

Access and Choice Programme: *Monitoring report on progress and achievements at five years*

April 2025





Access and Choice Programme: Monitoring report on progress and achievements at five years

A report issued by Te Hīringa Mahara—New Zealand Mental Health and Wellbeing Commission (Te Hīringa Mahara).

Authored by Te Hīringa Mahara.

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

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www.mhwc.govt.nz

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Kupu Whakataki

Foreword

Te Hiringa Mahara has oversight of the mental health and wellbeing system, reporting publicly on system performance and leading for improved mental health and wellbeing outcomes.

To improve access to and choice of mental health and addiction services to provide support for ‘mild to moderate’ needs relating to mental health and problematic substance use or gambling, a substantial investment into a new mental health frontline service was made in 2019. This investment was in response to the He Ara Oranga report (Government Inquiry into Mental Health and Addiction, 2018).

Government invested \$664 million over five years into the Access and Choice programme and new primary and community services with an expectation that, by the end of the roll-out, 325,000 people a year would access these new services (Government of New Zealand, 2019).

We have closely monitored the programme, and our first report in late 2021 covered the first two years of the programme. We want to be sure this level of investment produces the intended results and creates the momentum for change across the system.

The Access and Choice programme has been rolled out in a time of considerable change. The COVID-19 pandemic had a major impact on the wider community, the health system, and primary and community services. It is a considerable achievement to see the increase in these important primary and community services within this context.

There is a lot to celebrate for this programme. More than 200,000 people each year are now accessing support and choosing options that suit them, and services are available throughout Aotearoa New Zealand – making it easier to access mental health support.

In this report, we indicate the improvements we’d like to see: ensuring the programme reaches full capacity, growing and developing the workforce, and establishing better data collection so we can understand outcomes for people and whānau.

The foundations have been established, and this needs to be celebrated. It is now time to bring renewed energy and focus to fully realise the benefit of this substantial investment. These primary and community services are critical to ensuring people have early access to services and supports when needed.



Hayden Wano
Chair, Te Hiringa Mahara



Ngā Ihirangi

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Ngā Mihi

Acknowledgements

Thank you to the many people who supported the development of this report.

We met with over 25 providers of Kaupapa Māori, Pacific, and Youth services to understand how the Access and Choice programme was working for them and what could be improved. We also received feedback from Integrated Primary Mental Health and Addiction providers as well as from General Practice NZ and Te Tumu Waiora. These organisations took time to talk with us and/or supply us with information, and we would like to acknowledge them for their important contribution to the report.

Thank you to the members of our reference groups, who worked with us to provide insights on the Access and Choice programme's progress and the changes we'd like to see to the programme. Lived experience reference group members include: Leilani Maraku, Suzy Baird, Malcolm McKenna, Moko Kairua, Romy Lee, Rose Tei, Rangimokai Fruen, Tyson Smith, Alexandria Green, Jodie Bennett, Ivan Yeo, and Gloria Sheridan. Sector reference group members include: Ben Birks-Ang, Carole Koha, Genevieve Obbeek, David Codyre, Hine Moeke-Murray, Jo Chiplin, Sue Hallwright, Elizabeth Loudon, Raechel Osborne, Tina Harrison, Terri Cassidy, and Renee Richards-Berry.

Health New Zealand | Te Whatu Ora supplied us with the majority of the data and met with us several times to discuss it with us. We really appreciate the time spent collating the data and working with us to analyse and interpret the data. We also received some data from Te Pou and the Ministry of Health, and we thank the staff from all agencies for this assistance.

We are grateful to have the input from our two external reviewers, Tony Dowell and Peter Huskinson. Your contributions helped shape the story and context of the report.

Thank you to te Reo Māori translators, Easy Read translator, proofreader, and report designer.

Lastly, we acknowledge the people who engage with the services provided by the Access and Choice programme as well as the programme staff. We hope that this report serves as a mechanism to enhance the programme's services and ensure that they are sustained.

Whakamōhiotanga whānui

Overall summary

The Access and Choice programme was funded from the 2019 Wellbeing Budget (Government of New Zealand, 2019) to provide support for ‘mild to moderate’ needs relating to mental health and problematic substance use or gambling in primary care and community settings.

The national roll-out of the programme has come a long way in a difficult environment. There were some delays in the roll-out of the programme, related to a range of issues, including COVID-19 and recruitment challenges. Programme implementation is now on track, and there are opportunities to build on what has been achieved so far.

Access to and choice of services have improved

The Access and Choice programme has provided increased access to support for needs relating to mental health and problematic substance use or gambling, as well as more choice in services. The investment in this programme has significantly expanded support available and enabled easier and earlier intervention for those needing support.

We heard about the positive benefits of the programme and that it is supporting people on their journey to mental wellbeing. Kaupapa Māori and Pacific services offer whānau-centred, holistic support. Youth services also offer holistic support in ways that are acceptable to young people. Services report that the additional capacity of Access and Choice programme staff has alleviated time pressures and boosted their capability to respond to those with mental health and substance use/gambling needs.

Aim is projected to be achieved by June 2026

By the last year of the programme, the funding had been fully committed. While the number of people seen per year by services has increased steadily over the last five years, to over 207,000 for the 2023/24 financial year, it falls short of the programme’s aim of 325,000. However, the aim is projected to be met by the end of 2025/26 or shortly after, based on previous years’ reach.

Reaching the programme aim of seeing 325,000 people annually will require sustained funding; full implementation with services operating at full capacity; integration of the Integrated Primary Mental Health and Addiction (IPMHA) model into primary care settings; accelerated workforce development, recruitment, and productivity; and improved access to specialist services so that providers are able to refer those who require a more intensive service.

The programme has achieved good coverage

Access and Choice services are now available to people living across Aotearoa New Zealand. As of 30 June 2024, IPMHA services were available to 68 per cent of those enrolled with general practices (nearly reaching the goal of 70 per cent).

Kaupapa Māori and Youth services are available in every district as well, and Pacific services are available in nine districts where there is a higher representation of Pacific peoples. These services are not only benefiting the priority populations they cater for, but others too – e.g. Kaupapa Māori providers are seeing nearly a quarter of clients who are non-Māori.

As the programme was funded to provide coverage to 70 per cent of the enrolled population, availability of the services is limited in some locations. For example, 32 per cent of the enrolled population has no access to IPMHA services, as these services are not provided in their local practice (although they may be able to access Kaupapa Māori, Pacific, and Youth services as appropriate).

Workforce opportunities and challenges remain

The programme has boosted the capacity of the primary and community care workforce and is now a substantial part of the primary and community mental health and addiction sector. Dedicated investment in workforce development has supported these boosts.

The workforce growth has kept pace with the expansion of the services, with 84 per cent of the contracted full-time equivalents (FTEs) in place. The need to establish an Access and Choice programme workforce has implications for other health workforces, especially clinical roles.

Reducing variation across the country

It will be important to understand variation in IPMHA services to enable more people to access these services. Understanding regional variation in clinical to non-clinical FTE ratios and intensity of services will be key. Expanding access to virtual options and multi-practice models could enable further reach and increased access.

Productivity of Access and Choice programme roles are difficult to determine when some services are still not at full capacity and there are data quality issues. However, there are some early indications that, for IPMHA roles in practices where the programme is fully rolled out, average productivity ranges from around 6–7 sessions delivered per FTE per day. Understanding utilisation of FTEs in place will be important to support ongoing improvement of the programme.

Improved data collection and reporting would improve our understanding of the impact of the Access and Choice programme on people as well as on the mental health and addiction landscape.

Programme funding must be sustained and prioritised

The government invested \$664 million over five years from 2019/20 to 2023/24 for the programme, with 20 per cent committed for Kaupapa Māori services, 7 per cent for Pacific services, 15 per cent for Youth services, and 58 per cent for IPMHA services by 30 June 2024.

Given the increases in psychological distress and unmet need for mental health care over the last several years, the programme investment and level of service delivery that were planned at the start of the programme need to be sustained.

Whakamōhiotanga whānui

I whakawhiwhia te hōtaka Whai Wāhi, Kōwhiringa hoki ki te pūtea i te Tahua Pūtea Waiora o 2019 (Te Kāwanatanga o Aotearoa, 2019) ki te tuku tautoko āpiti ki ngā matea hauora hinengaro, pūmatū tūkino, mahi petipeti hoki 'e māmā ana, e āhua kaha ana rānei' i ngā horopaki tiaki matua, hapori hoki.

Kua whanake haere te kōkiritanga ā-motu o te hōtaka Whai Wāhi, Kōwhiringa hoki i te taiao uaua. Tērā ētahi takaroatanga i takaroa ai te te kōkiritanga o te hōtaka nā runga i ētahi take pēnei i te Mate Kowheori-19 me ngā wero rapu kaimahi hoki. Kei te rite ngā mahi kōkiri ki tā mātau i manako ai ināianei, tērā hoki ngā huarahi hei whaihanga ake i te kaupapa i runga i ngā mahi me ngā hua kua oti kē.

Kua pai ake te whai wāhi atu me te kōwhiringa o ngā ratonga

Kua whakapiki ake te hōtaka Whai Wāhi, Kōwhiringa hoki i te whai wāhitanga atu ki ngā tautoko hauora hinengaro, pūmatū tūkino, mahi petipeti hoki, kua nui ake hoki te kōwhiringa i ēnei ratonga. Ko te pūtea i tukuna atu ki tēnei hōtaka kua āta whakawhānui i te tautoko e wātea ana, kua whakaāhei hoki i te tuku āwhina ki te hunga kei te matea ki te āwhina, arā kia māmā ake, kia wawe ake.

Kua rongu kōrero mātau mō ngā hua takatika o te hōtaka, koia kei te tautoko i ngā tāngata e whai ana i te huarahi ki te hauora hinengaro. Ka whakawhiwhi atu ngā ratonga Kaupapa Māori, Moana-nui-a-Kiwa hoki i te tautoko whānui e aro nui ana ki te whānau. Ka whakawhiwhi atu hoki ngā ratonga Rangatahi i te tautoko whānui e rite ana ki te hunga taiohi. Kua whakamōhio mai ngā ratonga, tērā kua whakamāmā te raukaha tāpiri o ngā kaimahi i te hōtaka Whai Wāhi, Kōwhiringa hoki i ngā pēhinga wātaka, kua whakapiki hoki i te āheinga ki te aro nui ki te hunga e whai matea ana mō te hauora hinengaro, whakamahi pūmatū/mahi petipeti whakamahi pūmatū/mahi petipeti hoki.

E matapaetia ana ka tutuki te whāinga hei te Pipiri o 2026

I pau katoa te pūtea-ā-tau i te pito whakamutunga o te hōtaka. Kua piki haere te tokomaha o ngā tāngata i āwhinatia e ngā ratonga i roto i te rima tau kua hori nei, kia eke ki te 207,000 i te tau pūtea 2023/24, heoi kei raro tonu tēnei i te whāinga o te hōtaka kia eke ki te 325,000 tāngata. Hei ahakoa, e matapaetia ana ka tutuki te whāinga nei hei te mutunga o 2025/26, hei muri paku atu rānei, i runga i te tokomaha o te tau kua hori.

Kia tutuki te whāinga o te hōtaka, arā kia eke ki te 325,000 tāngata e āwhinatia ana i ia tau, me whai pūtea pūmau; me mahi ngā ratonga ki tā rātau nui ka taea e rātau; me kōtuitui i te tauira mahi IPMHA ki roto i ngā horopaki tiaki matua; me tere ake te whakawhanake i te kapa kaimahi, te kopou kaimahi me te whakapiki huamahi; me nui ake hoki te āheinga atu ki ngā ratonga whāiti kia taea e ngā kaiwhakarato te tuku atu i te hunga e hiahia ana kia ngoto ake te ratonga.

Kua pai te horahanga o te hōtaka

E wātea ana ngā ratonga Whai Wāhi, Kōwhiringa hoki ki ngā tāngata puta noa i Aotearoa. Nō te 30 Pipiri 2024, i te wātea ngā ratonga Ngā Ratonga Mahi Tahi a te Hauora Hinengaro me te Waranga Matua (IPMHA) ki te 68 ōrau o ngā tāngata i rēhitatia ki ngā whare rata whānui (e tata ana ki te whāinga o te 70 ōrau).

E wātea ana hoki ngā ratonga Kaupapa Māori, Rangatahi hoki i ia rohe, e wātea ana ngā ratonga Moana-nui-a-Kiwa i ngā rohe e iwa kei reira te tokomaha o ngā iwi Moana-nui-a-Kiwa e noho ana. Ka whai painga ngā ratonga nei ki ngā taupori e aro ana rātau, me ētahi atu anō hoki – hei tauira, ka āwhina ngā kaiwhakarato Kaupapa Māori i te āhua hauwhā o ngā kiritaki ehara i te Māori.

Ko te pūtea i whakawhiwhia ki te hōtaka i rite ki te 70% o te taupori kua rēhita, nā konei ka āhua kōpiri o ngā ratonga i ētahi wāhi. Hei tauira, tērā ko te 32 ōrau o te taupori kua rēhita kāore i whai wāhi ki ngā ratonga IPMHA, nō te mea kāore i whakawhiwhia atu aua momo ratonga i tō rātau whare rata (heoi ka taea tonu pea te whai wāhi atu ki ngā ratonga Kaupapa Māori, Moana-nui-a-Kiwa, Rangatahi hoki mehemea e hāngai ana).

Tērā tonu ngā angitu me ngā wero kapa kaimahi

Kua whakapiki te hōtaka i te raukaha o te kapa kaimahi matua, hāpori hoki, he wāhanga nui ia ināianei o te rāngai hauora hinengaro, waranga matua, hāpori hoki. Kua tautoko te tuku pūtea tautapa ki ngā mahi whakawhanake kapamahi i ngā pikinga nei.

Kua rite tonu te tupu o te kapamahi ki te whakawhānui haere o ngā ratonga, ko te 84 ōrau o ngā kaimahi whai kirimana ukiuki (FTE) kei ngā wāhi mahi e mahi ana. Ka whai pānga te whakawhanaketanga o te kapa kaimahi Whai Wāhi, Kōwhiringa hoki ki ētahi atu kapa kaimahi hauora, tae atu ki ngā tūranga whare haumanu.

Te whakaiti i te rerekētanga puta noa i te motu

He mea nui tonu te mārama ki ngā rerekētanga i ngā ratonga IPMHA kia nui ake ngā tāngata ka taea e rātau te whai wāhi kia aua ratonga. He mea waiwai tonu kia mārama ki ngā rerekētanga ā-rohe i ngā ōwehenga kaimahi ukiuki mahi haumanu, ehara i te mahi haumanu me te ngoto hoki o ngā mahi. Mā te whakawhānui i te āheinga ki ngā huarahi matihiko me ngā tauira momo mahi maha e whakaahei ai i te toronga atu me te āheinga mai.

He uaua te whakatau i te whai waahi/whaihua o ngā tūranga o te hōtaka o ngā tūranga Whai Wāhi, Kōwhiringa hoki i te mea kāore anō ētahi ratonga kia eke ki te nui o ngā mahi ka taea, ā, tērā hoki ētahi raruraru ki te kounga o te raraunga. Heoi, tērā ētahi tautohu tōmua e tohu ana, mō ngā tūranga IPMHA i ngā whare rata e tino kōkiri ana i te hōtaka, ka eke te taurite huamahi ki te 6–7 nohonga a ia kaimahi ukiuki i ia rā. He mea hirahira te mārama ki te whakamahitanga o te kaimahi ukiuki i te wāhi mahi kia tautokona te whakapaipai haere i te hōtaka.

Mā te whakapai haere i ngā mahi kohikohi raraunga, whakapūrongo hoki e whakapiki te mārama ki te whai pānga o te hōtaka Whai Wāhi, Kōwhiringa hoki ki te tāngata me te taiao hauora hinengaro, waranga whānui.

Me whakapūmau, me whakatōmua hoki i te pūtea mō te hōtaka

I tuku pūtea te kāwanatanga ki te hōtaka, arā he \$664 miriona i te rima tau mai i 2019/20 ki 2023/24, e 20 ōrau ka tautohua ki ngā ratonga Kaupapa Māori, e 7 ōrau mō ngā ratonga Moana-nui-a-Kiwa, 15 ōrau mō ngā ratonga Rangatahi, me te 58 ōrau mō te taupori whānui mā ngā ratonga IPMHA, tae atu ki te 30 Pipiri 2024.

Nā runga i te tipu haere o te auhitanga ā-hinengaro me te hiahia kore tutuki ki te maimoatanga hauora hinengaro i ngā tau o nā tata nei, me whakataimau tonu i te pūtea me te taumata whakarato i maheretia i te tīmatanga o te hōtaka.

