Submission from the New Zealand Psychological Society Rōpū Mātai Hinengaro o Aotearoa on the *Draft Mental Health and Wellbeing Strategy 2026–2036*

About the New Zealand Psychological Society (NZPsS)

The New Zealand Psychological Society (NZPsS) represents more than 2,400 professional psychologists working in the field of psychology, as well as psychology students. Our members range across the breadth of psychological practice – general, clinical, educational, health, forensic, ABA, community, counselling, child and family, organisational, coaching – as well as researchers and academics. Members work in various settings, from schools to the health system to private practice to universities and organisations.

In this submission, we outline our five key concerns and then discuss these in relation, firstly, to the lack of integration of the Draft Strategy with New Zealand's *Disabled People Strategy* and the UNCRPD Committee's *Concluding Observations on New Zealand* and, secondly, the lack of reference to the *Carers' Strategy Action Plan*. We then respond to the specific questions asked of submitters and, finally, provide some additional information and references to support our recommendations.

1. Key concerns

Lack of community input

Drawing from community perspectives to inform the design and implementation of this Strategy was a highlighted priority from *He Ara Oranga* (2018). It is unclear, based on the consultative document, how consultation was developed to inform the strategic and implementation plan, indicating a top-down formulation rather than a consultative approach driven by community-led initiatives.

Te Tiriti o Waitangi principles ignored

The Strategy clearly highlights that Māori communities experience the highest and most complex mental health needs, calling for a focus on a strategic and implementation approach that directly addresses these inequities. Yet, it proceeded to omit Te Tiriti-led principles that call on the need for robust iwi, hapu and whānau-led consultation and guidance at strategic, implementation, and delivery phases. The Waitangi Tribunal Hauora Report articulated these priorities as listed here:

(a) The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of primary health care.

(b) The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.

(c) The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.

(d) The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori primary health services. Furthermore, the Crown is obliged to ensure that all primary health care services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.

Omission of a robust consultative process that embeds these principles in strategic planning and implementation, particularly in light of the persistent health-related inequities experienced by Māori across all health-related policy and service development pathways, undermines said recommendations highlighted by the Waitangi Tribunal and has the potential to further exacerbate these inequities as a result.

Transformative co-design recommendations omitted

He Ara Oranga was further noted as a guiding document informing the current Strategy, yet it also omits recommendations from this report for a transformative co-design approach, which includes all levels of cross-sector interface with "NGOs, Kaupapa Māori services, Pacific health services, Whānau Ora services, other providers, advocacy and representative organisations, professional bodies, families and whānau, employers and key government agencies" necessary to embed this approach. Engaging in a transformative co-design approach to service design and delivery further allows opportunities to address the inequities highlighted in the Strategy across Māori, Pasifika, Asian, youth, and rural communities, and the impact of intersectionalities across diverse populations.

Whole-of-government approach to wellbeing not addressed

He Ara Oranga further called for a whole-of-government approach to wellbeing and prevention that addresses the economic and social determinants of health. The current Strategy recognises the impacts of social and economic determinants on wellbeing yet fails to identify how a whole-of-government approach to prevention will be coordinated and applied to address these impacts across sectors. Including the need for this approach to form the basis of the learning environment is necessary for the advancement of cross-sector collaboration. This includes developing a better understanding of and prioritising of workforce wellbeing.

Absence of disabled people and carers

These people consistently experience poorer mental health outcomes and are disproportionately affected by structural and systemic barriers to wellbeing. However, carers are entirely absent from

the draft Strategy and there is limited disability voice included. We have the following specific concerns:

- There is an absence of disability, disabled voices, carers, and carer voice.
- While accessibility is mentioned, it is poorly defined and it is not clear whether this means accessibility in terms of disability access, or whether it refers to people being able to find and attend a service.
- No actions specifically for disabled persons or carers' wellbeing.
- Family/unpaid/informal carers are not mentioned at all in the strategy, not even as a priority group, despite having recognised poorer mental health outcomes.
- There is no mention of the Carers' Strategy or Action Plan.
- The Strategy is heavily focused on addictions (gambling, alcohol, drugs) and the delivery of individualised clinical interventions.
- There is no mention of rights-based approaches for disabled persons, or training of staff in this.
- The Strategy does not link to *Health of Disabled People Strategy*.

