

Community Mental Health Care in Aotearoa New Zealand: Past, Present, and the Road Ahead

Организация амбулаторной психиатрической службы в Новой Зеландии: прошлое, настоящее и будущее

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Short communication

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ABSTRACT

The healthcare system in Aotearoa New Zealand is currently undergoing a far-reaching overhaul. When it comes to mental health reforms, it is helpful to look at the road ahead, while paying attention to the road behind. Policies and services concerning the mental health and addiction sectors have undergone various reforms; first, during the transition from a hospital-centered to the current community-based system, and second, in the successive attempts to improve this system. In this article, we provide an overview of the current mental health and addiction health care system. We also discuss the impact of colonization on community mental health, the emergence of community-based mental health and addiction policy and services in Aotearoa New Zealand, and the challenges along the way. Finally, we identify five key areas requiring special attention during the current period of reform. Over all, we believe there is broad support for reducing the emphasis on individualized approaches to mental wellbeing and moving all systems and structures towards models inclusive of social context, including approaches that incorporate service users' perspectives, family, communities, and culture. We look forward to policy and services with a much stronger orientation to the diverse needs of our population.

АННОТАЦИЯ

Существующая система здравоохранения Новой Зеландии (маори. *Aotearoa*) переживает период значительных изменений. Реформация сферы охраны психического здоровья требует прогнозирования, оценки перспектив и накопленного опыта. Принципы оказания помощи в области психиатрии и наркологии и услуги в этой сфере претерпели ряд реформ: первая была связана с переходом от стационарной системы психиатрической помощи к амбулаторной, вторая — с последовательными попытками улучшения амбулаторной помощи. В данной статье мы представили обзор современной системы здравоохранения в области психиатрии и наркологии. Также в формате дискуссии мы обсудили влияние колониального исторического прошлого на психическое здоровье населения, появление психиатрической и наркологической амбулаторной службы в Новой Зеландии, а также проблемы на пути становления этих служб. Мы выделили пять ключевых областей, которые требуют пристального внимания в ходе текущего реформирования системы амбулаторной помощи. Была выявлена тенденция к уменьшению значимости индивидуализированных подходов к психическому благополучию, все системы и структуры должны учитывать социальный контекст, потребности людей, которым оказывается помощь, роль семьи пациента и его сообщества, культурную составляющую. Мы надеемся, что в будущем принципы оказания помощи и службы охраны психического здоровья Новой Зеландии будут в значительной степени ориентированы на разнообразие потребностей местного населения.

Keywords: *mental health; Aotearoa; New Zealand; community health services; community mental health care; deinstitutionalization*

Ключевые слова: *психическое здоровье; Аотеароа; Новая Зеландия; службы общественного здравоохранения; амбулаторная психиатрическая служба; деинституционализация*

INTRODUCTION

A relatively remote island nation situated in the southwestern Pacific Ocean, geographically, Aotearoa New Zealand (from here on Aotearoa NZ) encompasses two main landmasses, with a combined total mass of about 268,021 km. These landmasses refer to the North Island, or Te Ika-a-Māui (the fish of Maui), and the South Island, or Te Waipounamu (the water[s] of greenstone) — as well as many smaller surrounding islands. Aotearoa NZ has an estimated resident population of five million people, with most New Zealanders concentrated in rapidly expanding urban centers on both main islands. This growing population includes people of Māori (16.5%) (the Indigenous people of Aotearoa NZ), European (70.2%), Asian (15.1%), and Pacific (8.1%) descent, as well as other ethnicities, such as Middle Eastern, Latin American, and African (MELAA) [1].

