Mental Health and Wellbeing Strategy Consultation

Ministry of Health

Wellington

Via email to: mhasp.engagement@health.govt.nz

RE: Feedback on the Draft Mental Health and Wellbeing Strategy 2026–2036| Discussion Paper

1. About this submission

The Royal Australian and New Zealand College of Psychiatrists is the peak body representing psychiatrists in Australia and Aotearoa New Zealand. We are a binational college that trains doctors to become medical specialists in psychiatry. We support and enhance clinical practice, advocate for people affected by mental illness and addiction, and advise governments on matters related to mental health and addiction care. We represent over 9000 members, including more than 6,500 qualified psychiatrists and 2,500 trainees. Our training, policy, and advocacy work is led by expert committees of psychiatrists and subject-matter experts with academic, clinical, and service-delivery experience in mental health and addiction. Our members work across acute inpatient units, community mental health and addiction teams, child and adolescent services, perinatal and infant mental health, old age, forensic, consultation-liaison, intellectual disability, neurodivergent, rural, kaupapa Māori and private and primary care settings.

We broadly support the strategy's vision and its four priorities. This submission addresses a single question: **what would it take to close the canyon between the vision on the page and what tāngata whai ora and whānau actually experience when they reach for help?** We make this submission in continuation of the argument we advanced in our submission on the Healthy Futures (Pae Ora) Amendment Bill 2025.

2. The canyon

There is a gaping canyon between where we are and where we need to be — and the crevasses between our systems are where our people are still falling.

This is not a rhetorical flourish. It is what our members and whai ora describe from the service floor every day. We know unmet need has doubled since 2016/17, and it is critical we make sustained changes to this, as we also know people accessing specialist mental health services die up to 25 years earlier than the general population. Aotearoa runs 16 old-age psychiatry beds per 100,000 older adults against an international minimum of 30 — and two districts have none. Only 9% of the mental health and addiction ringfence is spent on alcohol and other drug services, for conditions affecting 20–25% of presentations. The system is making decisions about a $2.859 billion ringfence on prevalence data last gathered in 2003/04.

These numbers describe a canyon. The crevasses inside it are at every interface our members work across:

> *"The crevasses are at every interface: prison entry/exit, Emergency Departments, primary/secondary handover, mental health/addictions split. The seamless service is a fiction."*
>
> *— Faculty of Forensics Psychiatry, May 2026*

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> *"Care is being provided by clinicians outside their scope of practice — GPs for severe psychotic disorders, nurses doing complex psychiatric assessment without specialist support. Our mental health care service is not able to consistently meet a safe standard of care for people with severe mental illness."*
>
> *— Faculty of Consultation Liaison Psychiatry member, May 2026*
>
> *"Whānau are increasingly functioning as the informal mental health and addiction care system, carrying burden that would otherwise sit within formal services — without recognition or support."*
>
> *— Lived Experience Advisor, May 2026*

These observations are not RANZCP's alone. Te Hiringa Mahara's *Assessment of wellbeing for people who interact with mental health and addiction services* (May 2026), published this month, found **no improvement in any of 22 wellbeing measures** for people who interacted with mental health and addiction services between 2018 and 2023: 59% reported good life satisfaction against 82% of the wider population; one in three experience loneliness; one in three reported discrimination; two in three have gone without fresh fruit or vegetables to keep costs down. The accompanying *What matters for mental wellbeing* analysis identifies three factors most strongly associated with mental wellbeing for tāngata whai ora — good self-reported health, social connection and whanaungatanga, and material wellbeing. The strategy must be implemented in a way that moves all three.

The strategy is right about direction. It is the implementation machinery to close this canyon, and to bridge these crevasses, that is not yet visible. We note that our particular focus is from a specialist psychiatry lens, and our core responsibility is to advocate for the most vulnerable peoples with the greatest need, who can experience a multitude of vulnerabilities on top of one another. They and their families deserve a system that is ready and able to respond to the acuity of their needs whenever they arise, whether episodic or enduring throughout their lifetime.

That is what this submission is for.

3. Our position and ten headline recommendations

The four priorities — prevention, access, workforce, effectiveness — are broadly the right architecture. The strategy as drafted, however, leaves two questions unanswered: how will the system be held to account for delivering this architecture across the seams; and how will we know whether engagement with services is producing meaningful, hope-restoring change for the people and whānau the strategy is for?