Key programme data



64%

of the aim for people seen was achieved



Aim: 325,000 people to be seen per year (6.5% of the total population) by 30 June 2024

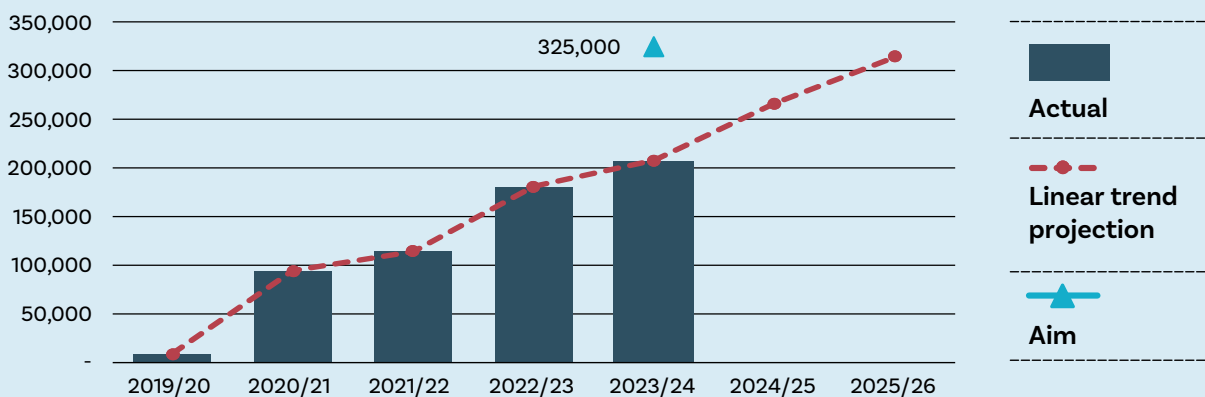


Achieved: Over **207,000** people seen in 2023/24 (3.9% of the total population)

Service	People seen by 30 June 2024	Aim for people seen
Integrated Primary Mental Health and Addiction (IPMHA)	159,869	248,000
Kaupapa Māori	26,668	
Pacific	10,137	77,000
Youth	10,932	
Total	over 207,000	325,000

The aim of reaching 325,000 people is projected to be met in 2025/26

Projected number of people seen per year to 2025/26



The most common presenting issue was anxiety

The five most common presenting issues were:

1. Anxiety
2. Depression/low mood
3. Generalised stress
4. Other physical wellbeing issue
5. Diabetes



84%

1,262 employed of 1,495 contracted FTEs by 30 June 2024

Access and Choice staff who previously worked in the mental health and addiction sector:

57% Health Improvement Practitioners (HIPs)

25% Health Coaches (HCs)

The services are reaching a broad range of people, including:

26.8%

Māori

10.9%

Pacific people

9.3%

Asian people

20.2%

Young people

The coverage aim was nearly achieved:

Integrated Primary Mental Health and Addiction (IPMHA) services are available to **68%** of the enrolled population (the aim was **70%**).



32 Kaupapa Māori services in all 20 districts



13 Pacific services in all 9 districts (that were planned to have them)



24 Youth services in all 20 districts

IPMHA is reported as being helpful to people. Most frequently reported helpfulness ratings ranged from **8-10** (out of 10) for IPMHA.

The majority of programme funding has been spent

Total funding committed and allocated by workstream, 2019/20-2023/24¹

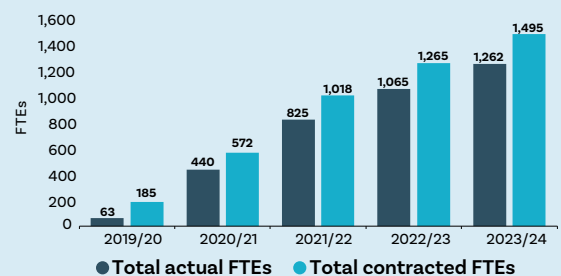
	Committed (\$m)	Allocated (\$m)	Difference (\$m)
IPMHA	313.95	287.16	26.79
Kaupapa Māori	83.28	97.25	-13.97
Pacific	33.14	38.90	-5.76
Youth	75.86	93.09	-17.24
Workforce development	85.95	99.73	-13.78
Enablers	32.01	48.15	-16.14
Total	627.82	664.29	36.47

¹ Not presented in the table is \$3.63m committed for hospital chaplaincy mental health, which had no funding allocated to it.

Workforce has increased each year



Total actual versus contracted FTEs, as of 30 June 24



Ngā huringa e hiahiatia ana

The changes we want to see

In this section, we set out the system changes (based on our key findings) that we want to see to support the ongoing delivery of these services and future developments.

Sustained focus on roll-out and delivery

- **Enhance service utilisation and productivity** to achieve the reach aim of 325,000 people seen annually with the continued expansion of multi-practice models and virtual services.
- Continued **implementation support** (enabler funding) until services are fully rolled out and operating at full capacity. Embedding Integrated Primary Mental Health and Addiction (IPMHA) services into the primary care team is a key success factor, and implementation support will be needed to support these teams to reach full capacity.
- Extended contract periods for Access and Choice providers to **ensure sustainability** of the programme and enable **communities of practice** to drive continuous improvement and **address variation** across the country.
- **Increased access** by raising awareness of the programme and addressing barriers to entry.
- Further work to understand if these services are **meeting the needs** of people with **substance use or gambling issues**.
- **Ongoing workforce needs** of Access and Choice services reflected in workforce planning and associated funding (see recommendation 4 in Kua Tīmata Te Haerenga) (Te Hiringa Mahara, 2024a).

Enhanced productivity

- Assessment of productivity across Access and Choice services (and for benchmarks to be developed accordingly).

Extended coverage

- Investigation into whether current services provide **sufficient coverage** to meet service needs for Māori, Pacific, youth, and Asian populations, including conducting a mental health prevalence study to quantify these needs.
- Guidance provided on what else would be needed to extend coverage and reach **those missing out**, including those whose general practice does not have IPMHA services and those who are not enrolled with a general practice.

Improved core data set to drive continuous improvement

- Move to more **automated, National Health Indicator-based reporting requirements** to reduce administrative burden in collecting/reporting on outcome and experience data and to understand programme impacts.

Ngā Tūtohu

Recommendations

In this section, we set out three recommendations based on the monitoring findings. These recommendations provide more detail about what success looks like so action can be taken and progress monitored.

The recommendations included here are the more specific ‘who needs to do what’ to enable this programme to thrive.

We recommend that:

1. Health New Zealand | Te Whatu Ora (Health NZ) increase programme reach to deliver services to 325,000 people per annum by 30 June 2026, as intended in the 2019 Wellbeing Budget.
2. By 30 June 2026, Health NZ develop a plan to streamline pathways and ensure that Access and Choice Youth services and Infant, Child and Adolescent Mental Health Services (ICAMHS) work together to meet the needs of young people across the continuum of care, including shared care arrangements.
3. Health NZ develop a plan to reduce unwarranted variation across the country in relation to fidelity (including access and entry pathways) to the IPMHA model by 30 June 2026.

Kupu arataki

Introduction

The purpose of this report is to provide an independent assessment of the large investment into primary mental health and addiction services and to inform future development.

Our independent monitoring role

Te Hiringa Mahara—Mental Health and Wellbeing Commission (Te Hiringa Mahara) is an independent Crown entity that has the mandated function to monitor mental health and addiction services in Aotearoa New Zealand and to advocate for improvements to those services. We seek to shine a light on what's working well along with identifying areas for improvement.

While our reports are aimed at people who can bring about change (the leaders within services, organisations, and government), our focus is always on the people who can benefit from change and their whānau.

We have made a strong commitment to achieving better and equitable mental health and wellbeing outcomes for Māori, and our grounding in Te Tiriti o Waitangi is expressed in **Te Tauāki ki Te Tiriti o Waitangi | Te Tiriti o Waitangi position statement** of Te Hiringa Mahara. We are committed to prioritising the voices of people who experience mental distress, substance harm, gambling harm or addiction, and advocating for their needs and aspirations. This is expressed in our **Lived Experience position statement**.

Monitoring of the Access and Choice programme

This is the third and final monitoring report that Te Hiringa Mahara will be publishing on the Access and Choice programme, as the five-year roll-out period is now complete. Te Hiringa Mahara released reports in **October 2021** (Te Hiringa Mahara, 2021) and **November 2022** (Te Hiringa Mahara, 2022) to provide independent updates on the implementation of the programme. This report builds on our two previous reports and looks at how the services have been implemented across the 5-year roll-out period. It looks at the impacts of the programme on people and on the mental health and addiction sector. In addition to an analysis of the quantitative data, it includes insights from engagements with relevant stakeholders.

In parallel to drafting this report, we commissioned a literature scan to explore both New Zealand and international approaches to primary mental health. The literature scan places the Access and Choice programme within that context and contributes to the future development of the programme. The scan identified and described 27 models, including Primary Care Behavioural Health (PCBH), the model on which the Integrated Primary Mental Health and Addiction (IPMHA) services were partially based (Premium Research, 2025).

Access and Choice programme services are now part of ongoing service delivery, and future monitoring of these services will be part of our annual service monitoring (using **He Ara Āwhina framework**) reported through our **online dashboard**. Other organisations may also wish to continue their monitoring and evaluation activities of the programme.

Rates of psychological distress have been increasing

Over the last several years, reported levels of moderate psychological distress have increased in Aotearoa New Zealand. In 2019/20, 14.2 per cent of people aged 15 years and over reported experiencing moderate psychological distress; this increased to 19.1 per cent in 2023/24, which is equal to approximately 828,000 adults (aged 15 and above) (Ministry of Health, 2024).

Reported rates in 2023/24 were higher for disabled adults (25.4 per cent) and young people aged 15–24 (23.6 per cent) but lower for Asian adults (14.9 per cent). Rates were also higher for Māori (22.5 per cent) and Pacific people (20.5 per cent), but the difference between these rates and those of non-Māori and non-Pacific (respectively) were not statistically significant (Ministry of Health, 2024). While this data does not tell us the level of service need (a comprehensive prevalence study is needed for this), it does give an indication of trends.

The Access and Choice programme was funded from the 2019 Wellbeing Budget

The impetus for the creation of the national Access and Choice programme was the 2018 He Ara Oranga report (Government Inquiry into Mental Health and Addiction, 2018). In line with recommendations in He Ara Oranga, the Access and Choice programme became a priority initiative from the 2019 Wellbeing Budget with funding of \$664 million² allocated for its roll-out over a five-year period from 2019/20 to 2023/24.

There is considerable interest in the Access and Choice programme, including from people and their whānau, mental health advocates, primary care providers, mental health and addiction service providers, Health New Zealand | Te Whatu Ora (Health NZ), Ministry of Health, and the Minister for Mental Health.

Access and Choice programme provides free, immediate support via four types of services

The aim of the Access and Choice programme is to provide free, accessible support for 325,000 people annually (6.5 per cent of the total population as at 2019/20) with mild to moderate mental health and harmful substance use/gambling needs. The programme's intention is to support and enhance the way that services are delivered and connect people with services in a range of health settings – Kaupapa Māori, Pacific, and Youth specific settings, as well as in general practice and the community. There is no clinical criteria for access, for example, thresholds or diagnoses.

2 Budget 2019 included \$455 million over four years (2019/20 to 2022/23) for the Access and Choice programme, and \$209 million funding for 2023/24, bringing the five-year funding path to \$664 million. In subsequent years, there have been inflationary cost uplifts to the funding.

The Access and Choice programme comprises four types of services:

1. **Integrated Primary Mental Health and Addiction (IPMHA) services:** services provided in general practices that are available to everyone enrolled in those practices. IPMHA services are available in some Kaupapa Māori and Pacific general practices. IPMHA includes the following roles:
 - a. Health Improvement Practitioners (HIPs) are registered health practitioners who have received HIP training and work with people of all ages and their whānau and family. They help people with any issues that are impacting on their health and wellbeing.
 - b. Health Coaches (HCs) support people to gain the confidence, skills, and knowledge they need to better manage their health and can also help people to find resources to better support their wellbeing. Unlike HIPs, they are not registered as health practitioners. They also tend to be more focused on the overall wellbeing of people with physical wellness (e.g. managing chronic illness) compared with HIPs.
 - c. Support Workers (SWs) support people to address circumstances that impact on their wellbeing, e.g. by connecting people with supports in their community. In some areas, there are combined HC-SW roles.
2. **Kaupapa Māori services:** whānau-centred services delivered by Māori for Māori.
3. **Pacific services:** Pacific-led services that reflect Pacific culture, languages, values, and models of care.
4. **Youth services:** services delivered in settings that are acceptable and accessible to young people.

The design of Access and Choice services reflects learnings from international approaches to primary mental health interventions (Premium Research, 2025). The intention was that IPMHA services would deliver a mainstream service based in general practices that would achieve a high reach of people using a consistent, universal model. The mainstream model is complemented with additional services that are tailored to meet the needs of priority population groups. Kaupapa Māori, Pacific, and Youth services have been designed to provide tailored support that is culturally appropriate for their respective groups' needs. As a result, the mainstream and targeted services together have the capacity and capability to meet the needs of much of the population.



“

... the population-based models tended to reach larger numbers of people, but there were gaps in their reach (with lower take up from some groups of people). The targeted models tended to be smaller in scale and reached fewer people but drew in ‘harder to reach’ people via their tailored approach.

”

Premium Research, 2025

The **Access and Choice programme website** provides information about the services, including where they are located and how to access them.

Access and Choice programme funds service delivery, workforce development, and enablers

The allocated investment of \$664.29 million for the Access and Choice programme covered the following three areas for the five-year roll-out period:

- **Service delivery:** \$516.40 million funds allocated to the four services described above (this largely covers the workforce FTE requirements).
- **Workforce development:** \$99.73 million funds allocated to the growing and upskilling of existing workforces, in addition to building new workforces.

- **Enablers:** \$48.15 million allocated to fund system enablers, including programme design, evaluation, implementation support, information technology (IT) services, and capacity and capability for the relevant government agency (originally Ministry of Health and now Health NZ).

Table 1 shows how the allocation of each of the three streams was scaled up in funding annually over the roll-out period. Note that the \$209.21 million allocated in 2023/24 is intended to be sustained into the future to continue supporting the programme.

Table 1: Budget 2019 – Access and Choice programme allocated funding by year (\$ million)

Funding stream	2019/20	2020/21	2021/22	2022/23	2023/24 (and beyond)	5-year totals
IPMHA services	10.00	37.41	57.71	80.87	101.18	287.16
Kaupapa Māori services	0	13.13	20.25	28.38	35.50	97.25
Pacific services	0	5.25	8.1	11.35	14.2	38.90
Youth services	15.00	15.0	15.19	21.28	26.63	93.09
Workforce development	13.89	18.19	22.33	22.66	22.66	99.73
Enablers	9.25	8.25	10.05	11.55	9.05	48.15
Total	48.14	97.22	133.63	176.09	209.21	664.29

Significant large-scale shifts have occurred over our five years of monitoring

Significant large-scale shifts have occurred over the last five years that have affected the pattern of New Zealanders' demand for mental health services, as well as the mix, capacity, capability, and performance of services to respond. These shifts are:

1. **Shift One**—the system response to a landmark inquiry into the mental health and addiction system (Government Inquiry into Mental Health and Addiction, 2018).
2. **Shift Two**—the impact of COVID-19 on demand for mental health services and on service delivery.
3. **Shift Three**—a fundamental restructure of publicly funded health services of Aotearoa.

Positively, Shift One has provided the much-needed investment in mental health and addiction services and included funding for the Access and Choice programme.

The psychological impacts of the COVID-19 pandemic (Shift 2) likely created additional demand for mental health services but also led to more services being adapted to reach people during lockdowns, such as using telephone or video methods. Related to the Access and Choice programme, the information that agencies provided shows that the COVID-19 pandemic delayed the programme roll-out by slowing commissioning, workforce development, and recruitment, and it affected people's ability to easily access the services in person. This impact was more significant for the Auckland and Waikato areas, which experienced extended lockdowns.

Under Shift Three, responsibility for funding the health initiatives shifted over the five-year period from the Ministry of Health (1 July 2019 to 30 June 2022) to Health NZ and Te Aka Whai Ora (1 July 2022 to 30 June 2023) and then solely to Health NZ from 1 July 2023 onwards. This shift has contributed to disruptions and delays in terms of contract management, reporting, and data provision.

This report addresses two key monitoring questions

This report monitors the Access and Choice programme roll-out to 30 June 2024 – the five-year point. It monitors the programme mainly at a national level and by each of the four service types.³

This report aims to address the following two key questions:

1. What was delivered by the Access and Choice programme, and how does this compare with its intended roll-out?
2. How has the Access and Choice programme contributed to changing the mental health and addiction service landscape?

To address these questions, eight key areas related to the implementation and impact of the Access and Choice programme are examined in this report. They include: reach of services, coverage of new services, workforce, investment, presenting issues, productivity of roles, impact on people, and impact on the mental health and addiction landscape.

3 This monitoring report is not an evaluation report, so we do not seek to evaluate the effectiveness of the programme (or whether another programme would be more effective).

This report draws from multiple information sources

In writing this report, we used information from a number of sources:

- quantitative data supplied from Health NZ,⁴ Te Pou, and the Ministry of Health
- qualitative insights gained from focus groups, talanoa, and wānanga that we conducted with various Kaupapa Māori, Pacific, and Youth service providers (we will refer to these as ‘our engagements’ in this report)
- insights and reports shared with us by primary care clinical leaders, General Practice NZ, GPs, primary health organisations, and individual service providers
- insights provided by two reference groups that we convened for the purpose of supporting this report
- insights gained from our broader monitoring reports, including our mental health and addiction service monitoring report, Kua Tīmata Te Haerenga (Te Hiringa Mahara, 2024a, 2024b)
- insights gained from other organisations monitoring, assessing, or evaluating the Access and Choice programme (Awa Associates, 2023; Codyre, Andrews & Kliejunas, 2023; Dovetail Consulting, 2023; King, Crocket, Field, 2023; Malatest International, 2022; PwC, 2022; Synergia, 2023).

