Mental health services

by Warwick Brunton

Around 47% of New Zealanders are likely to experience some form of mental illness during their lives. New Zealand's first lunatic asylum opened in 1854, and for nearly 130 years most mentally ill people were looked after in special-purpose residential institutions. In the 21st century most people suffering from mental illness are cared for in the community.

Mental health and mental illness

Mental health is a process that enables people to realise their abilities, deal with life's challenges and stresses, enjoy life, work productively and contribute to their communities. Mental health is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, personal dignity and diversity. Mental health also refers euphemistically to mental problems, illnesses or disorders and services for treating them.

Mental health problems are psychological or emotional reactions that may lead temporarily to unusual behaviour but do not interrupt established routines and activities.

A mental illness or disorder is more serious and involves medically diagnosed conditions. Its symptoms may include hallucinations (a sense of something that does not exist), delusions (firm but false beliefs), highly inappropriate or violent behaviour, sadness, depression, anxiety, addiction or suicide attempts.

Types of mental illness

Mental illness includes mood disorders like bipolar, depressive or anxiety disorders, cognitive (reasoning) disorders, personality disorders, schizophrenia and other psychotic disorders, eating disorders and substance-related disorders.

Rates of mental illness

Mental illness is extremely common. In any 12-month period, more than 20% of people in New Zealand are likely to experience some form of mental illness; 47% of New Zealanders are likely to experience a form of mental illness at some point in their lives. The Dunedin longitudinal study suggests an even higher lifetime

prevalence, given that 83% of the cohort had experienced mental illness and/or addiction by age 38.

Suicide is a significant health challenge. In 2011 New Zealand's male and female suicide rates were around the middle of the range for OECD countries, but both youth rates were second-highest. Increased risk of suicide is often linked with mental illness. Serious mental disorders and risk of suicide are most common among people who have few educational qualifications or low household incomes. Often they are Māori or Pasifika, females, younger people, urban dwellers or people with an existing mental disorder. Gay, lesbian, bisexual, transgender, queer and intersex people experience higher levels of mental health distress, and are at more risk of suicide, than the heterosexual population. Anxiety disorders, major depression and eating disorders are more common among women. Substance-use disorders (such as alcohol and drug addictions) are more common among men. People with experience of mental illness make up 35% of those on the sickness benefit, and 27% of those on the invalid's benefit.

Beliefs about mental illness

In all eras and cultures people have explained mental health and illness in their own way. Mental illness has been explained in terms of supernatural, natural, biological or psychological causes. In pre-colonial times Māori held a supernatural view and distinguished between the insane (pōrangi, pōrewarewa, haurangi, pōtētē), the demented (wairangi, karearea), the intellectually disabled (karakiraki, pororirori) and people who were possessed by spirits (apa, mate kikokiko).

In contemporary western society mental illness is believed to be influenced by a combination of biological, psychological and social factors.

Mental health and the law

Every year in New Zealand about 4,000 people are committed to treatment under compulsory-detention, assessment and treatment orders on the grounds of mental disorder. Balancing the liberty, safety and welfare of these individuals and their families, their caregivers and the public calls for complex medical and legal decisions.

Mental health of prisoners

Those sentenced to prison have higher rates of substance abuse and other forms of mental illness than the general population. While they are not imprisoned because they are mentally ill, their high levels of drug dependency, traumatic brain injury, fetal alcohol syndrome and other mental health conditions may contribute to the behaviours that result in the imprisonment. A survey of prisoners in 2015 indicated that 62% of respondents had been diagnosed with a mental health or substance abuse disorder in the last 12 months. They were three times more likely to be

diagnosed with a mental health disorder in the preceding year than the general population. This research prompted the allocation of more resources to mental health services for those in New Zealand prisons.

Lunatic asylums, 1840s to 1900s

In early colonial New Zealand the authorities tried to respond in a practical way to mentally ill people (known at that time as 'lunatics') who threatened public safety, could not look after themselves or had no one to care for them.

The earliest home for lunatics in New Zealand was a wooden building attached to the Wellington gaol in 1844' a similar facility opened at Auckland gaol in the same year. Inmates received no treatment but were confined and watched to stop them harming themselves or others. Soon gaols in other towns were also used to hold mentally ill people along with debtors, drunkards and vagrants. Gaolers found them hard to deal with and wanted them removed, but the only alternative was the overcrowded wards of public hospitals.

