Mental Health Foundation
mauri tū, mauri ora
OF NEW ZEALAND

Submission: Public consultation on the New Zealand Disability Strategy 2026-2030

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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Whaikaha | Ministry of Disabled People

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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
Rau rangatira mā, ānei ngā whakaaro me ngā kōrero nā Te Hauora Hinengaro.

Thank you for the opportunity to comment on the draft *New Zealand Disability Strategy 2026-2030* (the Strategy).

The Mental Health Foundation of New Zealand (MHF) 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. We value the voices of people with mental health challenges (or tāngata whaiora) and we aim to reflect their needs and aspirations in the work we do.

The MHF is contributing to this consultation because people living with long-term mental health conditions are recognised as disabled under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), and because disabled people experience disproportionately high rates of psychological distress.

General comments

The MHF welcomes the Strategy's focus on improving outcomes for disabled people, and we acknowledge that the Strategy is guided by the definition of disability set out in the UNCRPD, which includes those who have "long-term physical, mental, intellectual, or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."

This framing aligns with the social model of disability and reflects a strong commitment to inclusivity.

While we support using this broad definition of disability, there remains some uncertainty about how this definition is carried through into the proposed actions. It is not clear how people with long-term or chronic experiences of mental illness and/or distress, neurodevelopmental, neurodegenerative or neurological conditions, and other forms of cognitive impairment[i] will benefit from the intended outcomes, despite being included under the UNCRPD definition – while recognising that some of these individuals may not identify as disabled or use the language of 'impairment'. **We recommend clarifying how the definition of disability applies consistently across the actions.** Doing so would strengthen alignment with both the UNCRPD definition of disability and enhance the Strategy's relevance and applicability across both the mental health and broader health and disability sectors. Without this clarity, there is a risk that some groups will be overlooked in its implementation.

Mental health inequities remain stark for the disabled community, with disabled people much more likely to experience mental distress than the general population.[1] The MHF recommends highlighting key statistics related to this in 'the case for change' under the health priority outcome area. Over the past six years, mental health outcomes for disabled adults have significantly worsened, with 33.2 percent reporting experiencing high or very high psychological distress in 2023/24, compared with 11.2 percent of non-disabled adults. This is up from 27.1 percent in 2018/19.[2] Young people with disabilities report particularly high levels of mental health concerns, which are significantly more prevalent than among their non-disabled peers.[3]

We recommend the Strategy name relevant government strategies (e.g., the *Health of Disabled People Strategy*, the *Oranga Tamariki Disability Strategy*, and the *Carers' Strategy and Action Plan*, etc.) and explain how the Strategy relates to them. Similarly, it would be helpful to explain what is unique and distinct in the

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[i] This may include (non-exhaustively) people experiencing schizophrenia, bipolar disorder, major depression, or post-traumatic stress disorder; those with autism spectrum disorder (ASD), attention-deficit hyperactivity disorder (ADHD), or fetal alcohol spectrum disorder (FASD); people with dementia, Parkinson's disease, acquired brain injuries, or other cognitive impairments.

current Strategy's scope and intent. While we acknowledge that the Ministry of Health | Manatū Hauora is responsible for developing the (separate and provisional) *Health of Disabled People Strategy* that addresses the mental health of disabled people within the health system, we hold the strong view that this Strategy is the primary vehicle for more broadly addressing disabled peoples' mental health and wellbeing through a cross-system, integrated approach.

We support publishing the key indicators, supporting measures and contextual evidence and data in interactive dashboards, and suggest this material is also presented in simpler accessible formats (for those who may have trouble deciphering dashboards).

Vision and principles

While the MHF acknowledges the vision and principles have been developed with robust input from tāngata whaikaha Māori and disabled people, **we recommend the Strategy explicitly adopt the *Enabling Good Lives* (EGL) vision and principles as a foundation for positive change**. We recognise that, since 2013, the EGL approach has been promoted and tested throughout Aotearoa New Zealand and, through evaluation, it has been found to make a meaningful difference in the lives of disabled people, tāngata whaikaha Māori, families and whānau. As such, we support the call issued by the EGL National Leadership Group (NEGL).[ii]

We also support amending the Strategy's vision to explicitly centre the right of disabled people, tāngata whaikaha Māori, families and whānau to exercise greater choice and control over the supports and life pathways that work for them. As the NEGL has noted, this framing affirms self-determination and moves away from a deficit-based model toward one that celebrates the strengths, aspirations and leadership of disabled people and their families.

