Approaches to reducing wait times in mental health and addiction services

Key performance indicator literature review, March 2025

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Executive summary

Long wait times for access to mental health and addiction services can negatively impact the wellbeing of tāngata whai ora. Timely access to services is a key sector and policy priority in Aotearoa New Zealand (Government Inquiry into Mental Health and Addiction, 2018; Minister of Health, 2024). As part of the Government's health sector priorities for 2024 to 2027, it established wait time targets of seeing 80 percent of tāngata whai ora accessing mental health support (through specialist or primary care services) within three weeks.

Available data across Health New Zealand | Te Whatu Ora and non-government organisation (NGOs) mental health and addiction service providers shows that in the past five years, just under 80 percent of tāngata whai ora waited less than three weeks to be seen (KPI Programme, 2024). The data further shows disparities in wait times; in 2023 almost 1 in 3 rangatahi aged under 24 years waited longer than 3 weeks to access services. While these show services are close to achieving the wait time target, there is a need to place more focus on further reducing wait times so more tāngata whai ora receive timely support.

Wait times are influenced by several factors including range and availability of services, lack of continuity between services, workforce shortages, and limited capacity and bottlenecking within services (Controller and Auditor-General, 2024; Government Inquiry into Mental Health and Addiction, 2018; Te Pou, 2023a, 2023b). Meeting the national target for wait times and enabling timely access to services will require effort at both system and service levels. It is vital to understand what services and the wider mental health and addiction system can do to shorten wait times and support people waiting to access services.

Aim and objectives

This report builds on the KPI Programme's previous literature review for its wait time indicator (Te Pou, 2022c).[1] It summarises recent evidence on service-level strategies to shorten wait times for people accessing mental health and addiction services. Findings are primarily drawn from literature published since 2022 to provide an evidence update. The following key questions guide this review.

- What strategies have been used effectively by services locally and overseas to reduce wait times?
- What can local services learn from these examples?

Key findings

Prominent approaches to reducing wait times in recent literature can be broadly categorised into provision of interim support for tāngata whai ora and optimisation of administrative processes.

[1] The first wait time report can be accessed on the KPI Programme's website, www.mhakpi.health.nz

Interim support refers to active outreach by services to support people while they wait for their appointments. This includes psychoeducation, eHealth, and peer support, which this report outlines in detail; other examples of interim support include cultural support, brief interventions, and regular check-ins (Controller and Auditor-General, 2024; Jennings et al., 2023; Wang et al., 2023; Wellspring et al., 2024). Providing interim support can reduce perceptions of wait times, support wellbeing, broaden support options, and make people feel valued (Berger et al., 2022; Taylor et al., 2023; Thomas et al., 2021; Wilson-Burke, 2024, 2024).

The way services manage administrative tasks like referrals, intake, and correspondence can impact on people's access to services (Ansell et al., 2017a; Francia et al., 2023). Enhancing the efficiency of these processes, such as by simplifying intake and triaging, can reduce wait times.

Table 1 summarises some benefits and considerations of approaches to reducing wait times. Because no single approach alone is likely to shorten wait times for all services and tāngata whai ora, services may need to examine what approaches, or combinations and aspects of them, are potentially useful to them and feasibly implemented.

Table 1. Summary of approaches to reducing wait times

Approach	Description	Benefits	Considerations
Interim support			
Psychoeducation	Information and resources provided to help people better understand wellbeing, coping skills, and support options	Empower and enhance people's knowledge and skills in managing wellbeing Enhance service engagement and retention	Information can be perceived as generic and unhelpful Accessibility, eg complexity of information, visual or audio formats
eHealth	Digital and technology-based tools designed to remotely support people's wellbeing	Typically requires no wait times Can give sense of choice, control, anonymity, and connection Cost-effective	Accessibility, eg access to internet and devices, cognitive or sensory impairments Can be difficult to engage with Concerns around quality and privacy
Peer support	People who can support tāngata whai ora by sharing knowledge and assistance based on mutual experiences	Provide valuable insights and knowledge Help people navigate and access services	Availability of peer support

		Listen to, empathise, and validate experiences	
Optimise administrative processes			
Centralise intake	Establish a single entry point for multiple providers	Coordinate demand and intake across independent services, including removing duplications	Requires a strong network of integrated services Requires adequate funding, resources, and training to implement
Enhance triaging	Prioritise access based on urgency of people's needs	Streamline resources and staff capacity	Can prolong wait for people deemed to need services 'less urgently'

Conclusion

A range of approaches may help shorten wait times for tāngata whai ora. These reflect the importance of services taking an active approach to outreach and addressing organisational factors that prolong wait times. There is a need to ensure approaches are effective for specific groups of tāngata whai ora. In addition to service-level strategies, system-level changes are required to reduce wait times, such as addressing workforce shortages and the continuity and integration of services.

