforce mix, and building a more comprehensive continuum of supports.

Workforce development

Workforce challenges remain the most significant risk for the continued delivery of services across the mental health and addiction continuum, and directly impact those in need of ervices Mental health and addiction workforce challenges are long-standing and integrally linked to the wider health workforce challenges and system barriers. They are also not limited to New Zealand; there are shortages of health workforce globally.

The 2023 Mental Health and Wellbeing Commission | Te Hiringa Mahara monitor ng report reported an 11% rate of vacancy in the total adult specialist menta health service workforce (increased by 6.5% from 2018). This figure includes all mental health and addiction services, but the vacancy rates in hospital and specialist services are much higher than this, with particularly high rates in the child and youth, mental health forensic and intellectual disability forensic sub-specialties.

Agencies have a strong focus on workforce development and are implementing a range of initiatives through a dedicated workforce programme which you can build on. Ongoing and sustained effort and investment is needed, including work with the education sector to address broader pipeline issues and targeted recruitment and retention programmes to attract workers both nationally and internationally.

Peer support model

There is strong evidence that, when combined with more traditional models, peer-based support models improve outcomes. This model involves a workforce of people with lived experience of mental health or addiction challenges who have received training to provide peer support to others experiencing these concerns. There is a current focus on expanding peer support in the mild and moderate service levels, but it will also be a key solution to strengthening the full continuum including in acute settings.

There is an opportunity to expand the capacity of mental health and addiction services more quickly with structured supports and investment in the peer workforce, alongside an ongoing focus on growing clinical workforces.

Kaupapa Māori services

Māori have experienced persistent inequitable mental health and addiction outcomes. For example, from the most recent confirmed reporting, the suicide rate was higher for Māori than other ethnic groups, with a rate of 18.2 per 100,000 Māori population compared with 10.6 per 100,000 for non-Māori. A notable difference in the rate of suicide between Māori and non-Māori was the 15–24 years age group, at 2.1 times that for non-Māori in the same age group.

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga) noted that the strong consensus among Māori was that te ao Māori, mātauranga Māori, whānau, and te reo me ona tikanga are essential aspects of wellbeing for Māori.

Currently, investment in kaupapa Māori services lags behind the identified need for these services. Investment in kaupapa Māori services will provide more choices for Māori seeking support, and a skilled cultural workforce will be able to deliver appropriate and effective services. A Treaty-based approach that involves iwi and Māori community leaders will also be highly pertinent to tackling the wider social determinants that underlie intergenerational trauma and inequity in our society.

Community-based acute alternatives

There is significant pressure on specialist mental health and addiction services. Whilst mental health and addiction services for people with mild and moderate mental health and addiction needs are important, and that is where most recent new investment has focused, it is also critical that we do not neglect appropriate care for those with acute and high and complex needs.

Community-based acute alternative services are provided by NGOs with a strong peer/clinical model of care and are supported by specialist clinical teams. There is an opportunity to expand these services to support the acute continuum, noting they are not a replacement for acute inpatient units but can ease pressure. These services work well where they are present, can be provided at a lower cost, and can integrate seamlessly into the acute continuum.

Child and youth mental health and wellbeing

There has been a large increase in self-reported psychological distress among people aged 15–24, according to the New Zealand Health Survey. For children aged 0–14, there has been an increase in anxiety disorders and emotional/behavioural problems, both of which have roughly doubled from 2011/12 to 2021/22. These increases disproportionately affect Māori given the younger population profile. There are both immediate benefits and long-term savings realisable through investing early in the life course.

There are opportunities to scale up targeted programmes underway by Health New Zealand and the Māori Health Authority to support children and young people's mental health and wellbeing across a range of settings, as well as to build on the strategic cross-government work the Ministry is leading unde the Child and Youth Wellbeing Strategy. We suggest these are worth early inves igation and can provide further advice on this area.

Suicide prevention

Suicide remains a concern in New Zealand. The latest confirmed suicide data are from 2018 and showed there were 623 suicide deaths (a rate of 12.1 per 100,000 population). In the most recent suspected intentionally self-inflicted death data for 2022/23, 565 people died by suspected su cide (a rate of 10.6 per 100,000).

Since late 2022, the Māori Health Authority has been responsible for commissioning whole-of-population suicide prevention services, acknowledging the disproportionate impact suicidality has on Māori. The Māori Health Authority has strengthened Kia Piki Te Ora kaupapa Māori suicide prevention services, which have expanded from 9 providers to 23 providers delivering across 24 sites nationwide. The regional suicide prevention and postvention coordinators currently within Health New Zealand continue to work across the spectrum of suicide prevention, intervention and postvention.

The Suicide Prevention Office, within the Ministry, leads cross-government work on suicide prevention, guided by *Every Life Matters: He Tapu te Oranga*, the national 10 year strategy and 5-year action plan. The current action plan is set to end in 2024. The Suicide Prevention Office is leading the development of the 2025–2029 action plan and will provide you with further advice, seeking your views on the approach and timing of this work.

Legislation reform

Work is well underway to repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) in line with the recommendation of *He Ara Oranga* for new legislation that upholds human rights, aligns with modern models of mental health care (including supported decision-making and greater family involvement in care), and minimises the use of seclusion and restraint.

A Mental Health Bill that would repeal and replace the current Mental Health Act is being drafted following wide public consultation and policy proposals developed in consultation with experts from clinical, lived experience and Māori perspectives. The Ministry anticipates being in a position to discuss a draft Bill with you in December this year. This will include advice on discussing the legislative priority for this Bill with the Minister of Health.

Longstanding government policy has been to reduce the use of restraint and eliminate the use of seclusion, but limited progress has been made. While seclusion rates overall have decreased by about a quarter, the number of Māori secluded has nearly doubled. The Māori Health Authority has been investigating whether kaupapa Māori approaches could potentially support the goal of eliminating seclusion and limiting/eliminating restraint.

There will be implementation implications to new legislation, which the M nistry is working through with Health New Zealand, the Māori Health Authority and other agencies with roles under the Mental Health Act. This includes implications for workforce capacity, time and capability associated with new ways of working, which will require additional resource.

Officials will provide further advice on work to repeal and replace the Mental Health Act in due course, but there will be opportunities for early policy action in this area.

Implementing the *Oranga Hinengaro System and Service Framework*

Published in April 2023 by the Ministry, the *System and Service Framework* sets out the core components of a contemporary mental health and addiction system with a 10-year timeframe and the critical shifts required to get there. The emphasis is on service commissioning that responds to local needs and preferences, while maintaining an equitable and nationally consistent level of access to services.

As an initial step in the implementation of the *System and Service Framework*, Health New Zealand is undertaking a stocktake of national investment by service type and geographical location to understand national variation in availability of mental health and addiction services. This stocktake is expected to be completed by the end of 2023.

Health New Zealand, in partnership with the Māori Health Authority, is also establishing strategic design and clinical networks. These networks, planned for establishment in 2024, will help re-design mental health and addiction services and develop national standards and models of care and to reduce unwarranted variation in service provision.

Developing a multi-agency response to 111 calls relating to mental distress

The Ministry, Health New Zealand, the Māori Health Authority and New Zealand Police are working in partnership to develop a five-year plan to transition the currently Police-led response to people experiencing mental distress who call 111 into a multi-agency response. The plan will include the core components of a whole-of-system approach, proposed phasing of a staged transition, and an outline of agencies' roles and responsibilities.