The healthcare system in Aotearoa NZ is currently under a large-scale reform effort, with the development of Te Whatu Ora — Health New Zealand, a newly developed overarching organization responsible for the national health service. At the same time, a recently published in-depth and independent Inquiry into Mental Health and Addiction, *He Ara Oranga* [2], has put forward 40 recommendations that will require significant changes in the system if it is to respond effectively to the country's needs. The impact of these reforms is yet to be seen. However, when it comes to mental health reforms, it is helpful to look at the road ahead, while paying attention to the road behind [3, 4]. This includes paying particular attention to the ongoing impact of colonization and the various health reforms the country has faced in the past. To help with this goal, the aim of this paper is to provide an overview of the country's historical transition from an institutional model to a community-based mental health care model, discussing challenges along the way, and key areas to pay attention to on the road ahead.

Our paper is structured as follows: In the following section, we begin with a discussion of Aotearoa NZ's colonial history as a precursor to the disruption of

community mental health, particularly for Māori. Next, we offer a brief overview of the mental health system in the country. This is followed by a description of, first, the policy landscape, and, second, mental health and addiction services, including details from Aotearoa NZ's early mental health provision to contemporary efforts to respond to our diverse communities' needs. Finally, we discuss the road ahead, suggesting key areas requiring substantial change moving forward.

COLONIZATION AS A DISRUPTION TO COMMUNITY MENTAL HEALTH

By the 1790s, Europeans had begun to settle in earnest in Aotearoa NZ. Initially, they were highly dependent on Māori goodwill and economic and social support [5]. In 1840, the Treaty of Waitangi (English version) and Te Tiriti o Waitangi (Māori version) were signed between the British Crown and several tribal leaders and these are considered the country's founding documents. These were documents that “had the potential to deliver benefits to all parties” [6]. This was unique, as even at the height of British imperialism, fueled primarily by greed and pseudo-scientific racism [7, 8], the colonial government could not dismiss Indigenous claims for political recognition [9]. While the development of Aotearoa NZ as a bicultural nation-state would appear to be firmly grounded in egalitarian values, historical and ongoing colonial processes posit that this is not always so in practice.

The settler government quickly imposed British notions of title and ownership. The resulting land alienation and the confiscation of land and resources from Māori who resisted meant that by the mid-1800s the Crown and the New Zealand Company had obtained nearly 99 percent of the South Island and 20 percent of the North Island [6, 10]. With colonialism came urbanization, displacement, disease, war, death, and knowledge suppression, resulting in the degradation of Māori kinship systems, economic capacity, culture, and spiritual connectedness [11]. In contemporary Aotearoa NZ, histories of domination and repression carry grave consequences for the mental

health and wellbeing of Māori [12]. As such, Māori live with constant reminders of the ongoing impacts of colonization in terms of the disproportionate rates of suicide, domestic violence, homicide, substance abuse, and addiction, incarceration, hospitalization, children taken into state care, mental illness, homelessness, and ill health in comparison to Aotearoa NZ's settler society [13].

In the framework of the Te Tiriti o Waitangi, the Crown is required to provide services that meet the needs of Māori. For example, the Ministry of Health, as a department of public service, has a responsibility to meet its obligations under Te Tiriti o Waitangi. This means that Māori service users and providers need to be included in the research, definition, planning, implementation, and evaluation of mental health services to ensure they are informed by Māori values. Further, kaupapa Māori service providers (holistic and humanistic approaches embedded within Māori cultural practices) are best able to provide support for those Māori with mental health and addiction issues. Government agencies and many non-Māori service providers are frequently not well equipped to offer a culturally dynamic service due to an undersupply of speakers of te Reo Māori, staff trained in bicultural protocols, and referral processes that allow for working constructively with Māori service providers. Although colonial structural intrusions have posed significant challenges to Māori wellness, it is important to note that Māori are not, and never have been, passive in the face of socio-political upheavals [14]. Claims to, and the affirmation of, cultural identities and Indigenous mental health practices by Indigenous peoples are common responses to such histories of oppression and offer authenticity, a sense of belonging, and the basis for gaining human rights [15, 16].

