Mental Health Foundation OF NEW ZEALAND
mauri tū, mauri ora

Submission on the draft Mental Health and Wellbeing Strategy 2026-2036

By the Mental Health Foundation of New Zealand

Phone: 09 623 4810 | www.mentalhealth.org.nz
Eden 3, Ground floor, 16 Normanby Road, Mount Eden, Auckland
PO Box 10051, Dominion Road, Auckland 1446

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Ministry of Health | Manatū Hauora

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Tuia te rangi e tū nei
Tuia te papa e takoto nei
Tuia i te here tangata
Tihei mauri ora.

He hōnore, he korōria ki te atua ki te runga rawa
He whakaaro maha ki a rātou kua haere ki te wāhi ngaro
E ngā rau rangatira mā, ānei ngā whakaaro me ngā kōrero nā Te Hauora Hinengaro.

Introduction

Thank you for the opportunity to comment on the draft *Mental Health and Wellbeing Strategy 2026-2036* (the Strategy).

The Mental Health Foundation of New Zealand (MHF) is a charity that promotes everyday actions that lift mental wellbeing, provides tools that support people through tough times, and advocates for a better mental health system and society.

Our submission has been informed by the voices of young people, tāngata whaiora Māori, and experts in suicide prevention and postvention.

Overview of feedback

The MHF welcomes the development of a long-term Mental Health and Wellbeing Strategy and recognises the important role it will play in maintaining national focus and momentum on improving mental health, wellbeing and addiction outcomes across Aotearoa New Zealand. We are heartened to see many of MHF's past and current advocacy asks reflected, either explicitly or conceptually, through this draft, including:

Phone: 09 623 4810 | www.mentalhealth.org.nz
Eden 3, Ground floor, 16 Normanby Road, Mount Eden, Auckland
PO Box 10051, Dominion Road, Auckland 1446

- our call for a mental health and wellbeing system implementation plan
- a focus on prevention, early intervention, and mental wellbeing promotion
- recognition of youth mental health as a priority
- growing the mental health and addiction workforce
- embedding lived experience leadership across multiple levels of the system
- improving data, prevalence information, monitoring, evaluation, and evidence
- building a more connected continuum of care
- shifting towards more partnership-based approaches to commissioning, and
- strengthening community-based and integrated responses.

While most of these asks are reflected in principle, the draft has not yet provided the level of specificity we would expect from a robust strategic document. As a package, the Strategy and implementation plan must provide clear responsibilities, accountabilities, milestones, resourcing, measures and targets required to support implementation and monitor progress over time. Although we understand the rationale for consulting on the Strategy prior to finalising the implementation detail, the lack of operational specificity makes it difficult to meaningfully assess many of the proposed strategic actions. Where cross-government or cross-sector action is implied, the draft also provides limited detail on the mechanisms that would support this work to happen.

The draft is underdeveloped in areas that are consistently recommended by national system frameworks, official recommendations[1] and international best practice guidance[2] for mental health system transformation. In our view, the most significant gaps are:

- operationalising Te Tiriti o Waitangi obligations; strengthening kaupapa Māori, Māori-led and whānau-centred services and supports; addressing inequities across the continuum of care,

[1] *Oranga Hinengaro System and Service Framework* and the Mental Health and Wellbeing Commission | Te Hiringa Mahara's *Six shifts to improve mental health & wellbeing outcomes*
[2] The World Health Organization's *Comprehensive Mental Health Action Plan 2013-2030* and their guidance on mental health policy and strategic action plans (modules 2: *Key reform areas, directives, strategies, and actions for mental health policy & strategic action plans* and 3: *Process for developing, implementing, and evaluating mental health policy & strategic action plans*)

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Eden 3, Ground floor, 16 Normanby Road, Mount Eden, Auckland
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- primary prevention and cross-government action on the determinants of wellbeing,
- governance and accountability mechanisms,
- implementation detail, and
- monitoring and evaluation approaches that meaningfully capture equity, quality and lived experience outcomes.

We address these areas in more detail below. Note we have included specific language change recommendations at Appendix 1.

Significant gaps

Te Tiriti o Waitangi and equity

While the draft Strategy acknowledges inequities in mental health and wellbeing outcomes for marginalised populations, including Māori, these inequities are not meaningfully addressed as an operational priority. This is concerning given the Crown's obligations under Te Tiriti o Waitangi, and because meeting these obligations is necessary to achieve pae ora.[3] **In our view, Te Tiriti o Waitangi and equity need to be explicitly referenced as part of the vision, priorities and system design, as well as clearly carried through from the Strategy's high-level framing into its actions, implementation approach, resourcing, accountability arrangements and monitoring. The Strategy must explicitly recognise Māori as tangata whenua and rights-holders, not just as a priority population**.