2. Lack of integration with UNCRPD Committee's *Concluding Observations on New Zealand* and the *Disabled People Strategy*

The consultation document for the Strategy sets out a broad systems-level approach to improving mental health outcomes through prevention, early intervention, improved access to services, workforce capability, and improved quality of care (Ministry of Health, 2026). However, despite the existence of a dedicated and recently published *Health of Disabled People Strategy* (2023), the consultation document does not explicitly reference, map, or integrate this strategy as a core guiding framework for disabled people's mental health and wellbeing.

This omission is significant given that the *Health of Disabled People Strategy* establishes a clear, disability-specific framework for achieving equity in health outcomes, grounded in self-determination, accessibility, cross-government action, workforce capability, and improved data and evidence (Ministry of Health, 2023). These priorities are directly relevant to mental health system design, particularly for disabled people, who experience significantly higher rates of psychological distress and unmet mental health need. By failing to explicitly align this Strategy with the Health of Disabled People Strategy, the consultation risks perpetuating a siloed policy approach in which disability health policy and mental health policy operate in parallel rather than as an integrated system.

This lack of explicit alignment also sits in tension with Aotearoa's obligations under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which requires a coherent, rights-based approach to health that ensures disabled people can access the highest attainable standard of health without discrimination (UNCRPD Committee, 2022). The UNCRPD Committee's *Concluding Observations on New Zealand* emphasised the need for strengthened community-based supports, supported decision-making, and removal of structural barriers to equitable mental health outcomes. Similarly, OECD evidence consistently demonstrates that poor mental health outcomes among disabled people are driven by intersecting structural determinants – including

service fragmentation, income insecurity, and barriers to accessible care – which require coordinated cross-policy responses rather than standalone sector strategies.

The absence of explicit integration between the draft *Mental Health and Wellbeing Strategy* and the *Health of Disabled People* Strategy is a significant failure of policy alignment. Without clear mapping between the two strategies, disabled people will be assumed to be included in "population-wide" mental health approaches. Yet, unless the *Mental Health and Wellbeing Strategy* has adequate recognition of disabled persons' distinct inequities and rights-based entitlements, they will remain excluded and invisibilised. The specific system redesign commitments already articulated in the disability health strategy must be included in the *Mental Health and Wellbeing Strategy*. Failing to ensure that disability equity is embedded as a core design principle in mental health system reform is worrisome indeed.

***Health of Disabled People Strategy* (2023) Priority Area**	**What this requires in practice**	**How the *Mental Health & Wellbeing Strategy* addresses this**	**Gaps and omissions**	**Impact on mental health and equity outcomes**
Self-determination and disabled people's voice	Disabled people have control over decisions affecting their health and wellbeing	Lived experience and participation referenced generally	No explicit disability-led decision-making framework embedded in mental health system design	Reduced autonomy in mental health contexts; weaker alignment with rights-based care
Accessibility of health services	Services are physically, culturally, financially, and cognitively accessible	General commitment to access and equity	No disability-specific accessibility standards or implementation requirements in mental health services	Ongoing barriers to accessing mental health care; delayed treatment and unmet need
Equitable health and wellbeing outcomes	System must actively reduce disability-related health inequities	Equity referenced broadly across population groups	No explicit disability equity targets or outcome measures in mental health strategy	Persistent gap in psychological distress and wellbeing outcomes for disabled people
Cross-government action on determinants of health	Housing, income, education, employment integrated into health response	Social determinants acknowledged in general terms	No structured cross-sector disability – mental health integration mechanism	Structural drivers of poor mental health remain unaddressed
Workforce capability and disability competence	Workforce trained in disability-responsive practice	Workforce development included at high level	No explicit disability competency requirements for mental health workforce	Continued misrecognition, diagnostic overshadowing, and poorer care quality