Furthermore, while the Strategy includes important values in the draft principles such as choice and control, accessibility, and equity, we note that the foundational principles of EGL, which have been widely endorsed across the disability sector, are not fully reflected. In particular, the Strategy's principles lack emphasis on early

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[ii] *A call to disabled people, Tangata Whaikaha Māori, families, whānau and allies regarding the need to explicitly include EGL in the refreshed NZ Disability Strategy*

intervention and preventative measures (e.g., investment in whānau and natural supports), designing systems that are easy to use and navigate, fostering relationship-building and community inclusion, and ensuring truly person-centred, holistic planning. Incorporating these principles would strengthen the Strategy's alignment with existing disability transformation efforts and ensure a more integrated, life-course approach to supporting disabled people and whānau.

The MHF recommends the 'choice and control' principle empowers individuals to self-identify as disabled, if they see themselves as part of this community. The lack of clarity about how the Strategy's actions relate to those with long-term or chronic experiences of mental illness and/or distress and other forms of cognitive impairment risks leaving some people unsure whether they are entitled to the rights, supports, and recognition afforded by disability policy. Empowering people to make their own decisions about identity and affiliation is a vital aspect of dignity and autonomy and should be made explicit.

We recommend strengthening the 'participation and inclusion' principle, so that it "recognises disabled people's right to be active members of their communities and cultures in all aspects of life, *free from stigma and discrimination*".

The MHF recommends removing reference to "partnership, participation and protection" under the Treaty of Waitangi (Te Tiriti o Waitangi) principle, as this is an outdated and insufficient interpretation of the principles of Te Tiriti o Waitangi. Instead, we recommend explicitly referring to the articles of Te Tiriti o Waitangi,[iii] or the Tiriti principles for the health and disability system (as articulated in the Waitangi Tribunal's 2019 *Hauora* report). Tino rangatiratanga, which provides for Māori self-determination over their own lives, wellbeing, and health and disability services, is a particularly critical concept that should be acknowledged under this principle, as well as elsewhere in the Strategy. This would support a shift away from a paternalistic framing, towards a Tiriti-consistent approach that centres Māori self-determination and leadership. Upholding tino rangatiratanga also means ensuring tāngata whaikaha Māori have genuine authority in governance, decision-making, and monitoring of the Strategy's implementation.

Additionally, despite the Treaty of Waitangi being named as a core principle of the Strategy, this commitment is not strongly carried through into the priority outcome

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[iii] Kāwanatanga, tino rangatiratanga, ōritetanga and wairuatanga.

areas or their corresponding measures of success and actions. **We recommend strengthening this by explicitly embedding Te Tiriti o Waitangi obligations within each outcome area, and by naming which text of Te Tiriti/Treaty is being relied upon**. We suggest the Strategy adopt the Māori text (Te Tiriti o Waitangi), which provides the most authentic basis for Crown obligations. At a minimum, clarity and consistency on this point are essential to provide a firmer foundation for implementation.

Priority outcome areas and actions

While we recognise the need to balance simplicity and achievability with sufficient breadth, the Strategy should consider other pertinent factors to support disabled people's fullest participation in society. These include factors such as accessibility of public spaces and services; transport and mobility; disaster preparedness and safety; accessible information and communication systems; standards of living that go beyond housing (including efforts to reduce homelessness); opportunities for social inclusion, sport, recreation and cultural connection; and reducing stigma and discrimination. International examples from comparable jurisdictions, such as the Australian and Irish disability strategies, demonstrate that a broader, interconnected approach addressing the full range of social determinants is critical to enabling meaningful change and positive outcomes.