THE MENTAL HEALTH SYSTEM OF AOTEAROA NEW ZEALAND

In Aotearoa NZ, the health system is primarily funded by the central government via the Ministry of Health. The country's total health and disability expenditure is about 9.5% of the gross domestic product (GDP), and taxpayers fund most of this health expenditure, about 7% of GDP [17]. Until July 2022, the Ministry of Health funded 20 District Health Boards (DHBs), which were local systems responsible for planning, funding, and overseeing care for their population. Each DHB funds public hospitals, primary health organizations, and

community-based services. The system is currently under reform, and in July 2022, all twenty DHBs merged their functions into one large agency, Te Whatu Ora — Health New Zealand, which now oversees the whole country.

Nearly all hospitals and specialty healthcare services are free for residents at the entry point. Although funded by the DHBs, primary health care services sit outside them and include general practitioners, private practitioners, and various non-governmental organizations. The country also has a national Accident Compensation (ACC) scheme, which covers most costs from treatment and rehabilitation resulting from accidents for both residents and visitors. Still, over a third of New Zealanders also have some form of private health insurance, mainly for elective and specialist services, as they provide only non-urgent services [18]. The mental health system in Aotearoa NZ, up until recently, included services within DHBs and outside of them. Each DHB oversaw tertiary and secondary services, such as inpatient services and community mental health services. In the mid-90s, a 'ring fence' was introduced around mental health and addiction funding to prevent this funding from being reallocated to other service areas.

Mental health and addiction services in Aotearoa NZ are largely community-based. Community mental health and addiction services are set up to provide care for those with moderate-severe or high-risk mental health needs. People accessing these services are normally referred to them by primary care providers. However, most of the population with mental health and addiction issues, those with mild-moderate needs, are seen by primary care services for which people are charged a fee. Depending on the DHB, mental health services also include special programs, such as early psychosis intervention teams, mental health crisis teams, child and youth mental health services, older adults services, medical detoxification services, opioid treatment services, Pacific mental health, and Māori mental health and addictions services. A more recent development in the system includes the funding of Health Improvement Practitioners (HIP) who are placed in primary care services to respond to mild-to-moderate mental health and addiction concerns. In hospital settings, particularly in the larger hospitals, mental health liaison teams provide mental health support across the hospital.

The mental health and addiction sector comprises a clinical and a non-clinical workforce, plus the administration and management team [19]. The clinical workforce includes

medical professionals, nursing, and allied health workers, such as social workers, addiction practitioners, and co-existing problems clinicians. The non-clinical workforce includes support workers, such as residential support workers, peer workers, and family support workers, and cultural advice and support, such as Māori health practitioners and Pasifika cultural advisors. The District Health Board's workforce is largely made up of people in clinical roles (about 77%), while non-government services are primarily non-clinical staff and mainly support workers (about 60%) [19]. In the country, per 100,000 population, there is an average of 8.66 psychiatrists, 9.62 psychologists, 11.86 other specialized mental health workers, and 71.59 mental health nurses [20]. The majority of this workforce work in community-based services linked to small inpatient units within general hospitals.

Mental health policies

Throughout the years, various mental health policies have informed mental health care in Aotearoa NZ. From the beginning, these various legislations provided alternatives to hospitalized institutional care — although these alternatives were not widely enacted at first. The *Lunatics Ordinance* of 1846 was the country's first mental health legislation. The Ordinance set a framework where a person with a certified mental illness would be incarcerated or sent to a public hospital. As such, this legislation prioritized seclusion over care and support, providing an impetus for the development of asylums [21]. The legislation also allowed relatives and friends to care for the person in mental distress, albeit following the approval granted by a Judge or two Justices of the Peace that the person was a 'peaceful' individual [22].

Numerous asylums were developed during the 1860s and 1870s. Around the same time, the country adopted a more comprehensive mental health legislation, the 1868 *Lunatics Act*. This legislation made further provisions for the care of people with mental illness outside these institutions. Among these additional provisions were the "licensed houses." These houses, overseen by a medical practitioner, could accommodate up to, and in some cases more than, 100 patients. But, the rapid development of the asylums, and reports of poor standards of care in them (further discussed below), led to the development of a Lunatics Asylum Department in 1876. This department was set up to oversee the functioning of these institutions

at a national level. These changes in legislation also rooted an institutional system in mental health care, and by 1886 most people categorized as lunatics at the time were secluded in asylums [23].