Background

This report is written for the Key Performance Indicator (KPI) Programme for Mental Health and Addiction to inform discussions around the wait times indicator with the sector. It builds on an earlier review (Te Pou, 2022c) and focuses on approaches services can consider to reduce wait times. This report describes available evidence, examples, and case studies of some effective wait time reduction strategies.

People need timely access to support

Wait times are one of the main barriers to accessing services for tāngata whai ora and whānau in Aotearoa New Zealand (Te Hiringa Mahara New Zealand Mental Health and Wellbeing Commission, 2024b). Submissions to *He Ara Oranga* (2018) illustrate how lengthy waits for services can increase people's distress and make them feel unworthy of support.

There is an increasing need for mental health and addiction support in Aotearoa New Zealand. The proportion of people experiencing moderate or greater symptoms of anxiety and/or depression in the past 2 weeks has increased from 9 percent to 14 percent between 2016/17 and 2023/24 (Ministry of Health, 2024). Over the same period, rates of high psychological distress increased from 7.6 to 13 percent.

To achieve equity in outcomes and wellbeing for tāngata whai ora it is critical to ensure people can access support when they need it. This is particularly important for groups who experience disproportionate rates of mental health challenges and barriers to accessing services including Māori, Pacific peoples, rangatahi, and disabled people (Government Inquiry into Mental Health and Addiction, 2018; Minister of Health, 2023a, 2023c). Enabling timely access to a range of support options upholds the health system's commitments to Te Tiriti o Waitangi (Ministry of Health Manatū Hauora, 2024).

Reducing wait times is a national priority in Aotearoa New Zealand

Reducing wait times is a government and sector priority (Government Inquiry into Mental Health and Addiction, 2018; Minister of Health, 2024). The *Government Policy Statement on Health 2024-2027* identifies five mental health and addiction targets broadly focused on achieving timely access to quality healthcare (Minister of Health, 2024). These include two targets related to wait times:

- 80 percent of tāngata whai ora accessing specialist mental health and addiction services are seen within three (3) weeks
- 80 percent of tāngata whai ora accessing primary mental health and addiction services through the Access and Choice programme are seen within one week.[2]

[2] The KPI Programme does not have access to primary care data so is unable to report against this target.

Long wait times can negatively affect people's wellbeing

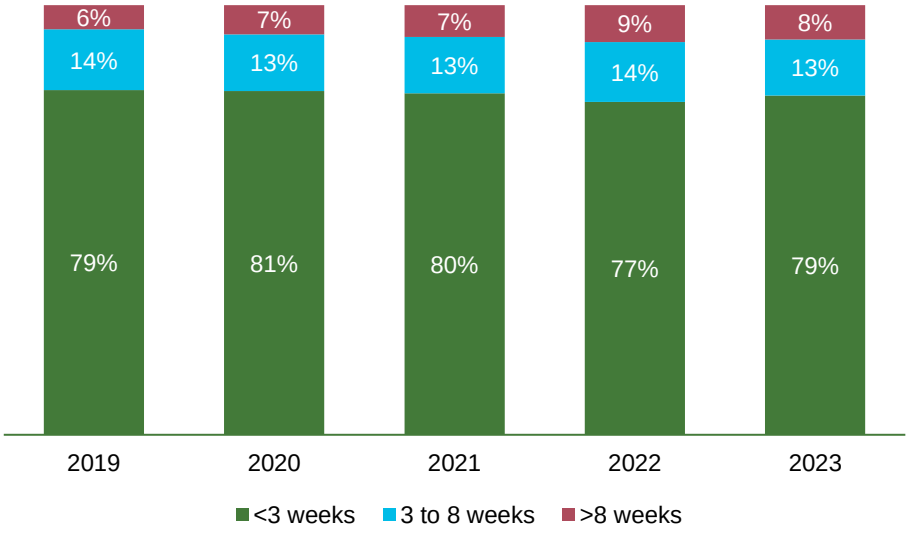
Long wait times can decrease people's likelihood of accessing services, motivation for treatment and trust in services, and attending appointments; and exacerbate mental health and addiction challenges (Every-Palmer et al., 2024; Kwon et al., 2023; Prudon, 2023; Smye et al., 2023; Te Pou, 2022c; Wang et al., 2023).

Over 1 in 5 people experience long wait times

The KPI Programme measures wait times as the number of days (or weeks) between when people are referred to a service and their first and third contacts with them.[3] This measurement approach aligns with those used internationally (Te Pou, 2022c).[4]

Figure 1 shows national wait times for services in the past 5 years as reported by the KPI Programme's wait times indicator dashboards (KPI Programme, 2024). In 2023, 79 percent of people were seen within three weeks, or 21 days, of referral.

Figure 1. National average wait time to first contact with mental health and addiction services, 2018 to 2023



Source: KPI Programme wait times indicator dashboards (accessed July 2024).