Ten recommendations follow from this:

1. Anchor implementation in Te Tiriti o Waitangi — as the named foundation of governance, commissioning, workforce, monitoring and equity accountability, not as acknowledgement.
2. More clearly discern between the needs of tangata whai ora experiencing wellbeing, those experiencing transient distress and those experiencing mental illness. This language matters as wellbeing relates to public health, perinatal, school-based and workplace based prevention, distress relates to the availability of timely, peer and clinician provided crisis support and mental illness requires specialist acute and ongoing care.
3. Treat the interface as the unit of accountability — between primary, community/NGO and specialist mental health services; between health services and other agencies, such as justice and social; and between health services and whānau.

4. Protect the ringfence with visible, defended floors for kaupapa Māori, Pacific-led, child and youth, old age, addiction, perinatal, lived-experience workforce, and prevention; resolve the ringfence-administration anomaly whereby some old-age psychiatry services (including Christchurch) sit under older persons' health rather than mental health; and move providers to contracts that genuinely enable wellness and alleviate the core stressors that exacerbate mental illness, distress and addiction or suicidality.
5. Replace the "500 practitioners per year" target with profession- and subspecialty-specific, equity-weighted workforce targets that explicitly include psychiatry, specialist clinical capacity for people living with severe and enduring mental illness — alongside cultural safety, digital capability, and explicit closure of the Hauora Māori workforce gap.
6. Commission a complementary, cross-government national primary prevention plan — to address what a health-system strategy cannot reach alone: poverty and income inequality, family and sexual violence, racism, and the commercial determinants of mental illness and distress (the alcohol, gambling and digital/social-media industries whose products and marketing produce harm at population scale). Action on alcohol in particular is cheap relative to its downstream gain, and a national public-health campaign on methamphetamine — its speed of addiction and the rapid physical and mental health deterioration it causes — should sit alongside it.
7. Establish Cabinet-level joint Ministerial accountability for mental health and wellbeing outcomes produced across portfolios, not only Vote Health nd build accountability frameworks that reward lifetime value, not annual spend, underpinned by long-term cross-party funding.
8. Legislate and resource the independent monitoring role of Te Hiringa Mahara (Mental Health and Wellbeing Commission), with public dashboards, Auditor-General reviews at five and ten years, and intergenerational and cumulative-harm indicators.
9. Commission a national long-term mental health and addiction data and insights plan, anchored in Te Hiringa Mahara's He Ara Oranga Wellbeing Outcomes Framework — including completion of the child and youth prevalence survey already in train and updating Te Rau Hinengaro (2003/04).
10. Guarantee preventative resource access — housing, income, employment, child and family support — on discharge from acute, addiction and forensic care, as a non-discretionary entitlement integrated into treatment, not a discharge add-on.

4. Te Tiriti and the original Pae Ora architecture as the foundation

Te Tiriti o Waitangi is the legal and ethical foundation on which any mental health and wellbeing strategy in Aotearoa must rest. The Pae Ora (Healthy Futures) Act 2022, in its original form, set out the legislative architecture through which that foundation reaches the system — including the Māori Health Authority (Te Aka Whai Ora), iwi-Māori partnership boards, explicit Te Tiriti obligations on Health New Zealand, and required alignment between the Mental Health and Wellbeing Strategy and the other strategies issued under the Act. In the current draft of the Mental Health and Wellbeing Strategy, Te Tiriti is largely implicit, and the Pae Ora architecture is underused. Of great concern, the Pae Ora (Healthy Futures) Act was amended so significantly in 2025 that it weakened the very levers on which the Mental Health and Wellbeing Strategy depends for credibility — disestablishing the Māori Health Authority, diluting iwi-Māori partnership board functions, and softening Te Tiriti obligations. Our position is unequivocal: the original intentions of the Pae Ora Act must be upheld; the Amendment Bill, as it stands, undermines the credibility of this strategy before its implementation plan has even been written.

- Reinstate the original Pae Ora (Healthy Futures) Act 2022 in its substantive Te Tiriti provisions, and use that architecture to give the strategy corresponding statutory and operational obligations across governance, commissioning, workforce planning, monitoring and equity accountability. The Amendment Bill, in its current form, should not be allowed to gut those provisions.