The Lunatics Ordinance 1846 stated that after certification by two doctors and a magistrate, a 'lunatic' could be held either in a gaol or other prison, or in a public hospital or asylum. New Zealand then had no specialist asylums, so this legislation foresaw a system where the insane would be cared for at state expense.

A disappointing country?

In 1871, at an inquiry into New Zealand's lunatic asylums, Legislative Councillor Dr M. S. Grace offered this comment on the country's rate of mental illness: 'Insanity is much more common in [New Zealand] than it is [in Britain], chiefly on account of the limited range of sympathy which the isolation of individuals and families in the country gives rise to, and also on account of the oppressive loneliness which many newcomers experience even in our crowded towns. Many immigrants, too, form the most extravagant anticipations of their new home and are proportionally depressed by the result of actual experience.[1]

First asylums

Asylums aimed to provide better care for mentally ill people than the gaols or general hospitals, with a minimum of physical restraint. The only treatment given was 'moral management' – quiet routines of physical work and exercise, church services, and dances and other recreation, with the staff providing role models for orderly behaviour.

In the 1860s and 1870s provincial governments established small purpose-built asylums, usually on the edge of the provincial capitals, to encourage community involvement and farming activities. They included Karori, near Wellington (1854), Dunedin and Sunnyside, Christchurch (1863), the Whau, Auckland (1867), Seaview, Hokitika (1872), and Nelson (1876). New Zealand adopted the prevailing English system of institutional care rather than the Scottish mixed system of institutional and supervised community placements.

The next generation of buildings were in more remote areas and were much larger. They included Seacliff, near Dunedin (1879), and Porirua, near Wellington (1887).

From 1876 to 1972 all public mental institutions were under the control of a government department. Scottish-trained medical administrators including Frederick Skae, Duncan MacGregor, Frank Hay, Sir Frederic Truby King and Theodore Gray ran the mental-hospital system from 1886 to 1947, and copied innovative features from the Scottish system.

Treatment in asylums

The early asylums were staffed mainly by people with no medical training, although medical advice was available. Some achieved very high standards in implementing 'moral management'. Seclusion and restraint of dangerous or destructive patients in locked gloves or clothes (strait or soft jackets) was sometimes practised.

The buildings were surrounded by their own farms and gardens. Patients were expected to work both inside and outdoors to the extent they were able, helping with domestic chores, farming and gardening.

Strong humanitarian sentiment underpinned the moves to establish proper asylums. In 1864 a select committee of the Otago Provincial Council advised that 'lunatics should be regarded by the state as objects of tender solicitude, and ... no pains or expense should be spared in ameliorating their condition. They wholly condemn their being treated as paupers or prisoners.'[3] The Lunatics Act 1868 introduced regular independent inspection of asylums.

Moral management

James Hume, the lay superintendent of the Dunedin Asylum (1864–82), believed that 'Patience, gentle treatment, nourishing diet, Cleanliness with light employment or Exercise goes far to recover the Lunatic and in Chronic Cases serves to make them Comfortable or even happy. Amusements for the insane are indispensable ...and where space can be found in an asylum, a weekly concert with dance – both sexes carefully chosen can join in the entertainment and conduct themselves with the greatest decorum. Good example in the attendants is the greatest guide, and gives confidence to the patients."[2]

Patients in asylums

By the late 19th century public asylums held all kinds and ages of mentally ill people, including children, together in the same areas. The emphasis was less on treatment and cure than on long-term care and custody. Asylums provided some advantages over families caring for mentally ill members themselves, but they were also used to confine categories of people rejected by society, such as elderly people suffering from mild confusion.

Footnotes

- Appendices to the Journals of the House of Representatives, 1871, H-10. Back
- Dunedin Asylum keeper's journal, 20 April 1864, Health Care Otago Archives, Archives New Zealand, Dunedin, DAHI D 264/1. Back

- 'Report of the Commission of Enquiry into the Constitution and Management of the Dunedin Hospital and Lunatic Asylum'. Votes and Proceedings of the Provincial Council of the Province of Otago, session 15 (1864). Back

Mental hospitals, 1910s to 1930s

Mental Defectives Act 1911

The Mental Defectives Act 1911 allowed people to admit themselves to mental hospitals voluntarily. This encouraged early treatment of some mental illnesses and helped reduce the stigma of committal (compulsory admission) and residence in a mental institution. The official term 'asylum' was replaced by 'mental hospital', a 'lunatic' became an 'inmate', and female 'attendants' became 'mental nurses' (male staff were still called attendants). A 1928 amendment to this Act anticipated separate training institutions for intellectually handicapped patients.