Rangatahi experience the longest wait times

The Controller and Auditor-General's audit (2024) highlights concerns around how services are supporting the mental health of rangatahi. The audit found median wait times for mental health and addiction services among rangatahi have increased over time from 15 days in 2017/18 to 23 days in 2022/23. The proportion of declined referrals has also increased over time, meaning rangatahi may wait even longer for support and have to seek and access alternate options. Data reported by the KPI Programme wait times indicator further shows in

[3] Data is drawn from the Programme for the Integration of Mental Health Data (PRIMHD) database. Full details of the indicator are shown on the KPI Programme website.

[4] There are variations in how wait times are measured nationally, such as the definition used by Te Whatu Ora (Te Whatu Ora, 2024).

2023 rangatahi (aged up to 19 years) experienced the longest wait times compared to other groups; almost one-third (32 percent) waited longer than 3 weeks, and around 1 in 8 (13 percent) waited longer than 8 weeks to be seen by services.[5] These figures indicate the importance of understanding what barriers young people may experience when accessing services, and how services and the wider system can address these.

Local wait time data does not currently capture how long some people's wait times can be. Anecdotally, wait times for young people have been reported to be as long as 12 months (Cardwell, 2021; Meier & Lourens, 2021). Recognising limitations in available data supports a person-centered focus in understanding the extent of the impacts of long wait times.

A range of factors impact on wait times

He Ara Oranga (2018) identifies system-level drivers of long wait times including limited options for accessing support, lack of continuity between services, and limited availability of and capacity in services (Government Inquiry into Mental Health and Addiction, 2018). Changes implemented since *He Ara Oranga* include investments in mental health and addiction services in primary care which supported 185,000 people in 2022/23, including 3,000 rangatahi each month (Controller and Auditor-General, 2024; Te Hiringa Mahara - Mental Health and Wellbeing Commission, 2024). While these investments enhanced service availability and continuity, wider factors continue to affect services' ability to provide timely support.

Local evidence further highlights the ongoing impacts of COVID-19 pandemic on the wellbeing of tāngata whai ora and the workforce, increased service demand, and rapid changes in service delivery (Controller and Auditor-General, 2024; Every-Palmer et al., 2024; Officer et al., 2022; Rodda et al., 2022). Additionally, workforce shortages across Health New Zealand | Te Whatu Ora and non-government organisation (NGO) mental health and addiction services limit services' capacity to provide timely support (Every-Palmer et al., 2024; Te Pou, 2023a, 2023b). In this context, there is a need to understand practical strategies or approaches services can use to enable timely support.

Aim and objectives

This report summarises available evidence on effective strategies to reduce wait times for mental health and addiction services. Key questions are outlined below.

- What strategies have local and overseas services used to reduce wait times?
- What can local services learn from these examples?

Method

This report builds on the first wait times report published in 2022 (Te Pou, 2022c). Literature searches were undertaken using Google, Google Scholar, and EBSCOHost (Academic

[5] Figure 7 in Appendix A shows some differences in wait times across ethnic groups.

Search Complete, CINAHL Complete, MEDLINE Complete, Psychology and Behavioral Sciences Collection) in July 2024. Journal articles and grey literature published since 2022 are prioritised to provide an updated overview of evidence that has emerged since the first report; older sources are included where relevant literature is limited.

Searches were based on the following search terms:

- service, access, barriers
- wait/waiting times, delay
- mental health, addiction, behavioural health, substance use, treatment
- strategy, approach, initiative, intervention, case study, solution, implementation.

This report draws primarily from literature focused on wait times for community and specialist mental health and addiction services. Given the limited availability of evidence on the effectiveness of wait time reduction strategies within this context, articles from broader health settings are also included. This report draws from reviews and sources from Aotearoa New Zealand or Australia where possible.

Most articles included are single studies and reports. Due to time constraints no formal evaluation of studies was undertaken.

Case studies are presented throughout to illustrate how strategies have been implemented in services and their outcomes. Case studies from local mental health and addiction settings are prioritised; those from broader health settings are included where closer examples could not be identified but nevertheless illustrate approaches to reduce wait times.

Findings

This section outlines key approaches to reduce wait times in mental health and addiction services identified in the literature.

Prominent approaches in recent literature can be grouped into two broad categories:

- provision of interim support – including psychoeducation, eHealth, and peer support
- optimisation of administrative processes – including centralised intake and triaging.[6]

While no single approach is likely to reduce wait times for all tāngata whai ora, services can consider systematically implementing a range of strategies, or aspects of them, to facilitate access for different people and contexts (Eichstedt et al., 2024). It is also important to note that reducing wait times should not come at the cost of service quality (Edbrooke-Childs & Deighton, 2020).

[6] The previous KPI Programme wait times indicator report describes other approaches to reducing wait times including open-access appointments, the Choice and Partnership Approach, and integrating support across different services (Te Pou, 2022). These were not included in this report as no updated evidence or case studies were identified.