Improved disability data and monitoring	Systematic collection of disability-disaggregated data	Population-level mental health data proposed	No requirement for disability-disaggregated mental health reporting	Invisibility of disabled people's mental health inequities in system performance data
Community-based supports and inclusion	Shift away from institutional dependence toward community inclusion	Community mental health emphasis present	No explicit linkage to disability community inclusion obligations	Risk of continued service fragmentation and institutional reliance
Reduction of coercion and support for autonomy (UNCRPD-aligned)	Supported decision-making and reduced coercive practices	Coercion not explicitly addressed in consultation document	No explicit alignment with UNCRPD Article 12/14 principles in mental health design	Continued risk of coercive mental health experiences for disabled people
Equitable access for high-needs disabled people	Tailored services for people with complex needs	High-needs groups referenced generally	No specific design features for disabled people with co-occurring mental health needs	Service exclusion or inadequate support for highest-need groups
Whānau and family inclusion in support systems	Whānau engaged as partners in disability support systems	Whānau referenced broadly	No structured integration between disability whānau support and mental health system	Fragmented care, increased burden on families, poorer continuity

3. Lack of integration with the Carers' Strategy Action Plan

In addition, the draft *Mental Health and Wellbeing Strategy* does not explicitly reference, map, or operationalise the *Carers' Strategy Action Plan*, including *Mahi Aroha*. This represents a significant policy coherence gap, given the central role carers play in sustaining mental health and disability support systems. While the *Mental Health and Wellbeing Strategy* consultation emphasises system integration, prevention, and improved access to services, it does not explicitly incorporate key carers' strategy actions that directly function as upstream mental health interventions. For example, the Carers' Strategy action areas on public recognition of carers, improved service navigation, early identification and support, respite provision, and financial security are all strongly associated with mental health outcomes yet are *not* explicitly translated into mental health system design within the consultation document.

The absence of explicit integration between the *Mental Health and Wellbeing Strategy* and the *Carers' Strategy Action Plan* represents a missed opportunity for policy coherence across mental health, disability, and unpaid care systems, and risks perpetuating a fragmented approach in which carers' wellbeing continues to be of significant concern.

Carers' Strategy Action Plan area	What the Action Plan requires in practice	*Mental Health & Wellbeing Strategy* addresses it?	Gaps and omissions	Impact on mental health and system outcomes
Public awareness and recognition of carers	Systematic identification of carers by frontline staff and public recognition of caring roles	No explicit recognition of carers as a distinct mental health population	Carers are not identified as a priority group within mental health system design	Carers remain invisible exacerbating delays in accessing support, increased stress leading to higher risks of anxiety/depression and caregiver burnout and fatigue
Service navigation and system coordination	Clear, proactive navigation support across health, disability, and social services	General commitment to access and integration but no carer-specific navigation function	No dedicated navigation model for carers	System complexity remains a key driver of distress, confusion, and unmet need
Early identification and proactive support for carers	Carers identified early through GPs, NASCs, schools, and frontline services	Early intervention referenced generally but not operationalised for carers	No structured pathway for early carer identification	Missed prevention opportunities perpetuates escalations in crisis mental health presentations
Respite and breaks from caring	Flexible, accessible respite (planned, emergency, in-home, out-of-home)	Not explicitly embedded as a mental health prevention intervention	No recognition of respite as mental health infrastructure	High risk of burnout, chronic stress, and carer breakdown; increased downstream system demand
Carer wellbeing support (health and mental wellbeing focus)	Targeted support for carers' physical and mental wellbeing	General population wellbeing focus: carers not specifically addressed	No carer-specific wellbeing outcomes framework	Carers' high rates of psychological distress remain unaddressed in system design
Financial security and hardship reduction	Improved access to financial supports and	Social determinants acknowledged broadly but not linked to carers specifically	No targeted financial stress response for carers	Financial strain persists as a major driver of anxiety,

	recognition of caring-related income loss			depression, and inequity
Employment and participation support for carers	Flexible employment pathways, recognition of skills, support to remain in work/education	Employment considered in general terms, not carer-specific	No explicit linkage between caring and workforce participation	Increased un/underemployment=reduced wellbeing and higher mental health risk
Carer inclusion in assessment and decision-making	Carers included as partners in care planning (where appropriate)	Service-user focus present, but carers not explicitly embedded	No formal requirement for carer inclusion	Reduced agency, poorer system coordination, increased stress and frustration
Culturally safe and responsive carer support	Services adapted for Māori, Pacific, and diverse carer communities	Cultural responsiveness broadly referenced but not carer-specific	No culturally tailored carer implementation pathway	Inequitable access to support and higher unmet need in priority populations
Data, monitoring, and outcome measurement for carers	Carer indicators embedded in system data (including demographics, wellbeing, service access)	Mental health outcomes measured at population level only	Carers not included as a distinct monitored population	Carer distress remains invisible in system performance and accountability frameworks

