Independent review of mental health and addiction telehealth services

Assessing the safety of telehealth services supporting people experiencing acute distress

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SYNERGIA

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What you should know about New Zealand's mental health and addiction telehealth services

How to contact the services

This report reviews three national mental health and addiction telehealth providers: Whakarongorau Aotearoa, Youthline, and Lifeline Aotearoa. These services exist to support people across Aotearoa New Zealand who are experiencing distress, facing life challenges, or who simply need someone to talk to. If you or someone you know needs support, please reach out - these services are there for you.

Service	Who it's for	Contact	Hours
1737 Need to Talk (Whakarongorau Aotearoa)	Anyone experiencing mental health or addiction distress	Call or text **1737**	24/7
Youthline	Young people (primarily 12-24 and adults supporting young people)	Call **0800 376 633**, text **234,** webchat at **youthline.co.nz,** WhatsApp **09 886 5696,** email **talk@youthline.co.nz**	24/7
Lifeline Helpline (Lifeline Aotearoa)	Anyone, regardless of age, location, or what you're going through	Call **0800 543 354**	7am - midnight
Tautoko Suicide Crisis Service (Lifeline Aotearoa)	People experiencing suicidal distress	Call **0508 828 865**	7am -midnight

All services are free and confidential.

The people who work in these services care
The counsellors, clinicians, and peer support workers staffing these services are committed to helping people through difficult times. They are trained to listen without judgement and to respond with care and compassion - whether you are in acute distress or simply need someone to talk to.

If you are experiencing distress, or need someone to talk to, services are here to help
All three providers have processes in place for responding when someone's safety is at risk. If you are in distress or concerned about your own or someone else's wellbeing, please reach out. These services will take your concerns seriously and can connect you with the right support. Our report has highlighted that sometimes wait times can be longer to connect with someone to talk to. Please know that you are valued and people working in these services care and want to be there to support you, even if you have to wait a while to get through.

A note about this report
This is an independent review commissioned by the Minister for Mental Health. Its purpose is to give decision-makers an overview of how these services can better meet the needs of the people who may need to use them. Identifying areas for improvement is a normal and necessary part of ensuring these services remain as safe and effective as possible - it is not a reason to hesitate to use them. These are valued services staffed by dedicated people, and they are there for you.

Definitions

Term	Definition	Basis
Acute distress	An intense emotional or psychological state arising from experiences that exceed a person's current capacity to cope. Acute distress is related to, but distinct from, functional impairment. A person may be in significant distress without their functioning being visibly impaired, and vice versa. Acute distress is not fixed, it is a dynamic and fluctuating experience. It is shaped by what is happening in a person's life, their familiarity with their own distress, the relationships and resources available to them, and the quality of support they receive. Distress can ease through connection, validation, and low-intensity support, which is a core part of what telehealth services offer. It may arise from grief, trauma, relationship breakdown, financial hardship, loneliness, substance use, escalating mental health challenges, family violence, or sexual violence. A person reaching out to a telehealth service has already taken an active step, and the appropriate response works with their own understanding of their distress and their preferences for support. Not all acute distress involves serious and imminent risk to life or health. Both experiences require a response, however the nature of that response will differ.	CAN/HSO 22006:2026 Crisis and Distress Lines; SAMHSA (2025) National Guidelines for a Behavioural Health Coordinated System of Crisis Care; panel discussion, 15 May 2026
Serious threat to life or health	The threshold under the Health Information Privacy Code (HIPC Rule 11) at which a telehealth service may disclose a caller's health information without their consent. A serious threat is assessed against three factors: (1) the likelihood of the threat occurring; (2) the seriousness of the threat and the harm that could eventuate; and (3) the imminence of the threat. Imminence is a consideration, not a stand-alone prerequisite. Disclosure must be to a person or agency capable of lessening or preventing the threat, and only to the extent necessary to do so. This threshold applies broadly across the health and social sectors and supports a range of responses - from contacting a whānau member, to facilitating a warm handover, to disclosing information to police, ambulance, or crisis services. These responses differ significantly in nature and in how they are experienced by the person concerned. Where possible, actions taken under this threshold should involve the person's informed consent. This definition is distinct from, but sits alongside, the narrower concept of imminent risk (see below).	Health Information Privacy Code 2020, Rule 11; Privacy Act 2020, IPP 11(1)(f); NZ Office of the Privacy Commissioner guidance
Imminent risk	A situation in which there are clear indicators that serious harm to a person's life or physical safety is likely to occur in the immediate term, typically within hours, without intervention. Imminent risk is a more specific threshold than "serious threat to life or health" under the Privacy Act and provides the appropriate basis for escalation to emergency services including police and ambulance. Indicators may include a stated plan or intent, access to means, recent preparatory actions, sudden calm following acute distress, or withdrawal from contact. These indicators must be understood in context, including the person's history, their current circumstances, and the nature of the interaction. Clarity about what constitutes imminent risk is currently inconsistent across the sector; telehealth services, community mental health, primary health, and emergency services do not share a common protocol.	Health Information Privacy Code 2020, Rule 11; Privacy Act 2020, IPP 11(1)(f); NZ Office of the Privacy Commissioner guidance; panel discussion, 15 May 2026
Appropriate support	A telehealth response that is timely, person-centred or person-led, culturally and relationally safe, and calibrated to the nature and severity of the caller's distress. Appropriate support comprises: (1) *access* - the person is able to make contact in a reasonable timeframe; (2) *genuine engagement* - the responder listens, validates the caller's experience, and works collaboratively with them; (3) *de-escalation and regulation* - the service helps the person move through their distress, not simply determine whether escalation is required; (4) *resourcing* - the caller is connected to relevant information, services, and/or follow-up support; (5) *consent-based escalation* - where emergency response is required, this is pursued transparently and, where safe, with the caller's knowledge; (6) *equity* - the quality of response does not vary based on a caller's history of contact, diagnosis, or demographic characteristics; and (7) *continuity* - the service maintains engagement until handover is confirmed. A referral to emergency services is not, in itself, an appropriate response if the caller has not been supported through the process or if no response is confirmed.	SAMHSA (2025); panel discussion, 15 May 2026
System	For the purpose of this report, 'the system' includes to the MHA telehealth services, the district specialist mental health and addiction service, community services, primary care services and emergency services. System level assurance refers to the relationships, consistencies, interfaces and collective impact of the MHA telehealth services, and their effective integration, as a whole, into wider community support, health, mental health, emergency response services and systems.	Panel discussion 30 June 2026, Independent review of mental health and addiction telehealth terms of reference.

Executive Summary

This review was commissioned by the Minister for Mental Health to provide independent assurance that the three national mental health and addiction (MHA) telehealth providers in scope for this review, Whakarongorau Aotearoa, Youthline, and Lifeline Aotearoa, are appropriately equipped to support people experiencing acute distress. It examines how each service identifies and responds to risk, how people are supported when they are experiencing acute distress, what escalation arrangements are in place, and whether those arrangements are effective. The review was conducted against five Terms of Reference covering service access and responsiveness; triage and risk management; clinical governance; integration with the wider system; and operational performance monitoring.

Process

The review was conducted between April and June 2026 by an independent expert panel comprising of Dr Barbara Disley ONZM (mental health system leader), Dr Murray Patton (senior psychiatrist), Kelly Pope (lived experience leader and peer advocate), and Dr Alan Woodward (international crisis line expert). Synergia provided secretariat support, including evidence gathering, analysis, and report drafting. The panel drew on document review, performance data analysis, site visits to each provider, and direct consultation with Lived Experience groups, primary care providers, emergency services, and regional Health New Zealand (Health NZ) mental health and addiction leaders.

System overview

The three MHA telehealth providers within scope of this review are components of a broader mental health and addiction system. They operate general mental health and addiction support functions, some of which extend to acute distress.

The diagram below illustrates the formal referral pathways within the system, as identified during this review. Other referral pathways and feedback loops may exist. Please refer to Figure 4 in section 4.2.1 for a breakdown of the proportion of calls that are escalated to emergency services.

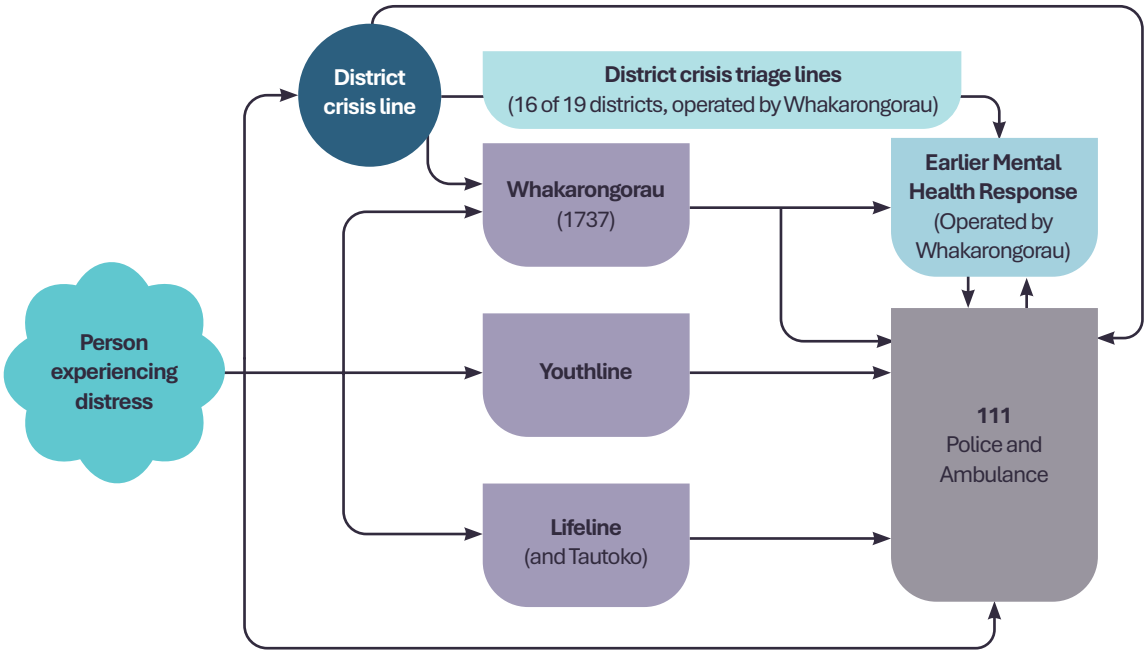


Figure 1: Mental health and addiction telehealth services formal referral pathways

From our activities and deliberations, we highlight the following key observations:

- All three providers have protocols and practices to recognise people experiencing acute distress, engage with them, and escalate situations where life and safety are at imminent risk. These are reliant on people disclosing their levels of distress, which lived experience engagement confirmed requires a sense of safety and trust.
- All three providers have suitably trained staff and clinically qualified supervisors overseeing their processes. Each has a clinical governance framework in place.
- All three providers have mechanisms for referrals to emergency services when urgent response is required and may signpost or refer to Health NZ specialist mental health services.
- All providers are providing support to people experiencing different kinds and levels of distress including callers who are experiencing acute distress.

Accordingly, the Minister can be assured that at a provider level, these services have the foundations required to respond to people experiencing acute distress. However, this review has identified opportunities for strengthening the system's ability to safely respond to people experiencing acute distress.

Findings

The findings set out below identify opportunities to strengthen safety across the system and form the basis for the recommendations that follow.

Finding 1: Too many people who attempt to contact MHA telehealth services are not getting through

Finding 2: Providers have the basic components of a safe system. Safety concerns lie at the interfaces between providers and the wider system

Finding 3: Outcomes are not routinely monitored across the system. Monitoring outcomes would support data-informed practice for providers and safety oversight for funders

Finding 4: Routine call-back is not occurring across the system. This practice could improve safety and continuity of care for people calling when experiencing acute distress

Finding 5: Bounded anonymity enables access to these services and must be protected in any system change

Finding 6: Information sharing across MHA telehealth services is nuanced and requires careful system design

Finding 7: The number of children and young people contacting MHA telehealth services is increasing and they are currently being served under models that were not designed for them

Finding 8: The service model does not distinguish between the different needs of callers, and there is an opportunity to develop more tailored responses

Finding 9: There is a need for improved service responses to Māori

Finding 10: Pacific people, disabled people and other priority populations may face additional barriers to access or be less well-served by current models of support

Finding 11: A shared clinical practice and quality framework would strengthen safety, consistency and accountability across the system

Finding 12: Current commissioning does not enable a coherent system-level response to people contacting MHA telehealth services while experiencing acute distress.

Safety assessments

The following statements respond to the question of whether this system can be assessed as safe against each of the objectives as outlined in the terms of reference for this review.

Objective 1

Assess whether telehealth services have appropriate clinical safety systems in place to safely manage callers

The review can provide assurance that clinical safety systems are in place across the three providers to safely respond to callers who are able to establish contact. However, these systems are reliant on a person feeling sufficiently safe and supported to disclose information for a safety assessment to be effectively undertaken.

Objective 2

Evaluate whether calls are received and responded to in a timely manner

The review cannot provide assurance that calls are being received and responded to in a timely manner. Too many people approaching these services do not get their calls answered, a proportion of whom may be experiencing acute distress.

Objective 3

Assess the effectiveness of triage and risk assessment processes

The review can provide assurance that triage and risk assessment processes are in place at each provider. It cannot provide assurance that these processes are consistent, comparable, or effective at a system level.

Objective 4

Examine escalation pathways for callers experiencing significant distress or crisis

The review can provide assurance that all providers have established escalation pathways. The panel cannot provide assurance that pathways are operating consistently across the system.

Objective 5

Assess integration with wider services including specialist mental health services, ambulance, police, and primary care

The review cannot provide assurance that MHA telehealth services are adequately integrated with the wider mental health and addiction and emergency response systems.

Objective 6

Review key operational performance indicators including wait times and abandoned call rates

The review can provide assurance that individual providers have a level of operational performance monitoring. However, performance targets have been persistently missed, and providers aren't routinely measuring service outcomes for people.

Objective 7

Examine clinical governance arrangements including supervision, training, workforce capability, and escalation protocols

The review can provide assurance that clinical governance arrangements are in place within each provider, however Māori and Lived Experience input is yet to be embedded. It cannot provide assurance that governance is adequate at a system level.

Recommendations

The recommendations in this report are organised into three tiers. Tier 1 identifies actions that should be taken immediately to address the most pressing safety concerns. Tier 2 sets out the enabling actions needed to build a more coherent and accountable system. Tier 3 describes the longer-term system changes required for a safe, sustainable and equitable national response. The tiers are not strictly sequential and work on Tier 2 and Tier 3 actions can and should begin in parallel with Tier 1 where capacity allows.

Tier 1: Immediate action

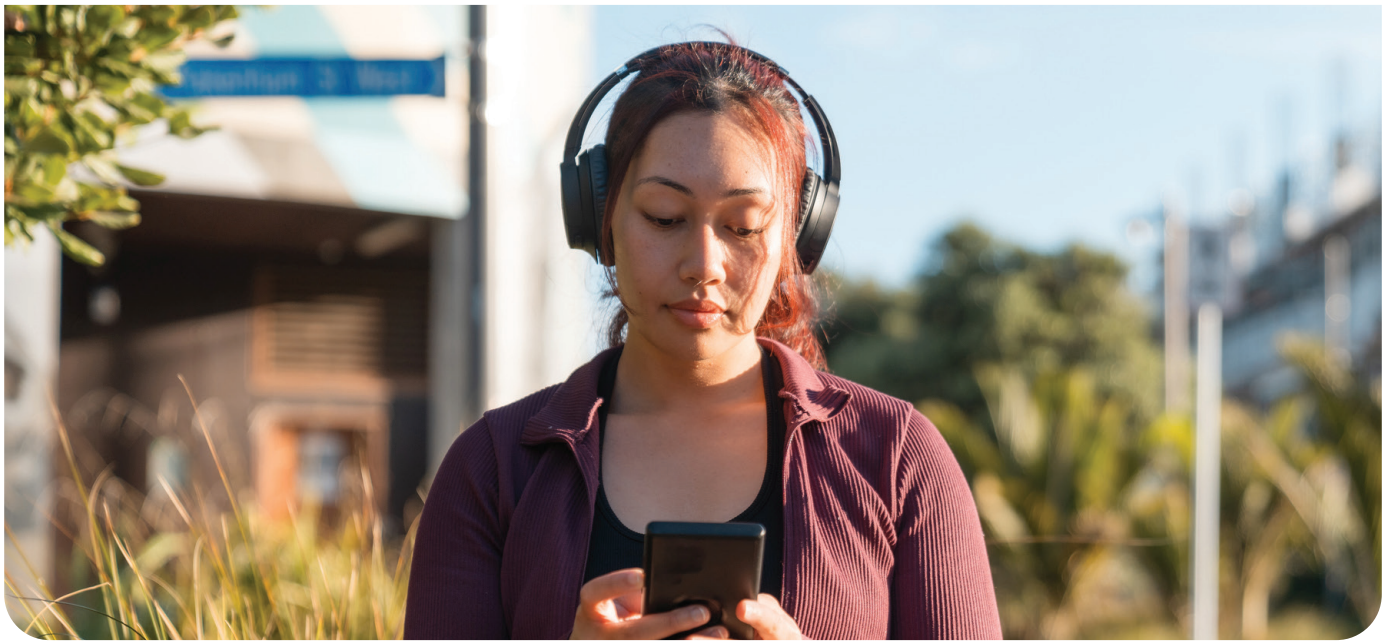
Recommendation 1. Improve call answer rates across the system, with a focus on people experiencing acute distress.
Recommendation 2. Standardise escalation protocols and formalise communication arrangements with emergency services.
Recommendation 3. Further strengthen MHA telehealth services clinical governance and quality systems.
Recommendation 4. Commission and evaluate a call-back pilot for callers who have contacted an MHA telehealth service while experiencing acute distress.
Recommendation 5. Embed relational models of care into practice and expand peer support to operate 24/7.
Recommendation 6. Inform callers of their rights, the nature of the service, and the circumstances under which their information may be shared.

Tier 2: Enabling actions

Recommendation 7. Define the scope and purpose of each commissioned service and understand the distinct needs of the populations it serves.
Recommendation 8. Engage with Māori to ensure the needs and perspectives of tāngata whenua inform future decisions on system configuration and service provision.
Recommendation 9. Understand and address the barriers Pacific people and priority populations face in accessing MHA telehealth services.
Recommendation 10. Co-design a process to determine the circumstances in which information sharing between providers is appropriate and how people using the services will be informed.

Tier 3: Longer-term system changes

Recommendation 11. Use the outputs of Tiers 1 and 2 to inform future system-wide improvements and design.
Recommendation 12. Develop a shared clinical practice and quality framework for all MHA telehealth providers.
Recommendation 13. Develop an outcomes and data measures framework so the system can determine whether it is achieving its purpose.
Recommendation 14. Establish a clearly designated 24/7 national suicide prevention crisis line function for people experiencing suicidal distress.
Recommendation 15. Develop a dedicated framework and service model for children accessing MHA telehealth services.
Recommendation 16. Formalise and strengthen referral pathways between MHA telehealth services and the wider health and emergency system.



1. The review

1.1 Purpose of this review

This review was commissioned by the Minister for Mental Health (the Minister) to provide independent assurance that the three national Mental Health and Addiction (MHA) telehealth services in scope for this review are appropriately equipped to support people experiencing acute distress. It examines how three national providers identify and respond to people experiencing acute distress, what procedures are in place for escalating calls from people with imminent risk to life or health, and whether those arrangements are effective.

The review was requested in the context of growing pressure across the MHA telehealth system. Acuity and complexity of calls to telehealth services have been reported by services as having increased substantially over recent years. Police are in the process of changing how they respond to mental health call outs under the Mental Health Response Change Programme. Significant questions exist about the capacity and sustainability of services to meet current and future demand. These pressures make independent review and assurance a matter of urgency.

Three services were within scope:

- Whakarongorau Aotearoa, telehealth and digital mental health services, including the 1737 helpline, the Earlier Mental Health Response (EMHR) and the mental health crisis triage function (within certain districts).
- Youthline, helpline, text, webchat, email and WhatsApp services.
- Lifeline Aotearoa, Helpline line, text service and Tautoko, Suicide Crisis Helpline service.

The review was conducted by an independent expert panel:

- Dr Barbara Disley ONZM, a mental health system leader and Deputy Chair of the Mental Health and Wellbeing Commission.
- Dr Murray Patton, a senior psychiatrist and former President of the Royal Australian and New Zealand College of Psychiatrists.
- Kelly Pope, a lived experience leader and peer advocate.
- Dr Alan Woodward, international expert in crisis lines; former Australian Mental Health Commissioner and policy advisor on mental health and suicide prevention.

Synergia provided secretariat support, including evidence gathering, analysis, and report drafting.

1.1.1 How this review differs from earlier reviews

This review is one of several pieces of work examining the MHA telehealth system in 2026, and it is important to be clear about what distinguishes it from those other workstreams.

In April 2026, a review commissioned by Health New Zealand | Te Whatu Ora (Health NZ) examined how the three services operate, where they overlap and differ, what gaps exist in the current configuration, and what opportunities exist for a more integrated MHA telehealth pathway. That review focused on service provision, comparative analysis, and system integration. Health NZ also recently completed an issues-based audit of Whakarongorau Aotearoa, the written findings of which were made available to this review panel. A separate, provider-led workstream is examining what a contemporary future model of care for MHA telehealth services might look like, with a focus on service scope, volumes, and configuration.

This review focuses on clinical safety, operational performance, assurance arrangements. It was commissioned by the Ministry of Health and Health NZ and conducted by an independent panel. The Review canvased and incorporated voices of lived experience.

1.2 Methods

The review was conducted between May and June 2026. The panel used four methods: document review, data analysis, site visits to each of the three providers, and direct consultation with lived experience groups, primary care providers, regional leaders of Health NZ specialist MHA services, and emergency services.

Document review included service specifications, clinical governance frameworks, operational policies, workforce data, and performance reporting provided by Whakarongorau Aotearoa, Youthline, and Lifeline Aotearoa. The panel also reviewed findings from the Review of MHA Telehealth Services in Aotearoa New Zealand (Phase 1, April 2026).