The MHF supports the inclusion of actions within the Strategy itself, as this has the potential to drive tangible change. However, the government agencies responsible for delivering and supporting the actions are not clearly specified,[iv] and actions are frequently broad, vague (e.g., "review and improve policies and practices") and/or indirect (e.g., using language like "work to [do action]"). **To ensure progress on the Strategy is transparent, timely and measurable, we recommend explicitly assigning lead (and supporting, if relevant) government agencies for each action, setting clear timeframes for implementation, and for each action to have a clearly defined deliverable date.** This could involve breaking broader actions into

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[iv] Beyond the mention that "the Ministry will ask government agencies to report back on the progress of actions they are responsible for" and the implication that government bodies whose subject matter expertise is aligned with each priority outcome area will take responsibility for actions within that area.

more focused, measurable and staged parts. We provide more detailed commentary on this point in other relevant parts of the submission.

We also suggest acknowledging when actions or priority outcome areas are addressing a UNCRPD Concluding Observation, and potentially the UNCRPD articles relevant to each area.

Education

The MHF recommends briefly defining the scope of "education" in this section, and specifying the education setting(s) each action applies to, for clarity. It is currently unclear if the actions in this section apply across the full spectrum of education settings (e.g., from early learning and childcare, primary and secondary schools and kura, tertiary education, "mainstream" and specialist schools, etc.), though they appear to primarily refer to school- and kura-based education, with one action relevant to tertiary education.

We would like to see support for disabled ākonga/learners' social, emotional and mental wellbeing acknowledged in this outcome area, particularly for young disabled learners. Schools and kura are critical sites for early mental health intervention and teaching young people how to manage their own wellbeing. This is especially important for young people with disabilities as they are more likely to experience mental distress.

Relatedly, we note in this section's "case for change" it is mentioned that "many [disabled students] feel like they do not belong". While actions to improve teacher training, education programmes, and accessibility of learning environments and learning support will play a role in fostering a sense of belonging, **we recommend adding an action specifically geared towards making learning environments welcoming and inclusive for disabled learners**. This could cover, for example, ensuring learning environments support disabled learners to feel accepted and like they (and their cultures and diversity) belong, offer them opportunities to engage with their disabled and non-disabled peers and make friends, and protect them from bullying. Social and "school connectedness"[v] are associated with higher overall

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[v] The extent to which students feel valued, supported and accepted in their school environment (also known as "school belonging").[5]

wellbeing, fewer risk factors for poor wellbeing, and better academic achievement in students.[4]

The MHF suggests considering bespoke actions to improve the capacity of the education system to support learners who are neurodivergent or experience significant mental illness and/or distress. Disabled learners can have different experiences at learning places depending on their impairments and needs. For example, learners who are neurodivergent are more likely to be discouraged from enrolment or asked by the school to stay home.[6] Lack of understanding of and support for significant mental illness and/or distress and neurodivergence can lead to decreased academic performance, less engagement with learning and peers, challenging behaviours and school exclusion,[7] which illustrates the importance of supporting learners with these needs specifically.

We recommend adding an action to support ākonga/learners' transitions between learning places and/or types of education (e.g., from early years to school, or from school to tertiary). Major life transitions such as moving from high school into further education and training are identified as especially challenging for disabled young people and a time when they "fall through the cracks" with support services.[8] Better coordination of supports for disabled learners and pathways in and beyond school has also been identified as a key area for improvement by the Education Review Office.[9]

Employment

While the MHF generally supports the goal and definition of success for employment, we believe the actions need strengthening to truly give effect to these intentions. In particular, we believe **the identified need to shift toward "better pathways into employment" could be better supported with actions that seek to directly create or expand specialist employment services and employment opportunities that reflect the potential and aspirations of disabled people.** This could include, for example, exploring initiatives like paid internships, apprenticeships or work placements, and integrated employment and health, mental health and/or disability services. Individual placement and support (IPS), an evidence-based approach that has been effective in raising employment rates, qualifications and independent income for people with mental health conditions or problematic substance use in Aotearoa New Zealand,[10] is an example of an effective employment support approach that could be supported by the Strategy to be scaled up and used as a model to lift disabled people's employment opportunities and experiences.[vi]

We suggest using clearer and more assertive language (e.g., "centralise" rather than "work to centralise") and ensuring actions are well-defined and have tangible outcomes, as this will help drive measurable progress. For example, "review specialist employment supports to improve employment outcomes" is vague (what are improved employment outcomes?) and could be strengthened with a subsequent requirement to act on the review (e.g., to expand effective employment supports, develop/pilot suitable additional supports, etc.). Similarly, the meaning of "improved employment outcomes" or "better employment outcomes" is unclear (does this mean closing the employment gap between disabled and non-disabled people, longer-term employment, more inclusive work environments, etc.?). We also recommend rewording "disability-confident employers recognise…" to "all employers will be disability-confident, recognising…" to avoid this being misinterpreted as suggesting it is permissible for employers to not recognise disabled people's talents and so on if they are not yet "disability-confident".