The 1911 *Mental Defectives Act* placed further emphasis on the role of healthcare providers, particularly medical practitioners, in mental health. As such, it represented a shift from containment to care in mental health legislation. It also allowed voluntary admissions for the first time [24]. Still, the asylums were overwhelmed by a continuously growing number of secluded patients, including large groups of institutionally aging patients [23]. It was the 1969 *Mental Health Act* that legally ratified the shift toward deinstitutionalization and community care. It also formed the basis of the following mental health legislation, including the Mental Health Act of 1992, which redefined mental illness and put further emphasis on patients' rights.

In 1994, the country adopted a National Mental Health Strategy titled *Looking Forward* [25] and a ministerial committee was developed to monitor its implementation. *Looking Forward* provided five strategic directions to a developing mental health system. These strategic directions included developing community-based and comprehensive mental health services, designing services appropriate to Māori needs, ensuring Māori involvement in the planning of services, increasing the quality of care, balancing individual rights and public protection, and developing a national alcohol and drugs policy. The Mental Health Commission, established in 1996 to replace the ministerial committee, monitored the implementation of the National Mental Health Strategy. As part of their role, the Commission published the *Blueprint for Mental Health Services in New Zealand: How things need to be* [26]. The Blueprint called for adopting a recovery approach in all mental health services. It provided guidance about the importance of meeting people's needs, how to do it, and who should do it — discussing the type of workforce required.

In 1997, a new strategy called *Moving Forward* was adopted [27]. The new strategy was built on the previous one. Amongst the seven strategic directions it presented, the need for more and better health services and strengthened promotion and prevention were included. In 2012, the Mental Health Commission published its *Blueprint II* [28], which adopted people-centeredness and people-directed recovery and resiliency as its core values, supporting various mental health and addiction

reforms. Despite these growing efforts to strengthen the nation-wide adopted transition to community-based mental health care, it became increasingly evident that mental health services were not delivered adequately. In the 2010s, this situation became even more glaring. Mental health statistics highlighted ongoing high suicide rates, poor access to services (particularly for Māori, Pacific, LGBTIQ+ and rural communities), a lack of services for mild-to-moderate mental health concerns, and treatment approaches that were not responsive to family needs, culture, and context.

Something needed to change, and in 2017 the Government ordered a Royal Commission inquiry that eventuated in the *He Ara Oranga* report [2]. This report provided many recommendations for change that emphasized greater inclusion of service users, Māori and Pacific models, and community and family-oriented approaches. In 2020, a newly constituted Mental Health and Wellbeing Commission was set up and is currently in the process of developing frameworks for implementing these recommendations.

The following two sections provide a brief overview of key phases and milestones in the emergence of mental health and addiction services in Aotearoa NZ. This overview will focus first on mental health services and then on the parallel development of addiction services.

Mental health services

The first large-scale investment into mental health services was the construction of large psychiatric hospitals (initially termed “Asylums for the Mentally Insane”). They included Karori (near Wellington 1854), Dunedin and Sunnyside (near Christchurch 1863), the Whau (Auckland, later Carrington Hospital 1867), Seaview, Hokitika (1872), Nelson (1876) Seacliff (near Dunedin 1879) and Porirua (near Wellington 1887) [29]. These psychiatric hospitals were mainly sited outside major population centers, in the countryside. The majority of service users were compulsorily admitted under the *Lunatics Ordinance 1846* and the *Mental Defectives Act 1911*, and the use of coercive forms of restraint, such as seclusion and straitjackets, were commonplace. By the 1930s, new forms of treatment were introduced that included the use of insulin coma, prefrontal leucotomy, and electroconvulsive therapy (ECT). From the mid-1950s, new psychotropic drugs became available and hospital admissions moved from

22% voluntary in 1939 to 71% voluntary by 1964 [29]. The increasing voluntary admissions placed more emphasis on the therapeutic value of hospital care.