Changing the asylum model

The aim was that mental hospitals would replace the discredited asylum model by acquiring the therapeutic status and public acceptability of general hospitals. Mental hospitals facilitated easier admission procedures, active early treatment, and professional care by specialist psychiatrists and trained mental health nurses. They also provided separate 'reception homes' or 'neuropathic hospitals' for early treatment.

The villa system

The villa system was a hospital design based on a group of small detached buildings rather than a single large and imposing structure. This design became government policy from 1903, making it much easier to classify patients by age, gender, behaviour, likelihood of recovery and, to some extent, social class. A typical self-contained 40–50-bed villa had several dormitories and single rooms, kitchen, dining room, lounge and offices. In 1969 a quarter of all mental patients were still housed in traditional asylum-era buildings. These 19th-century buildings were much harder to modernise.

The effect of shell shock

New Zealand psychiatry

Dr T. Gray, a young British-trained psychiatrist, described his first experience of New Zealand mental hospitals in the early 20th century: 'The almost complete divorcement of psychiatry from general medicine created a profound impression upon me when I came to New Zealand [in 1911]. I was struck by the singularly isolated position which the mental hospitals occupied in the public life of the country ... their existence was merely tolerated as a necessary evil and their drab and dreary structure and routine

> symbolised the hopelessly pessimistic attitude of the public towards the prognosis of those who had to be admitted.'[1]

Public pressure for 'halfway houses' to treat nervous disorders helped take services out of mental hospitals, especially those for war veterans. Queen Mary Hospital at Hanmer Springs opened in 1916 as the first 'halfway house' to treat nervous breakdown, shell shock and borderline mental conditions. The treatment and status of people suffering from mental illness improved after the First World War, as numbers of shell-shocked war veterans returned to New Zealand. Patriotism demanded that these men should not be treated like ordinary mental patients, who were then widely regarded as incurable.

War veterans were treated with dignity and compassion, and gently encouraged to talk about the circumstances that had caused their illness. Because of the rapid success of this early form of psychotherapy, it was later applied to some other groups of patients in mental hospitals.

In the same period, a few doctors in general hospitals grew more interested in psychiatry (the diagnosis and treatment of mental disorders). Some hospital boards began providing observation wards for mental patients at base general hospitals, to protect 'those of unsound mind from the indignity, distress and humiliation of being treated as delinquents and criminals'.[2] Psychiatrists in mental hospitals set up outpatient clinics where they could treat less serious patients without admitting them.

New treatments

From the late 1930s a number of new treatments for severe mental illness were introduced. It was hoped that these would transform the lives of people with chronic illness. They included injecting patients to induce insulin coma and prefrontal leucotomy (a form of surgery on the brain). Both produced serious side effects and were eventually discontinued. Convulsive therapy was initially introduced using a chemical to induce a seizure but electroconvulsive therapy (ECT) soon replaced it as more reliable and safer. While considered a beneficial treatment for some, it has become increasingly controversial. Over time ECT was modified for greater safety, and it is still occasionally used.

Footnotes

- Quoted in Wendy Hunter Williams, Out of mind, out of sight: the story of Porirua Hospital. Porirua: Porirua Hospital, 1987, p. 78. Back
- T. G. Gray, 'The president's address: psychiatry in New Zealand.' New Zealand Medical Journal 46 (1947), p. 85. Back

Psychiatric hospitals, 1940s to 1960s

From the 1950s new drugs became available and were widely used to treat psychosis, depression, anxiety and mania. These were supplemented by psychological treatments such as individual or group psychotherapy for some acute patients. As more effective treatments for mental illness were introduced, patients became more willing to enter mental hospitals voluntarily. Between 1935 and 1939 22.4% of patients were voluntary. From 1955 to 1959, when the first wave of new drugs became available, 47.5% of admissions were voluntary. This grew to 71.4% between 1960 and 1964.

Therapeutic developments, and the introduction in 1939 of free treatment in state mental hospitals, transformed psychiatric hospitals, as they were known from the 1950s. Patients' behaviour could be stabilised, and they could often be discharged from hospital much sooner then in the past. This, however, created a 'revolving door' pattern of re-admission and trial leave. Psychiatric hospitals, however, were still home for large numbers of long-term and institutionalised patients.

