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An Overview of Early Psychosis Care in New Zealand—A Need for Culturally Adapted Service Models

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ABSTRACT

Background: It has been over 20 years since a review of early psychosis services in New Zealand was completed, and it is unclear if services now meet international best practice. Furthermore, significant disparities in psychosis experiences exist in New Zealand, and it is unclear whether service structure might contribute to such disparities. Given the current restructuring of the health system in New Zealand, now is the optimal time to understand strengths and weaknesses in early psychosis care provision.

Methods: All early psychosis services in New Zealand ($n = 12$) were surveyed. Leads from each service completed a survey on the general elements of their service, alongside the First-Episode Psychosis Services Fidelity Scale, which allows comparison with international early psychosis services.

Results: Specific services are provided across 11/20 districts, leaving 9 without any dedicated early psychosis care. Service strengths included short wait lists, comprehensive assessments, good provision of case managers, team managers and psychiatrists and good length of care. Relative weaknesses included provision of therapy, limited age ranges, high numbers of inpatient referrals, poor Clozapine usage and limited family participation. There was also a lack of services for people at risk for psychosis. Lack of cultural support staff, models and confidence in meeting cultural needs was also evident.

Conclusion: While New Zealand early psychosis services are relatively comparable to international services, certain areas of weakness need to be addressed by decreasing variability in service eligibility, increasing care for those at-risk, wider availability of therapy and family involvement and improved cultural services.

1 | Introduction

Early intervention for psychosis is an effective mental health model both in New Zealand (Grattan, Baxendine, and Smith 2025; Theuma et al. 2007) and internationally (De Maio et al. 2015). However, it has been over 20 years since a review of early psychosis care in New Zealand was completed (see Turner 2002). Research on best-practice has moved on since that time, and it is unclear if early psychosis care in New Zealand currently meets international standards (Addington et al. 2018). Furthermore, inequities in early psychosis for Māori, including higher rates of psychosis, are evident in recent research (Petrović-van der Deen et al. 2020), signalling that changes in care provision are imperative. International reviews of early psychosis services are taking place (Niendam et al. 2019; Nolin et al. 2016), and indigenous mental health approaches are being

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highlighted in recent work (Pomare et al. 2023), providing an optimal time to understand if New Zealand services are meeting current standards (Niendam et al. 2019; Nolin et al. 2016).

Early psychosis care in New Zealand emerged in the 1990s based on the Early Psychosis Prevention and Intervention Centre (EPPIC) care model established in Melbourne, Australia (McGorry et al. 1996). The 1996 Mason Report enquiry into mental health services in New Zealand resulted in the establishment of the Mental Health Commission to monitor and improve mental health services (Brunton 2022). An initial guiding document for service provision for early psychosis in New Zealand was developed at this time (New Zealand. Mental Health Commission 1999). This document detailed a recovery-oriented approach primarily guided by the EPPIC model (McGorry et al. 1996). Despite such guidance, an early review of the New Zealand early psychosis services indicated services were falling short on meeting several aspects of this model (Turner 2002). It was reported that while larger centres were following the EPPIC model, many other services were providing piecemeal models adapted to their specific local needs. This may indicate historic difficulties in resourcing for services in rural areas, which may compound issues of systemic racism, as a higher proportion of Māori live rurally than New Zealand Europeans. Other issues highlighted included a lack of New Zealand specific models of care. Because this review in 2002 early psychosis services in New Zealand have remained relatively unchecked, and thus, it is unclear how services are functioning today, over 20 years later, and whether these services meet international standards of early psychosis care (Addington et al. 2018).

The 1999 guidance document included one section on cultural services that is specific to New Zealand (New Zealand. Mental Health Commission 1999). This section, titled 'Culturally Appropriate Services', provides guidance around working with Māori clients experiencing early psychosis, including recommendations, such as the need for Kaupapa Māori services wherever possible (services designed by Māori, for Māori), services to be based on the Treaty of Waitangi, to have Māori consultation 'on all matters that affect them', to base services on Māori models of health, to employ Māori staff where possible, to provide access to Māori mental health workers, to receive advice from kaumātua (Māori elders) and for non-Māori staff to receive bicultural training (New Zealand. Mental Health Commission 1999). It also includes a small section on working with Pacific peoples and those from other cultures. While providing a strong foundation, many of these elements are not implemented due to a combination of poor resourcing and the ongoing impacts of institutionalised racism (Manuel et al. 2023). The Early Intervention in Psychosis Guidance Note likely requires updating to account for both the last 23 years of research and shifts in perspectives about approaching indigenous inequity.

