Submission on the Draft Mental Health and Wellbeing Strategy 2026–2036

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Executive summary

This submission identifies structural problems with the Draft Mental Health and Wellbeing Strategy 2026–2036 that, if not addressed, will produce another decade of rising caseload and rising spending without proportionate improvement in outcomes. The five most consequential are:

1. **The strategy never asks what mental health IS.** It treats mental health, mental distress, mental illness, wellbeing, addiction, substance harm, and gambling harm as a single category. They are not. A grieving widow has no condition. A person with brain injury has a physical problem. A person in inadequate housing has a social problem. A person with treatment-caused PSSD has a medication-caused condition. Each requires a different response. Conflating them produces a strategy that cannot match response to need.
2. **The strategy does not name brain injury.** Concussion, repetitive head impact, chronic traumatic encephalopathy, and sub-concussive injury produce symptoms indistinguishable from many mental health diagnoses. A person with undiagnosed brain injury treated for depression for thirty years deteriorates while consuming hundreds of thousands of dollars in mental health services. Building an assessment pathway is a one-time cost with a multi-decade return.
3. **The strategy does not name the state's own production of caseload.** Oranga Tamariki's operational policy — refusing help to families in distress who ask, engaging only on complaint — produces preventable family separations whose downstream mental health caseload is permanent. The Health and Physical Education curriculum's content is a measurable input to the youth distress figures the strategy reports. The teaching workforce, deprofessionalised by the removal of The Philosophy of Education from teacher training, is itself in distress. Each is a producer of caseload the Ministry of Health is paying to manage.
4. **The strategy does not name treatment-caused harm.** Post-SSRI Sexual Dysfunction (PSSD), recognised by the European Medicines Agency in 2019, is a known consequence of SSRI use. A young person who began SSRI medication in adolescence may never recover the function the curriculum then specifies as normal. The strategy proposes expansion of the medication pathway that produces this condition without naming the condition.
5. **The strategy is fiscally unsustainable on its own data.** Mental health and addiction funding has risen 30% in three years ($2.201 billion to $2.859 billion), while distress has risen across every measure. The trajectory projected continues this pattern for ten more years. A doubling of youth distress is a fiscal emergency, not a service-design opportunity.

The submission asks the Ministry to begin with First Principles, to name what other parts of the state are producing, and to cost out upstream prevention against downstream management. The full argument follows.

Foundation of this submission

This submission responds to the Draft Mental Health and Wellbeing Strategy 2026–2036 from a different starting point than most. It does not begin from inside the existing categories the strategy uses, because those categories are the problem. Until that is addressed, successive ten-year strategies will continue to produce the same outcomes: rising distress, growing unmet need, expanding workforces, and increasing investment without proportionate improvement in the lives of New Zealanders.

The strategy never asks the foundational question. It asks what mental health and wellbeing are *for*, how they are *supported*, who *delivers* them, and how they should be *measured*. It does not ask what they *are*. That omission is not incidental — it is the structural fault on which every subsequent action rests.

Part 1 — The First Principles question never asked

The Philosophy of Education — a substantive analytical discipline, associated with R. S. Peters and his successors, that grounds education in first principles rather than treating it as a delivery mechanism for predetermined content, and that formed New Zealand teachers (and therefore most of the New Zealand population) until it was removed from teacher training in 1980 and from university Education programmes in the early 1990s — begins with the question: *what is the thing itself?* Not what it is for, not how to deliver it, not how to measure it. What IS it?

Apply that question to this strategy.

What IS mental health?

The document does not say. It uses the phrase as if its meaning were self-evident, agreed, and stable. It is none of these things. The strategy itself contains within its scope:

- Ordinary human distress arising from grief, fear, loss, and adversity
- Effects of inadequate housing, poverty, family violence, and discrimination (which the document itself acknowledges drive 60–90% of "mental health challenges")
- Acquired brain injury and neurodegenerative conditions
- Effects of trauma, including state-care trauma documented in the Royal Commission's report
- Substance use and gambling harm
- Persistent harms caused by medical treatment itself, including PSSD
- Psychiatric conditions arising from neurochemical or structural causes

These are not the same category. They have different causes, different responses, and different appropriate responders. Treating them as a single category called "mental health" — and then building a "system" to "deliver" "support" for that category — is not a coherent project. It is the production of activity around an undefined object.

What IS wellbeing?