Interim support can offset some potential negative impacts

Interim support refers to ways services can support people's wellbeing while they wait for scheduled appointments. This can include psychoeducation, eHealth, peer support, brief interventions, bridging clinics and programmes, and check-ins (Controller and Auditor-General, 2024; Jennings et al., 2023; Wang et al., 2023; Wellspring et al., 2024). Providing interim support can reduce perceptions of wait times, enable access to alternative support options, enhance service engagement, provide helpful information, and facilitate the start of therapeutic alliances (Berger et al., 2022; Neale et al., 2024; Taylor et al., 2023; Thomas et al., 2021; Tran, 2024; Wilson-Burke, 2024). A systematic review found that interim support including psychoeducation and parental support can improve wellbeing outcomes for children and young people specifically (Valentine et al., 2024).[7] Interim support aligns with the broader importance of ensuring continuity of care when people access services (OECD, 2021; Smith et al., 2021).

Psychoeducation, eHealth, and peer support are some ways services can provide interim support. These are discussed further given their prominence in recent literature.

Psychoeducation

Psychoeducation refers to information that helps people better understand mental health, addiction, broader areas of wellbeing, what services and support are available and how to access other support options, and build coping skills. Psychoeducation can be given verbally by service providers, or through various formats (including printed resources and eHealth) that are freely accessible (eg websites) or provided by services (eg programs).

Psychoeducation provides people with information and resources to engage with while they wait to access services. A systematic review found psychoeducation is a component in most waitlist management strategies for children and young people waiting to access mental health services (Valentine et al., 2024). Across different settings, psychoeducation has been shown to improve wellbeing outcomes, enhance people's understanding of their symptoms and diagnoses, improve service engagement and retention, and increase coping and resilience skills (Fursland et al., 2018; Gore et al., 2023; Mak et al., 2019), including for children and young people (Özdemir & Bengisoy, 2022).

It is important to ensure psychoeducation is relevant and helpful for the person it is being offered to. This involves tailoring the information and resources being provided, assessing whether it is locally and culturally relevant, and relates to the support people need (Gore et al., 2023; Valentine et al., 2024).[8] For example, in a local study exploring young people's experiences of accessing mental health services, rangatahi noted that it would be helpful to

[7] Emerging Minds, an Australian organisation for infant, child, and youth mental health, provides a resource for practitioners focused on supporting families with children who are waiting for healthcare services (Abdi, 2022).

[8] *Te Hikuwai: Resources for wellbeing* is a series of resources that provide information and tips to assist people to self-manage a range of mental health, addiction, and wellbeing issues. The resources are available at www.tepou.co.nz/initiatives/te-hikuwai

have a resource listing locally available services they could access (Wilson-Burke, 2024).[9] There is a need to support access to psychoeducation (such as offering a range of formats like physical and online resources, text, images, or videos) that suit different people's preferences for learning and receiving information. Services could offer outreach to support people to engage with psychoeducation (Gore et al., 2023; Wilson-Burke, 2024).

Psychoeducation for healthcare professionals can help to reduce wait times. Across studies, parents and people accessing services report that lack of provider knowledge about specific conditions (such as autism and learning disabilities) is a key barrier to accessing services due to factors like misdiagnosis and low trust and confidence in healthcare professionals (Adams & Young, 2021; Reardon et al., 2017). Increasing provider expertise can involve knowledge about the various conditions tāngata whai ora may have, and what accommodations and communication approaches can be used with different people to support engagement (Bradshaw et al., 2019; Huot et al., 2019). Ensuring staff have adequate knowledge and skills to support a range of people can reduce the need and time spent for tāngata whai ora and whānau to contact multiple services to find one appropriate for them (Chaplyn et al., 2024; Mason et al., 2019). This highlights the importance of staff having opportunities and dedicated time to engage with ongoing training and development.

eHealth

eHealth refers to digital, communication, and technology-based tools (including telehealth, web-based or mobile applications, and computerised therapies) designed to provide remote support for wellbeing (Timakum, 2022; World Health Organization, n.d.).[10,11] As well as interim support they can be used as standalone treatments, alongside in-person support, and integrated into primary care (Ebert et al., 2017; Quanbeck et al., 2018). eHealth can also support health promotion through screening, prevention, and providing psychoeducation (Timakum, 2022). Emerging evidence shows eHealth can improve wellbeing outcomes for people experiencing mental health, addiction, and other health challenges (Fleming et al., 2021; Philippe et al., 2022; Quanbeck et al., 2018; Te Pou, 2022a; Timakum, 2022).

A key benefit of eHealth is accessibility as there are typically no wait times to use digital tools (Garrett et al., 2024; Mental Health Commission of Canada, 2014; Quanbeck et al., 2018). Local evidence indicates eHealth tools are easily accessible for many people, particularly rangatahi, and can broaden the range of support options they can access (Garrett et al., 2024; Te Hiringa Mahara New Zealand Mental Health and Wellbeing Commission, 2024a). Studies further highlight the accessibility value of eHealth particularly

[9] A list of mental health support options is available on the Healthify | He Puna Waiora website, www.healthify.nz/support/m/mental-health-support

[10] mHealth (mobile health) shares many of the same support and information delivery approaches as eHealth including telehealth, apps, and web browsing (NZ Telehealth, n.d.), but excludes computerised therapies.

