

The future of primary and community responses to mental health and substance use needs

A short paper following a Think Tank discussion convened by Te Hīringa Mahara - Mental Health and Wellbeing Commission in August 2025

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Te Hiringa Mahara - New Zealand Mental Health and Wellbeing Commission—was set up in February 2021 and works under the Mental Health and Wellbeing Commission Act 2020. Our purpose is to contribute to better and equitable mental health and wellbeing outcomes for people in Aotearoa New Zealand.

For more information, please visit our website: www.mhwc.govt.nz

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Context

Te Hiringa Mahara - Mental Health and Wellbeing Commission hosted a 'Think Tank' workshop to discuss the future of primary responses to mental health and substance use needs. This discussion followed the release of our final monitoring report on Access and Choice, published in April 2025. Through our monitoring of the Access and Choice programme since 2021 we heard extensive feedback from people with lived experience, whānau and the broader sector.

For this Think Tank we intentionally invited senior thought leaders and decision-makers from a range of organisations that support mental health and substance use needs to participate in the discussion. The discussion was purposely kept broad to facilitate a range of ideas and 'blue sky' thinking to emerge. This paper describes the key themes that surfaced in the session. It focuses on the key questions:

- What do we think the primary care landscape should look like in 10 years time?
- How do we get there?

What does the primary care landscape need to look like?

It needs to be organised with local leadership and flexibility

A substantial theme throughout the discussion was that the primary care landscape needed to be locally-led and flexible. Communities have the answers for their own needs and tapping into this is the way forward. Local leadership requires the right people to hold decision making space – including lived experience leadership and community-based leadership. It would require inverting the power distribution, whereby resources are allocated to communities for localised responses. Integrated Primary Mental Health and Addiction (IPMHA) was shared as an example that worked well in general practice where it had been flexible in its roll-out.

Locally-led approaches benefit from having trusted people with existing community relationships who can connect people with support earlier and be flexible to respond to diverse contexts and issues. Flexibility to local community needs enables approaches that address inequities for specific groups, including local iwi approaches.

Some members also noted the need for locally-led services to be connected into national services (such as 1737 phone support) and for devolved decision making to connect with larger scale structures that provide functions with greater efficiency.

It needs to be integrated across key boundaries

Horizontal integration with community services

There was consensus across the group that the primary care landscape needs to be horizontally integrated. It needs to be connected to a range of community services that would enable a seamless experience for people to receive a wider range of supports beyond medical interventions, such as social services to address social determinants of mental health. An example of horizontal integration including iwi, employment support, and addiction services was shared. A suggestion to improve horizontal integration was the ability for primary care to refer directly into community respite or acute alternatives. This type of system redesign would prevent people needing to present to ED in order to get access to these supports through specialist service referrals.

Vertical integration with specialist services

A key discussion point was about the “upward drift” in terms of severity and complexity of mental health and substance use needs being supported in the wider primary care landscape. There was a question about whether the future of primary care initiatives such as the Access and Choice programme should build capability to support this shift, or whether there needed to be a re-focusing on the intended mild to moderate wellbeing needs.

What was agreed, was that meeting the future mental health and substance use needs of people also requires specialist services to have the capacity to respond to people with higher needs. The primary care sector, particularly NGOs, often support people impacted by specialist capacity issues. Primary care needs to be closely connected to specialist services to improve care transitions, improve appropriate flows in and out of specialist care and therefore improve whānau experience and reduce demand on both primary and specialist systems.

It needs to be easily accessible

There was discussion about what people need from the primary care landscape to meet their needs. Multiple people commented about the need for primary care to be easily accessible at the right time, in the right way, delivered with quality and cultural safety. Various components of what this looked like were raised across members and included: bringing primary care out into community settings such as marae and schools, expanding the use of technology to enable more digital and tele-health contact, and building trusted relationships through how we connect and respond.

It was generally acknowledged that having greater understanding of where people first turn to when in need of support is important to identify system constraints and implement the options that people want.

It needs to provide holistic support with a wellbeing focus

There was consensus across the group that the support people access from primary care needs to focus on their wellbeing and holistic health needs. It is common for people to present with co-morbidities that span both physical and mental health needs. Mental health and physical health are closely intertwined and should not be separated when providing primary level care. This wellbeing focus is most effective when working in genuine partnership with people and whānau. It is supported by models of wellbeing such as Te Whare Tapa Whā which also include family/social and spiritual aspects of wellbeing¹.