The strategy uses this word approximately two hundred times. It does not define it. It is used as if everyone agrees what it means. They do not. The 1948 World Health Organization definition of health as "a state of complete physical, mental and social well-being and not

merely the absence of disease or infirmity" introduced wellbeing as a category that absorbs almost any human concern into the medical jurisdiction. That move has consequences. When wellbeing is everything, health becomes a project of total management, and there is no domain of human life that is properly outside the system's reach.

If the strategy cannot define what it is producing, it cannot measure whether it has produced it.

The first principle of health. If mental health is a subset of health, the first principle of health must apply. That first principle, as old as Hippocrates, is *first, do no harm.* The strategy contemplates no audit against this principle. It does not ask whether the system as currently designed is doing harm. It does not measure harm caused by treatment. It does not name the people who have been damaged by the very pathways it proposes to expand. A strategy in the field of health that does not begin with *first, do no harm* is operating outside the foundational principle of its own discipline.

The unwritten first principle of the current system. Read the strategy carefully and a different first principle emerges. The system, in operation, treats the person presenting with distress as the problem. The distress is the person's deficit. The system's response is to manage the deficit. The system itself is never the object of audit. When a person's distress is consequent on treatment, the response is more treatment. When the distress is consequent on family separation, the response is services for the separated person, not restoration. When the distress is consequent on curriculum content, the response is more wellbeing programmes in the same school. The unwritten first principle is: *the person is the problem. The system is the solution.* This is the structure of blaming the victim. It is not a fit principle for a health discipline.

A more honest name. If the strategy is to be honest about what it is doing, the category "mental health" might be more accurately renamed *What Happened.* Mental health, as currently constructed, is not a description of a state of the mind. It is a category that absorbs everything that has happened to a person — the brain injury, the medication harm, the family separation, the curriculum content, the housing failure, the agency refusal — and re-presents it as the person's own pathology. *What Happened* names the field correctly. It points outward to the events, the conditions, and the state's own actions that produced the distress. It points back at the producers of the caseload, not at the people who carry it.

The devastation of not being believed. A particular form of harm requires naming. When a person presents with what is in fact a brain injury, a treatment-caused condition, or a response to identifiable events, and is told that what she is reporting is mental illness — that her account of what happened to her is invalid, that the cause she identifies is not the cause, that the system knows better than she does what has occurred in her own body and mind — the disbelief is itself a devastation. For Māori, this devastation falls on mana — on the person's standing and dignity. For all people, the experience of not being believed about one's own experience produces a further harm that is then categorised, by the same system, as more mental illness to be managed. A health system that does not believe its patients about what has happened to them is not a health system. It is a category-imposition system that converts patient testimony into compliance with its own pre-existing categories.

Part 2 — The category error and its consequences

The strategy treats the following as a coherent group — either by explicit categorisation or by absorption of conditions it does not name separately:

- Mental health

- Mental distress
- Mental illness
- Wellbeing
- Addiction
- Substance-related harm
- Gambling harm
- Brain injury (not named explicitly, but in practice processed within these categories)
- Persistent harms caused by medical treatment itself (similarly absorbed without separate naming)
- Ordinary human distress as response to adverse circumstances (not pathology, but absorbed)

These categories overlap in some cases and are unrelated in others. A grieving widow has no condition. A child in a violent home has a situation, not an illness. A rugby player with sub-concussive brain injury has a physical condition with neurological symptoms. A person with a structural psychotic disorder has a psychiatric illness. A person responding to inadequate housing and poverty has a social problem manifesting in distress. A young person with PSSD has a treatment-caused condition that the system itself produced. None of these is helpfully captured by "mental health and wellbeing."

When categories are conflated, responses are confused. The widow is offered counselling for what is not a condition. The child is offered a school-based wellbeing programme while the violent home is unchanged. The rugby player is treated for depression while the underlying brain injury progresses. The person with a structural psychiatric condition is processed through a system designed primarily for distress. The person without adequate housing is provided with wraparound support that cannot give them a house. The young person with PSSD is offered more of the medication that caused the condition.

This is not a workforce problem or an access problem. It is a category problem. No amount of additional investment in a confused category will produce clarity.

Part 3 — The brain injury blind spot

The strategy does not mention brain injury.

Search the document. Concussion is absent. Repetitive head impact is absent. Chronic traumatic encephalopathy is absent. Sub-concussive injury is absent. Traumatic brain injury appears only by indirect implication, if at all.