Post-war legislation

Significant changes to the cornerstone mental health statute in 1947, 1961, 1969 and 1992 gave effect to the policies of destigmatising and relaxing admission procedures, mandating extramural services and facilitating integration of mental health with broader health services administration.

Hospital hotels

In 1942 a major earthquake forced the evacuation of 800 patients from Porirua Hospital. Many were temporarily transferred to the country's best-known tourist hotels: Chateau Tongariro, at National Park, and Wairakei Hotel near Taupō.

Reforming the institutions

Most mentally ill people were still treated at specialist hospitals. In 1969 New Zealand's 11 psychiatric hospitals and four 'psychopaedic' hospitals (for intellectually handicapped people) represented 43% of public hospital beds and 37% of all hospital beds. As these hospitals came to be seen as therapeutic communities, they were equipped with halls, libraries, canteens, chapels and swimming pools.

From the 1940s new types of professional staff, such as social workers and occupational therapists, were employed to prepare and support patients for life and work outside, and to liaise with community groups. Until the late 1960s able-bodied patients were still encouraged to help with daily chores around the hospital and grounds. This physical activity was justified therapeutically as providing stimulation and relief from boredom, but also provided the constantly overcrowded and underfunded facilities with a large labour pool of long-term patients for basic functioning.

Short- and long-term patients

The eternal now

A growing gap developed between short-term psychiatric patients and long-term patients who had lost outside links and established a home in their hospital. The first group were cared for individually in 'front' wards, while the remaining patients were managed as efficiently as limited resources allowed. Internationally renowned author Janet Frame was a psychiatric patient in the 1940s and 1950s, and in her writing she vividly described the differences between front and back wards, and newer and older institutions.

Renowned author Janet Frame drew on her experience in mental hospitals in several of her books, both fictional and autobiographical: 'There was a personal, geographical, even linguistic exclusiveness in this community of the insane who yet had no legal or personal external identity – no clothes of their own to wear, no handbags, no purses, no possessions but a temporary bed to sleep in with a locker beside it, and a room to sit in and stare, called a dayroom. Many patients confined in other wards of Seacliff had no name, only a nickname, no past, no future, only an imprisoned Now.'[1]

Footnotes

- Janet Frame, An angel at my table: an autobiography: volume two. Auckland: Hutchison, 1984, pp. 72–73. Back

Closing the hospitals, 1960s to 1990s

Deinstitutionalisation

From the 1960s psychiatric patients were encouraged to take a more active role in their own care and treatment. The community also became more tolerant of the mentally ill. In this period many of the more manageable patients were discharged from hospital. Planning for new psychiatric hospitals ended in 1963 and no extra beds were provided from 1973. From the 1970s psychiatric services came to emphasise outpatient care, community-based treatment and more modern facilities. Every mental hospital patient was assessed in 1973, and 26% of psychiatric and 46% of intellectually handicapped patients were recommended for accommodation outside a major psychiatric or psychopaedic hospital.

Rise of community care

From the 1970s, under the umbrella term 'community care', most people with mental disorders received support from a range of non-governmental organisations. These developed alternatives to institutional care, helped change public attitudes and built international links.

Community organisations included the Intellectually Handicapped Children's (now IHC) Parents' Association (1949), the Schizophrenia Fellowship (1977) and the Richmond New Zealand Trust (1978). The Mental Health Foundation, formed in 1977, concentrated on policy issues and advocacy to promote mental health and lower the rate of mental illness.

Problems of transition

In response to a mix of ideological and fiscal imperatives, almost all psychiatric hospitals were run down, closed, repurposed or sold off by the 1990s. This was a result of haphazard local schemes rather than a carefully managed national plan. In this final phase of deinstitutionalisation, very few psychiatric hospitals retained any services on their historic campuses. One exception was Hillmorton Hospital in Christchurch, formerly Sunnyside Hospital.

The transition to a system of community-based services became very complex and messy as it coincided with several waves of health sector restructuring in the 1980s and 1990s. The rapid growth and spread of multiple agencies – public, private and voluntary, local, regional, national, and culturally-based – funded under different contracts to provide aspects of care and support lacked coordination and certainty of outcomes.

Patients, families of patients, and carers were caught in the cracks, and there were harrowing and occasionally tragic tales of poor communication, missed opportunities, poor support, lack of continuity of care and unsuitable placements.

The risks of community care

Psychiatrist Fraser McDonald served as the medical superintendent at both Carrington and Kingseat hospitals in Auckland. He warned of the risks, as well as advantages, of phasing out psychiatric hospital services in place of community care.

