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Ministry of Disabled People, Whaikaha
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Submission on the New Zealand Disability Strategy 2026-2030

Thank you for the opportunity to submit on the New Zealand Disability Strategy 2026 – 2030 (Strategy). We acknowledge this is a foundational strategy for improving outcomes for disabled people and whānau. Our submission focuses on improving mental health outcomes for disabled people, including areas we would like to see included in the Strategy, strengthened and actions that we support.

About Te Hīringa Mahara

Te Hīringa Mahara – Mental Health and Wellbeing Commission (the Commission) is making this submission on the development of the Strategy, in recognition that disabled people are a priority group for the Commission under Schedule 2 of the Mental Health and Wellbeing Commission Act 2020 (the Act). The Act established the Commission as an independent Crown entity, following He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction.

We acknowledge Te Tiriti o Waitangi as the founding document of Aotearoa New Zealand and an agreement between two parties, the Crown and Māori.

Our legislated role is to:

- assess and report on the mental health and wellbeing of people in New Zealand, and the factors and approaches that affect them
- make recommendations to improve the effectiveness, efficiency, and adequacy of approaches to mental health and wellbeing
- monitor mental health and addiction services and to advocate improvements to those services
- promote alignment, collaboration, and communication between entities involved in mental health and wellbeing
- advocate for the collective interests of people who experience mental distress or addiction (or both), and the persons (including family and whānau) who support them.

When performing our functions under the Act, we must have regard to available evidence, factors that affect people's mental health and wellbeing, actions to improve positive mental health and wellbeing, build resilience and prevent poor mental health and

wellbeing, and identify and respond to people experiencing poor mental health and wellbeing, including those who support them.

He Ara Oranga (report of the Inquiry into Mental Health and Addiction) highlighted that disabled people experience significantly higher rates of mental distress. This is reflected in Schedule 2 of our Act with disabled people listed as one priority group for the Commission.

How we include disabled people in our work

Te Hiringa Mahara has committed to a “nothing about us without us” approach, promising to work alongside tāngata whaiora (people seeking wellness, or people with lived experience) and whānau in all aspects of our work. Lived experiences inform all our work, and we aim to advocate for the collective interests of people who experience mental distress or addiction.

We regularly meet with disabled people and whānau, disabled peoples organisations, tāngata whaiora Māori, tāngata whaikaha Māori and lived experience networks.

Our work with disabled people over the past four years has included elevating disabled peoples’ perspectives on access to mental health and addiction services ([Voices report: accompanying report to Kia Timata te Haerenga](#)), elevating young disabled peoples voices on the drivers of wellbeing ([Youth Wellbeing Insights](#)), monitoring wellbeing outcomes for people with a disability ([Te Rau Tira](#)), assessing mental health and wellbeing of rangatahi and young people with a disability ([Infographic – assessment of youth and rangatahi wellbeing and access to services](#)) and publishing insights about the disability community’s experience of the COVID-19 response ([Wellbeing impacts of the COVID-19 pandemic](#)).

Our feedback on the strategy

The following sections summarise our feedback on the strategy. Our advice reflects our monitoring work and work we have done to shine a light on experiences and outcomes for disabled people, including what we have heard directly from disabled people and whānau.

Mental health and addiction should be explicitly included in the Strategy

The Strategy should acknowledge how mental health outcomes will be improved for disabled people and whānau

1. The draft Strategy notes that disabled people are more likely to have unmet mental healthcare needs than non-disabled people, and that whānau of disabled people experience higher rates of stress. The Strategy also notes that under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), disabled people include those who have a long-term mental impairment.

2. Despite these references to poorer mental health outcomes – and the inclusion of peoples with a long-term mental impairment – the strategy does not include a focus on improving mental health outcomes for disabled people and their whānau.
3. We want to see the Strategy explicitly referencing mental health and addiction, specifically improving mental health and wellbeing outcomes, within the context of the health priority. This includes referencing the mental health and addiction workforce and actions to remove barriers to accessing mental health and addiction services.