This is a serious omission for a country in which:

- Contact sport is widely played from childhood
- Family and intimate-partner violence rates are high
- Falls, accidents, and assaults are common causes of head injury
- Military and emergency-service personnel sustain repetitive blast and impact exposures
- The justice system contains people with very high rates of undiagnosed head injury

Brain injury produces symptoms that are routinely diagnosed and treated as mental health conditions: depression, irritability, impulsivity, mood instability, cognitive change, sleep disruption, suicidal ideation. When a person with an underlying brain injury is treated within the mental health system, the brain injury continues to progress while the person is

medicated, counselled, and referred for psychological intervention that cannot address the underlying physical condition.

Chronic traumatic encephalopathy is the most striking example, but it is not the only one. Across a wide range of conditions where the underlying problem is physical injury or degeneration of brain tissue, the current system is structurally unable to recognise what it is dealing with.

This is not a fringe concern. The Royal Commission's report on abuse in state and faith-based institutions, which the strategy cites, documents head injury as part of the experience of many survivors. The strategy refers to that Commission's report. It does not refer to the head injuries the report documents.

A strategy that does not name brain injury cannot serve the people who have brain injuries and have been told for years that what they have is mental illness.

Part 4 — The neologism problem

Words function in this document in a way that should be examined. Several terms are used heavily and never defined:

Wellbeing — used as if self-evident, treated as a thing to be produced, never defined.

Lived experience — used to denote a category of person whose voice should be elevated. Everyone has lived experience. The term selects without naming what it is selecting for. In practice, it appears to mean people who have used services and remain within the conceptual framework those services use.

Trauma-informed — used as a desirable property of services. The phrase suggests services that recognise trauma. In practice it can equally describe services that interpret all distress as trauma, narrowing rather than widening the response.

Holistic — used to suggest comprehensiveness. In practice it can describe responses that extend health-system reach into housing, employment, and other domains that are not health-system competencies.

Population-centred, person-centred, recovery-oriented, community-based — each of these is presented as a solution. None is defined. Each could equally describe a number of incompatible practices.

Consumer — used in the phrase "Consumer, Peer Support and Lived Experience workforce." The word reduces a person to an economic transaction. A person who is unwell, in distress, or in crisis is not a consumer. They are a person needing care. The choice of "consumer" to designate this category of person reveals the conceptual frame within which the strategy is operating: care as a service purchased by a consumer rather than given to a person. The frame is industrial, not relational. It produces, over time, a relationship between service providers and care recipients that resembles a transaction more than a healing relationship — and it betrays the concept of health itself, which has never properly been a matter of consumption.

When the language of a document is not anchored to clearly defined terms, the document can mean almost anything in implementation. Activity continues; meaning shifts.

The strategy reports that 60–90% of mental health challenges are driven by social, economic, environmental, and cultural conditions — housing, physical health, family and sexual violence, and poverty.

It then proposes a ten-year programme of expanded health-system response.

If 60–90% of the problem originates outside the health system, the most effective response cannot be a health-system response. A genuinely serious strategy on this evidence would say: *most of what we are about to be asked to manage is produced by other parts of government. The health system is not the right responder, and we should say so plainly. We will take care of what is properly ours, and we will name what is not.*

The strategy does not do this. Instead, the health system expands its scope to include the social, economic, and environmental drivers themselves, through "cross-sector working" and "wraparound support." This makes the health system responsible for outcomes it cannot produce.

The alternative is to say clearly: a person in inadequate housing needs a house. A child in a violent home needs the violence to stop. A community in deep poverty needs material conditions to change. These are not mental health problems. To call them mental health problems is to misname them and so to mis-respond.

Part 6 — The state's own production of mental health caseload

The strategy treats mental health caseload as if it arrives from elsewhere — as if the state's role were to receive and respond. In substantial part, the caseload is produced by other state activity. Two examples illustrate the pattern.

State-induced family separation

When children are removed from their parents by state agencies, the consequences include lasting distress for the parent, the child, and the wider whānau. Mothers whose children have been dispersed across multiple placements present, in time, with what the system categorises as complex trauma, depression, anxiety, addiction, and suicidality. The mental health and addiction system then receives the resulting caseload — and the strategy proposes more services to address it.

The pattern affects mothers across all population groups, irrespective of background. The agency's operational design — discussed below — applies universally. The Royal Commission's report on abuse in state and faith-based institutions, which the strategy cites, documents the pattern over many decades, including documented disproportionate impact on Māori mothers and children. That over-representation is a serious matter in its own right. But the structural problem — the agency's refusal to provide early help to mothers in distress — falls on mothers of any background who turn to the agency. A mother whose children remain dispersed under various agency-arranged placements is structurally produced as a long-term mental health and addiction client, regardless of her ethnicity, faith, or class. Her actual needs — housing of sufficient size to receive her children, legal recognition of her standing as a parent, and family restoration — are not within the strategy's scope. They sit in other ministries, other agencies, and other budget lines.