While better economic security is mentioned as a positive outcome of employment, **this section could more clearly acknowledge the challenges disabled people can face navigating and retaining adequate financial assistance alongside employment**. On average, disabled people work fewer hours, are more likely to work part-time, and have lower incomes than non-disabled people,[11] and will often need to supplement their incomes with government assistance. It is important that welfare systems can support disabled people to engage in diverse, flexible and dynamic working arrangements (including part-time and intermittent work) suited to their needs and aspirations without risk of economic insecurity, sanctions or administrative burdens.

[vi] See also the recommendations from: OECD. (2018). *Mental Health and Work: New Zealand*. OECD Publishing, Paris. https://doi.org/10.1787/9789264307315-en.

Health

The MHF recommends the goal for health specifies "…the highest possible standard of *physical and mental* health and wellbeing".

We recommend amending part of the 'success in health' section to state "Tāngata whaikaha Māori are understood as part of a collective, and *the health system will actively work with tāngata whaikaha Māori* to involve whānau in their health in the ways they want." It is crucial the health system proactively enables whānau involvement, rather than placing the responsibility on tāngata whaikaha Māori to request it.

We recommend adopting a more comprehensive definition of quality of life in this Strategy, such as "The health system will enhance quality of life for disabled people, so they have the ability to achieve the highest attainable standard of physical and mental health, to live with dignity and inclusion, and to participate fully in social, cultural and economic life free from stigma and discrimination." This would ensure that quality of life is measured against the full range of factors that enable disabled people to live well. For disabled people, success in health should also mean being able to live free from preventable mental and physical health inequities, which can be achieved by having equitable access to appropriate physical and mental health care, freedom from stigma and discrimination within health and social services, and the ability to participate fully in social, cultural and economic life. Other jurisdictions have already taken this more holistic approach. For example, *Australia's Disability Strategy* explicitly states: *"Good health and wellbeing are critical determinants of a person's quality of life. This is especially the case for people with disability. In addition to the physical aspects of health and wellbeing, improving mental health outcomes for people with disability is also a key focus… It is also important to address the social, cultural and economic determinants of health and wellbeing."*

The MHF recommends clearly defining "the health system" and taking a broad definition, rather than a narrow interpretation limited to hospital and clinical services. For disabled people, health outcomes are shaped by a wide range of supports and environments, including primary and community care, mental health services, disability support services, public health initiatives, and the social, cultural, and economic determinants of health. Defining the health system more broadly would help ensure the Strategy promotes integrated, cross-sector approaches that reflect the realities of disabled people's lives.

Disabled people, including those with chronic physical or mental health conditions, experience poorer health outcomes compared with non-disabled people, and have higher rates of mortality and lower life expectancy.[12] **We recommend adding an additional point regarding success in health, such as: "Parity of esteem between mental and physical health will be embedded across the health system, so that disabled people experience equitable access, quality, and outcomes for both mental and physical health, including those whose primary disability is a mental health condition."** Embedding parity of esteem (that is, ensuring that mental health is valued equally with physical health) is essential to help close inequities in health outcomes and access to care for disabled people. This is already recognised in the Pae Ora (Healthy Futures) Act 2022 as a core health sector principle.[vii] Parity of esteem means more than equal recognition – it requires that the quality of care, timeliness of access, and health outcomes for mental health are comparable to those for physical health.

Action 1: Review and improve policies and practices, so the health journey is equitable, accessible and inclusive.