- Preserve and use the original Pae Ora Act's requirement for alignment between the Mental Health and Wellbeing Strategy and the other strategies issued under the Act — particularly the Hauora Māori Strategy, the Pacific Health Strategy and the Health of Disabled People Strategy — and extend that alignment to non-health strategies (Child and Youth Strategy 2024–27, Te Aorerekura) whose outcomes drive mental health and wellbeing. The Amendment Bill must not be allowed to remove these alignment obligations.
- Direct partnership funding lines to iwi and Māori health entities under Te Tiriti, rather than only sub-contracting through Health New Zealand; ring-fence kaupapa Māori investment and protect it from reallocation.
- Recognise kaupapa Māori evaluation and mātauranga-Māori monitoring as legitimate evidence in their own right.
- Embed an equity framework with named, enforceable accountability for closing identified gaps — compulsory care rates, suicide, life expectancy, child and youth access, and outcomes for whānau — and explicit action on structural racism and discrimination as drivers of inequitable outcomes.

5. The interface is the unit of accountability

People's lives do not run in straight lines and the four priorities cannot be delivered side by side. They have to be woven together at the seams. Three interfaces matter most.

5.1 The specialist–community/NGO–primary care–whānau interface

People exit acute or specialist mental health, addiction and forensic care into communities that are under-resourced and into whānau that may themselves be under-resourced or stretched beyond capacity. There is no redundancy in adult or old-age acute services to absorb the resulting bounce-backs. When Priority 2 discharges into a vacuum, Priority 1 fails. The children of the people we treated yesterday become the young people we treat in five years' time. Bolstering this interface —between specialist care, mandatory whānau-aware discharge, funded post-crisis wraparound, perinatal and infant pathways in every district, and assured housing, income and child and family support on discharge — is the single highest-leverage move available to the system.

5.2 The cross-agency and cross-determinant interface

The strategy correctly states that 60–90% of mental health challenges are driven by social, economic, environmental and cultural conditions — and Te Hiringa Mahara's May 2026 analysis locates that influence in three factors: self-reported physical health, social connection and whanaungatanga, and material wellbeing. Yet implementation is largely delegated to Health New Zealand and the ringfence. This mismatch is the structural reason previous strategies have under-delivered. The implementation plan must name, fund and report on accountabilities between Vote Health and Justice, Police, Corrections, Housing, Education, Disability (including the neurodiverse, intellectual-disability social-care gap — respite, residential care and supported independent living — whose absence cascades into avoidable ED, inpatient and police contact), Addiction, Oranga Tamariki, MSD and ACC; on the elimination of family, sexual and gender-based violence; and on commercial determinants alongside service-level harm reduction.

5.3 The adult–tamariki interface and the populations the system already abandons

When an adult is admitted to acute mental health, addiction or forensic care, the system rarely asks about that person's dependent children in a structured, accountable way. That single moment is one of the most important opportunities the system has to interrupt intergenerational harm — and it is currently being missed.

The interface is failing some of the most vulnerable people in our society — and this must be named, not implied. People with neurodiversity, intellectual disability (including people with Fetal Alcohol

Spectrum Disorder (FASD)), neurodiverse tāngata whai ora, those with combinations of intellectual disability and mental illness and AOD use, and tāngata whai ora whose criminogenic adult lives began as untreated childhood and youth distress sit at the centre of this failure. The gap between need and access — for assessment, specialist care and safe housing — is, in our members' direct experience, glaring.

Our intellectual disability psychiatrists describe a clinical pipeline they meet every week: people now in the adult forensic system who needed, and did not get, the right care as children and youth. Untreated childhood and youth distress, unidentified neurodiversity, intellectual disability and FASD, no kaupapa-appropriate community support — these are not separate stories. They are the upstream of a forensic population, for which the strategy is otherwise silent. The same pattern repeats at the other end of the life course: the absence of specialist psychogeriatric capacity (16 beds per 100,000 against an international minimum of 30, two districts with none) leaves older adults with severe mental illness and dementia, and the whānau caring for them, in equivalent circumstances.

Whānau who are also experiencing poverty and are under-resourced are impacted disproportionately. They contend with a system that is already understaffed and under-capacity, are told that no service is available in their district, and, when something is available, are then gated out by cost: from safe housing, from the needs assessments that unlock disability and respite support, from the social care that prevents the next crisis, episodic relapse, or emergency department presentation. Members describe the result in terms that a policy document cannot soften: whānau are left in what one called *"hell on earth"* circumstances, seeking help in good faith and being told there is none.