The strategic actions do not sufficiently set out how inequities will be reduced, and it is unclear how progress will be measured. In particular, the draft does not include clear commitments to resource kaupapa Māori, Māori-led, and whānau-centred and holistic services and supports, or to address the specific mental health and wellbeing needs of Māori. We understand this was a key area of focus in feedback provided by the Te Hiringa Mahara | Mental Health and Wellbeing Commission.[i]

[3] As stated in *Oranga Hinengaro System and Service Framework* (pg. 16).

Phone: 09 623 4810 | www.mentalhealth.org.nz
Eden 3, Ground floor, 16 Normanby Road, Mount Eden, Auckland
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This is a significant omission given longstanding underinvestment in kaupapa Māori mental health and addiction services. Despite high need,[4] fewer than one third of Māori accessing specialist mental health and addiction services could access kaupapa Māori services,[ii] and less than 10 percent of mental health and addiction service investment is allocated to kaupapa Māori options.[iii] The Waitangi Tribunal's 2019 *Hauora* report found that the Crown has failed to address persistent Māori health inequities, give effect to tino rangatiratanga, and properly resource Māori health organisations and providers. **These issues should be directly addressed through the Strategy and implementation plan.**

We are concerned that the need to improve the cultural safety and responsiveness of services is not sufficiently addressed. Although the draft refers to "culturally appropriate" services, including through one strategic action, it does not set out how cultural safety will be embedded, measured, monitored, or strengthened across the mental health and addiction system. The distinction in language is important. "Culturally appropriate" generally refers to tailoring services to different cultural groups, whereas culturally safe and culturally responsive practice requires ongoing reflection on bias, racism and inequity within the system itself, with safety defined by the experiences of people and whānau receiving care.

The draft Strategy makes no explicit reference to spiritual wellbeing or whānau wellbeing, despite these being two core dimensions of health and wellbeing within Te Whare Tapa Whā and other holistic models of wellbeing. Their omission risks reinforcing an overly individualised and clinical framing of mental health, rather than recognising the important role of whānau, culture, identity, belonging and spirituality in supporting wellbeing and recovery. **We recommend the Strategy more clearly reflect holistic understandings of wellbeing throughout its strategic framing and actions**.

[4] E.g., Māori experience significant inequities in the mental health and addiction system, including higher rates of coercive practices like compulsory treatment and solitary confinement ("seclusion") in mental health units (Te Hiringa Mahara, 2024), higher prevalence of "mental disorder" (Ministry of Health, 2006) and higher, and rising, rates of mental distress (Ministry of Health, 2025).

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Eden 3, Ground floor, 16 Normanby Road, Mount Eden, Auckland
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Primary prevention and cross-government action

We welcome the inclusion of prevention and early intervention as a strategic priority. However, the draft Strategy does not give sufficient weight to primary prevention as a core system function and areas for action given that "60-90% of mental health challenges are driven by social, economic, environmental and cultural conditions" (p.11). Much of the proposed action is focused on service responses once distress or harm has already emerged, rather than creating the conditions that support positive mental health and wellbeing across the whole population and reduce the risk factors that drive mental distress. **In our view, primary prevention should be reflected more consistently throughout the Strategy, including through cross-government action, investment priorities, implementation planning and outcome measures.**

We recommend cross-government action on the determinants of mental health and wellbeing be explicitly named as a "critical system enabler" (p.6) and later setting out how these drivers will be addressed in practice. We understand Te Hiringa Mahara also identified this as a key gap and recommended there should be strengthened action on determinants to tackle increasing population rates of psychological distress.[iv]

The draft Strategy lacks clarity regarding cross-sector leadership. If the Strategy seeks to build a connected and collaborative system, **it should articulate how the Ministry of Health and Health New Zealand will lead, enable and coordinate cross-government action to address the determinants of mental health and wellbeing, including the governance and accountability mechanisms that will support implementation in practice.** While we recognise this Strategy cannot directly impose obligations on other agencies, **it should establish the strongest possible expectations and mechanisms for cross-government engagement, collaboration and delivery**.