[11] A library of eHealth apps is available on the Healthify | He Puna Waiora website, www.healthify.nz/apps

for people living in rural or remote areas who may experience difficulties accessing services in person (Children's Mental Health Ontario, 2020; Paton et al., 2021; Wilson et al., 2023).

eHealth provides an additional option to conventional in-person treatment. In a local study exploring people's attitudes towards digital health and wellbeing tools, participants reported a range of benefits compared to in-person support (Wilson et al., 2023). These include a sense of choice and control over their own wellbeing, convenience and flexibility over scheduled in-person appointments, shorter wait times, and reduced travel costs. International evidence supports these findings, with participants valuing the sense of connection with others using the same platform and that anonymity can bypass stigma associated with conventional treatment (Borghouts et al., 2021; Dar et al., 2023; Philippe et al., 2022; Quanbeck et al., 2018; Wilson et al., 2023).

A limitation of eHealth is people may not always have access to technology needed to use these tools (Dar et al., 2023). It is important to consider and offer other support options for people who do not have consistent internet access, who are not familiar with navigating the internet or devices, or have sensory or cognitive impairments that limit the benefits they gain from eHealth (Clough et al., 2019; Meurk et al., 2016; Wilson et al., 2023). For example, mental health and addiction challenges can themselves be a barrier to engaging with digital tools, warranting the need for tailored support options (Borghouts et al., 2021).

Developing workforce knowledge and skills can support the safe and effective implementation of eHealth. Across studies, practitioners highlight increasing knowledge, skills, and confidence as enablers to implementing eHealth in practice (Feijt et al., 2018; Peipert et al., 2022; Subotic-Kerry et al., 2018). Additionally, because eHealth is an emerging area that utilises newer technologies, there is an ongoing need to develop best practices and workforce skills to ensure the safety and privacy of people's data and information (Grover et al., 2020; Steindl, 2023). This is supported by local findings indicating people recognise the benefits of eHealth but have concerns around privacy, quality, and technical issues (Garrett et al., 2024; Wilson et al., 2023). International literature also outlines the need for regulatory frameworks and policies to support the benefits and safe use of eHealth (Dar et al., 2023; Grover et al., 2020; Steindl, 2023).[12]

Figure 2 presents a case study outlining the impacts of an online programme providing psychoeducation, skills, and self-report activities. It highlights that having an online platform where people can self-report their experiences and participate in self-directed activities can benefit both people's wellbeing and service capacity.

[12] The Digital Mental Health and Addiction Tool (DMHAT) is an assessment framework available in Aotearoa New Zealand that can help people involved in the design, development, and use of e-mental health tools ensure baseline safety and cultural standards. The introductory guide and full access to the tool is on the DMHAT website.

Figure 2. Case study: Online pain management program (Wellmind Health, n.d.)

Context	**Challenge**	**Solution**	**Outcomes**
Chronic pain programme in Hampshire and Isle of Wight region (UK)	High demand, limited service capacity, and time-consuming consultations and support for chronic pain leading to long wait times	Implemented Pathway through Pain (PTP) – an online cognitive behavioural therapy (CBT) programme that provides psychoeducation, mindfulness, relaxation, and stretching exercises • interactive questionnaires measuring anxiety and depression symptoms, and perceived level of health and disability • online journal to record experiences • clinicians can monitor progress	Reduced clinician administrative time and people's wait times for treatment Improved service capacity, accessibility, flexibility, and choice People empowered to take control of their treatment and wellbeing Reduced anxiety and depression symptoms

Figure 3 outlines a local program looking to implement a self-directed online CBT tool (Just a Thought) for people waiting longer than 5 weeks to access mental health support (Guiney et al., 2023). It is currently being evaluated and assessed on its acceptability (ie people's satisfaction) and effectiveness (ie change in distress) compared to providing generic wellbeing information.

Figure 3. Case study: Self-directed online CBT tool for waitlist support (Guiney et al., 2023)

Context	**Challenge**	**Solution**	**Expected outcomes**
Large primary healthcare network in Auckland, Aotearoa New Zealand that provides mental health support	High demand for mental health support leads to long wait times	Provide access to Just a Thought which offers courses focused on depression, anxiety, and sleep problems which include: • activities for people to apply learnings to their own experiences • resources and worksheets to enhance skills and techniques Engagement encouraged by study project manager	Engagement leads to greater satisfaction and reductions in distress than waiting as usual with generic wellbeing information

Peer support

Peer support can be an important source of support for tāngata whai ora and whānau waiting to access services. Peer support refers to when people with similar experiences (such as mental health challenges and addiction) mutually share their knowledge and insights to support each other (Te Pou, 2022b). Peer support workers and others in dedicated lived experience roles play a crucial part in mental health service delivery and people's recovery (Te Pou, 2020). Their roles centre around utilising lived experience to help people navigate services, support people's engagement and motivation for treatment, provide a listening and empathetic ear, and engage with whānau (De Beer et al., 2024; Stanojlović & Davidson, 2021; Te Pou, 2022b).