To address the unique needs of New Zealand, the needs of the different cultural populations experiencing early psychosis in New Zealand must be understood. Recent evidence shows there are significant disparities in experiences of psychosis in Aotearoa; 40% of those experiencing first-episode psychosis are Māori (Petrović-van der Deen et al. 2020). Given approximately 17% of New Zealand's population are Māori, this is a significant disparity (Grattan, Mehta, and Clifford 2023). Māori also experience poorer outcomes, including higher rates of inpatient admission (Carr et al. 2023) and premature mortality (Monk et al. 2024). Systemic issues, such as racism and discrimination in New Zealand, appear to contribute to these statistics (Grattan, Mehta, and Clifford 2023; Manuel et al. 2023). Current models of early psychosis care were developed internationally and do not reflect Māori or other ethnic group models of wellbeing, meaning they are unlikely to adequately meet their mental health needs. It is unknown how New Zealand early psychosis services currently manage such cultural needs.

Thus, this study had three aims: (1) review current early psychosis services in New Zealand, (2) evaluate if services are meeting international standards and (3) review cultural elements of early psychosis care for Māori and other minority ethnic groups.

2 | Methods

2.1 | Design

This study utilised a cross-sectional descriptive study method. From November 2022 to November 2023, early psychosis services across New Zealand were identified through health system websites and the New Zealand Early Psychosis Society. Services were contacted via email with a project overview and participation request. Following service identification, remaining mental health services in each region across New Zealand that did not have an early psychosis service listed ($n = 9$) were contacted. Only services reporting a dedicated early psychosis programme were surveyed in more detail ($n = 12$). Each of these services provided written consent to participate, and then a 'service lead' or other representative completed the survey. This survey was provided to them by email, in person or over the phone as required. In areas with more than one programme, both programmes completed the survey independently.

Ethical approval was provided by the Victoria University of Wellington Human Ethics Committee (#30453) and where required approval was also obtained from the health boards overseeing the early psychosis services, which included approval from Te Whatu Ora Counties Manukau Research & Evaluation Office (#1773).

2.2 | Survey

The survey was designed to gather information about the characteristics of early psychosis services across New Zealand. Key service characteristics measured included the ethnicity of clients served, number of staff, service inclusion/exclusion criteria and service model. In addition, the 35-item First-Episode Psychosis Services Fidelity Scale (FEPS; Addington et al. 2016) was included as part of the survey to allow comparisons with international services. The FEPS assesses the presence and the absence of treatment model components and was developed in the United States. Small edits were made to allow relevance in a New Zealand sample. This included minor wording changes (e.g., the addition of the word whānau [wider family and community], alongside family, cultural support added as an element of care) and the addition of three questions based on community consultation with early psychosis clinicians in

New Zealand. This included questions about the role of a clinical psychologist, whether peer support was included in the service and the extent of the Te Tiriti o Waitangi commitment of the service (how much the service is able to uphold principles from the Treaty of Waitangi, a constitutional document that established relationships between Māori and the Crown). Finally, one question on psychiatrist caseload was omitted as it was addressed elsewhere in the survey. This resulted in a 37-item scale.

3 | Results

We received responses from 100% of the 20 district health boards in New Zealand. Of these, 11 districts reported having at least one dedicated early psychosis services established (55%), with two out of the 11 reporting two established early psychosis services within their district, resulting in a total of 13 early psychosis services in total across New Zealand. The two Waitemata services were treated, as one service within analyses as they are two sites that run under one service leadership, each with the same structure; however, the two Canterbury services were treated separately, as they offer very different services, leaving analysis of the 12 services shown in Figure 1. Figure 1 shows the approximate area served by each early psychosis service. Service characteristics are detailed in Table 1. Of the 9 districts that did not have dedicated early psychosis services, one offered specific early psychosis care, including a dedicated nurse.