Governance, accountability and transparency

We recommend including a strong commitment to accountability and public reporting, including clear commitments for the frequency and accessibility of reporting by Health New Zealand and the Ministry of Health on progress against the Strategy and implementation plan. **We recommend that monitoring and**

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Eden 3, Ground floor, 16 Normanby Road, Mount Eden, Auckland
PO Box 10051, Dominion Road, Auckland 1446

evaluation functions include an appropriate level of independent oversight, rather than relying primarily on self-monitoring arrangements.

We agree not everything can be done at once. However, the Strategy does not provide sufficient detail to articulate which strategic actions will be prioritised, scaled and funded. In reference to page 10, **we recommend being more transparent about what 'basics' will be fixed and what will be duplicated or expanded from the array of approaches, supports and services that already 'work'**. For example, the Strategy could set out clear criteria in which prioritisation decisions will be made to determine the inclusion/exclusion of actions or time sequencing of actions in the implementation plan. Such criteria could include assessment of population need, equity, return on investment and strength of evidence.

Monitoring and evaluation

While quantitative measures are essential for monitoring progress, and we welcome the commitment in Appendix 1 to track outcomes and equity for specific population groups, our view is that the proposed monitoring framework is not yet sufficiently developed. It does not set out how qualitative evidence, lived experience insights, strengths-based outcomes, or population-specific experiences will be collected, analysed and used to inform ongoing implementation. **Ideally, quantitative indicators should be complemented by qualitative approaches to evaluation developed with priority population groups.** Doing so ensures progress is not largely measured through service activity and target achievement but by whether supports and services are improving outcomes and experiences in ways that matter to people, whānau and communities and those who experience disproportionately poorer mental health outcomes.

We recommend the Strategy and implementation plan include a more explicit equity- and needs-based monitoring and evaluation framework. This should clarify how progress will be assessed for priority populations, how inequities will be identified and acted on, and how investment and service access will be aligned with population need.

To better align with World Health Organization (WHO) best practice guidance, **the Strategy and implementation plan should specify baselines, desired levels of**

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Eden 3, Ground floor, 16 Normanby Road, Mount Eden, Auckland
PO Box 10051, Dominion Road, Auckland 1446

change, targets, timeframes, reporting frequency, accountable agencies, and how monitoring data will be used to support continuous learning and course correction. This should be supported by routine data collection and reporting against a core set of indicators, disaggregated by relevant population characteristics where possible, including age, sex/gender, ethnicity and disability, to monitor inequities and health outcomes over time.

Many of the proposed measures will help track system activity, access, or population-level trends, but will not necessarily show whether changes are attributable to the Strategy's actions. **The monitoring framework should therefore include evaluation methods that can assess contribution, causality where possible, and the quality and impact of implementation.**

Prevention measures

We recommend including a measure using existing data sources to track reductions in population and sub-population levels of psychological distress or mental disorders over time. The current measures focus strongly on service access and use. While these are important, they do not on their own show whether prevention efforts are reducing distress or improving mental health and wellbeing at a population level.

For children and young people, the proposed measure focuses on mental health and addiction service access rates and wait times broadly, rather than early intervention specifically. **We recommend using a measure that can indicate whether or not young people are receiving the right support early enough to prevent escalation.**

We recommend including a population-level wellbeing measure, tracked over time and disaggregated by priority populations where possible. This could draw on wellbeing indicators already collected by Stats NZ.

Effectiveness measures

We recommend including a measure to track the proportion of people under compulsory care with an advance mental health directive (or other advance preference statement), as this would help to give an idea of the extent to which supported decision-making is being enabled.

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We recommend embedding clear reduction and elimination targets for seclusion within the monitoring framework, accompanied by balancing measures to identify any substitution effects or unintended increases in other restrictive practices. This should include routine monitoring and public reporting on physical and chemical restraint and coercion.

In addition to measuring the number, spread and operations of lived experience leadership roles across Health New Zealand, **we recommend including qualitative and co-produced measures that assess the influence and impact of lived experience leadership on decision-making, service design and system change**. The Australian *National Suicide Prevention Outcomes Framework* provides a useful example through its commitment to "create and report on co-produced [measures and] outcomes that demonstrate the activity and impact of embedding people with lived and living experience [of mental distress and suicide] in government decision-making."