There is a structural explanation for the documented Māori over-representation that warrants stating plainly, because the absence of that explanation has allowed the disparity

to be framed in ways that locate the problem in the wrong place. The system requires written advocacy of a specific formal kind to navigate out of — submissions, applications, formal correspondence with agencies, engagement with legal architecture, the production of paperwork at multiple stages. This advocacy demands cultural and linguistic capacities that are distributed unevenly across the population. Mothers whose linguistic strengths lie in oral tradition, community storytelling, and direct face-to-face speech are at a structural disadvantage when the only door out of the system is formal written argumentation in a particular register. This is not a deficit in those mothers. It is a feature of a system that has chosen formal written advocacy as its gatekeeping mechanism. The literate-in-the-required-form are unevenly distributed across the population. The documented over-representation of Māori in state care is consistent with this structural pattern. No other explanation is required — and any explanation that locates the cause in Māori parenting rather than in the system's chosen entry and exit conditions is misnaming what is happening.

The agency design compounds the problem. Oranga Tamariki (and Child, Youth and Family Services before it) operates by default in investigatory and removal mode. Early help — the kind that would prevent a family situation from deteriorating in the first place — is structurally unavailable from the agency to which mothers in distress naturally turn. The threshold for engagement is a complaint, not a request.

I should note that this pattern is observable. A mother in distress — whether from illness, from an adverse reaction to medication, from circumstance, or from any other source — who recognises her own need and telephones the agency to ask for help is, under current operating policy, refused. The agency cannot engage unless it has received a complaint. The structural message is unmistakable: the agency does not exist to support mothers in distress who reach for help. It exists to respond when a third party files a complaint against them.

The consequences of this operational threshold are predictable. The mother who has asked for help and been refused manages alone. The situation either resolves through her own resources, or it deteriorates. If it deteriorates, eventually a complaint arises — frequently arising from the very deterioration that earlier support could have prevented. At that point the agency engages, but in investigatory mode. Removal of children becomes a live possibility where early support would have prevented the deterioration entirely.

This is a system whose operational threshold generates the very caseload it then responds to — and generates, downstream, the mental health and addiction caseload that this strategy proposes to manage. The mother who asked for help and was refused becomes a future mental health caseload. The children who could have been supported in their own home become potential future cases under various headings.

The strategy does not name this mechanism. It cannot effectively respond to a caseload it does not name as a caseload produced by other state action. The clinical workforce expanded by this strategy will spend a portion of its working life addressing distress that another part of the state is currently producing, while declining to prevent.

A strategy serious about reducing mental health and addiction caseload would, at minimum, ask: *what proportion of current caseload is composed of mothers, fathers, children, and whānau members whose distress is consequent on state-arranged family separation, or on the agency's refusal to provide early help to families in distress?* The question applies across all populations. The over-representation of Māori in state care makes the question particularly important for any genuine effort to close equity gaps, but the structural answer applies to all New Zealand families. That question is not asked. The answer would change the picture.

Schooling system production of youth distress

The strategy reports that 22.9% of young people aged 15–24 report high or very high psychological distress, and that this figure has nearly doubled. It treats this as a phenomenon to be managed by expanded wellbeing supports in schools, more digital tools, and a more responsive workforce.

It does not ask what schools are currently teaching.

The current Draft Health and Physical Education Curriculum (Ministry of Education, October 2025), delivered compulsorily to children aged 5–15 across Years 1–10, has been the subject of a systematic ten-year structural analysis that I have conducted using the INESCAPABLE Method. The findings are documented and available, and they bear directly on the mental health caseload this strategy proposes to manage. The full analysis is being prepared for a separate setting. The following summary indicates why the Ministry of Health should be reading the Ministry of Education's curriculum, not as an unexamined backdrop, but as a measurable input to youth mental health outcomes.