Performance data examined in this review included data and documentation from 2020 to 2026. The panel reviewed contact volumes, triage and risk categorisation, escalation rates, and outcome data where available.

The review also drew on international best practice and benchmarking, examining comparable crisis line and telehealth models to identify where New Zealand services perform well and where there may be opportunities to strengthen practice.

Providers were given an opportunity to validate summaries presented in Appendix B, and an opportunity to review a draft of this report prior to finalisation.

1.2.1 Limitations

Performance data was provided by the services themselves and was not independently validated, except where it could be cross-referenced against Health NZ audit findings or the Phase 1 review. Some data gaps existed, particularly in relation to outcomes.

The review was conducted within a six-week timeframe, which imposed practical constraints on the depth of engagement possible.

Lifeline Aotearoa is not currently funded by Health NZ, thus there was limited performance monitoring data held by Health NZ for that service. The panel relied primarily on information provided directly by Lifeline and on the Phase 1 review findings.

2. The MHA telehealth system

New Zealand's MHA telehealth system includes a range of telephone and digital support services operated by community and health providers. The volume, clinical capability, and responsiveness of many of these services are not well understood at a system level. This review focuses on three national providers identified in the terms of reference: Whakarongorau Aotearoa, Youthline, and Lifeline Aotearoa. These three services provide an important interface with people experiencing acute mental health, addiction and psychological distress and with formal crisis response pathways. Other services operating in this space are not discussed or included in the analysis.

The diagram below illustrates the formal referral pathways within the system, as identified during this review. Other referral pathways and feedback loops may exist. Please refer to Figure 4 in section 4.2.1 for a breakdown of the proportion of calls that are escalated to emergency services.

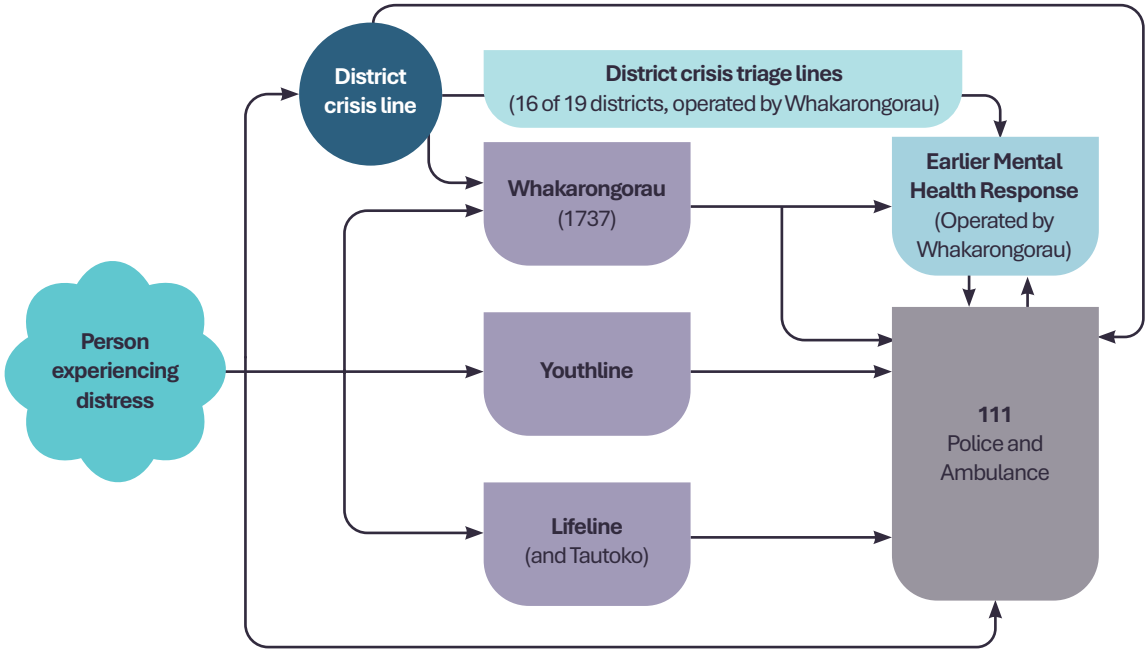


Figure 1: Mental health and addiction telehealth services formal referral pathways

Providers

Whakarongorau Aotearoa is the largest provider in scope for this review, delivering New Zealand's National Telehealth Service under a fully funded contract with Health NZ. Its mental health and addiction portfolio includes:

- 1737 Need to Talk, a free, confidential helpline available via phone and text for people experiencing mild to moderate mental health and addiction distress. A peer support line operates through the 1737 number, sub contracted to Ka Puta Ka Ora Emerge Aotearoa.
- The Earlier Mental Health Response (EMHR), calls diverted from the 111-call centre that have a mental health element but do not require an emergency response.
- District Crisis Triage, a clinically staffed service providing acute mental health crisis response across 16 of 19 districts

1737 and EMHR operate 24/7 and the peer support line operates from 2-10pm. The District Crisis Triage hours vary by district.

Youthline provides free, confidential support to young people and is funded by Health NZ through the Access and Choice primary mental health programme, supplemented by philanthropic funding and fundraising. Contact channels include phone, text and SMS, webchat, and WhatsApp, operating 24 hours a day, seven days a week. Youthline's contracted target population is 12- to 24-year-olds, though in practice the service accepts contacts from people of all ages. As it is an anonymous service, Youthline does not know the age of the client until it is disclosed by the client. If the person is over 24 years old, and they are not an adult supporting a young person, the conversation is completed with the client encouraged to contact one of the other Helplines in future, or the client is supported to contact another Helpline. Its purpose is to provide emotional support, information, and referral to other services for young people experiencing distress. Youthline services are operational 24/7.

Lifeline Aotearoa operates the Lifeline Helpline and the Tautoko suicide crisis line, both available to anyone in New Zealand regardless of age, location, or presenting issue. Lifeline also hosts the regional Warmline peer support service. Lifeline operates within Presbyterian Support Northern, a charitable organisation. It does not receive direct government funding for its Lifeline or Tautoko helplines. Lifeline relies on charitable funding and fundraising to sustain these services. Health NZ holds a contract with Presbyterian Support Northern for the Warmline service only (outside of the scope of this review). Tautoko is specifically intended for people experiencing suicidal distress. Lifeline (including Tautoko) operates 7am-midnight.

3. Findings

The findings presented in this section represent the panel's overarching conclusions about the MHA telehealth system. They have been drawn from the full body of evidence gathered during the review, including detailed findings across each of the five Terms of Reference areas, observations from site visits and stakeholder consultation, and the perspectives of people with lived experience of these services. The detailed findings that underpin each headline finding are set out in Section 4, with supporting evidence in Appendix B.

Finding 1: Too many people who attempt to contact MHA telehealth services are not getting through

Telehealth services play a critical role in the mental health and addiction system. They may be the first, and sometimes the only, point of contact for people in acute distress.

The access picture across the system raises serious concerns about the capacity of these services to respond to people experiencing acute distress. Approximately half of people who attempt to contact these services do not get through. There are no indications for people on hold how long the wait time will be, and there are currently no call-back options if the stress of waiting to connect becomes too much. The people who give up in a queue or put the phone down are not visible to the system, therefore their level of distress, their need, and what happened to them next is unknown.

The panel heard through Lived Experience engagement that failed access is not simply an issue of inconvenience. For someone who reached out to a telehealth service in a moment of acute distress, an unanswered call can compound their distress, create feelings of worthlessness and make future help-seeking less likely.

At a system level, a 50% answer rate means that any assurance about the safety of these services is necessarily limited: a system that does not reach half of the people who seek it out cannot be assessed as safe, regardless of the quality of what happens once a call is answered.

Finding 2: Providers have the basic components of a safe system. Safety concerns lie at the interfaces between providers and the wider system

The three providers have established the basic components of a safe service: triage and risk assessment frameworks, clinical governance structures, escalation protocols and supervision arrangements. Safety concerns do not lie primarily within any individual provider, but at the interfaces between them and with the wider emergency and health system. Providers are not operating as a formally connected system leading to formal changes in contracts and specifications, however there is some connection and discussion occurring between providers as they attempt to adapt to changing demands. Providers have limited ability to create pathways beyond their own service boundaries, and the connections that matter most in acute distress (to whānau, crisis teams, emergency services, primary care, and to each other) are fragmented, inconsistent, or absent across the system. Providers are lacking processes for connecting with a person's whānau, family, friends or support people, limiting the options and choice for people in acute distress around who is involved in helping them stay safe, and limiting the support they have if escalation to police, ambulance or crisis teams occurs.

Finding 3: Outcomes are not routinely monitored across the system. Monitoring outcomes would support data-informed practice for providers and safety oversight for funders

There is no formal or routine process for monitoring outcomes for people after a call is escalated to emergency services or referred elsewhere.

Data collected across the system is not standardised and outcome data is absent. The system cannot identify who is, and is not, being reached, cannot measure whether contacts result in reduced distress or improved safety and wellbeing, and cannot make data-informed decisions about workforce deployment or demand management. The absence of outcome data leaves providers making operational decisions without a meaningful picture of the people they serve, and leaves funders and monitors without the information needed to determine whether the system is safe or effective.

Finding 4: Routine call-back is not occurring across the system. This practice could improve safety and continuity of care for people experiencing acute distress

MHA telehealth providers in scope for this review aren't routinely following up with people who call in acute distress or in situations where their risk of harm is high. Once a caller disconnects, the system has no visibility of what happens next. Their level of distress, whether they engaged with further support, and whether a safe outcome was achieved are largely unknown.

There is an opportunity to introduce call-back as routine practice across telehealth providers where people consent to this additional support. Lived experience engagement during the review advocated the value that a call back option would add for people experiencing acute distress. Internationally, proactive follow-up models have been implemented in comparable crisis services. The evidence indicates that follow-up contact for people who have disclosed suicidality can reduce distress, facilitate engagement with primary and secondary care, and support continuity of care beyond the initial contact.

Introducing routine call-back processes would also support the system's ability to monitor outcomes for people who call or message in the highest-risk situations (see finding 3).

Finding 5: Bounded anonymity enables access to these services and must be protected in any system change

Bounded anonymity is a core feature of these services and must be preserved. The bounded anonymity MHA telehealth services offer is a deliberate and valued feature. For many callers, particularly those who would not present to a GP, emergency department, or mental health service, it is precisely what makes reaching out possible.

Lived experience engagement during this review reinforced this. People shared that knowing your call is anonymous when seeking support from MHA telehealth services is often what makes them a preferred channel for accessing support when experiencing distress. For some callers, particularly those with prior difficult experiences with mental health services, concerns about information sharing can deter them from seeking help.

Maintaining bounded anonymity should be a core consideration of future system changes, especially in relation to information sharing, as discussed in finding 6.

Finding 6: Information sharing across MHA telehealth services is nuanced and requires careful system design

Anonymity is a deliberate and valued feature of MHA telehealth services. As discussed in finding 5, for many callers, particularly those who would not present to a GP, emergency department, or formal mental health service, it is what makes reaching out possible. Any consideration of information sharing must start from that premise.

This review identified three distinct points in the system where opportunities for information sharing should be considered. Each with different risks, different relationships, and different implications for caller safety and privacy.

The first relates to diversion from district crisis lines to Whakarongorau. In some districts, people contacting a district crisis line are diverted to Whakarongorau without always being aware this is happening. People have a right to know their call is being diverted.

A related difficulty where calls are diverted from a district line to Whakarongorau, is that people may expect call takers to have access to their notes, however there is currently no mechanism for sharing notes between district crisis lines and Whakarongorau. This lack of access to notes can cause frustration and lead to less optimal service for people who have been diverted.

The second is between providers and emergency services. Stakeholder engagement identified that once a call has been escalated to emergency services, the inability of the telehealth provider to know if the caller has been connected to external support can be a safety risk. This points to a gap in the feedback loop between telehealth and emergency services as a system responding to people experiencing to acute distress.

The third, and most complex, is cross-provider information sharing. The current system does not have the mechanism to share information about people who have made contact with multiple services. This feature of the system supports the anonymity and privacy of callers. For the majority of callers, this is appropriate. Whether or not the ability to share information between providers when imminent risk to life or safety is present requires further exploration and careful consideration.
This tension is especially complex for children and young people. The rights and responsibilities of caregivers, the appropriate role of providers when a child is at risk, and the circumstances under which a duty of care might override a child's expressed wishes, all require specific consideration. These are not questions this review can resolve, but they are questions the system must address.

Resolving tensions relating to information sharing between providers and within the wider system requires deliberate system design informed by genuine engagement with people who use these services.

Finding 7: The number of children and young people contacting MHA telehealth services is increasing and they are currently being served under models that were not designed for them

Youthline is the only service in the system designed for young people, with a contracted target population of 12- to 24-year-olds. The other two providers operate under models developed for adults, yet both receive contacts from young people.

There is a growing number of children under the age of 12 contacting MHA telehealth services. Youthline's data shows contacts from children under 12 now represent a significant and growing share of their workload.

This raises concerns because the frameworks that apply to adolescents and adults are not automatically appropriate for children. Standard consent processes, safeguarding thresholds, and clinical requirements differ meaningfully between these groups. At present, children under 12 contacting any of these services are being supported under frameworks that were not designed for them, leaving unresolved questions about parental rights and responsibilities, provider obligations toward caregivers, and what is required to keep younger callers safe.

Developing dedicated safeguards and service models for children and young people should be considered, and international examples exist to draw on. The Children's Commissioner holds policy expertise directly relevant to these questions and should be consulted as part of that work. Young people with lived experience of accessing these services should also be involved in the development of any new models and approaches aimed at better supporting their safety and wellbeing.

Finding 8: The service model does not distinguish between the different needs of callers, and there is an opportunity to develop more tailored responses

The three services broadly apply a single model to a varied caller population. MHA telehealth users have different needs, different expectations, and different patterns of contact. For example, those who use a service often are likely to have different needs from those who contact once or a few times.

In practice, callers fall into meaningfully different groups. Some are seeking general psychosocial support or short-term advice. Others are reaching while experiencing acute distress and may be seeking emotional support, de-escalation, or support with safety planning, and others at risk of imminent harm may need escalation to emergency services to ensure their safety. Frequent callers needs can vary considerably and are not well served by a single operational response.

This review identified cases of operational responses to frequent callers that deprioritise or limit their access, without a mechanism to distinguish between people contacting out of isolation or social need, and those in intense recurring distress who need co-regulation and de-escalation. For the latter group, these responses are not clinically appropriate.

International research shows that patterns of service use across a population can be identified and used to plan differentiated responses, including through better use of service data. Developing tailored response frameworks for different caller groups and ensuring the scope of each commissioned service matches population need, would improve both safety and experience for people using these services.

Finding 9: There is a need for improved service responses to Māori

Providers have taken some steps to respond to the needs of Māori. However, the services have not been co-designed with Māori from inception, and no national kaupapa Māori telehealth mental health option exists. Given the significantly higher rates of mental health distress, addiction, and suicide among Māori, this is an area of the system that should be strengthened.

Finding 10: Pacific people, disabled people and other priority populations may face additional barriers to access or be less well-served by current models of support

He Ara Oranga identifies a range of populations with unmet mental health needs and poorer outcomes, including Pacific people, disabled people, takatāpui and Rainbow communities and refugees and migrants. This review was not able to consult widely to understand communities needs and experiences with MHA telehealth services.

From the consultation undertaken during this review, Pacific people may face distinct barriers including language, layered shame and stigma, and spiritual and religious beliefs, though these may be less pronounced for younger or New Zealand-born Pacific people. Lived experience engagement also identified deaf and disabled people, and people who rely on text as their primary channel, as groups whose access needs are not well served by a system oriented around voice calls.

Further engagement with these communities is needed to properly understand how access can be promoted for priority populations.

Finding 11: A shared clinical practice and quality framework would strengthen safety, consistency and accountability across the system

All three providers have developed clinical frameworks, triage tools, and quality systems that are functional and robust at a provider level. This is a genuine strength. Safety at a systems level could be strengthened by building on this foundation with a shared clinical practice and quality framework. This would give providers a common reference point, support independent verification of safety and clinical frameworks, and provide external benchmarks against which to oversee and monitor performance.

The foundational frameworks developed by providers have not been co-designed with service users, Māori, or other priority groups. Developing a shared framework could provide an opportunity to address this gap, without displacing what providers have already built.

Developing a shared framework in partnership with providers, people with lived experience, and Māori would also ensure it reflects the populations these services exist to serve.

Finding 12: Current commissioning does not enable a coherent system-level response to people contacting MHA telehealth services while experiencing acute distress

The current funding and commissioning arrangements do not support a coherent, sustainable system. Providers are funded separately against different contractual requirements, with no shared framework or coordinated oversight. Lifeline operates entirely outside the commissioning system despite being a widely used crisis service. Funding for this provider's highest-acuity service depends on philanthropy.

4. Evidence and observations

This section presents the evidence and observations that inform the findings set out in section 3. It is organised across lived experience and the five Terms of Reference. The lived experience evidence is drawn from four focus group sessions held in Auckland and Christchurch, supplemented by individual conversations with people who could not attend the sessions. The Terms of Reference evidence draws on document review, performance data, site visits to each of the three providers, and consultation with stakeholders across the health and emergency system. Each subsection closes with a set of numbered observations that capture the panel's assessment of what the evidence shows. These observations sit at a more granular level than the headline findings in section 3 and form the evidentiary basis for the panel's safety assessments in section 5 and recommendations in section 6.

4.1 Lived Experience

The Lived Experience evidence gathered for this review draws on four focus group sessions held in Auckland and Christchurch, supplemented by individual conversations three people who could not attend the focus group sessions who brought personal and whānau lived experience perspectives. Taken together, this evidence offers a coherent and important account of what makes contact with a telehealth service useful, and what gets in the way. These perspectives go directly to questions of access, clinical quality, and safety that sit at the heart of this review.

Accessing services when experiencing acute distress
Reaching out in acute distress involves personal vulnerability, and the conditions under which a call is received can shape not only whether it helps but whether the person is likely to try again. Participants described a reluctance to occupy a resource that someone else might need more, a hesitation that compounds the difficulty of calling in the first place. Callers who have delayed seeking support may arrive with a depleted sense of self-worth, and an unanswered call or a poor response can be experienced as confirmation that they are not worth answering. The experience of not getting through, or of being met poorly when they do, was described consistently as making future help-seeking less likely. Wait times were the most common piece of feedback heard from families and whānau who had reached out to these services. Primary care clinicians recognised the same pattern, noting that clients who give up before connecting are less willing to try again.

The quality of human connection can determine whether anything else in a call is useful. Participants described the best calls as those where the call taker introduced themselves by name, showed genuine curiosity, and made space for the caller to be a person before moving into content. Yet people described a pattern that when people experiencing distress or their family and whānau do get through, there can be a mismatch between what they are seeking and what is provided. Services were not experienced as well connected to other supports and not felt to be practically helpful for whānau trying to support a loved one or manage their own distress.

> "It's the whānau who needs to know what to do"
> *– Lived Experience engagement*

Whānau are often the most significant resource in a person's safety, yet the current model does not resource or support their involvement.

Partial de-escalation and ongoing distress
Participants shared that time-pressured calls can result in partial de-escalation, where a caller is brought down from acute distress but not to a place of genuine safety. Opening up on a call can be distressing for callers, and in the period immediately after a call ends it can pull a person back into that state. For many callers, contact ends without connection to further support or follow-up from providers. Participants described a follow-up call, even briefly later the same day, as making a significant practical and relational difference. This is not routine practice within the MHA telehealth system, despite being supported by international evidence (see section 5).

Service design, user needs and peer support
Lived experience engagement suggests the current service model may be misaligned with the needs of callers who have extensive personal experience of mental health distress. One participant, who described living with suicidality as a regular part of their life and having developed considerable expertise in navigating it, shared that the standard telehealth response tends to focus on their experiences of suicidal ideation, rather than the under lying difficulties they were experiencing. For someone for whom distress, and suicidal thinking are a regular and managed part of life, a risk-assessment-first model can eclipse rather than support their actual needs.

Peer support was identified as a distinct and potentially more effective form of contact, particularly for people who would be reluctant to engage with a clinical service. The peer workforce has potential in reframing how risk is held and approached, but this is not being utilised consistently across the system.

Barriers for Māori and whānau engagement
Lived experience engagement suggests additional barriers to access for Māori and Pacific people. Te Kete Pounamu (the National Māori Lived Experience network) has mobilised crisis support numbers during high-stress periods, including Christmas and COVID-19, to provide peer support to their community, but this is not an ongoing or resourced part of the MHA telehealth system. The observation that whānau cannot access crisis support for a loved one if that person cannot or will not engage themselves highlights that the current model is built around the individual caller rather than promoting whānau engagement.

> "There's a real massive difference between keeping someone safe physically and actually making somebody feel safe."
> *– Lived Experience engagement*

Access challenges for disabled people
Lived experience engagement found Deaf and disabled people, and people who rely on text as their primary or preferred channel, can face specific access barriers in a system oriented around voice calls. Engagement also found for autistic people and other callers for which text is the more accessible format, the current design assumption that text and chat are supplementary options can mean people are unable to access these services in the way that works best for them.

These services are valued
Despite these concerns, lived experience participants were clear that these services matter and that the case for investing in them is strong. Participants described a landscape where people in their communities know these services exist and understand them as somewhere to turn when they are experiencing distress. The concerns raised in this section are not arguments against the provision of these services, instead they are perspectives that should be considered when designing a system that better meets the needs of service users.

Observation 1: Reaching out to a telehealth service in acute distress requires personal vulnerability, and the conditions under which a call is received shape both whether it helps and whether the person is likely to try again.

Observation 2: The quality of human connection can determine whether anything else in a call is useful.

Observation 3: For some callers, call time limits can work against the quality of connection that makes contact valuable and can result in partial de-escalation rather than genuine safety.

Observation 4: There is an opportunity to connect callers to further support after contact, and to provide follow-up that checks whether they got what they needed.

Observation 5: Peer support is valued by people with lived experience as a distinct and potentially more effective form of contact, particularly for people who would be reluctant to engage with a clinical service.

Observation 6: The current model limits whānau engagement and does not reflect Te Ao Māori approaches to wellbeing.

