

## Feedback on draft Mental Health and Wellbeing Strategy - June 2025

Te Hiringa Mahara - Mental Health and Wellbeing Commission (the Commission) appreciates the ongoing engagement and the opportunity to respond to the draft Mental Health and Wellbeing Strategy (the Strategy).

On 27 May 2025, the Commission provided proactive advice on the development of the Strategy based on our work to date from monitoring, insights and engagement with lived experience communities. The content of our previous advice is still relevant, and we take it as read. We build on that advice here with respect to the draft Strategy, highlighting key points that arise when considering alignment of the draft Strategy with our proactive advice including the recommended key system shifts. We also provide specific feedback on the Commission's role.

### Vision and direction

The strategy is broad, and we support that. However, we consider that there is a need for a greater sense of urgency, acknowledging that the challenges highlighted are complex and long-running matters. This should be reflected in the vision and objectives of the Strategy and implementation plan.

We expect the Strategy to inspire hope and change. It should provide a shared view of what a good mental health and addiction system looks like. The 8-year timeframe provides a real opportunity for system leadership to focus on the critical changes that cannot be realised within the normal planning cycles of 1-3 years. To drive change over the next 8 years, we would hope that - more than parity with physical health - the Strategy could aspire to protect and improve the mental health and wellbeing of all people in New Zealand.

The final Strategy should include concrete and measurable objectives which contribute to the future state sought by the Strategy. Measurable strategic objectives with enough specificity will ensure achievement across the series of implementation plans.

There is good alignment between the draft Strategy and our upcoming system performance monitoring report. This means there is overlap with the measures for monitoring progress. We suggest you draw liberally from the measures in our report, and we can provide further advice as we refine these measures over time.

The Strategy needs to bring together government strategies and plans that address mental health. In particular, the status of Kia Manawanui needs to be clearly defined. We suggest the Strategy makes clearer that the two documents are meant to work together, and as the newer and longer-reaching of the two, the Strategy should make clear how it will contribute to delivering the outcomes of Kia Manawanui, and vice versa.

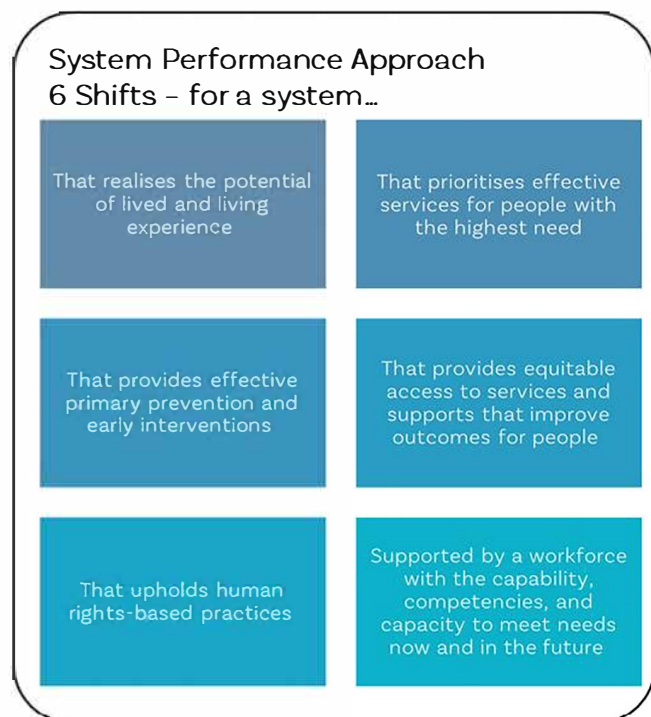
To support alignment, the Strategy could better articulate what the “landscape” looks like, outlining what services and supports are available across all regions of New Zealand, and how the health and other systems work together.

### The Strategy’s Priorities

The four priorities provide a broad approach to supporting mental health and wellbeing outcomes. Overall, they align with key system shifts 2, 3, 4 and 6 outlined in our performance monitoring report.

While the strategy doesn’t specifically prioritise realising the potential of lived experience (shift 1), highest need (shift 2), or human rights-based practices (shift 5), all of these are included to some degree. This is good to see, and expected given our shared understanding of the challenges and known solutions. That said, key elements of the shifts could be strengthened, and if they are not in the Strategy, it would be good to see them feature in the implementation plans.

Some of the Strategy’s priorities and objectives are tangible and realistic, such as suicide prevention work, crisis support, and reducing seclusion, but many of the objectives are too high-level, and need more specificity to drive improvement. For example, it is not clear what difference people will see from ‘strengthen access to mental health and addiction services for those people engaging with wider government agencies’, or how that will be delivered.



### Prevention and early intervention

We appreciate the broad description of prevention in the draft Strategy, and the role of cross-government, community and societal efforts to support outcomes. However, the strategy tends to blend prevention/early intervention with equitable access to services, and there seems to be an assumption that improving access will automatically improve equity.