Young people as a system priority

We strongly support the consistent recognition of young people and the disproportionate mental health and wellbeing challenges they experience throughout the Strategy. **We recommend reinforcing the commitment to develop a youth mental health roadmap and action plan**, as committed to by the Minister for Mental Health as part of the inaugural Youthline Youth Mental Health Summit in March 2026, and progressing the priority actions arising from the Summit. **We recommend clarifying how the proposed roadmap and action plan will align with and support this Strategy and implementation plan**.

Young people should be meaningfully involved not only in consultation processes, but in the ongoing design, governance, implementation and evaluation of services and supports. While the draft Strategy acknowledges the importance of youth participation, it does not clearly set out how young people will hold influence or decision-making power within the system. Meaningful youth involvement should include sustained and appropriately resourced youth advisory and leadership structures, representation from diverse communities and experiences, and clear feedback mechanisms demonstrating how young people's input has shaped decisions and service development.

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PO Box 10051, Dominion Road, Auckland 1446

We encourage the Strategy to directly reflect the day-to-day realities shaping young people's mental health and wellbeing, including cost of living pressures, racism, bullying and discrimination, online harms and social media pressures, identity-related challenges, school stress, and difficulties accessing support without fear of judgement or dismissal.

Young people highlighted to us the importance of safe, accessible, well-promoted and confidential (where possible) supports in the environments where they already spend time, particularly schools, online spaces, whānau and communities. This includes access to school-based counselling and early intervention services, such as Youth One Stop Shops. Young people also identified the importance of equipping whānau with practical resources and support to help them talk openly about mental health and wellbeing, listen without judgement, recognise signs of distress, and respond supportively when young people seek help. **We look forward to seeing these solutions reflected in the Strategy and implementation plan, as well as all recommendations that came out of the Summit in the upcoming roadmap and action plan.**

Relationship to other strategies and plans

While the draft Strategy refers to working alongside other strategies to create a unified approach to better mental health and wellbeing (Figure 2), the intended scope of this Strategy and how it interfaces with related strategies and action plan is not always clear. For example, the purpose and scope section states that the Strategy "provides clear direction on the system-level actions required to improve mental health and wellbeing outcomes, and prevent and reduce harm from substance use, gambling, and addiction." However, Priority 1 also includes strategic actions relating to suicide prevention and postvention, despite suicide not being explicitly included within the stated scope of the Strategy.

We recommend the Strategy more explicitly define the remit, responsibilities and relationship between these interconnected strategies and plans, including how priorities, implementation responsibilities, accountability arrangements and reporting will align across the wider strategic landscape. This would help reduce duplication, strengthen system coherence, and provide greater clarity about where responsibility for particular actions and outcomes sits.

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PO Box 10051, Dominion Road, Auckland 1446

We note the Strategy's broad acknowledgement of international conventions to which Aotearoa New Zealand is a signatory. However, **we recommend the Strategy explicitly name relevant conventions**, including the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

Strategic direction

We note that physical health is mentioned throughout the Strategy and is a key component of the vision statement. We strongly support the recognition that mental health and addiction, physical health, and social wellbeing are interconnected. However, this recognition is not matched by concrete strategic action to address the significant physical health inequities experienced by people with mental health and addiction challenges, despite the draft acknowledging this issue.

We note one of the strategic actions seeks to generally improve continuity of care and transitions between mental health and other health services but **we recommend including a strategic action that *explicitly* seeks to strengthen integrated mental and physical health care for people experiencing mental health and addiction challenges**, including through routine physical health screening, prevention, early intervention, health promotion, and clear pathways into primary and specialist physical health services and integration across mental health services.

We are concerned by the claim that there has been a shift "from a health-only response to a whole-of-government approach" (p.8). We support this direction of travel, but do not consider the current system has yet shifted sufficiently to substantiate this claim. In practice, cross-government action on the determinants of mental health and wellbeing remains limited, and the draft Strategy does not yet set out the mechanisms, responsibilities or resourcing needed to embed a genuinely whole-of-government approach.

Priority areas

We recommend reviewing the priority areas and associated strategic actions to ensure they are not overly constrained by the Government's existing mental health and addiction targets. While the MHF supports the four priority areas identified, a ten-year Strategy should provide a broader and more enduring

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Eden 3, Ground floor, 16 Normanby Road, Mount Eden, Auckland
PO Box 10051, Dominion Road, Auckland 1446

direction for mental health and wellbeing system transformation than the current target framework alone can offer.