4. Responses to consultation questions on the draft *Mental Health and Wellbeing Strategy 2026–2036*

1. **From your experience, what most gets in the way of people or whānau getting the mental health or wellbeing support they need, including support for addiction, substance harm and gambling?**

Systemic barriers through policy development omission of the Principles of Te Tiriti o Waitangi denoted by the Waitangi Tribunal in the *Hauora Report* (2023) have historically affected Māori health outcomes. Further omission of these principles has the potential to significantly exacerbate systemic inequities to whānau accessing appropriate care in a timely and efficacious manner.

The State of Caring Survey shows that carers experience high rates of anxiety and depression, alongside loneliness, financial strain, and reduced quality of life. Despite this, many carers do not access adequate support.

Key barriers include:

- **Fragmented and difficult-to-navigate systems** Carers report significant difficulty identifying and accessing supports and entitlements, contributing to unmet need and avoidable stress.
- **Exclusion from decision-making** Carers are frequently excluded from needs assessments and service planning, despite their central role in sustaining care. Notably, 86% of carers support having their own needs assessment.
- **Financial and employment pressures** Half of carers reduce or leave employment, with high rates of financial hardship and inability to meet basic living costs, all of which are strongly associated with poor mental health outcomes.
- **Limited access to respite** Almost half of carers report insufficient or emergency-only access to respite, contributing to chronic stress and burnout.
- **Inaccessible and inappropriate services** Disabled people and whānau continue to face physical barriers. Services remain poorly responsive to disability and inappropriately designed.

These findings from the State of Caring survey align with international evidence showing that caregiver mental health is strongly shaped by social and economic determinants, including financial insecurity, service fragmentation, and inadequate formal support (Radcliffe, Bolling and Patrick, 2025).

To strengthen system coherence, equity, and prevention-focused mental health policy, the Mental Health and Wellbeing Strategy should explicitly integrate and operationalise key actions from *Mahi Aroha – Carers' Strategy Action Plan*. These actions function as core mental health prevention and system sustainability mechanisms.

The *Health of Disabled People Strategy* (Ministry of Health, 2023) recognises structural issues, explicitly identifying that disabled people experience poorer health outcomes and that barriers to accessibility, participation, and system navigation must be addressed to achieve equitable wellbeing. Its emphasis on self-determination, accessibility, workforce capability, and cross-sector action aligns with the issues identified in this submission.

The UNCRPD Committee's Concluding Observations on New Zealand (2022) highlights systemic barriers in Aotearoa New Zealand that affect mental health outcomes for disabled people. These are insufficient access to disability-related health services (including psychosocial supports), ongoing reliance on coercive practices in mental health settings, and inadequate implementation of supported decision-making frameworks under Article 12 of the UNCRPD. These issues reflect structural barriers to wellbeing and autonomy within mental health.

The issues identified above are *not* well addressed in the existing draft strategy.

2. **From your experience, what most helps people or whānau to stay mentally well or get the support they need for their mental health and wellbeing, including gambling and substance related harm?**

Evidence consistently shows that mental wellbeing improves when systems reduce pressure on carers and provide accessible, coordinated support.

Key enablers identified from the State of Caring survey include:

- **Access to flexible and reliable respite** Regular respite is essential to prevent burnout and sustain caring roles.
- **Clear whānau ora and lived experience navigation and system coordination** Accessible information and system navigation reduce missed entitlements and stress.
- **Financial and employment support** Financial security and workplace flexibility are strongly associated with improved mental health outcomes.
- **Recognition and inclusion of carers** Involving carers in assessment and planning improves outcomes and system responsiveness.
- **Integrated disability and mental health services** Coordinated services reduce fragmentation and improve continuity of care.