To be clear about what we are and are not asking for. Respite services, supported independent living, secure housing and specialist pathways do exist in Aotearoa, in some configurations. They are not at the scale or accessibility the need requires. We make a strong note here that without dedicated data collection through a national prevalence study, we will consistently fail to meet the needs of people and their whānau desperately requiring services, safe and secure accommodation and specialist care adequately — a pain felt on the ground by whai ora, whānau and us as specialists who see the harrowing realities of people seeking care who are often on waiting lists, fighting to meet eligibility thresholds, or bear the brunt of unequal geographic distribution, and prohibitive care costs. It falls hardest on whānau who do not have the means or the capacity to advocate, and on those whose first language is not English or whose cultural realities are not centred in how services are designed. Many whānau cannot indefinitely plug the gaps left by a public system that has not yet responded to community-level need and asking them to keep doing so is itself a system failure.

We are *not* arguing for a purely biomedical model of care, nor for a return to institutional placement. We *are* arguing for a whole-system, preventative approach in which every care provider — clinical, kaupapa Māori, Pacific-led, NGO, social care, primary care, peer-led, and the natural supports of whānau and community — is funded, accountable and connected to wrap around the person and the whānau in front of them, in response to their existing needs and experiences. That is what whānau-centred care actually requires, and what we mean by interrupting the next crisis before it happens.

The implementation plan must therefore address this interface as a population-level commitment, not only a discharge-planning task. That means: structured identification of dependent children, neurodivergence and intellectual disability at every adult acute, addiction, forensic and Emergency Department mental health presentation; funded specialist pathways for children and youth so that the criminogenic adult forensic population is not still being produced in 2036 by the same gaps we are looking at in 2026; cost-removed access to needs assessments, safe housing and respite for whānau caring for people with intellectual disability, FASD or severe and enduring mental illness; and an equivalent commitment at the older-adult end of the life course.

6. Implementation mechanisms

The mechanisms below are offered as candidates for the three-year implementation plan, the Government Policy Statement on Health, Health New Zealand's commissioning approach, and Te Hiringa Mahara's monitoring framework. They are also relevant to Parliament's consideration of the Pae Ora (Healthy Futures) Amendment Bill: the credibility of this strategy depends on the original Pae Ora architecture remaining intact.

A note on what we mean by "early intervention". Throughout the mechanisms that follow, the strategy's prevention and early-intervention frame should be read as a system-wide commitment with three explicit and simultaneous components — wraparound socio-economic and whānau-driven systems, specialist services for inherently lifelong and intergenerational conditions (including neurodiversity, intellectual disability and severe and enduring mental illness), and equivalent investment for an older population with equally high needs. We expand this in section 6.3.

6.1 Workforce

The specialist clinical workforce is irreducible — and access to it must not be displaced by the prevention frame. The argument for prevention and early intervention has been won, and rightly. But people already living with severe and enduring mental illness — those who have, in one of our members' phrases, missed the boat for early intervention — must not become invisible to a strategy organised around upstream effort. Adult, old-age and forensic specialist services have no redundancy. Subspecialty shortages are acute in child and adolescent, addiction, old age, forensic, perinatal and infant, intellectual disability, neurodiversity, and consultation-liaison psychiatry (the latter at 0.2 per 100,000, well below international benchmarks). The FCLP member quoted in section 2 spoke for many: care is being provided by clinicians outside their scope of practice, and the service cannot consistently meet a safe standard for people with severe mental illness. Peer and clinical workforces are an *and-and*, not an either-or.

Reframe early intervention as a system-wide, life-course commitment with three simultaneous components. In the implementation plan, "early intervention" cannot continue to mean a single age-window for a single person. It must be funded explicitly as three things at once.

First, wraparound socio-economic and whānau-driven systems that act on the social determinants before clinical need crystallises — housing, income, employment, primary care without cost barriers, family and sexual violence prevention, kaupapa Māori community supports, Whānau Ora, and the resourcing of whānau already carrying the system informally (per section 7).

Second, specialist clinical services for conditions that are inherently lifelong and intergenerational, including neurodiversity, intellectual disability (including FASD) — where "early" must be redefined as *intergenerational early*. Investment in the parental generation is what prevents the child's generation; investment in the child and youth generation is what prevents the adult forensic and acute caseload of the next decade. Clinical pathways must be lifelong and episodic, not time-limited.

Third, equivalent investment for an ever-growing older population whose needs are equally high and equally early in the sense that matters — intervention before crisis, before whānau are exhausted, before a person is placed hours from their home district to access a bed. The system cannot organise itself around childhood, youth and the parental years while older adults with severe mental illness and dementia, and the whānau caring for them, are left without services — particularly given the demographic trajectory of the next decade. The 16-versus-30 psychogeriatric bed gap, and the two districts with no beds, are the visible face of this.