Additionally, we have reservations about the "what the future will look like" sections related to each priority area. While we appreciate the value of articulating an ambitious long-term vision for mental health, addiction and wellbeing in Aotearoa New Zealand, the draft relies heavily on aspirational future-state language, with limited alignment between the scale of change described and the scope of the corresponding strategic actions and proposed measures. This suggests the Strategy is not positioned in a way that can deliver the transformational outcomes envisaged.

Priority 1: Prevention and early intervention

The MHF strongly supports the focus on prevention and early intervention, including mental wellbeing promotion, as a priority area. **We recommend clearly defining and distinguishing between primary prevention, mental wellbeing promotion, and early intervention**. These are connected but distinct functions, requiring different actions, investment approaches and measures. Primary prevention should focus on reducing risk factors and strengthening protective factors across the whole population; mental wellbeing promotion should support people, whānau and communities to build and sustain positive wellbeing; and early intervention should ensure timely support is available when distress or harm begins to emerge.

We recommend including a strategic action for the Ministry of Health to lead the development and implementation of a 'mental health and wellbeing in all policies' approach to support a true cross-government approach to improving population mental health and wellbeing outcomes.

We also recommend adding an action requiring the Ministry of Health to develop and lead an all-of government mental health budget to support cross-agency consensus and investment to reduce the determinants of mental distress and increase the protective factors that support wellbeing.

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Feedback on Priority 1 strategic actions

1. Strengthen wellbeing promotion efforts and literacy related to mental health, substance and gambling related harms, and addiction across a range of settings and tailored to population groups at higher risk of distress and harm including suicide.
We recommend providing greater clarity regarding the settings and population groups this action refers to. We recommend the implementation plan explicitly name schools and workplaces as key settings for wellbeing promotion and literacy, alongside other community settings where people live, learn, work and connect. **We recommend a specific focus on high-deprivation areas.** Priority population groups, including Māori, Pacific peoples, Asian communities, disabled people, rainbow communities, young people and other groups experiencing inequities should be explicitly named.
2. Provide and promote comprehensive access to early support to address emerging mental health and wellbeing challenges.
We recommend clarifying whether "early support" refers to support early in the life course, early in the development of distress or harm, or both. These are related but distinct approaches, and **we recommend both are covered by this action**. We would welcome more detail about how comprehensive access to early support will be achieved, including which services, settings, pathways, or population groups will be prioritised. **We recommend strengthening the role of accessible and confidential school-based mental health supports**, including counselling and early intervention services, as schools are often one of the primary places young people seek support before reaching crisis point.
3. Implement evidence-based suicide prevention and postvention, and substance and gambling harm prevention and reduction programmes.
We support the inclusion of this action and recommend clarifying how it relates to existing strategies and action plans, including the *Suicide Prevention and Postvention Strategy and Action Plan*, the *Action Plan to Prevent and Reduce Substance Harm*, and the *Strategy to Prevent and Minimise Gambling Harm*. The Strategy and implementation plan should make clear how these work programmes

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will be mutually reinforcing, avoid duplication, and support clear accountability for delivery.

We recommend these programmes are designed, delivered, governed, and evaluated with lived experience, existing services and those working in the suicide prevention and postvention and substance and gambling harm sectors.

4. Grow community-based supports and services, and enhanced models of care, to foster positive mental health and wellbeing for pregnant women and parents with young children, and to support mental health and addiction needs within the family.

We support this action and recommend it explicitly include specialist mental health and addiction services to complement community-based supports and enhanced models of care. Pregnancy, the early years, and transitions into parenthood are critical periods for prevention and early intervention across the life course. The action should actively support community-based, primary and specialist services to work together to provide timely, integrated and wraparound care for parents, babies, young children and whānau, including culturally grounded antenatal and early parenting supports.

5. Expand access to a range of evidence-informed resources, supports and services for children and young people tailored to their age and developmental stage, with flexible age range eligibility criteria to enable them to engage fully in important developmental experiences.

We recommend strengthening this action to explicitly state that resources, supports and services for children and young people should be designed and developed with them. While the "what the future will look like" section refers to young people being involved in the design of supports, this should also be embedded in the strategic action itself to ensure it is carried through into implementation. Youth-responsive support must go beyond tailoring predominantly adult-centric models to fit rangatahi.

6. Ensure people engaged with, or transitioning from, the mental health and addiction system who lack basic supports, such as housing and employment, receive integrated or wraparound support.