Observation 7: Deaf and disabled people, and autistic people for whom text is the most accessible format, face specific barriers in a system oriented around voice calls.

Observation 8: People who use these services value them and want to see them supported and well resourced.

The diagram on the following page illustrates the factors that can increase or decrease peoples experience when reaching out to MHA telehealth services. Red indicates the factor has a negative influence, and blue indicates the factor has a positive influence.

Factors that influence peoples experience when reaching out to mental health and addiction healthcare services

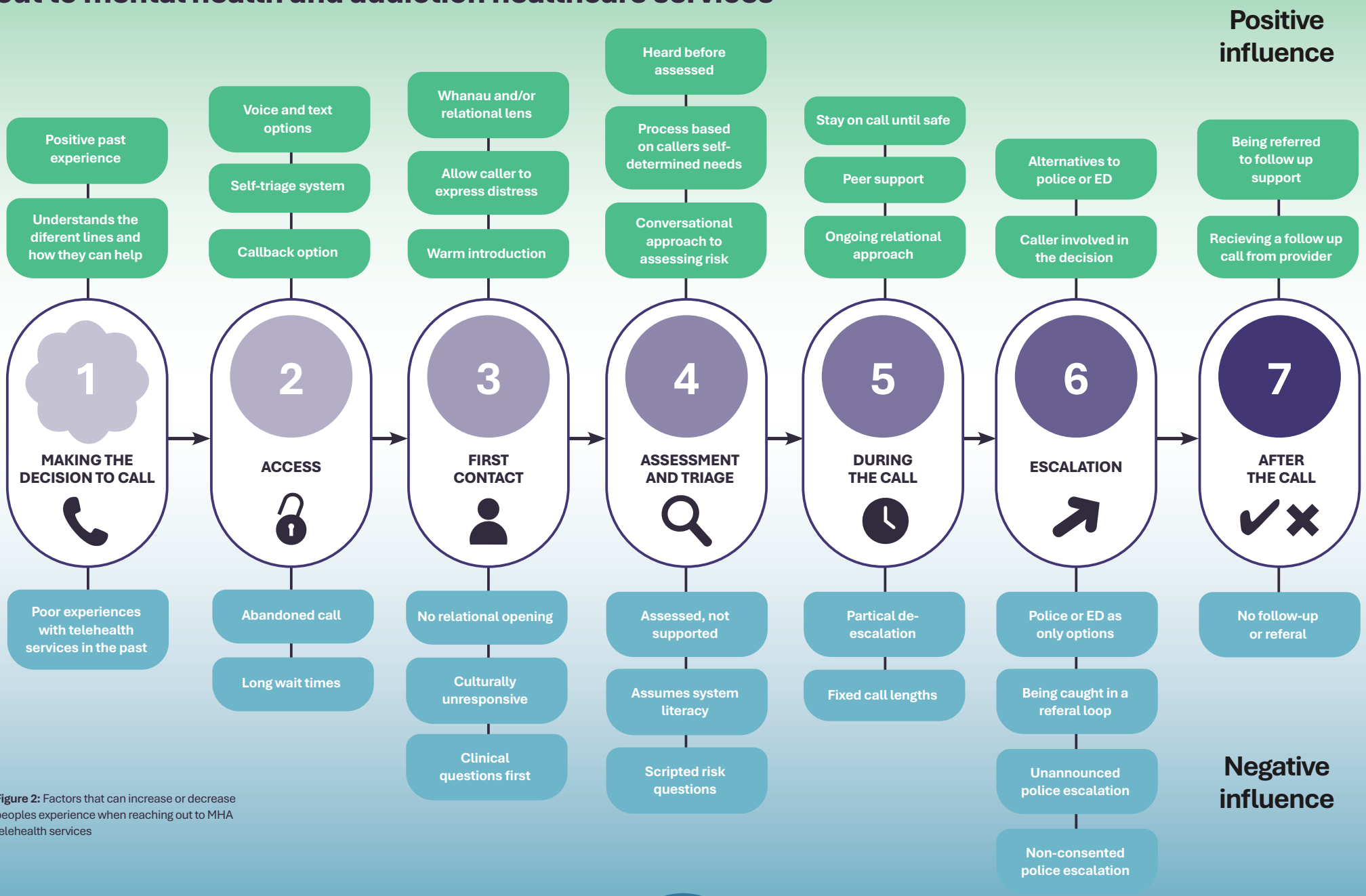


Figure 2: Factors that can increase or decrease peoples experience when reaching out to MHA telehealth services

4.2 Terms of reference

This section presents the panel's findings across the five areas of focus set out in the Terms of Reference: Service Access and Responsiveness; Triage and Risk Management; Clinical Governance; Integration with the Wider System; and Operational Performance Monitoring. Each area is addressed, with findings drawn from the full range of evidence gathered during the review, including provider data, site visits, stakeholder consultation, and lived experience sessions. The findings in this section form the evidentiary basis for the panel's assessment of the system in section 5 and the recommendations in section 6.

4.2.1 Service access and responsiveness

Wait times and abandonment rates

Access to MHA telehealth services is compromised. Across all three providers, approximately half of calls are abandoned primarily due to long wait times. There is no consistent measure of abandonment across the providers, the findings below are presented using abandonment rates as reported by each provider. Whakarongorau's 1737 MHA line has an abandonment rate of between 29-33%, Lifeline's main line recorded abandonment rates of 57-69% and 49-68% for Tautoko. Youthline's process differs from the other providers, as callers are redirected to text and webchat after approximately three minutes. This leads to a high phone abandonment rate of 74.6% (2025), however a proportion of these callers will continue to engage via text. Across all channels, Youthlines overall abandonment rate is 31.2%, driven primarily by the phone channel.

Wait times for callers vary across providers and lines. The shortest wait is at Youthline, with calls that are not diverted to text being answered in roughly 2 minutes. Lifelines mainline answers calls within approximately 5-6 minutes and their Tautoko suicide crisis line in approximately 3-4 minutes. At Whakarongorau, the average wait time for 1737 is 21-26 minutes, with approximately 50% answered within 10 minutes, while the EMHR line answers 97% to 99% of calls within ten minutes. Stakeholder primary care leads and regional leaders for specialist MHA services shared that they have received feedback from people who had been redirected from the district crisis line to Whakarongorau about having to wait up to 40 minutes to be connected to a call taker.

It is important to acknowledge the impact of these access barriers on people attempting to connect to the system. Lived experience participants described the courage it takes to make a contact when experiencing acute distress, and the harm associated with the wait, or of not getting through at all. Call takers shared that callers who have waited a long time to be connected, or have tried multiple lines, are often frustrated when they do eventually get through. It is unknown how many abandoned calls are from people experiencing acute distress, and whether they were able to access alternative support.

> "It takes a lot of courage to make that call, and the longer you're waiting, the more opportunities you have to lose that courage and just hang up"
> *– Lived Experience engagement*

Primary care clinicians shared these concerns, suggesting that long waits compound distress and leave people less willing to try again. Engagement during this review suggests in some regions, clinicians are losing confidence in the 1737 line as a referral option due to concerns with the accessibility of the service.

Lifeline's reduction from 24/7 to 7am to midnight operation in April 2025 has likely contributed to growing access challenges in over-night callers. People calling outside of their service hours are met with a recorded message advising them to call 1737, and Youthline experienced an approximate 31% increase in overnight demand

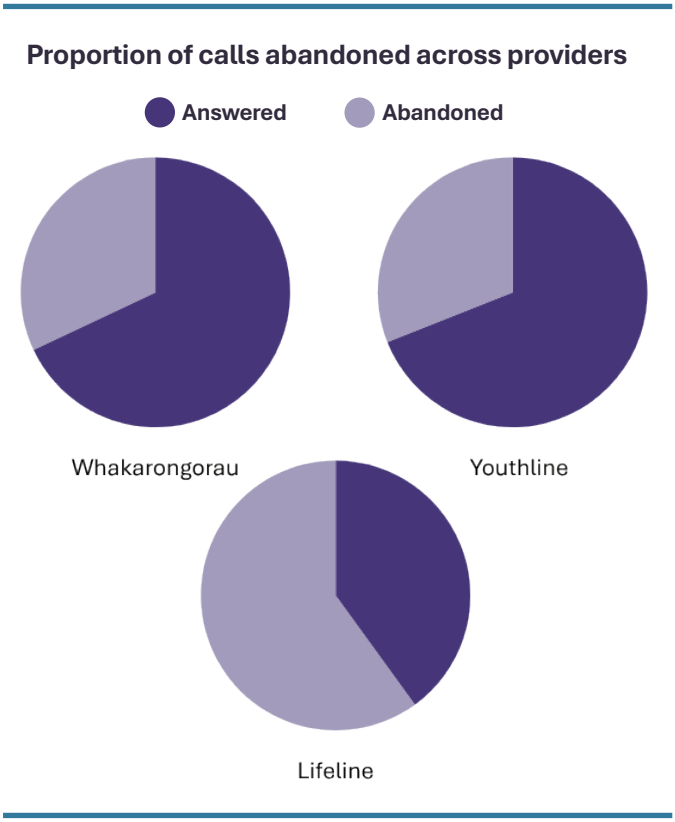


Figure 3: Proportion of abandoned calls by provider

directly following the reduction in Lifelines hours. There has not been a coordinated system-level response to this shift.

Managing access and demand

The three providers have different approaches to managing general access and demand challenges and have additional processes in place to increase call capacity in response to events that can trigger higher call volumes. A unique feature of Youthline's service model is routinely redirecting callers to text or webchat after approximately three minutes in a voice queue. This is to ensure every caller has an opportunity to receive a response from the service. No equivalent queue management mechanism operates at the other two providers before call-taker contact.

Text and webchat may be a preferred an effective communication for a proportion of Youthline contacts (with text-based conversations now representing approximately 86% of engagement), lived experience participants noted these channels may not serve other callers well in acute distress.

Demographic data and priority populations

The collection of demographic data is limited and inconsistent across providers, which creates difficulties for accessing access across population groups. Providers typically record ethnicity only where callers voluntarily provide it, as is not always appropriate or a priority to gather this information during a call, especially if the caller is experiencing acute distress. This finding is to be expected within the telehealth sector and reflects international trends (see section 6).

However, stakeholder and lived experience engagement suggests Māori and Pacific people face additional barriers to access. Lived experience participants described current services as built on a Western clinical model that does not align with te ao Māori approaches. Primary care engagement found assessment and support models don't align with other ways of experiencing and expressing distress or mental health, and that the absence of interpreters creates a barrier for people with English as a second language.

Although providers are conscious of the needs of Māori and have incorporated cultural elements into their existing services, no service has been co-designed with Māori from inception.

Primary care leads identified Te Kaupapa as an example of a working model using Māori clinicians and a whānau-centred approach that could be adapted to a telehealth context. Internationally, Australia has seen improved outcomes following the introduction of an indigenous designed and operated telehealth service (see section 6).

Responses to people considered "frequent callers"

Each provider has a different approach to responding to people who call frequently, and the "frequent caller" framing applied across Whakarongorau and Lifeline appear to conflate people contacting repeatedly out of isolation or loneliness, and people in intense, recurring distress who need co-regulation and de-escalation. There are cases of operational responses that deprioritise or limit access for frequent callers. The review panel regards these approaches to be inappropriate for frequent callers who may be experiencing intense recurring distress. Youthline however, seems to take a case management approach to responding to "frequent callers".

Providers report they are aware of this challenge and have taken steps at different times to try to address it, however, no shared or agreed approach to responding to frequent callers currently exists across the system.

Complexity and the scope of services

The complexity of distress experienced by people connecting with two providers has represented a shift in scope from their original service design. The original 1737 model was designed to respond to people with a mild-to-moderate mental health needs, however high-risk contacts have risen from approximately 7-8% of all contacts in 2020 to 13% of all contacts in 2025. A 2020 evaluation found callers were frequently confused about what the service was for. This finding is supported by stakeholder engagement during this review, which suggests there is inconsistent understanding of MHA telehealth services among primary care clinicians, and that advice to call 1737 is being incorporated into patient crisis plans. In addition, the MHA telehealth lines in scope for this review are widely marketed to the public when potentially distressing content is reported on or shared. Whakarongorau are aware of and are responding to this acuity shift, which they now describe as irreversible. Youthline is also experiencing shifting caller trends, with contacts from children under 12 now a significant and growing share of its workload. Both patterns reflect a need to ensure the scope of the MHA telehealth system matches population need.

The diagram below illustrates the proportion of calls that are abandoned, the proportion of answered calls that are escalated to emergency services, and the proportion of which are escalated with or without consent.

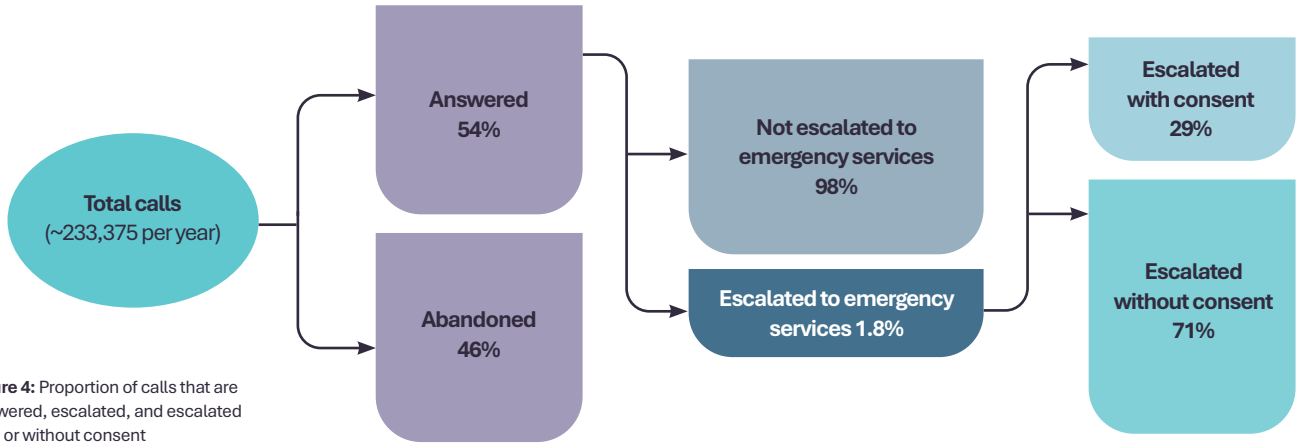


Figure 4: Proportion of calls that are answered, escalated, and escalated with or without consent

Observation 9: Ensuring more people seeking support get their calls answered is one of the most significant opportunities to improve access across the system.

Observation 10: Operating hours across the three providers are no longer consistent, with Lifeline's reduction from 24/7 coverage creating a gap that has likely placed increased demand on the remaining two contracted providers.

Observation 11: The three providers manage access and demand differently, and channel design choices have consequences for who can get through.

Observation 12: Improving the quality and consistency of demographic data collection would strengthen the system's ability to understand and respond to access differences across population groups.

Observation 13: None of the three services were designed with and for Māori, and no kaupapa Māori telehealth mental health service exists anywhere in the system.

Observation 14: Pacific peoples face distinct barriers to access, including language, layered shame and stigma tied to family and community, and spiritual and religious beliefs, and these are not currently reflected in service design.

Observation 15: There is an opportunity to expand contact channel options to better serve callers whose needs or preferences are not well met by voice calls alone.

Observation 16: The frequent caller framing used across providers conflates two distinct populations: people calling out of isolation and loneliness, and people in intense distress with trauma histories who need co-regulation and de-escalation.

Observation 17: The scope and complexity of contacts at both 1737 and Youthline have shifted significantly from their original design, and there is an opportunity to ensure the commissioned scope of each service reflects current population need.

4.2.2 Triage and risk management

Precontact and self- triage approaches

MHA telehealth services can triage callers pre-contact as well as during the call. While all providers are triaging during the call, there are only a few opportunities for pre-contact triage to occur. Pre-contact mechanisms allow callers to self-triage before they reach a call taker, while in-call risk assessment frameworks are during the conversation itself. Both provide an opportunity to identify people experiencing higher levels of distress and risk, and pre-contact approaches can support caller prioritisation.

At a pre-contact level, Lifeline operates the main Lifeline helpline and the Tautoko suicide crisis line, each with their own number and marketed for different caller needs. Callers are effectively self-triaging by choosing which number to dial based on their presenting need. This distinction is directing higher-risk callers toward a line designed for higher of acuity from the outset, and calls from this line are prioritised in the shared call centre. Youthline offers an alternative method via all channels, allowing callers to respond with the number that indicates their level of distress before connecting to a counsellor. Panel members observed during the site visit that this approach functions as an effective and low-barrier form of triage, enabling the service to prioritise contacts based on expressed need without requiring a clinical conversation to begin first. Both Lifeline and Youthline observed callers as realistic about their perceived level of distress when self-triaging. Whakarongorau does not operate an equivalent pre-contact triage mechanism across its 1737 MHA line, though the EMHR line serves a distinct and higher-acuity function for people being referred from district crisis lines and emergency services.

During call triage processes and suicide risk assessment

All three providers have established triage processes supported by a range of risk assessment frameworks that are used during calls. This as a baseline strength within each of the providers. Youthline uses the Ladder Up Framework, the Helpline Risk Scale that is adapted from the UK Mental Health triage scale (also used by Whakarongorau) and the Helpline Conversation Model. This combination was endorsed by its Clinical Governance Committee in October 2025. It enables a conversational approach to risk assessment, where the questions are woven into discussion with the caller rather than conducted as a separate clinical step. As a youth service, this model is important. Whakarongorau uses the Ladder Up framework for the 1737 MHA line, with a mandatory safety check for all new callers, and the UK Mental Health Triage Scale for EMHR. Lifeline uses the C-FRED model with an Active and Imminent Risk distinction, a three-threshold assessment covering plan, means, and timeline, and shift supervisor oversight of all escalation decisions.

Although these frameworks are functional, robust and safe at a provider level, they do not support shared language at a systems level. This creates challenges for assessing and comparing how risk is identified and responded to at a systems level. Lived experience engagement suggests callers experiencing acute distress can find standard risk assessment approaches confronting, and conversational and relational approaches to assessing risk may be better suited to the needs of callers. Lived experience contributors also shared the quality of human connection in a call can shape what callers are willing to disclose, which in turn can shape the accuracy of risk assessment.

> “Please upskill people so that they know how to ‘meet people’ rather than ‘manage’ them. How to hold space, how to let the expertise lie in the person to resolve their own issues”
> *– Lived Experience engagement*

Primary care stakeholders and regional leaders of specialist MHA services reported that callers who do not feel heard are less likely to disclose the full extent of their distress, producing incomplete risk pictures. In a service where identifying and responding to risk is a key function, the relational conditions for disclosure are as clinically significant as the assessment framework itself.

Escalation rates

Across the service providers, escalation to emergency services accounts for 1.8% of total answered call volume. Overall, this proportion is comparable to international service systems (see section 6).

However, escalation rates vary across providers, and both Youthline and Whakarongorau have seen an increase in escalation rates in recent years. Lifeline has the lowest escalation rates of the three providers in scope for this review, possibly due to a practice of holding a higher of level of risk within the service and taking collaborative steps towards safety with a person before referring to external escalation.

Although rates of escalation vary between providers, the rate of non-consensual escalation is consistently high across the three service providers. Across Whakarongorau’s MHA lines, 71.4% of escalations are non-consensual. At Lifeline, 46% to 67% of escalations are non-consensual, and at Youthline 70% are non-consensual. Each of the providers have different framework and criteria for identifying when non-consensual escalation should occur. Lived experience participants shared that fear of non-consensual escalation can be a barrier to honest disclosure, especially for callers with prior experience of a service acting outside of their expressed wishes. This is an important consideration, as how escalation is communicated, and whether the person feels consulted, can impact future help-seeking. There are opportunities across the service providers to increase the proportion of consensual escalations to emergency services.

> “She would have preferred them to tell her ‘we’re going to ring the police, just stay put’. There was nothing. They just called.”
> *– Lived Experience engagement*

Audit systems

All three providers have audit and quality assurance systems in place, though these vary in scope, sophistication, and integration. Whakarongorau’s audit programme covers a range of external and internal audits covering clinical practice, quality systems, and governance. Youthline’s automated audit system generates individual practice feedback and aggregated governance data from mandatory SOAP (Subjective, Objective, Assessment, Plan) notes and risk incident reports; the October 2025 voluntary programme pause, triggered by internal quality signals and corroborated by an independent review, demonstrates audit systems working as intended. Lifeline completes session notes in Salesforce; emergency services data is maintained in a parallel spreadsheet outside the main system.

Outcome tracking, data informed processes and call-backs

Outcomes are not being routinely monitored following escalation to emergency services, as a result neither providers nor the system can determine whether escalated callers are receiving appropriate follow up. Furthermore, the absence of routine monitoring limits the ability to develop data informed processes and improvements within providers and the system as a whole.

Providers aren’t currently practicing call-backs as routine practice following contact from callers experiencing acute distress or high-risk situations, although there are some circumstances where this has occurred. International evidence indicates that follow-up contact for people who have disclosed suicidality can significantly reduce distress and facilitate uptake of primary and secondary health services (see section 6). The

absence of outcome tracking and call-back processes presents a safety gap in the system. Monitoring what happens for people experiencing high levels of distress or risk after their contact with a MHA telehealth service ends and providing a call-back service would enable the ability to know whether safe outcomes are being achieved and promote engagement with primary and secondary care.

Observation 18: All three providers have established triage and risk assessment frameworks, and developing a common framework and shared risk language across providers would strengthen consistency at a system level.

Observation 19: All three providers have approaches to suicide risk assessment, though these differ in method, integration with clinical process, and the volume of high-acuity contacts each is responding to.

Observation 20 All three providers have escalation protocols in place, however there is an opportunity to align thresholds and approaches across the system to improve consistency for people who are contacting these services, and for practice improvements to advance least invasive service responses in interactions with people.

Observation 21: The quality of human connection in a call shapes what callers are willing to disclose, which in turn shapes the accuracy of risk assessment.

Observation 22: All three providers have audit and quality assurance systems in place, though these vary in scope, sophistication, and integration.