'Let there be no misunderstanding, if these social structures are to be established and are seen as utterly essential for the proper healthy development of community psychiatry they ... will need to involve at least as much money and as many people as have been involved in creating and maintaining the old institutions. To do anything less will be false economy of the cruellest kind.'[1]

Such challenges, however, elicited for the first time the strong and influential voice of patients (or consumers as they were increasingly called), carers and families who shared their experiences and concerns. A number of former psychiatric hospital patients lodged legal claims alleging abuse by staff and doctors. Some received official apologies. Many more consumers contributed to the general inquiry into mental health services chaired by Judge Ken Mason (1995–6) and the Confidential Forum for Former In-Patients of Psychiatric Hospitals (2005–7). The inquiry's report cited many such stories about the inadequacy of services. The forum, the first of its kind in New Zealand, offered a constructive approach to dealing with historic matters that had deeply affected people. Many individual narratives revealed negative themes around institutional culture and treatment regimes. On the positive side, many participants told the forum of their recognition and lasting appreciation of care they had received from staff members or other patients.

System changes

The 1990s also saw a number of important advances in mental health services. These included the development of regionally based forensic psychiatry services, legislative revision, the detachment of intellectual handicap from mental health services, and more attention to the needs of Māori, who were over-represented in mental health statistics.

Public consultation by health agencies also encouraged action based on responses from the consumers of mental health services. The Mason Inquiry's criticism of the Ministry of Health's lack of leadership, influence and capacity to infuse the system with vision and purpose led to major organisational changes. The Mental Health Commission was set up in 1996 as a watchdog over the sector. It worked closely with the ministry to shape the future by advising the government on the needs of people experiencing mental illness, encouraging research and advocating improvements. The latter included appropriate services for Māori, the integration of drug and alcohol policy and services with those for mental health, better promotion of mental health, and the prevention of mental illness. The commission was intended to be a temporary body, and its residual functions were moved to the Health and Disability Commission in 2012. A Mental Health and Wellbeing Commission was re-established in 2021

Footnotes

- Quoted in Asylum Collective, Idlers, indigents, vagrants, artists, criminals, children, savages, brutes, religious fanatics, idiots, madmen. Auckland: Photoforum in collaboration with the Asylum Collective, 1994, p. 12. Back

Community care, 1990s onwards

GP and general hospital care

Working closely with the Ministry of Health to give effect to a stream of national standards, guidelines and protocols, the Mental Health Commission published two 'blueprints' for improving services in 1998 and 2012 that focused on strategies for recovery, addressing discrimination and the specific needs of Māori and Pacific peoples.

As a result of the blueprints and similar initiatives, specialised services for the mentally ill were expected to support primary health care services such as general practitioners (GPs). In 2011/12 15% of referrals to specialist mental health services came from GPs. People with moderate or mild mental disorders might not need any specialist services. However, GPs were concerned that their patients might understate their mental health problems or delay treatment. In 2007 less than 10% of people visiting a GP gave mental health problems as the main reason for the visit, although about half may have been in psychological distress.

In the 2010s most specialist mental health services were provided by district health boards, contracted by the Ministry of Health. They included crisis and emergency teams, inpatient units, supported accommodation and liaison services. Some services were designed for specific groups such as children and adolescents, mothers

and families, older people, Māori or Pasifika, and those with addictions or eating disorders. All services were required to meet national standards, guidelines and protocols.

Community and inpatient care

Community, rather than hospital-based services have become the largest part of the mental health system since the early 2000s, using nearly three-quarters of total mental health funding. In 2014 only 9% of patients who used district health board services for mental health issues were seen by inpatient teams for close observation, intensive investigation or intervention. Many of those patients were using inpatient services repeatedly. Psycho-pharmaceuticals (drugs designed to combat mental disorders) were the main method of treatment.

A growing proportion of mental health services is provided through non-governmental organisations (NGOs). In 2011/12, 27% of mental health clients were seen by NGOs. They ranged from well-known national organisations with multi-million-dollar budgets to very small groups of consumers or caregivers. They provided telephone crisis services, drop-in centres, consumer-run self-help groups, family and community support and a variety of residential services. Christchurch's Stepping Stone Trust, for example, runs residential and respite services, and visits people in their own homes.

All Black kicks the 'black dog'

The world's first online self-management programme for mild to moderate depression was launched in 2010. 'The journal', fronted by former All Black John Kirwan, who has experienced depression himself, takes people through a series of online video clips, then encourages them to complete a task during their daily routine. The website teaches people techniques to manage their own depression, such as staying positive, better nutrition and physical activity, and finding creative solutions to problems.