We support this action and recommend reframing it to avoid deficit-based language such as "people who lack basic supports", which risks obscuring the

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PO Box 10051, Dominion Road, Auckland 1446

systemic barriers people face in accessing stable housing, employment, income and other social supports. The action should instead focus on the responsibility of the health system, working alongside other agencies and sectors, to provide integrated and wraparound pathways for people who also need housing, employment and other support. You might, for example, phrase this as: "Ensure people engaged with, or transitioning from, the mental health and addiction system are equipped with basic supports such as…".

We recommend cross-referencing this action under Priority 2, as housing and employment support is not only preventative but essential for people already engaged with, or transitioning from, mental health and addiction services. The implementation plan should clarify how integrated support will be delivered, such as access to dedicated housing and employment advisors or equivalent roles within, or closely connected to, mental health and addiction services.

Priority 2: Access to supports and services

The MHF recommends including an action to address Te Hiringa Mahara's recommendation for Health New Zealand to develop a nationally cohesive and networked mental health crisis response system by 30 June 2027. The draft does not sufficiently set out how crisis responses will become more coordinated, accessible, trauma-informed and connected across regions and services.

We recommend strengthening the focus on genuinely person-centred, recovery-oriented and rights-based support, consistent with WHO guidance. While the actions under Priority 2 include positive references to accessibility, responsiveness and continuity of care, they should more clearly reflect principles of choice and autonomy, co-design with people and whānau, flexibility of supports, and services organised around people's goals and needs rather than service boundaries. We note that 'choice' should not be conflated with 'options' – both are essential, especially for supporting diverse population groups. The existence of multiple service options does not necessarily mean people can exercise meaningful choice if supports are not culturally safe, geographically accessible, affordable, flexible, or aligned with people's preferences and circumstances.

We recommend including explicit commitments within the Priority 2 actions to scale up kaupapa Māori services and supports. Māori make up nearly one third of

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Eden 3, Ground floor, 16 Normanby Road, Mount Eden, Auckland
PO Box 10051, Dominion Road, Auckland 1446

those accessing specialist mental health and addiction services.[v] As noted by Te Hiringa Mahara, this reflects a broader context of inequity for Māori, including unequal access to protective determinants of health, culturally safe care, prevention and early support. As a result, higher use of specialist services reflects greater need – in 2024/25, Māori adults experienced one of the highest rates of unmet need for mental health or substance use care across ethnic groups, at 16.1 percent.[vi]

Feedback on Priority 2 strategic actions

1. Scale up community supports and strengthen access to and options of mental health and addiction services across a comprehensive continuum of care including specialist services, eating disorders services, crisis support services and forensic services.
We recommend explicitly including primary mental health and addiction care within this action if the intention is to reflect the full continuum of care.
3. Deliver safe, trauma-informed, responsive, accessible, and age and culturally appropriate services for populations with specific needs.
We recommend strengthening this action to deliver culturally safe and culturally responsive services, rather than referring only to "safe" and "culturally appropriate" services.
5. Collaboratively develop consistent models of care across mental health and addiction services, with ongoing improvements to reflect emerging evidence, and clear expectations for geographic availability.
We recommend clarifying accountability arrangements for the development, oversight, implementation and evaluation of these models of care, including which agencies will be responsible for ensuring national consistency and equitable geographic availability.

Priority 3: Workforce

While we strongly support further developing and utilising the essential skillset of the Consumer, Peer Support and Lived Experience (CPSLE) workforce, we have heard concerns from the lived experience community that the draft Strategy may place disproportionate emphasis on growing the peer workforce as a rapid response to

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PO Box 10051, Dominion Road, Auckland 1446

workforce shortages at the expense of sustainably growing workforce capacity across all disciplines. The importance of sustaining and growing specialist clinical workforce capacity is currently under-reflected in the draft Strategy.

Careful consideration should be given to how the peer workforce is expanded into complex settings such as crisis response. This will require appropriate training, supervision, workforce support, leadership capability, cultural readiness, and organisational infrastructure to ensure peer workers are safe, well-supported and able to work effectively within multidisciplinary environments.

We recommend making a clear link between the Strategy and Health New Zealand's *Mental Health & Addiction Workforce Plan 2024–2027*, including setting out how these documents will align to support workforce planning and implementation while reducing any duplication.

We recommend committing to routine public reporting on mental health and addiction workforce composition and FTEs across all disciplines, including the private workforce. We recommend that Health New Zealand engage with, and consider the role of, the private mental health and addiction workforce to ensure their capability, capacity, and role in continuity of care are appropriately reflected in national workforce planning and system coordination.

