

Mental health and addiction target data caveats

Quarter 2 2025/26



Introduction

These are the mental health and addiction target (MH&A) data caveats for quarter two 2025/26, to be viewed alongside all material, dashboards and resources on the [MH&A targets](#) webpage and the [MH&A targets performance resources 2025/26](#) webpage.

General

All historic results from quarter one 2024/25 onwards (when the targets came into effect) reported in the quarter two 2025/26 MH&A target products (i.e. downloadable files) reflect the first published result. For data caveats applying to previously published results, please see the relevant [quarter's published results](#).

Results are based on point-in-time snapshots and may differ from other published statistics due to differences in timing, methodology, or data sources. Some underlying historic numerator and denominator data in the health target interactive dashboards have minor variances. This is due to different extraction dates for the data used to prepare previously published fact sheets and previously published dashboard content (outlined within the individual target caveats, below). These variances do not affect the overarching measure result. Health NZ has been continuously improving its reporting practices and since quarter four 2024/25 data used to produce published fact sheets, dashboards and other resources for the quarter has been extracted on the same day to ensure consistency.

Where a rural and urban breakdown in results is reported, data is classified using the Geographical Classification of Health (GCH) rural–urban geographic classification. Health NZ is currently using the 2018 GCH population proportions for each group, mapped to the 2023/24/25 populations. According to the GCH, Hutt Valley is classified as fully urban, and West Coast is classified as fully rural. Therefore, urban and rural results for these districts are blank for some metrics. Where rural results are reported for Hutt Valley or urban for West Coast, this is due to patients from other districts (for example, rural domicile patients from Wairarapa receiving care in the Hutt Valley).

Region, district, ethnicity, and rurality classifications may be unknown for a small number of events within each measure. If this data is unavailable, those events will be excluded from the relevant disaggregation. These cases represent only a very small proportion of the total, and the reported breakdowns are representative of performance. All events, including those with missing classifications, are included in the aggregate results.

For data definitions and sources, please see Health NZ's [Accountability Performance Measure Specifications](#) document.

Faster access to specialist MH&A services

Data was extracted on 5 February 2026.

As reported in quarter one, there are ongoing data accuracy issues for the Northland district arising from a transition to a new patient management system (MyWai). This is being investigated and we are currently supporting kaimahi to record and capture their work, supporting reporting of activity.

Faster access to primary MH&A services

Data was extracted on 19 February 2026.

The Access and Choice Programme (A&C) includes four workstreams: Integrated Primary Mental Health and Addictions (IPMHA) Services; Youth; Pacific; and Kaupapa Māori services.

During 2024/25 results for this measure only included IPMHA data. Reporting referral dates became mandatory for IPMHA providers from 1 October 2024, meaning prior to this, wait times were not measured or reported using the same definitions and are not comparable. Youth A&C data has been included in results for this measure from quarter one 2025/26, which means that comparison with historical published results (which did not include this data) is not a like for like comparison. Between them, IPMHA and Youth providers deliver approximately 80 percent of A&C service activity. There is a staged plan to transition the Pacific and Kaupapa Māori A&C providers' to event level reporting during 2025/26 and 2026/27, at which point they will be included in results reporting for this measure.

Tairāwhiti A&C services are delivered across all four workstreams to meet the needs of geographically diverse and isolated communities. Services are delivered in a collaborative and integrated model, which enables greater flexibility to deliver services in a range of settings and to engage as many whānau as possible. Summary level data is captured and reported, but it does not align with other A&C data, so Tairāwhiti performance is not currently included in reporting.

Rural and urban results may look slightly different to published quarter one results. This is due to a calculation error in quarter one which has now been fixed.

Shorter MH&A-related stays in emergency departments

Data was extracted on 5 February 2026.

Four level-2 emergency department (ED) facilities (Clutha Health First, Gore Health Limited, Maniototo and Wanaka after hours) are excluded from the result calculation.

Where there are no results for ethnicity and rurality at district level, this is because no patients with those demographics attended ED with MH&A related presentations during the quarter.

Increased MH&A workforce development

The definition 'Train 500 mental health and addiction professionals each year' includes:

- clinical psychology interns
- new entry to specialist practice registered nurses
- occupational therapists
- social workers, and
- stage one psychiatry registrars.

Strengthened focus on prevention and early intervention

Prevention includes mental wellbeing promotion and suicide prevention.

Early intervention includes both services that intervene early:

- during distress (such as primary MH&A); and
- in the life course (such as maternal, infant, child and youth specialist services).

This measure is reported annually in quarter two.