This action is too vague, broad and potentially too ambitious. It attempts to encompass multiple complex domains (communication, information, technology, decision-making, service design and delivery, and the built environment) under a single review, with little indication of scope, priority, or sequencing. Without clarity on leadership, accountability, or specific measures of success, there is a risk this becomes an aspirational statement rather than a practical action. **We recommend breaking this into more focused, staged actions, and explicitly linking it to work either planned or underway in the domains mentioned.**

That said, the MHF does support the intention to make tools for self-determination and supported decision-making standard practice in health care. **We suggest this includes or aligns with adequate implementation planning and resourcing for the new supported decision-making provisions in the Mental Health Bill before the**

[vii] Section 7(1)(e)(iii): *The health sector should protect and promote people's health and wellbeing, including by— working to improve mental and physical health and diagnose and treat mental and physical health problems equitably.*

new law comes into force, and the expected repeal and replacement of the Protection of Personal and Property Rights Act 1988. **We also suggest this action strengthen policies and practices to increase the use and mandate of advance directives** (e.g., resources, guidance, information infrastructure, time and support).

Action 2: Build health workforce capability to deliver services that are inclusive, culturally safe, and easy to navigate.

While we support increasing the proportion of disabled people in the health and disability workforce, **we recommend this action explicitly commits to building the disability competency (across physical and mental conditions) of the non-disabled workforce**. While this may be implied, it is essential to highlight that workforce capability should not rely primarily on disabled staff and clinicians to meet the needs of their communities – particularly given the many barriers to education, training, and employment currently faced by disabled people. This includes embedding cultural safety and inclusive practice into mandatory training and ongoing professional development for *all* care providers, as well as "disability responsiveness and lived experience." Clear accountabilities and measurable outcomes should be established to ensure these efforts translate into improved accessibility and navigability of health services for disabled people.

We suggest considering how well the framing of this action extends to *all* disabilities and impairments, as people with chronic or long-term mental illness and/or distress and those who are neurodivergent face unique barriers to securing and retaining employment (as explored more fully in our comments on the employment outcome area, above).

Action 4: Identify disabled people in national health data.

The MHF is supportive of this action as it could significantly improve monitoring of health outcomes and patient experiences. However, it may be useful to clarify how identification will occur (e.g., self-identification versus inferred from service use) and how ethical considerations, autonomy, and potential stigma will be addressed. Ensuring that data collection respects the rights and preferences of disabled people will be critical to achieving meaningful and equitable outcomes. **We recommend that progress on this action is guided by disability community expectations, with an emphasis on protecting data sovereignty, as noted in action five.** It would also be beneficial to clarify the intended level of data disaggregation, including whether the data will capture and report on outcomes for tāngata whaikaha Māori.

Action 5: Implement systems to enable disabled people to record their accessibility needs against their National Health Index.

We are strongly supportive of this action, as it has clear benefits for both disabled people and providers. However, it is essential its implementation ensures equitable access, including raising awareness of the system and supporting people to use it, so that all disabled people can record their accessibility needs if they choose. **We recommend the system also be designed to reflect cultural and community diversity, ensuring it is responsive to the needs of groups such as rangatahi/youth, kaumātua Māori and older adults, and takatāpui and rainbow communities.**

Other comments

We recommend the Strategy include specific actions on prevention, timely and equitable access to appropriate health services, and integrated approaches that meet the full range of disabled people's health needs.

Overall, the MHF is concerned that the proposed health actions are largely structural and system-focused, with no dedicated actions addressing public health promotion, prevention, or early intervention. Early access to information and diagnosis, as well as proactive and accessible community-based prevention and health promotion, are critical to improving health outcomes for disabled people and their whānau. Without explicit attention to these areas, the Strategy risks reinforcing a reactive model of care rather than supporting disabled people to achieve wellbeing across the life course.

We are concerned by the lack of actions to improve availability of and access to health services (including mental health) for disabled people and tāngata whaikaha, or to increase health workforce capacity, despite the Strategy identifying multiple access barriers and highlighting unmet need as a key issue. Findings from the 2023/24 New Zealand Health Survey show that disabled adults are significantly more likely than others to seek support for their mental health from either family or professional providers.[13] This indicates that the problem lies not in a lack of help-seeking, but in systemic barriers to accessible and available services. Ensuring access to health services and mental health supports are central features of international disability strategies. Australia's Disability Strategy states *"Having appropriate, effective and accessible mental health supports and services, including in forensic mental health settings, which meet the needs of people with disability, and embedding a cross-sector approach to building mental health and wellbeing, are essential."*

Finally, the MHF remains concerned about how the health and disability system in Aotearoa New Zealand often fails to accommodate people with 'comorbid' or intersecting disabilities (such as having concurrent mental and physical disabilities, or multiple disabilities that require support across different parts of the system). For example, Te Pou notes longstanding concerns regarding access to effective treatment and support for autistic people and people with learning disabilities who also experience mental distress and/or addiction.[14] These individuals are often caught between disability and mental health services, resulting in fragmented or inadequate support to meet their full range of needs.