This work is likely to have a significant impact on health services, and changes will take time and require potentially substantial additional resources. A response needs to be carefully worked through to ensure it makes best use of a scarce workforce and that there is sufficient health system capacity to implement the approach without destabilising other services.

A joint Minister of Police/Minister of Health report back is due to Cabinet in March 2024 including a high-level estimate of the resourcing required to implement the transition plan. Officials will provide you and the Ministers of Police and Health with joint advice ahead of this.

Development of an overdose harm reduction and preparedness plan

There are increasing concerns about the harms of overdose as well as initial evidence that overdose deaths in New Zealand are increasing. Consistent with our prevention and harm reduction approach, health organisations are working across government on harm reduction and overdose avoidance and the development of an overdose plan. A plan will assist the coordination of activities and actions at both a national and local level to prevent and reduce the harm from overdoses. This work is in the initial scoping stages and further advice regarding scope and timeframes will be provided in early 2024.

Population prevalence information

The last epidemiological study of mental health and substance use was completed 18 years ago. This means that there is a lack of up-to-date information about the prevalence of mental health and addiction needs in our communities, as distinct from levels of distress more broadly. In addition, there is a lack of robust, consistent and accessible activity data across the system, with a need to consolidate collection.

Further investment would be required for a prevalence survey to ensure that there is reliable and robust data available to support commissioning and funding decisions, and to improve data collection to understand how people are accessing services and whether services are improving outcomes. Officials can provide you with further advice on this in the context of upcoming Budget discussions if desired.

Upcoming decisions and advice

As noted above, officials will provide further advice to support upcoming decisions and to support your consideration of key issues and opportunities. A more fulsome list of upcoming advice and decisions over the next six months is attached as **Appendix 4**.

Part 2: Mental health and addiction in New Zealand

Mental wellbeing is shaped by many factors

Mental wellbeing impacts the lives of all people in New Zealand. What constitutes mental wellbeing will differ across people and across time, but everyone can enjoy good mental wellbeing, regardless of the presence or absence of a ment l health condition or addiction.

We know that mental wellbeing is strengthened by a range of protective factors and compromised by adverse social, cultural, environmental and economic factors (determinants of health). People with different backgrounds and circumstances will experience determinants of mental wellbeing inequitably and at different times of their lives. Māori and Pacific, disabled people, rainbow communities and those experiencing socioeconomic disadvantage, have more risk factors and fewer protective factors than other groups of people.

For children and young people, there is evidence that early experiences contribute significantly to mental wellbeing and other health outcomes. Adverse childhood experiences can be stressful or traumatic. Childhood experiences such as abuse, neglect, or forms of household dysfunction can lead to increased risk of unhealthy behaviours, lower engagement in education, and thinking about suicide.

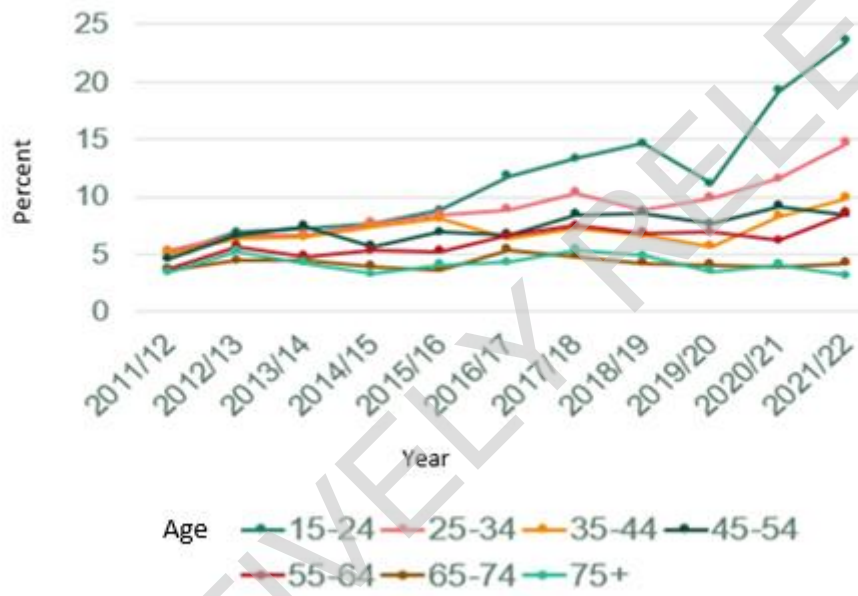
The mental health and addiction system needs to work effectively alongside our partners across the health, social, and economic sectors and with communities, whānau and individuals to address key determinants of health. There is also activity underway and may be further opportunities to target efforts at improving outcomes for shared population groups across sectors (eg, people interacting with the justice system, children in the care of Oranga Tamariki and people who have experienced family violence).

There may be opportunities for you to influence prioritisation of mental health and wellbeing in other portfolios, which officials can support you with.

Psychological distress and substance use harms are increasing

Our understanding of the population prevalence of mental health and addiction issues is limited, as the last epidemiological study was completed in the early 2000s, but self-reported levels of distress and substance use harms are increasing according to the New Zealand Health Survey 2021/2022.

Figure 1: High psychological distress over time by age group (NZ Health Survey data)



For those over 15 years of age, 11.2% experienced high levels of psychological distress in the 4 weeks prior to be ng surveyed – an increase from 4.6% 10 years earlier.

This is more acute for younger people, with 23.6% of people aged 15–24 years reporting high levels of psychological distress, compared with 5.1% 10 years earlier.

The COVID-19 pandemic and other recent significant events have also likely increased distress and may continue to do so. It is important to note that not all people who are distressed will require a mental health and addiction service response, but these trends and events have led to increasing pressure across the mental health and addiction system. Further information about mental wellbeing/distress, prevalence and responding to needs is included in the infographics attached at the end of this briefing.

Alcohol is the most used harmful substance in New Zealand, and the corresponding harms are higher compared with other substances. On an international scale, our use of alcohol is high, with 18.8% of New Zealand adults having an established pattern of drinking that carries a high risk of damage to physical or mental health.

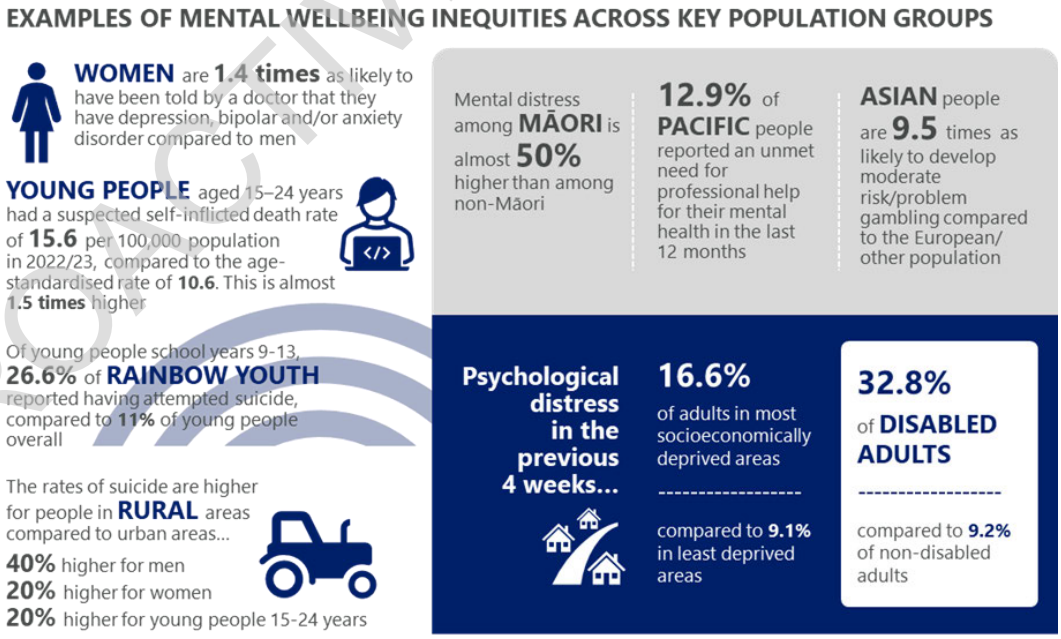
The latest New Zealand Health Survey self-reported levels of other drug use show minimal changes in prevalence of use over the past 4 years; however, overdoses are a growing concern. Though there are limitations in the data available, New Zealand Drug Foundation analysis of coronial inquest data indicates an increase in fatal overdoses of 54% across the 5-year period from 2017–2021. Two or more substances (including illicit drugs, alcohol and medicines) were involved in 91% of fatal overdose cases.