3.1 | Client Population Characteristics

Participants estimated the percentage of ethnicity groups seen by their service. On average, services reported seeing 52.8% Māori (ranging from 25% to 95%, SD = 24.33), 9.5% Pasifika (ranging from 3% to 24%, SD = 7.42) and 8.75% Asian (ranging from 1% to 22%, SD = 5.87) clients. The remainder were primarily New Zealand European.

Inclusion and exclusion criteria for people experiencing full threshold psychosis differed across the services. The lower end of the age range seen varied from 13 to 18, and the upper end of the age range ranged from 18 in the youth only service ($n = 1$), to 25–30 in the more general services ($n = 11$). Several services reported exclusion criteria of a past treatment for psychosis ($n = 8$), although there were exceptions to this such as if it was a transfer of care. Exclusions included past psychosis treatment for 6 months or more ($n = 2$), treatment for more than 1 year ($n = 2$), treatment for more than 2 years ($n = 2$), 3 months or more on an anti-psychotic ($n = 1$) and no previous treatment allowed ($n = 1$). Treatment was typically

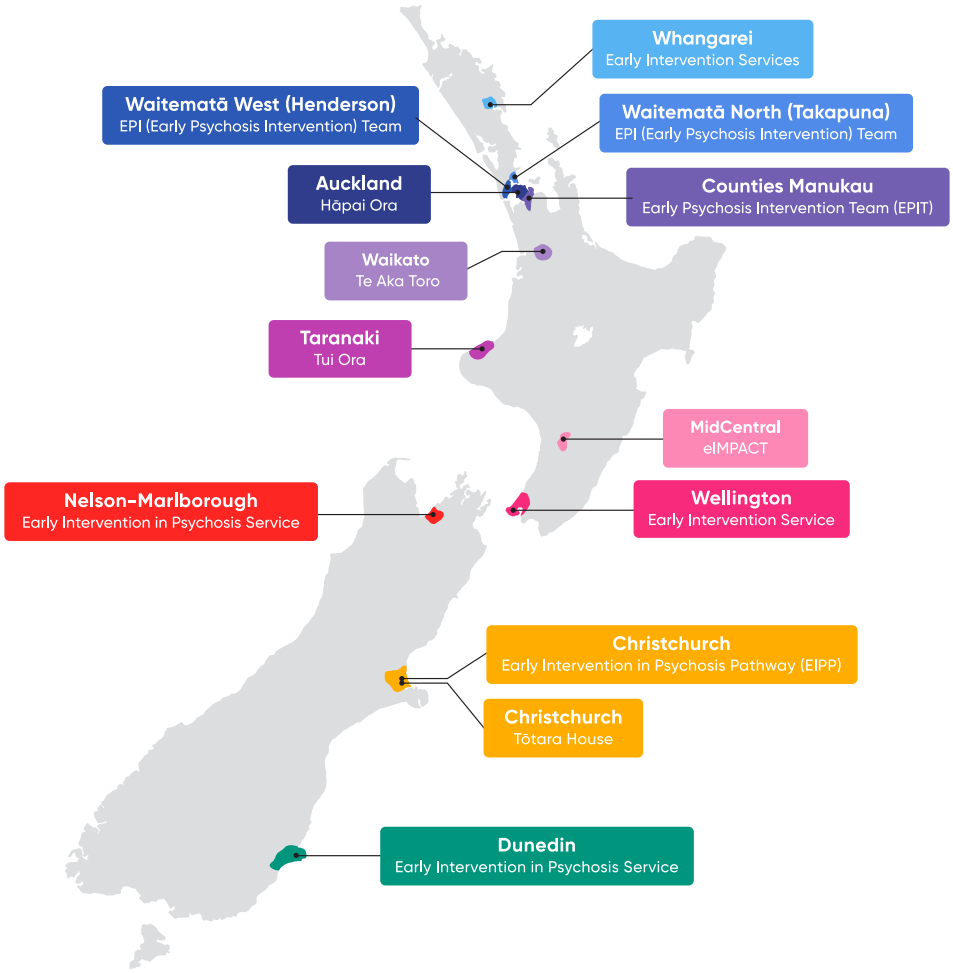


FIGURE 1 | Map of the early psychosis service locations in New Zealand.

TABLE 1 | Districts in New Zealand and early psychosis services provided.