Reducing barriers to accessing mental health and addiction services should be stronger in the health priority

4. Reducing barriers to access health services – and particularly mental health and addiction services and support – should be a priority, as we are acutely aware that barriers, such as diagnostic overshadowing, cost, accessibility (such as translators and locations), cultural awareness and safety, make it harder for disabled people to access appropriate and timely support¹.
5. Reducing barriers to mental health and addiction services is particularly important for young people with a disability because female, Māori, Pacific, Asian, disabled, and rainbow young people are more likely than other groups of young people to report experiencing mental distress². Some young people with disabilities have shared how their efforts to access services for mental health were ignored or attributed solely to their disability³. There is an ongoing and tangible impact of inequitable access to resources or support, particularly those who experience intersecting forms of discrimination such as rainbow young people and young people with disabilities.
6. People with learning disabilities and/or people with autism are much more likely to experience mental distress than the general population. However, this is not reflected in the way related assessments, funding, supports, training, and services are provided in Aotearoa New Zealand. Inevitably, disabled people experiencing mental health and addiction-related needs have been caught between disability and mental health sectors, often resulting in them falling through the gaps and losing out both ways⁴.

¹ Te Hīringa Mahara – Mental Health and Wellbeing Commission (2024). *Voices report: Accompanying report to Kua Timata Te Haerenga / The Journey Has Begun*. Wellington: New Zealand.

² Office of the Auditor General (2024). *Meeting the mental health needs of young New Zealanders*. Wellington: New Zealand. Pg 10.

³ Te Hīringa Mahara – the Mental Health and Wellbeing Commission (2022). *Young people speak out about Wellbeing: An insights report into the Wellbeing of Rangatahi Māori and other Young People in Aotearoa*. Wellington: New Zealand. P.16

⁴ Te Pou (2022). *The Equitable Access to Wellbeing Framework*. New Zealand.

7. We encourage Whaikaha to work closely with the Ministry of Health and Health New Zealand to make sure that the needs of people with dual disabilities are met appropriately within services.

Improving mental health outcomes will rely on services that are accessible, inclusive and equitable for all disabled people

8. Mental health and addiction services for disabled rangatahi, young people and adults need to be tailored to the needs of the disabled person through taking an intersectional approach. An intersectional approach acknowledges that different parts of a person's identity or lived experience can expose them to overlapping forms of discrimination and marginalisation, and can influence their health outcomes.⁵ This overlap is key contributor in mental health and wellbeing inequities in New Zealand.
9. For example, for disabled people living rurally, the intersecting experiences of rurality and disability need to be considered to ensure health services are accessible, inclusive, and equitable.⁶ This particularly impacts Māori and Pacific peoples, who have the highest rates of age adjusted disability.⁷ Furthermore, a literature review in 2023 confirmed that racism is well established as key determinant of adverse population mental health for indigenous and ethnic minorities globally.⁸ Rangatahi Māori, Pasifika and youth from ethnic minority backgrounds (Asian, African, Middle Eastern, Latin American) experience markedly poorer mental health and wellbeing compared to Pakeha and European youth.⁹
10. Relevant to the Strategy's priority areas of health and housing and justice, there are issues in specialist mental health services related to supporting people with intersecting mental health and other disability needs, particularly intellectual or learning disabilities and neurodiversity. People with these intersecting needs often have much longer inpatient unit stays due to not having other options that are suitable to meet their needs for them to move onto¹⁰. People with intersecting needs of mental health and other disability needs, such as

⁵ Hankivsky, O., et al. (2014). *An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. International journal for equity in health*. New Zealand. Pg 1-16

⁶ Health New Zealand, Te Whatu Ora (2024). *Annual Report 2023/24*. Wellington: New Zealand. pg 59.

⁷ The Treasury (2023). *Pacific peoples' wellbeing, Background Paper to Te Tai Waiora: Wellbeing in Aotearoa New Zealand 2022*. Wellington: New Zealand.

⁸ Stubbing, Simon-Kumar, Gluckman (2023). *A summary of literature reflecting the perspectives of young people in Aotearoa on systemic factors affecting their wellbeing*. Auckland: New Zealand.