Peer support can contribute to improved wellbeing and recovery outcomes (Lyons et al., 2021; Smit et al., 2023; White et al., 2020). A systematic review highlights that peer support workers in adult and youth mental health settings promote hope, enhance self-esteem, and facilitate support people's engagement with services (De Beer et al., 2024). In a local study, rangatahi identified that peer support improved their experiences of waiting to access services by offering insights, checking in on them, and helping to cope with mental health challenges (Wilson-Burke, 2024). Rangatahi further highlighted the value of having peers to listen to, empathise with, and validate their experiences. This is supported by Australian studies with people accessing services and family members which highlight how peer support helped them to navigate services, cope, and have additional sources of emotional support (Bryant et al., 2022; Leggatt & Woodhead, 2016).

Optimise administrative processes

Another prominent approach to reducing wait times in recent literature includes the optimisation of administrative processes – including centralised intake and triaging.

The way services manage tasks like referrals, intake, communication, and correspondence can impact the timeliness of the support they provide (Ansell et al., 2017b; Francia et al., 2023; Kreindler, 2008). The case studies below illustrate examples of actions taken by services to respond to factors associated with long wait times and improve service efficiency. The first example (Figure 4) demonstrates the impact of redesigning appointment scheduling in a mental health clinic and ensuring relevant staff can work well together. The second (Figure 5) is a local example highlighting the impact of a range of actions (including improving referral information collection, using telehealth, and distributing administrative tasks) on wait times for a physiotherapy service.

An important caveat is that even if administrative processes are made more efficient through planning and implementation, limited service capacity can still result in bottlenecks (van den Berk-Clark et al., 2018).

Figure 4. Case study: Re-designing intake at a community mental health clinic (Weaver et al., 2013)

Context	**Challenge**	**Solutions**	**Outcomes**
A semi-rural community mental	Analysis of intake processes highlighted	Implement direct intake scheduling –	Wait times for a first appointment overall

health clinic participated in a regional effort to implement the Toyota Production System[13] as a toolkit for evaluating processes and procedures that impact consumer engagement	key issues that likely increased people's appointment wait times and negatively impacted their engagement	where all aspects of intake happen when a person requests a service Observe and learn from another local service that uses direct intake scheduling Place support staff and intake workers in the same working space	reduced from an average of 11 days to 8 days

Figure 5. Case study: Improving administration in a community physiotherapy service (Simmons, 2023)

Context	**Challenge**	**Solutions**	**Outcomes**
People referred to community physiotherapy services are at risk of preventable falls and hospital admissions while waiting for appointments	In 2022: • 33% were seen within 14 days and 80% within 80 days • Longest wait time 175 days • Māori and Pasifika disproportionately represented in the group who waited between 60 and 144 days	• Improve referral information to identify people at greater risk of falls • Use telehealth to mitigate risk during wait periods • Use electronic documentation • Have assistants complete tasks previously done by physiotherapists	In 2023: • 56% were seen within 14 days and 88% within 45 days • Longest wait time reduced from 175 to 118 days

Centralise intake across services

Centralised intake or single-entry models involve one intake team taking requests for support before screening, assessment, and referral to service providers. Coordinating demand and intake can enhance relationships between service providers, increase people's

[13] A people-focused management philosophy and practice that aims to reduce inconsistency and waste by increasing steps that add value to organizational processes while reducing steps that do not. It emphasises the importance of examining processes from consumers' perspectives, and involving staff and teams in problem solving and change processes to drive organisational learning and reflection. While this approach stems from the manufacturing and logistics industry it has been implemented in mental health and healthcare settings to reduce wait times and improve outcomes (Weaver et al., 2013).

awareness of services available to them, and address gaps that increase wait times (Isaacs et al., 2023). While implementation of this approach is relatively new in non-acute mental health and addiction settings, they have been widely implemented in broader health settings (Isaacs et al., 2023).

Centralised intake models have been shown to reduce wait times across different settings. A systematic review on access to outpatient specialist physician and allied health visits identified average wait time reductions of up to 57 percent (Milakovic et al., 2021). Additionally, centralised intake was associated with high satisfaction among people accessing services and service providers. In a Canadian study on the impacts of centralised intake for child and adolescent services, mean wait times reduced from 46 to 27 days in non-acute mental health services, and from 7 to 2 days in urgent services (Melathopolous & Cawthorpe, 2019).