There are existing strengths in the provision of holistic care across the primary care landscape. Data indicates approximately 30% of GP interactions with patients involve a mental health and/or addiction component² and two members noted that the proportion of patients experiencing symptoms is likely higher, indicating that mental health and addiction relates to a significant volume of the care that they provide³. The IPMHA programme that was rolled-out as part of the Access and Choice programme, also has its origins as a wellbeing programme. For example, the Health Coach and Community Support Worker roles have a key part to play in supporting wellbeing for people with long-term conditions.

It needs to empower people and their whānau

In different ways, members talked about the value of empowering people and taking a whānau-centred approach. Capacity building to enhance the skills of people and their whānau can support self-care, facilitate positive relationship between people and the system, and contribute to sustainability of the changes needed for wellbeing. There was also some acknowledgement that people want their own expertise to be acknowledged when they are seeking support, and they are often the expert in what they need. Giving effect to empowering people in their own care requires shared knowledge and mutual learning between people and those providing care.

Evidence was raised about the effectiveness of investing in the first 1,000 days of life to set a person on a life trajectory with good health outcomes⁴. This investment in the first 1,000 days is intended for the whole whānau, to enable the early

¹ [Te Whare Tapa Whā model of Māori health | Ministry of Health NZ](#)

² Murton, Samantha. 2020. Primary care provision for mental health. *New Zealand Medical Student Journal* (30), 19-20.

³ Bushnell, J. A., McLeod, D., Dowell, A. D., Salmond, C., Ramage, S., Collings, S., Ellis, P. M., Kljakovic, M. & McBain, L. (2003). The nature and prevalence of psychological problems in New Zealand primary healthcare: a report on Mental Health and General Practice Investigation (MaGPIe). *New Zealand Medical Journal*, 116 (1171), 1-15.

⁴ Luijk MPCM, Roseboom TJ. Editorial: Supporting families in the first 1,000 days of life - a balancing act. *J Child Psychol Psychiatry*. 2025 Oct;66(10):1445-1448. doi: 10.1111/jcpp.70041. Epub 2025 Sep 8. PMID: 40916987; PMCID: PMC12447689.

relationships, experiences and conditions needed to thrive as babies' wellbeing is so dependent on that of their caregivers and wider whānau.

The Whānau Ora programme provides a good example of what the primary and community care sector should look like to support wellbeing. Whānau Ora is a culturally-based and whānau-centred approach to wellbeing focused on whānau (family group) as a whole as the decision makers who determine their goals and aspirations. It empowers people and whānau to address their own priorities to improve their health and wellbeing.

It needs to be connected to a focus on social determinants

There was strong consensus across the group that social determinants of health (and mental health) are crucial to address as part of an ideal primary care landscape. These determinants include a range of personal, social, economic and environmental factors that affect health and wellbeing. The literature estimates that these determinants account for a large proportion of health and mental health outcomes with ranges from 30% - 80% of outcomes being attributable to social determinants^{5,6}. A greater focus on improving the determinants of health could reduce the need and demand for medical interventions.

How do we get there?

Use funding approaches that support change

Funding and the way it is distributed was noted as having a substantial role in influencing what is delivered. However, there were differences in views about what needed to happen regarding funding to move towards this future primary care landscape. Ideas included social investment approaches, tight-loose-tight commissioning, and appropriate investment in addressing the social determinants of health.

Some members acknowledged the current fiscal constraints of the country and questioned whether more funding was needed and/or whether we could do better with smarter use of existing public funding. An example was given of integrating funding across siloed sources to reduce unhelpful overheads. The funding of mental health and addiction services needs to be prioritised within the primary care system.

⁵ Alegría M, Alvarez K, Cheng M, Falgas-Bague I. Recent advances on social determinants of mental health: looking fast forward. *American Journal of Psychiatry*. 2023 Jul 1;180(7):473-82.

⁶ <https://carejourney.com/social-determinants-of-health/>

Evaluate impact

In order to be smarter with public funding, there is a need for evidence about outcomes and impact of public investments. Once the vision for the future of primary care is set, we are able to assess investments (existing services and new interventions or proposals) against how well they progress the system towards this vision. This evidence will help inform aligned action in adjusting policy and funding as opposed to risk adverse inaction.