Housing

Consistent with our other comments on other areas of the Strategy, **the MHF suggests ensuring the housing actions (especially actions two and five) extend to people experiencing chronic or long-term mental illness and/or distress and neurodivergence and considering if any bespoke actions for these communities are warranted**. We note that people with long-term and/or significant mental health conditions face many barriers to accessing quality, healthy, long-term housing, including unaffordability and discrimination (e.g., by housing providers).

Specifically, retaining housing while experiencing occasional fluctuations in mental health can be a challenge as people may have to stop or reduce work and/or spend time in hospital (which, if longer than 13 weeks, results in significant cuts to any government benefits or payments). The lack of suitable, available housing and strict entry criteria for housing services for people recovering from acute mental distress has at times meant tāngata whaiora have been detained under the Mental

Health (Compulsory Treatment and Assessment) Act 1992 (the Mental Health Act) longer than clinically necessary.[viii]

In general, we support the intent of the actions to make dwellings more accessible (via the housing sector, private market and so on). **However, we are concerned that none of the actions meaningfully address the overwhelming issue of affordability** (and relatedly, low availability of social housing and thresholds for social housing that discriminate against disabled people[ix]).

We also suggest adding actions that support disabled people to navigate the housing system and access housing support pathways, free from discrimination.

Justice

The MHF supports the alignment with the Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions, particularly action one. **We recommend this action include safeguards to prevent the unethical placement of prisoners with significant mental health conditions in solitary confinement.**

We suggest acknowledging or addressing in this action the UNCRPD Concluding Observation 30 ("take immediate action to eliminate the use of solitary confinement, seclusion, physical and chemical restraints and other restrictive practices in places of detention"). The continued use of seclusion and restraint in involuntary mental health care settings is a human rights concern and is still permitted in the new legislation to replace the Mental Health Act.

Relatedly, we note that **any references to the Mental Health Act in the final Strategy (such as in action four) will need to eventually reflect the new legislation** replacing the Mental Health Act, when this is passed.

[viii] See, for example, the 2020 OPCAT report on an inspection of the mental health unit at Auckland City Hospital.

[ix] For example, disabled people currently living in housing that doesn't meet their needs (such as with parents) being perceived as ineligible for social housing because they are not technically "homeless".

Finally, **we recommend clarifying the meaning of "lived experience" in this section (e.g., lived experience of disability and/or the effects of crime, the criminal justice system, etc.) and "experiences of crime" (e.g., whether this means being affected by or perpetrating crime or both), and suggest action seven use the term "disability responsive" rather than "competent"**, as this emphasises a more ongoing and adaptive process of interacting.

Summary

The Mental Health Foundation of New Zealand welcomes the intent of the *New Zealand Disability Strategy 2026–2030* and its commitment to improving outcomes for disabled people. However, the Strategy should more explicitly support people with long-term experiences of mental illness and/or mental distress, neurodivergence, and other cognitive impairments, and the mental health of disabled people more broadly, to ensure their rights and needs are visible across all outcome areas.

We recommend the Strategy explicitly adopt the Enabling Good Lives principles, strengthen its commitments to Te Tiriti o Waitangi and tino rangatiratanga, and provide clarity on how responsibilities for actions will be assigned, resourced, and measured. The Strategy should also broaden its focus to include prevention, early intervention, and access to and availability of health services (including mental health), alongside addressing wider social determinants such as social inclusion and reducing stigma and discrimination. With these changes, the Strategy can move beyond high-level aspiration to become a practical, rights-based framework that drives measurable improvements in health, wellbeing, and participation for all disabled people, tāngata whaikaha Māori, whānau, and communities.

Mauri tū, mauri ora,

Shaun Robinson
Chief Executive

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