Further, the draft Strategy describes ‘early intervention’ being both about early in the development of mental health challenges, and early in the life course. These are both relevant, but the Strategy risks conflating two separate approaches here. With respect

to the life course, we would suggest specific mention of maternal mental health, particularly given its importance to the Strategy's focus on the first 2000 days.

We support action toward connection within communities. Planning and support mechanisms, such as increased investment, and funding processes that work for community organisations would strengthen this. Also important, but missing, is a connection to land, whānau, communities and culture. These are critical drivers of Māori mental health and wellbeing.

### Increased access to support

It is good to see a desire for a range of accessible forms of support, including digital services – and recognition that barriers to access need to be addressed. As our recent monitoring reports have shown, one of the more urgent needs for action is improving access to specialist mental health services. A focus on primary and *community* specialist services in the key objectives of the Strategy would help deliver this. This priority focuses faster access on ED wait times – faster access is needed across a range of services.

The emphasis on reduction in drug harm and overdoses is positive. Greater detail on the action to be taken will determine its impact though, with a strong harm reduction approach is needed.

The Strategy should highlight the need for – and pathways to improve – a diversity of services reaching people where they are. Youth One Stop Shops, integrated hauora services, and integrated health and social services are good examples of these that could be supported through the Strategy.

### Improved effectiveness

Alongside the description of services that are integrated, tailored, evidence -based, and protect rights, this section should include consideration of services proven to work – the future state described does not consider the efficacy of services.

The draft Strategy highlights “tailored services for populations with specific needs” under this priority, which is welcome, but the case could be made more strongly in the context section first also. One size does not fit all: different population groups and with the highest needs will require models and approaches that are important, relevant and effective, for example kaupapa Māori.

We would hope to see a commitment to increased investment in Kaupapa Māori services in this priority. A specific section on building and supporting pathways for Māori could better address the disproportionate need experienced by Māori, as outlined in the current state section of the Strategy, the 2023 Health Status Report, and elsewhere. This could support building competence and population representativeness, and support Māori options to self-determine.

This priority includes mention of the importance of lived experience in achieving better outcomes, however does not detail what that means. Here, and elsewhere in the Strategy, we would hope to see equal prioritisation of lived experience knowledge, and specific reference to investment in this workforce. In our view, lived experience leadership and support should be a priority of its own in the Strategy.

Further, we hope to see lived experience engagement strongly represented in the development of the Strategy itself. There are a few instances through the Strategy where the discussion of mental health issues and need does not reflect the views we hear from the lived experience communities.

## Workforce

The workforce priority seems focused mainly on growing and reinforcing the existing workforce. The Strategy does not acknowledge the systemic issues that have led to the current workforce challenges, and it could better explain why a well-supported and diverse workforce matters, to deliver the priorities throughout the Strategy. Further, it is missing specific description of the planning, investment, and resourcing needed for the future workforce.

The workforce priority should support improved effectiveness through lived experience leadership, as described above, and better reflect the importance and future role of the peer workforce, in mental health, and alcohol and other drug services. As well as improving effectiveness of services, growing these workforces will reduce the strain on other parts of the system, and grow the total workforce.

## The role of the Commission

We expect to have a role in monitoring and supporting the Strategy. In line with the expectations laid out in our establishment, the role of the Commission is to provide independent advice and oversight of the mental health and wellbeing system. The Commission is not a health entity under the Act. In the 'who is it for' section, and in 'measuring and monitoring', the Commission's monitoring role would be better described as:

- The Commission provides independent leadership and oversight of the mental health and wellbeing system, to hold the system and government to account.
- The Commission assesses and reports on population level mental health and wellbeing outcomes, and the effectiveness of approaches and system outcomes that contribute to population outcomes such as the determinants of mental health.
- The Commission monitors MHA services, as services are key contributors to system performance.
- The Commission has powers to obtain information and make

recommendations to enable it to carry out these functions

## Miscellaneous

We have identified a few minor details that may need fixing in the draft Strategy:

- In the landscape section, it may be worth highlighting that gambling support funding also sits outside the ring fence.
- Under current state: In the analysis of psychological distress rates, it may be better to take the 15-25 year cohort out of the adults over 15yrs and older: including them in the total population means influence the overall rate.
- In Trends and future factors: On changing demographics, it is important to reflect different needs across ages and communities, *and* changing expectations. For example, while ageing population is important, so is the level and type of need for younger people.
- Under Strategic direction, it may be good to be clear about delivering “the Pae Ora Act’s focus”, rather than “Act’s focus”.
- Under the access priority, you could consider expanding the objective to cover improvement for all overdose supports, rather than a specific focus on ‘unintentional overdoses’.
- In the same section, work with MSD/Work and Income (disability support) would be important to highlight before or instead of tertiary institutions.
- In the effectiveness priority, legislative settings are discussed, but only the Mental Health Act is referred to. It is likely that work on the Misuse of Drugs Act and Alcohol legislation will be required to meaningfully improve outcomes and reduce harm – these could be specifically mentioned.
- Under the prevention priority, a specific area to consider including would be violence, abuse and trauma. While family violence is critical to work on, there are other areas of concern in intra person violence outside whanau.