⁹ Stubbing, Simon-Kumar, Gluckman (2023). *A summary of literature reflecting the perspectives of young people in Aotearoa on systemic factors affecting their wellbeing*. Auckland: New Zealand. Pg 17

¹⁰ Te Hiringa Mahara – Mental Health and Wellbeing Commission (2024). *Kua Timata Te Haerenga*. Wellington: New Zealand. Pg. 44.

neurodiversity, are also more commonly presenting to mental health and addiction services¹¹.

The Strategy could have a stronger emphasis on assessing progress, to ensure it is effective and has appropriate accountabilities

11. We want to see the Strategy include an assessment of progress, rather than a measurement approach to annual reporting. We suggest 'How we will assess progress' provides a more comprehensive and flexible approach towards achieving the goals and vision. In the draft Strategy, progress on the actions described calls for evidence-informed policy that draws on experiential evidence and research. Statistical data alone is insufficient due to the almost impossible task to capture the intersectionality characteristics of some groups of disabled people.
12. The draft Strategy proposes a dashboard for monitoring the five priority areas, without describing how the selected indicators will relate to policy development and implementation of actions across all sectors. Through our own work in services and system monitoring, we are aware of the importance to understand what might be driving data trends up or down at population indicator levels so the case for change can be explained, innovative practice can be shared, and improved outcomes can be attributed to government contributions.

The Strategy needs to address systemic barriers and ensure a cross-agency approach to improving outcomes for disabled people

Integrated pathways through the mental health and addiction system for disabled people is required

13. In 2024, the Office of the Controller and Auditor General found about a third of disabled young people are not in education, employment, or training. No government agency specifically collects data on the mental health needs of young people who are not in education, employment, or training.¹² Young people in care, not in education, employment, or training, or in prison are all at significant risk of experiencing mental health issues.
14. However, the agencies involved in supporting them might have little understanding of their mental health needs or barriers to accessing mental health care. In our view, there is a lack of clear and integrated care pathways through the mental health system for at-risk groups of young people to access mental health support. Without these pathways, some of our most at-risk

¹¹ Te Hīringa Mahara – Mental Health and Wellbeing Commission (2024). *Kua Tīmata Te Haerenga*. Wellington: New Zealand. Pg. 28.

¹² Office of the Auditor General (2024). *Meeting the mental health needs of young New Zealanders*. Wellington: New Zealand. Pg 52.

young people could miss out on the support they need to address their mental health needs.¹³

Building capability of the mental health, addiction and disability workforces will be crucial for improving outcomes for disabled people

15. We have heard from disabled people and whānau that there is significant unmet need for mental health and addiction services, and the mental health and addiction workforce is an opportunity to increase peer support roles for disabled people and those with lived experience of distress or addiction¹⁴.
16. The peer support workforce fulfils a critical role for enabling recovery, improving hope and in transforming the landscape of mental health and addiction services¹⁵. We would like to see the development of peer support roles for disabled people and whānau included as an action either through the health or education priority.
17. We have also heard concerns from disabled people that disability service providers may know little about mental health, and mental health providers may know little about disability. The strategy needs to include actions to address these capability issues to support these workforces to better support disabled people.

Supporting whānau and carers should be strengthened

18. We also consider that there is more to be done to support whānau and carers of disabled people, noting that the Carers Strategy Action Plan is under development. We have also advocated for that strategy to have a strong focus on improving mental health outcomes for carers and whānau.

Review of legislation that impacts disabled people using mental health and addiction services

19. We support the action in the draft strategy regarding the Law Commission's review of the Criminal Procedure (Mentally Impaired Persons) Act and its relation to other legislation, including the Intellectual Disability (Compulsory Care and Rehabilitation) Act and the Mental Health (Compulsory Assessment and Treatment) Act. It is important to acknowledge that new legislation will also replace the Mental Health Act.

¹³ Office of the Auditor General (2024). *Meeting the mental health needs of young New Zealanders*. Wellington: New Zealand. Pg 41

¹⁴ Te Hīringa Mahara – Mental Health and Wellbeing Commission (2024). *Voices report: Accompanying report to Kua Timata Te Haerenga / The Journey Has Begun*. Wellington: New Zealand.

¹⁵ Te Hīringa Mahara – Mental Health and Wellbeing Commission (2023). *Peer support workforce paper 2023*. Wellington: New Zealand.