Observation 23: Monitoring outcomes following escalation to emergency services would give providers and commissioners visibility of whether the highest-risk contacts are receiving safe follow-up.

4.2.3 Clinical governance

Clinical governance frameworks

All three providers have established clinical governance structures, and the review has identified this as a strength across the system. Whakarongorau holds ISO 9001:2015 accreditation, operates a Clinical Governance Committee chaired by an independent board member with external clinical members, and convenes a monthly Quality Forum. A Learning and Healing from Harm framework has been adopted for serious adverse events, and the January 2026 issues-based audit found the governance framework is structurally sound. Youthline established its Clinical Governance Committee in June 2025 and demonstrates consistent quarterly board reporting and a clear governance pathway from quality committee through to board level. Lifeline's frontline practice culture and processes are robust, though its governance structures are less formal and independently accountable compared to the other providers.

Governance maturity varies across the system. Without shared governance standards at a systems level, providers are largely developing and regulating against their own frameworks. Although these processes appeared robust within the three providers included in this review, the absence of shared governance standards creates difficulties for assessing the safety of clinical governance at a systems level. It is not clear to what extent Ngā Paerewa (the Health and Disability Services Standards) apply to MHA telehealth services.

Supervision processes

Supervision arrangements are in place across all three providers. At Whakarongorau, staff wellbeing is formally on the Clinical Governance Committee agenda, and a debriefing procedure is in place for challenging contacts. At Youthline, staff complete structured session notes and risk incident reports that feed into an automated audit system, alongside peer debriefing, monthly external supervision, and an employee assistance programme. At Lifeline, counsellors participate in weekly group supervision and individual external supervision. Despite these structures, frontline staff across the system reported pressures including burnout and sustained stress linked to staffing shortfalls and the cumulative weight of crisis work. Lived experience participants shared that investing in staff conditions is part of investing in caller outcomes.

Providers demonstrate a commitment to improving the capability of their staff; however workforce pressures exist across the system. The Whakarongorau MHA workforce declined from approximately 45 full-time equivalents at the COVID-19 peak to approximately 27 at the time of the review and quality-related roles were vacant at Whakarongorau at the time of the review. At Lifeline, the practice lead role has been vacant for approximately ten months. While some staff without qualifications remain in post, new staff in call-centre and supervisor roles are required to hold health or clinical qualifications. Youthline has retrained staff to respond to a shift in caller demographics, including the growth in under-12 contacts. Of the three providers, Youthline appeared to face the lowest rates of staff turnover.

Cultural responsiveness and Lived Experience input

Lived experience participants described services as built on a mainstream clinical model that may not meet the needs of Māori when seeking support from an MHA telehealth service.

People with lived experience have minimal formal involvement in clinical governance across the system. Youthline is in the process of developing a Youth Advisory Council with ongoing input into clinical governance and quality forums intended. Whakarongorau engages with Changing Minds when MHA servies are seeking specific lived experience input. Lifeline does not have a formal process for Lived Experience or consumer input; however they have an informal process of engagement with peer-support workers operating PSN's Warmline peer service (outside of the scope of this review).

Feedback and complaints processes

All providers have complaints policies and a mechanism for receiving complaints, however at the time of this review these were not considered easily accessible to service users. One provider includes detailed information about complaints policy and process on the website for its service. Lived Experience engagement suggested formal complaints processes are difficult to navigate, with one user's complaint taking two to three months to receive a substantive reply. The absence of routine feedback mechanisms limits insight into the experiences of people engaging with these services.

Service users rights

There is no consistent approach across the three providers for informing callers of their rights, the nature of the service they have reached, or the circumstances under which their information may be shared. Lifeline provides an automated consent message prior to connection, notifying callers that emergency services may be contacted if there is imminent risk to life. Youthline has a fully automated consent message and directs to 111 or Crisis Assessment and Treatment Team (CATT), as well as an automated privacy statement. Lived experience participants shared that concerns about information storage and sharing can deter some people from calling, particularly those with prior disempowering experiences with mental health services.

The absence of clear consumer rights frameworks also needs to be considered in relation to children and young people. While Youthline provides privacy and rights information in youth-friendly

language on its website, contacts from children under the age of 12 are increasing. These calls are being responded to under the existing consent and safeguarding frameworks. Standard adult informed consent processes are not considered appropriate for children, and the current absence of child-specific frameworks leaves both callers and call takers without clear and consistent guidance on parental rights, provider obligations, and the standards required to keep young children safe when accessing these services.

It is worth noting that all helpline staff and volunteers at Youthline complete ICAMHS 1, 2 and 3 (infant, child and youth), specifically adapted for the telehealth context, with Whāraurau. In addition, the Conversation Model has been partly introduced to support younger young people accessing Youthline.

Observation 24: All three providers have established clinical governance structures, though these vary in maturity, formality, and independence.

Observation 25: Supervision arrangements are in place across all three providers, and all shifts involve continuous oversight from a clinical supervisor.

Observation 26: All three providers face workforce pressures and addressing these would improve both caller access and the conditions under which staff are providing support.

Observation 27: None of the three providers demonstrated strong cultural capability or responsiveness to Māori, and no kaupapa Māori telehealth mental health service exists.

Observation 28: Strengthening the formal involvement of people with lived experience in clinical governance would improve the relevance and accountability of provider oversight across the system.

Observation 29: A consistent approach to informing callers of their rights, the nature of the service, and the circumstances under which information may be shared would strengthen transparency and caller trust across the system.

Observation 30: Non-consensual escalation rates are relatively high across all three providers.

Observation 31: Developing clear consumer rights frameworks across the system would support callers to understand what they can expect and how to raise concerns.

Observation 32: The growing number of children under 12 accessing MHA telehealth services points to a need for dedicated safeguards and service frameworks designed specifically for this age group.

4.2.4 Integration with the wider system

System fragmentation

Although each of the providers have established triage, risk assessment and clinical governance frameworks to support the callers who get through to their services, integration between MHA telehealth services and the wider system is fragmented. The three providers operate as parallel services without formal coordination, shared language or frameworks, or collective infrastructure. Engagement during this review suggested this fragmentation at a systems level is where most of the challenges arise, and where the system requires strengthening is at the interfaces between providers and the wider emergency and health system.

Referral pathways

Providers are routinely signposting and providing contact details for specialist mental health services to callers, however formal referral pathways from MHA telehealth services to specialist mental health services are limited across the system. Outside serious harm thresholds, no direct referral pathway to specialist services exists at Youthline or Lifeline. Approximately 55 to 60% of Youthline contacts involve provision of a referral resource, but with no mechanism for direct or warm handover, callers are expected to follow up independently. Lifeline signposts callers via Healthpoint. The Whakarongorau warm transfer capability allows callers to be transferred to their peer-support service or EMHR. The current structure of the system does not allow for warm transfer to occur between providers.

EMHR provides an established crisis interface across 16 Health NZ districts and receives a 15% emergency response rate and a 38% Health NZ district referral rate, though EMHR staff do not have access to district health board clinical notes despite operating as part of the crisis system. Engagement during this review suggests circular loops are occurring in EMHR referral attempts. This pattern has been documented by Youthline, with 105 non-acute refusals and 111 capacity claims across three consecutive board reporting periods, subsequently escalated to Health NZ.

Connections between telehealth services and the wider primary and secondary care system are limited and largely informal. A referral pathway exists between 1737 and health improvement practitioners (HIPs) in enrolled general practices, however this referral pathway may be underutilised.

Interface between emergency services and providers
The interface with emergency services presents an opportunity to reduce risk at a system level. Memoranda of understanding between Whakarongorau and Police and St John are in place, however these predate the 2024 Police Communications framework change. Lifeline has no memorandum of understanding with Police or ambulance services. Engagement with Youthline suggests there have been communication and language challenges when escalating to police, which has resulted in Health NZ producing a resource to support communication with emergency services as a workaround.

Under the current model, unless a verbal handover can occur, ambulance crews responding to jobs transferred from EMHR receive only a note on priority level. Furthermore, when a person in mental health distress calls 111, there is no mental health pathway at first point of contact. Calls are most often transferred to police, however Lived Experience participants shared that Police as the default escalation option tends to amplify rather than de-escalate crisis.

> "You end up going in a cop car, and you're freaking out. You're thinking you're in trouble when you were just seeking help. It causes a lot of fear when you go to reach out to these [services] in the future." – *Lived Experience engagement*

Participants identified preferred alternatives to Police, including mobile community teams, crisis cafes, and dedicated youth crisis response roles, though coverage of these options was described as inconsistent across the country, and their accessibility as limited by location and opening hours.

Information sharing and transparency
Engagement during this review identified the tension between information sharing and maintaining the integrity of MHA telehealth services. There are three points within the system where information sharing processes were explored, each requiring careful consideration of how to balance the tension between maintaining privacy and anonymity, and what intervention is appropriate when imminent risk to life or safety is identified.

The first relates to diversion from district crisis lines to Whakarongorau. In some districts, people contacting a district crisis line are diverted to Whakarongorau without always being aware this is happening. People have a right to know their call is being diverted, and the absence of clear communication at this point may limit their ability to give informed feedback or make a complaint about their experience of the service.

A related difficulty is that people diverted from a district crisis line to Whakarongorau may expect call takers to have access to their notes and care plans. There is currently no mechanism for sharing notes between district crisis lines and Whakarongorau, which can cause frustration and result in a less informed response for people who have already engaged with district mental health services.

The second relates to information sharing between providers and emergency services. Once a call has been escalated, telehealth providers have no mechanism for knowing whether a caller has been connected to the support they were referred to. This gap in the feedback loop between telehealth and emergency services represents a risk for people experiencing acute distress, where confirmation of a safe handover can be critical.

A separate but related issue is that providers don't have visibility of callers' interactions, risk assessment outcomes or care plans held or conducted by other providers. This review highlights that the privacy and anonymity of MHA telehealth services reflect deliberate service design choices that matter to the people these services exist to support. Lived experience participants shared that concerns about information sharing are a deterrent to calling, particularly for people with prior difficult experiences with mental health services.

Although these challenges have been identified, the extent to which information sharing occurs between providers and with emergency services is a topic that requires careful consideration. Resolving this tension requires deliberate and considered system design informed by genuine engagement with people who use these services, rather than a straightforward mandate for data sharing.

Observation 33: Strengthening formal referral pathways from telehealth services to specialist mental health services would reduce the gap callers currently face when they need more than a telehealth service can provide.

Observation 34: There is an opportunity to formalise and strengthen connections between telehealth providers and the wider primary and secondary care system, reducing reliance on informal arrangements that vary across regions.

Observation 35: Interfaces between the telehealth providers and emergency services are inconsistent, poorly formalised, and in some areas carrying active risk.

Observation 36: No cross-provider data sharing infrastructure exists between the telehealth providers or with Health NZ mental health services and mental health notes are held across multiple different district systems with no national mental health record.

4.2.5 Operational performance monitoring

Performance monitoring and accountability
Strengthening performance monitoring and accountability would improve the system's ability to demonstrate whether MHA telehealth services are achieving their intended purpose. At present, where targets exist within contracts they have generally not been met. An opportunity for improving safety at a systems level exists in shifting performance measurement toward outcomes, rather than orienting contractual KPIs towards call volume and access measures. No provider currently measures whether contact results in reduced distress, improved safety, or connection to appropriate follow-up, meaning neither providers nor commissioners can assess whether funded services are meeting their core purpose. Developing outcome measures would address this gap and better capture the real impact these services have for people in distress.

Data reporting shows some strengths to build from within the MHA telehealth system. Whakarongorau has submitted six years of monthly data across 18 workbook sheets with regional disaggregation. Youthline tracks external intervention rates and reports monthly under its Health NZ contract. Lifeline has two years of call data, though its emergency services data sits in a parallel spreadsheet outside the main system. However, feedback from people who have used the services is not routinely collected across the system. Developing a consistent post-contact feedback mechanism would strengthen quality monitoring across all three providers. All three providers have complaints policies aligned

with the Health and Disability Commissioner Code of Rights, and complaints rates are very low. However, there is scope to improve how these processes are communicated to callers. Lived experience participants described current pathways as slow and difficult to navigate, particularly for people who lack the capacity to engage with them at a time of distress. Two formal complaints described during this review took months to receive a substantive reply, with no follow-up on whether the person had since accessed support.

Contracts and commissioning

Contract arrangements present further opportunity for system strengthening. Youthline's current contract expires in June 2026 and the helplines highest-acuity overnight service is funded through ASB philanthropy to June 2027. Whakarongorau's NTS contract is approaching renegotiation around the time of this review and their CMHT contract remains valid until June 2027. Lifeline's main helpline and Tautoko suicide crisis line operate without a Health New Zealand contract and therefore without external performance accountability. Aligning future contracts with clinical outcome and safety measures would give commissioners a basis for assessing impact, and all three providers a clearer framework for demonstrating the value of their services. A standard approach to identifying and reporting call complexity would also support more responsive commissioning as all three providers report increasing complexity but no common definition or reporting method exists.

Observation 38: Introducing outcome and safety KPIs across all providers would shift performance monitoring toward measuring the extent to which contact results in reduced distress, improved safety, and connection to appropriate follow-up.

Observation 39: Standardising data reporting and developing consistent mechanisms for outcome measurement and caller feedback would strengthen what can be known about service quality across the system.

Observation 40: There is an opportunity to align contract monitoring with clinical risk and safety outcomes, so that commissioning arrangements reflect the core purpose of these services.

Observation 41: All three providers have complaints policies aligned with the Health and Disability Code of Rights and complaints rates are very low. There is an opportunity to make complaint processes more clearly signposted and accessible, and to develop consistent mechanisms for collecting caller feedback post-contact across the system.

5. Assessing and evaluating the safety of the system

The previous section set out the panel's findings across each of the five Terms of Reference. This section draws on those findings to address each of the nine review objectives directly and provides the Minister with the panel's assessment of the level of assurance it can offer in relation to each.

Objective 1: Assess whether telehealth services have appropriate clinical safety systems in place to safely manage callers

The clinical safety of systems was assessed by reviewing governance frameworks, operational policies, and quality documentation at each provider, and testing these against observed practice during site visits and interviews with clinical staff.

Assessment 1 | *The review can provide assurance that clinical safety systems are in place across the three providers to safely respond to callers who are able to establish contact. However, these systems are reliant on a person feeling sufficiently safe and supported to disclose information for a safety assessment to be effectively undertaken.*

Objective 2: Evaluate whether calls are received and responded to in a timely manner

The responsiveness to calls was evaluated using six years of performance data provided by each provider, covering contact volumes, answer rates and abandonment rates.

Assessment 2 | *The review cannot provide assurance that calls are being received and responded to in a timely manner. Too many people approaching these services while experiencing acute distress do not get their calls answered.*

Objective 3: Assess the effectiveness of triage and risk assessment processes

The effectiveness of triage and risk assessment processes was examined by reviewing frameworks and tools at each provider, observing their application during site visits, and consulting with clinical staff and stakeholders about how they operate in practice.

Assessment 3 | *The review can provide assurance that triage and risk assessment processes are in place at each provider. It cannot provide assurance that these processes are consistent, comparable, or effective at a system level.*

Objective 4: Examine escalation pathways for callers experiencing significant distress or crisis

Escalation pathways were reviewed by examining protocols and memoranda of understanding at each provider, analysing escalation rate data, and consulting with Police, ambulance, and regional leaders of specialist MHA services.

Assessment 4 | *The review can provide assurance that all providers have established escalation pathways. The panel cannot provide assurance that pathways are operating consistently across the system.*

Objective 5: Assess integration with wider services including specialist mental health services, ambulance, police, and primary care

Integration with the wider system was explored through consultation with primary care, regional leaders of specialist mental health services, Police, and ambulance services, and by reviewing formal arrangements between telehealth providers and the wider system.

Assessment 5 | *The review cannot provide assurance that MHA telehealth services are adequately integrated with the wider mental health and addiction and emergency response systems.*

Objective 6: Review key operational performance indicators including wait times and abandoned call rates

Operational performance was analysed by examining data submitted by each provider against their contracted targets and reviewing contract monitoring arrangements held by Health NZ.

Assessment 6 | *The review can provide assurance that individual providers have a level of operational performance monitoring. However, performance targets have been persistently missed, and providers aren't routinely measuring service outcomes for people.*

Objective 7: Examine clinical governance arrangements including supervision, training, workforce capability, and escalation protocols

Clinical governance arrangements were considered by reviewing documentation at each provider, including frameworks, supervision policies, workforce data, and training records, and through conversations with clinical leaders during site visits.

Assessment 7 | *The review can provide assurance that clinical governance arrangements are in place within each provider, however Māori and Lived Experience input is yet to be embedded. It cannot provide assurance that governance is adequate at a system level.*

Objective 8: Identify opportunities to strengthen clinical assurance across the telehealth system

Presented in section 7 recommendations

Objective 9: Provide recommendations for enhancements to improve clinical safety and service integration

Presented in section 7 recommendations

6. International examples of best practice

New Zealand is not alone in facing the pressures identified in this review. A number of comparable countries have developed responses to similar challenges; some are well established and others emerging. The examples below are not presented as direct transfer solutions. They are offered to show that workable responses exist and have informed the development of recommendations.

Proactive callback models (United States)
The US National Suicide Prevention Lifeline network introduced proactive follow-up calls for callers assessed as medium-to-high risk of suicide. An evaluation of 550 callers who received at least one follow-up call found that 80% said the call had prevented them from suicide, 91% said it kept them safe (Gould et al.,2018). The model does not require callers to call back during a future crisis; instead, the service initiates contact. This is relevant to findings from this review and is the basis for the 'tier one' recommendation to commission and evaluate a callback pilot.

Purpose-built services for children and young people (Australia)
Kids Helpline, operated by YourTown, is Australia's free, confidential 24/7 counselling service for young people aged 5 to 25. Unlike generic helpline services, it is structured into age-specific tiers (5–12, 13–17, 18–25), with content, language, and support approaches tailored to each developmental stage. The service offers phone, webchat, and a moderated peer support platform (My Circle), alongside school education programmes. A study of 1.4 million contacts between 2012 and 2018 found a marked shift toward webchat, driven by young people's preference for text-based contact for reasons of privacy, autonomy, and reduced emotional intensity (Watling et al., 2021). This model is similar to Youthline in New Zealand; however it extends to formally respond to children aged 5-12, a cohort not currently considered in the New Zealand system.

Workforce capability in digital mental health navigation (Australia)
eMHPRAC (e-Mental Health in Practice) is an Australian Government-funded programme led by Queensland University of Technology in consortium with the Black Dog Institute, Menzies School of Health Research, and the University Centre for Rural Health. It trains the health and wellbeing workforce, including GPs, allied health professionals, and the Indigenous health workforce, to navigate and refer to digital mental health services. Since 2014, the programme has trained over 109,000 health practitioners and achieved a 278% increase in practitioner referrals to online programmes. It maintains a curated national directory of free, evidence-based digital mental health resources. An eMHPRAC-style programme could be utilised to improve collaboration between MHA telehealth services, primary care, community mental health, and emergency services.

A national standard for crisis and distress lines (Canada)
In April 2026, Canada published its first national standard for crisis and distress lines (CAN/HSO 22006:2026), developed with people with lived experience, clinicians, researchers, and policymakers. The standard covers eight areas: governance and leadership, service design, technology, service user rights, service delivery, service user autonomy and safety, workforce, and continuous quality improvement. It explicitly requires trauma-informed, culturally safe service delivery, mandates outcome measurement, and addresses the overreliance on law enforcement as a systemic failure mode. New Zealand has no equivalent standard, and this is one of the clearest structural gaps identified in this review. The Canadian standard offers a ready-made benchmark and a potential framework for developing New Zealand-specific requirements.

Imminent risk definition and protocol (USA)
In 2015, a standard for service responses to standard callers to the US National Suicide Prevention Lifeline who were at imminent risk to their lives/safety was published in Suicide and Life-Threatening Behaviour. It addressed the application of suicide prevention frameworks, and principles of human rights in mental health crisis care such as disclosure, consent and least intrusive responses to secure a person's safety. This publication stands as a watershed in crisis response practices for digital/telehealth services. It could be used as the basis for the development of a New Zealand appropriate definition of imminent risk, the necessary identifying features of imminent risk and practice responses for telehealth services and the wider emergency and health service systems to adopt.

Population-specific crisis services (Canada)
Canada's 9-8-8 Suicide Crisis Helpline, launched late 2023, operates through a network of 40 local, provincial, and national crisis lines. Dedicated services exist for First Nations, Inuit and Métis peoples, children, and young adults, delivered by trained responders using trauma-informed and culturally appropriate approaches. This model demonstrates that a nationally coordinated telehealth crisis system can be designed using a single contact number with equity built in from the outset, rather than retrofitted after the fact.

A systems-level view of crisis care (United States)
SAMHSA's 2025 model framework describes crisis care across three components: Someone to Contact (helplines and crisis lines); Someone to Respond (mobile crisis teams, co-responder models); and A Safe Place for Help (crisis residential and step-down options). Assessed against this framework, New Zealand's current system is almost entirely a "Contact" system, with very limited "Respond" capacity and no formal referral pathways to "Safe Place" options. The co-responder mobile crisis team model, pairing a behavioural health practitioner with emergency services, offers an evidence-based alternative to police-only escalation, directly relevant to the interface failures documented in this review.

An indigenous-designed and operated crisis line (Australia)
13YARN (13 92 76) is Australia's first national crisis support line designed, led, and delivered by Aboriginal and Torres Strait Islander people. Established with Australian Government funding and developed in collaboration with Gayaa Dhuwi (Proud Spirit) Australia, the service operates within the organisational structure of Lifeline Australia. This arrangement gives 13YARN access to Lifeline's technology platform, clinical governance infrastructure, and organisational supports, while retaining an independently designed cultural service model and approach. Crisis supporters are Aboriginal and Torres Strait Islander people, and the service is governed by an Aboriginal and Torres Strait Islander Advisory Committee and led by an Aboriginal and Torres Strait Islander management team.