There are persistent and avoidable inequities in outcomes

While the prevalence of mental distress among Māori is almost 50% higher than among non-Māori, Māori are 30% less likely than other ethnic groups to have their mental illness diagnosed. Māori are also more likely to die by suicide and more likely to experience addiction. Unmet need is also worse for Māori and Pacific peoples, with 12.9% of those populations reporting an unmet need. However, despite this and other strong evidence that mainstream health services and models of care are not working for Māori, less than a third of Māori who access specialist mental health and addiction services have had access to kaupapa Māori services.

As demonstrated below, other population groups that also experience inequitable mental wellbeing outcomes include women, young people, rainbow communities, people who live in rural areas, Pacific peoples, Asian people, disabled people, and people who live in the most economically deprived areas.

Figure 2: Examples of mental wellbeing inequities across key population groups



People with severe mental health or addiction challenges have higher rates of many health conditions and shorter life expectancy, and this gap has increased over time. New Zealanders accessing specialist mental health services have doubled the risk of premature

mortality compared with the overall population and their life expectancy is shorter by up to 25 years.

The mental health and addiction system spans a continuum of supports and is under increasing pressure

The health system plays a key role in supporting mental health and wellbeing through the provision of a continuum of mental health and addiction services to respond to different levels of need. Roles and responsibilities within the health system are laid out in **Appendix 1**.

The mental health and addiction service continuum ranges from wellbeing promotion activities; to primary and community supports; to specialist services for those with higher needs, including crisis responses and forensic services for people interacting with the justice system, as well as kaupapa Māori services that integrate mātauranga Māori to meet the needs of Māori.

A majority of mental health and addiction service delivery is community-based, with only the highest acuity and/or intensity services delivered within hospital settings. There are also a range of crisis respite services, alternatives to acute admission and residential services in most parts of the country. The NGO sector plays a vital and significant role in providing aspects of rehabilitation and other support for people with enduring mental health conditions and addiction requiring ongoing community care.

Recent investment has focused on increasing opportunities for people with mild and moderate mental health and addiction needs. Continued investment across the continuum of mental health and addiction services is important. While access to some service types has increased due to previous investment, overall service demand has grown faster than access, and there is increasing pressure on the acute end of the continuum. Additional resource and a strong focus on workforce development and innovative models of care will be required to stabilise the system.

Further information about the mental health and addiction continuum and system pressures is included in **Appendix 2**.

Part 3: Mechanisms to influence the mental health and addiction system

There is significant work underway across government agencies to improve mental health and wellbeing outcomes, but sustained effort and investment is needed. There will be opportunities for you to influence the strategic direction and to build on progress made to ensure your priorities are reflected and achieved.

Planning and direction setting

The Pae Ora (Health Futures) Act 2022 (the Pae Ora Act) establishes a range of planning, accountability and direction setting documents for the health system including 6 specific health strategies, a Government Policy Statement, and Te Pae Tata | New Zealand Health Plan. These requirements are key levers for Ministers to set the direction of the health system so that it can meet Government priorities. The Minister of Health holds the responsibility for these levers, however there are opportunities to engage with the Minister of Health to ensure mental health and addiction is adequately reflected as a priority.

As an example while there is currently no mental health strategy required under the Pae Ora Act, mental health and addiction is embedded within each of the 6 health strategies. In the event of a change to the Pae Ora Act to require a mental health and addiction strategy through the *Pae Ora (Healthy Futures) (Improving Mental Health Outcomes) Amendment Bill*, *Kia Manawanui: Long-term pathway for mental wellbeing* can serve as a robust framework to ensure a dedicated Pae Ora strategy reflects the voices of key stakeholders and communities and retains the evidence-informed components that will further the Government's priorities. Officials can provide further advice regarding this Bill and/or any potential future mental health and addiction strategy.

Further information about the current strategic approach to mental health and wellbeing is included in **Appendix 2**.

Monitoring

The performance of the mental health and addiction sector is closely monitored, with continued political, public and media scrutiny on the performance of the sector. As per our respective statutory functions:

- The Ministry has responsibility for monitoring health system performance, as well as progress implementing the mental health and wellbeing-related strategies, and monitors the performance of the Māori Health Authority and Health New Zealand in relation to their functions.
- The Māori Health Authority and its board monitor the services it commissions and hauora Māori outcomes more broadly.
- Health New Zealand and its board monitor the performance of mental health and addiction services it provides and commissions.

The Office of the Director of Mental Health within the Ministry monitors the use of compulsory treatment under the Mental Health Act and Substance Addiction (Compulsory Assessment and Treatment) Act. District Inspectors routinely inspect facilities that deliver compulsory treatment under both acts and provide routine reports to the Director of Mental Health and Addictions. Separately, the Office of th Ombudsman inspects all inpatient facilities where people are detained to check their treatment and conditions.

The Mental Health and Wellbeing Commission | Te Hiringa Mahara also independently monitors, assesses, and reports on mental health and addiction services and approaches that support people's mental health and wellbeing in New Zealand. Te Hiringa Mahara is providing you with a separate briefing.

The system performance and monitoring approach is evolving, and there will be opportunities for you to shape the monitoring approach and potential performance targets for mental health and addiction. The Ministry will provide you with further information and advice egarding mental health and addiction system and service performance.

Funding

Vote Health funding related to mental health and addiction sits across a number of appropriations. It is important to note that baseline funding levels for mental health and addiction were set based on assumptions about access that are lower than known needs, and additional resource will be required to increase service capacity to better reflect needs levels. For example:

- Specialist mental health and addiction services are funded based on the expectation that 3% of the population will access them; however, our latest prevalence data estimates that 4.7% of the population will experience a serious mental disorder in a 12-month period.
- The national rollout of new primary mental health and addiction services is resourced to see about 6.5% of the population, compared to the approximately 16% of the population estimated to experience a mild or moderate mental disorder.

The mental health and addiction ringfence is a key accountability mechanism to ensure dedicated funding for mental health and addiction services across appropriations is protected and that investment grows each year at least in line with other areas of health expenditure. The ringfence sets the expectation for the minimum level of expenditure on mental health and addiction. The objective of the ringfence is to ensure that the amount spent on mental health and addiction services at least increases each year to account for demographic and cost pressures, and to ensure mental health and addiction expenditure is not reallocated to other service areas.