	Region served	Approximate population of region[a]	Dedicated early psychosis service	Early psychosis service	Part of region served by EP service	Additional service information
South Island						
1	Southern district	330000	Yes	Dunedin Early Intervention in Psychosis Service	Wider Dunedin area and rural Otago on a case by case basis	None
2	South Canterbury district	30000	No	N/A	N/A	Early psychosis cases seen within general community mental health services
3	Canterbury district	600000	Yes—two	Tōtara House—Christchurch	All of Christchurch and surrounding area	Serves adults 18+
3	Canterbury district	600000	Yes—two	Early Intervention in Psychosis Pathway Christchurch Youth team	Canterbury—including Darflield, Ashburton, Banks Peninsula, Hamner Springs and Kaikoura	Serves youth up to age 18
4	Nelson-Malborough district	100000	Yes	Nelson Marlborough—Early Intervention in Psychosis Service	Nelson and Tasman excluding Golden Bay	Early psychosis cases seen
5	West Coast district	30000	No	N/A	N/A	Early psychosis cases seen within general community mental health services
North Island						
6	Capital and Coast district	300000	Yes	Wellington Early Intervention Services	Wellington, Porirua, Kapiti and Hutt areas	None
7	Hutt Valley district	150000	No	N/A	N/A	Served by the Capital & Coast EIP team
8	Mid Central district	160000	Yes	Mid Central – eIMPACT	Midcentral area/ Palmerston north	None
9	Lakes district	110000	No	N/A	N/A	Early psychosis cases seen within general community mental health services

(Continues)

TABLE 1 | (Continued)

	Region served	Approximate population of region[a]	Dedicated early psychosis service	Early psychosis service	Part of region served by EP service	Additional service information
10	Hawkes Bay district	180000	No	N/A	N/A	Early intervention in psychosis nurse sits within general mental health team
11	Waikato district	500000	Yes	Waikato—Te Aka Toro	Waikato region	None
12	Taranaki district	120000	Yes	Taranaki—Tui Ora	Taranaki area	None
13	Counties Manukau district	540000	Yes	Counties Manukau Early Psychosis Intervention Team	Counties Manukau (South and East Auckland)	None
14	Auckland district	507000	Yes	Te Toka Tumai—Hāpai Ora Early Intervention Psychosis Team	Central Auckland including CBD	None
15	Waitemata district	640000	Yes—two	Waitematā North and West Early Psychosis Intervention Team	All of Waitemata catchment, from North Shore Auckland up to Te Hana north of Wellsford and across to both west and east coasts of Nth Island	None
16	Northland district	160000	Yes	Whangarei Early Intervention Services	Whangarei area	None
17	Whanganui district	65000	No	N/A	N/A	Capital & Coast provide consultation and people are seen through general mental health service
18	Wairarapa district	46000	No	N/A	N/A	Served by Capital & Coast EIP team
19	Tairawhiti district	49000	No	N/A	N/A	Early psychosis cases seen within general community mental health services
20	Bay of Plenty district	309000	No	N/A	N/A	Capital & Coast provide consultation and people are seen through general mental health service

[a]Populations estimated from official district health board websites or Statistics NZ if population was not noted on websites.

defined as contact with a mental health service for psychosis symptoms. Some services had exclusion criteria based on the duration of psychosis symptoms ($n = 6$), including if psychosis had been present for more than 2 years ($n = 4$), or the presentation needed to be their first psychosis presentation ($n = 2$). One service did not report any inclusion or exclusion criteria. Other exclusions included if the client's symptoms were primarily related to a personality disorder ($n = 6$), psychosis that was only occurring during manic episodes ($n = 1$), mood disorder with no psychosis ($n = 3$), symptoms occurring primarily due to PTSD ($n = 4$), symptoms occurring primarily due to head injury or dementia ($n = 6$), symptoms occurring during substance intoxication or withdrawal ($n = 5$), symptoms occurring within a developmental disorder presentation, for example, ASD ($n = 2$), diagnosis of schizophrenia or established psychosis ($n = 1$) and psychosis symptoms occurring alongside maternal mental health issues ($n = 1$). In some cases, services reported exclusion was on a case-by-case basis, and they might provide consultation for another more appropriate service. Some services also reported inclusion criteria, such as functional decline as noted by clinical assessment ($n = 2$) or a *diagnosis* of psychosis (which would include functional decline; $n = 3$). In terms of flexibility on inclusion criteria, most services reported that there was some limited flexibility on a case-by-case basis for things, such as age ($n = 1$), duration of psychosis ($n = 1$), needing more assessment to complete a differential diagnosis ($n = 2$) and moving from a different region ($n = 1$). However, the client's residential area was reported to be inflexible by all services. Most services reported that there was a designated location area within their district that was served by the service, and people within the district (but outside this location area) such as in rural settings might only be served on a case-by-case basis due to resourcing limitations ($n = 5$). Only one service reported that everyone within their district was served.