Further detail on the methodology for drafting this report is included in Appendix A.

Tairāwhiti data are not included in our analyses

This report includes data from all regions in Aotearoa New Zealand, apart from Tairāwhiti. The reason for this relates to how the Access and Choice programme is delivered in Tairāwhiti. Previously, traditional service models have not been successful in Tairāwhiti due to its geographic characteristics that make it more isolated and whereby Māori live in dispersed urban and rural areas across the region. As a result, the programme was negotiated to be delivered differently in Tairāwhiti when it was transferred from the Ministry of Health to Te Aka Whaiora so that it better met the needs of the Tairāwhiti community.

Kaupapa Māori, IPMHA, and Youth services are offered in Tairāwhiti in a more collaborative and integrated model, which enables flexibility to deliver services in a range of settings and to engage as many whānau as possible. As a result, the data required to be reported is different from the requirements for the rest of the programme and cannot be integrated with the wider data set.

4 The quantitative data supplied to us by Health NZ does not contain complete data for the Tairāwhiti district. We have funding data for this district, but we have incomplete data relating to workforce, coverage and reach of services, and presenting issues.

Ngā Kitenga

Findings

1. What was delivered by the Access and Choice Programme, and how does this compare with what was intended?

Over 207,000 people were seen in 2023/24, which represents 64 per cent of the annual aim of 325,000. All the funding was fully committed for the last year. More than 676,000 sessions were delivered.

Integrated Primary Mental Health and Addiction (IPMHA) services were available to 68 per cent of people enrolled with a general practice, nearly reaching the goal of 70 per cent. Kaupapa Māori and Youth services were available in all districts, while Pacific services were established in nine targeted districts.

The Access and Choice workforce has increased over the roll-out period as the services have expanded. Preliminary data suggest that HIPs and HCs are delivering about 6-7 sessions per day, on average.

The most frequently reported presenting issues (in order from most frequent to least) were anxiety, depression/low mood, generalised stress, other physical wellbeing issue, and diabetes.

1.1 Reach of services

This section describes what was delivered by the Access and Choice programme in terms of the reach of services (the number of sessions delivered and number of people seen).

The number of people seen has increased steadily but falls short of the programme’s aim

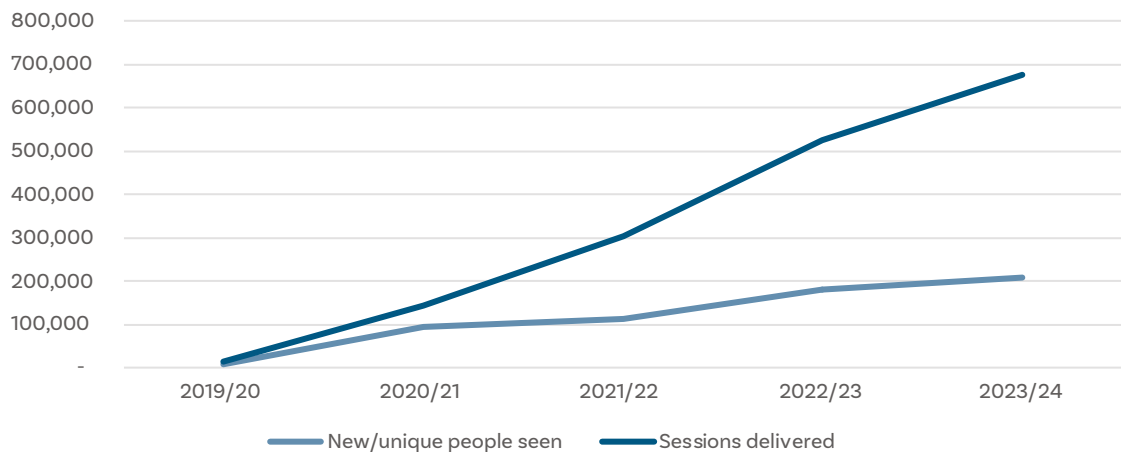
Figure 1 shows the total number of new/unique people seen⁵ and total number of sessions delivered for all service types combined over the roll-out period. Both figures increased steadily across the five years, culminating in over 207,000 new/unique people seen and 676,261 sessions delivered in 2023/24. The trend for the number

of sessions delivered indicates a steady increase in the amount of service that has been delivered.

While there has been a steady increase in the number of people seen per year, this figure falls short of the aim of reaching 325,000 people per year⁶ (approximately 64 per cent of the aim was achieved).

Also evident in Figure 1 is a smaller increase in reach from 2022/23 (180,697 people seen) to 2023/24 (207,606). The reasons for this observation are unclear but may include slowing workforce recruitment (discussed further in section 1.3), productivity issues (discussed in section 1.6), and increasing levels of complexity (resulting in more time dedicated to each person/whānau).

Figure 1: Total number of new/unique people seen each year and sessions delivered, across all services by year



- 5 For IPMHA services, the data provided relate to the number of **unique** people seen, as these are tied to NHI numbers. For Kaupapa Māori, Pacific, and Youth services, the data provided relate to the number of **new** people seen, meaning those who have not been seen in the prior 11 months of reporting.
- 6 We note that there are inconsistencies in the understanding of the reach aim between what has been published by Treasury and what the Ministry of Health and Health NZ have stated. Treasury has stated that the programme investment ‘will improve access to primary care by more than 100% with 325,000 people able to access services by 2023/24’ (The Treasury, 2019). The Ministry of Health and Health NZ understand the reach aim as having the *capacity in place* to reach 325,000 by June 2024 but that this number is expected to be reached by the end of 2024/25, the first year that the programme is intended to be at full scale.

Figure 2 below estimates the number of people likely to be reached by the programme over the next two years based on previous years' reach.⁷

The dotted line shows that the programme is poised to reach the aim of 325,000 people seen per year during the 2025/26 year or shortly after.

Figure 2: Projected number of people seen per year to 2025/26

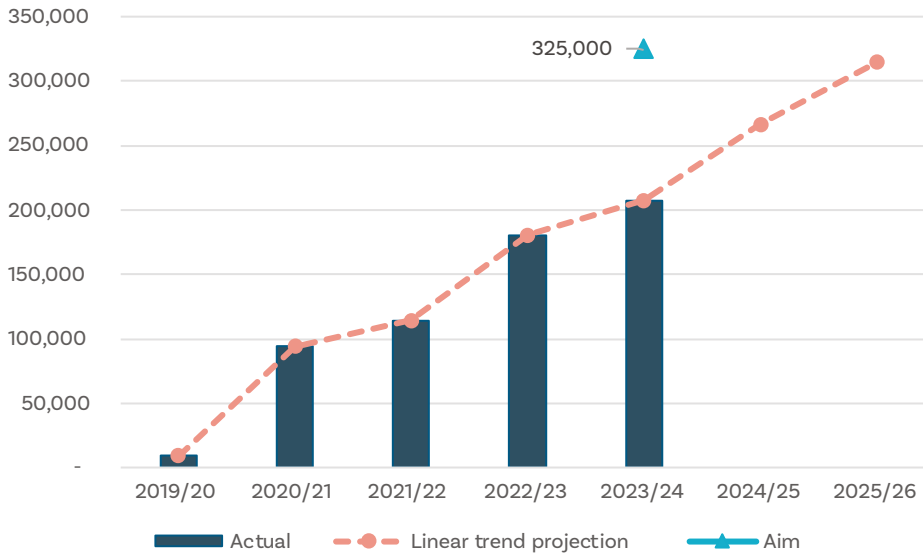


Table 2 shows the number of people seen by service type each year of the programme as well as the intended reach.⁸ The trend in the number of new/unique people seen varies by service type. This number steadily increased for IPMHA, Youth, and Pacific services each year. Previously, we called for more attention to support the development and implementation of Pacific services (Te Hiringa Mahara, 2022). This has been achieved, which is reflected in the significant increase in the number of new people seen from 2021/22 (5,829) to 2022/23 (9,308).

For Kaupapa Māori services, the data shows that the number of new people seen also significantly increased from 2020/21 (913) to 2021/22 (8,886) and again in 2022/23 (29,575). Afterward, however, it declined slightly in 2023/24 (26,668) from the previous year. It is unclear if this finding is a true finding or a possible issue with the data that were collected and reported; given that the number of services and sessions increased for Kaupapa Māori services, it is more likely to be a data issue.

7 The method used to project the future reach was a best-fit linear trend projection.

8 2019/20 reach data for Kaupapa Māori, Pacific, and Youth services was not collected due to the services still being set up that year. The intended reach is derived from the interim Government Policy Statement on Health 2022-2024 (Ministry of Health, 2022).

Table 2: Number of unique/new people seen by service type and year

Service	2019/20	2020/21	2021/22	2022/23	2023/24	Intended annual reach
IPMHA	9,130	86,437	95,273	135,138	159,869	248,000
Kaupapa Māori	n/a	913	8,886	29,575	26,668	
Pacific	n/a	3,212	5,829	9,308	10,137	77,000 ⁹
Youth	n/a	3,549	4,535	6,676	10,932	
Total	9,130	94,111	114,523	180,697	207,606	325,000

One key difference between Kaupapa Māori and Pacific services and other services is the way that they are delivered; we heard from our engagements that it is common in one session to see many whānau and family members in Kaupapa Māori and Pacific services (but is only counted as one person reached). This approach will result in longer sessions and may involve more than one worker supporting a session. Therefore, whānau service delivery may impact the number of new individuals who are seen as well as obscure the true number of people reached.

Service visibility and integration affect reach

We heard that the IPMHA programme is not always as well integrated as it could be within some practices, which can result in an underutilisation of Access and Choice programme staff. This underutilisation affects the programme reach. Most frequently, these stories pointed to the need for general practice staff to have greater education and socialisation related to the HIP, Health Coach, and Support Worker roles. All general practice staff, from GPs to receptionists, need to be aware of IPMHA services and introduce them to people.



“

I sat in a GP practice for the whole day with loads of slots available and ... the nurse had sat there and gone, ‘cannot find any free therapy services for this person.’

”

Primary sector



“

There are [GPs] that you never hear any referrals from. Again, is it because they’re completely overloaded in knowing all the different options or is it actually just because they don’t know you exist ...

”

Primary sector

Some barriers to accessing Access and Choice services would also likely impact utilisation and reach. We have heard that there is variation in IPMHA services regarding access to a HIP or HC: some practices require a person to first see a GP, who may then refer the person to a HIP/HC. This referral requirement presents cost and time barriers to accessing a HIP/HC, which also influence utilisation and reach.

9 The intended reach of 77,000 was combined for Kaupapa Māori, Pacific, and Youth services (Ministry of Health, 2022). Separate aims for each service type were not set.



“

Different in different GP practices. So, in one GP practice, yes, the nurses are not allowed to refer to me. They have to get the GP’s permission.

”

Primary sector

New mental health and addiction targets have been set

On 4 July 2024, the Minister for Mental Health announced five mental health and addiction targets. One of these is ‘Faster access to primary mental health and addiction services – 80 per cent of people accessing primary mental health and addiction services through the Access and Choice programme are seen within one week’. As this report covers data to 30 June 2024, monitoring of the target will be included in our future monitoring products.

Kaupapa Māori, Pacific, and Youth services are seeing people both inside and outside of the targeted population group

The Access and Choice programme was designed and funded to provide a mainstream service (IPMHA) to reach a greater number of people that is inclusive of priority population groups, while also developing specific service delivery models that are tailored to the programme’s three priority groups (Māori, Pacific, and Youth). This design and funding approach is evident in the number of people from the three priority groups seen in each of the services (Table 3). IPMHA saw the majority of all people seen (approximately 77 per cent) in Access and Choice services, and the Kaupapa Māori, Pacific, and Youth services provided another choice of services to reach their respective priority population groups (approximately 23 per cent). Youth services saw a significant number of Māori (n=3,802, 35 per cent of Youth total). Likewise, young people aged 12–24 were seen in all the services, not just Youth services, with 54 per cent of those aged 12–24 being seen in IPMHA services.

Table 3: Number of unique/new people seen by ethnicity and priority age group, by service (2023/24)

	IPMHA	Kaupapa Māori	Pacific	Youth	Total
Māori	30,463	20,313	1,103	3,802	55,681
Pacific	12,078	1,704	7,558	1,387	22,727
Asian	17,112	1,132	496	476	19,216
Other	99,891	3,519	973	4,098	108,481
Ethnicity missing	407	0	7	1,169	1,583
Total (Ethnicity)	159,951	26,668	10,137	10,932	207,688¹⁰
Young people (12–24 years)	22,690¹¹	8,310	1,797	9,122	41,919

10 The total number of new/unique people seen by ethnicity (207,688) slightly differs from the total number of new/unique people seen reported in Table 2 (207,606) due to a small number of people reporting their ethnicity differently from one data collection point to another.

11 Data for people seen in IPMHA by age was provided to us broken down further by ethnicity, which means that the true total number of young people aged 12–24 seen in IPMHA will slightly differ from what has been presented for the reason stated in the footnote above.

Table 3 also shows us that Kaupapa Māori and Pacific services are seeing people whose prioritised ethnicity is non-Māori or non-Pacific, respectively.¹² For example, of the 26,668 people who accessed Kaupapa Māori services in 2023/24, 6,355 (24 per cent) were non-Māori. Pacific services saw 2,572 people (25 per cent) who were non-Pacific (although given Māori is the prioritised ethnicity, some of these people may identify as Pacific people). This mix of people engaging with Access and Choice may mirror providers' existing client bases but also demonstrates that these services are offering support to many who find them acceptable, even though they may not be within the target population group.

During our engagements, some of the Kaupapa Māori providers spoke of seeing non-Māori at their service:



“

I think those are some of the value-add components of how hauora works ... hauora providers have been intentional with linking with the health providers and the HIPs to maximise because we don't only work with Māori, we work with non-Māori, we work with all ethnicities.

”

Kaupapa Māori service

Kaupapa Māori, Pacific, and Youth services appear to be reaching their intended groups of people

Table 4 includes additional demographic data about the people accessing each service type. Within this breakdown are the programme's three priority groups, i.e. Māori, Pacific, and young people aged 12–24. Approximately one-fifth (19.1 per cent) of people accessing IPMHA are Māori, and 7.6 per cent are Pacific. Approximately one-quarter (26.8 per cent) of everyone using Access and Choice services (all services combined) are Māori; this same figure for Pacific people is 10.9 per cent. Given that Māori and Pacific people comprise 17.5 per cent and 8.9 per cent, respectively, of the national population, these findings suggest that Māori and Pacific people are being reached by Access and Choice services.

By age, 14.2 per cent of people accessing IPMHA are young people 12–24 years. One-fifth (20.2 per cent) of all people using Access and Choice services is aged 12–24 (equivalent to 41,829 young people). Given that young people aged 12–24 comprise 16.5 per cent of the national population, these data suggest that the Access and Choice programme is also reaching young people.

The Access and Choice programme does not appear to be reaching the fast-growing Asian population as well as it is for other groups: while 9.3 per cent of people using Access and Choice services are of Asian ethnicity, Asian people represent 18.3 per cent of the national population. The lower service coverage in Auckland and Waitematā may be contributing to this. We can see that 4–5 per cent of the people accessing Kaupapa Māori, Pacific, and Youth services and 10.7 per cent of people accessing IPMHA services are of Asian ethnicity. This is not entirely surprising given that Asian communities were not one of the priority populations during the design of the Access and Choice programme.

12 Data were provided to us using prioritised ethnicity, rather than total ethnicity, given we are reporting unique people seen. As a result, people who identify with multiple ethnic groups are identified in the data as having one prioritised ethnicity, with the prioritisation being Māori, then Pacific, then Asian, then Other ethnicity.