During the late 1960s, the need for large psychiatric hospitals was being questioned. Criticisms arose due to, on the one hand, the extent to which the institutionalization of service users was leading to increasing numbers of permanent residents, and on the other hand, the introduction of improved psychiatric medication, which made control and confinement less ‘necessary’. However, institutionalization was not the only concern. The use of coercive treatment methods was being challenged from a human rights perspective. Also, people expressed uneasiness with accounts of neglect and physical, emotional, and sexual abuse.

The full extent of the abuse did not become apparent until many years later. In 2001, former judge Rodney Gallen conducted an inquiry into abuse at Lake Alice Hospital that prompted a Government apology and the establishment of a “Confidential Forum,” to which, between 2005 and 2007, 493 people reported their experiences of abuse [30]. In subsequent years this contributed to a string of individual citizens taking court action, insisting on the Government’s responsibility for the abuse. However, the most revealing process has been a Royal Commission of Inquiry into *Abuse in Care*, an ongoing series of investigations into in-state and church institutions, with over two thousand people sharing their stories of abuse [31].

During the 1970s and 1980s, a process of reform sought the closure of the large psychiatric hospitals and their replacement with community care [32, 33]. This was a long process that required the placement of institutionalized service users into alternative locations and the development of services in the community. These initially consisted of a network of boarding houses and the setting up of community mental health centers in suburban areas. Also, during this time, the mental health workforce began to diversify, with social workers, occupational therapists, and psychologists developing specialist pathways. Alongside these developments was the emergence of new roles in initiatives seeking to advance employment opportunities and supportive accommodation. These changes were further supported by non-governmental organizations (NGO) such as the Schizophrenia Fellowship (formed 1977) and Mental Health Foundation (formed 1977).

However, progress was hampered because successive governments failed to invest adequately in the realization of a community approach. This contributed to poor quality of life for service users and the tendency for community mental health centers to function more as psychiatric wards placed in the community rather than genuinely community-oriented organizations [34]. The practices of psychiatry and psychiatric nursing still dominated services, and the diversifying workforce tended to be relegated to support roles.

During the 1990s, the service landscape changed in more fundamental ways due to the influence of three important social movements that emerged outside mainstream services. First, there was a clearer articulation of *kaupapa Māori* (Indigenous approaches) to mental wellbeing. Second, there was the development of *recovery approaches* and the strengthening of service user voice. Third, there was the application of public health approaches chiefly in the form of *mental health promotion*. The following briefly summarizes each of these in turn.

Kaupapa Māori approaches to Māori mental health gathered momentum in the wake of work by prominent Māori psychiatrist Mason Durie, which articulated a holistic understanding of wellbeing based on the interaction between *taha tinana* (physical wellbeing), *taha hinengaro* (mental wellbeing), *taha whānau* (family and social wellbeing), and *taha wairua* (spiritual wellbeing) [35, 36]. His work and the work of other Māori scholars demanded the development of services that adopted Māori cultural principles and practices, as well as developing systems for evaluation [37].

Recovery approaches took off in response to three inquiries in the late 1980s and early 90s into mental health services led by Judge Ken Mason, resulting in the controversial *Mason Reports* [38, 39]. The reports identified a wide range of ways in which service users had been poorly served and recommended wide-range reforms, including the appointment of a mental health commissioner to oversee the changes. In 1996, the Mental Health Commission was established, and it set to work in compiling its *Blueprint I* [26] (see above), in which they advocated for improving resources for people with serious mental health concerns and stronger participation of those with lived experience of mental illness in the planning and delivery of services [40]. By the 2000s, service users were finding a voice in articles, books, the media, and their own forums [41, 42],

and the Commission became a key advocate for the incorporation of recovery approaches into services and a shift in emphasis to people pursuing quality of life with mental illness rather than letting mental illness define them [43].