The value of a dedicated indigenous crisis line was demonstrated during the 2023 Voice referendum period. Calls to 13YARN more than tripled in the days following the referendum result, reflecting the acute distress the debate generated across Aboriginal and Torres Strait Islander communities. The service's ability to absorb that surge, and to respond in a culturally safe way at a moment of community-wide stress, illustrates what a purpose-built, community-led service can offer that a mainstream service cannot.

The 13YARN model is directly relevant to this review's finding that no kaupapa Māori telehealth mental health service exists in New Zealand. It demonstrates that an indigenous-designed crisis line can be operationally viable, nationally accessible, and culturally distinct while sitting within an established organisational and governance structure. An evaluation of 13YARN commissioned by the Australian Department of Health has recently been completed. The panel understands that report is not publicly available but recommends that Health New Zealand request a copy through its Australian counterparts.

Data and research evidence on different caller/contact profiles

Telehealth services are used by people for different reasons and in different ways. The services generate data on usage and patterns of contact that can be used for service planning, demand management and workforce development. The review has noted that this is not done beyond a rudimentary level by the New Zealand telehealth services, suggesting opportunities for improved collation and use of data to better manage demand and create positive user experiences. The research evidence shows that people who use the services have different expectations and needs; they are not homogenous, and services should be designed on that knowledge (Mazzer et al., 2021; Middleton, 2015). Those who use services more often are likely to have different needs to those who use a service once or a few times only (O'Neill, 2019; Middleton, 2016) There are patterns of service use across the population and these can be identified (including through machine learning) and used in planning service responses (O'Neill 2019) Mental health conditions are likely to be present in a high proportion of service users, notably anxiety, but not all service users have underlying mental health conditions (Burgess, 2008) Psychological distress levels are associated with knowledge of, intent to use and actual use of telehealth crisis services, suggesting demand planning can be considered against population levels of psychological distress (Purtle, 2023).

Outcomes measurement for telehealth services

A recent systematic review of international literature on this topic has been published (Chari, 2026). Its findings may be useful developing some benchmarks for telehealth services in New Zealand. The systematic review identifies, as is done in other studies, that telehealth services-helplines are effective in reducing high psychological distress levels with service users. They are also effective in attracting suicidal persons, reducing their suicidality and enabling early crisis intervention to prevent loss of life or injury. The authors note accordingly that these services perform a preventative mental health function and that preventative mental health is recognised as having a high value in any country's mental health system. The systematic review also found that the criteria for service evaluations is less clear from the evidence identified. Heterogeneous studies, often based on one service only, cover criteria such as user satisfaction, cost effectiveness, pathway creation to other services, and the extent to which the services meet user and stakeholder expectations. There needs to be measures based on the service user and community's understanding and expectations of the services, to monitor the extent to which they do and can meet those expectations within the scope and capability of such services, as well as identifying the linkages that they form with other parts of the health and social services systems. One source of guidance is a Delphi study involving people with lived experience, professionals/clinicians and researchers which identified ten key outcomes for telehealth-helpline services (Curll, 2024): [reduced] distress, feeling heard, [decreased] suicide risk, [enhanced] connectedness/support, [lessened] hopelessness, [less] overwhelmed, [reduced] non-suicidal self-injury risk, [positive] service experience, [less] helplessness, and [enabling] next steps.

7. Recommendations

7.1 Tier one: Immediate action

Things providers and Health New Zealand can do now, without waiting for procurement or system redesign.

Recommendation 1: Improve call answer rates across the system, with a focus on people experiencing acute distress

Improving call answer rates across the system is the most immediate opportunity to increase the safety of the system for people experiencing acute distress. Too many people are not getting through, and action can be taken to address this before the next procurement round. A collaborative effort involving Health NZ, providers, and external expertise can identify short-term solutions and inform longer-term access improvement.

1.1. Convene a collaborative process across all three providers and Health NZ to identify short-term actions to improve answer rates, with a particular focus on access for people experiencing acute distress
1.2. Use the outputs of this process to inform future commissioning, ensuring access performance targets reflect the safety risk of unanswered contacts
1.3. Review current after-hours coverage across the system and identify gaps created by changes to provider operating hours

Recommendation 2: Standardise escalation protocols and formalise communication arrangements with emergency services

Providers differ in how they communicate risk and manage escalation to emergency services. There is no shared language or consistent protocol across providers, and the 2024 Police Communications framework change has created escalation difficulties that remain unresolved.

2.1. Convene a collaborative process across all three providers to develop consistent escalation language and shared protocols for communicating with Police and ambulance services in situations of imminent risk.
2.2. Ensure memoranda of understanding between providers and Police and ambulance services are current, reflect the 2024 Police Communications framework, and are reviewed regularly.
2.3. Update escalation training to ensure staff are equipped to communicate clearly and consistently with emergency services when escalating contacts.

Recommendation 3: Further strengthen MHA telehealth services clinical governance and quality systems

While clinical governance is a recognised strength across the system, there are opportunities to strengthen service quality improvement processes, especially with regard to lived experience input, and the transparency with which practice development occurs within service provider's existing structures.

3.1 Prioritise filling current vacancies in quality and practice roles
3.2 Ensure each provider has genuine Māori input into clinical governance forums, including through funded relationships with Māori health experts or tāngata whaiora Māori
3.3 Ensure each provider has genuine Lived Experience input into clinical governance forums
3.4. Ensure feedback and complaints processes are clearly signposted on provider websites and accessible to people who may have difficulty navigating formal processes

Recommendation 4: Commission and evaluate a call-back pilot for callers who have contacted an MHA telehealth service while experiencing acute distress

International evidence indicates that follow-up contact for people who have disclosed suicidality can significantly reduce distress and facilitate uptake of other support. Introducing call-back as routine practice across the system would build on this evidence and address a gap in continuity of care for the highest-risk callers.

4.1. Health NZ to consider commissioning a call-back pilot to offer outbound follow-up contact to people who have been in acute distress, with their consent obtained during the initial call.
4.2. Independently evaluate the pilot to explore caller safety outcomes and lived experience of receiving the follow-up contact. These evaluation findings should be considered in t future commissioning of MHA telehealth services.

Recommendation 5: Embed relational models of care into practice and expand peer support to operate 24/7

A relational model of care, where call takers take adequate time and build the trust necessary for genuine disclosure, produces better outcomes for callers. Peer support is a distinct and valued form of contact with potential to reach people who would not engage with a clinical service. Strengthening both across the services consistently would improve people's experiences of the MHA telehealth serivces. Service capabilities for achieving safety and positive outcomes for those who use them will also be enhanced.

5.1. Build on existing practice frameworks for safety planning during calls, including introducing the option of bringing a nominated support person into a three-way call with the caller's consent.
5.2. Ensure commissioning arrangements support adequate call lengths for callers in acute distress, rather than incentivising call throughput.
5.3. Facilitate shared learning across providers on relational practice models and reflect this in contract requirements.
5.4. Explore how extended peer support hours can be supported across the system
5.5. Ensure peer support practice frameworks recognise lived experience as a foundation of expertise, distinguish peer support from counselling, and support peer workers with training oriented specifically to the peer worker role rather than clinical training and supervision.
5.6. Work with the sector, including people with lived experience and Māori, to identify or develop an appropriate peer workforce training pathway in the New Zealand context. The goal should be peer workers having equivalent standing to clinical staff in governance and quality structures.

Recommendation 6: Inform callers of their rights, the nature of the service, and the circumstances under which their information may be shared

People experiencing acute distress have a right to understand what service they have reached, what the call taker's role is, how their information may be shared, and what escalation looks like. Transparency at point of contact is foundational to the system's ability to identify and respond to risk.

6.1. All three providers should implement consistent communication processes at point of first contact, informing callers of the nature of the service, the call taker's role, and the circumstances under which information may be shared with third parties.
6.2. Health NZ should implement these processes as part of a contractual measure; verified through contract monitoring.

6.3. Providers ensure complaint processes are clearly signposted at point of contact and accessible to callers who may have difficulty navigating formal processes.

7.2 Tier two: Enabling actions

These recommendations present a work programme that should occur alongside the commissioning process to ensure future system design is informed by the needs of people for whom the services are intended to support.

Recommendation 7: Define the scope and purpose of each commissioned service and understand the distinct needs of the populations it serves

Defining the scope and purpose of each commissioned service and understanding the distinct needs of the populations it serves, would give the system a clearer foundation for commissioning decisions and help ensure services are designed to meet actual demand.

7.1. Understand the distinct needs of different groups of callers accessing MHA telehealth services.
7.2. Work with providers to define the scope and purpose of each commissioned service and ensure this is available for public information and referring clinicians.
7.3. Health NZ work with providers to develop differentiated response frameworks for frequent callers, distinguishing between callers contacting out of isolation or social need and callers in intense, recurring distress. Operational protocols that deprioritise or limit access for the latter group should be replaced with clinically appropriate alternatives.
7.4 Ensure marketing, communications and community outreach for the MHA telehealth services adopts messages that clarify the scope and purpose of each commissioned service.

Recommendation 8: Engage with Māori to ensure the needs and perspectives of Tangata whenua inform future decisions on system configuration and service provision

Health NZ has obligations under Te Tiriti o Waitangi to ensure MHA telehealth services are equitable and responsive to Māori. Genuine engagement with Māori communities, tāngata whaiora Māori, and whānau before any reconfiguration would ensure that future services are shaped by the needs and perspectives of people the current system is not adequately reaching. The current MHA telehealth system has not been co-designed with Māori, and this work should be priorotised to support the next commissioning round

8.1. Engage with Māori communities, tāngata whaiora Māori, and whānau to understand what is needed for MHA telehealth services to be accessible and effective for Māori, including whether a dedicated kaupapa Māori service should be developed.

8.2. Engagement with Māori should be genuine, co-designed, and directly shape what is commissioned in the future.

Recommendation 9: Understand and address the barriers Pacific people and priority populations face in accessing MHA telehealth services

Pacific people and other priority populations (as defined in He Ara Oranga) are likely to face distinct barriers to accessing MHA telehealth services that are not currently reflected in how those services are designed or delivered. Engagement with communities and health providers serving these communities would ensure the next system configuration is meeting a diverse range of needs

9.1. Engage with Pacific communities and Pacific health providers to understand the barriers Pacific peoples face in accessing MHA telehealth services.
9.2. Engagement with Pacific people should be genuine, co-designed, and directly shape what is commissioned in the future.

Recommendation 10: Co-design a process to determine the circumstances in which information sharing between providers is appropriate and how people using the services will be informed.

The anonymity these services offer is a deliberate and valued feature that makes them accessible to people who would not otherwise seek help. Resolving the tension between maintaining that anonymity and improving safety at system interfaces requires deliberate system design, defined criteria and thresholds, and genuine engagement with people who use these services.

10.1. Lead a co-designed process to determine appropriate information sharing arrangements for MHA telehealth services, with meaningful input from people with lived experience, Māori, and privacy experts. This process should define the criteria, thresholds, and processes under which information may be shared, rather than assuming a single approach applies across all circumstances.
10.2. Any information sharing framework should be transparent to callers at point of contact, limited to circumstances of elevated safety concern, and consistent across all three providers.
10.3. Explore mechanisms for cross-provider risk information sharing in emergency circumstances, informed by the fatal outcome identified during this review.

7.3 Tier three: Longer-term system changes

Supported by recommendations in Tiers 1 and 2, and feed into ongoing and system-wide improvements.

Recommendation 11: Use outputs of Tiers 1 and 2 to inform future system-wide improvements and design

The current configuration places all three providers at the interface with acute distress without a clearly designated crisis response function, and funds them as parallel services without coordination, shared frameworks, or collective infrastructure. These issues can be resolved through the next procurement cycle, informed by the population needs analysis and engagement work in Tiers 1 and 2.

11.1. Use outputs of Tiers 1 and 2 to inform a decision on the future configuration of MHA telehealth services, including whether a distinct national acute distress function is required.
11.2. Ensure the next procurement cycle reflects a considered system design rather than the renewal of existing fragmented arrangements.
11.3. State a preference in the next commissioning round for consortia or collaborative arrangements that can demonstrate the flexibility and capability to meet a range of presenting needs, including effective identification and response to people in acute distress.
11.4. Require commissioning respondents to demonstrate how their proposed configuration would address the fragmentation and inconsistency identified in this review.
11.5. Ensure contract monitoring arrangements for MHA telehealth services are calibrated to clinical risk, with quality and safety outcomes (not just access metrics) forming a core part of how provider performance is assessed.

Recommendation 12: Develop a shared clinical practice and quality framework for all MHA telehealth providers

Developing a shared clinical practice and quality framework would give all providers a common reference point, support independent verification of safety, and provide shared benchmarks for oversight and monitoring.

12.1. Develop a clinical practice and quality framework for MHA telehealth services, drawing on international frameworks and tailored to the New Zealand context.
12.2. The framework should cover clinical quality and safety, responses to acute distress, imminent risk, consumer rights, privacy, workforce competency, and technology requirements.
12.3. The framework to apply to all MHA telehealth providers regardless of funding status and form the basis of a transparent quality assurance system.
12.4. The clinical practice and quality framework should be designed to interface with existing oversight mechanisms, including the Health and Disability Commissioner and the Mental Health Commission, so that accountability for quality and safety in MHA telehealth services sits within the existing system rather than requiring a new function.
12.5. Providers should prioritise filling quality and practice leadership vacancies and ensure these roles have adequate mandate and resource.

Recommendation 13: Develop an outcomes and data measures framework so the system can determine whether it is achieving its purpose

Developing an outcomes and data framework would give providers and commissioners the evidence base needed to demonstrate whether the system is achieving its core purpose and to make data-informed improvements over time.

13.1. Health NZ develop a data collection framework applicable to all MHA telehealth providers regardless of funding status.
13.2. The framework to include measures of complexity and acuity, caller experience data, clinical outcome measures, demographic data, and a core set of KPIs for reporting.
13.3. Require providers to report against this framework as a contractual obligation and publish aggregate data annually.

Recommendation 14: Establish a clearly designated 24/7 national suicide prevention crisis line function for people experiencing suicidal distress

There is currently no identifiable 24/7 crisis line function for suicide prevention in the commissioned national MHA telehealth system. International evidence and WHO guidelines are clear that a nationally accessible, high-availability crisis line is an essential component of a suicide prevention system.

14.1. The designated 24/7 national suicide prevention crisis line should provide non-judgemental, confidential emotional support to people experiencing acute distress, with immediate access and particular capability to respond to people experiencing suicidality.
14.2. Set clear access requirements for the suicide prevention crisis line function, including response time targets that reflect the safety risk of delayed access for people in acute distress.

Recommendation 15: Develop a dedicated framework and service model for children accessing MHA telehealth services

Developing a dedicated framework for children would give providers clear, consistent guidance on consent, safeguarding thresholds, and caregiver rights, and ensure that children who reach out in acute distress receive a response designed for their age and circumstances. International models, including Kids Helpline Australia, demonstrate that purpose-built, age-tiered service models can be designed and delivered effectively.

15.1 Develop a standalone child-specific framework for MHA telehealth services covering consent processes, information sharing, safeguarding thresholds, and caregiver rights.
15.2 Draw on a broad range of expertise in developing this framework, including Child Helpline International, the Children's Commissioner, youth sector experts, and people with lived experience of accessing mental health support as children or young people.
15.3 Review current responses to contacts from children under 12 at a provider level and identify interim safeguards that can be put in place while the dedicated framework is developed.

Recommendation 16: Formalise and strengthen referral pathways between MHA telehealth services and the wider health and emergency system

Integration between MHA telehealth services and primary care, community providers, Health NZ specialist MHA services, and emergency services is fragmented. Strengthening two-way connections would improve caller outcomes and reduce pressure on crisis services. (add specialist servicers)

16.1. Strengthen referral pathways between MHA telehealth services and primary care, including improving GP awareness across primary health organisations

16.2. Explore the introduction of a programme to support collaboration between telehealth, primary care, community mental health, and emergency services. This could be based on the e-Mental Health in Practice (eMHPRAC) programme in Australia that provides training to the health and wellbeing workforce on navigating and referring to digital mental health services (www.emhprac.org.au)

16.3 Strengthen connections between MHA telehealth services and community organisations, including peer support networks, kaupapa Māori providers, community crisis response services and Health NZ acute mental health services.

7.4 Responsibility matrix

Below is an indicative matrix that outlines the potential responsibilities of Health NZ and MHA telehealth providers in actioning the recommendations from this report.

P - Primary responsibility **S** - Supporting role

Tier 1: Immediate actions

#	Recommendation	Key actions	HNZ	Providers
1	Improve call answer rates across the system, with a focus on people experiencing acute distress	1. Convene a collaborative process across providers and Health NZ to identify short-term improvements to answer rates. 2. Use outputs to inform future commissioning, ensuring access performance targets reflect the safety risk of unanswered contacts. 3. Review current after-hours coverage and identify gaps.	P	S
2	Standardise escalation protocols and formalise communication arrangements with emergency services	1. Convene a collaborative process to develop consistent escalation language and shared protocols with Police and ambulance. 2. Ensure MOUs are current and reflect the 2024 Police Communications framework. 3. Update escalation training to ensure staff can communicate clearly with emergency services.	S	P
3	Further strengthen MHA telehealth services clinical governance and quality systems	1. Prioritise filling quality and practice vacancies. 2. Ensure genuine Māori input into clinical governance forums. 3. Ensure genuine lived experience input into clinical governance forums. 4. Ensure complaints processes are clearly signposted and accessible.	S	P
4	Commission and evaluate a call-back pilot for callers who have contacted an MHA telehealth service while experiencing acute distress	1. Commission and fund a call-back pilot with consent obtained at point of contact. 2. Independently evaluate caller safety outcomes and lived experience of receiving follow-up contact. 3. Use findings to inform future commissioning.	P	S
5	Embed relational models of care into practice and expand peer support to operate 24/7	1. Build on existing practice frameworks for safety planning, including the option of a three-way call with a nominated support person. 2. Ensure commissioning supports adequate call lengths rather than incentivising throughput. 3. Facilitate shared learning across providers on relational practice. 4. Explore how extended peer support hours can be supported. 5. Develop an appropriate peer workforce training pathway in the New Zealand context.	P	S
6	Inform callers of their rights, the nature of the service, and the circumstances under which their information may be shared	1. Implement consistent communication processes at point of first contact across all three providers. 2. Embed as a contractual measure verified through contract monitoring. 3. Ensure complaints processes are signposted at point of contact and accessible.	P	P

Tier 2: Enabling actions

#	Recommendation	Key actions	HNZ	Providers
7	Define the scope and purpose of each commissioned service and understand the distinct needs of the populations it serves	1. Understand the distinct needs of different caller groups. 2. Work with providers to define and publish the scope and purpose of each service. 3. Develop differentiated response frameworks for frequent callers. 4. Ensure marketing and outreach clarifies the scope and purpose of each service.	P	S
8	Engage with Māori to ensure the needs and perspectives of tāngata whenua inform future decisions on system configuration and service provision	1. Lead genuine engagement with Māori communities, tāngata whaiora Māori, and whānau to understand what is needed for MHA telehealth to be accessible and effective for Māori, including whether a dedicated kaupapa Māori service should be developed. 2. Ensure engagement is genuine, co-designed, and directly shapes future commissioning.	P	S
9	Understand and address the barriers Pacific people and priority populations face in accessing MHA telehealth services	1. Engage with Pacific communities and Pacific health providers to understand barriers to access. 2. Ensure engagement is genuine, co-designed, and directly shapes future commissioning.	P	S
10	Co-design a process to determine the circumstances in which information sharing between providers is appropriate and how people using the services will be informed	1. Lead a co-designed process with lived experience, Māori, and privacy experts to define criteria, thresholds, and processes for information sharing. 2. Ensure any framework is transparent to callers and consistent across providers. 3. Explore cross-provider risk information sharing mechanisms in emergency circumstances.	P	S

Tier 3: Longer-term system changes

#	Recommendation	Key actions	HNZ	Providers
11	Use outputs of Tiers 1 and 2 to inform future system-wide improvements and design	1. Use Tier 1 and 2 outputs to inform a decision on future configuration. 2. Ensure the next procurement reflects considered system design rather than renewal of existing arrangements. 3. State a preference for consortia or collaborative arrangements in the next commissioning round. 4. Require respondents to demonstrate how their configuration would address fragmentation. 5. Calibrate contract monitoring to clinical risk, with quality and safety outcomes as a core measure.	**P**	**-**
12	Develop a shared clinical practice and quality framework for all MHA telehealth providers	1. Develop a shared framework drawing on international models and tailored to the New Zealand context. 2. Cover clinical quality and safety, acute distress, consumer rights, privacy, workforce competency, and technology. 3. Apply to all providers regardless of funding status. 4. Ensure the framework interfaces with existing oversight mechanisms, including the HDC and Mental Health Commission.	**P**	**S**
13	Develop an outcomes and data measures framework so the system can determine whether it is achieving its purpose	1. Develop a data collection framework applicable to all providers regardless of funding status. 2. Include measures of complexity, acuity, caller experience, clinical outcomes, demographics, and core KPIs. 3. Require providers to report against the framework contractually and publish aggregate data annually.	**P**	**S**
14	Establish a clearly designated 24/7 national suicide prevention crisis line function for people experiencing suicidal distress	1. Define and commission a 24/7 national suicide prevention crisis line with clear scope and quality standards. 2. Set access requirements including response time targets that reflect the safety risk of delayed access.	**P**	**-**
15	Develop a dedicated framework and service model for children accessing MHA telehealth services	1. Develop a standalone child-specific framework covering consent, information sharing, safeguarding, and caregiver rights. 2. Draw on international expertise, including Child Helpline International, the Children's Commissioner, and lived experience. 3. Review current responses to under-12 contacts and identify interim safeguards.	**P**	**S**
16	Formalise and strengthen referral pathways between MHA telehealth services and the wider health and emergency system	1. Strengthen pathways to primary care and improve GP awareness across PHOs. 2. Explore a programme to support collaboration across telehealth, primary care, community mental health, and emergency services. 3. Strengthen connections with community organisations, kaupapa Māori providers, and Health NZ acute services.	**P**	**S**

7.5 Recommendations matrix

This table shows each of the recommendations in relation to their alignment to the terms of reference focus areas and objectives of the review. Ticks represent which focus area and objective are covered by the recommendation.