The Curriculum, in summary:

- Introduces sexualised content at year levels where children are developmentally below the threshold required to receive it without harm. Year 8 (age 12–13) introduces explicit sexual content, including content about pornography. Year 9 (age 13–14) introduces the institutional classification of the child's interior sexual experience as "normal" or otherwise. Year 10 (age 14–15) specifies what normal sexual pleasure and normal physiological sexual response should be.
- Systematically displaces the family from the protective architecture of formation. Across all ten year levels, parents are not named as a help-seeking destination. In the sexual health domain (Year 8 onwards), the help-seeking destination is explicitly "confidential sexual health services" — a designation that, by definition, excludes the parent.
- Performs what the analysis identifies as a splitting operation between the child and her parents. From Year 5 onwards, the Curriculum installs an escalating set of categories — "unconscious bias," "stereotypes," "personal biases" — through which the child is trained to identify her parents' speech, beliefs, and cultural inheritance as suspect. The parent who teaches her child that male is male and female is female has been pre-classified, by the framework, as a propagator of stereotyping. The parent who holds a traditional faith or a settled moral framework has been classified in advance as carrying bias. The child becomes the institution's inspector of her own family. The disclosure pathway is rerouted away from parents and toward "confidential" institutional services. The family is reclassified as "influence" to be critically evaluated, no longer as authority.
- Manufactures distress about normal development, and then offers that manufactured distress back to the child as the child's own problem requiring institutional remedy. Each year level's content installs anxiety, embarrassment, or self-monitoring categories the child did not previously carry, and then offers the institution's "resilience" tools as the remedy.

These findings bear on the Mental Health Strategy in three specific ways the strategy does not address.

The published instrument that performs the splitting in classroom activity. *Mental Health Education and Hauora: Teaching Interpersonal Skills, Resilience, and Wellbeing* (Fitzpatrick, Wells, Tasker, Webber & Riedel, 2018, NZCER Press) is distributed to New

Zealand schools and used in the Health Education strand of the HPE learning area with students in Years 7 to 11. Its Lesson 2, on "rangatiratanga — self-determination," directs children to identify scenarios in which their desires are opposed to parental authority — a teen who wants a different career, a teen who wants to eat differently, a teen who wants to dress in a way parents disapprove of, an 18-year-old who wants to move cities against parental wishes — and to articulate self-determination against those parental positions in classroom discussion. The published lesson is structured. The activity is performed in classrooms. The wedge between child and parent is driven by design. This is a published, distributed, identifiable text. It is not a theoretical concern. It is in classroom use right now.

The pharmacological baseline issue. The Year 10 Curriculum specifies what normal sexual pleasure and normal physiological sexual response should be. It does so without acknowledgement that a significant proportion of adolescents in New Zealand have been prescribed chemical agents — including SSRIs, SNRIs, antipsychotics, and hormonal contraceptives — whose documented effects include anorgasmia, decreased libido, sexual numbness, and the elimination of the physiological responses the Curriculum specifies as normal.

For these adolescents, the Curriculum creates a deficit category they did not have before the Curriculum supplied the standard against which to measure themselves. They now fail at something they did not know they were supposed to be succeeding at. The Curriculum gives them no words for this gap. The help-seeking destination — confidential sexual health services — does not know what chemical agents they are on. Their parents, who do know, have been excluded from the formation architecture by the design of the Curriculum's disclosure pathways. The prescribing doctor, who could help, is not the named destination.

The consequences extend beyond the period of medication. **Post-SSRI Sexual Dysfunction (PSSD)** is a documented condition in which sexual dysfunction caused by SSRI treatment persists indefinitely after the medication is discontinued. The European Medicines Agency formally recognised PSSD as a possible consequence of SSRI use in 2019. A young person who began SSRI medication in adolescence may never recover the sexual function the Curriculum specifies as normal. New Zealand has not, in any of the strategy's predecessors or in this one, acknowledged the condition as a known risk of medication prescribed under the mental health system's umbrella. The young people living with PSSD in this country exist. They are not named in the strategy. The strategy proposes to expand the medication pathway that produced their condition.

This is the dimension the strategy must reckon with: the system itself is producing the conditions it then categorises as mental health caseload. The mental health system prescribes. The education system specifies what normal function should look like. The young person, having been routed away from her parents by the curriculum's disclosure architecture, carries the gap alone. No one in the current architecture is responsible for this loop. The Ministry of Health prescribes the medications. The Ministry of Education specifies the standard. The young person carries the casualty.

Youth suicide and the unnamed production. The strategy reports the rate of suspected suicide at 11.0 per 100,000 people in 2024/25, with higher rates for males and for Māori. It reports rising rates of self-harm hospitalisation, particularly for young people. It proposes more suicide prevention programmes.

It does not ask what produced the suicides.