Since the 2022 health system reforms, the ringfence encompasses Health New Zealand and the Māori Health Authority mental health and addiction expenditure across hospi al and specialist services and primary and community services. The ringfence for 2022/23 was set by the Ministry at approximately $2.2 billion. The actual spend will be assessed against this expectation once audited end of year figures have been provided by Health New Zealand and the Māori Health Authority.

Appendix 3 provides more information regarding the ringfence and mental health and addiction service funding.

In conclusion, we welcome the priority focus on mental health and addiction indicated through the creation of a dedicated mental health Minis erial portfolio. We are ready to support you to take forward your agenda, and look forward to working with you and to learning more about your vision for mental health and addiction in New Zealand.

Appendix 1: Roles and responsibilities

Legislative framework

The governing legislation for the publicly-funded health sector is the Pae Ora (Healthy Futures) Act 2022. That Act establishes the health entities and provides for planning and accountability documents. The Government Policy Statement is the Minister of Health's instruction to the health entities, to which they must then give effect in the New Zealand Health Plan, which is approved by the Minister of Health.

The Act provides principles to guide health entities. They set out that the health sector should be equitable, should engage with people to develop and deliver services, should provide opportunities for Māori to exercise decision making on matters important to them, should provide choice of quality ervices and protect and promote people's health and wellbeing, including by treating mental and physical health equitably.

Since 1 July 2022, Health New Zealand and the Māori Health Authority play key roles alongside the Ministry and other entities in supporting health outcomes and delivering the Government's health priorities The Act also recognises iwi-Māori partnership boards as a vehicle representing loca Māori perspectives on the needs and aspirations of Māori, how the health sector is performing for Māori, and the design and delivery of services within their respective areas.

Roles of the Ministry of Health, Health New Zealand and the Māori Health Authority

The Ministry of Health is the chief steward of the health of the population and the health system, and lead advisor to government on health. The Ministry sets direction, policy, the regulatory framework, and investment for health, and monitors outcomes and system performance. In the context of mental health and addiction these functions are supported by clinical and lived experience advisors within the Ministry. The Suicide Prevention Office is also located within the Ministry and provides national leadership for suicide prevention efforts.

Health New Zealand is a Crown entity with a board. Health New Zealand has taken over responsibility for funding and delivering health services from the previous 20 district health boards. Health New Zealand plans, commissions, and provides most

publicly funded health services through a nationally coordinated and regionally delivered health system. Health New Zealand regions oversee commissioning of primary and community services and manage the delivery of hospital and specialist services networks. Health New Zealand has also taken over responsibility for the management of buildings and capital investment. As a Crown agent[1], their objectives are set by the Government through strategic directions and policy settings.

With respect to mental health and addiction services, Health New Zealand has a responsibility for system design, and funds and provides (through hospital and specialist services) inpatient and community specialist mental health and addiction services, and commissions primary and community mental health and addictions services. It also has a key role in training and clinical placement for the mental health and addiction workforce.

The Māori Health Authority has been established as an independent statutory entity, led by a board, to ensure that planning and service delivery respond to the aspirations and needs of Māori, and to design, deliver and arrange services to achieve the best possible outcomes for Māori. The Māori Health Authority also has a role in providing strategy and policy advice to the Minister of Health on matters relevant to Hauora Māori. The Māori Health Authority works in partnership with Health New Zealand to plan and commission all health services jointly at a national, regional, and local level, commission Hauora Māori services directly, and monitor system performance for Māori in collaboration with the Ministry and Te Puni Kōkiri | Ministry of Māori Development.

The Māori Health Authority also works with local communities and Hauora Māori partners to commission kaupapa Māori services within the areas of suicide prevention, addiction harm prevention and treatment, young people, community-based mental health services, and to provide additional support for Māori accessing specialist inpatient mental health services. The Māori Health Authority also works directly with staff and providers to support existing mental health and addiction services to improve health outcomes for Māori.

How we work together and across government

The roles of Health New Zealand and the Māori Health Authority have been designed to partner each other, to create a central group of Crown entities with common aims, distinct yet complementary functions and shared accountability, via their respective boards, to the Minister of Health. The Ministry and the Māori Health Authority generally work together in formulating policy advice, but the Māori Health Authority may also advise independently.

In addition to the roles and responsibilities carried out by the three main health system organisations, there is an important programme of cross-government work for mental wellbeing underway. This includes work with the Department of Corrections, Whaikaha | Ministry for Disabled People, and Oranga Tamariki to ensure people in their care or in the community receive the support and treatment they need. As well, the Accident Compensation Corporation is an important funder of trauma-related counselling services (typically through the sensitive claims process).

[1] Crown agents are one of three types of statutory Crown entity under the Crown Entities Act 2004.

Additional entities with roles related to mental health and addiction

While the Ministry, Health New Zealand, and the Māori Health Authority are the primary government entities within the mental health and addiction system, there are two additional Crown entities with important roles:

- **Mental Health and Wellbeing Commission | Te Hiringa Mahara** was established as an independent Crown entity in response to *He Ara Oranga*, to provide system-level oversight of mental health and wellbeing in New Zealand. One of its key objectives is to contribute to better and more equitable mental health and wellbeing for people in New Zealand. The statutory independence of the Mental Health and Wellbeing Commission from government policy is important to ensure it can carry out its oversight and monitoring function.
- **Health Quality and Safety Commission | Te Tāhū Hauora** leads and coordinates work across the health sector, for the purposes of monitoring and improving the quality and safety of health services. This includes a specific mental health and addiction quality improvement programme to ensure people that experience mental health and addiction issues receive high-quality care and support.

Mental health and addiction legislation

While mental health and addiction services are provided for under the legislation governing the public health system in general, there are specific pieces of legislation related to compulsory treatment. The Mental Health Act governs compulsory mental health services, and the Substance Addiction (Compulsory Assessment and Treatment) Act governs compulsory addiction services. The Mental Health Act is under review, which is discussed in Part 1 of this briefing.

The Office of the Director of Mental Health and Addiction within the Ministry monitors and oversees the use of compulsory mental health and addiction legislation in New Zea and and is responsible for the general administration of this legislation under the direction of the Minister of Health and Director-General of Health. As part of that, the D rector of Mental Health is responsible for the oversight and certain decisions relating to the rehabilitation pathway of around 400 special patients and restricted patients under the Mental Health Act.

The Minister of Health has a statutory responsibility for the granting of long leave (greater than 7 days) and change of status for special patients, we anticipate this will likely be delegated to you. The Ministry will provide further information in due course on your specific statutory responsibilities relating to mental health and addiction once delegations have been confirmed.

Appendix 2: Overview of the mental health and addiction system

Strategic approach

The current strategic approach to mental health and addiction h s been informed by the recommendations of *He Ara Oranga*, as well as significant engagement with key stakeholders including people with lived experience of navigating the mental health and addiction system, whānau, clinicians and service providers. The approach also reflects best evidence about how to maximise the reach and impact of investment to improve population outcomes.

Key elements of the current strategic approach to mental health and wellbeing include:

- a **whole-of-government focus**, acknowledging the importance of addressing the social, cultural, environmental and economic determinants of mental health. The health system cannot improve mental health outcomes alone; other government agencies play a critical role
- a **population-based approach** which seeks both to improve mental wellbeing outcomes for the whole population (including a focus on mental wellbeing promotion and equipping community to look after their own mental wellbeing) and to address inequities that lead to disparities in mental health and wellbeing outcomes for specific population groups.
- provision of **mental health and addiction services** across a comprehensive continuum for those who need them. This includes increasing opportunities for early in ervention for people before their concerns become serious and require more intensive services, while also ensuring specialist services are available to people with the highest needs.