Four out of the 12 services reported that they provide care for people at risk for psychosis, and 3 out of the 12 services reported limited services for people at risk for psychosis, including extended assessment to allow follow-up ($n = 2$), and treatment only if they meet the criteria for a diagnosis of psychosis ($n = 1$). Five services reported that no services are offered to people at risk for psychosis. Of those admitting people at risk for psychosis, the eligibility criteria differed. One used standard At-Risk Mental State (ARMS) criteria (Thompson, Marwaha, and Broome 2016), one reported their criteria was 'probable mild psychosis symptoms', one reported that the psychosis must be the primary issue in the persons presentation and the final service reported admission of people at risk was intended primarily for Māori clients.

3.2 | Characteristics of Services

Overall, the key elements of early psychosis care are provided by the majority of early psychosis services in New Zealand. As shown in Figure 2, nine services met at least 42% of the criteria for early psychosis services internationally, as defined by the FEPS scale. Table 2 presents how New Zealand services meet the international standards. Note that for treatment-related issues (rather than service-level issues), a service is marked as meeting the criteria if it occurs for more than 80% of cases. New Zealand services tended to meet the following standards: seeing clients within 2 weeks of referral (including following an inpatient stay), provision of case managers and comprehensive intake assessments, treatment for clients lasting at least 2 years and provision of a team leader and psychiatrist integrated within the early psychosis teams. However, there were also common gaps where services in New Zealand was not meeting the standard. As shown in Table 2, some of the elements of early psychosis care not provided included serving the entire spectrum of ages (12–65+), provision of cognitive-behavioural therapy (or other talking therapy), inclusion of families in care, provision of Clozapine for treatment resistance and admitting the majority of people prior to inpatient care.

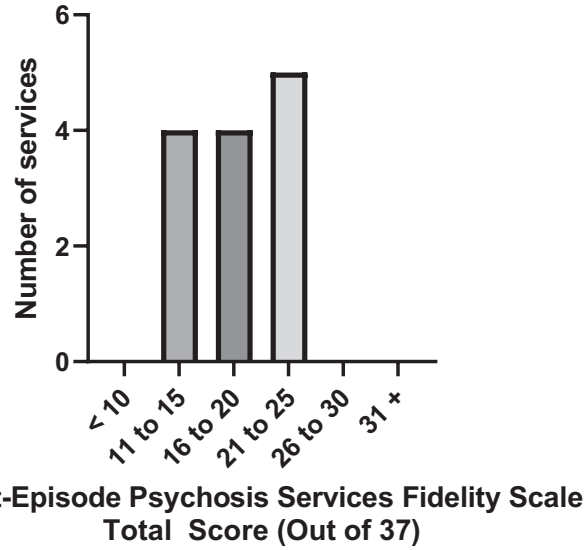


FIGURE 2 | Services total First Episode Psychosis Services Fidelity Scale scores (out of 37 on modified version).

Service leads were asked what model their early psychosis service is based on and the following were reported: Specialist standalone model ($n = 1$), EPPIC model ($n = 3$), combination of EPPIC and United Kingdom models ($n = 1$), te whānau hāpai pathway (a model prioritising connection with family and wider community; $n = 1$), recovery approach ($n = 1$), service specific model incorporating elements such as recovery approach, non-stigmatising environment and medication at lowest effective dose ($n = 1$), shared decision-making integrative model with team-based approach ($n = 1$), model not described ($n = 1$) and no service model used ($n = 2$).