The pharmacological pathway, the curriculum-induced identity dissolution, the state-induced family separation, the brain injury misdiagnosis, the housing failures, the agency-refusal-of-help pattern — each of these is a documented producer of suicidal distress. The

strategy treats suicide as an outcome to be prevented through downstream service expansion. It does not treat the rate as a measure of upstream production by other state activity. A young person who has been routed through SSRI prescription, curriculum-induced identity dissolution, and a help-seeking pathway that excludes the people who love her, is being produced as a candidate for the very crisis the strategy then proposes to prevent. The prevention is downstream of the production. The production continues.

The teaching workforce. The strategy proposes to grow the workforce and to make schools a delivery site for wellbeing supports. It does not address the condition of the existing teaching workforce that is being asked to deliver this content.

Teachers in New Zealand have been progressively deprofessionalised over the past four decades. The Philosophy of Education — the discipline that once enabled teachers to evaluate the materials they deliver against first principles — was removed from teacher training under Minister Wellington from 1980 onwards, and from university Education programmes in the early 1990s. The current teaching workforce has been trained without that foundational discipline. They are required to deliver pre-scripted curriculum content they did not write, were not consulted on, and have no professional framework against which to evaluate. They cannot exercise the professional judgement that would once have allowed them to refuse content that would harm children, because the framework that grounded that judgement has been removed from their training.

The result is a workforce in structural distress. Teachers are themselves producing — and themselves becoming casualties of — the mental health caseload. The strategy's proposal to add teachers to the "wellbeing workforce" requires teachers who are already structurally exhausted to also deliver mental health services into schools whose curriculum is producing some of the distress those services are meant to manage.

The teacher in this picture is not the perpetrator. The teacher is also caught. The architecture that processed teachers through training without The Philosophy of Education is the same architecture that now requires them to deliver curriculum content the structural analysis identifies as producing distress in children. They are inside the same system that is harming the children they are trying to help. Many teachers know this. They cannot say it without professional cost. The strategy that proposes to expand their role does not acknowledge what has been done to them.

A strategy serious about youth mental health, and serious about workforce wellbeing, would acknowledge that the teaching workforce is producing distress in itself and in the children it teaches because of structural decisions made by the state over the past four decades. Those decisions are not within the Ministry of Health's reach to reverse. But the consequences are within the caseload the Ministry of Health is paying to manage.

Until the Ministry of Health and the Ministry of Education look at the territory together — at the curriculum content, at the teaching workforce condition, at the chemical agents prescribed alongside the curriculum's specifications, at the suicides the strategy reports without locating their production — the mental health response in schools will continue to function as downstream management of upstream production. The strategy as drafted will, over its ten years, supply workforce and services into the institutional setting that is generating some of the demand. The demand will continue to grow.

Part 7 — The economic case

The strategy is a spending plan. The economic question is whether the spending it proposes will reduce, maintain, or grow the caseload it is meant to address.

Reading the strategy itself, the answer is: grow the caseload.

The strategy reports that mental health and addiction ringfence funding has risen from $2.201 billion in 2022/23 to $2.859 billion in 2025/26 — a 30% increase in three years. Capital investment in mental health infrastructure stands at $1.012 billion across 18 projects as at November 2025. Across the same period the strategy reports rising distress, rising unmet need, declining access for some population groups, and youth distress nearly doubled. The trajectory of the last three years is the trajectory the strategy proposes to continue for another ten.

The question that should be put to this strategy is direct: *given that the strategy's own figures show distress rising despite a 30% budget increase, why would a further ten years of the same trajectory produce a different result?*

The strategy does not answer this question. It does not appear to have asked it.

The economic case for getting the categories right is large. The strategy itself reports that per-person investment in specialist adult mental health services runs at approximately $11,000 per year, and in specialist child and adolescent services at approximately $7,000 per year. A person who enters specialist services in their twenties and remains in them for forty years represents in the order of $440,000 in direct service costs alone — before accounting for emergency department presentations, inpatient admissions, lost productivity, justice system involvement, and physical health consequences. Multiply that by the number of people currently misclassified, and the figure is very large.

Consider the patterns named in this submission.

Brain injury misdiagnosis. A person with an undiagnosed brain injury who is treated for depression for thirty years receives several hundred thousand dollars of direct mental health services — and continues to deteriorate. Early correct identification, even at significant diagnostic cost per person, would be dramatically cheaper over a lifetime. Building an assessment pathway is a one-time investment with a multi-decade return.