These elements are underpinned by a commitment to uphold the Crown's obligations under Te Tiriti o Waitangi, to achieve equitable outcomes for Māori and other population groups, and to elevate the voices of people with lived experience at all levels of the system.

This strategic approach is reflected in the strategies and key direction-setting documents specifically related to mental health and addiction:

- *Kia Manawanui Aotearoa: Long-term pathway for mental wellbeing (Kia Manawanui). Kia Manawanui* is the 10-year whole-of-government strategy from 2021 to 2031 to shift New Zealand's approach to mental wellbeing. It includes short, medium and long-term actions focused on ensuring national system settings like leadership,

policy, investment, technology, information and workforce enable the strategic approach above.

- *Oranga Hinengaro System and Service Framework (the System and Services Framework)*. Published in April 2023 by the Ministry, the *System and Service Framework* sets expectations for the health system with a 10-year view about the range of mental health and addiction services that should be available to New Zealanders, as well as the critical shifts needed within the system. Health New Zealand and the Māori Health Authority are implementing the shifts set out in the *System and Service Framework*.
- *Every Life Matters – He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024* (*He Tapu te Oranga*) Work to prevent suicide in New Zealand is guided by *He Tapu te Oranga,* which emphasises the need for collective ownership to deliver on the vision of a future where there is no suicide in New Zealand. Responsibility for Vote Health suicide prevention commissioning sits with the Māori Health Authority in acknowledgement of the disproportionate impacts of suicide on Māori.
- *Strategy to Prevent and Minimise Gambling Harm 2022/23 to 2024/25* The Strategy comprises of a strategic overview and three-year service plan with costs and the levy rates applied to each of the 4 gambling industry sec o s: non-casino gaming machine (pokie) operators, casinos, TAB NZ and Lotto New Zealand. Health New Zealand and the Māori Health Authority procure services in accordance with the Strategy.

Continuum of mental health and addiction services

Mental health and addiction services are delivered across a continuum from promotion and prevention supports and services aimed at a population or community level, to specialist treatment services for individuals experiencing the most severe mental health and addiction concerns. Across this continuum there are also targeted Kaupapa Māori services, which are available for both Māori and non-Māori.

Wellbeing promotion

Mental health and wellbeing promotion is integral to both break down the stigma that prevents some New Zealanders from reaching out for support and to equip people with the information and tools to look after their own mental health and wellbeing and that of their broader communities. These programmes can be for the whole population or targeted populations (eg, Māori, young people and rural communities). Services in this part of the continuum include digital tools and mental wellbeing campaigns such as Mental Health Awareness Week and the All Sorts Campaign, and school-based programmes such as Sparklers, among others.

There was a critical need for whole-of-population and targeted wellbeing messaging and promotion of available services during the COVID-19 lockdowns and the severe weather events in the North Island in early 2023. However, historically there has been

very limited investment in mental health promotion in New Zealand. Organisations such as the Mental Health Foundation play a key role in this area and are strong advocates of the need for further investment in mental wellbeing promotion programmes.

Primary mental health and addiction services

Primary mental health and addiction services provide supports and services for people with mild and moderate mental health and addiction needs who do not meet the threshold for specialist services. These services generally provide assessment and interventions that help people to address the mental health or addiction concern and equip people with the tools to move forward. This part of the service continuum has historically had minimal investment, however it has been the focus of most new recent investment.

There has been significant focus on expanding primary mental health and addiction services in recent years which has built on the evidence base from the 2016 Fit for the Future programme, which trialled new and integrated models of primary mental health and addiction service delivery.

Primary mental health and addiction services are delivered by a mixture of NGOs and Primary Health Organisations (PHOs) in general practice (including free access to mental health clinicians and health coaches in many areas), kaupapa Māori, Pacific and youth-specific settings in the community. Primary-level supports also include telehealth services such as 1737 and Youthline, school-based mental wellbeing programmes in primary, intermediate and secondary schools, and mental health supports provided in tertiary institutes.

These services are aimed at recognising and responding to mental distress early and fill what has to date been a significant gap in the mental health and addiction service continuum. More detail on these programmes can be provided upon request.

Specialist mental health and addiction services

Specialist services are for people that experience the most severe mental health and addiction concerns. These are available both within the community as well as within acute hospital settings and are delivered by both Health New Zealand and NGOs. These services include community mental health centres, residential and supported living, crisis services, forensic services, alcohol and other drug community and residential treatment services, and services for focused population groups such as eating disorders or maternal mental health. There are also Kaupapa Māori specialist services available.

It is important to be aware that like other acute hospital services, there are significant rehabilitation, community, and forensic service capacity constraints that impact the flow of patients into and out of acute settings. Additionally, there are long prison waiting lists for people who are acutely unwell and require forensic inpatient care. These people are often not receiving treatment.

There is a cohort of people with high and complex needs who are in acute settings but require a different level of care with appropriate resourcing to be managed in community settings. This type of service can be provided by NGOs, but there is limited capacity in the NGO system as well; these services need to be adequately resourced and well supported by specialist clinical services.

Kaupapa Māori services

Kaupapa Māori services provide health and social services for Māori within a Māori cultural context across a broad range of conditions and ailments and within a whānau centred framework. Kaupapa Māori services provide health and social services that are:

- whānau centred
- delivering services for Māori by Māori
- supportive of kaupapa Māori principles and practices
- strong in te reo Māori
- skilled in tikanga Māori
- steeped in mātauranga Māori
- experienced in rongoā Māori.

This includes Māori health service providers, which are owned and governed by Māori and currently funded by the Māori Health Autho ity, Health New Zealand or PHOs for the provision of health services and deliver health and disability services primarily but not exclusively for Māori.

The Māori Health Authority is now funding 33 kaupapa Māori oranga hinengaro services through recent investment in primary and community mental health and addiction services, providing full-service coverage for people accessing services and their whānau across the country.

Appendix 3: Vote Health funding for mental health and addiction

Vote Health is the main source of public funding for health servi es (excluding ACC related funding for claims on the Non-Earners' Account) and is administered by the Ministry. Vote Health directly supports the day-to-day operation of health services delivered by the health workforce in our communities, hospitals, and other care settings. Mental health and addiction funding sits across the following appropriations within Vote Health:

- Delivering hauora Māori services – this appropriation is used for services commissioned by the Māori Health Authority
- Delivering Hospital and Specialist Services – this appropriation is used by Health New Zealand for hospital and specialist services, including mental health and addiction services
- Delivering Primary, Community, Public and Population Health Services – this appropriation is used by Health New Zealand for primary, community, public and population health services, including mental health and addiction services
- Problem Gambling Se vices – this appropriation is used by the Ministry, Health New Zealand and the Māori Health Authority for services that minimise the harm from gambling, in accordance with the Gambling Act 2003.

The mental health and addiction ringfence is an important accountability mechanism that sits across the first three appropriations listed above. Together, Health New Zealand and the Māori Health Authority are expected to spend at least the ringfenced amount on mental health and addiction services, but can choose to spend more. The mental health and addiction ringfence expectation includes both previously devolved former district health board mental health and addiction funding and funding held nationally prior to the health system reforms (eg, funding allocated through recent Budget processes).

In addition to the ringfenced mental health and addiction funding, some of the Vote Health capital expenditure goes towards mental health and addiction facilities, and funding for the Mental Health and Wellbeing Commission sits within the Monitoring and Protecting Health and Disability Consumer Interests appropriation.