Feedback on Priority 3 strategic actions

1. Grow the workforce through expanded training, internship, and placement opportunities supported by appropriate supervision arrangements and career progression pathways to enable a smooth flow of new graduates into the workforce.
We recommend exploring the benefits and feasibility of paid internships and placements to support workforce sustainability, equity, wellbeing and retention, particularly given the financial barriers many students and trainees face when entering the mental health and addiction workforce. The reference to new graduates appears to frame workforce growth primarily through traditional clinical education and training pathways. If the Strategy is seeking to genuinely diversify the workforce, it should recognise and invest in pathways for the non-regulated and community-based workforces by reflecting a

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broader range of entry points, training models and careers pathways across both regulated and non-regulated parts of the mental health and addiction workforce.
2. Diversify the range of roles that can support mental health, addiction and wellbeing and support professionals to work to the top of their scope of practice to enhance system productivity.
We support workforce diversification and enabling professionals to work to the top of their scope of practice where appropriate. Careful consideration is required to determine how this is implemented across different parts of the system. In particular, crisis response and acute care settings require a high level of clinical judgement, experience, supervision and organisational support. **The Strategy and implementation plan should avoid creating undue pressure for unregulated workers, newly graduated professionals, or less experienced practitioners** to work beyond their capabilities in high-risk environments without appropriate training, support, infrastructure and multidisciplinary oversight.
4. Implement targeted strategies to improve recruitment and retention, seeking to ensure employment conditions make mental health and addiction an attractive space to work and improving representativeness.
We recommend clarifying how this will be operationally supported, such as through competitive remuneration, manageable workloads, professional development opportunities, and mental wellbeing supports for the workforce. The Strategy should clarify how workforce representativeness will be measured and strengthened across disciplines and leadership levels.
5. Further develop the Consumer, Peer Support and Lived Experience workforce with intentional planning, coordination and support mechanisms to enable this workforce to play a significant role in supports and services.
We support this action in principle. **The Strategy and implementation plan should more clearly articulate and support the infrastructure required to sustainably grow and support the CPSLE workforce**, including training, supervision, organisational readiness, cultural safety, workforce wellbeing, and pathways into leadership, governance, policy and advisory roles.

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6. Support and promote other health and social service workforces to access upskill training to enable them to recognise and support mental health, addiction and wellbeing challenges alongside physical health and social sector needs.
We recommend explicitly including the education sector within this action. Teachers and the wider education workforce are often key points of early identification and support for children and young people experiencing distress and should be appropriately trained and supported as part of a broader cross-sector workforce approach.

Priority 4: Effectiveness

We recommend committing to the development of a national mental health and addiction data, research and insights plan to help meaningfully deliver on Priority 4 actions relating to monitoring, evaluation, evidence and system effectiveness. We note the Cross-Party Mental Health and Addictions Wellbeing Group signalled in December 2025 that it would "reach out to the Minister for Mental Health regarding the need for a national mental health, addiction and wellbeing data and research plan to guide evidence-based commissioning."

A long-term plan is timely, given the previous national mental health data and research plan was developed approximately 20 years ago.[5] A refreshed plan could help align national priorities, investment and commissioning, and embed an iterative series of epidemiological studies.[6] This plan should sit alongside the Strategy, implementation plan, and related strategies and action plans.

International evidence supports the value of long-term stewardship and coordinated data and research planning in strengthening system performance, accountability and policy alignment. OECD benchmarking highlights the importance of these approaches,[vii] and comparable countries including Ireland and Australia have developed such plans aligned with their national mental health strategies.

[5] Gaines et al. (2003). *New Zealand Mental Health Classification and Outcomes Study: Final Report*. Health Research Council of New Zealand: Auckland
[6] Building on the work already underway on the Child and Youth Mental Health Study.

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Eden 3, Ground floor, 16 Normanby Road, Mount Eden, Auckland
PO Box 10051, Dominion Road, Auckland 1446