All three are early intervention. The implementation plan should fund all three together, or it will under-deliver on the strategy's vision regardless of how well any single component is resourced.

- Disaggregate the 500-per-year target into profession- and subspecialty-specific targets — explicitly including specialist clinical capacity for people living with severe and enduring mental illness in adult, old age and forensic services — with fully funded training pipelines (trainee FTE, supervision, protected non-clinical time, accreditation, infrastructure).
- Set an equity workforce target structured around populations served — Māori workforce proportional to the Māori population, Pacific and Asian workforce growth, lived-experience workforce ratios and rural/regional distribution targets — with explicit closure of the Hauora Māori workforce gap. Distinguish growth of the lived-experience peer workforce from embedding lived-experience leadership in governance and commissioning; treat family/whānau lived experience as distinct from personal lived experience of mental illness, addiction, and distress.
- Embed cultural safety and digital capability (including the safe, ethical use of AI) as core, accredited workforce capabilities — resourced with the IT, data and administrative roles that sit behind digital ambition, not only clinician training.
- Address retention before recruitment. Our members consistently report that the system loses experienced clinicians who could be retained through better working conditions and senior-supervises-junior service design — smaller direct caseloads for senior clinicians paired with explicit supervision, teaching and case-consultation responsibilities for junior and allied staff.
- Guarantee access to specialist diagnostic capability and specialist treatments as a structural floor of specialist services — not contingent on geography, workforce vacancies or local commissioning choices.
- Refocus the workforce centres on supporting the specialist (and wider) mental health workforce to access training in evidence-based, safe, generally and culturally acceptable interventions.
- Close named training gaps — including the absence of neurodiversity and intellectual disability training for psychiatrists and other mental health professionals.
- Fund CPD time and budgets for all mental health professionals.
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6.2 Funding and commissioning of mental health services

- Maintain the ringfence with visible, defended floors for kaupapa Māori, Pacific-led, child and youth, old age, addiction and detox, perinatal and infant, the CPSLE, Peer and Lived Experience workforce and prevention. Resolve the structural anomaly whereby some old-age psychiatry services (including Christchurch) sit under older persons' health rather than the mental health ringfence — a configuration that distorts visibility, accountability and resourcing for psychogeriatric care.
- Set a minimum real-terms growth pathway (CPI plus a demand-growth factor) for at least the first five years, and address the documented per-capita gap between specialist child/adolescent ($7k) and adult ($11k) services with a published equity adjustment.
- Move kaupapa Māori, Pacific-led and NGO providers from 1–3 year cycles to contracts that are with financial security that is protected if the data they are collecting demonstrates real value for tāngata whai ora and whānau, paired with sector capability investment. Direct partnership funding to iwi and Māori health entities under Te Tiriti, not only via sub-contracting; ring-fence kaupapa Māori investment and protect it from reallocation.
- Operationalise the 25% prevention and early-intervention target with a published baseline, annual trajectory, sector-agreed definitions and independent verification by Te Hiringa Mahara.
- Guarantee a non-discretionary minimum bundle of housing, income, primary care enrolment, and child and family support on discharge from acute, addiction or forensic care, jointly underwritten by Health, MSD, Housing and (where relevant) Oranga Tamariki and Corrections.
- Remove the cost barrier to primary care for people with severe mental illness on discharge. Our members report that GP visit costs are a routine reason people stop medication and re-present in

crisis — a clinical, not a social, issue. Options include free GP enrolment for tāngata whai ora discharged from specialist care, automatic Community Services Card status, or co-located free primary care alongside busy EDs and acute MH services (as established in parts of Scotland). Te Hiringa Mahara estimates roughly 30% of GP interactions already involve a mental health or addiction component.

6.3 Cross-government governance

- A Cabinet sub-committee on Mental Health and Wellbeing, chaired by the Minister for Mental Health, with standing membership from Ministers for Health, Education, Justice, Police, Corrections, Social Development, Children, Housing, Disability Issues, Māori Development, Pacific Peoples and Whānau Ora — and a Cross-Agency Implementation Committee at CE level reporting publicly against quarterly milestones.
- Mandatory MOUs between Health New Zealand and each interface agency, with named outcomes, funded deliverables and joint accountability for housing on discharge, justice transitions, school-based support, disability co-management, detox access and post-care whānau wraparound.
- A complementary cross-government national primary prevention plan, with health leading, addressing poverty and income inequality, family and sexual violence, FASD, commercial determinants and community-building investment.
- Place-based localities and iwi/Māori partnership tables with cross-agency representation, dedicated resourcing and Te Tiriti compliance — aligned with Te Hiringa Mahara's planned 2027 cross-government forum, led by people with lived experience.