3.3 | Cultural Elements Within Services

Service leads reported cultural services provided, as shown in Table 3, and barriers to addressing cultural needs at their services, including lack of any or enough cultural staff embedded in programme ($n = 7$), poor availability of cultural support for certain cultural groups, for example, Asian, Pasifika ($n = 3$), not enough cultural knowledge/confidence in staff members ($n = 2$), service model and/or manual does not account for cultural differences ($n = 2$), 'lack of resourcing' for specific cultural needs,

TABLE 2 | Services meeting the international standards of early psychosis care as measured by the First Episode Psychosis Services Fidelity Scale.

International standard of early psychosis care	Number of services fully meeting this element (% of total)
FEP programme serves patients for at least 2 years	12 (100.0%)
Patients admitted to the hospital are seen at the service within 2 weeks from discharge[a]	12 (100%)
Patients have assigned case manager[a]	12 (100%)
Team leader that provides more than admin	11 (91.7%)
Patients are seen within 2 weeks of referral[a]	11 (91.7%)
Comprehensive clinical assessments are completed[a]	11 (91.7%)
Team includes a psychiatrist who is an active team member and attends meetings	11 (91.7%)
At least 40% of the time of a designated team member is spent conducting proactive outreach	10 (83.3%)
All team members attend weekly meetings	10 (83.3%)
Patients receive antipsychotic medication dosing within guidelines[a]	9 (75.0%)
Team includes a clinical psychologist who is an active team member and attends meetings	8 (66.7%)
Service provides information to community/outreach	8 (66.7%)
Comprehensive needs assessments are completed[a]	8 (66.7%)
Patients receive prescription for antipsychotic medication if needed[a]	8 (66.7%)
Adequate communication between FEP and inpatient services including visit to patient on ward, involvement in discharge planning, family communication and outpatient appointment scheduled prior to discharge	8 (66.7%)
Target ratio of active patient to provider (i.e., team members) is 20:1	7 (58.3%)
Psychiatrist caseload is no more than 30 patients per 0.2 FTE	7 (58.3%)
Families are seen during care[a]	7 (58.3%)
Less than 10% of patients drop-out	6 (50.0%)
Patients participate in 12 sessions of psycho-education[a]	6 (50.0%)
Comprehensive annual assessments conducted[a]	6 (50.0%)
Team provides all gold standard early psychosis services[b]	5 (41.7%)
Patients are provided with a clinical treatment plan[a]	5 (41.7%)
Programme offers peer support	5 (41.7%)
Comprehensive services for substance use disorders are provided including routine assessment, addressed in psychoeducation, brief therapy and continuity of care to other needed services	5 (41.7%)
More than 90% population served meet admission criteria	5 (41.7%)
Team provides weekday drop-in crisis support plus 24/7 crisis support	3 (25.0%)
Comprehensive supported education is provided including a designated specialist	3 (25.0%)
Programme has and monitors quality standards	3 (25.0%)
Comprehensive supported employment is provided including a trained specialist	2 (16.7%)
Supportive health management is provided including weight monitoring, side effect monitoring and other health support, for example, quitting smoking	2 (16.7%)
Programme is informed by Māori worldviews and mental health models, te reo Māori is used regularly and clinicians are confident in these skills	2 (16.7%)
Programme serves the entire age spectrum from ages 14–65	1 (8.3%)

TABLE 2 | (Continued)

International standard of early psychosis care	Number of services fully meeting this element (% of total)
Less than 20% of patients receive inpatient care prior to FEPS admission	1 (8.3%)
More than 4% of patients with schizophrenia spectrum disorders are prescribed Clozapine if they do not respond to two courses of first line medications	1 (8.3%)
Families participate in an evidence-based family education and support programme[a]	1 (8.3%)
More than 60% patients received at least 10 sessions of cognitive behavioural therapy	0 (0.0%)

[a]At least 80% of cases meeting this criteria.
[b]It includes case management, health services, psychotherapy, substance use management, supported employment, family education, patient psychoeducation, pharmacotherapy and cultural support.

TABLE 3 | Cultural elements provided by each service.