Feedback on Priority 4 strategic actions

1. Embed the infrastructure needed to support lived experience leadership at all levels of the system and meaningfully involve people with lived experience, their families and communities in design and delivery of supports and services.
We strongly support inclusion of this action. It would be beneficial to clarify the definition of "lived experience". **We recommend explicitly including those bereaved by suicide in this definition and action**.
2. Implement targeted strategies to combat prejudice and discrimination and change attitudes in the health system and across sectors to improve equity for people experiencing mental health and addiction challenges, particularly those with severe and enduring needs.
We support this action. The current anti-discrimination programme *Nōku Te Ao: Like Minds* is under review and it will be vital that the value of this work is robustly identified and assessed and the future programme adequately resourced. Reducing prejudice and discrimination is fundamental to the success of all priority areas within the Strategy, including prevention and early intervention, service access, workforce development, lived experience leadership and service effectiveness. Prejudice and discrimination can act as major barriers to help-seeking, quality care, interdisciplinary collaboration and the meaningful integration of peer support and lived experience expertise across the system. **We recommend the Strategy and implementation plan explicitly recognise anti-prejudice and anti-discrimination work as a core system enabler**.
5. Improve the quality and safety of services for people receiving mental health care through supported decision making, minimising the use and duration of compulsory care, robust monitoring, and reducing and eliminating the use of seclusion and restraint for people receiving compulsory mental health care.
We support the inclusion of this action and agree that robust monitoring will be essential to reducing compulsory care, seclusion and restraint. However, the Strategy understates the scale of system change required to achieve this. Monitoring and transparency relating to compulsory care practices remain inconsistent and, in some areas, appear to have weakened. For example, recent reports from the Director of Mental Health and Addition Services have been substantially delayed, and restraint data is not routinely publicly reported. Progress towards eliminating seclusion has stalled at times over the past decade.

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The Strategy and implementation plan should include stronger accountability mechanisms, transparent reporting requirements, and clearer expectations for how services will be supported to reduce coercive practices over time.

Here it would also be appropriate to recognise the importance of preventing iatrogenic harm and escalation through clinical interventions and practices by promoting trauma-responsive, culturally safe and recovery-oriented practice throughout the continuum of care.

Thank you

We appreciate the opportunity to provide feedback and would welcome ongoing engagement as the Strategy and implementation plan are further developed.

Mauri tū, mauri ora,

Shaun Robinson
Chief Executive

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Appendix 1: Language change recommendations

Section	Recommendation
Figure 4: Continuum of mental health and addiction system services and supports (p.5)	We welcome the continuum conceptualisation that spans promotion and prevention, early intervention through to specialist mental health and addiction services. **We recommend reconsidering the phrase of "mental wellbeing supports including early intervention and harm reduction"**, as supporting positive mental health and wellbeing is not the same as early intervention at the early signs of mental health challenges.
Following paragraph which discusses barriers to access (p.5)	**We recommend revising this paragraph**. As currently framed, it appears to focus primarily on pathways into secondary or specialist services, rather than recognising barriers people may face when trying to access support at any point across the continuum. **We also recommend replacing "unique population needs" with "diverse population needs"**, as all people experience unique needs regardless of which population group they belong to.
First paragraph under "What the future will look like" (p.15)	**We recommend adding "culturally safe/responsive and trauma-informed"** to "This workforce will be equipped to deliver care that is inclusive, age appropriate, culturally responsive, and person-centred."
References to "pregnant women"	**We recommend using more inclusive language by replacing "pregnant women" with "pregnant people".**

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References

[i] Te Hiringa Mahara—Mental Health and Wellbeing Commission. (2026, April 8). *Mental Health and Wellbeing Strategy consultation now open.* https://www.mhwc.govt.nz/news-and-resources/mental-health-and-wellbeing-strategy-consultation

[ii] Te Hiringa Mahara — Mental Health and Wellbeing Commission. (2025, June 11). *He Ara Āwhina* dashboard.

[iii] Ibid.

[iv] Te Hiringa Mahara—Mental Health and Wellbeing Commission. (2026, April 8). *Mental Health and Wellbeing Strategy consultation now open.* https://www.mhwc.govt.nz/news-and-resources/mental-health-and-wellbeing-strategy-consultation

[v] In 2024/2025, 30.6% of all people using specialist services were Māori.

Te Hiringa Mahara—Mental Health and Wellbeing Commission. (2026). *Access to mental health and addiction services.* https://www.mhwc.govt.nz/assets/Reports/HAA-monitoring/MHWC-Access-data-summary-Feb-2026.pdf

[vi] Te Hiringa Mahara—Mental Health and Wellbeing Commission. (2026). *Mental health and substance use data summary: Key findings from the NZ Health Survey 2024/2025.* https://www.mhwc.govt.nz/news-and-resources/nz-health-survey-2024-25-mental-health-and-substance-use-data-summary-downloads/

[vii] OECD. (2021). *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/4ed890f6-en

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