6.4 Independent monitoring and public reporting

- Protect the statutory independence of Te Hiringa Mahara in any future legislative changes; resource it adequately; require an annual report to Parliament covering target performance, equity gaps, lived-experience and whānau experience data, and implementation progress. Commission Auditor-General reviews at five and ten years, alongside lived-experience assessment.
- Publish quarterly, district-level dashboards for the five MH&A targets, disaggregated by ethnicity, age, gender, disability and rurality, with explicit reduction-of-gap trajectories rather than national averages alone.
- Commission a national long-term MH&A data and insights plan — restarting a staged prevalence survey programme (young people first, then adults, then older people), with sustained investment in mātauranga-Māori, kaupapa Māori, Pacific, Asian and lived-experience research capacity.
- Develop NGO and provider quality standards — modelled on the UK College Centre for Quality Improvement — to which organisations (including NGOs) must sign up to continue receiving funding.
- Pair the wellbeing outcomes framework with clinical effectiveness, quality and diagnostic accuracy measures. Wellbeing outcomes complement clinical outcomes; neither replaces the other.

6.5 What we measure: the most important shift

This is the most important single change the implementation plan should make. What we measure shapes what we deliver. Appendix 1 is dominated by access and process indicators — *saw a mental health worker, seen within a week, admitted within six hours*. Those tell us whether someone reached the system. They tell us almost nothing about whether the engagement was safe, mana-enhancing, culturally responsive, hope-restoring, or actually shifted wellbeing for the person and their whānau. A system that measures only whether engagement occurred will reward throughput over transformation. The natural anchor for a wellbeing-outcome framework already exists: Te Hiringa Mahara's *He Ara Oranga Wellbeing*

Outcomes Framework, built on the views and input of tāngata whai ora, and used in the Commission's May 2026 assessment to demonstrate that none of 22 wellbeing measures has improved for people interacting with services since 2018. The implementation plan should adopt this framework as the strategy's outcomes spine, alongside three deliberate measurement shifts and an equity reach test.

Shift 1 — from process to outcome and lived experience. For every episode of engagement, the system should be able to answer: did this make a meaningful, positive difference for the person and their whānau? The framework should capture whether engagement was experienced as **safe** (physically, emotionally, culturally, and — for tāngata whai ora under compulsory care — in terms of human rights), **culturally responsive**, **meaningful**, **targeted**, and **recovery- and hope-enabling**.

Shift 2 — from individual snapshots to whānau and real-time. Whānau-rated experience measures (whānau PREMs) collected routinely from the whānau of people receiving specialist MH&A care; real-time, in-the-moment service feedback with safe escalation pathways for safety or coercion concerns; longitudinal wellbeing tracking *between*, not only at, episodes of care; and cumulative and intergenerational indicators reported alongside individual measures.

Shift 3 — from quantitative-only to mixed methods, qualitative data collection, mātauranga and whānau wisdoms activation. Kaupapa Māori evaluation and mātauranga-Māori frameworks recognised as legitimate evidence in their own right; talanoa, fono and community-led inquiry as part of routine service understanding; whānau wānanga and lived-experience hui producing published findings that inform commissioning; narrative outcome measures of meaningful life change — returning to work or education, reconnecting with whānau and culture, reducing reliance on crisis and acute services, restoring hope — alongside numerical indicators; and independent qualitative reviews of the experience of people receiving compulsory care, with explicit human-rights framing.

The equity reach test. All measurement equity-stratified by ethnicity, age, gender, disability and rurality, with Māori-defined indicators developed in partnership with iwi, hapū and Māori health entities, reported on as a matter of right. If high-need Māori and Pacific communities, rural communities, disabled people, rainbow communities or other groups facing structural inequity are not being reached and are not seeing improvement, the strategy is not working — regardless of national-level target attainment.

Resourcing measurement — not loading it onto the frontline. A measurement framework of this ambition will only succeed if it is resourced as work in its own right. Our members already spend significant clinical time on InterRAI, HoNOS and other instruments, with limited confidence in the quality of what is collected when it is squeezed into the margins of clinical work. The implementation plan must therefore (a) name who is responsible for collection at each level — service, district and system — and provide for dedicated data and analyst roles rather than defaulting to frontline clinicians; (b) fund collection separately from clinical FTE, so that measurement does not come at the cost of *kanohi ki te kanohi* time with tāngata whai ora and whānau; and (c) rationalise existing instruments — assessing what HoNOS, InterRAI and other tools actually add against the burden they impose — rather than piling new measurement on top of old. Better data does not come from more forms; it comes from fewer, better-resourced ones.