State-induced family separation. The cost of state-arranged placement of a child is in the order of tens of thousands of dollars per child per year, and continues for as long as the placement does. The downstream mental health caseload for the separated mother is multi-decade. The downstream caseload for the separated child often runs through adolescence and into adulthood. The downstream caseload for the wider whānau extends further. Against this combined cost: the cost of providing housing of sufficient size to enable family restoration, and of providing genuine early help when a mother in distress asks for it, is — in most cases — substantially lower than the cost of maintaining the separation and managing the resulting caseload across multiple lives and decades. The refusal to provide early support is not a cost-saving. It is a cost-deferring measure that increases total spend.

Curriculum-induced youth distress. Youth distress at 22.9% is the next decade of mental health caseload. If even a small proportion of that distress is consequent on identifiable curriculum content, changing the curriculum is essentially a one-time cost. The downstream caseload it would prevent — measured in lifetime service costs per affected young person — runs into the billions over the lives of those affected. The Ministry of Education holds the lever that the Ministry of Health is paying to manage the absence of.

The pharmacological pathway. Adolescents prescribed psychotropic agents under one part of the system, who then encounter curriculum content from another part of the system specifying the function those agents have altered, generate downstream caseload that nobody in the current architecture is responsible for. The cost of this caseload — including the management of PSSD, the management of distress arising from the unacknowledged interaction, the management of suicide attempts — is borne entirely by the Mental Health

Strategy. The cost of preventing it would be borne, in the first instance, by joint clinical-curriculum review at essentially nil incremental cost.

The teaching workforce. Teacher attrition, teacher burnout, and teacher mental health caseload are direct costs to the strategy. The cost of restoring The Philosophy of Education to teacher training, and of returning curriculum delivery to professional judgement rather than pre-scripted compliance, is one-time and modest. The cost of continuing to process casualties of the current arrangement is permanent and growing.

The strategy as drafted proposes to grow the workforce, grow the services, and grow the budget — to manage caseload that other parts of the state are actively producing while declining to alter the production. This is, in pure cost-allocation terms, a poor use of public funds. Money spent downstream cannot resolve what is being produced upstream. It can only manage the symptoms while the production continues.

A cost-effective mental health strategy would identify the upstream producers and intervene there. Those interventions sit, for the most part, in other ministries: Education, Oranga Tamariki, Housing. The Ministry of Health is not the right purchaser of those interventions, but it is well placed to name the cost it is currently absorbing because those interventions are not being made.

The larger economic point

There is an economic point larger than the strategy itself contemplates.

A thriving economy depends on a thriving population — not on a mental-health-managed population. People who can work, parent, contribute, build, and pass on what they have built to their children are the basis of every economic indicator the Government tracks. A strategy that produces, over ten years, a larger mental health caseload, a more medicated young adult cohort, a more dispersed family structure, and a more dependent population overall, is not just expensive in direct service costs. It is destructive of the productive base on which all government revenue ultimately rests.

The strategy assumes the economy will fund the management. The economy depends on the population not needing the management at the scale the strategy projects. The strategy's success criterion is more efficient service delivery to a growing caseload. The economy's success criterion is a population that does not become the caseload in the first place. These are not the same goal. The strategy as drafted optimises for the wrong one.

A government concerned about the long-run health of the economy should treat a doubling of youth distress as a fiscal emergency, not as a service-design opportunity. A government concerned about its productive base should treat the medication and management of an increasing proportion of its young adult population as a warning signal, not as a measure of system success. A government concerned about the cost of social services in the 2050s should treat the dispersal of families in the 2020s as the producer of those costs.

If economic discipline is a value the Government holds, the next strategy must do something this strategy does not: cost out the upstream production, and cost out the downstream management, and compare the two. The comparison will reveal that the cheapest mental health strategy is, in substantial part, not a mental health strategy at all.

The strategic point

There is a point larger than fiscal arithmetic.

A country's capacity to continue as a country — to defend its borders, to maintain its institutions, to transmit its culture, to produce the human resources every other domain of government depends on — rests on the condition of its population. A robust population can

sustain a country. A population processed through pharmaceutical pathways, identity-dissolved, family-separated, and reporting historically high distress cannot sustain anything beyond its own management.

The strategy projects a continued growth of the population requiring management. Youth distress has nearly doubled. Prescriptions for psychotropic agents have risen. Family dispersal continues. Each of these produces further caseload. Each is also a producer of population characteristics — medicated, identity-dissolved, family-separated — that the country cannot, in the long run, function with.

A mental-health-managed population is not a strategically robust one. It is a strategically vulnerable one. The young men and women who would, in a robust generation, be the basis of the country's defence, its workforce, its parenting, and its civic life are increasingly inside the system rather than outside it. The intergenerational transmission of competence, loyalty, courage, and moral seriousness depends on intact families and a confident culture. The strategy as drafted assumes the continued erosion of both.