Cultural service	Number of services providing this service
Cultural elements included in service model: 1. Te reo Māori regularly used 2. Māori models of mental health included in care 3. Māori worldviews considered 4. Clinicians confident in 1–3	8/12 included at least ¾ of these criteria
Kaupapa Māori service (designed by Māori for Māori)	2/12
Staff member within team who provides Māori cultural services	6/12
Cultural services accessible in or outside team	11/12

for example, socioeconomic issues ($n = 2$), 'lack of connection with cultural leaders or healers in the community' ($n = 1$), service set-up with a clinical feel ($n = 1$) and the 'resourcing to address cultural needs is not always seen as important' by internal staff and external stakeholders ($n = 1$).

4 | Discussion

This report provides a descriptive summary of all early psychosis services in New Zealand from November 2022 to November 2023. Services are provided for people across 11/20 districts in New Zealand, leaving 9 districts without dedicated early psychosis services. While the majority of the New Zealand population have access to early psychosis services (given the services are positioned in highly populated districts), people living in rural areas within these districts may not have access to the services, and people living in districts without dedicated services are not served. It was noted that areas where the Māori population is denser, often more rural areas such as the east coast of the North Island, are not well served. For example, the Bay of Plenty (approximate population of 309 000 of which 29% are Māori) has no early psychosis service (Stats New Zealand 2018). Of note, there were significant differences across services in inclusion and exclusion criteria for age, co-morbid difficulties, and history of psychosis symptoms or treatment. Many services did not provide care to people at risk for psychosis ($n = 5$), and as such there was a lack of an overall preventative approach to early psychosis care.

New Zealand early psychosis services are meeting the standard of care in many of the areas commonly identified as most important by senior early psychosis staff (Savill et al. 2019), including seeing clients within 2 weeks of referral (including after an inpatient stay), completing comprehensive initial assessments, assigning case managers and seeing clients for up to 2 years. Nearly all of the services had an involved team manager and a psychiatrist. Teams also mostly had weekly meetings, were prescribing within guidelines, had good communication with inpatient services, were providing outreach, and 8/12 had clinical psychologists. However, there were some clear weaknesses of the New Zealand services, including limited provision of cognitive-behavioural therapy, serving limited age ranges, not seeing people before they required an inpatient stay, not prescribing Clozapine to non-responders and limited family participation. These elements of care, where nearly all services were not meeting international standards, may reflect a lack of resourcing (e.g., they are not resourced to see people across the age range). The lack of therapy provision and family involvement may reflect a lack of resourcing, for example, clinical psychology time, opportunities for non-psychology staff to train in cognitive-behavioural therapy, or may reflect the composition of teams following more medical models of care. Interestingly, in two areas New Zealand services were falling behind in terms of early intervention. Most services were not offering comprehensive care to people who are at risk for psychosis, and most services were not meeting the guideline for seeing people prior to inpatient stays (i.e., not seeing people before their symptoms are so severe that they require hospital care). This seems to be a key focus for future development. The lack of prescribing Clozapine to non-responders has been previously described in New Zealand (Dey et al. 2016). This could be related to challenges in accessing resources needed to initiate Clozapine safely in the community (e.g., nurse time taking observations and ensuring daily adherence to medication) or as an inpatient (e.g., accessing an inpatient bed for a non-acute reason).

Compared to other international locations that have similarly evaluated their services (California and Canada), the types of care offered appeared similar, such as case management, health services, pharmacology, evidence-based therapy, supported employment and outreach (Niendam et al. 2019; Nolin et al. 2016). The Californian services appeared to be stronger

than the New Zealand services on elements such as involving family and providing therapy services but were not as strong as the New Zealand services at elements such as providing comprehensive intake assessments, providing medication within guidelines, and providing care for at least 2 years (Niendam et al. 2019). Canadian services reported a similar range of age limits on their services to New Zealand, but more services offered care past the 2-year mark (Nolin et al. 2016), and more services offered care to people with substance-induced psychosis. Both the California services and Canadian services appeared to have better data collection and quality monitoring than the New Zealand services where only 3 services reported monitoring quality (Niendam et al. 2019; Nolin et al. 2016). A lower percentage of the New Zealand services care for people at risk for psychosis than California services where 22 out of 29 see people at risk (Niendam et al. 2019), but more New Zealand services offered care for those at risk than Canada, where only 3 out of 11 early psychosis services offered care to people at risk. Cultural services across the Californian and Canadian services were not discussed in these papers, and only New Zealand services reported dedicated workers for addressing cultural needs.