Key

ToR Areas of Focus (T)
T1: Service Access and Responsiveness
T2: Triage and Risk Management
T3: Clinical Governance
T4: Integration with the Wider System
T5: Operational Performance Monitoring

Objectives (O)
O1: Assess clinical safety systems
O2: Evaluate timeliness of call response
O3: Assess triage and risk assessment effectiveness
O4: Examine escalation pathways
O5: Assess integration with wider services
O6: Review operational performance indicators
O7: Examine clinical governance arrangements
O8: Identify opportunities to strengthen clinical assurance
O9: Provide recommendations for clinical safety and service integration

Recommendation	T1	T2	T3	T4	T5		01	02	03	04	05	06	07	08	09
1	✔				✔			✔				✔			✔
2		✔		✔						✔	✔			✔	✔
3			✔				✔						✔	✔	✔
4		✔					✔								✔
5		✔					✔		✔						✔
6	✔	✔						✔							
7	✔														✔
8				✔							✔				✔
9				✔							✔				✔
10		✔								✔				✔	✔
11					✔							✔			✔
12			✔				✔						✔	✔	
13					✔							✔			✔
14	✔							✔						✔	
15		✔	✔						✔					✔	
16				✔							✔			✔	

8. References

The references below relate to the international examples of best practice from section 6.

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9. Appendices

Appendix A

Terms of reference

Independent review of mental health and addiction telehealth services

Purpose

The purpose of this review is to provide assurance to the Minister of Mental Health, via the Ministry of Health, that Mental Health and Addiction (MHA) telehealth services operating within the national crisis support system have appropriate clinical safety measures, governance arrangements, and operational processes in place.

Services within scope

- Whakarongorau Aotearoa (including the 1737 service)
- Youthline
- Lifeline Aotearoa

Review objectives

1. Assess whether telehealth services have appropriate clinical safety systems in place to safely manage callers
2. Evaluate whether calls are received and responded to in a timely manner
3. Assess the effectiveness of triage and risk assessment processes
4. Examine escalation pathways for callers experiencing significant distress or crisis
5. Assess integration with wider services including specialist mental health services and primary care
6. Review key operational performance indicators including wait times and abandoned call rates
7. Examine clinical governance arrangements including supervision, workforce capability, and escalation protocols
8. Identify opportunities to strengthen clinical assurance across the telehealth system
9. Provide recommendations for enhancements to improve clinical safety and service integration

Areas of focus

Service access and responsiveness

- Call answer times
- Queue management processes
- Wait times
- Abandoned call rates

Triage and risk management

- Triage frameworks and assessment processes
- Suicide risk assessment processes
- Escalation protocols for high-risk callers

Clinical governance

- Clinical leadership and oversight
- Clinical supervision arrangements
- Workforce capability and training
- Risk management systems

Integration with the wider system

- Pathways to specialist mental health services
- Pathways to primary care
- Interface with crisis services and emergency services

Operational performance monitoring

- Key performance indicators
- Data reporting and monitoring systems
- Contract monitoring arrangements where applicable

Appendix B

Document analysis and site visit findings

Lifeline summary by terms of reference area

This appendix summarises findings across the five ToR areas. Findings are drawn from provider submissions (May 2026) and, site visit summaries (Lifeline 12 May 2026). The code in brackets relates to the document index in Appendix E

ToR 1: Service access and responsiveness

- Overall answer rate approximately 40% across all lines [LIF-002; LIF-003]
- Main line (Lifeline 247): 5,000-6,100 calls offered per month in 2025, abandonment 57-69% (average approximately 61%) [LIF-003]. Tautoko line: 49-68% abandonment [LIF-003]
- Calls are answered within approximately 5-6 minutes on the Lifeline Helpline and approximately 3-4 minutes on the Tautoko suicide crisis line [LA site visit, 12 May 2026]
- Frequent Callers offered volume declined 51% for the period Jan 2025 to Jan 2026 (1,696 to 822 per month), consistent with demand suppression [LIF-003; LIF-009]. Lifeline have developed a plan for managing frequent callers [LA site visit, 12 May 2026]
- Service operates 7am to midnight only; ceased 24/7 operation April 2025 due to funding constraints [LA site visit, 12 May 2026; LIF-002; LIF-038]
- Overnight callers redirected via recorded message to 1737 with no warm handover [LA site visit, 12 May 2026]
- Between 2024-2025 Māori contacts as proportion of callers who disclosed ethnicity varied between 4-9% of contacts. For Pacific it varied between 1-3% [LIF-002]. Ethnicity only recorded if a caller provides the information as they operate as an anonymous service; no cultural responsiveness strategy [review panel assessment of submitted materials]

ToR 2: Triage and risk management

- Well-considered and consistently applied risk framework: C-FRED model [LIF-001] with Active and Imminent Risk distinction [LA site visit, 12 May 2026; LIF-012], three-threshold assessment (plan, means, timeline) [LA site visit, 12 May 2026; LIF-010; LIF-011], and shift supervisor oversight of all escalation decisions [LIF-001; LA site visit, 12 May 2026].
- Since June 2024 Lifeline have only been hiring staff with NZAC or SWRB Registration. Many of their volunteers do not have recognised qualifications and are not used on the Tautoko line for this reason
- [LA site visit, 12 May 2026].
- The service's self-determination philosophy (treating escalation to emergency services as a last resort) is clinically grounded and research-supported, producing an external escalation rate of under 1% of answered calls [LA site visit, 12 May 2026; LIF-001; LIF-008; LIF-038] alongside 4,736 safety plans created in FY2025 [LIF-035].
- A proactive call-back protocol supports follow-through on high-risk disclosures [LA site visit, 12 May 2026].
- The main development area is the practice lead vacancy (approximately ten months), which is a gap in the formal oversight structure rather than in the quality of frontline practice [LA site visit, 12 May 2026].
- The two lines (Tautoko and Lifeline) act an initial self-triage tool for callers.
- Callers receive an automated informed consent message prior to connection, notifying them that emergency services may be contacted if there is imminent risk to life during the call [LIF-041; LIF-001].
- Consent is sought before escalating; where consent cannot be obtained, non-consensual disclosure proceeds at the decision of a shift supervisor rather than the individual counsellor [LIF-001].
- Data provided suggests 46-67% of escalations are non-consensual, 16-23% are consensual

ToR 3: Clinical governance

- Strong practice culture with clear clinical accountability: live shift supervision on all shifts, health-professional-qualified staff, real-time risk monitoring by the shift supervisor, and an embedded trauma-

informed philosophy [LA site visit, 12 May 2026; LIF-001].

- PSN organisational governance provides broader oversight [LA site visit, 12 May 2026].
- The funding model, rather than governance intent, is the primary constraint on formal infrastructure: the practice lead vacancy (approximately ten months) is directly attributable to funding uncertainty and recruitment difficulty, not a lack of commitment to oversight [LA site visit, 12 May 2026].
- The trauma-informed philosophy is held through culture and is present in frontline practice; the development need is to document it in formal frameworks to ensure continuity [LA site visit, 12 May 2026].
- Board has set a June 2026 funding deadline [LA site visit, 12 May 2026].
- Contact takers contribute to clinical governance through timely completion of Salesforce session notes, which support service monitoring and continuity of care.
- Call recordings and session data inform performance and development conversations, and counsellors participate in weekly group supervision and individual external supervision (LIF-001; LIF-022; LIF-025; LIF-037; LA site visit, 12 May 2026).
- Contact taker wellbeing is foundational to service quality. PSN provides in-shift debrief support, access to the TELUS Health EAP, and a Wellbeing Navigator network (LIF-015; LIF-013).

ToR 4: Integration with the wider system

- No MOU with Police or ambulance; arrangements managed through informal liaison only [LIF-038; LA site visit, 12 May 2026].
- Ambulance now default response for overdoses (established through direct liaison, not formalised) [LA site visit, 12 May 2026].
- Relationship with MH crisis teams described across multiple sessions as consistently poor nationally; teams reportedly redirect back to Police rather than engaging [LA site visit, 12 May 2026].
- Cannot make referrals or warm transfers; signposting via Healthpoint website only [LA site visit, 12 May 2026].
- Overnight gap (midnight to 7am) creates a structural no-wrong-door failure: no redirect, no warm transfer, no alternative pathway [LIF-002; LA site visit, 12 May 2026].
- Absence of information-sharing across providers identified as a systemic safety risk; a specific case was described in which a fatal outcome may have been preventable with cross-service risk information [LIF-030; LA site visit, 12 May 2026].

ToR 5: Operational performance monitoring

- No HNZ contract for the main Lifeline crisis service (PSN has invested approximately $25-28 million over nine to ten years [LA site visit, 12 May 2026]); KPIs self-determined with no external accountability [LIF-001; LIF-002; LIF-038; LA site visit, 12 May 2026].
- Two years of Genesys call data confirms abandonment 57-69% on the main line [LIF-003].
- Emergency Callout, Prevention Plan, and 24-Hour outcome categories tracked from February 2026 [LIF-003; LA site visit, 12 May 2026].
- Emergency services data maintained in a parallel spreadsheet outside Salesforce [LIF-005; LA site visit, 12 May 2026].
- PSN has aimed for a 70% answer rate target for nine years without it being achieved, however given the challenges with funding the PSN Board has not set this as a KPI [LIF-036; LA site visit, 12 May 2026].
- Board has set a June 2026 funding deadline; the service faces closure if a funded pathway is not secured [LA site visit, 12 May 2026].

Whakarongorau Summary by Terms of Reference Area

This appendix summarises findings across the five ToR areas. Findings are drawn from provider submissions (May 2026) and site visit summaries (Whakarongorau 11 May 2026). The code in brackets relates to the document index in Appendix E

ToR 1: Service access and responsiveness

- EMHR wait time is 97-99% answered within 10 minutes [DOC-013].
- The 1737 MHA line average speed of answer 21-26 minutes, approximately 50% answered within 10 minutes against a KPI of 80% (note this is not a contractual breach) [DOC-009; DOC-005].
- MHA FTE has declined from approximately 45 (COVID-19 peak) to approximately 27 at the time of the site visit [WA site visit, 11 May 2026], while base contract funding has not increased in real terms since 2019 [WA site visit, 11 May 2026; WHA-071b; WHA-092].
- Approximately 56,000 calls abandoned in Q2 2025/26 [DOC-012; WHA-056].
- Cultural responsiveness frameworks have been developed (Te Korowai, WOVEN consumer panel, Changing Minds) [WA site visit, 11 May 2026; DOC-003; WHA-055], though Māori NPS declined in Q2 2025/26 [DOC-012]

ToR 2: Triage and risk management

- Structured and well-governed risk management across the portfolio.
- Ladder Up for 1737 MHA (telephone-specific, Spectrum-prompted with mandatory safety check for all new callers) [WA site visit, 11 May 2026; WHA-015]; UK Mental Health Triage Scale (A-G) for EMHR and CMHT [WHA-014; WHA-026].
- Break glass events are systematically tracked and audited [DOC-002; DOC-005; WHA-019].
- The 2023 Break Glass Audit identified specific areas for improvement, and corrective actions were agreed at director level, reflecting active governance engagement with risk quality [WHA-063; WA site visit, 11 May 2026].
- Four-fold increase in monthly break-glass events over two years [WHA-019; WHA-063; WA site visit, 11 May 2026].
- EMHR and 1737 use different frameworks internally; a clinical lead is actively working to build consistency where possible, noting scope of each service is different therefore triage and risk framework will differ [WA site visit, 11 May 2026].
- The audit programme itself is evidence of a governance culture that takes risk seriously and commissions self-critical review [WHA-063; DOC-003; WHA-060].
- Across MHA lines 71.4% non-consensual escalations, 28.6% consensual [WHA-097].

ToR 3: Clinical governance

- ISO 9001:2015 accredited [WHA-059]. CGC chaired by an independent board member with external clinical members [WHA-039; WHA-028; WA site visit, 11 May 2026].
- Quality Forum meets monthly [WHA-041]. Learning and Healing from Harm framework adopted for serious adverse events [WA site visit, 11 May 2026].
- Systematic multi-year audit programme (break glass, supervision, IVR, documentation, debrief audits spanning 2021-2026) [WHA-062; WHA-063; WHA-064; WHA-065; WHA-066].
- January 2026 issues-based audit confirmed the governance framework is structurally sound [DOC-003].
- Consumer voice mechanisms in place (Te Korowai, WOVEN consumer panel, Changing Minds) [WA site visit, 11 May 2026].
- NPS data collected and reported for 1737 [DOC-012].
- The Pienaar Review (December 2024) reflects a governance culture that commissions and responds to self-critical internal review; identified areas for further development include post-induction embedding and training currency [DOC-002].
- Frontline kaimahi contribute to clinical governance through timely completion of contact records (tracked for quality trends and reported to the CGC) and ongoing quality reviews of calls and counselling practice, which feed into performance review and management [WHA-018; WHA-040; WHA-065d; WHA-049].
- Kaimahi wellbeing is explicitly part of the CGC agenda, supported by annual resilience reporting to

ARAC, clinical supervision framed around personal resilience, and a debriefing SOP for challenging contacts [WHA-030; WHA-023; WHA-043; WHA-005; WHA-031; WA site visit, 11 May 2026].
- Frontline kaimahi identified pressures including burnout and stress linked to staffing shortfalls and sustained crisis work [WA site visit, 11 May 2026; WHA-005; WHA-047].

ToR 4: Integration with the wider system

- Warm Transfer SOP enables transfers within the WA portfolio (between 1737, EMHR, and CMHT lines) but does not extend to Youthline or Lifeline [WHA-025].
- MOUs with Police (June 2017) and St John (March 2017) predate the 2024 Police Communications framework change; currency requires verification [WHA-053; WHA-054; WHA-052; DOC-039].
- EMHR provides a functioning crisis interface across 16 districts: 15% emergency response, 38% DHB referral rate [DOC-013; WHA-093].
- 1737 does not routinely share consult reports with GPs or specialist services [WA site visit, 11 May 2026].
- Referral pathway to IPMHA health improvement practitioners in place for non-acute presentations, with 22 warm introductions in Q2 2025/26 [DOC-012; WHA-049].
- No mechanism to transfer callers to non-WA providers [WHA-025; review panel assessment].

ToR 5: Operational performance monitoring

- Six years of monthly data across 18 workbook sheets; regional disaggregation submitted [DOC-020].
- CMHT contract (April 2026 to June 2027) specifies access KPIs (80% within 10 minutes, ASA 4 minutes or under, abandonment 15% or below) [DOC-040; WHA-058].
- 1737 MHA has equivalent contracted thresholds (95% calls answered in 10 minutes, 10% calls abandoned after 2 minutes [WHA-097].
- No clinical outcome or safety KPIs for 1737 MHA [WHA-056; WHA-057; review panel assessment].
- SMS automated-acknowledgement data may overstate digital responsiveness [WA site visit, 11 May 2026].
- Demographic completeness variable; no outcome data submitted [DOC-020; review panel assessment].
- Base funding unchanged in real terms since 2019; MHA counselling workforce costs increased approximately 25% [WA site visit, 11 May 2026; WHA-071b; WHA-092].
- 10-year NTS contract is at or approaching renegotiation [DOC-018; DOC-012; WHA-057; WHA-058].

Youthline Summary by Terms of Reference Area

This appendix summarises findings across the five ToR areas. Findings are drawn from provider submissions (May 2026) and site visit summaries (Youthline 14 May). The code in brackets relates to the document index in Appendix E

ToR 1: Service access and responsiveness

- Average phone wait 1 minute 40 seconds to 2 minutes 3 seconds, with a deliberate 3-minute 10-second queue cap redirecting callers to text or web chat, both answered 100% of the time [DOC-009].
- 24/7 coverage; overnight service launched September 2023 [YOU-014] and funded by ASB philanthropy to June 2027 [YOU-014].
- Approximately 35% increase in overnight contacts between 2024-2025 [DOC-014; YOU-045]. Approx. 31% increase in demand, for the overnight service immediately following Lifeline reducing their hours, which Helpline leadership has anecdotally attributed to Lifeline reducing their hours, at that point.
- Channel shift significant: text and web chat now 35.5% of contacts [YOU-001; DOC-014; YOU-045].
- Pacific contacts varies from 3% to 12% of disclosed contacts, raising potential equity concerns [DOC-021 to DOC-024].
- Ethnicity disclosure rate 16-21% [DOC-014; YOU-001].

ToR 2: Triage and risk management

- Clear, clinically grounded risk framework: Helpline Risk Scale (A-E across five risk domains) [YOU-029; YOU-046] and Helpline Conversation Model endorsed by the CGC in October 2025 [YOU-028; YOU-032].
- Risk assessment is woven into conversation rather than conducted as a separate clinical process. This is a deliberate and appropriate design for the service's youth cohort [YOU-028; YOU-046; YL site visit, 14 May 2026].
- Intervention rate near-doubled from 4.5% to 11.6% (April to December 2025), reflecting appropriate responsiveness to rising acuity [DOC-014; YOU-045].
- Clinical practitioners hold risk oversight on all shifts including overnight; volunteers hold no risk decision-making authority [YL site visit, 14 May 2026; YOU-029; YOU-046].
- The October 2025 volunteer programme pause was triggered by internal quality signals and corroborated by the independent Gold Tree Therapy review [YOU-042; YOU-041] this process is itself evidence of a governance system responding as intended [DOC-014; YL site visit, 14 May 2026; YOU-032; YOU-041].
- Written channels allow for initial self-triage by selecting number that reflects severity of SU distress [YL site visit, 14 May 2026].
- 988 total external interventions were recorded for 2025 [YOU-045]. Consented interventions were 30% for 2025 and non-consented interventions were 70%
- The Risk Management SOP (v1.2, October 2025) provides a legal framework for both consensual and non-consensual disclosure, grounded in the Privacy Act 2020 and Health Information Privacy Code 2020, with the operative threshold defined as "serious harm" following a 2025 terminology revision from "imminent risk" [YOU-046]. Intervention scripts include explicit language for both scenarios — consensual ("I have permission from the young person to share these concerns") and non-consensual ("this is a non-consented disclosure of information that I am making for safety") [YOU-015; YOU-030].

ToR 3: Clinical governance

- CGC established June 2025 with quarterly board reporting now consistent [YOU-008; YOU-032; YL site visit, 14 May 2026].
- Governance pathway: Quality Committee (six-weekly, including Youth Advisory Council coordinator) to CGC (quarterly) to Board [YOU-008; YOU-032; YL site visit, 14 May 2026].
- Automated quality audit system provides real-time practice data and drives active governance decisions [YOU-039; YOU-032].
- The October 2025 volunteer programme pause (triggered by internal quality signals and corroborated by the independent Gold Tree Therapy review [YOU-042; YOU-054]) is a direct example of governance working as intended: a safety concern was identified, escalated, and acted on [YOU-032; DOC-014; YL

site visit, 14 May 2026; YOU-054].

- Independent evaluation (Koi tu, August 2025): 68% of respondents felt genuinely helped; 80% reported no one else to turn to [YL site visit, 14 May 2026; Koi Tu report].
- State of the Generation (May 2026): Youthline most recognised MHA support organisation for young people [YOU-055].
- The main development area is ensuring the accountability pathway from CGC to frontline practice is fully embedded as the new structure matures [YL site visit, 14 May 2026; YOU-032].
- Contact takers feed into clinical governance through mandatory SOAP notes, risk incident reports, and end-of-shift summaries that flow through the Quality Committee to the CGC and Board; the automated audit system generates individual practice feedback and aggregated governance data [YOU-039; YOU-032; YOU-034; YOU-054; YL site visit, 14 May 2026].
- Contact taker wellbeing is supported through peer debriefing, monthly external supervision, and EAP, with wellbeing formally integrated into the Health, Safety and Wellbeing framework in August 2025 [YOU-010; YOU-024; YOU-040; YL site visit, 14 May 2026].

ToR 4: Integration with the wider system

- External Intervention Scripts for Police, Ambulance, and MH Crisis Teams provide structured escalation language including specific responses to Police pushback [YOU-015; YOU-016; YOU-030; YL site visit, 14 May 2026].
- Police welfare check removal (November 2024) and undisclosed Police Communications framework change have created significant escalation difficulties [DOC-039; YOU-034; YL site visit, 14 May 2026].
- 105 (non-acute) refusals and 111 (emergency) capacity claims documented across three consecutive board reporting periods, escalated to HNZ [YOU-032; YOU-033; YOU-034; YOU-031].
- Circular loop documented: Police redirects to crisis team; crisis team redirects back to Police [YOU-033; YOU-034].
- HNZ has created a translation resource to align helpline language with Police response criteria [YL site visit, 14 May 2026; YOU-033].
- Youthline can contact Police, Ambulance, and CATT teams directly on a caller's behalf when serious harm thresholds are met (external intervention). Outside those thresholds, no direct referral pathway to specialist services exists and callers must self-initiate contact [YL site visit, 14 May 2026; YOU-030; YOU-046].
- Approximately 55–60% of contacts involve provision of a referral resource from a vetted list covering crisis, mental health, and social services. Youthline has no mechanism for direct or warm handover to these services; the referral model is resource provision only, with callers following up independently [YL site visit, 14 May 2026; YOU-047].
- Operates beyond contracted scope informally to provide support to under 12 year olds and absorb other cross provider overflow. Under 12 now 10% of conversations as of 2025 with a 12% growth in the under 12 share in a single year [DOC-009; DOC-014].

ToR 5: Operational performance monitoring

- Monthly reporting under C576/07 covering FTE, outputs, new people seen by ethnicity and age, people waiting more than five days, and outcomes [YOU-027; YOU-004]. However, Youthline is not subject to the ‘waiting more than five days’ metric due to its delivery and service model.
- External intervention rate tracked [DOC-014; YOU-001]. 988 external interventions in 2025, up 84% on 2024 [YOU-045].
- Ethnicity disclosure 16-21%, substantially below the NTS average of approximately 53% [DOC-014; YOU-001; DOC-020]. Youthline is an anonymous service and does not ask for client demographics and does not require clients to disclose their ethnicity to receive support. Any client demographics are self-identified by the client or identified by Helpline staff based on the information the client provides.
- No outcome data [review panel assessment]. No outcome data was provided as there is no current metric for Youthline to capture this, as they do not know what happens after a contact; there is no feedback loop with emergency services, and they are unable to make direct referrals to secondary services. Therefore, the only data they do capture are rates of referrals to emergency services/MH Crisis Teams and referral information provided to Youthline services and Other organisations.
- Phone abandonment rate definition differs from other providers due to deliberate queue cap of

approximately 3 minutes, limiting cross-provider comparison [YOU-001; YL site visit, 14 May 2026].

