The Royal Australian & New Zealand College of Psychiatrists
Tū Te Akaaka Roa
New Zealand National Office

Your Health in Mind
Hauora hinengaro Manatuhia

Submission to Social Services and Community Committee
Disability Support Services Bill
June 2026

Improve the mental health outcomes for communities

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About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the peak body representing psychiatrists in Aotearoa New Zealand and Australia. 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.

The recommendation provided are based on the collective expertise and experience of members of the RANZCP New Zealand Section of Psychiatry of Intellectual and Neurodevelopmental Disability, comprised of psychiatrists working with tāngata whai ora and whānau living with a dual diagnosis of an intellectual and/or neurodevelopmental disability and mental illness.

Key Messages

Tū Te Akaaka Roa, the Aotearoa New Zealand Branch of the RANZCP, appreciates the opportunity to provide feedback on the Disability Support Services Bill (the Bill).

While we agree with the need for an improved legislative framework for the provision of disability support services, we do not support this Bill in its current form, which may exacerbate long-standing inequity and inconsistency in the care and health of tāngata whaikaha and their whānau.

Specifically, we submit:

- The Bill's ‘family first’ framing creates unacceptable risk for people with lifelong mental illness and complex needs
- The Bill presumes whānau capacity without any corresponding Crown obligation to resource it
- The litigation bar removes human rights protections without providing adequate alternatives
- The Bill is silent on Te Tiriti o Waitangi obligations, despite tāngata whaikaha Māori being disproportionately represented among DSS recipients
- The concentration of power in Ministerial regulation without adequate safeguards creates dangerous instability for people who depend on certainty

The ‘Family First’ Principle and Its Implications for People with Lifelong Mental Illness and Disability

Clause 8 establishes that ‘families, whānau, and other culturally recognised family groups, where appropriate, have responsibility in the first instance for the well-being of their members,’

and that eligible persons should, before receiving DSS-funded support, use their own resources and those available from family, whānau, and community.

RANZCP New Zealand is concerned that this framing, as written, is clinically inappropriate and potentially harmful when applied to people with lifelong mental illness, intellectual disability, and/or complex neurodevelopmental presentations.

People supported by our members frequently have family systems that are already stretched to capacity or are themselves a source of stress or harm. Informal carer burden is a significant determinant of both carer wellbeing and outcomes for tāngata whai ora and the proposed legislative measure risk:

- Accelerating carer burnout in whānau already providing intensive unpaid support
- Increasing the likelihood of family breakdown, which is itself a major risk factor for deterioration in wellbeing and acute presentation
- Silently transferring clinical responsibility from the state to whānau who lack the training, resources, or capacity to carry it
- Creating barriers to DSS access that disproportionately affect people whose family systems are most fragmented — often those with the most enduring and complex support needs

We acknowledge the Bill uses the qualifier 'where appropriate.' However, the Bill does not provide a definition of 'appropriate', no appropriate safeguards to protect the rights and safety of disabled people and their whānau, and no independent pathway for a disabled person or their clinician to contest a determination that family support is available. The qualifier is doing significant work with no legislative scaffolding to support it.

Recommendation

> We recommend Clause 8 be rewritten to clearly exclude from the 'family first' principle situations where a person's clinical presentation, safety needs, or family circumstances make family-provided care inappropriate. Clinical judgement — including psychiatric input — should be explicitly recognised as a relevant consideration in DSS assessment decisions.

Whānau Burnout and the Presumption of Capacity

The 'family first' principle begins with the wrong assumption. The question this Bill should be asking is not whether whānau are willing to care, but what the Crown must provide to ensure whānau who want to care are genuinely able to provide this care.

Tū Te Akaaka Roa's submission to the Carers' Strategy Action Plan consultation (March 2026) identified this gap in direct terms: many whānau want to care for their loved one at home or within their community. This is frequently both their preference and the clinically preferable option. What stands between that intention and reality is not motivation – it is infrastructure. The Bill legislates the expectation of family care while providing no corresponding Crown obligation to make that care possible.