Table 4: Demographic breakdown for each service type, 2023/24

	IPMHA	Kaupapa Māori	Pacific	Youth	Total	National population representation
Māori	19.1%	76.2%	10.9%	34.8%	26.8%	17.5%
Pacific	7.6%	6.4%	74.6%	12.7%	10.9%	8.9%
Asian	10.7%	4.2%	4.9%	4.4%	9.3%	18.3%
Other	62.5%	13.2%	9.6%	37.5%	52.2%	55.3%
Youth (12-24 years)	14.2%	31.2%	17.7%	83.4%	20.2%	16.5%

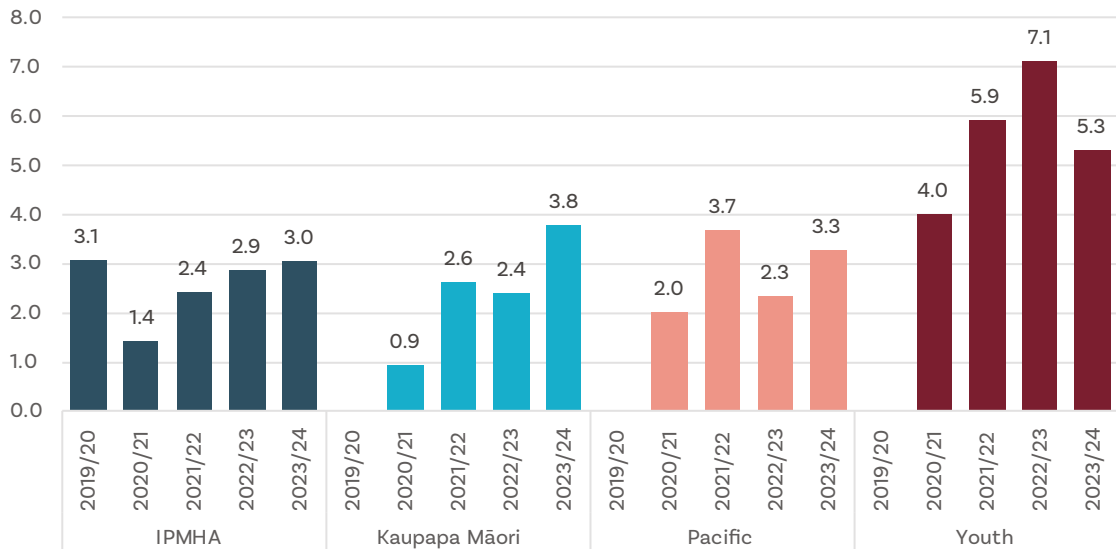
The number of sessions per person varies by service type

The average number of sessions per new/unique person seen varies by service type (Figure 3).¹³ For IPMHA, Kaupapa Māori, and Pacific services, the average number of sessions per person ranged from approximately one to four sessions each year. The number of Youth sessions was higher than for the other services, ranging from four to seven each year. Once the services are fully implemented and stabilised, we can examine if this pattern remains regarding the higher number of sessions per person in Youth services.

We have heard from providers that two possible reasons for the higher number of averages sessions in Youth services has to do with more complex needs of young people as well as providers continuing to see young people for longer due to the lack of accessibility of specialist services when a referral to specialist care is appropriate. This is of particular concern if a young person’s level of psychological distress is beyond moderate, and they cannot access specialist services.

13 There is no data for 2019/20 for Kaupapa Māori, Pacific, or Youth services, as these services were co-designed during 2019/20. Where services had begun, data reporting mechanisms were still being developed. Data was provided to us from July 2020 onwards.

Figure 3: Average number of sessions per unique/new people seen, by service type and year



1.2 Coverage of new services

This section describes what was delivered by the Access and Choice programme in terms of the population coverage of new services.

IPMHA service coverage aim has nearly been reached

Nationally, as of 30 June 2024, IPMHA services were available to 68.0 per cent of people enrolled with a general practice. This rate has increased from 62.7 per cent in 2023 and from 50% in 2022. This rate nearly reaches the goal of 70 per cent coverage and represents positive progress for the programme.¹⁴ With the goal of the roll-out being 70 per cent coverage of IPMHA services, the intent was never to reach 100% coverage. As such, the roll-out has been implemented mainly as planned.

As we indicated in our 2022 report (Te Hiringa Mahara, 2022), we are concerned about the remaining 30 per cent of people enrolled with a general practice who do not have access to IPMHA services. Kaupapa Māori, Pacific, and Youth services partially fill this gap for the unenrolled population. In terms of what else can be done, an option for enhancing coverage includes extending the use of multi-practice models; for example, HIPs and HCs can offer services to nearby general practices that do not provide IPMHA services. In some areas, HIPs and HCs may be able to increase their offering of virtual services to extend coverage further.

¹⁴ This overall coverage rate excludes data from Tairāwhiti district, which has IPMHA services. If the data had been included, it would increase the national coverage rate by approximately 1 percentage point.

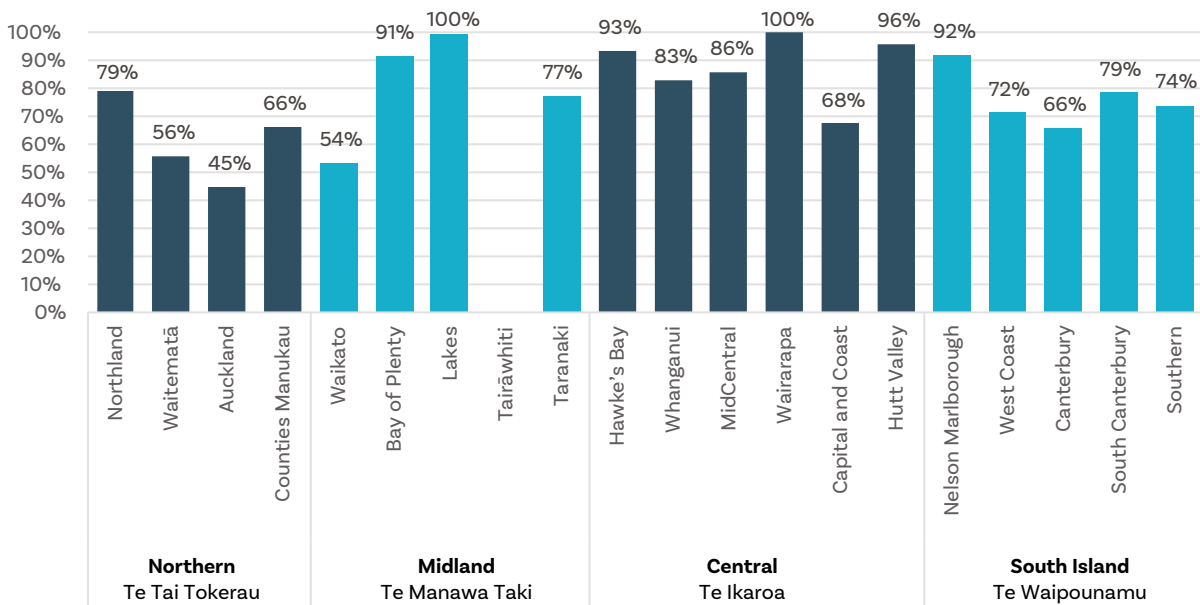
IPMHA service coverage varies by district

Figure 4 shows, by district, the proportion of people who had access to IPMHA services through the general practice with which they were enrolled.¹⁵

Large variations in IPMHA service access exist by district. Six districts achieved 91-100 per cent coverage, 10 had coverage ranging from 66-86 per cent, and the remaining three districts had

coverage from 45-56 per cent. We heard from our sector reference group that there are several reasons that the Auckland region has lower coverage. These reasons include delays from COVID-19 lockdowns (resulting in some services still not being at full capacity), a focus on areas with higher representation of priority population groups, population growth, and workforce recruitment challenges.

Figure 4: Proportion of enrolled population with access to IPMHA services by district, 2023/24



Coverage has increased for Kaupapa Māori, Pacific, and Youth services

Kaupapa Māori, Pacific, and Youth services were well established by the end of the programme roll-out period (Table 5). By 2023/24, Kaupapa Māori and Youth services had been implemented in all 20 districts. Pacific services were available in nine districts with greater numbers of Pacific

communities, as intended.¹⁶ The number of services established by 2023/24 totalled 32 for Kaupapa Māori, 13 for Pacific, and 24 for Youth services. Since our 2022 report (Te Hiringa Mahara, 2022), each of the three service types experienced an increase in the number of districts or the number of services (or both), which is a positive step forward for the programme.

15 Tairāwhiti has IPMHA services, but the coverage data was not available.

16 Districts with Pacific services include Auckland, Canterbury, Capital and Coast, Counties Manukau, Hawke's Bay, Hutt Valley, Southern, Waikato, and Waitematā.

Table 5: Number of Kaupapa Māori, Pacific, and Youth services across number of districts, 2021/22 and 2023/24

Service	# Districts		# Services	
	2021/22	2023/24	2021/22	2023/24
Kaupapa Māori	20	20	29	32
Pacific	7	9	9	13
Youth	18	20	23	24

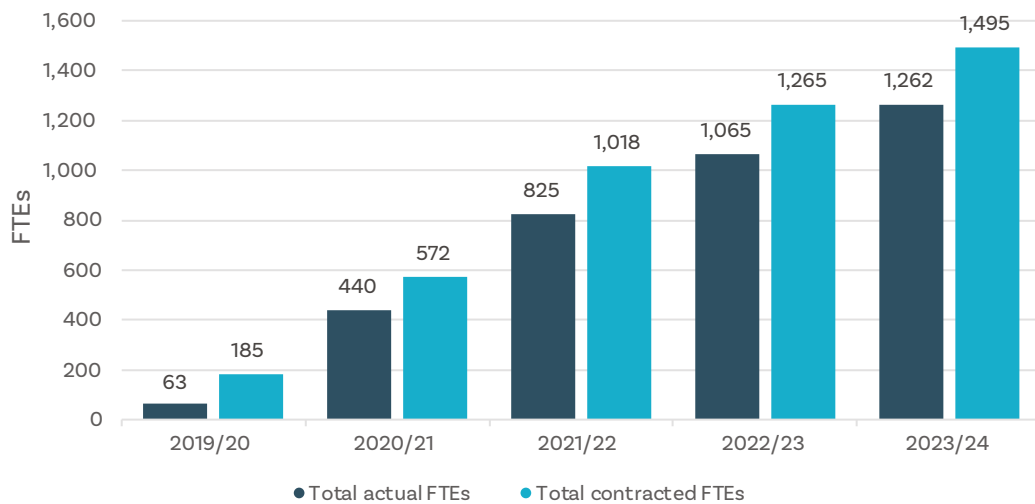
1.3 Workforce

This section describes what was delivered by the Access and Choice programme in terms of the required workforce that was successfully employed.

The workforce has grown as the services have expanded

The workforce needed to provide the Access and Choice programme is not at full capacity yet, but development initiatives are in place to grow and upskill the workforce. By 30 June 2024, 1,262.1 FTE (84 per cent) were employed out of 1,495.1 that were contracted (funded) across all services.¹⁷ (Figure 5).

Figure 5: Total actual FTEs compared with contracted FTEs, as of 30 June 2024



¹⁷ In our previous Access and Choice programme reports, the Ministry of Health had advised us that 1,626 FTEs were estimated to be required by the end of 2023/24. The most recent data we received from Health NZ is 1,495.1 contracted FTEs.

As an indicator of vacancy rates, we can look at the actual FTEs employed compared with the total contracted FTEs. Where the total actual FTEs are lower than the total contracted FTEs, this indicates that there were unfilled roles. Because of general turnover and recruitment phasing, we would expect to see 80-100 per cent of the contracted roles filled once the roll-out is complete.¹⁸ Furthermore, as the services expanded over time and investment increased accordingly, this resulted in new vacancies until the roles were filled.

Figure 6 shows these percentages for each service type by year. From 2021/22 onwards, recruitment for IPMHA and Kaupapa Māori service FTEs appears to have levelled off (the same occurred for Youth services from 2022/23 onwards). Part of the reason for differences between the number of contracted and actual FTEs relates to the ongoing roll-out of services, which continually creates new roles to be filled.

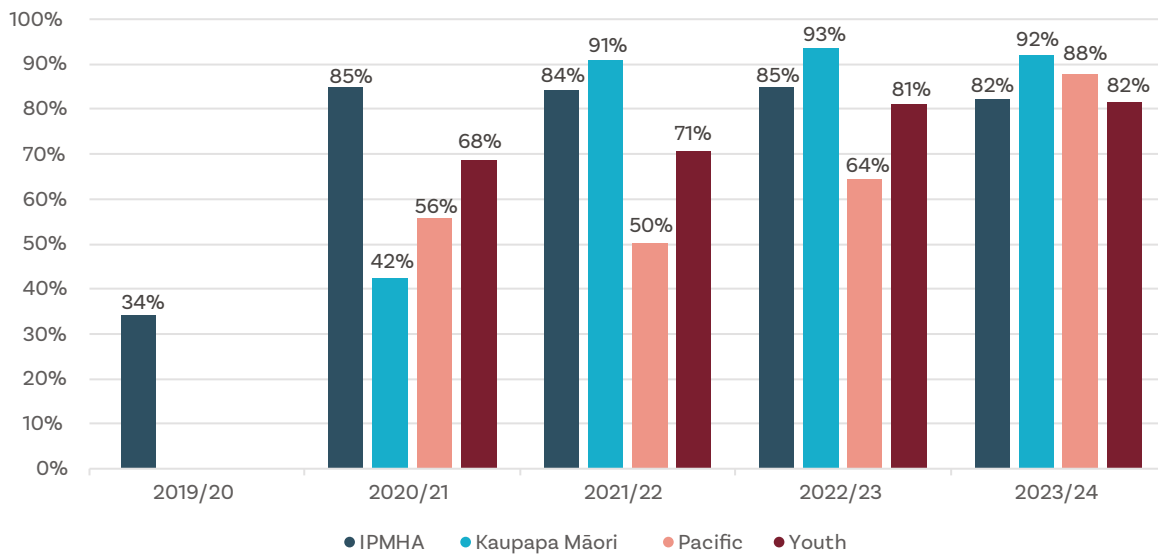
There were some differences in trends across the four service types. In the first year of the programme (2019/20), approximately 34 per cent of IPMHA contracted FTEs were employed.

This percentage significantly increased by the second year and averaged approximately 84 per cent across the subsequent four years for IPMHA services.

Kaupapa Māori service roles experienced a large increase in the percentage employed from the first year of service delivery to the second (from 42 per cent in 2020/21 to 91 per cent in 2021/22) and maintained this level of employment for the last two years of the roll-out period.

Pacific services experienced the lowest percentage of filled FTEs, particularly during the first three years of the service’s roll-out (around 57 per cent on average from 2020/21 to 2022/23). We highlighted this challenge in our 2022 report (Te Hiringa Mahara, 2022) and note that this percentage significantly increased to 88 per cent in the final roll-out year, representing a major increase in the Pacific services workforce.

Figure 6: Filled roles as a percentage of contracted FTEs (at the end of the financial year) (all services)



18 For the workforce shortages, it would be helpful to understand the vacancies due to staff turnover compared with recruitment challenges, as there are different drivers for each. This analysis was out of scope for this report.

The percentage of filled Youth service roles increased halfway through its roll-out (from approximately 70 per cent in 2020/21 and 2021/22 to approximately 80 per cent in 2022/23 and 2023/24).

For IPMHA services, there is a range of clinical to non-clinical role ratios

IPMHA services are required to employ a mutually agreed average ratio of registered to non-registered workforce. There is an allowed range of 1:1 to 1:1.5 clinical (HIPs) to non-clinical FTEs (HCs and SWs). As of 30 June 2024, the national average ratio was 1:1.44 for employed FTEs and 1:1.24 for contracted FTEs, both of which fall within the allowed range.

The Auckland region has a higher ratio of HCs and SWs to HIPs than the other areas, meaning that it employs relatively more HCs and SWs than other areas. While local variation is an expected feature of the programme, this needs to be balanced with ensuring the programme can achieve the reach intended.

Workforce development initiatives are well under way

The Access and Choice workforce development stream is focused on growing and upskilling existing workforces as well as developing new and emerging workforces. This is intended to support ongoing service delivery and help ensure new services are able to grow without impacting existing services. These initiatives help to support the implementation of the IPMHA services through HIP and HC training, cultural competence training, and additional nursing, social work, occupational therapy, and clinical psychology places. In addition, there was investment in targeted workforce development programmes for Kaupapa Māori services (through Te Rau Ora), Pacific services (through Le Va), and Youth services (through Whāraurau).

We previously called for a comprehensive workforce strategy and roadmap to be developed to address persistent mental health and addiction workforce shortages (Te Hiringa Mahara, 2022). Access and Choice workforce development funding will benefit Access and Choice services but is also helping to build the workforce across all service types and settings.

Regarding the IPMHA workforce trainee profile, from 1 January 2021 to 30 June 2024, approximately 700 and 600 people had received training for HCs and HIPs, respectively (Te Pou, 2024). Of the HCs who provided demographic information, they were more likely to be aged under 40, female, and Māori (compared with the total population). HIPs were more likely to be older than HCs, female (compared with the total population) and had proportions of Māori and Pacific people that were similar to the total population. Data on more recent trainees indicate that Māori representation decreased for HCs but increased for HIPs, while Pacific representation increased for recent health coach trainees.

Access and Choice programme is increasing capability of primary care

The new roles and trainings (e.g. trainings for HIPs) created by the Access and Choice programme provide professional development opportunities for people within the mental health and addiction sector or other areas of health. Furthermore, our insights gained from the Access and Choice programme providers indicate a ‘seeding effect’, where their other staff members benefit from the HIP and HC trainings/backgrounds. For example, if a HIP has a specialty in a specific area, they can increase their colleagues’ capability through formal or informal upskilling within the practice. As a result, the Access and Choice programme appears to be increasing the mental health and addiction capability in the overall workforce as well as with the Access and Choice programme workforce.

Access and Choice programme workforce requirements are impacting other workforces

The workforce is shifting to meet the staffing requirements for the Access and Choice programme, which may impact workforces for other mental health and addiction services. Of the HIPs and HCs who provided information to Te Pou¹⁹ (Te Pou, 2024), a quarter of the HCs previously worked in the mental health and addiction sector and a further 35 per cent previously worked in other health services. Thirty-four per cent of HIPs are registered social workers, 31 per cent are nurses, and 16 per cent are occupational therapists. Furthermore, the majority of HIPs previously worked in mental health and addiction services (57 per cent) or other health services (24 per cent) (Te Pou, 2024). These professions and sectors, which already experience workforce challenges, may be further affected as a result of staff movement into Access and Choice-funded services.