Together, these shifts are the difference between a system that knows it ran a service and a system that knows whether the service helped.

7. Whānau-centred mechanisms

These mechanisms are not additional to the four priorities. They are the fibres that weave the four priorities into a system. They concentrate at the highest-leverage point in the canyon: the crisis–community–whānau interface.

Distress, illness and unmet need travel in both directions across a whānau. This is the clinical reality our members work in every day. Unwell parents shape Adverse Childhood Experiences for their tamariki. Unwell children and rangatahi shape carer burnout, financial hardship and mental distress in the parents, grandparents and siblings who hold them. A partner or parent living with dementia or psychogeriatric need, without supports, exhausts the whānau caring for them — and the wellbeing of that whānau then becomes the next clinical caseload. One person's experience shapes intergenerational experiences of wellness in real time. Mechanisms that act on the person without also acting on the whānau will under-deliver on every priority — and mechanisms that act on prevention without also funding the specialist services that whānau in crisis need will under-deliver in the other direction. The whānau-centred system this submission asks for is preventative because it is wraparound, and wraparound because it is whānau-centred.

- **Embedded specialist psychiatric consultation in primary care and community settings.** GPs, primary mental health teams and community providers caring for people with severe mental illness, intellectual disability, neurodiversity, FASD or complex presentations should have timely, structured access to specialist psychiatric advice without forcing the person back through the specialist-services front door.
- **Whānau-aware discharge as a system standard.** Mandatory whānau-aware discharge planning for every acute MH, addiction, forensic and ED mental health presentation, with named clinical and whānau accountabilities and publicly reported 7-, 30- and 90-day follow-up indicators.
- **A documented COPMIA pathway.** Routine, structured identification of dependent children and whānau caring responsibilities at the point of admission to any acute, addiction or forensic service, with a documented Children of Parents with Mental Illness or Addiction pathway building on Supporting Parents Healthy Children.
- **Funded Whānau Hauora roles** attached to every adult community MH&A team, responsible for engaging whānau, identifying tamariki at risk and linking with Well Child Tamariki Ora, school-based services, Whānau Ora and disability providers; with funded support for whānau affected by a loved one's drinking, drug use or gambling (5-Step Method).
- **An equity-weighted post-discharge wraparound bundle** for high-risk whānau — Housing First, MSD case-managed income support, peer support, primary care enrolment, child and family support — under an inter-agency MOU guaranteeing rapid activation.
- **Perinatal and infant pathways in every district,** co-located with kaupapa Māori and Pacific providers, midwifery, primary care and Whānau Ora; with assertive community treatment and consultation-liaison models for parents living with severe and enduring mental illness or addiction, and explicit responsibilities towards their tamariki.
- **Intergenerational indicators in the monitoring framework:** rate of tamariki entering Oranga Tamariki care in the 12 months following a parent's acute admission; children's mental health service access rates in the 12 months following parental admission; homelessness, justice contact and unmet income-support need at 90 days post-discharge.

Done well, these mechanisms would interrupt intergenerational harm in a way no other single intervention could.

8. Closing

Aotearoa has not been short of mental health strategies — from the Blueprint (1998) to Kia Manawanui (2021), each partially delivered. The Minister's foreword is right that what must be different this time is *"concrete steps, clear milestones, and accountability"*. The implementation plan is where that promise is kept or broken. At the core of our submission is the goal to advocate and honour the people we serve, the whai ora and their whānau who experience some of the highest vulnerabilities related to severe and

enduring mental illness or comorbidities. The people who are most vulnerable deserve the best care, *the care that we would all feel safe our loved ones receiving,* the care delivered by well-trained specialists within well-functioning teams, in a system that understands the need (has prevalence data) and can respond accordingly; Respond to the need, whatever that may look like, to enable recovery, safety, and wellness. This may include secure and safe accommodation, whānau and community wraparounds and ease of access to specialist services, and always includes caring, compassionate, well-trained specialists providing evidence-based and effective interventions.

Treating the interface as the unit of accountability, bolstering the specialist–crisis – community–whānau seam, and — above all — rebuilding what we measure so the system is held to account for hope-restoring change rather than throughput, would together do more to make the four priorities work than any other set of changes. The test of the implementation plan is straightforward: does it make Te Tiriti and the original intentions of Pae Ora operational, and does a person reaching for help meet a caring person who gets them what they need, when they need it? As the medical college responsible for psychiatric training and standards in Aotearoa, Tū Te Akaaka Roa welcomes ongoing dialogue with the Ministry, Health New Zealand and Te Hiringa Mahara on the implementation plan.