The *Health of Disabled People Strategy* (Ministry of Health, 2023) reinforces these enablers through its focus on accessibility, self-determination, workforce capability, and addressing broader determinants of health, providing a clear domestic policy mandate for action. The Waitangi Tribunal (2023) reinforce these determinants, highlighting clear commitments required to address these determinants to address Māori health outcomes.

International evidence confirms that improving carers' access to social and economic supports is central to improving mental health outcomes (Radcliffe, Bolling and Patrick, 2025).

The UNCRPD Committee's Concluding Observations on New Zealand (2022) reinforces the importance of strengthening community-based supports and reducing reliance on institutional or coercive approaches, both of which are closely linked to improved psychosocial wellbeing and rights-based mental health systems.

3. What parts of the strategy feel the most right or important to you? Why?

The strategy's focus on prevention, early intervention, integrated care, lived experience leadership, and stigma reduction is strongly supported by evidence.

The strategy recognises the role of whānau and informal support. The recognition of whānau and community roles aligns with both the *Health of Disabled People Strategy* (2023) and the reality of how care is delivered in practice. While the *Health of Disabled People Strategy* provides a strong framework for addressing disability inequities, there remains a gap between strategic intent and implementation in relation to both disabled people's mental health outcomes and carer wellbeing.

Evidence shows carers are already experiencing high levels of psychological distress, financial strain, and unmet need (Carers NZ and Carers Alliance, 2022). They are literally utterly exhausted from providing informal support, without receiving any support themselves. This reality is absent from the strategy, which assumes that whānau have endless capacity and resources to keep meeting the gap between available supports and what is needed.

The UNCRPD Committee's Concluding Observations on New Zealand (2022) emphasises that mental health and wellbeing outcomes for disabled people are deeply shaped by system design, access to community supports, and respect for autonomy. There is a need for stronger

implementation of rights-based approaches across all mental health services. There is no mention on this in the draft strategy.

4. What changes would make the strategy work better for people and whānau? Why?

Embed Te Tiriti principles as recommended by the Waitangi Tribunal Hauora Report would make the strategy work better for people and whānau. The strategy would be strengthened by explicitly recognising carers and disabled people as priority populations with *targeted* supports. It is insufficient to simply include disability but not include specific actions to ensure accessibility. Family carers are not mentioned at all in the strategy. There is limited mention of whānau, except as providers of support to someone in need. More needs to be done to provide support to whānau so that they have the needed resilience, resources, and capacity.

Recommended changes:

- **Recognise carers as a priority group** Given the high prevalence of anxiety, depression, and financial stress, carers require explicit inclusion in mental health policy.
- **Introduce dedicated carer supports** Including needs assessments, mental health support, and navigation services.
- **Expand and reform respite provision** Increase availability, flexibility, and reliability of respite services.
- **Address financial and employment impacts** Reduce the income and employment penalties associated with caregiving.
- **Strengthen disability-responsive mental health services** Align implementation with the *Health of Disabled People Strategy* (2023) and UNCRPD obligations.

The UNCRPD Committee's Concluding Observations on New Zealand (2022) reinforces the need for supported decision-making, reduced coercion in mental health systems, and improved access to community-based supports, all of which are directly relevant to improving mental health outcomes for disabled people.

5. This strategy will come with a plan that sets out what needs to happen to bring it to life. The first plan will have a three-year focus. What are the most important steps we should take in the next three years to make the biggest difference to people's mental health and wellbeing, including reducing substance and gambling-related harm? Please tell us why.

Priority actions should focus on reducing immediate harm and preventing system breakdown, including the following:

- Clear strategies addressing inequities using a needs-based framework that priorities access and responsive engagement
- Rapid expansion of respite services
- Introduction of carer needs assessments
- Improved access to community-based mental health support
- Strengthened navigation and coordination support
- Investment in disability and mental health workforce capability

6. **If you could choose just one thing for us to do to make the biggest difference in the next three years, what would it be?**

Guarantee access to Tiriti-led and trauma-informed service delivery and ensure the provision of adequate, flexible, and regular respite for all carers. This is the most effective intervention for reducing psychological distress, preventing burnout, and sustaining informal care systems.