1.4 Investment

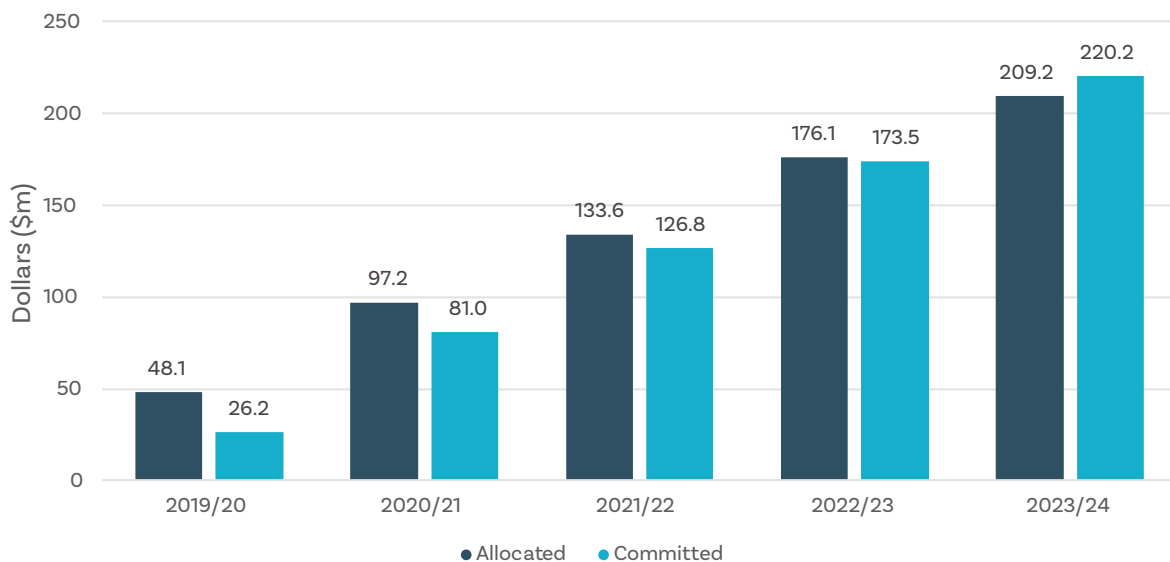
This section describes what was delivered by the Access and Choice programme in terms of the investment made into each of the service types.

After underspends in the earlier years, investment is now mainly on track

The 2019 Wellbeing Budget invested \$664 million²⁰ over five years from 2019/20 to 2023/24 for the national roll-out of the Access and Choice programme. By 30 June 2024, \$628 million had been committed.

The funding allocated and committed²¹ for the programme (including the four different service types, workforce development, and enablers) increased over the five years (Figure 7). This increase represents a gradual build-up of investment over the roll-out period.

Figure 7: Total Access and Choice programme funding allocated and committed, by year



19 Out of the 600 HIPs who were trained, 523 provided this information to Te Pou. The same numbers for HCs were 431 out of 700.

20 The funding for this programme is usually quoted as \$455 million over four years, which reflects the standard Budget forecast period of four years (Government of New Zealand, 2019).

21 Funding “allocated” refers to funding that has been budgeted for a particular item. Funding “committed” refers to funding that has been spent or is committed to be spent through an existing contract as of 30 June 2024.

The programme experienced underspends in the period 1 July 2019 to 30 June 2022. COVID-19 impacted the implementation of the programme by slowing the process of contracting providers, recruiting staff, and making it more difficult for people to access the services. Most of the underspend in each year was transferred to cover the programme’s baseline funding for the next year (and so on). Five million dollars of the underspend was reprioritised to the initiative ‘Continuing Mana Ake – Stronger for Tomorrow’, and \$5.5 million was transferred to cover departmental expenses.

The programme transferred to Health NZ and Te Aka Whai Ora on 1 July 2022. During the last year of the roll-out, the funding had been fully committed.²² There is a contract management

process with service providers that looks at programme underspends. If an underspend is small, the funding may be spent on support activities (e.g. outcomes reporting, IT developments). If the underspend is significant, it is returned to Health NZ.

Table 6 presents the committed and allocated funding for each of the Access and Choice programme workstreams. The last column shows the difference between the allocated and committed amounts.²³ All workstreams apart from IPMHA experienced underspends, which were transferred to cover the programme’s baseline funding for the next year (as discussed above). Due to these transfers, Health NZ does not have the total difference of \$36.47 million available as ‘unspent funds’.

Table 6: Total funding committed and allocated by workstream, 2019/20 – 2023/24²⁴

Workstream	Committed (\$m)	Allocated (\$m)	Difference (\$m)
IPMHA	313.95	287.16	26.79
Kaupapa Māori	83.28	97.25	-13.97
Pacific	33.14	38.90	-5.76
Youth	75.86	93.09	-17.24
Workforce development	85.95	99.73	-13.78
Enablers	32.01	48.15	-16.14
Total	627.82	664.29	36.47

Figure 8 shows how IPMHA service funding steadily increased from 2019/20 to 2023/24. When the Access and Choice programme began, the Ministry of Health accelerated implementation of IPMHA services as providers were ready to expand the services more quickly than expected (the model was already co-designed and

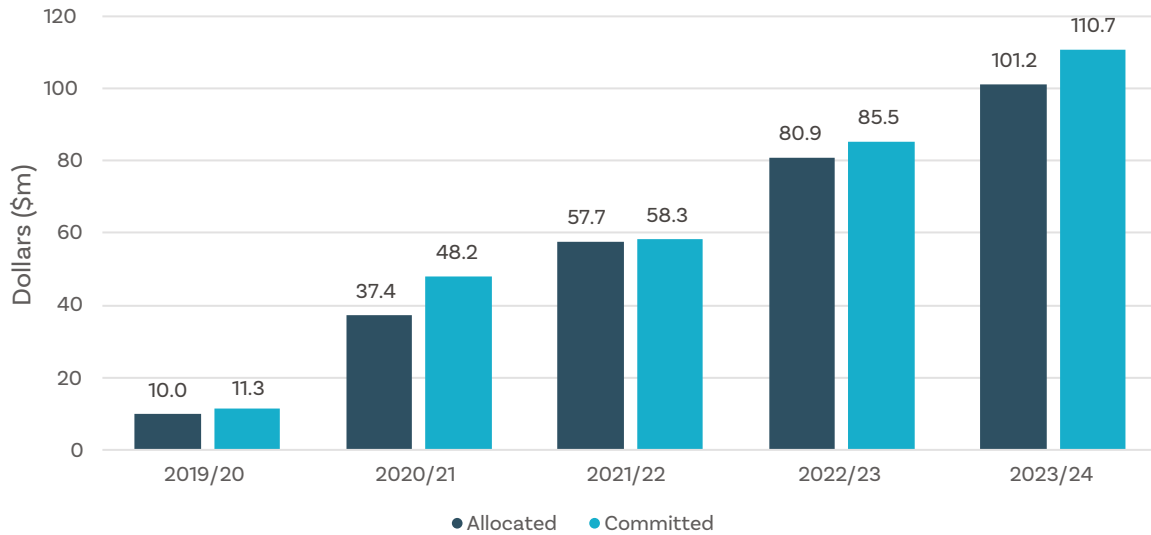
implemented in the Tāmaki Makaurau region). As a result, funding committed for IPMHA services exceeded funding allocated each year of the roll-out. This arrangement ensured that available funding for the overall programme each year was utilised where providers were ready to deliver services.

22 The funding for the last two years of the roll-out was covered by the original funding allocated and subsequent Consumer Price Index (CPI) funding uplifts. Funding committed may be more or less than Health NZ’s actual expenditure on the programme.

23 Negative numbers in the difference column indicate an underspend. Positive numbers indicate an overspend.

24 Not presented in the table is \$3.63 million committed for hospital chaplaincy mental health, which had no funding allocated to it.

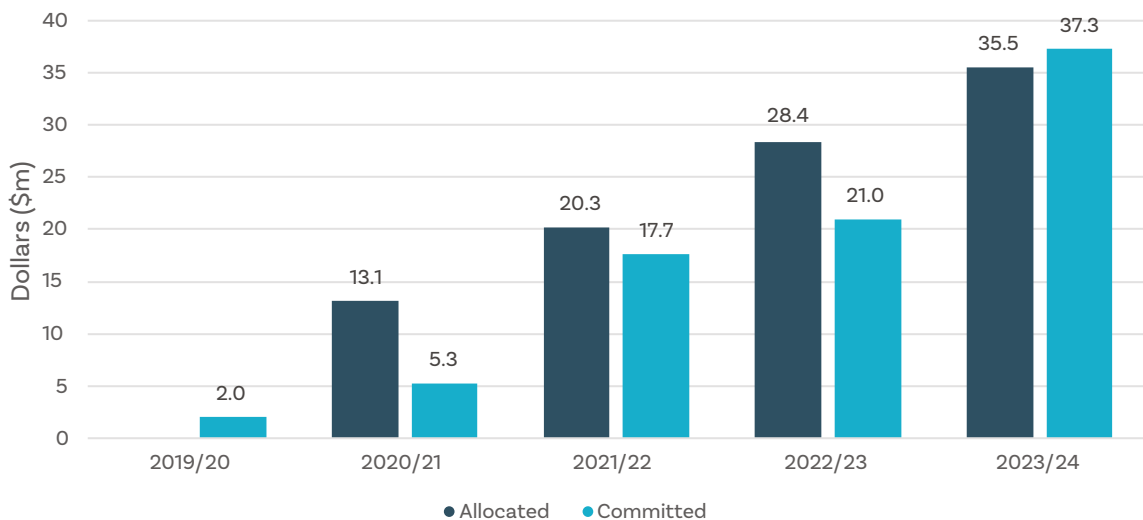
Figure 8: Funding allocated and committed for IPMHA services, 2019/20 – 2023/24²⁵



For Kaupapa Māori services (Figure 9), funding allocated and committed also increased each year. There were significant commissioning delays for Kaupapa Māori services in the first two years of the programme roll-out due to the COVID-19 pandemic and the impacts of lockdown.

These delays resulted in significant underspends, with the highest underspend occurring in 2020/21 at approximately 60 per cent. Since then, however, commissioning of these priority services has progressed well, with funding commitments now on track.

Figure 9: Funding allocated and committed for Kaupapa Māori services, 2019/20 – 2023/24²⁶



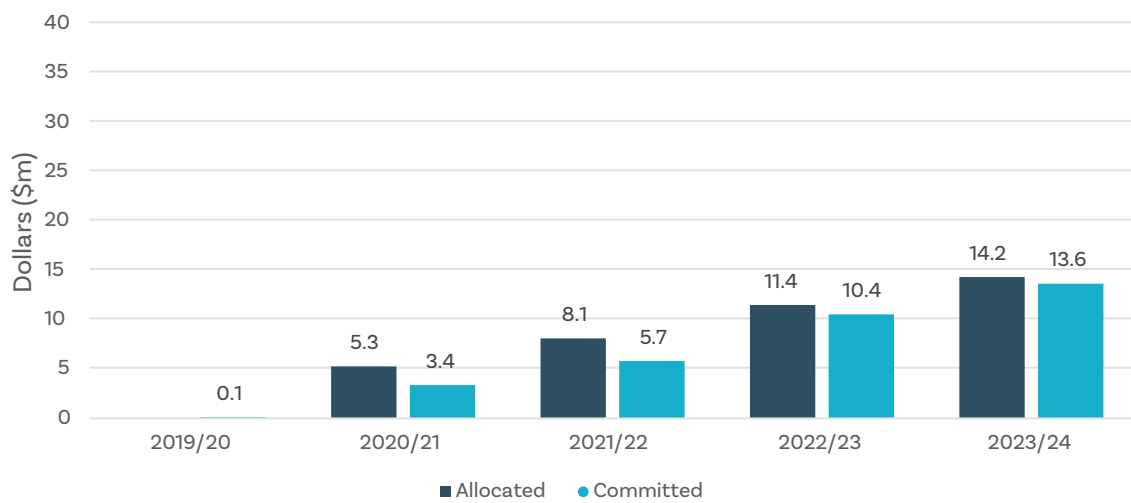
25 The apparent overspends are due to the committed funding including additional funding (uplift) applied to all existing services over the last two years that was not included in the original allocated funding.

26 See footnote 25.

Establishment of Pacific services was slow over the first three years of the roll-out due to the time required for service co-design and challenges in procuring providers. We indicated in our **report on the first three years** that more focused attention was required to support the development of Pacific services (Te Hiringa Mahara, 2022). The slower progress developing and commissioning

these services is reflected in the annual underspends, which was approximately 36 per cent in 2020/21 (Figure 10). Since then, however, Pacific services funding allocation and commitment have steadily increased over the roll-out period. By 30 June 2024, the commissioning was close to completion, with the annual funding commitments on track.

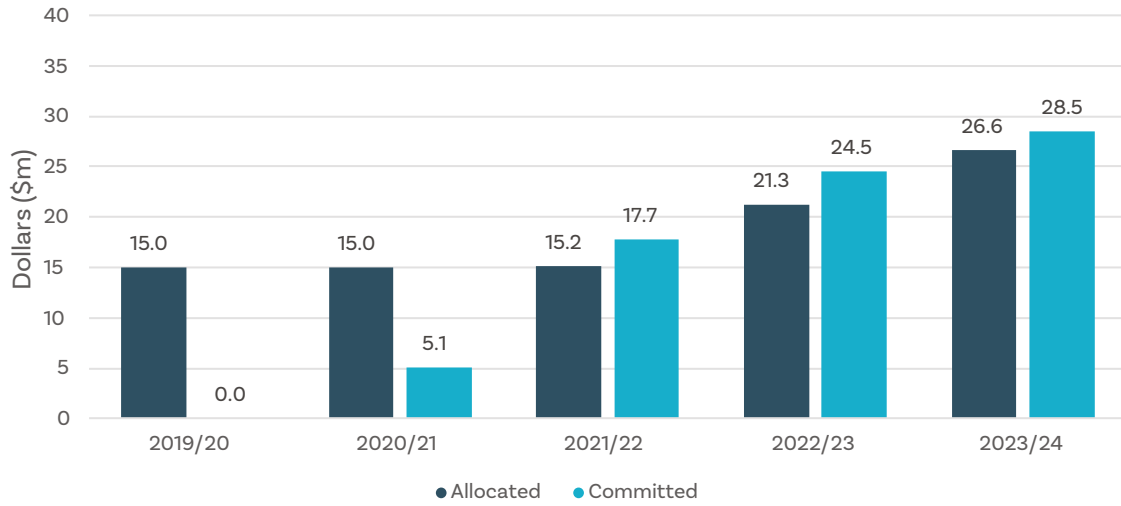
Figure 10: Funding allocated and committed for Pacific services, 2019/20 - 2023/24



The trend in funding allocated and committed for Youth services (Figure 11) was different from the other service types due to ‘front loading’ of funding for Youth services in 2019/20 in response to the urgent need for services acceptable and accessible to young people. Engagement with young people and service design processes during the first year of the Access and Choice

programme meant there was no committed funding for Youth services contracts. However, committed funding increased in 2020/21 and then sharply increased in subsequent years as the services were commissioned. Annual funding commitments were close to being on track by 30 June 2024.

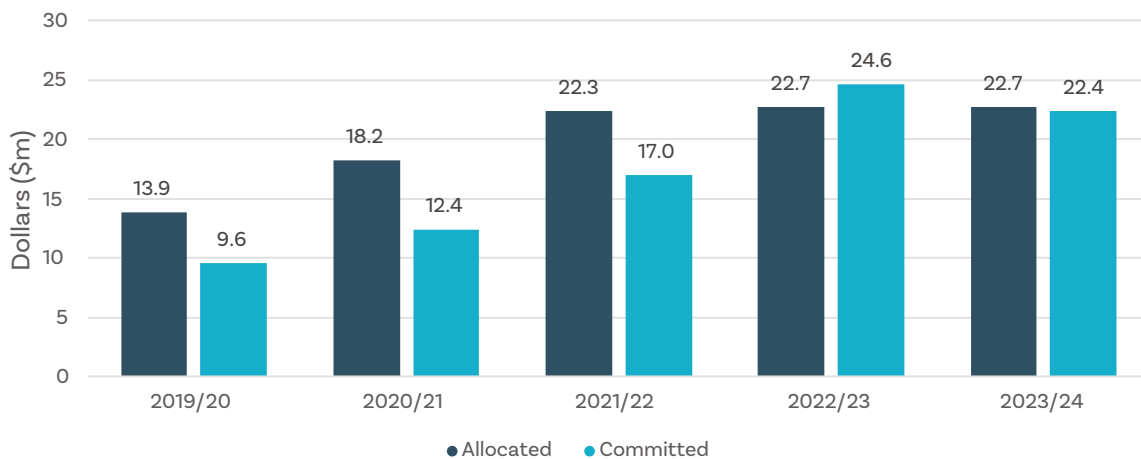
Figure 11: Funding allocated and committed for youth services, 2019/20 – 2023/24²⁷



Funding allocated and committed for workforce development (Figure 12) followed a similar pattern to the four service types over the roll-out period. In each year, the amount of funding increased. While there was an overall underspend for the five years of 15 per cent, the last two years were on

track. The spending of this funding in the last two years represents an improvement from the first three years' underspend, which we highlighted in a previous monitoring report (Te Hiringa Mahara, 2023).