There are also two levies that specifically support activity with respect to certain substance and addiction issues: the gambling levy and the alcohol levy. The purposes

for which funding received from these two levies can be used are specified within legislation meaning there is limited scope to alter how these funds are spent.

Gambling levy

Under the Gambling Act, the Ministry is responsible for developing a problem gambling strategy focused on public health, including a three-year service plan with costs and the levy rates applied to each of the 4 gambling industry sectors: non-casino gaming machine (pokie) operators, casinos, TAB NZ and Lotto New Zealand. The current strategy (from 2022/23 to 2024/25) and levy rates run to 30 June 2025. The total cost of the three-year strategy is $76.123 million.

This means that services to prevent and minimise gambling harm are not funded through the regular Budget process. The Minster of Internal Affairs and the Minister of Health (responsible Ministers) jointly seek Cabinet approval for the strategy, service plan and the problem gambling levy every four years.

The Ministry, Health New Zealand and the Māori Health Authority all have responsibility for implementing the strategy.

Alcohol levy

A levy is raised on alcohol produced or imported for sale in New Zealand. The levy's purpose is to recover costs incurred by the health system in addressing alcohol-related harm. The Ministers of Health and Finance agree an aggregate expenditure figure for this purpose annually. The current aggregate levy figure is approximately $11.5 million per year, with minor fluctuations annually depending on current rates of alcohol production and sale.

The Ministry has commissioned an independent review of the levy (and programmes actually and potentially funded by it), which will consider the adequacy of the levy to fund ongoing and established programmes, any resources for additional alcohol work that may be required, and includes substantial stakeholder engagement to gather views on how the levy functions. The review report is due in November this year and the next decision on the aggregate figure for the levy will be in April 2024.

Recent Vote Health investment in mental health and addiction

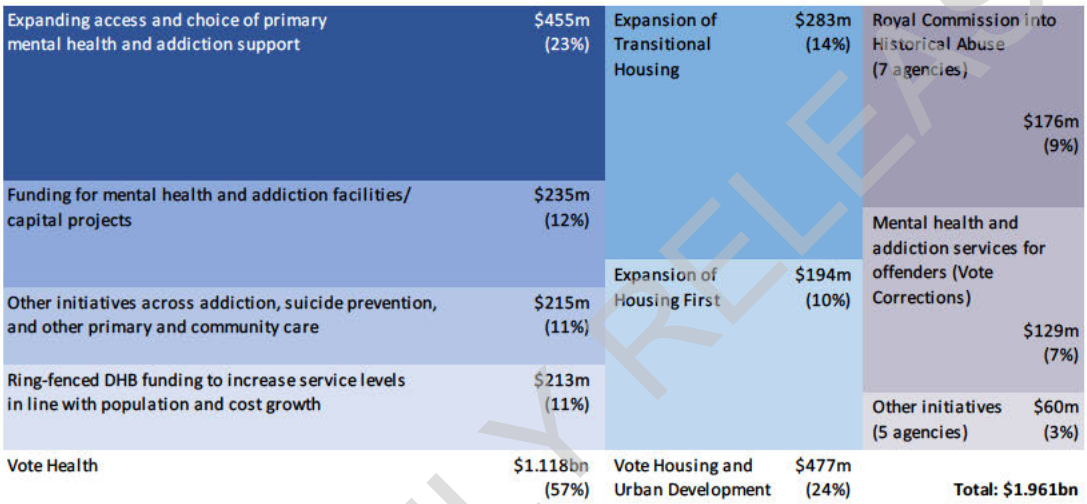
Most of the recent new investment in mental health and addiction came through the $1.9 billion Budget 2019 cross-government mental wellbeing package and the $202 million Budget 2022 Vote Health mental wellbeing package. Further, smaller investments in Vote Health mental health and addiction were made during other years and Budgets.

While investment in mental health and addiction services has increased in recent years, following a significant period of minimal investment and building on a low baseline, much of this growth relates to cost pressure uplifts, rather than service expansion. There is still significant pressure on some parts of the system, and there remain gaps in coverage across the continuum of need.

Budget 2019

Budget 2019 allocated $1.9 billion to improve mental wellbeing. The money was allocated cross Votes, rather than being purely Vote Health funding.

Figure 3: Budget 2019 funding allocation



Of the Vote Health funding, the largest component was $455 million to support expansion of primary and community mental health and addiction services for people with mild and moderate needs. As of 30 June 2023, this funding had supported about one million mental health and addiction sessions in primary care settings.

Budget 2022

Budget 2022 allocated investment of approximately $202 million over four years in a Vote Health mental wellbeing package. As the table below shows, this funding was phased over the four-year period, with only a limited amount of funding available in the initial years. It was also spread across a number of service types, providing smaller uplift across a wider range of supports.

Table 1: Budget 2022 Vote Health mental wellbeing initiatives

Budget 2022 Vote Health mental wellbeing initiatives	2022/23 ($m)	2023/24 ($m)	2024/25 ($m)	2025/26 ($m)	4-year total ($m)
Increasing Availability of Specialist Mental Health and Addiction Services	**9.400**	**14.700**	**25.900**	**50.000**	**100.000**
Eating disorders services	0.700	0.750	1.000	1.500	3.950
Maternal and infant specialist mental health and addiction services	1.000	1.300	2.600	5.200	10.100

Budget 2022 Vote Health mental wellbeing initiatives	2022/23 ($m)	2023/24 ($m)	2024/25 ($m)	2025/26 ($m)	4-year total ($m)
Community-based crisis services	2.500	3.050	6.450	15.450	27.450
Child and adolescent specialist mental health and addiction services	2.000	2.600	4.550	9.550	18.700
Kaupapa Māori specialist mental health and addiction services	1.000	1.650	3.350	8.250	14.250
Drug checking services	-	1.050	1.050	1.050	3.150
Te Ara Oranga, Eastern Bay of Plenty Expansion	-	0.500	1.500	1.500	3.500
Workforce development	1.000	2.000	3.000	4.000	10.000
Enablers	1.200	1.800	2.400	3.500	8.900
Mana Ake – Expansion of Mental Wellbeing Support for Primary and Intermediate School Students	**14.333**	**21.817**	**24.456**	**28.734**	**89.340**
Piki – Continuation of Integrated Primary Mental Health and Addiction Support for Young People in Greater Wellington	**1.750**	**3.500**	**3.500**	**3.500**	**12.250**
TOTAL	**25.483**	**40.017**	**53.856**	**82.234**	**201.590**

Other recent Vote Health investment

Other recent Vote Health investment includes:

- $25 million over four years to mental wellbeing support for tertiary students through the COVID-19 Response and Recovery Fund established in Budget 2020
- reprioritisation through Budget 2021 of $12 million in one-off funding to provide to continue the delivery of Mana Ake in Canterbury and Kaikōura and begin co-design of Mana Ake services in 5 additional areas in 2021/22
- $10 million of one-off funding in 2023/24 allocated through Budget 2023 to support the mental health and wellbeing response to the North Island weather events.

Smaller one-off investments (eg, $15 million in 2020 and $5.6 million in 2021) were also made to support the psychosocial response to COVID-19. This investment supported wellbeing promotion campaigns, digital self-help tools, telehealth services and some targeted support for priority population groups.

Subsequent advice around system performance and work programmes will include further information on the status of key initiatives.