Recent reports from New Zealand have shown that the organisational culture within early psychosis providers continues to impact Māori through systemic racism (Manuel et al. 2023), indicating work still needs to be done to achieve equity in early psychosis care. Our data support this finding in several ways. Firstly, services did not appear to measure up to the 1999 New Zealand early psychosis guiding document. Cultural support staff were lacking across services, and consistency in care provision with specific reference to Māori values and models of health is still needed. Other cultural models of health were similarly unaddressed, for the most part, with few services discussing cultural supports for groups other than Māori. This may reflect a lack of resourcing and availability of clinicians, but it may also reflect a lack of early psychosis care models developed from differing cultural perspectives, resulting in uncertainty for staff. Internationally, low levels of implementation of processes related to cultural diversity are evident (Jones et al. 2021). In Australia, a consultation process with Indigenous mental health workers indicated Indigenous subteams integrated within mental health services appeared to improve engagement, and an option for early psychosis could be to deliver early psychosis care through such teams (Catts et al. 2013). This proposal is yet to be examined for effectiveness. Together, this indicates a need to develop evidence-based early psychosis care that accounts for cultural diversity, and in New Zealand, this requires a particular focus on Māori early psychosis needs.

This study is a descriptive assessment of the early psychosis services in New Zealand and is based on survey data reported by service lead staff. Thus, findings are subjective and contingent on the accuracy of these reports. Future research could strengthen this evaluation by assessing services directly using independent evaluators in collaboration with Māori community members. Participants may have wanted to report particularly favourable or unfavourable outcomes in order to access certain outcomes, for example, resourcing, and so some bias may be present. Findings reflect service usage and not early psychosis needs in New Zealand more broadly. However, this is the first examination of these services in over 20 years, and important data that can inform decision making about ongoing changes to services.

Overall, this summary of the early psychosis services provided across New Zealand has several important implications, and we have included suggested next steps for New Zealand early psychosis care. New Zealand has unique sociocultural needs that cannot be accounted for by international early psychosis models, and specific models of care that account for indigenous perspectives of psychosis are needed. Furthermore, there is a clear lack of consistency across early psychosis services including across inclusion and exclusion criteria, ages accepted into programmes, quality and breadth of care provided and early psychosis models applied. While some flexibility across services appears helpful for addressing local needs (e.g., Kaupapa Māori services based in areas with high Māori populations), other differences will simply be resulting in disparities and confusion for referring bodies and people using the services. There are clear groups of underserved populations. Firstly, those in rural or less populated areas have no access to early psychosis care. This appeared to be linked with a lack of resourcing. Secondly, people at high risk for early psychosis are often ineligible for services, which goes against the EPPIC model (McGorry et al. 1996), and means the 'early' part of early psychosis care is significantly lacking in New Zealand. This is evidenced by the majority of services not meeting standards for low numbers of referrals coming through inpatient settings and does not fit with the New Zealand Ministry of Health's priority for early intervention (Ministry of Health 2021). Suggested next steps include (1) Develop standardised early psychosis guidelines specific to New Zealand, such as is provided in Australia (Early Psychosis Guidelines Writing Group and EPPIC National Support Program 2016) and services should be supported to meet such guidelines through increased resourcing, (2) the development of indigenous early intervention for psychosis models alongside increased cultural support for treatment teams, to support the reduction of the ongoing impacts of systemic racism on Māori mental health and (3) expansion of services to serve rural areas and to those at risk for psychosis.

In summary, New Zealand early psychosis services are providing good services in the early psychosis space, however, like other countries, certain challenges such as resource allocation and lack of consistency means our services do not meet all standards. There are several areas that need to be addressed, and the upcoming reform of the New Zealand health system may be an opportune time to do so. We are not yet adequately addressing cultural needs in early psychosis, and while this is an international issue, New Zealand has the opportunity to be a leader in this space, by developing early psychosis models in consultation with Māori and other cultural groups, to improve care for all.

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Conflicts of Interest

Dr. Rebecca E. Grattan and Dr. Joanna Cowland are both members of the New Zealand Early Intervention in Psychosis Society, and the members of this group supported the authors with participant recruitment. The other authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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