The caring that whānau provide for people with lifelong mental illness or disability is not well captured by frameworks of daily living assistance. It encompasses sustained vigilance, emotional attunement, crisis management, safety monitoring, and system navigation. Whānau are often left to absorb functions the formal system cannot, or does not, provide. This work carries profound consequences for the health and wellbeing of those who do it. Carer burden is associated with significant rates of depression, anxiety, physical ill-health, and financial hardship, impacting their capacity to provide ongoing support, which can lead to crisis situations or hospital admissions**.**

Whānau who want to care but face structural barriers

Whānau who cannot provide care, e.g., because of geographic challenges, because they are themselves unwell or disabled, financial precarity makes sustained involvement impossible, or because the relationship carries its own complexity, are rendered invisible in this framework. The barriers to family caregiving are overwhelmingly structural, not motivational. Legislation that treats them as the latter causes harm without solving anything.

Respite as a clinical necessity

Respite care is one of the most critical supports for sustaining family-based caregiving over time. However, access to respite services is limited, particularly for tāngata whai ora with complex needs and many respite providers lack the skills to safely support youth with dual diagnosis. Equitable access to appropriate respite services must be considered as part of an effective legislative framework; yet is not mentioned anywhere in the Bill. When whānau carers of people with lifelong disability reach exhaustion, the person they care for frequently presents to an emergency department or is admitted to an inpatient ward — not because their clinical needs have changed, but because their carer can no longer hold. In those settings, medications are too often used to manage the consequences of a system that failed to provide adequate respite. This pattern is measurable, preventable, and significantly more expensive than the upstream investment it replaces.

For whānau in rural and provincial Aotearoa, including many Māori and Pasifika communities, respite is already scarce or absent. The postcode lottery of support provision is not new. The Bill does nothing to address it.

The financial trap

Many whānau face a fundamental financial contradiction. To care for a loved one with lifelong mental illness or disability, they may need to leave paid work or reduce their hours — but without income, they cannot survive. The result is that people who could be cared for at home, by people who love them, end up in residential care or hospital not because that is clinically best, but because the people who love them cannot afford to care for them.

This is a systemic failure with direct financial consequences for the health and social services system. Hospital admissions and residential care placements are substantially more costly than supported community care. The investment in whānau carers is both an equity argument and an economic one. A Bill that transfers responsibility to whānau without transferring resources does not save money, it shifts costs downstream, where they arrive larger, harder, and at greater human expense.

Recommendation

> The Bill must establish a corresponding Crown obligation to resource family caregiving, including adequate respite, financial recognition, and culturally responsive community support wherever it legislates family responsibility.

Downstream and Cumulative Harms: What the Bill Does Not Account For

The Bill's framing is almost entirely administrative. What is absent is any reckoning with what happens to people when the system fails them. Psychiatrists do not have that luxury. We work with the consequences.

Needs assessment as a gatekeeping barrier

The Bill delegates eligibility criteria to Ministerial programmes, with no legislative protections and explicit provision for income and asset-based criteria. Needs assessments processes are difficult to navigate difficult to access, culturally inappropriate, inconsistently applied and can be experienced by many whānau as arduous, dehumanizing. Those without adequate advocacy support or resources are often left without support. But the need does not disappear. It accumulates. The Bill risks exacerbating access challenges and inequities, particularly for people with lifelong mental illness or disability, cognitive differences and/or communication needs.

Housing, safety, and the absence of adequate planning

For people with lifelong psychiatric disability, housing stability is not separable from wellbeing. Many people our members work alongside are in supported or transitional accommodation precisely because that scaffolding makes it possible for them to live safely in their communities. The Bill contains no provisions addressing long-term housing needs, no recognition of the interface between DSS and supported accommodation, and no safety planning obligations for people who may be at risk when support is reduced or withdrawn.

The consequences of inadequately supported transitions from hospital, residential care, or family homes are not abstract. They include deterioration in wellbeing, loss of community connection, and, for some, contact with acute or forensic services that could have been prevented. These are not inevitable outcomes of a person's diagnosis. They are predictable outcomes of system failure.

Substandard care and the vulnerability of outsourcing

Where whānau care is unavailable or has broken down, the alternative is frequently contracted residential or community care. The Bill's concentration of detail in secondary legislation means there is no legislative guarantee of safe, quality care in outsourced settings. People with lifelong disability or mental illness who rely on contracted care are among those most at risk when oversight is inadequate. Safeguarding provisions are explicitly deferred to a 'further phase' of legislation that has not yet been introduced. The history of institutional care in Aotearoa is not distant enough from this omission to pass without comment.