Overview of mental health and addiction investment, service access, needs and constraints

We have attached two infographics to the end of this briefing in Appendix 4 that explain in detail the breakdown of investments in mental health and addiction from 2017/18 to 2021/22. Section 1 of the first infographic shows the amount of expenditure by category of mental health and addiction service. Over that period there has been an increase in investment of 33%, however, a large portion of this was to address cost pressures.

The largest proportional increase in investment was in primary mental health and addiction services beginning in 2019/20 (Section 3 of the first infographic shows this in more detail). The funding from Budget 2022 is not included in the investment graph in Section 1.

Section 2 of the first infographic shows the provision of services over time, with the sharp increase in services seen in primary mental health and addiction services from 2020. Sections 4–6 of the second infographic then show the increasing levels of mental distress and unmet need over time, as well as what we know about the prevalence of mental disorders and the constraints within the mental health and addiction system in responding to increasing needs.

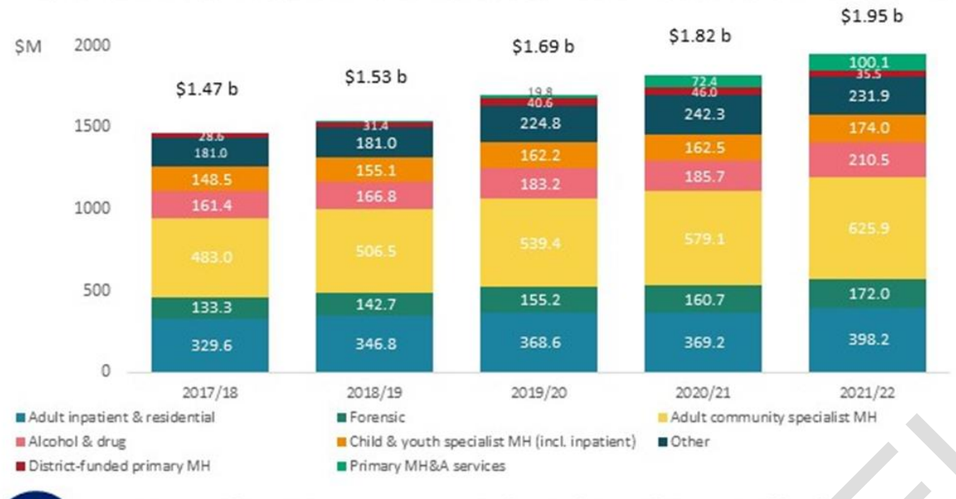
Appendix 4: Upcoming decisions and advice

2023	
Title	**From**
Māori Health Authority: Briefing to the Incoming Minister	Māori Health Authority
Health New Zealand mental health and addiction: secondary briefing	Health New Zealand
Mental health and addiction legislative delegations and responsibilities	Ministry of Health
s 9(2)(f)(iv) [redacted]	Ministry of Health, Health New Zealand
Mental health and addiction system performance and monitoring	Ministry of Health
Developing the next suicide prevention action plan	Ministry of Health
Decision on progressing the Mental Health Bill	Ministry of Health
2024	
s 9(2)(f)(iv) [redacted]	Ministry of Health
s 9(2)(f)(iv) [redacted]	Ministry of Health
s 9(2)(f)(iv) [redacted]	Ministry of Health, Health New Zealand, Māori Health Authority

Mental health and addiction services (1 of 2)

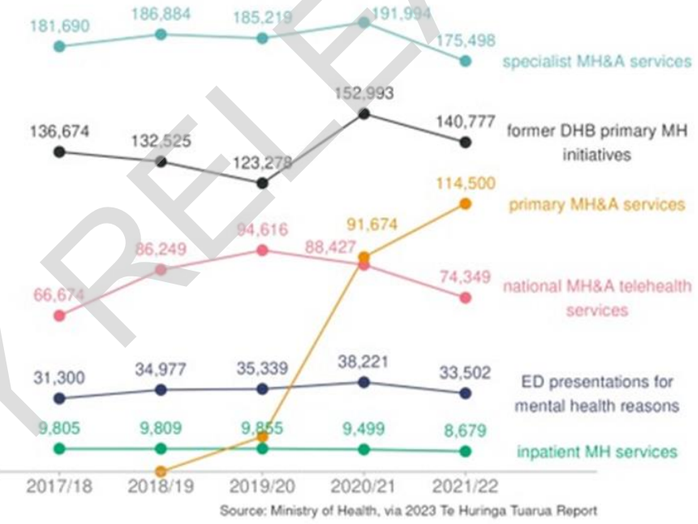
1 Investment in mental health and addiction (MH&A) services has increased in recent years

- **Investment in MH&A services has increased** from ~$1.47 b in 2017/18 to ~$1.95 b in 2021/22 (approx. 33%) following a decade with minimal investment and building on a low baseline. However, much of this growth relates to **cost pressure** uplifts rather than expansion.
- Not all B19 'mental wellbeing' investment went towards MH&A services, and the vast majority that did went to **primary MH&A services** for people with mild and moderate MH&A needs.



2 There are now more MH&A service options available and overall access has increased

- **Overall access to MH&A services has increased** since 2017/18 although access to some service types has declined. This may reflect positive factors (eg, more options available including self-help and more people being seen in primary/community settings than inpatient) but may also reflect increasing workforce shortages, different types of engagement, or data completeness.



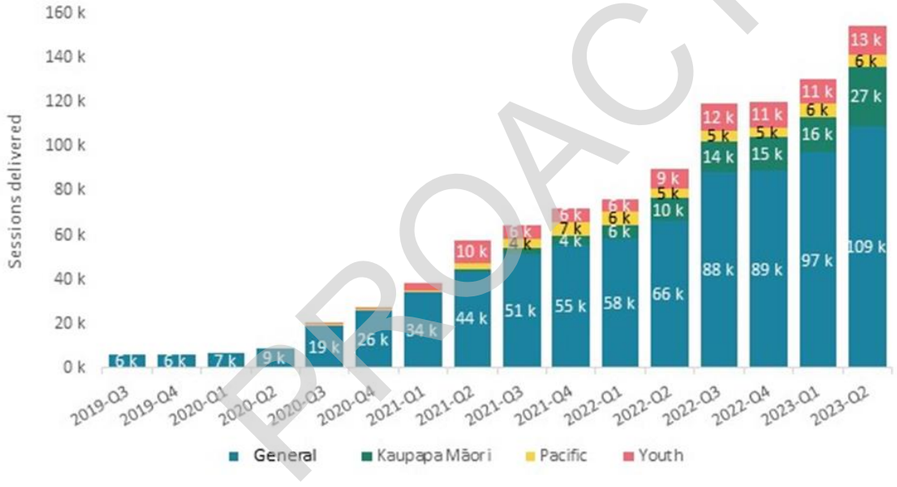
There is also a **range of other MH&A supports which aren't reflected here**, eg:

- school-based services
- digital supports
- estimated ~30% of GP consults that relate to MH&A

Graph notes: People may have accessed different types of service within a year. Summing the figures above may result in double counting. For 'primary MH&A services' figures for 2019/20 and 2020/21 are estimates, with the accuracy of NHI-linked data improved from November 2021 onwards.

3 New primary MH&A services have been rolled out nationally filling a longstanding gap in the continuum

- Since starting in 2019/20, new primary MH&A services have delivered **over 1 m sessions**. These services will continue to grow to see **325,000 people per annum** from 2024/25.
- There are specific services for **Māori, Pacific and youth,** and there are no access criteria.