To enhance service access and ensure people receive adequate support, key elements of centralised intake models include having strong individual and organisational leadership and a network of integrated and collaborative services (Isaacs et al., 2023). These must be supported by a shared vision for change across all stakeholders, alignment of policies and processes, collaborative engagement with the workforce, workforce development opportunities, and continuous communication with two-way feedback (Te Pou, 2024). Implementing centralised intake can therefore be complex and resource-intensive at both service and system levels (Melathopolous & Cawthorpe, 2019). In lieu of system-wide implementation, services could incorporate specific elements of these models to reduce wait times, such as simplifying intake procedures and collaborating with other services.

Enhance triaging processes

Triaging can enhance service efficiency and capacity by prioritising treatment based on the urgency of people's needs. This streamlines resources and staff capacity towards people who need support most urgently while offering alternative support and resources to those with less urgent needs (Khan et al., 2021). Converging evidence demonstrates how triaging reduces wait times by up to half across a range of settings including university counselling and routine and urgent child and adolescent mental health service appointments (Hardy et al., 2011; Melathopolous & Cawthorpe, 2019).

Triaging service access based on level of urgency may not equitably reduce wait times. Local evidence indicates that prioritising people whose needs are deemed urgent can risk prolonging wait times for people whose needs are deemed 'less urgent' (Government Inquiry into Mental Health and Addiction, 2018). This can cause people to feel ignored and inadvertently worsen people's challenges. Broader literature suggests that working through waitlists sequentially without reprioritisation, and instead focus on increasing access in other ways, can prevent prolonging people's wait times (Kreindler, 2008; NHS Improving Quality, 2014). Ultimately, services need to assess whether triaging, sequential access, or other approaches are more appropriate for reducing wait times given their services' capacity, resources, and communities' needs.

Figure 6 presents a case study illustrating how triaging within a mental health crisis centre was improved. Key to this was whole-of-service involvement in the change process, and the gap analysis which informed the redesign of policies and procedures.

Figure 6. Case study: Improving triaging in a mental health crisis centre (Health Informatics New Zealand, 2023)

Context	**Challenge**	**Solutions**	**Outcomes**
Crisis Response Centre – a 24-hour mental health crisis centre in Tucson, Arizona that provides support for people (treatment, stabilisation, discharge planning) as an alternative to prison and hospital emergency departments	Identified urgent operational issues related to people's wait times and safety	Map and perform gap analysis on the triage process Develop new policies and procedures for clinical assessments, patient flow, and space utilisation • Condense check-in process from two to one assessment with a crisis worker, freeing up health technician time • Triage people according to 'risk'	Within 3 months: • median stay within the clinic decreased by 225 minutes • median stay within the observation unit decreased by 120 minutes • for people admitted to the observation unit, wait time to seeing a doctor decreased by 396 minutes

Discussion

This report summarises evidence and examples of strategies to reduce wait times. Broadly, approaches include those providing direct support for tāngata whai ora waiting to access services and enhancing the efficiency of management processes. Because no single approach is likely to shorten wait times for all services and tāngata whai ora, different approaches, a combination, or using aspects of them, may work across different settings. Services need to identify the range of possible options and examine what approaches are feasible and effective given their individual contexts.

Providing direct interim support for tāngata whai ora aligns with the health system's commitments to upholding Te Tiriti o Waitangi by ensuring people can access a range of options when they need support (Government Inquiry into Mental Health and Addiction, 2018; Ministry of Health Manatū Hauora, 2024). It supports continuity of care by ensuring people are supported during the 'gap' between referral and service access. This report discusses how psychoeducation, eHealth, and peer support can support wellbeing for people and whānau waiting for services. The eHealth case studies highlight how providing people with a range of wellbeing resources and activities can enhance wellbeing, sense of control, and service capacity. Overall, the literature highlights interim support as an effective

way to support people's wellbeing, skills, and engagement with services and peers; and broaden access to and options for support.

Strategies for optimising aspects of service management are well-established approaches to reducing wait times (Te Pou, 2022c; Thomas et al., 2021). Services can consider how aspects of their intake, administrative, and triaging procedures can be enhanced to enable more timely access. Centralised intake models are a prominent example in broader health literature but fully implementing these can be complex, resource-intensive, and require system-wide processes. The presented case studies provide some learnings that may assist services including the simplification of intake processes, collaboration and integration with other service providers, use of digital solutions like telehealth and electronic documentation, and provision of person-centred support tailored to people's needs.

Integrating the proposed approaches into service delivery to reduce wait times requires effective implementation. Though there is no single best way to implement new approaches into services due to different settings, contexts, and people involved, there are some key components of effective implementation. These include strong leadership, collaborative planning, co-designed and flexible approaches, continuous workforce development opportunities, and two-way feedback channels (Bauer & Kirchner, 2020; Harrison et al., 2021; McGeown et al., 2023; Trischler et al., 2019). Putting these supporting factors into place may require organisational transformation which can take considerable time and resources (Lowenthal, 2020). Services can use tools such as implementation frameworks and change management models to support the implementation process (Te Pou, 2024).[14]

Ongoing continuous improvement is required

Available evidence illustrates how different approaches can shorten wait times within services generally, and for adults and rangatahi separately. It is not clear, and therefore important to understand, whether these approaches equitably benefit all tāngata whai ora. As part of broader efforts to enhance equity in service access and outcomes there is a need to understand what strategies are effective and appropriate for groups who experience service access barriers including disabled and neurodivergent people, and rural communities (Adams & Young, 2021; Minister of Health, 2023b; Mulraney et al., 2021). Understanding what approaches are appropriate requires engagement with tāngata whai ora from different communities to hear what works for them.