- C576 Variation 07 ($1,045,975.49) expires June 2026; successor arrangements not confirmed [YOU-027].
- Overnight service (highest acuity) funded outside HNZ contract; ASB commitment to June 2027 only [YOU-014].

Appendix C

Lived Experience engagement summary

These findings draw on four Lived Experience focus group sessions conducted in May 2026 (LE Sessions 1 to 4), and three additional interviews in June 2026. Participants included people with personal experience of mental distress, family members, whānau and supporters, people working in peer support and community roles, and advocates with experience of formal complaints processes. Several participants also brought professional perspective from working in or alongside telehealth and crisis services.

Findings are organised by the five areas in the terms of reference, with an additional section for broader findings.

Summary by ToR area

Service access and responsiveness

Key messages:

- Participants across all four sessions shared that these services are widely understood as crisis-only lines, which shapes who calls and when.
- Wait times were consistently identified as a barrier to access, particularly for people already in acute distress.
- Several groups were identified as being poorly served by current access models, including Māori, rural and isolated communities, disabled people, non-English speakers, and young people under 16.
- Participants noted that many people are unaware that peer support operators are available through 1737, and suggested this, if better known, would encourage more people to reach out.

Services are seen as crisis-only

Participants across all four sessions shared that, in their experience, people in their communities understand these services as crisis lines: somewhere to call when things are at their worst, not when distress is building but manageable. This was described as a barrier to earlier contact (LE Sessions 1, 2, 3, 4).

"People go, 'I'm not suicidal. I don't want to harm myself. Therefore, I don't need to call these lines.' It's like you call these lines because you [want to] die or things are absolutely terrible." (LE Session 1)

Participants shared that by the time people are in their worst state, their self-compassion has often dropped to the point where they no longer feel entitled to call. One participant described this as a second battle layered over the first, where people find themselves struggling with the distress and simultaneously questioning whether they deserve a response (LE Session 1). Another noted that if someone is not in acute crisis, they are more likely to go to friends, family, or community workers, because helplines are not understood as being for that level of need (LE Session 3).

One person, who had also previously volunteered with helplines, described the ideal moment for a helpline call as being in "the orange", when distress is there, but not yet at its worst. They noted that if people could be supported to call, and were able to get through at that point, rather than waiting until things had deteriorated further, the conversation would be more useful for everyone involved (LE Session 1).

Wait times undermine help-seeking

Participants across all four sessions shared that wait times are a major barrier to reaching out, particularly for those already in acute distress. The time spent on hold was described as working against the courage it had taken to make the call, with participants noting that the longer the wait, the more likely people are to hang up without speaking to anyone (LE Sessions 1, 2, 3, 4).

"It takes a lot of courage to make that call, and the longer you're waiting, the more opportunities you have to lose that courage and to just hang up." (LE Session 2)

Participants shared that people they had supported had called, waited, and ultimately hung up, and in some cases self referred to an emergency department instead. Some noted that certain services, rather than placing callers on hold, will simply not answer if no one is available and direct people to try elsewhere, with no callback

or follow-up offered (LE Session 2). Participants in LE Session 4 described waits of over an hour, and suggested a callback option as a straightforward improvement: letting callers know when to expect a response rather than leaving them in silence.

Participants also shared that reaching out to these services carries significant emotional weight, particularly for people who have been disappointed or harmed by services in the past. One participant noted that before you reach out, there is still an idealised possibility of being helped; it is only once you call and are not met well that possibility closes (LE Session 3).

Who these services are not reaching

Participants identified several groups as being poorly served by current access models. Rural and isolated communities were described as having limited awareness that these services exist, with advertising concentrated in cities and poor cell reception or regular power outages making access unreliable in some areas (LE Sessions 2, 4). Māori participants shared that the model of care does not fit, describing their experience of helplines as "extremely clinical, like going to the doctors," with no space for the relational connection that is central to Māori approaches to wellbeing (LE Session 2). Pacific communities, recent immigrants, and non-English speakers were also identified as underserved, with participants noting limited interpreter access as a specific gap (LE Sessions 2, 4).

Participants shared that people without a phone or stable address face obvious structural barriers to access, and that people with complex or chronic distress have in some cases been declined service after calling frequently (LE Sessions 2, 4). Deaf and disabled people were raised as a group with difficulty accessing phone-based services (LE Sessions 2, 4).

Text and chat options were acknowledged by participants as helpful for some people, and particularly for those who experience anxiety around phone calls. However, participants were clear that these options do not work well in acute crisis, when composing text is difficult and response times are slow compared to the instant communication people are now accustomed to (LE Sessions 2, 3). One participant noted that for some people, including those who are autistic, text is not a step toward a phone call but the preferred and most accessible format in its own right, and being prompted to move to phone can undermine rather than support access (LE Session 3).

Participants valued the existence of specialist services for specific communities, such as those serving rainbow youth, noting that knowing who will answer before you call makes a difference to whether people reach out at all (LE Session 2).

A person connected to a peer support service for family and whānau noted that whānau often cannot access crisis support for a loved one if that person does not have the capacity to initiate contact themselves. The current peer support model requires the person in distress to be the one to call, leaving whānau with limited options when they are trying to support someone who cannot or will not reach out. When whānau do manage to make contact, the feedback shared was that responses often feel like platitudes, with call-takers perceived as poorly connected to other supports and unable to offer practical guidance about what to do next.

Awareness of peer support options

Participants noted that many people in their communities do not know that peer support operators are available through 1737, and that this is not clearly communicated in advertising. The view shared was that if this were better known, it could encourage more people to reach out, particularly those who would be reluctant to speak with a counsellor (LE Sessions 2, 4).

"*If they could maybe promote the fact that they have peer operators, that it is a peer service, I wonder if that would encourage people a bit more. That's not always where people don't always want to talk to a counsellor, but if they thought they could talk to a peer, they might feel more inclined." (LE Session 4)*

Triage and risk management

Key messages:

- Participants shared that genuine disclosure depends on feeling heard as a person before being assessed as a risk. Scripted risk questions, particularly when a caller has encountered them before, were described as reducing honesty rather than supporting it.

- Non-consented escalation to police was consistently identified as a barrier to future help-seeking, with participants describing police involvement as tending to amplify rather than reduce distress.
- Participants noted that risk assessment language assumes a level of self-knowledge and familiarity with services that many people, particularly young people and first-time callers, do not have.
- The difference between keeping someone physically safe and making them feel safe was raised as a distinction that services need to hold more deliberately.

Risk assessment language does not reach everyone

Participants shared that standard risk assessment questions are calibrated for people who have been through services before and are familiar with how they think about risk. For young people, or anyone new to crisis, those questions were described as not landing (LE Sessions 1, 2).

"We've got our little young ones saying, 'I feel yuck tonight.' What does yuck mean? We don't know. And it could be that this is a young one who's been sitting with suicidality for a long time. For all we know, they've already taken pills." (LE Session 1)

Participants noted that questions like "Are you going to be safe tonight?" assume a level of self-awareness and system literacy that most people in crisis do not yet have. The implication shared was not that risk questions should be removed, but that they need to be embedded in a genuine conversational relationship rather than delivered as a checklist (LE Session 1).

Standard questions can reduce honest disclosure

Participants shared that when someone has called a helpline more than once or has previously used mental health services, and recognises the same script being used, it stops feeling like a human being trying to understand them and starts feeling like a process being completed. One participant described this as making them want to give less honest answers, not more (LE Session 2).

"After about the second time someone had asked me these kind of questions, I knew this is just the standard questions, this is just going along these boxes. It doesn't feel very human. It doesn't feel like there's connection or anything like that. It just feels like we're going through this process, and that kind of made me want to not give honest answers to those questions, because I feel like I'm up against the system, not a human." (LE Session 2)

Participants in LE Session 4 shared a similar view, noting that trust and disclosure depend on feeling heard as a person first. Participants saw the value in a conversational approach throughout the call, and that engaging with how someone is feeling before moving into risk questions makes a meaningful difference to what people are willing to share.

For people who have lived with recurring distress for many years and developed sophisticated self-knowledge about their own risk, the default risk-assessment approach of telehealth services can be unhelpful, and in some cases harmful. The concern raised was that services typically orient around risk to life, rather than the underlying distress driving the crisis. For someone who has long experience managing suicidality, being assessed for risk rather than supported to work through what is wrong can increase rather than reduce their distress. The participant noted that these services may work well for someone new to crisis or without access to other support, but that a single model applied uniformly across callers does not serve people whose needs are more specific. What was described as helpful was having someone who could treat them as an expert in their own experience and act as a reflective sounding board, rather than conducting an assessment.

Feeling a sense of safety is important for service users

Participants shared that there is a meaningful difference between de-escalating someone to a lower level of acute risk and actually making them feel safe. The clinical orientation required for the first was described as often undermining the second (LE Sessions 2, 3).

"There's a real massive difference between keeping someone safe physically and actually making somebody feel safe. The kind of clinical attitudes that go behind that, I understand why they're necessary and why they're important, but it does completely remove the human aspect from it." (LE Session 2)

Participants noted that when people feel they are being processed rather than seen, they become guarded and do not share what is actually going on. One participant described this as a safety problem in its own right, not just an experience problem (LE Session 2).

Fear of losing agency as a barrier to disclosure

Participants shared that fear of escalation is a significant reason why people do not disclose fully during a crisis contact. Where someone believes that sharing what is actually happening may result in action being taken outside their control, they will hold back (LE Sessions 3, 4).

"People who don't know that your chances of getting anything escalated anywhere in the mental health system are remote will be scared that some kind of action will be taken outside of their own agency, that they're going to lose agency. That's a barrier to feeling trust in sharing what's going on." (LE Session 3)

Escalation without consent

Participants across multiple sessions described experiences of police being called without the caller's knowledge or agreement, and the lasting impact this had on their willingness to reach out again. In one account, a caller in serious distress was hung up on more than once over several days, after which police arrived without warning and without the caller being given any opportunity to prepare (LE Sessions 2, 4).

"She would have preferred them to tell her: we're going to ring the police, just stay put. There was nothing. They just called. It becomes one big flow-on effect." (LE Session 4)

Participants were not arguing that escalation is never necessary. What was shared was that how escalation is communicated, and whether the person feels consulted in that decision, makes a significant difference to whether they will be willing to reach out in the future (LE Sessions 2, 4). One participant described the framing sometimes used as presenting a binary: settle down or be taken to hospital. This was described as amplifying distress at exactly the moment when a collaborative approach is most needed (LE Session 2).

The Samaritans model was raised by one participant as a useful point of comparison: a service that would only contact police or emergency services if the caller explicitly wanted that, and which was trusted by the public precisely because of that commitment (LE Session 4).

Inconsistency in how risk is understood across the system

Participants shared that what counts as sufficient risk to act on varies considerably across different parts of the system: phone lines, crisis teams, emergency departments, and police each operate with different thresholds. People moving through more than one part of the system in a single crisis encounter these inconsistencies directly (LE Sessions 1, 4).

One participant advocated for a consistent risk framework across telehealth and crisis services, one that distinguishes between risk to health and risk to life and allows for both the caller's self-assessment and the worker's intuitive read to be recorded (LE Session 1).

Clinical governance

Key messages:

- Participants consistently shared that genuine human connection is the foundation of a useful helpline call. Skills, techniques, and clinical tools were described as of limited use until the person feels genuinely heard.
- Staff training via online modules was widely described as inadequate for work of this complexity. Participants called for proper training, external supervision, and in-person professional development.
- Call time limits were identified across multiple sessions as incompatible with the kind of connection that actually helps. Participants shared that managing calls to a time target changes the nature of the interaction.
- The peer support workforce was seen as having real potential that is not being realised, with participants noting that having lived experience is not the same as practising well as a peer.

Connection before everything else

Participants across all four sessions shared that the quality of human connection in a call determines whether anything else is useful. Asking someone what they would like from the conversation, whether that is empathy, solutions, or both, was described as a simple but powerful way to orient the call toward what the person actually needs (LE Session 1).

"The big question that I've learned to ask people is: 'What would you like out of this conversation now? Would you like some empathy? Would you like some solutions? Would you like a bit of both, or something else?' And then I found people often say that they want some ideas or solutions, but actually they wanted some empathy. Some real, connected empathy is what a good helpline call can do really, really well." (LE Session 1)

Participants shared that the best calls they had experienced, or that people they supported had described, were ones where the counsellor introduced themselves by name, showed genuine curiosity, and made space for the caller to be a person before moving into content (LE Sessions 2, 3). One participant noted that what people remember from good calls is often a small, deeply human moment rather than a technique or piece of advice (LE Session 1).

Participants in LE Session 3 described this distinction as the difference between being "met" and being "managed," a framing that ran throughout that session and connects to findings across the other three.

"Please upskill people so that they know how to 'meet people' rather than 'manage' them. How to hold space, how to let the expertise lie in the person to resolve their own issues, to not presuppose anything but take a learning orientation." (LE Session 3)

Staff training and conditions

Participants shared that the training available to staff does not reflect the complexity and sensitivity of the work. Online modules were described as a cost-saving measure that is inadequate for people who are taking calls from people in serious distress (LE Sessions 2, 4). Participants called for proper training, external supervision, and in-person professional development as baseline requirements rather than optional additions (LE Session 4).

One participant who had worked alongside a phone line described management practices in which staff were pulled up for taking calls longer than twenty minutes, shown their call-time data, and pressured to keep interactions short. They shared that this directly damages the quality of care, producing workers who are oriented toward completing calls rather than connecting within them (LE Session 4).

"Proper training, if they're just learning on modules, I can understand that they're reasonably cheap for the organisation to roll out, but you're really talking about some critical areas and touch points for people." (LE Session 4)

Participants also shared that the emotional demands of doing this work well are significant, and that staff who do it most effectively are also the most vulnerable to burnout if they are not properly supported. The view expressed was that investing in staff conditions is inseparable from investing in caller outcomes (LE Sessions 1, 4).

"They're tired, and they actually want people to not call them back, because then that's one call down, rather than actually: if that's my cousin, if that's my sister on the phone, I actually want to chase you a little bit." (LE Session 1)

Call time limits

Participants across multiple sessions shared that fixed call time limits are experienced as incompatible with genuine connection. The twenty-minute limit was raised specifically, with participants noting that some callers take most of a call to build up to sharing what is really going on (LE Sessions 1, 3, 4).

"One minute it was 19 minutes, so I've got to finish in 20. Now you're really careful how you have that conversation, and some people might be only just beginning to share what's really happening in that last minute or two." (LE Session 4)

One participant noted that a timed call communicates factory logic to both the worker and the caller, and that the resource argument for time limits, while understandable, produces a service that manages people rather than meets them (LE Session 3).

A related pattern was raised in Session 2: that time-pressured calls can result in partial de-escalation, where a caller is brought down from acute distress but not to a place of genuine safety. One participant observed that "a lot of the time what it feels like is they just want to de-escalate, and a lot of time maybe they'll de-escalate to get you off the phone, but then oftentimes what will happen is young people end up calling back up anyway, because as soon as they get off the phone it goes back up" (LE Session 2). Another participant shared that opening up is itself distressing, and that "in the 20 minutes or an hour after the call, it can really pull you back into that distress." Participants saw a need for call takers to remain on the line until a caller reaches a genuinely

safe place, rather than simply a lower-risk one (LE Session 2).

The peer support workforce

Participants shared that peer support, when done well, is among the most effective things these services can offer. However, the view expressed across multiple sessions was that the current peer workforce is inconsistent, and that having lived experience does not automatically make someone a skilled peer practitioner (LE Sessions 1, 2, 3).

"There's an awful lot of 'well, when I was [experiencing that], this is what I did and I found this helpful,' and that isn't peer support in the slightest, that's advice giving." (LE Session 3)

Participants noted that the peer workforce has particular potential in reframing how risk is approached and held, but that this potential is not being realised without sufficient investment in training and practice development (LE Session 3). One participant noted that awareness of peer operators at 1737 is low, and that better promotion of this option could shift who uses the service (LE Sessions 2, 4).

Cultural responsiveness

Participants shared that services built on a Western clinical model are not accessible to many of the people who most need them. Māori participants described their experience of helplines as clinical and disconnected from relational ways of engaging, noting that whanaungatanga cannot be replicated over a phone line designed around NHI numbers and presenting problems (LE Sessions 2, 3).

"Most of these services are built on a Western model, not shaped for Māori to access. Māori are, you know, we do face to face, so it's all about that whanaungatanga, and you can't really do that over the phone." (LE Session 2)

Participants suggested that adjustments to how conversations begin, and what kind of relational foundation is built before clinical questions start, would make a significant difference to accessibility for Māori callers and others whose cultural backgrounds shape how they seek and receive care (LE Sessions 2, 3).

One participant expressed that they would trust their life to their whānau before they would trust it to services, because in their experience services have tended to coerce. This framing connects the findings on fear of escalation and non-consented police contact to the reality that for some Māori, the reluctance to engage with telehealth services is not primarily about cultural fit or access barriers, but about a reasonable, experience-based distrust of what services will do when someone has a high need for support.

Integration with the wider system

Key messages:

- Participants consistently shared that after a call ends, most people are left without any connection to what comes next. Follow-up calls were described as a straightforward improvement that would make a meaningful practical and relational difference.
- Police as the default escalation option was described as a structural problem. Participants noted that police involvement tends to amplify rather than reduce distress, and that the lasting impact on willingness to reach out again is significant.
- National phone lines were described as having limited ability to connect people with local community supports, with participants noting that local knowledge is essential to useful referral.
- Participants shared concerns about information sharing across the system, describing it as a deterrent to calling rather than a safety feature for many people.

After the call ends

Participants across all four sessions shared a consistent experience: a call ends and there is nowhere obvious to go next, no connection made to another service, and no one checking whether the person got what they needed (LE Sessions 1, 2, 3, 4).

"If you call somewhere and you want help, it's good to have some kind of system where it's like you know where they're going to go afterwards. I don't feel like a lot of these services do that. It's just like a chat, but then it's just sort of like it doesn't solve anything. It's sort of like an isolation." (LE Session 2)

Participants shared that a follow-up call, even a brief one later the same day or the following day, would make a significant difference not only practically but relationally. The suggestion was that knowing someone will call back gives a person something to hold onto through the rest of the day (LE Sessions 2, 4).

"That even just sets up this: 'Okay, I can get through the rest of today, and someone's going to call in at 6pm and see how I'm doing.' And yeah, it's building that relational side as well." (LE Session 2)

Participants in LE Session 4 described a specific recommendation: structured daily callbacks for callers with complex or persistent distress, from a consistent counsellor who knows them, with running notes and the ability, with consent, to contact significant others.

Police as the default escalation option

Participants across all four sessions shared that when a helpline runs out of other options, police are frequently who gets called, and that this tends to amplify rather than de-escalate a crisis (LE Sessions 1, 2, 3, 4).

"You end up going in a cop car, and you're freaking out. You're thinking you're in absolute trouble when you were just seeking help. It causes a lot of fear when you go to reach out to these things in the future." (LE Session 2)

Participants were not arguing that police should never be involved. What was shared was that police as the only available option when a helpline has exhausted other possibilities is a structural gap, and that the fear of this response prevents some people from calling at all (LE Sessions 2, 3, 4). Concrete alternatives were raised, including mobile community teams, crisis cafes, after-hours safe spaces, and dedicated youth crisis response roles. Participants noted that some of these options are developing in parts of the country but that coverage is patchy and hours are limited (LE Session 2).

A member of Te Kete Pounamu noted that some Māori and Pacific communities have developed their own peer-led responses to crisis, including activating informal call networks during periods of heightened need such as Christmas and the COVID pandemic. These responses exist because the formal system is not accessible or trusted, but they are not resourced, recognised, or connected to the MHA telehealth system. The view shared was that there are no deliberate access pathways for Māori or Pacific peoples within the current telehealth model, and that equity requires cultural responsiveness within existing services as well as resourcing the community-led alternatives that are already doing this work.

The referral loop and service fragmentation

Participants shared that different parts of the system frequently refer people to each other without any part taking clear responsibility. This was described as people being passed around rather than held, with phone lines, crisis teams, and emergency departments each directing people on without following through (LE Sessions 2, 4).

"The crisis team would consistently play hot potatoes with people. Crisis resolution said they'd be here today, and it's now 6 o'clock at night, and they haven't turned up." (LE Session 4)

The experience of having to call multiple numbers in sequence while in crisis was also raised, with participants describing this as exhausting and often impossible (LE Session 2).

Local knowledge and national services

Participants shared that national phone lines are not well placed to connect people with local community supports, because they do not know the specific landscape of what is available in each region. One participant described the Family Services database as a tool with variable usefulness, noting that being listed on a database does not mean there is space, or that the service is right for a particular person (LE Session 1). The suggestion offered was a community navigator role: someone with genuine local knowledge who could follow up with a caller about what was actually available to them (LE Session 1).

Information sharing concerns

Participants shared that concerns about how information is stored and shared across the system are a deterrent to calling for many people, particularly those who have had difficult past experiences with services (LE Sessions 3, 4). One participant described discovering retrospectively that the triage for a crisis team they had contacted was being handled by an external provider, without their knowledge (LE Session 3). Another described seeing, while working on a phone line, that staff could access health records from other services unrelated to mental health, and that judgements about callers were made on that basis (LE Session 4).