Private mental health services

Privately owned and operated mental health services have always been rare in New Zealand. Ashburn Hall (now the Ashburn Clinic) in Dunedin was set up in 1882 as a licensed private institution. It is still the only such institution outside the state system, although it also provides some services through publicly funded contracts. In 2000 around 15% of psychiatrists worked wholly or part-time in private practice.

Contemporary issues

The stigma of mental illness

Long-standing but misleading stereotypes that associate mental illness with bizarre or dangerous behaviour perpetuate fear, misunderstanding and a reluctance to seek help. In 1998 the Mental Health Commission reported, 'One of the biggest barriers to recovery is discrimination. That is why stopping discrimination and championing respect, rights and equality for people with mental illness is just as important as providing the best treatments and therapies.'[1] The commission advocated

empowering and protecting the rights of people with mental illness, enabling them to participate fully in society and preventing discrimination against them.

Like Minds, Like Mine

In 1998 a national public education programme, Like Minds, Like Mine, was launched with the aim of creating 'a nation that truly values and includes people with mental illness'.[3] The programme worked to reduce traditional misunderstandings and discrimination. Many high-profile New Zealanders, including former All Black John Kirwan, and musicians Mahinaarangi Tocker and Mike Chunn, spoke openly about their own experience of mental illness and related problems.

Mental illness at work

People who have experienced mental illness may be treated unfairly in the workplace. The Like Minds, Like Mine programme aims to reduce misunderstanding and discrimination. One person told the campaign: 'Disclosing my history of mental illness ... was a pretty natural process ... When I've had to have time off work or needed a bit of extra support because I've hit a rough patch, it's barely raised an eyebrow ... When you weigh up what people with mental illness have to offer a mental health workforce, any time off is seemingly inconsequential.'[2]

Māori mental health

The proportion of Māori who are consumers of mental health services is much higher than their proportion of New Zealand's total population. To respond effectively to their mental health issues, health providers have aimed since the late 1980s to involve Māori with mental illness (tangata whaiora) and incorporate traditional Māori healing practices into mental health services. The Mason Clinic in Auckland, built on part of the site of the former Carrington Hospital, includes Te Papakainga o Tane Whakapiripiri. This unit, opened in 2006, is designed like a Māori village with a meeting house, dining hall, accommodation area and courtyard with traditional symbols of healing and cleansing.

Pacific Islanders' mental health

People from other Pacific countries are also over-represented as consumers of mental health services. Pacific peoples traditionally may have viewed mental disorder as spiritual possession, usually caused by breaches of sacred customs. In contemporary New Zealand, mental illness among people who identify as Pasifika may also be linked to a wide range of social, economic and behavioural factors. Pacific peoples have generally approached mental health services for treatment at a much later stage of mental illness than other New Zealanders. Often those services were contacted because the patient was referred by an official agency such as the police or a hospital emergency department.

Contemporary policy issues

In 2018, following unprecedented public interest in mental health and rising demand for mental health and addiction services, the government established an inquiry into mental health and addiction. The inquiry looked at mental health and

addiction challenges from mild mental distress to acute mental illness. It also considered mental health and addiction needs, with the goals of meeting mental health and addiction challenges, promoting mental well-being, and preventing suicide. The findings were published in He ara oranga: report of the government inquiry into mental health and addiction.

The government's response to the report was a commitment to improve mental health and addiction support across a range of initiatives delivered by many government agencies. It took a 'population health' approach, emphasising the need to build the social, cultural, environmental and economic foundations of mental well-being and to support the whole population to stay well. It envisaged increased investment in specialist mental health and addiction services, and the physical facilities they are delivered in.

The government also committed itself to expanding the primary mental health and addiction system for those in what He ara oranga called the 'missing middle' – those individuals and whānau who have mental health and addiction needs, but do not meet the threshold for accessing publicly-funded specialist services. This will involve the provision of services through general practices, as well as tailored kaupapa Māori, Pacific and youth-specific services.

Footnotes

- Blueprint for mental health services in New Zealand: how things need to be. Wellington: Mental Health Commission, 1998, p. 18. Back
- 'Renee Torrington.' Like Minds, Like Mine, http://www.likeminds.org.nz/page/121-People-Like-You+Renee-Torrington (last accessed 23 August 2010). Back
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