Figure 12: Funding allocated and committed for workforce development, 2019/20 – 2023/24

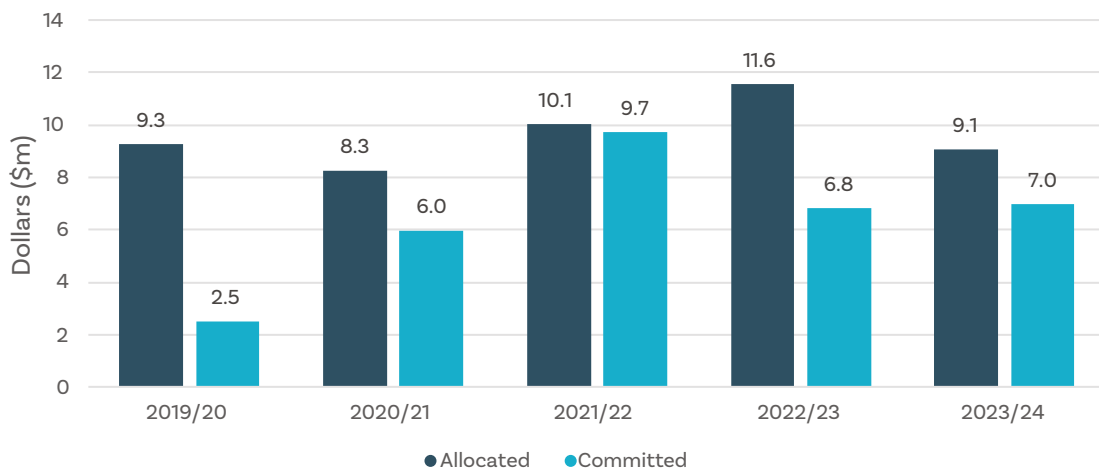


²⁷ The apparent overspends are due to the committed funding including additional funding (uplift) applied to all existing services over the last two years that was not included in the original allocated funding.

Funding allocated and committed for enablers²⁸ (Figure 13) followed a somewhat different pattern to the other funding streams over the roll-out period. The amounts of allocated and committed funding were variable each year, with

underspends occurring each year to varying extents. The annual underspends totalled approximately 34 per cent of the allocated funding for the five-year period.

Figure 13: Funding allocated and committed for enablers, 2019/20 – 2023/24



By 30 June 2024, funding commitments were in line with planned investment for Kaupapa Māori, Pacific, and Youth services

In our [report on the first three years of the programme](#), we indicated that we would be monitoring funding commitments throughout the roll-out to determine whether the ongoing funding levels for Kaupapa Māori, Pacific, and Youth services, as of 30 June 2024, were in line with the planned allocations (Te Hiringa Mahara, 2022). During the five-year roll-out, a higher proportion of funding has been committed to IPMHA services (62 per cent) due to slower design and commissioning processes for the other services.

However, by 30 June 2024, the planned allocation had almost been achieved, as shown in Table 7, with Pacific services 1 per cent behind the planned allocation²⁹ and IPMHA services 1 per cent above the planned allocation. Ongoing service delivery funding allocated for Kaupapa Māori services was set at 20 per cent from the end of 2023/24; this level of funding commitment has been achieved and will continue to be allocated in future years.

28 Enablers include programme design, evaluation, implementation support, IT services, and capacity and capability for the lead government agencies.

29 Pacific services were still not fully rolled out by 2023/24; however, the allocated funding is still available.

Table 7: Funding allocations by service type

Service	Funding committed over the 5 years	Funding committed 2023/2024	Planned allocation from the end of 2023/2024
Kaupapa Māori	16% of funding	20% of funding	20% of funding
Pacific	7% of funding	7% of funding	8% of funding
Youth	15% of funding	15% of funding	15% of funding
IPMHA	62% of funding	58% of funding	57% of funding

1.5 Presenting issues

This section provides context around what was delivered by the Access and Choice programme by outlining the reasons that people were seeking services and, therefore, the health needs that the programme helped to address.

Anxiety is the most common presenting issue to IPMHA services

Figure 14 shows the five most common presenting issues for people accessing IPMHA services in the last two years of the roll-out.³⁰ These are (in order of their frequency): anxiety, depression/low mood, generalised stress, other physical wellbeing issue, and diabetes.³¹ Anxiety was the most frequently presented issue in both

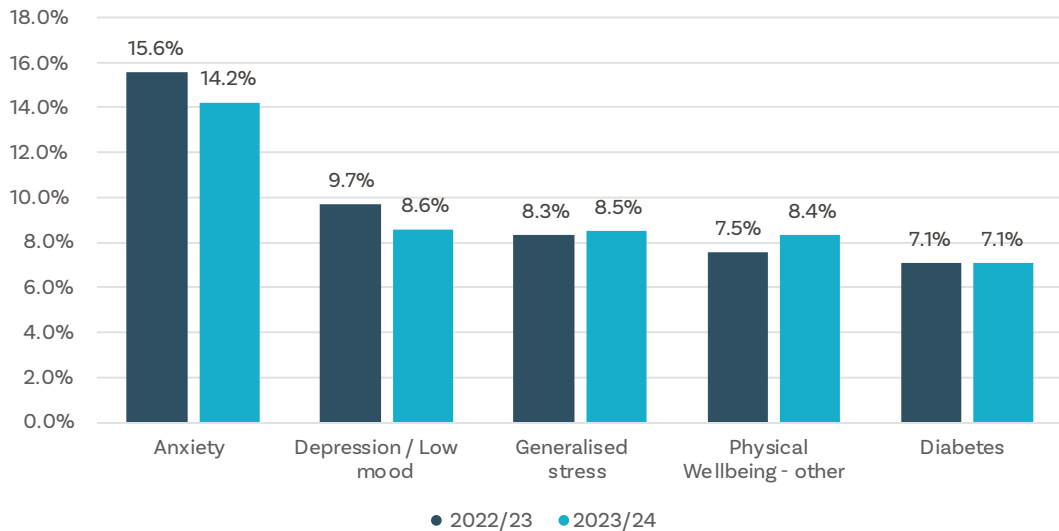
years, comprising 15.6 per cent of all presenting issues in 2022/23 and 14.2 per cent in 2023/24. After these five issues, the next two most common presenting issues were ‘mental wellbeing – other’ and ‘weight/obesity’. The patterns of most frequently presented issue were similar across the two years.

There is variation in presenting issues across the country. Anxiety is the most commonly reported presenting issue for the majority of services. In some areas, services are seeing high numbers of people with physical health issues who are also seeking support with their mental wellbeing. Understanding this variation will be important to ensure services are meeting the mental health and wellbeing needs of their local populations.

30 This data is not available for Kaupapa Māori, Pacific, or Youth services, as they are not yet submitting data at an individual level. For IPMHA services, there are over 50 codes for presenting issues; therefore, we have only presented the most commonly reported ones. Providers may choose up to three presenting issues when entering the clinical codes into the national system. The data we have suggest multiple presenting issues recorded per unique person.

31 Given that the Access and Choice programme supports people with physical issues as well as mental health and substance use/gambling issues, presenting issues such as diabetes are commonly addressed by the programme.

Figure 14: Five most common presenting issues for IPMHA services, 2022/23 – 2023/24



Issues relating to harm from substance use or gambling are not visible in the data

The Access and Choice programme is intended to provide support for mild to moderate issues relating to mental health and problematic substance use or gambling issues. The presenting issues data shows that only 1.9 per cent of people presented to IPMHA services for alcohol and other drug issues, gambling harm, or other related issues.³² However, we heard from our reference group that these issues are being discussed as part of the support provided, but are not always visible in the data.

Capturing substance use/gambling data is tricky, as these are often brought up with providers in relation to other issues in a person’s life, and people don’t always disclose. We heard about concerns in terms of how these issues are addressed and the importance of understanding key considerations related to stigma, trust, and ensuring that primary care is a safe space for people to disclose these issues.

We heard concerns about altered health care delivery as a result of disclosing, e.g. requirements of drug screenings in order to receive a prescription and fear of it going on record and ‘following them round’.

Further work is needed to fully understand if these services are meeting the needs of people with substance use, gambling, or other related issues. As we stressed in a previous report (Te Hiringa Mahara, 2022), the way in which services are delivered may require reconsideration for them to be accessible to people with problematic substance use or gambling issues.

32 Presenting issues data is not collected for Kaupapa Māori, Pacific, or Youth services.

1.6 Productivity measures

This section describes what was delivered by the Access and Choice programme in terms of the number of sessions delivered per day by staff.

Limited productivity data indicate that IPMHA staff are delivering about 6–7 sessions per day, on average

Productivity measures are a key part of monitoring performance, once services are established. Enhancing productivity will increase programme reach, which will be vital for the aim of 325,000 people seen per year to be achieved.

We can look at how many sessions Access and Choice programme staff are providing per day as an indicator of productivity. Data was provided by Health NZ for a small group of 15 established IPMHA practices that represented a range of locations including rural, urban, large, small, and high needs practices and that were consistently reporting³³ over the last two years.

This emerging data show an overall range for 2023/24 of 3.7 to 11.9 sessions per day³⁴ for HIPs/ HCs combined. The median for the HIPs is 5.7, HCs is 6.8, and combined roles is 5.9 sessions per day. In our previous report, we indicated it was expected that the number of sessions per HIP to eventually be 6.5 to 8 per day. These practices are showing progress towards this, and some are achieving the expectation. Productivity data would be improved by a feedback loop between Health NZ and providers on the reported data so that errors can be corrected and meaningful data is collected and analysed.



“

I have been in this role approximately four months and it's already very, very busy. So definitely getting utilised, a lot of mental health people coming through, seeing 10, 11 people a day easily.

”

Primary sector

Many factors can affect productivity, some of which are beyond the control of a provider. For example, we were told that, in some areas, Access and Choice programme staff may be supporting people for longer due to a lack of access to specialist mental health care. Another factor relates to the level of complexity of people's needs and amount of time that more complex cases require (especially when specialist care is less accessible). Lastly, areas with lower populations have fewer FTEs in place, so they must travel across more geographically spread sites compared with staff in areas with denser populations.

There are ways to improve FTE efficiency and service utilisation to address some of the challenges that arise from a decentralised model of service delivery. For example, we discussed earlier in the report the use of multi-practice models and virtual services to improve coverage and reach; these options would also increase productivity.

33 Significant data caveats were advised by Health NZ, including the data reported has not been quality checked to confirm its accuracy.

34 Sessions per day for each Access and Choice programme staff have been calculated by dividing their sessions delivered for 2023/24 by their average annual FTEs adjusted for 218 working days (accounting for public holidays, sick leave, and annual leave). There are several factors that couldn't be adjusted for, such as staff turnover and non-client time each day (which may vary across models and locations). Adjusting for these would show higher productivity.

2. How has the Access and Choice Programme contributed to changing the mental health and addiction landscape?

The Access and Choice programme has increased people's access to and choice of primary mental health services. A range of positive impacts have been reported to be experienced by people using the programme, including access to prompt support. Furthermore, the Access and Choice programme supports primary health care staff by providing additional capacity and reducing time pressures.

2.1 Impact on people

This section describes how the Access and Choice programme contributed to changing the mental health and addiction landscape in terms of the programme's impact on people. While contracts with IPMHA service providers include a requirement to use standardised outcome measurement tools,³⁵ this was not the case for all services. As a result, outcome and experience data are limited when looking at the national picture of programme impacts.

People reported that they found IPMHA services helpful

IPMHA service providers collect 'helpfulness ratings' data about how helpful people found their services so that practices can modify and improve their services. While this data needs to be interpreted with caution,³⁶ the average helpfulness rating ranges from 8.7 to 9.0 (on a 10-point scale) for 2022/23 and 2023/24 across the various IPMHA roles.³⁷

This finding is consistent with an IPMHA service rapid review, whereby 91 per cent of the sessions in the review period were rated as very helpful (8 or more on a 10-point scale) (Andrews and Kliejunas, 2023).

Evaluations paint a positive but incomplete picture of IPMHA services

Various evaluations of IPMHA services have been conducted over the roll-out period, which include some quantitative and qualitative evidence around their impacts on people. Many of them are service-specific (e.g. focused on IPMHA services only), cover only a portion of the roll-out period, are heavily focused on implementation aspects rather than outcomes for people and whānau, and have limited data for people who only attend one session. In addition, the outcome measures could be collected in a more methodologically robust manner and in a way that is consistent across all providers. Therefore, the picture around the impact of IPMHA services on people's outcomes is incomplete.

35 The measurement tools used are Hua Oranga for Māori or others where appropriate, the Duke Health Profile for adults, and the Strengths and Difficulties Questionnaire (SDQ) for children and young people.

36 Helpfulness ratings are often collected from the service user directly by the staff member (e.g. HIP) who delivered the service; as a result, it is exposed to significant bias (in this case, the tendency for people select a high rating because they don't wish to offend the staff member).

37 Excluding ratings for support workers, which are not collected.

A 12-month evaluation of a Southern district IPMHA programme, Tōku Oranga, found that DUKE ratings³⁸ between the first and last consultation showed statistically significant improvement in mental, physical, and social health domains (Synergia, 2023). A rapid review of the Auckland Wellbeing Collaborative providing IPMHA services found that 60 per cent of matched pre- and post-programme involvement showed improvements in wellbeing using DUKE and Hua Oranga³⁹ scores (Andrews & Kliejunas, 2023). For both evaluations, however, only a small number of matched pairs of pre- and post-service usage data were available for analyses; as a result, the ability to generalise these findings across IPMHA services is limited.

One primary health organisation (PHO) looked at four-year trends relating to diabetes indicators. They reported that people with diabetes who were referred to a Wellness Advisor/HIP or a HC experienced a reduction in their blood sugar levels (GPNZ PHO Network, personal communication, September 16, 2024).

More focus on people's outcomes

In our engagements with Kaupapa Māori, Pacific, and Youth service providers, we heard their views very clearly that the data that they are required to report has limited value in terms of measuring wellbeing outcomes that people experience as a result of engaging with the Access and Choice programme.⁴⁰ Providers report that the focus is on inputs and outputs, rather than on impacts and outcomes.



“

Access and Choice only collect widgets ... [they] look at how many whānau have gone through the service and how many have been referred to secondary services.

”

Kaupapa Māori service



“

It's not allowing us to tell the right story, and even though some of them say that they're outcomes, they're more output based.

”

Youth service

Providers are collecting experience and outcome data

Many of the Kaupapa Māori, Pacific, and Youth providers told us they are collecting a variety of experience and outcomes data, only some of which is reported to Health NZ. Often, these data help inform the service provider regarding what is going well and what requires improvement. Outcomes tools being used include Hua Oranga, Kessler Psychological Distress Scale (K10), Patient Health Questionnaire-9 (PHQ-9), General Anxiety Disorder-7 (GAD-7), SACS (Substance and Choices

38 A DUKE rating (Duke Health Profile) is derived from a self-reported instrument relating to various health measures, including physical health and mental health.

39 Hua Oranga is a brief Māori health outcome measure focused on Tāha Tinana (physical wellbeing), Tāha Wairua (spiritual wellbeing), Tāha Whānau (family/social wellbeing), and Tāha Hinengaro (mental and emotional wellbeing).

40 We refer to this type of data as 'outcome data', which includes changes in mental health status, lifestyle factors (e.g. sleep quality), health behaviours (e.g. smoking, drinking), employment/education, and quality of relationships.

Scale), and Strengths and Difficulties Questionnaire (SDQ). These are not consistently used across the programme, and data collection methods also vary and include various formats such as narrative reports, case studies, goal-setting, experience surveys, feedback boxes, evaluation forms, photography, and videos using 'whānau voice'. This variation in data collection prevents monitoring of experiences and outcomes at a national level.



“

We do a K10, and then depending on the score that comes out of the K10, we'll do a GAD-7, a PHQ-9 or a SACS ... When the engagement's ended, we put them in our access reporting ... so you can see where they were out here and now they're down here. It's got a really powerful approach ...

”

Youth service

Much of the feedback that is collected is positive

The feedback that Kaupapa Māori, Pacific, and Youth service providers collect is positive. Providers talked about feedback that expressed how thankful and appreciative people were for the support they received, being able to talk to someone, and the impact this had in their lives (e.g. positive changes in employment or education). Two Pacific services shared with us some of their collected feedback, which demonstrated high satisfaction with the service and positive outcomes. This feedback is sometimes received not just from the person receiving the service but from their wider network as well (e.g. whānau and school).

Central to this positive feedback is the fact that the treatment is holistic, focusing not just on the individual or on mental health but on the wider wellbeing for the whole whānau and family. Another driver of positive feedback is that people are able to navigate their own wellbeing journey how they wanted to.



“

We get some great stories coming through from our families as well, just about the differences that have been made in their families and just as a result of being able to have somebody that they can talk to.

”

Pacific service



“

The kaimahi that were on [a programme saw] the strength of this young person, to be a tuakana, so they have supported him and he's in a place now where he's back in education.