20. The Mental Health Bill is working its way through Parliament, and we note the Select Committee's report recommends 'dignity of risk' as an additional principle of compulsory care. It is our hope that this legislation be grounded in human rights, Te Tiriti o Waitangi and supported decision making. We are also aware the Law Commission's final report on review of adult decision-making capacity law (including the Protection of Personal and Property Rights Act) is not yet released.
21. In review of legislation that impacts rights of disabled people using mental health and addiction services, we support reform that ensures coherence across individual Acts that provide legal frameworks for agencies, institutions and services working in our mental health and wellbeing system. In our view, a coherent framework across relevant law will support agencies and communities to operationalise these Acts as intended, and consistently, to uphold rights in practice. The strategy should emphasise cross-sector work required to implement new legislation and apply current legislation in ways that ensure disabled people have these rights upheld.

Education could strengthen support for life transitions

22. When we engaged with young disabled people for our Youth Wellbeing Insights report¹⁶, they told us that more support was required when navigating life transitions, and that whānau and service providers should be more willing to facilitate transitions into higher education, as an example.
23. We consider that the education priority could be strengthened to include actions and provisions to better support young people to go through life transitions, with the tools, mentors and support networks they need to thrive.

We support work to improve the quality of data

24. We support the strategy's focus on improving data about disabled people. This is particularly an issue for our work, as there is limited data about mental health service use for disabled people and limited data about wellbeing outcomes for disabled people.
25. We encourage the strategy – and associated actions – to include mental health outcomes as part of the goal to improve data collection.
26. Te Hīringa Mahara welcomes the opportunity to support Whaikaha to improve mental health and wellbeing data collection, based on our existing monitoring

¹⁶ Te Hīringa Mahara – Mental Health and Wellbeing Commission (2023). *Young people speak up about wellbeing: an insights report into the wellbeing of rangatahi Māori and other young people in Aotearoa*. Wellington: New Zealand.

frameworks, indicators, and data collection methods, which could underpin the strategy.

Six shifts we want to see in the mental health and addiction system

27. As part of our system performance monitoring of the mental health and addiction system, we have brought together a shared view of what a good mental health and addiction system looks like.¹⁷
28. These system shifts reflect and draw from voices of people and communities heard through the Inquiry into Mental Health and Addiction, and brings together our partner frameworks, insights from our monitoring and recommendations, Kia Manawanui, literature on system performance and other system and service performance frameworks.
29. The shifts are strongly aligned with current Government priorities for mental health but also build on them for a longer-term view. The six shifts move us from the current state and include:
 - Shift 1: Towards a mental health and addiction system that realises the potential of lived and living experience.
 - Shift 2: Towards a mental health and addiction system that prioritises effective services for people with the highest need.
 - Shift 3: Towards a mental health and addiction system that provides effective primary prevention and early interventions.
 - Shift 4: Towards a mental health and addiction system that provides equitable access to services and supports that improve outcomes for people.
 - Shift 5: Towards a mental health and addiction system that upholds human rights-based practices.
 - Shift 6: Towards a mental health and addiction system supported by a workforce with the capability, competencies and capacity to meet needs now and in the future.
30. The disability system and mental health and addiction system are deeply intertwined. Therefore, we believe that all six shifts should be visible and delivered through the strategy and implementation plan with cross-sector and cross-government action. We encourage the Strategy to keep these six shifts in

¹⁷ Te Hīringa Mahara – Mental Health and Wellbeing Commission (2025). *Six shifts to improve mental health and wellbeing outcomes*. Wellington: New Zealand.

mind as the disability system and mental health and addiction system operate separately and we would like to see them working more closely together.

31. Aiming to improve the disability system and mental health and addiction system is crucial, and focusing on one system alone cannot deliver the required change. We consider the strategy could promote a genuine cross-sector and cross-government approach to address ongoing inequities, particularly for people – including disabled people – who experience mental distress or addiction. We particularly encourage the strategy to support and complement the upcoming Mental Health and Wellbeing Strategy.
32. We welcome the opportunity to discuss our feedback with Whaikaha in more detail.