Young people, early intervention, and compounding harm

Failure to provide adequate, timely, and appropriate support to rangatahi with emerging mental illness or lifelong disability does not produce costs that disappear. It produces trajectories of compounding disadvantages that are both predictable and preventable.

Young people who do not receive the support they need in school, within their whānau, or their communities do not simply manage. Unmet need accumulates and disrupts education, social disconnection, leading to a decline in wellbeing, and eventual crisis. The pathway to acute services, to chronic housing instability, or to forensic contact is not an expression of who a person is. It is the expression of a system that did not reach them when it could at lower cost, with greater humanity, and with far better outcomes for the person, their whānau, and their community. This Bill, as drafted, does not address these challenges. Its structural logic risks accelerating it by narrowing access, increasing assessment barriers, and transferring responsibility to whānau who may already be at capacity.

Together, these effects do not fall evenly. They fall on people and whānau already navigating the intersection of disability, mental illness, poverty, and systemic underservice. The human cost of getting this wrong is not a policy abstraction: it is measured in wellbeing diminished, whānau fractured, and people reaching crisis earlier. We urge Select Committee to hold these downstream consequences in view throughout its deliberations. Legislation that appears fiscally prudent at the point of introduction can generate human and financial costs that dwarf its short-term savings.

Recommendation

> We recommend adequate safeguarding provisions are included in the Bill, accounting for the full continuum of need including housing, safety planning, respite, and rural access to be provided by formal services.

The Litigation Bar Is Disproportionate and Premature

The Bill extinguishes existing employment claims (Schedule 1, clauses 10–15) and bars future claims regarding the employment status of paid family carers, including discrimination claims to the Human Rights Commission. This is a direct legislative response to Fleming v Attorney-General [2025] NZSC 188, in which the Supreme Court unanimously found that some family carers were in an employment relationship with the Crown.

RANZCP New Zealand does not take a position on the employment law dimensions of Fleming as such. However, we are concerned about adverse consequences for people whose family carers support them in the context of lifelong psychiatric disability, often providing what amounts to round-the-clock clinical-adjacent care such as monitoring mental state, managing medication, responding to crisis, facilitating engagement with services.

The Supreme Court's finding that this work constitutes employment, at least for some funded hours, recognises the significant commitment and work of carers who are often unable to continue their employment alongside providing care for their loved one. While we acknowledge the potential risks arising from financial incentives, the Bill removes the legal recognition of what is a reality for many before an alternative framework that recognises and resources family carers is in place.

We support the Government's stated commitment to developing a carer support package. However, removing legal protections before that package exists leaves carers — and by extension the people they support — in a more precarious position than before. We also note that the bar extends to discrimination complaints to the Human Rights Commission, raising

serious concerns about the Bill's compatibility with the New Zealand Bill of Rights Act 1990 and with New Zealand's obligations under the UN Convention on the Rights of Persons with Disabilities (UNCRPD).

Recommendation

> The litigation bar provisions be deferred until a credible, funded, consulted, and legislated alternative framework for family carer recognition has been implemented.

Te Tiriti o Waitangi

The Bill makes no reference to Te Tiriti o Waitangi. The Government's own disclosure documentation acknowledges that no Treaty analysis requiring legislative expression was identified. RANZCP New Zealand disputes that this assessment is adequate.

Tāngata whaikaha Māori are significantly overrepresented among DSS recipients. Māori are also disproportionately represented in mental health and addiction services, and among people with co-occurring disability and mental illness. The 'family first' principle in Clause 8, while expressed in language that references whānau and culturally recognised family groups, does not engage with the specific structural context of whānau Māori: the pressures of colonisation, poverty, and systemic underinvestment that shape the capacity of whānau to provide care.

Invoking 'whānau' as a concept without substantive Te Tiriti obligations attached to it risks using the language of te ao Māori to obscure a reduction in state responsibility. This is not tino rangatiratanga. It is not partnership. And it is inconsistent with the WAI 2575 Health Services and Outcomes Kaupapa Inquiry findings, which found systemic failures in the Crown's obligations to Māori in health findings, which apply with equal force to disability support.

RANZCP New Zealand has consistently advocated for psychiatric services in Aotearoa to centre Te Tiriti obligations as a structural commitment, not merely an aspirational concept. We have the same expectations regarding this legislation.

Recommendation

> The Bill be amended to include an explicit Te Tiriti o Waitangi clause requiring the Ministry and contracted providers to give effect to the principles of Te Tiriti in all DSS-funded decisions, and that a dedicated mechanism for Māori partnership in the governance of DSS be established.