Mental health promotion focuses on ways of promoting wellbeing and reducing psychological distress through applying health-promotion principles of community empowerment and community capacity building [44]. The Ministry of Health outlined a range of potential approaches in *Building on Strengths* [45]. Unfortunately, no funding was allocated to develop this further, but, despite this, some initiatives did manage to get off the ground. One example of a successful approach is the *Like Minds, Like Mine* campaign, launched in 1997 and involving a series of public awareness campaigns aimed at destigmatizing people with mental health concerns [46]. Those participating in the campaign included service users, national leaders, and media personalities. Another approach, with an addiction focus, involved the setting-up of a network of initiatives on Community Action on Youth and Drugs (CAYAD). These projects use health promotion principles in engaging communities in reducing alcohol and drug-related harm [47]. Each community interprets this mission in its own way, and while, initially, projects occurred in only a few sites, there are now over twenty communities in which CAYADs are taking place.

Addiction Services

Addiction services have followed a separate trajectory that has, at times, converged on and, at other times, has diverged away from how mental health services have evolved. Following the Second World War, the first major services took the form of twelve-step self-help groups championed by Alcoholics Anonymous (AA). This approach, developed in the United States, led to the spreading-out of a network of regular local meetings providing assistance to those with addiction issues (through AA and Narcotics Anonymous (NA)) and affected families (through AlAnon and NarAnon). As a grassroots movement, it generated public interest in improving responses to addiction. This then contributed to the setting-up of twelve-step residential programs attached to hospital services (such as Wolfe Home at Auckland's Carrington Hospital and Canterbury's Queen Mary's Hospital at Hamner Springs). The Salvation Army, which had been providing care services for alcoholism since

1907, also set up their residential “Bridge Programs” along similar lines [48]. In 1954, the National Society on Alcoholism (later the National Society for Alcohol and Drugs, NSAD) was founded. It was responsible for a number of innovations, including, in 1972, setting up the first methadone clinics in Wellington and Christchurch, and founding community-oriented treatment programs at Plimmerton and Featherstone (later to become part of Care NZ).

During the 1970s, the closure of large psychiatric hospitals contributed to the unwinding of hospital-based residential services for addiction. These programs then shifted across to community NGOs such as Odyssey Trust and CareNZ. Hospitals chose to concentrate their efforts on shorter-term counseling approaches offered by a network of community alcohol and drug services (CADS). While this was happening, public and Government interest in addiction services were on the rise and discussions began about setting up a peak agency to oversee developments. Services at that time were anticipating this agency would take primarily a treatment approach. To their surprise, in 1976, the Government passed an Act that established the Alcohol Liquor Advisory Council (ALAC), funded by a levy on alcohol consumption and with a primary focus on public health and harm reduction approaches to addiction-related harm. ALAC became a key agency in the 1980s and 90s in fostering a range of innovative approaches that included brief intervention in primary care, social marketing campaigns, workplace innovations, and host responsibility. However, during the 2000s, concerns were raised regarding the influence of the alcohol industry on ALAC [49, 50] and in 2012 ALAC was absorbed into the newly formed Health Promotion Agency [51]. Also, alongside these agencies, the Drug Foundation has played a major role in improvements to both alcohol and other drug legislation.

During the 1990s, gambling legislation was liberalized, leading to the widespread availability of gambling in the form of electronic gambling machines and casinos. The subsequent rise in consumption led to rapid increases in gambling harm, including poverty impacts and the debilitating effects of problem gambling on individuals and families [52]. The 2003 *Gambling Act* only partially addressed the broader issues of availability, leading to a consolidation of gambling harm [53]. Service responses to this have consisted of public health

and individual service initiatives, with an emphasis in more recent years on integrating gambling into addiction services.