”

Kaupapa Māori service

A range of positive impacts on people are reported for IPMHA services

From the provider perspective, some general practice team members have reported that the HIPs, HCs, and support workers were benefiting their clients in a number of ways. Insights from practices/PHOs identify a range of impacts experienced by people receiving IPMHA services, including immediate/prompt support for clients, better access/fewer barriers (e.g. free of cost, no eligibility criteria apart from being enrolled), longer appointments/flexibility to have as many appointments as needed, continuity of care for peoples/greater scope of care (e.g. holistic), support to navigate the complex health system, and access to non-pharmacological management options and skill sets/new perspectives that are different from the GPs/nurses (Loudon, 2023; Henderson, 2024; GPNZ PHO Network, personal communication, September 16, 2024).



“

We have improved patient contact with low income, Māori, and Pasifika patients.

”

General practice staff



“

With [Access and Choice services], we can offer a holistic approach to managing mental health and chronic health conditions.

”

General practice staff

Many of the benefits to people reported by general practice staff were echoed by people themselves in various reports (Synergia, 2023; Malatest International, 2022; Andrews and Kliejunas, 2023;

Henderson, 2024; Te Hiringa Mahara, 2024a, 2024b). For example, people reported that the services were accessible (free and with short wait times), holistic, and people-centred. They reported having positive interactions with staff, and Māori and Pacific people especially appreciated having Māori and Pacific staff. Other reported outcomes include learning new tools, increased confidence and wairua, reduced mental health and harmful substance use/gambling issues, and regaining a sense of purpose in life, including finding work and career changes. People also appreciated that they had a choice in when to exit the programme and could re-enter when and if needed.



“

But the best thing for me was I didn't revert back to my old drug taking ways ... So I'm on top of quite a lot of it now aye.

”

Patient/whānau (Malatest International, 2022)



“

The health coach had plenty of information on what steps to take next, and who I could be referred to [easily].

”

Te Hiringa Mahara, 2024b

Various barriers prevent outcome data collection from occurring

We heard in our engagements about various barriers to collecting and reporting outcome data. Some of these barriers include a lack of resources, training, and appropriate data/information management tools and templates, as well as current reporting requirements (including many contracts that all require

different reporting) and staff reluctance to report outcomes. Service providers also expressed disappointment that they put time and effort into reporting but did not receive much acknowledgement or feedback. Kaupapa Māori service providers also shared that there was some confusion around who should be sent the data, due to health system changes. Pacific and Youth service providers pointed out the time required to do care coordination is important but time consuming and therefore should be reported in terms of the number of hours spent on it.



“

The quarterly narrative also doesn't capture the depth and breadth of what we do and so again we are still putting the breadth and depth into the questions that aren't really relevant but ... we don't receive any feedback.

”

Kaupapa Māori service provider

Kaupapa Māori services – capturing outcomes

Aspects of the Kaupapa Māori services were seen to be highly beneficial to Māori but not captured in reporting. Beneficial characteristics include that the service is flexible, creative, holistic, and collaborative so that people determine the support they need and the outcomes they work towards.

Holistic services using Kaupapa Māori approaches support whānau with wraparound services, which may include engaging with whenua (land), rongoā Māori (traditional Māori remedies), pūrākau (legendary, mythical, ancient stories), maramataka (Māori lunar calendar), and other mahi toi (art).



“

The reconnection to indigenous self is what has been good for whānau in whatever way that looks. The whānau lead the kaimahi to those spaces.

”



“

A couple of tāngata whaiora have told me the change in their whole wairua when they engage in the whenua, so therapeutic which you don't find that in traditional mental health services outside of Kaupapa Māori.

”



“

So, we take whānau into the ngahere [bush] and we help them to reconnect with Papatūānuku and we help them to know our own healing modalities to utilise and how to make their own Rongoā and those things are really helpful.

”

Some Kaupapa Māori providers told us about the importance of skill-building for tāngata whaiora and suggested that it should be captured in reporting. Some of the skill-building resulted in skills being shared with whānau and friends and included baking rēwena (bread), first aid training, māra kai (gardening for food), making art, and parenting. Providers told us about the impact on rangatahi when kaimahi (staff) take an interest in them and build on their strengths, for example, encouraging rangatahi (young people) to re-enter education. Some tāngata whaiora who engaged with the services became mentors or kaimahi themselves.



“

Even learning how to make rēwena bread, and they go away with the bug. They take that to teach to their generation and their whānau.

We've been able to awahi our health coaches in that space ... [a] tane rōpū, from there we have put people into employment, got men coming back as mentors.

”

Kaupapa Māori service providers also expressed the importance of protecting whānau stories and not using them to justify a service. Some whānau accessing the services are not comfortable with their stories being shared, which could affect what can be reported nationally.



“

They have lots of virtual ways to collect whānau voice and providers decide how and in a way that whānau are okay with. Some whānau say no to giving because they don't know who it goes to in Wellington.

”

A range of other factors affect the ability of Kaupapa Māori providers to collect outcome data, either directly or indirectly (Awa Associates, 2023). Some enablers include enhanced capability/capacity through mechanisms such as workforce completion of both formal and in-house trainings/wānanga; additional administrative staff (and other kinds of FTE) being hired; and enhanced contract application capabilities. Some Kaupapa Māori providers welcomed the respect that came with having their mātauranga Māori expertise

recognised, which could also be reflected in outcome reporting.

Kaupapa Māori service providers expressed a desire to collaborate with other Kaupapa Māori service providers through collective hui to discuss how they would collect data and what to do with it, while protecting the tāngata whaiora and whānau who gifted the data to the provider.

Pacific services – capturing outcomes

Pacific service providers shared with us the importance of community engagement, which can support outcome reporting. They expressed the importance of sharing what they have been doing with the people who have used their services, as well as with their wider communities. Positive outcomes and experiences are a key part of the information that is shared. Related to this type of engagement is how Pacific service providers are doing community outreach to raise awareness of mental health and their services and to reduce stigma associated with mental health.



“

It needs to be meaningful for everybody, not just providers, cos it has to go back to the people ... in a meaningful way, so ... something more creative than a report, that would just go to a certain amount of people.

”

Additional enablers to support outcome reporting for Pacific services include providers are resilient in the face of adversities, they use their networks to share knowledge and resources, they feel positive about their relationship with the Ministry of Health, and they are dedicated to achieving better, more equitable outcomes for Pacific people (PwC, 2022).

Youth services – capturing outcomes

The Youth service providers who engaged with us discussed several barriers that hinder their ability to collect outcome data. One challenge relates to staff's reluctance to collect the data (for example, because they want to just focus on delivering services) or disagreement about how experiential data should be collected. Another barrier relates to young people disengaging with services and the additional time required to follow up with them.



“

It's ... a mixed team ... completely multidisciplinary ... so everybody has their own perspective on how do we obtain that and which questions we ask and what that looks like.

”



“

Sometimes young people come once or twice. You can't do formal outcome measures on that ... how do you know that you are making a difference? For me, it's those young people that then have another issue ... and they access the service again.

”

Additional barriers for Youth services relate to outcomes tools. There was mixed feedback in our engagements relating to the guidance received from Health NZ about which outcomes tools or case management systems they should use, with some providers wishing for more and some saying that they had received tools to use. Another major obstacle relates to the respective outcomes tools that should be used with younger age groups compared with older age groups, as well as a gap in outcomes tools that are suitable for 12- to 16-year-olds.



“

When I first came on board and started attending these quarterly hui, [Health NZ] were talking about having four standard outcome measures. ... Then, I think there was some restructuring changes in [the] team and that conversation went on the back burner.

”

Further barriers were reported by Youth service providers that make outcomes data collection difficult. Staff shared that services are tailored to suit the local community and therefore differ around the country. As a result, this tailoring makes it difficult to obtain a cohesive, national understanding of outcomes. Some providers said that the way in which a service is designed can make it difficult to collect and report on outcomes data, in particular, the brief intervention model. Lastly, inconsistent staff recruitment across regions also poses a barrier to outcome reporting (Dovetail Consulting, 2023).



“

We've got such diverse young people like nationwide, different communities, different localities, different spaces, and in some sense, the feedback from young people is we've got to stop trying to mould each young person.

”

Improving outcome reporting

Providers shared with us their suggestions on what is needed going forward in terms of outcome data: consistent outcome tools and templates; valuing data; collaboration with other Access and Choice service providers; and interest and guidance from Health NZ. Tools need to be determined in partnership with people who use services to select the most appropriate and useful ones. Youth service providers would like specific guidance on which tools to use for different age groups, and they also want a more connected mental health and addiction system (with greater connection between primary mental health and addiction services and specialist services). Goal setting was also mentioned as an outcome that could be captured.



“

If we want a change, I think we need to start involving some of the youth in these conversations because they are the ones that are going to receive ... the service from us.

”

Youth service provider



“

I just think that this programme has just allowed for a lot of innovation in this space and to hear those different stories of innovation would be great collectively.

”

Pacific service provider

2.2 Impact on the mental health and addiction landscape

This section describes how the Access and Choice programme contributed to changing the mental health and addiction landscape in terms of the programme’s impact on the sector.

The programme has increased access and choice regarding primary mental health services

The Access and Choice programme has enabled a shift in the mental health and addiction landscape. Prior to its implementation, primary care providers relied on limited support mechanisms to offer mental health care. Primary Mental Health Initiatives (PMHIs) provided access to a suite of mental health supports (e.g. psychological interventions, counselling sessions, extended GP visits) (Dowell et al, 2009). However, access to PMHIs was limited, they were not available in all areas, and funding for these often ran out in practices well before the end of the financial year.

The Access and Choice programme was developed to bolster the range of primary mental health support services available. Data earlier in this report shows that the programme is increasing access to primary mental health care support. Further, the different service types included in the programme’s design help to ensure that people have more choice in terms of the type of support that best fits their needs. Therefore, the programme appears to meet its high-level objective of enhancing access and choice for mental health support in primary care.

IPMHA services have positively impacted general practice staff

Multiple information sources have described the positive impact of the Access and Choice programme, particularly IPMHA services, on general practice staff (Malatest International, 2022; Loudon, n.d., 2023; Te Hiringa Mahara, 2024a, 2024b). One resounding theme that has emerged is that the additional IPMHA roles have increased the capacity for general practices to offer support to people with issues relating to mental health and problematic substance use or gambling. This extra capacity alleviates time pressures on general practice staff as well as reduced emotional overload that GPs experience. General practice staff have also reported more effective use of medication, less medical management of people, additional support for complex issues, and whole-of-team upskilling.

The positive aspects of IPMHA services listed above benefit not only general practice staff but people as well. People receive improved care that is less medically focused and more holistic. The following quotes demonstrate how some general practice staff perceive IPMHA services:



“

It feels good to meet a patient's needs even when feeling busy/overwhelmed.

”

General Practice provider (Loudon, n.d.)



“

GPs have said to me, 'I was close to burnout, and this has been helpful' ... the HIP is able to share the load a bit. Package of care has gone from 15 minutes to 45, and that somebody feels really supported in that moment.

”

Primary sector (Te Hiringa Mahara, 2024b)

The impact of Access and Choice on referrals to specialist services is mixed

While the number of people accessing primary and community care has continued to increase over the last five years, we also heard that some people with higher needs (moderate to severe) have had difficulty accessing specialist services in a timely way.

We have heard that the constraints in specialist services (increased pressure on the specialist workforce due to high vacancies and a focus on caring for those with higher and more severe needs) have changed some referral behaviour from general practices (Te Hiringa Mahara, 2024a). There was a 10.8 per cent decrease in referral numbers from GPs to specialist services from 2018/19 to 2022/23. However, we have also heard that growth in early intervention through primary care is having some positive impacts.

While the number of referrals has reduced, the number of referrals from GPs for 'new clients' accepted into specialist services has increased, suggesting more appropriate and/or improved quality of referrals. This improvement in the quality of referrals was echoed in our other monitoring work, whereby we were told that some HIPs are supporting GPs to access specialist support.



“

I think HIPs are bringing [these referral skills] to the clinical teams, to GPs and nurses, they'll say, 'Listen, I used to work in the crisis team. Let me help you write some things in the referral that will make it really easy for the triage nurse ... to go, "oh, okay, that's why ... I'll triage this person up"'. ”

”

Primary sector (Te Hiringa Mahara, 2024b)

We heard that there could be a reduction of referrals to specialist services in part because GPs are introducing people to HIPs and HCs rather than referring them to specialist services. Our previous monitoring found that some people with moderate needs (who would have previously been referred to specialist services) are now receiving support through the Access and Choice programme without the need for specialist care.



“

[I] ask parents whether or not somebody's [accessed a] HIP ... and if they have tried, that's great, but if they haven't, I'll say, 'Can you go back to your GP and get some of these sessions?' ”

”

Specialist service (Te Hiringa Mahara, 2024b)

Further investigation is needed to understand the impact the Access and Choice programme is having on referrals to specialist services nationally. This would require analysis of National Health Indicator-linked data to identify people accessing primary care services and specialist services.

More evidence is needed to understand the impact of the Access and Choice programme on other primary mental health initiatives

The Access and Choice programme was designed to complement other forms of primary mental health interventions, including PMHIs and Brief Intervention Services (BIS). While it would be useful to understand whether the Access and Choice programme affected the number of people being referred to and/or accessing PMHIs, the available data are unable to show whether access has changed since the Access and Choice programme has been implemented due to a 2022/23 change in the data collection process.

However, one IPMHA service evaluation was able to look at this issue before the data collection process changed. When analysing practices with and without IPMHA services, it found that those with IPMHA services experienced a statistically significant decrease in the number of referrals to Brief Intervention Services from 2019/20 to 2021/22. Those practices without IPMHA services experienced no statistically significant change (Synergia, 2023).



“

Our referrals to our brief intervention [PMHI] have dropped off significantly ... about 20 to 40 per cent. But the reason for that is we encourage people to see their HIP as a first port of call. ”

”

Primary sector (Te Hiringa Mahara, 2024a)

Lack of specialist service capacity is negatively impacting Access and Choice

In our engagements (particularly with Youth service providers), staff told us that the capacity of specialist services is impacting the length of time they are ‘holding onto’ young people, following referral to specialist services (Infant, Child, and Adolescent Mental Health Services, or ICAMHS). Staff reported that they are supporting young people for longer than intended. In some cases, we heard that young people are referred to primary Youth services rather than to ICAMHS services due to capacity issues, despite ICAMHS being more appropriate.

Youth service providers were concerned that they are dealing with higher risk in relation to young people’s mental distress due to other services not being available when needed. This has created unintended access barriers, including the use of wait lists for Youth services and decisions not to promote awareness of the service in order to manage capacity.



“

What our teams are finding is that they’re holding people before they can get into a specialist service. It’s more them trying to keep them ... at least okay enough before they move up in that waiting list.

”

Primary sector (Te Hiringa Mahara, 2024b)

Whakatepenga

Conclusion

This monitoring report is the final standalone report that Te Hiringa Mahara will publish on the Access and Choice programme, as it is the end of the five-year roll-out period. The overall summary and visuals in the beginning of the report summarise this monitoring story.

This report describes the roll-out of the Access and Choice programme in terms of what has been implemented compared with what was intended, as well as the programme's impacts on people and the mental health and addiction services landscape.

The literature scan we commissioned described the success factors for the PCBH model, off which IPMHA services were based (Premium Research, 2025). The success factors include the following: no conditions for programme entry; accessible and aims to see all people on the same day that the person presents in primary care; and programme staff are well-integrated into the primary care team, achieve high productivity, and play an educator role within their primary care team.

These identified success factors are highly relevant to IPMHA services, and we have highlighted the areas that are working well, e.g. services do not require a threshold or diagnosis for access, successful integration enhances reach and productivity, and HIPs may be able to support GPs with things such as referrals to specialists. PCBH's identified success factors also reinforce the areas requiring attention and recommendations that we have identified in this report, such as enhancing productivity to increase the programme's reach.

The literature scan also notes factors that have constrained international models and limited their reach. Some of these factors relate to the areas that we have highlighted as requiring

attention for the Access and Choice programme. These factors include insecure support and funding, short-term funding cycles, insufficient funding flexibility for communities, high programme staff turnover, lack of integration, and insufficient data to assess performance/ effectiveness (Premium Research, 2025).

We have identified the following areas that require attention for the programme to achieve its objectives:

- enhanced service utilisation and productivity
- continued implementation support, including enabler funding
- enhanced programme sustainability, including extended contract periods and communities of practice
- increased access, e.g. addressing barriers to entry
- assessment of productivity across Access and Choice services (and for benchmarks to be developed accordingly)
- investigation around whether the programme is meeting needs related to problematic substance use and gambling
- appropriate workforce planning and funding
- investigation around the sufficiency of coverage for Māori, Pacific, youth, and Asian populations

- guidance to extend coverage to those missing out from the programme
- automated, National Health Index-based reporting to improve understanding of the impacts of the programme on the wider system.

Based on these changes we want to see, we have made the following recommendations, as outlined earlier in this report:

1. Health New Zealand | Te Whatu Ora (Health NZ) increase programme reach to deliver services to 325,000 people per annum by 30 June 2026, as intended in the 2019 Wellbeing Budget.
2. By 30 June 2026, Health NZ develop a plan to streamline pathways and ensure that Access and Choice Youth services and Infant, Child and Adolescent Mental Health Services (ICAMHS) work together to meet the needs of young people across the continuum of care, including shared care arrangements.
3. Health NZ develop a plan to reduce unwarranted variation across the country in relation to fidelity (including access and entry pathways) to the IPMHA model by 30 June 2026.