Concentration of Ministerial Power Without a Legislative Floor

The Bill delegates the substantive architecture of DSS, such as eligibility criteria, funding levels, programme design, to Ministerial programmes and directions (clauses 10–11). These are secondary legislation, amendable without the scrutiny that primary legislation requires. Clause 11(3) explicitly permits income-based and asset-based criteria to be included in Ministerial

programmes, creating the legal architecture for means testing, a threshold that has never previously applied to disability support in Aotearoa New Zealand.

For psychiatrists working with people with lifelong mental illness and disability, instability in the support system is not a bureaucratic inconvenience - it is a clinical risk. Our members regularly see people whose wellbeing is directly affected by changes in their support arrangements. The prospect of a system in which a person's DSS package can be altered at Ministerial discretion with no legislative measures to protect the safety and rights of disabled people, and no independent appeals mechanism. We are deeply concerned about the potential impacts of this provision.

Our concerns are compounded by the Bill's explicit statement that DSS operates in a 'constrained funding environment' and framing of support as 'a contribution to care' rather than a right. This language signals a philosophical shift away from the social model of disability and away from New Zealand's obligations under the UNCRPD, without any genuine public debate.

Recommendation

> The primary legislation establish a minimum floor of support that cannot be removed or reduced by Ministerial regulation alone; asset and income-based criteria be explicitly excluded from Ministerial programme design unless approved by Parliament; an independent appeals mechanism for DSS decisions be established in primary legislation; and the Bill's purpose clause be aligned with the UNCRPD and Enabling Good Lives principles.

The Absence of Consultation

RANZCP New Zealand notes, with significant concern, that the Government's own Regulatory Impact Statement acknowledges no community consultation occurred prior to the Bill's introduction, and that this 'may be seen as inconsistent with' New Zealand's obligations under the UNCRPD to actively involve and closely consult with disabled people and their representative organisations.

This is not a technical procedural omission. Article 4.3 of the UNCRPD is a substantive obligation. A Select Committee process cannot remedy the absence of co-design at the policy development stage. We urge the Committee to consider whether the Bill, as structured, can be meaningfully improved through submission alone or whether a more substantive pause and re-engagement with disabled people and their communities is warranted before the Bill proceeds further.

Recommendation

> We recommend the Government commit to genuine co-design with tāngata whaikaha, whānau hauā, and disability communities before the Bill proceeds to its second reading, including specific engagement with tāngata whaikaha Māori as Treaty partners.

Summary of Recommendations

Recommendation 1: Rewrite Clause 8

> Rewrite Clause 8 to clearly exclude from the 'family first' principle situations where a person's clinical presentation, safety needs, or family circumstances make family-provided care inappropriate. Explicitly recognise clinical judgement — including psychiatric input — as a relevant consideration in DSS assessment decisions.

Recommendation 2: Resource what the Crown asks of whānau

> Establish a corresponding Crown obligation to resource family caregiving — including adequate respite, financial recognition, and culturally responsive community support — wherever the Bill legislates a family responsibility.

Recommendation 3: Account for the full continuum of need

> The Bill must address housing, safety planning, respite, and rural access. Safeguarding provisions must not be deferred to a future phase. Early intervention protections must ensure rangatahi with emerging disability or mental illness are not excluded from timely support by cost-prohibitive assessments or narrow eligibility criteria.

Recommendation 4: Defer the litigation bar

> Defer Schedule 1 clauses 10–15 until a funded, consulted, and legislated alternative carer recognition framework is in place.

Recommendation 5: Insert a substantive Te Tiriti clause

> Amend the Bill to require the Ministry and contracted providers to give effect to the principles of Te Tiriti in all DSS-funded decisions. Establish a dedicated Māori partnership mechanism in DSS governance.

Recommendation 6: Establish a legislative floor

> Establish a minimum floor below which Ministerial programmes cannot reduce support. Exclude means testing from secondary legislation. Provide for independent appeal. Align the purpose clause with the UNCRPD and Enabling Good Lives principles.

Recommendation 7: Commit to genuine co-design

> Commit to genuine co-design with tāngata whaikaha, whānau hauā, and disability communities before the Bill proceeds to its second reading, including specific engagement with tāngata whaikaha Māori as Treaty partners.