This report provides case studies illustrating approaches used to reduce wait times in various settings including mental health and broader health services, locally and overseas. There are likely more examples of how local mental health and addiction services have reduced wait times and provided interim support that are not reported or publicly available, and therefore captured here. For example, individual NGOs and Kaupapa Māori services may have their own ways of supporting tāngata whai ora on waitlists that are tailored and

[14] A literature review of trauma-informed approaches outlines implementation frameworks developed in Aotearoa New Zealand and a seven-step implementation process. The report can be accessed on the Te Pou website, www.tepou.co.nz

effective for local communities. Factors like capacity, resources, and staffing levels may impact on services' ability to report this.

The recently established wait times target of seeing 80 percent of tāngata whai ora within 3 weeks of referral provides a benchmark for services and the system to achieve. However, these are minimum standards rather than the ideal. That is, improvements should not stop when the 80 percent targets are met as that would leave a significant number of tāngata whai ora waiting longer than 3 weeks to access mental health and addiction support. When targets are achieved, it is important to ensure wait times are reduced equitably among people accessing services and remain shorter over time. Routine monitoring and ongoing wait time reduction interventions are required to promote continuous improvement.

Conclusion

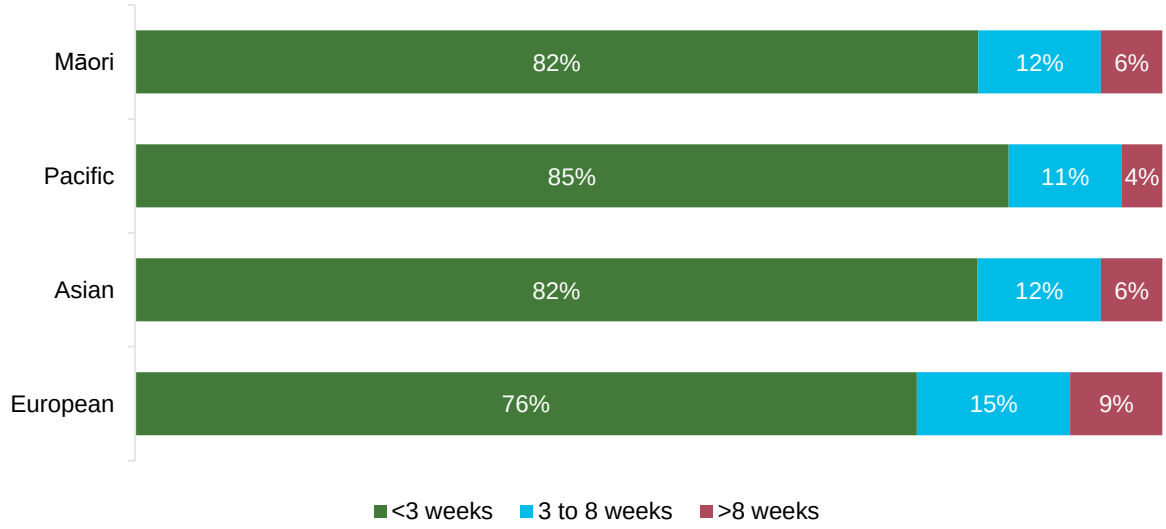
Reducing wait times is a national priority for the mental health, addiction, and broader health sector in Aotearoa New Zealand. The literature highlights a range of approaches to facilitate access including providing support for people waiting for appointments and enhancing service efficiency. Service and system-level strategies are needed to reduce wait times.

Wait times are a broad issue driven by many factors including those beyond individual services' control such as availability of services (including broader health and support services), continuity of care, workforce shortages and challenges, and increasing demand in the community (Government Inquiry into Mental Health and Addiction, 2018; Te Pou, 2023a, 2023b). The approaches outlined in this report are therefore short-term strategies services may use to reduce wait times as part of broader systemic efforts to improve service access and achieve national targets, such as investments in increasing access to mental health and addiction support in primary care and community-based services.

Appendix A: Wait times across ethnic groups

Figure 7 shows average wait times across different ethnic groups in 2023, drawn from PRIMHD data. The shortest average wait times in 2023 were among Pacific peoples, and the longest were among New Zealand Europeans. Wait time averages do not appear to indicate service access disparities typically experienced across ethnic groups, for example due to younger Māori and Pacific populations and the higher proportion of Māori living in rural areas (Stats NZ, 2024a, 2024b).

Figure 7. Average wait times for mental health and addiction services across ethnic groups, 2023



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