This report has identified a number of analyses that would be useful to understand the impacts of the Access and Choice programme. While a robust, comprehensive evaluation method including quantitative and qualitative methods would be ideal, it may be cost-prohibitive. Instead, one approach would be to focus on a few key areas of targeted analysis, including the impact of the Access and Choice programme on the number of referrals to specialists.

We acknowledge the successes that the Access and Choice programme has had so far. The programme needs to be accelerated to reach all its aims. This will require sustained interest, investment, and commitment to help ensure that people who most need access to support can receive it in a timely way that suits their needs.

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Appendix A: Tikanga mahi

Methodology

We used a combination of qualitative and quantitative data sources to describe how the Access and Choice programme has been implemented and what it has achieved in this report. Quantitative data was sourced mainly from Health NZ, the agency with responsibility for the implementation of the Access and Choice programme from the organisation's establishment on 1 July 2022. A small amount of quantitative data came from the Ministry of Health, the agency with responsibility for the Access and Choice programme prior to 1 July 2022; these data are mainly included in the report for the purpose of tracking changes in implementation over the course of the five-year roll-out.

Qualitative insights were collected in September and October 2024 through targeted focus groups, wānanga, and talanoa with a small number of Access and Choice providers of Kaupapa Māori, Pacific, and Youth services throughout Aotearoa. The purpose of this data collection was to hear about the outcomes that people experienced as a result of engaging with Access and Choice programme services as well as barriers and enablers to collecting outcome data. Thus, this data provided a greater depth and understanding of the quantitative data and helped to provide a more detailed picture of Access and Choice programme implementation and impacts.

Our qualitative data collection included:

- nine wānanga with 16 Kaupapa Māori services (kanoahi-ki-te-kanoahi) (face to face) across Aotearoa
- three online talanoa with three Pacific services
- two online focus groups attended by eight Youth services and an email from a provider unable to attend the focus groups.

Some providers shared their data with us about how the Access and Choice programme has impacted the lives of people accessing its services. A couple of primary health organisations (PHOs) also shared some of their insights and reports with us.

Throughout the qualitative data collection and analysis, we followed He Awa Whiria: A Braided River approach (Arago-Kemp and Hong, 2018) (Macfarlane, Derby, Macfarlane, 2024). Data from Kaupapa Māori services was collected and analysed separately by Māori staff before being integrated together for this report. To analyse the qualitative data, we also used a general inductive analysis approach as outlined by Thomas (2003).

In addition to these sources, we also formed two reference groups to advise us with this work. One group comprised lived experience representatives, while the other comprised mental health and addiction sector representatives. We held three hui with these reference groups, where we discussed how the Access and Choice programme has been implemented and identified areas that require attention for the future. In some places in this report, we have identified where the reference groups have highlighted particular issues that they have observed or experienced, and their insights have helped to guide our recommendations.

Many other data sources are referenced in this report. These include various reports, evaluations, articles, etc. authored by various organisations that have examined the Access and Choice programme and contribute to the wider knowledge about the programme.

Appendix B: He whakamārama i ngā ratonga Whai Wāhi, Kōwhiringa hoki

Background of the Access and Choice services

IPMHA services

In 2004/05, prior to the Access and Choice programme, Primary Mental Health Initiatives (PMHIs) were introduced as the first centrally funded primary mental health care. PMHIs provided a package of mental health services for people with mild to moderate mental illness.

In 2016, the Ministry of Health led out the 'Fit for the Future' programme of work to engage with the wide range of stakeholders to identify how to improve responses and outcomes for the group of people whose mental health and addiction needs are not easily met in primary care but who do not meet the threshold for specialist care. This led to some funding in 2017/18 to build on existing primary care initiatives and support the development of an evidence base for interventions that support people with mild to moderate mental health needs. It also led to the development of Te Kuwatawata, a Tairāwhiti initiative that continues today under the name of Te Waharoa.

In 2017, the Primary Mental Health and Wellbeing Model was being piloted in the Auckland metropolitan area as part of a wider approach to deliver holistic primary mental health services. Procure trialled the model in five of its practices, and the Ministry of Health funded Auckland and Waitematā District Health Boards (DHBs) to roll the model out further. Auckland District Health Board (DHB) along with its two primary health organisations (PHOs) and non-government organisation (NGO) partners were successful in securing some

funding to build upon three existing initiatives already being undertaken in Tāmaki Makaurau (Appleton-Dyer and Andrews, 2018). These initiatives were subsequently piloted as part of 'Fit for the Future'. They include:

- Awhi Ora Supporting Wellbeing, the purpose of which is to provide walk alongside, community-based NGO support to people experiencing life challenges or stress
- ProCare 'Te Tumu Wairoa' model, which consists of Health Improvement Practitioners
- East Tamaki Healthcare Health Coach model.

As the Access and Choice programme was rolled out, some variations in programme implementation occurred across the districts. Some of these variations intentionally allowed for flexibility to suit local needs, such as the ratio of registered to non-registered workforce (e.g. HIPs to HCs) and separate or combined Health Coach and Support Worker roles. In other instances, some aspects of programme implementation do not necessarily reflect intentional variations, such as whether a person needs to see their general practitioner before seeing a HIP.

As reported in our 2021 Access and Choice programme report, we had heard concerns from communities and providers about the lack of a co-design process (Te Hīringa Mahara, 2021). The Ministry of Health at the time advised that since the model was co-designed in the Tāmaki Makaurau region before being implemented across the country and this was used as the core basis for the core components required by all

IPMHA services across the motu (country), national co-design wasn't required. Instead, the Ministry set expectations for collaborative design at the local level, including the establishment of local collaboratives to govern the roll-out and make decisions on what parts of the service would best meet their district's needs.

Kaupapa Māori services

Kaupapa Māori services were co-designed with Ngāi Māori (whānau, hapū, iwi, Māori organisations, and tāngata whaiora Māori). The co-design process relied upon a Māori wānanga approach that embraced Te Ao Māori, kawa, tikanga, mātauranga, and te Reo rangatira. The Ministry of Health conducted a series of hui Māori-a-motu from September to November 2019 to gather information on the design of a Kaupapa Māori primary mental health and addiction service model. Analysis from 12 hui involving over 700 whānau voices from around the motu was completed (Awa Associates, 2019).

Amongst the key themes identified were that services should be whānau centred, delivered 'For Māori, by Māori', and steeped in Mātauranga Māori. This analysis informed the foundation for the new Kaupapa Māori primary mental health and addiction service model referred to as the 'Kawa' or national service specification.

A new procurement approach was developed for Kaupapa Māori services. This was based on feedback received from Māori providers during the hui Māori-a-mōtu that they were disadvantaged by traditional procurement approaches. This procurement approach involved two funding streams.

- **Tuakana stream:** best suited for established Māori providers with well-developed infrastructure, service delivery experience within mental health and addiction, or other social services.
- **Teina stream:** for new or smaller Māori providers with or without previous service experience in mental health and addiction but may have existing or previous experience working with

Māori in another social service sector, such as Whānau Ora, social services, or rehabilitation fields. The Teina stream also received extra support towards being contract and service delivery ready (subject to meeting criteria).

Pacific services

Pacific services were co-designed through a series of 14 Pacific community fono held between December 2019 and February 2020. The fono were attended by people with lived experience and their āiga (family), service providers, and community representatives. Key themes from the analysis identified include family connections, cultural connections, community connections, and connecting with youth (Faleafa, 2020; Ministry of Health, 2020). Following the design process, services were commissioned directly by the Ministry of Health.

Youth services

The design of Youth services was informed by responses to a survey about youth mental health and addiction support preferences. In October 2019, Te Manatū Whakahiato Taiohi | the Ministry of Youth Development engaged with over 1,200 young people on the development of the Youth Action Plan. Of these, over 600 young people participated in a workshop and 655 filled in an online survey. Feedback gathered through this engagement process was used to inform the core elements and features of the Youth services. Over 400 people responded to a survey question about preferred mental health and addiction support options. Youth services were commissioned directly by the Ministry of Health through contestable processes. In some instances, the successful application was a collaborative of providers led by the local DHB.

In parallel to the Access and Choice programme, other Youth services have been developed to address young people's mental health and addiction needs. For example, Piki (previously called Integrated Psychological Therapies Pilot) provides free support to people aged 18–25 in the Wellington region.

Appendix C: Ngā kōpiringa raraunga

Data limitations

Te Hīringa Mahara has statutory powers to request information from the government (Mental Health and Wellbeing Commission Act 2020). This power is pivotal for our legislative functions, including monitoring and publicly reporting on mental health and addiction services. Since the start of the Access and Choice programme, there have been some improvements in the availability and quality of data; however, significant data gaps remain. This is a broader issue than just the Access and Choice programme, which is why we made the following recommendation in our overall monitoring report, *Kua Tīmata Te Haerenga* (Te Hīringa Mahara, 2024a):

- Health NZ develops a mental health and addiction data plan by June 2025 that ensures information systems are integrated and enables collection of quality and timely data.
- The data plan should support collecting data across Te Ao Māori measures, experiences, outcomes, workforce, finance, and activity across primary care, NGOs, and hospital and specialist services. The data plan should ensure that all information systems can be linked to specific mental health and addiction services delivered.

A specific data gap in relation to the Access and Choice programme is the lack of visibility in the data of issues relating to addictions. This lack of data visibility means that it's unclear how well the Access and Choice programme is meeting the needs of people with addiction-related issues.

Another lack of data visibility relates to disabled people, who have significantly higher rates of psychological distress than non-disabled people.

It is difficult to identify disability status in the data; as a result, we don't understand how well disabled people are engaging with the Access and Choice programme or how well their needs are being met. It will be important to capture disability status of those seen to increase visibility of disabled people in the data collection, incorporating feedback from disabled communities on how best to capture this.

Outcomes data

The outcomes data that is collected as part of routine monitoring is somewhat piecemeal, and some of it is methodologically limited. Therefore, we can only paint an incomplete picture of the Access and Choice programme and its impacts. This is especially true for Kaupapa Māori, Pacific, and Youth services, which are not required to collect or report nationally some data that IPMHA services collect and report. As a result, we do not have a national picture of the impact of these services on people or how equitable the impacts are. Furthermore, there is a lack of agreement about which outcome measures are most important and relevant to which groups of people (e.g. relevance to Te Ao Māori), which reflects on the value of outcome measures that are traditionally used.

Outcome measures need to be co-designed with people with lived experience of mental distress and addiction (as well as with whānau). Providers need to be able to easily and consistently collect and report on these measures. This will help to ensure that meaningful data is collected that will help tell the story of how the Access and Choice programme has impacted people and the mental health and addiction sector.

Appendix D: Rārangi Kupu

Glossary

Note: For terms in te Reo Māori (Māori language) in this glossary, and also throughout the report, the meanings relate directly to the context of this report. We respectfully acknowledge there may be other interpretations and differences.

Word or term	Definition of word or term
Addiction services	Services that exist to respond to the experiences, needs, and aspirations of people and whānau who experience harm from substances or substance addiction.
(Infant,) Child and Adolescent Mental Health Services (CAMHS)	Specialist services for young people and their families. In some regions, these services are referred to as Infant, Child, and Adolescent Mental Health Services (ICAMHS). These services are usually for children and young people aged 0–18 years. However, the age range can vary around the motu.
Districts	The geographical locations consistent with the former district health board boundaries.
He Ara Āwhina framework	He Ara Āwhina means ‘pathways to support’. The framework He Ara Āwhina describes what an ideal mental health and addiction system looks like. For more detail, please visit our website .
Health improvement practitioner (HIP)	Registered mental health clinicians who work with people of all ages and their whānau and family. They help people with any issues that are impacting on their health and wellbeing. HIPs, like health coaches and support workers, are part of IPMHA services.
Health coach	Part of IPMHA services. They help people to gain the confidence, skills, and knowledge they need to better manage their health. Health coaches can also help people to find resources to better support their wellbeing. Unlike HIPs, they are not registered mental health professionals.
Health NZ services	Services provided currently by Health NZ since it was established 1 July 2022 and prior to this, by district health boards.

Word or term	Definition of word or term
Lived experience	Having personal experience of an issue or situation. It may be a person or a group that has this personal experience, and it can be current, recent, or in the past. For Te Hiringa Mahara, as outlined by our lived experience position statement , ‘lived experience’ relates to personal experiences of distress/mental distress, substance harm, gambling harm, psychiatric diagnosis, addiction, using mental health or addiction supports or services, or experience of barriers to accessing these support and services when someone needs them. Lived experience relates to how people self-identify and share their identity with others, so it is not our role to determine whether people have ‘lived experience’—it is each person’s decision as to how they identify.
Mātauranga Māori	An indigenous knowledge system originating from Māori ancestors that incorporates Māori worldview, philosophical thought, perspectives, and cultural practice.
Measure	A topic of data. For example, ‘workforce vacancy rates’. We use the term ‘measures’ when it relates to people who use services. In our other reports, we use the term ‘indicators’ where it relates to whole populations (consistent with Results Based Accountability terminology).
Mental health and addiction system	All supports and services that respond to the experiences, needs, and aspirations of people and whānau who experience distress, harm from substance use, or harm from gambling (or a combination of these). The mental health and addiction system is part of the wellbeing system.
Mental health services	Services that exist to respond to the experiences, needs, and aspirations of people and whānau who experience distress.
Non-governmental organisation (NGO) services	Diverse services that span from early intervention to specialist services, such as residential facilities, community support services, and addiction services.
Primary care services	Services provided at initial entry points, usually by general practices and other services such as pharmacists. NGOs, such as Māori and Pacific providers, can also provide primary care services so these have been described as primary and community care services.

Word or term	Definition of word or term
Specialist services	<p>Specialist mental health and addiction services are also known as secondary care services. Specialist services are designed to respond to the needs of people with the most severe and/or complex needs. They usually require a referral or assessment for entry.</p> <p>They are publicly funded services provided by Health NZ or NGOs. Specialist services include a range of services across inpatient and community settings. Most specialist services are community based, such as adult community, rehabilitation, alcohol and drug, and other specialist services.</p>
Support worker	<p>Part of IPMHA services. They are based in the community and can help people with anything that impacts on their wellbeing, such as by connecting people to wider supports in the community. In some regions, health coach and support worker roles are combined.</p>
Tāngata whaiora	<p>People of any age or ethnicity who are seeking wellbeing or support, including people who have recent or current experience of distress, harm from substance use, or harm from gambling (or a combination of these).</p> <p>Tāngata whaiora include people who have accessed or are accessing supports and services. They also include people who want mental health or addiction support but are not accessing supports and services.</p>
Te Ao Māori	<p>The Māori world view.</p>
Whānau	<p>Whānau has its whakapapa (history) and origins located in Te Ao Māori (Māori worldview) and refers specifically to blood connections that exist between generations of lineage that descend from atua Māori.</p> <p>In present times, whānau is also commonly used to include people who have close relationships and/or who come together for a common purpose. Tāngata whaiora can determine who their whānau and/or kaupapa whānau are when they are seeking or receiving support. For this reason, we have used 'whānau' in this report to also refer to family.</p>

Ki hea rapu āwhina ai

Where to get support

Tough times affect each of us differently. It's okay to reach out if you need to or, if you're worried about someone else, encourage them to reach out. We all need a bit of support from time to time. If you or someone you know is struggling, support is available. Whatever support you're looking for, there are a variety of online tools and helplines to choose from.

If it is an emergency situation and anyone is in immediate physical danger, phone 111. For urgent care, you can go to your nearest Urgent Care clinic (Accident and Medical) or Emergency department.

For urgent help, mental health crisis services, or medical advice

Phone your local Mental Health Crisis Assessment Team if you are concerned about a person's immediate safety. Stay with the person and help them to keep safe until support arrives.

To get help from a registered nurse, call Healthline: 0800 611 116.

If you would like to engage with the Access and Choice programme

Visit the website for the Access and Choice programme. You may click on 'Find Support' to locate a provider in your area:

www.wellbeingsupport.health.nz/about-access-and-choice

If you need to talk to someone

Free call or text **1737** any time, 24 hours a day, for support from a trained counsellor, or between 2pm and 10pm for a peer support worker.

Some other great places to get support 24 hours a day, 7 days a week include:

Are you OK: free phone 0800 456 450 (family violence help)

Anxiety NZ: free phone 0800 269 4389 (0800 ANXIETY)

Depression Helpline: free phone 0800 111 757 or free text 4202

Suicide Crisis Helpline: free phone 0508 828 865 (0508 TAUTOKO)

Lifeline Helpline: free phone 0800 543 354 or free text 4357 (HELP)

Alcohol & Drug Helpline: free phone 0800 787 797 or free text 8681

The Lowdown: for young people, free phone 0800 111 757 or free text 5626

Youthline: for young people, free phone 0800 376 633 or free text 234

Samaritans crisis helpline: free phone 0800 726 666 if you are experiencing loneliness, depression, despair, distress, or suicidal feelings.

OUTline NZ: free phone 0800 688 5463 for confidential telephone support for sexuality or gender identity issues.

Ola Lelei: free phone 0800 652 535, a free national Pacific helpline with Samoan, Tongan, Cook Islands Māori, and English languages available.

For more information about where to get support, visit the **Health NZ** website.