7. **To make space for new or better ways of doing things we might need to stop doing other things. What do you think we should stop doing, or do less of, so we can focus on what would work better? Please tell us why.**

- Stop omitting Te Tiriti principles in policy and service development.
- Stop utilising top-down approaches to policy development and implementation.
- Stop relying on crisis-driven service access.
- Stop assuming carers can absorb system gaps.
- Stop maintaining fragmented service systems.
- Stop under-investing in respite and navigation supports.

8. **We want to make sure that the things we do are making a difference for people. What should we be checking, measuring or keeping an eye on to know if the strategy is making a difference?**

For service users

- Aim to better understand individual and whānau needs by developing preventative community-led responsivity alongside lived experience and Tiriti-led trauma-informed approaches to all of government service delivery.

For carers

- Anxiety, depression, trauma and wellbeing indicators.
- Access to respite.
- Financial stress.
- Workforce participation impacts.

For disabled people

- Access to community-based supports.
- Mental health and wellbeing outcomes.
- Equity of service access.

For the system

- Embed a Te Tiriti-based principled approach to service development and delivery.
- Address unmet need.
- Ensure continuity of care.
- Crisis service utilisation.

- Commit to an all-of-government transformative co-design approach to care.

9. Are there any other thoughts, concerns, or ideas you want to share?

As with the Mental Health Bill 2024, we believe this strategy missed the opportunity to legislate for a transformative and greatly improved mental health network that would increase effective support and provide a safe landing spot when needed. The focus on building a new workforce of assistant psychologists also falls to address the demands already placed on psychologists in our workforce as moderate-to-severe needs escalate where most tend to focus their time and efforts. As a result, we have been informed by our members that recruitment and retention remain highly problematic despite an ever-increasing demand for psychological intervention and expertise. Furthermore, your focus on increasing the internship and lived experience workforce is innovative, although similarly problematic due to the lack of growth through recruitment and retention of the senior workforce, and therefore their availability to provide training and supervision in addition to the high demand for these professions already affecting service delivery.

The focus on early prevention and health literacy is admirable although not new. Rather, both were primary goals of earlier mental health strategies that led to the development of the Mental Health Foundation and the subsequent workforce development services that have actively advanced mental health awareness, literacy, and resourcing, leading to destigmatising mental health campaigns and normalising psychological well-being as a priority. This highlights the point that not all "traditional" approaches to mental health strategic development of the past 25 years have been ineffective, as cited in this plan; rather it calls to question the need for a more robust analysis of the previous strategies, their performance, and their outcomes before completely changing the direction of the current strategic plan, which fails to address the most significant concerns prevalent to mental health experiences in our communities. Namely, the increasing acuity highlighted in the plan, the inequities continuing to underlie these needs, and the lack of clear focus needed to address them.

The plan noted the aging population in our society, and we are already seeing higher demand for age-related care and increasing acuity in younger populations for age-related mental health problems. Yet, it has not signalled this as a growing priority or how these needs presently, or forthcoming, will be addressed. Again, the limitations in the strategic development necessary to meet the needs in our communities specific to this trend are not addressed.

Carers are a critical but often under-recognised part of the mental health and disability system. Evidence shows they experience substantial psychological, social, and financial strain (Carers NZ and Carers Alliance, 2022), consistent with international research on the care economy (International Labour Organization, 2018).

The *Health of Disabled People Strategy* (2023) provides a strong domestic framework for addressing disability inequities, but its impact will depend on implementation that meaningfully addresses accessibility, self-determination, and structural barriers.

The UNCRPD Committee (2022) reinforces that New Zealand must address systemic barriers in mental health and disability systems, including coercive practices, inadequate supported decision-

making, and insufficient community-based supports. These issues are directly relevant to mental health outcomes and system equity.

There is a risk that current system settings continue to rely heavily on unpaid care without adequate recognition or support, undermining both sustainability and wellbeing.