"Don't break glass. Far out, all you want is to be met by a human being, and your data is being shared all over the place. If you weren't paranoid before, you would be by the time that's finished." (LE Session 3)

Operational performance monitoring

Key messages:

- Participants shared that services appear to focus on throughput measures such as call volumes and call times, while what matters to people is whether they can get through to someone who is able to provide emotional support.
- Call time limits and KPI targets were described as shaping staff behaviour toward completing calls rather than connecting within them.
- Participants noted that the complaints process is slow, unclear, and not accessible to people who lack the capacity to navigate it.
- A consistent risk framework across services was raised as something that would support both quality of care and meaningful monitoring, however this would have to differ in some clear ways for the peer services though, because people also talked about the value of peer support options being their different approach to risk

Measuring the wrong things

Participants shared that the performance culture they had observed or experienced within these services was oriented around metrics that do not reflect quality of care. Staff were described as being managed against call-time data, with those spending longer on meaningful calls pulled up rather than supported (LE Sessions 1, 4).

"They were more concerned about their spreadsheets and their precious KPIs. Management not berating staff for spending longer than 20 minutes on a meaningful call, pulling people up, showing them their stupid graphs: that doesn't mean anything decent got done." (LE Session 4)

Participants noted that what is not being measured is whether people were supported: whether they felt heard, whether they were connected to something useful, and whether they felt able to call again (LE Sessions 1, 2, 4). One participant made a direct economic argument, noting that the cost of a well-resourced helpline call is small compared to the downstream costs of an emergency department admission or inpatient stay, and that measuring the right outcomes would make this case clearly (LE Session 1).

The complaints process

Participants in LE Session 4 described two formal complaints they had supported, both arising from situations where a caller in serious distress was hung up on and had police arrive without warning. In both cases the complaint process took months, the outcome was unclear, and there was no follow-up to check whether the person had been able to access help. Participants shared uncertainty about how accessible the complaints process is to people in distress, and whether many complaints go unmade simply because people do not know how to make one or do not have the capacity to pursue it.

A consistent risk framework

One participant raised the absence of a consistent risk framework across telehealth services and crisis teams as a monitoring gap. They described a situation where different parts of the system assess and record risk differently, meaning a person's history can be effectively lost when they move between services, with the same assessment beginning from scratch. The suggestion offered was a framework that distinguishes between risk to health and risk to life, and that travels with the person rather than being reset at each new contact (LE Session 1).

Themes across all five areas

Relational safety as the foundation

Participants across all four sessions returned to a consistent theme: a helpline call only works if the person on the other end of the line is genuinely present with the caller. This was described not as a quality-of-experience issue but as the precondition for honest disclosure, accurate risk assessment, and any useful connection to what comes next (LE Sessions 1, 2, 3, 4).

Lived experience leadership must be structural and ongoing

Participants raised the question of how services are designed and who gets to shape them. The view shared was that lived experience involvement needs to be embedded throughout service design, training, and accountability processes, not limited to one-off consultations held under time pressure (LE Sessions 2, 4).

"I think if there was more involvement from the start, you would have better outcomes for the people, because as advisors, we're coming from a perspective of we're trying to get involved with members of the community who are experiencing and using the services, and that information is incredibly valuable when designing anything." (LE Session 2)

These services are valued and worth investing in

Despite the concerns raised, participants across all four sessions were clear that these services matter and that the case for investing in them is strong. The argument made was not that helplines do not work, but that they could work considerably better with investment in staffing, training, and follow-up (LE Sessions 1, 2, 4).

Appendix D

Stakeholder engagement summary

This document summarises engagement conducted with sector stakeholders as part of the Mental Health and Addiction (MHA) Telehealth Review in June 2026. Five meetings were held with representatives from agencies that interact with the three national MHA telehealth providers in the course of their work. Those meetings included Health NZ regional leaders of specialist MHA services, NZ Police, primary health organisations (PHO) and ambulance services. The engagement aimed to gather frontline perspectives on how the telehealth services are experienced by the agencies and clinicians who regularly interact with them.

System access and wait times

Long wait times are a consistent barrier across the system. The PHO meeting identified wait times as the most significant practical barrier to access, with clients disengaging after poor first experiences and becoming less likely to try again.

Information sharing gaps

A structural absence of information sharing across systems was raised in multiple meetings. Mental health records are held across multiple separate electronic systems with no national mental health record; NHI is attached to physical health records but mental health records remain effectively siloed (Regional Health NZ specialist MHA leaders meeting). Districts have no visibility of calls made to 1737, Lifeline, or Youthline.

There is no formal mechanism for telehealth services to notify a GP or Health Improvement Practitioner (HIP) that their patient has called, what support was provided, or whether there was an escalation. This leaves primary care without risk information shared with telehealth services (PHO meeting).

Ambulance crews attending a scene do so without access to risk assessments or clinical notes from preceding telehealth contact (Ambulance meeting).

Circular referral loops and structural constraints

A circular referral loop between telehealth services, police emergency communications, and district crisis lines was confirmed from the police side. Callers presenting to 111 with a mental health concern are routed to police by default. Police then contact Whakarongorau for triage and calls that do not meet the emergency threshold can loop back without resolution (Police meeting).

The national emergency 111 line is operated by Spark New Zealand, rather than a government agency, this was raised as a factor that could impact the ability to reform triage options at first point of contact (Police meeting).

Referral pathways and awareness

Primary care engagement suggested that awareness of telehealth lines (particularly 1737) may be low among some GPs, nurses, and HIPs. Of the practices we spoke with, understanding of the lines tended to sit with staff who had prior sector experience rather than being embedded across primary care teams (PHO meeting). Stakeholder engagement found 1737 is not commonly suggested by specialist clinicians in secondary services and does not appear to have strong internal referral endorsement at district level (Regional Health NZ specialist MHA leaders meeting), however engagement also found there are cases where GPs are listing 1737 as an afterhours option when creating crisis plans for patients.

An existing referral pathway between 1737 and practices with IPMHA Health Improvement Practitioners has been operating for approximately a year, but there is no data on uptake or conversion rates.

Youthline was noted as well-placed for youth referrals from primary care but underutilised as a navigation tool (Regional Health NZ specialist MHA leaders meeting).

Cultural responsiveness

Feedback from PHO's reflected that connecting with an unfamiliar voice on a generic line is a barrier for many of their Māori and Pasifika clients, who reported services feeling too general and not culturally attuned (PHO meeting). Existing kaupapa Māori services outside of the telehealth system (characterised by Māori clinicians, a

Te Ao Māori framework, and a whānau-centred approach) were identified as examples of what works. A nationally available equivalent within the telehealth lines was described as a gap.

A primary care lead observed that a whānau lens can be incorporated through the way counsellors frame questions and invite discussion of support networks, without requiring structural change to the service model (PHO meeting).

Co-response and on-scene pathways

All three regional specialist MHA service leaders confirmed that the expected response to a caller with clear intent, identified means, and a time frame for taking their life is an urgent police response via 111, with concurrent notification to the district crisis team. Districts do not currently have a 24/7 co-response model; coverage is limited to certain hours and regions (Regional Health NZ specialist MHA leaders meeting).

There is no formal pathway for ambulance crews already on scene to transfer to 1737 or EMHR. On-scene options are ad hoc. Wellington Free Ambulance's tri-agency co-response model (ambulance, police, mental health) was described as the most effective arrangement observed, with the benefit being health system navigation rather than defaulting to ED transport (Ambulance meeting).

The Queensland model of embedding a clinical psychiatrist in emergency communications was discussed. A New Zealand equivalent would need to involve a government health agency rather than ambulance directly, given St John and Wellington Free Ambulance are NGOs (Police meeting).

Frequent callers and care planning

Regional specialist MHA service leaders shared that a small number of individuals nationally account for a disproportionate volume of calls across multiple services. Bespoke management plans from districts are not consistently in place for these individuals, and Whakarongorau has flagged insufficient care plan coverage for frequent callers. There is no integrated response plan across the services these individuals contact (Regional specialist MHA leaders meeting).

Continuity and workforce

PHO engagement raised continuity of care as a meaningful design gap, particularly for people using telehealth as a bridge between appointments with a known clinician.

Regional specialist MHA service leaders engagement raised the question of whether the highly skilled mental health nursing workforce in telehealth triage is being used at the top of scope, or whether a peer workforce could appropriately handle a significant proportion of advisory call volume.

Appendix E

Document index

This index lists the documents received from Health NZ and the three providers for reference during this review. Each document was given a code, which are used as references in appendix B.

Doc code	Document title
DOC-001	12-03-2026 - Briefing - Telehealth Review - HNZ00201597
DOC-002	FPienaar HNZ MHA Telehealth Review Phase1 April2026
DOC-003	Provider Audit Report - Final Whakarongorau
DOC-004	Crisis Mental Health Triage (2024-2026)
DOC-005	Q2 2026 - MHA Data Dashboard
DOC-006	Q1 2026 - MHA Data Dashboard
DOC-007	FINAL Literature Review - National Telehealth Review 2.10.24
DOC-008	Draper et al 2015 Helping Callers to the National Suicide Prevention Lifeline who are at imminent risk of suicide
DOC-009	12-03-2026 - Aide Memoire - Telehealth Provider Wait Times and Connection Pathways - HNZ00201253 np
DOC-010	Healthline and Related Services Review Summary Report
DOC-011	Q1 2026 NTS Quarterly Report
DOC-012	Q2 2026 NTS Quarterly Report
DOC-013	Q2 2026 - EMHR Data Dashboard
DOC-014	JAN 2026 - TWO MHA Helpline - Quarterly Report
DOC-015	Q3 APR 2025 - MOH National Helpline - Quarterly Report
DOC-016	Q4 JUL 2025 - TWO MHA fka MOH National Helpline - Quarterly Report
DOC-017	NTS Workshop summary V3
DOC-018	Procurement Plan for National Telehealth Services V4.0 (2026 Procurement)
DOC-019	Q2 JAN 2025 - Qtly Reporting
DOC-020	202603_MoH_Monthly_Data
DOC-021	APR 2025 (Due 19 May 2025) MOH Data Report
DOC-022	AUG 2025 (Due 19 Sep 2025) TWO MHA Data Report
DOC-023	DEC 2025 (Due 19 Jan 2026) TWO HL Data Report
DOC-024	FEB 2026 (Due 19 Mar 2026) TWO HL Data Report
DOC-025	JAN 2026 (Due 19 Feb 2026) TWO HL Data Report
DOC-026	JUL 2025 (Due 19 Aug 2025) TWO HL Data Reporting
DOC-027	JUN 2025 (Due 19 Jul 2025) TWO MHA fka MOH Data Report
DOC-028	MAY 2025 (Due 19 Jun) MOH Data Report
DOC-029	NOV 2025 (Due 19 Dec 2025) TWO HL Data Report
DOC-030	Burgess N et al Mental health profile of callers to a telephone counselling service
DOC-031	Middleton et al 2016 How do frequent callers of crisis helplines differ from other users

DOC-032	O Neill S et al Data Analytics of Call Log Dat
DOC-033	O Riordan et al Help seeker expectations and outcomes of a crisis support service
DOC-034	Purtle J et al Use, Potential Use and Awareness of the 988 Suicide and Crisis Lifeline by Level of Psychological Distress
DOC-035	Crisis and Distress Lines CAN-HSO-22006-2026(E)
DOC-038	Compassion-First
DOC-039	Mental Health Response Change Programme Overview
DOC-040	Mental health triage crisis lines service specification for Health NZ review V29-4-26
DOC-041	SAMHSA Model Definitions
Lifeline	
LIF-001	Lifeline Practice Guidelines
LIF-002	Volumes and Trends (2024 & 2025)
LIF-003	Abandoned call data
LIF-004	Times of the Day Demand Patterns
LIF-005	Emergency Call out Data
LIF-006	Lifeline Queue Form
LIF-007	PSN Emergency Response Business Continuity Plan
LIF-008	Care Plan Examples
LIF-009	Protocols for callers with Support plan
LIF-010	Responding to Callers at risk of Suicide Module 5
LIF-011	Safety and Risk Assessment Module 4
LIF-012	Triaging Risk
LIF-013	Challenging Situations Risks and Control measures
LIF-014	Compulsory Training for PSN & Lifeline
LIF-015	EAP & Wellbeing Navigator Summary Aug 2025 - 2026
LIF-016	Health and Safety Critical Risks
LIF-017	Incident Report
LIF-018	Leadership Org Chart
LIF-019	Lifeline Org Chart
LIF-020	PSN Hazard and Risk Management Procedure
LIF-021	PSN Incident Reporting and Management Procedure
LIF-022	PSN Supervision Policy Social Services
LIF-023	Redesigning-work-PSN-case-study
LIF-024	SkillUp Training Completion Report
LIF-025	Supervision Records
LIF-026	Supervisors' Supervision Meeting minutes
LIF-027	Letter of Support St Johns
LIF-028	PSN Maori Iwi Engagement List

LIF-029	Supervisor SHIFT Handover reports
LIF-030	Warmline Handover protocols
LIF-031	PSN Employee Annual Review Checklist
LIF-032	PSN One to One Catch Up Form
LIF-033	PSN Performance Review and Goal Setting Template
LIF-034	ANNUAL REPORT 2023-24
LIF-035	ANNUAL REPORT 2024-25
LIF-036	Lifeline Aotearoa - Contact Centre Health Check Review 2022
LIF-037	Lifeline Systems Summary
LIF-038	Services Review
LIF-039	User Compliment
LIF-040	Warmline
LIF-041	Informed consent message
LIF-042	Lifeline Community Resource List 2025
LIF-043	M2.6 PSN Complaint Policy
LIF-044	PSN RESPONSE Reg Complaints
Whakarongorau	
WHA-001	Ministerial Assurance Review of Telehealth Cover note
WHA-002	MHA and EMHR ContactData for MoH 20260505
WHA-003	Queue Management SOPs Series (8 files)
WHA-004	Business Continuity Plans and Outage SOPs Series (10 files)
WHA-005	MHA Wellbeing Response in the event of low staffing
WHA-006	Handling and responding to SMS via Message Media - SOP
WHA-007	EMHR N&P 26032026
WHA-008	[Duplicate of WHA-006]
WHA-009	EMHR MHAH Call Flow
WHA-010	Inbound Call Flow 1737 Depression
WHA-011	Call flow guideline EMHR Police or Ambulance 111 Telephone Triage
WHA-012	Call Back Guidelines MHA and Call Back Procedure EMHR SOP
WHA-013	Interaction with a Service User with high or complex needs - SOP
WHA-014	UK mental health triage scale
WHA-015	Ladder up Risk Assessment Overview
WHA-016	Busy SMS Message MHA - SOP
WHA-017	Child Protection Policy
WHA-018	Clinical Documentation Policy
WHA-019	Risk of Immediate Harm Policy and SOPs Series (6 files)
WHA-020	Guidelines MHA EMHR Clinical Support
WHA-021	MHA On Call Escalation January 2025

WHA-022	Required information for IP Address Break Glass
WHA-023	Supporting Staff During and After a Challenging Event - SOP
WHA-024	Transferring of Mental health Callers SOP
WHA-025	Warm Transfer of a Call - SOP
WHA-026	Document (High-risk threshold definitions)
WHA-027	EMHR Whakarongorau Management Plan Template + Overview
WHA-028	01 Whakarongorau Our Organisation governance structure
WHA-029	Whakarongorau Org Chart 5 May 2026
WHA-030	Clinical Supervision Policy - Mental Health and Social Services
WHA-031	Copy of Clinical Supervision MHA - EMHR
WHA-032	Credentialing of Health Professionals and Advisors - Policy
WHA-033	Induction Sign Off SOP
WHA-034	Learning and Development Policy
WHA-035	MHA & FaSH Shift Supervisors Selection & Training
WHA-036	Report MHA shift supervisor Induction Akoranga module completions
WHA-037	Onboarding and Induction Policy
WHA-038	Preceptorship Policy
WHA-039	Clinical Governance Committee (CGC) Terms of Reference
WHA-040	Clinical Governance Framework
WHA-041	Quality Forum Terms of Reference
WHA-042	Quality Management Plan
WHA-043	ARAC Report - Kaimahi Resilience May 2025
WHA-044	Staff Wellbeing Policy Bundle (5 policies)
WHA-045	Quality Improvement SOPs Series (8 documents)
WHA-046	02 Management of Risk and Feedback, Incidents and Hazards - Framework
WHA-047	Board Monthly H&S Reports Series — 14 meetings Jan 2025-Apr 2026
WHA-048	ARAC Quarterly Papers Series — 5 meetings Feb 2025-Feb 2026
WHA-049	CGC Quarterly Papers Series — 6 meetings Feb 2025-May 2026
WHA-050	Integration Section 04 cross-reference note
WHA-051	Verbal Handover, EMHR - SOP
WHA-052	Hato Hone St John & Whakarongorau MOU framework DRAFT FOR DISCUSSION
WHA-053	Signed Homecare Medical MOU March 2017 St John
WHA-054	Homecare Medical LOA with Police June 2017
WHA-055	Taki o Autahi Partnership Series (3 documents)
WHA-056	National Telehealth Service ISE reporting - quarter ending 31 Dec 2025
WHA-057	NTS - QSMR Meeting Pack 19 March 2026
WHA-058	HNZ V4 National CMHT 24-4-26 Redacted
WHA-059	ISO 9001 Audit Reports Series (2021-2025, 5 reports)

WHA-060	Provider Audit Report Issues Based Audit Jan 2026
WHA-061	TWO Audit December 2024 Notification
WHA-062	IVR Audit Reports Series (AUD 1040, 1593, 2129, 2453)
WHA-063	Break Glass Audit Reports (AUD 1592, 2130)
WHA-064	Professional Supervision Audit Reports (AUD 2128, 2454)
WHA-065	Standalone Internal Audit Reports (7 reports, 2022-2026)
WHA-066	Comprehensive Audit Records — Break Glass, IVR, Privacy (2021-2026)
WHA-067	Review of Whakarongorau mental health services - emerging trends
WHA-068	Understanding Mental Health Risk in Aotearoa NZMJ July 2025
WHA-069	Whakarongorau - 1737 future service design - 2030
WHA-070	Whakarongorau Atlantis Health 1737 Service Review Blueprint v1.0
WHA-071	NTS Annual Plans Series (2022-2024 and 2024-2026)
WHA-072	Akoranga Learning Platform Training Materials Series
WHA-073	Our Insights Reports Series (May 2024 and Dec 2025)
WHA-074	1737 Archetypes
WHA-075	First, Second and Third Party Service Users Policy
WHA-076	Service User Potential Service User Participation Policy
WHA-077	Acceptable and ethical use of AI
WHA-078	Anonymity and data collection Policy
WHA-079	Code of Conduct
WHA-080	Compliance Documents List
WHA-081	Conscientious Objection to the Provision of Contraception, Sterilisation and Abortion Policy
WHA-082	Cultural Diversity and Equity in Healthcare Policy
WHA-083	Diversity & Inclusion MILO Website
WHA-084	Ahurea Tuakiri — Our Cultural Identity MILO Website
WHA-085	End of Life Choice Act 2019 Policy
WHA-086	Identifying and Responding to Abuse and Neglect Policy
WHA-087	Interaction with a Service User with high or complex needs - SOP (2)
WHA-088	Privacy Policy
WHA-089	Professional Boundaries Policy
WHA-090	Research Strategy Policy
WHA-092	Our Insights May 2024
WHA-093	Our Insights Dec 2025
WHA-094	03 Incident vs. Complaint - SOP
WHA-095	Feedback process for Quality team - SOP
WHA-096	Whakarongorau combined EMHR MHA Complaint report 12 month analysis
WHA-097	Whakarongorau Outcomes, Risk and Break Glass Data

Youthline	
YOU-001	Data & Documentation Request - Independent Review
YOU-002	Aselo Paid Staff Guide v3 05 2026
YOU-003	Business Continuity Policy
YOU-004	C576 - Youth Primary Mental Health and Addiction Service HL - Service and Reporting Specifications
YOU-005	Checklist - HCPs
YOU-006	Child Protection Policy
YOU-007	Client Engagement and Service Delivery Policy
YOU-008	Clinical Governance Terms of Reference
YOU-009	Complaints Policy
YOU-010	Core Team Supervision Attendance Record
YOU-011	Cultural Diversity Policy
YOU-012	Draft Rangatahi Engagement Strategy 2026
YOU-013	Employment at Youthline Policy
YOU-014	FINAL ASB Youthline Helpline Extension First Year Evaluation Report
YOU-015	Form examples ISBAR
YOU-016	Getting the Right Help Talking to Police Poster
YOU-017	HL Client Feedback - July 2025
YOU-018	HL Client Feedback August 2025
YOU-019	HL Client Feedback January 2026
YOU-020	HL Client Feedback March 2026
YOU-021	HL Client Feedback November 2025
YOU-022	HL Client Feedback October 2025
YOU-023	Health & Safety Update April 2026
YOU-024	Health and Safety Report October 2025
YOU-025	Health and Safety Update February 2026
YOU-026	Health and Safety Policy
YOU-027	Helpline C576 - Variation 07 - MOH National Helpline
YOU-028	Helpline Conversation Model
YOU-029	Helpline Risk Scale Visual
YOU-030	Helpline scripts - External Interventions with Police/Ambulance/MH Crisis Teams
YOU-031	Risk Reporting to Board Helpline Specific
YOU-032	Clinical Governance Board Update Oct 2025 Helpline Specific
YOU-033	Clinical Governance Board Update Feb 2026 Helpline Specific
YOU-034	Clinical Governance Board Update April 2026 Helpline Specific
YOU-036	Onboarding Checklist Helpline
YOU-037	Onboarding Checklist

YOU-038	ORIGINAL MOH Expansion of National Helpline contract
YOU-039	Quality Control Assessment Procedure
YOU-040	Staff Supervision and Training Policy
YOU-041	Summary of the Gold Tree Therapy Report
YOU-042	*[removed duplicate of YOU-041]*
YOU-043	Te Ara Ngatahi - Youthline DEI Framework
YOU-044	Te Tiriti o Waitangi and Maori Health Equity Policy
YOU-045	Youthline Helpline 2025 Impact
YOU-046	Youthline Helpline SOP - Helpline Risk Management and Escalation
YOU-047	Youthline Referrals List
YOU-048	Youthline Code of Ethics
YOU-049	Youthline Te Ara Hou
YOU-055	Youthline ASB State of the Generation Report 2026
YOU-056	HL Complaints info
YOU-057	YL Complaints Policy
YOU-058	Youthline Helpline Evaluation Report (Koi Tu)


SYNERGIA