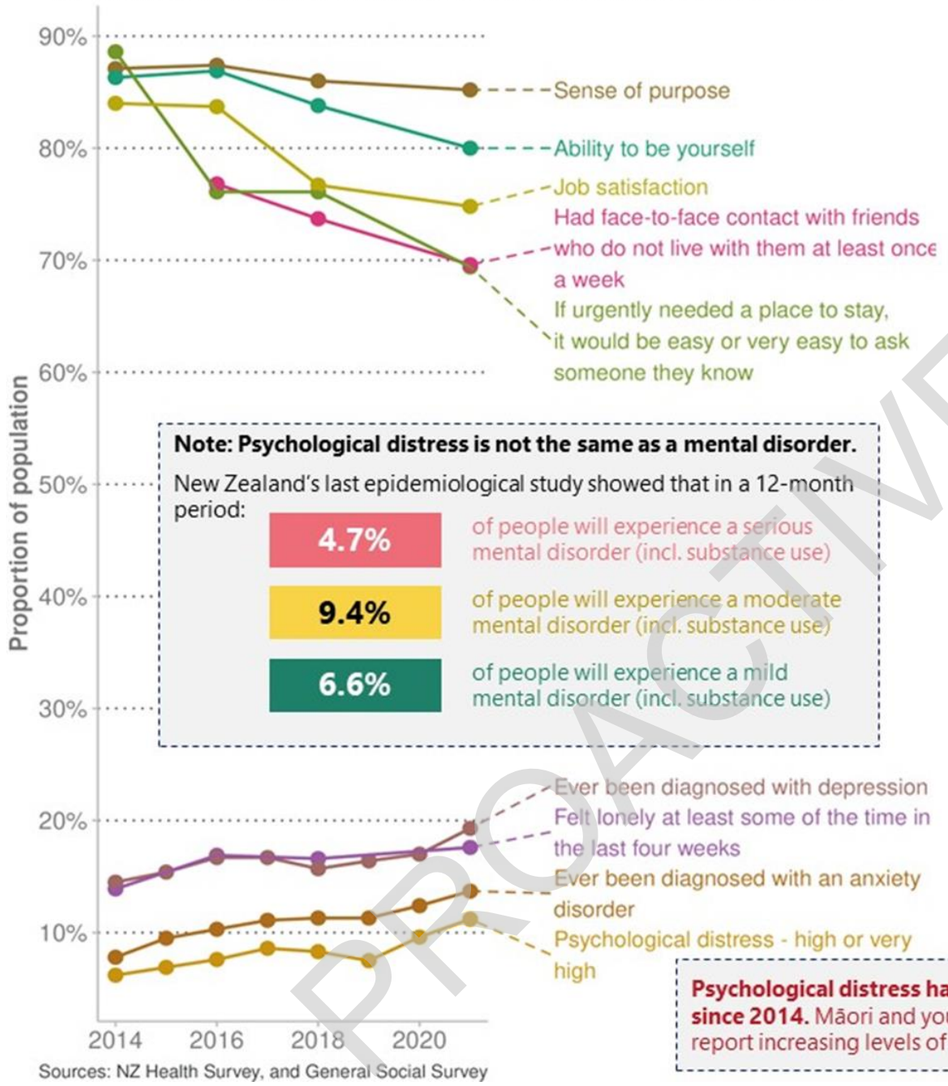
While we're providing more MH&A services than ever before, we know more is needed

- While there **are gaps in our data** and data quality issues, **access** to MH&A supports provided by the health system **has increased**.
- There is now a **greater suite of support across the continuum** (from wellbeing promotion, to primary and community services, to specialist and in patient services) including in person, telehealth and app-based supports.
- **Uptake of new services** is promising.
  - We are now reaching a group of people who had previously been missing out on support.
  - We are now reaching people sooner, before needs become more severe.
- We know that **there is still work to do.**
  - There are significant **MH&A workforce shortages** across the board.
  - Specialist services have received **minimal uplifts** and are under increasing pressure.
  - **Inequitable outcomes persist for Māori**, as well as other population groups, and there are regional disparities.

Mental wellbeing/distress, prevalence and responding to needs (2 of 2)

4 Psychological distress is increasing, while social protective factors are decreasing

- **Psychological distress has almost doubled** since 2014, with increased distress for **Māori and young people** in particular. This is a **global trend with many likely drivers** – uncertain futures, racism/discrimination, whānau wellbeing, cost of living, geo-political tensions, climate change, the recent pandemic and extreme weather events etc.
- Changes in the acceptability of talking about MH&A issues is also likely to contribute to **increased reporting** over time.
- **Caution is required** as surveys only represent a proportion of the population, are subjective in nature, and need to be considered in context (eg, social and economic climate).



Note: Psychological distress is not the same as a mental disorder.

New Zealand's last epidemiological study showed that in a 12-month period:

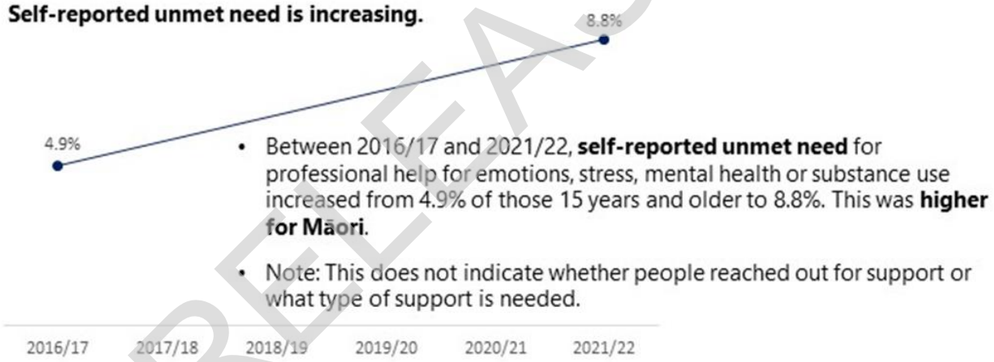
- **4.7%** of people will experience a serious mental disorder (incl. substance use)
- **9.4%** of people will experience a moderate mental disorder (incl. substance use)
- **6.6%** of people will experience a mild mental disorder (incl. substance use)

Psychological distress has almost doubled since 2014. Māori and young people in particular report increasing levels of distress.

Sources: NZ Health Survey, and General Social Survey

5 Not all who feel distressed require a MH&A service, but Health is responsible for providing services to those who do

Self-reported unmet need is increasing.



- Between 2016/17 and 2021/22, **self-reported unmet need** for professional help for emotions, stress, mental health or substance use increased from 4.9% of those 15 years and older to 8.8%. This was **higher for Māori**.
- Note: This does not indicate whether people reached out for support or what type of support is needed.

Not everyone experiencing psychological distress requires a formalised MH&A service response, but MH&A services might be needed when:

- someone's level of distress means they can't get on with their daily life/functions
- the distress is ongoing and not resolving
- the events impact existing MH&A conditions
- the person can't see a future for themselves.

6 MH&A services are primarily aimed at supporting people with mental disorders or substance use disorders, but there are capacity constraints

- **~3%** Specialist MH&A services are resourced based on an historic assumption that 3% of the population will access them
- **~6.5%** New primary MH&A services are funded to see approx. 6.5% of the population with mild and moderate MH&A needs
- **~11%** The MH&W Commission reported a 2023 vacancy rate of 11% in adult specialist MH services (up 6.5% from 2018) but this is likely an underestimate

A whole-of-government response is needed to respond to increasing psychological distress

Most people who are feeling distressed will require support from across our agencies to help meet their basic needs, strengthen protective factors and address the underlying drivers of distress.