Recruit and upskill a broad workforce

There was general agreement that a broad workforce is required to deliver holistic approaches to people in primary care. Different examples were given of workforce initiatives that have been successful in the primary care landscape including comprehensive primary care teams, peer support, and the community support and cultural workers in Access and Choice. Health workforce development plans and strategies should include a focus on development of mental health and addiction workforce development – both skills in the existing workforce and development of a range of roles to support wellbeing.

A question was raised about how growing technology innovations and artificial intelligence might have an impact on the workforce expectations and requirements of the future. This question was not answered but remains one to keep in mind as things advance.

Prioritise the enabling systems

There was some discussion touching on the various enablers that were required to shift towards the primary care landscape that had been envisaged. They included funding, commissioning, upskilling, co-design, quality improvement, clearly defined outcomes, navigation, tools/technology, and interoperability.

Build from existing strengths and innovation

Various examples of services and programmes within the primary care landscape that were meeting the needs of people were shared throughout the discussion. There was acknowledgement that there was good already happening that we don't want to lose. Taking an appreciative enquiry approach towards current work was raised as a way to build upon the existing progress that has been made.

The Access and Choice programme was considered to have made good progress and would benefit from further refinement. Access and Choice was established as a wellbeing programme to support people with mild to moderate mental health and substance use needs. However, the programme has evolved through its roll-out and may need some refinements to ensure it meets its original objectives.

In practice, both constraints in specialist care and the nature of changing population needs mean the Access and Choice programme (both in general practices and in NGOs) is also supporting people with moderate to severe needs. This results in straining the capacity of primary care and Access and Choice as well as a “drift” upwards to focus on treatment for those with the highest needs. In areas with high needs populations, this can mean everything seen by Access and Choice services is moderate to severe which threatens the sustainability of the programme.

The actual population seen by Access and Choice was hypothesised to be part of the reason the programme hasn’t achieved its reach goal as people with high needs require more time to support. There are other ways to improve reach by increasing the use of digital, tele, or virtual formats for providing support and expanding the programme into wider community settings. Enhanced integration and coordination to embed the programme into services, easier navigation, and continued quality improvement and outcomes measurement were also suggested.

Understanding what is working in order to enhance those components is crucial, as is understanding what is *not* working in order to make appropriate programme changes.

Te Hīringa Mahara have published a suite of monitoring reports on the Access and Choice programme throughout its five-year roll out. The final monitoring report published in April 2025 made three recommendations:

1. Health New Zealand | Te Whatu Ora (Health NZ) increase programme reach to deliver service to 325,000 people per annum by 30 June 2026, as intended in the 2019 Wellbeing Budget.
2. By 30 June 2026, Health NZ develop a plan to streamline pathways and ensure that Access and Choice Youth services and Infant, Child and Adolescent Mental Health Services (ICAMHS) work together to meet the needs of young people across the continuum of care, including shared care arrangements.
3. Health NZ develop a plan to reduce unwarranted variation across the country in relation to fidelity (including access and entry pathways) to the IPMHA model by 30 June 2026.

Conclusion

A range of important insights were explored about what a future primary care landscape that can respond to peoples' mental health and substance use issues needs to look like. There was strong support for the need for continued Access and Choice programme funding and approach as part of this future system. Other components of an effective landscape included:

- Community oriented, locally-led and flexible
- Integrated across key boundaries – both horizontally with community services and vertically with specialist services
- Access to primary care needs to be fast and accessible
- Mental health and physical health needs are intertwined, and responses need to be holistic with a wellbeing focus
- Support empowers people and their whānau
- A greater focus on social determinants could reduce demand for primary and community health services

Further work is required to determine concrete actions to achieve this vision but needs to include:

- Funding and commissioning approaches that support change
- Evaluating impact of existing and new services
- Recruit and upskill a broad workforce
- Prioritise the enabling systems
- Build from existing strengths and innovation, including refinement of Access and Choice.

Te Hiringa Mahara has published this paper to enable these insights to be shared with Ministers, decision makers and to contribute to the work of the Public Health Advisory Committee. We will build on these insights to inform future development of primary responses to mental health and substance use needs.

Think Tank members

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