Ngā mihi,

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Appendix A — Visual summary | From the canyon to a caring response

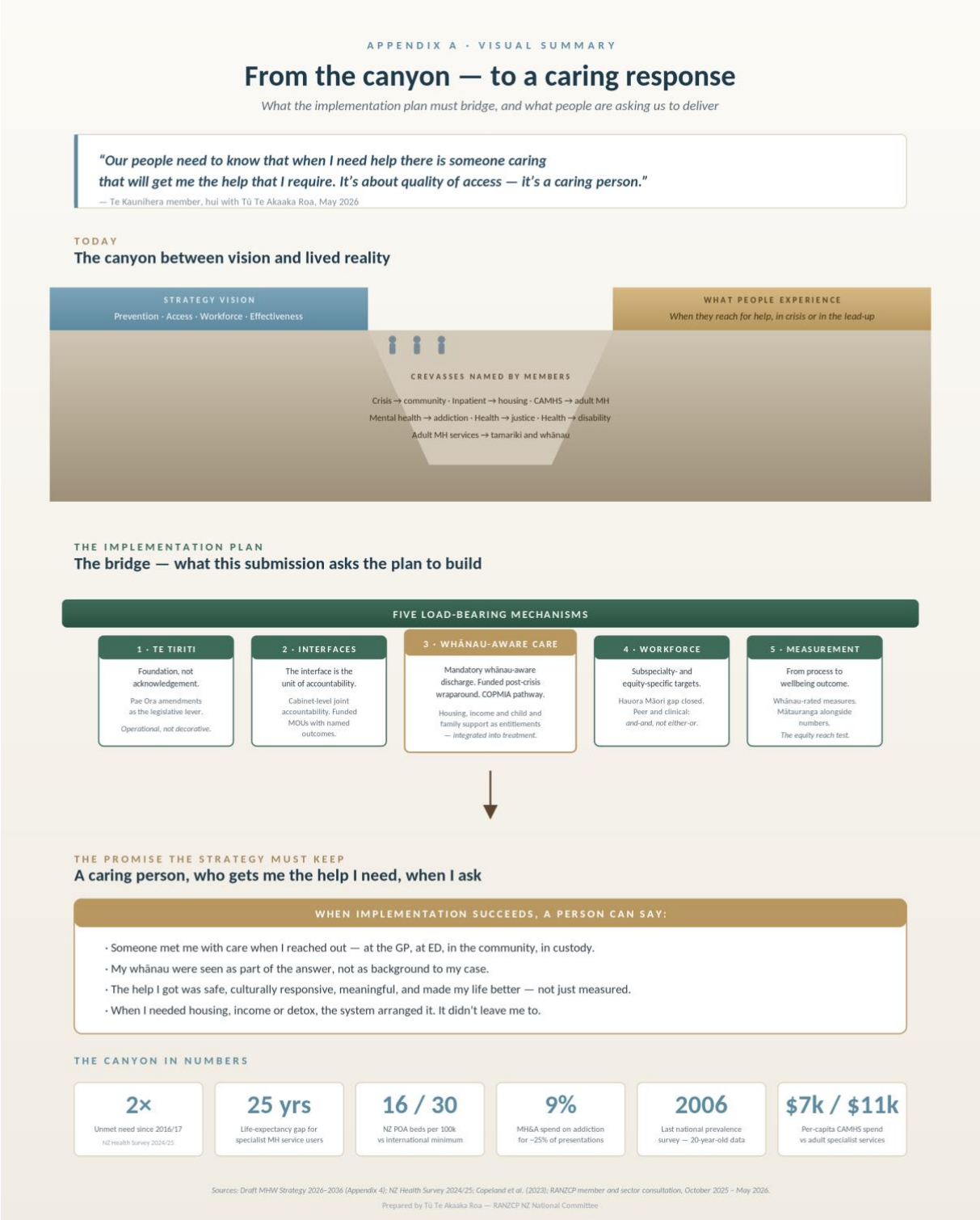

Figure A1. From the canyon to a caring response. Prepared by Tū Te Akaaka Roa from member and sector consultation feedback (October 2025 – May 2026) and the Draft Mental Health and Wellbeing Strategy 2026–2036.