References

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Whaikaha – Ministry of Disabled People (2023) *Disabled people experiencing poorer health and wellbeing than non-disabled people*. Wellington: Whaikaha.

APPENDIX 1

Notes on structural inequities in Aotearoa's mental health indicators

A substantial and growing body of New Zealand evidence demonstrates that minoritised and oppressed communities, including Māori, Pacific, Asian, Rainbow+, disabled people and informal/family carers, experience significantly poorer mental health outcomes than the general population. Data from the New Zealand Health Survey shows that disabled adults experience markedly higher levels of psychological distress, with rates approximately four to five times higher than non-disabled adults (Ministry of Health, 2021). This inequity is consistent across wellbeing indicators, including lower life satisfaction, higher loneliness, and poorer self-rated health outcomes (Whaikaha – Ministry of Disabled People, 2023). For informal and family carers, national research similarly identifies high levels of psychological strain. The Carers NZ State of Caring survey reports that a substantial proportion of carers experience symptoms of depression or anxiety alongside significant financial and social stressors associated with caregiving responsibilities (Carers NZ, 2022). This is supported by peer-reviewed New Zealand research that identifies elevated psychological distress, including depression and anxiety, among informal carers, particularly where caring demands are sustained and support is limited (New Zealand Medical Journal, 2018). Furthermore, the Hauora Report (2023) persistently noted inequities in Māori were further impacted by the lack of integration of Te Tiriti across all levels of service design, development, and delivery. Taken together, this evidence indicates that poorer mental health outcomes among these populations are not incidental, but reflect structural inequities, including barriers to services, inadequate support systems, and socioeconomic disadvantage.

Notes on the United Nations Committee on the Rights of Persons with Disabilities' *Concluding Observations on New Zealand*

The United Nations Committee on the Rights of Persons with Disabilities' *Concluding Observations on New Zealand* highlight important mental health–related concerns within a rights-based framework, particularly in relation to autonomy, service access, and coercive practices in mental health settings. The Committee expressed concern about the continued use of substituted decision-making and compulsory treatment under mental health legislation and emphasised the need to strengthen supported decision-making consistent with Article 12 of the UN Convention on the Rights of Persons with Disabilities (UNCRPD Committee, 2022). It also raised concerns regarding barriers to accessing disability-related health services, including psychosocial supports, and the adequacy and accessibility of community-based services for disabled people (UNCRPD Committee, 2022). The Committee's broader critique of institutionalisation and restrictive practices is directly relevant to mental health and wellbeing outcomes, as there is a well-established association between coercive care, segregated care environments, and poorer psychosocial wellbeing. The Concluding Observations situate mental health within wider systemic issues of rights protection, service accessibility, and community inclusion. Overall, they reinforce that mental health outcomes for disabled people are closely linked to structural conditions within health and disability systems rather than individual pathology alone (UNCRPD Committee, 2022).

Reference

UN Committee on the Rights of Persons with Disabilities (2022) *Concluding observations on the combined second and third periodic reports of New Zealand (CRPD/C/NZL/CO/2-3)*. Geneva: United Nations. Available at: https://digitallibrary.un.org/record/3988748

Notes on international evidence

International evidence from OECD countries consistently shows that disabled people and informal carers experience significantly poorer mental health outcomes compared to non-disabled populations and non-carers. Across OECD member states, disabled people are approximately twice as likely to report poor mental health, including higher rates of psychological distress, depression, and anxiety, alongside lower life satisfaction and greater social isolation (OECD, 2022; OECD, 2023). These disparities are closely linked to structural determinants such as income inequality, barriers to accessible healthcare, labour market exclusion, and inadequate social supports. Similarly, international evidence demonstrates that informal carers experience elevated levels of psychological distress, with higher rates of depression, anxiety, and stress particularly among those providing high-intensity or long-duration care (OECD, 2021; World Health Organization, 2021). This is driven by the cumulative impacts of unpaid care responsibilities, reduced workforce participation, financial strain, and limited access to respite and support services. New Zealand's evidence aligns closely with these international patterns, indicating that poorer mental health outcomes among disabled people and carers reflect a consistent structural issue across comparable high-income countries rather than a country-specific anomaly.

References

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