The relationship between addiction and mental health services has been a mixed bag. In some ways, the needs are similar, but under the banner of “mental health and addictions,” a number of agencies, including the Mental Health Commission, the Ministry of Health, and many hospital organizations, have paid scant attention to appropriate approaches to addiction and have more often transplanted mental health approaches onto the field [54]. For example, *Blueprint 1* focused attention on the top three percent of people with serious mental illness [26], and in the process, the addiction field’s focus on primary health languished from both a lack of interest and a lack of funding. Interestingly, one of the main recommendations from the Mental Health Inquiry (discussed below) was for reform of alcohol legislation. However, this is one of the two-out of the forty- recommendations that the Government has chosen not to act on.

THE ROAD AHEAD

The in-depth inquiry into mental health mentioned earlier, *He Ara Oranga* [2], identified widespread acceptance that the mental health system was failing to achieve its goals and that what is needed is a radical re-orientation of how the system operates. In 2021 the newly constituted Mental Health and Wellbeing Commission was charged and resourced to begin this process of re-orientation. Overall, there is broad support for reducing the emphasis on individualized approaches to mental wellbeing and moving all systems and structures towards models inclusive of social context, including approaches that incorporate family, communities, culture, and the needs of the broader society. Breaking this down, we interpret this as requiring substantial changes in the following key areas:

The first area where work is already underway is increasing Māori (Indigenous) participation in planning for all services and the incorporation of Māori models of care across the board. As it was mentioned above, Māori service users and providers need to be included in the development and evaluation of mental health services to ensure they are informed by Māori values and culturally safe.

The second major area of change concerns the recognition of the need for service users to have a stronger

say in design, implementation, and evaluation throughout the system. Lived experience perspectives need to be integrated throughout services both in hospitals and in the community, coupled with improved support services for long-term recovery.

The third area, which is related to the second area, concerns the scaling-down and, in some cases, the elimination of coercive practices such as the use of seclusion, restraints, and compulsory treatment orders. Changes here will require repeal and replacement of the Mental Health Act and rethinking of the relationship between mental health and the law.

The fourth area concerns incorporating both public health and primary health approaches into existing systems. This will require investment in innovative programs involving the application of mental health promotion principles in neighborhood and community contexts. Some changes are already underway in primary health, with the funding of health improvement professionals (HIP) who deliver services for those with mild-to-moderate mental health issues turning up in general practices. For addiction services, this also means further expansion of screening, brief intervention, and referral to treatment (SBIRT) approaches.

The fifth area relates specifically to addictions and calls for urgent legislative reform regarding tobacco, alcohol, gambling, and illicit drugs: for alcohol, the focus is on price reforms and reduced availability; for gambling, it is on reduced availability and product modifications; and, for illicit drugs, it is on moving away from approaches that criminalize users and towards health-oriented harm-reduction approaches.

The road ahead for all five of these key areas will call on a workforce that is capable of supporting the reorientation. This will mean improving the current workforce in areas such as cultural safety, particularly as it relates to Māori, Pasifika, and Asian populations, as well as a sound knowledge of cultural and recovery models. The changes will also require a workforce capable of working appropriately in both public health and primary health, as well as developing new roles in service user support services and family and community initiatives. The Government's 2019 Budget committed NZ\$1.9 billion (US\$1.2 billion) to improve mental health and addiction services. This, along with additional funds in subsequent budgets, is a big commitment for the country. Nevertheless, there is optimism in the sector that

services will be successfully re-oriented to better respond to the diverse mental health needs of the population.

CONCLUSION

Aotearoa NZ has a relatively long history of providing community-based mental health care. During that time, policies and services concerning the mental health and addiction sectors have undergone a variety of reforms. However, it is obvious to everyone involved that more changes are required, and that we are now entering a period of significant reform. In this paper, we have provided an historical overview of the emergence of and changes in mental health and addiction policies and services. We have also identified the key challenges for delivering community-based services and some of the priorities ahead. After the disruptions from COVID-19 settle, we are looking forward to policy and services with a much stronger orientation to the diverse needs of our population.

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