This is not a Ministry of Defence submission. But the population the Mental Health Strategy produces is the population every other ministry — including the ones responsible for the country's continued existence — must work with. The strategy is a strategic document whether it intends to be or not. Its trajectory is the country's trajectory. A country that processes its young people into permanent mental health caseload, that medicates an expanding share of them, that dissolves their families, and that strips them of moral and cultural confidence has eroded the human basis on which national capacity rests. The erosion is observable in the strategy's own figures. The trajectory continues it.

The economic case argues that the strategy is unaffordable. The strategic case argues that the strategy is incompatible with the long-term continuation of New Zealand as a country capable of defending and sustaining itself. Both arguments point in the same direction. A government concerned about either should not adopt the strategy as drafted.

Responses to the consultation questions

Q1. What most gets in the way of people or whānau getting the support they need?

The strategy itself, in its current form, is the largest barrier. By conflating distinct categories of human experience under the label "mental health and wellbeing", it ensures that the appropriate response is rarely the response received. People are processed within a system designed for the wrong problem.

Specific barriers include: failure to assess for brain injury; treatment of social and material conditions as psychological problems; treatment of state-induced family separation as personal trauma to be managed individually; treatment of curriculum-induced distress as personal mental health pathology; the structural refusal of Oranga Tamariki to provide early help to families in distress who ask for it; non-acknowledgement of the interaction between prescribed psychotropic agents and the curriculum's specifications of normal function; non-acknowledgement of PSSD as a condition produced by the system's own treatments; medication of distress that is a normal response to abnormal circumstances; the assumption that distress is the problem rather than a signal.

Q2. What most helps?

Correct naming. When a person's distress is correctly named — as grief, as response to violence, as brain injury, as a structural psychiatric condition, as a response to inadequate housing, as a response to state-arranged separation from one's children, as a response to

curriculum content one is being made to absorb, as harm caused by the very medication the system itself prescribed — appropriate help becomes possible. Until then, every intervention is a guess.

Early help, available when a parent asks for it rather than when a third party files a complaint, would itself prevent a great deal of downstream caseload.

Q3. What parts of the strategy feel most right?

The acknowledgement that most mental health challenges originate outside the health system is correct and important. The recognition that families, communities, and other settings are where people first seek support is correct. The intention to include voices that have not previously been heard is correct, though the mechanism for doing so needs work.

Q4. What changes would make the strategy work better?

Begin with First Principles. Define what is meant by mental health, mental illness, mental distress, and wellbeing. Make explicit which of these is a health-system responsibility and which is not. Separate the categories that have been conflated.

Acknowledge brain injury as a distinct domain that is routinely misclassified as mental illness. Build pathways to assess for brain injury in people presenting with what appears to be depression, mood disturbance, cognitive change, or behavioural change.

Name state-induced family separation as a producer of mental health caseload across all population groups, while attending to documented Māori over-representation. Establish, in partnership with Oranga Tamariki, the proportion of current caseload that is consequent on state-arranged separation or on the agency's refusal to provide early help. Propose family restoration — including housing of sufficient size and genuine early support when parents ask for it — as a primary intervention.

Name curriculum content as a measurable input to youth mental health outcomes. Establish, in partnership with the Ministry of Education, an examination of current Health and Physical Education curriculum content, and of the published Mental Health Education and Hauora text in classroom use, for material that predictably produces psychological distress, family rupture, and identity dissolution in children and young people.

Name PSSD as a condition produced by the system's own prescribing pathways. Examine the interaction between prescribed psychotropic agents in adolescents and the curriculum's specifications of normal sexual and physiological function.

Acknowledge the structural condition of the teaching workforce — deprofessionalised by the removal of The Philosophy of Education, required to deliver pre-scripted content without professional framework to evaluate it, now proposed to also deliver wellbeing services into schools whose curriculum is producing distress.

Replace the word "consumer" with "person" throughout. Care is not consumption.

Cost out the upstream production of mental health caseload by other state activity, and cost out the downstream management. Make the comparison public. Use the comparison to allocate funds where they will produce the largest reduction in caseload.

Stop using undefined terms as if they were defined.

Q5. Most important steps in the next three years?

1. A First Principles review of the categories used in the strategy.
2. Establishment of clear assessment pathways for brain injury in people presenting to mental health and addiction services with symptoms that overlap.

3. A joint Ministry of Health / Ministry of Education examination of current curriculum content — the Draft Health and Physical Education Curriculum (October 2025) and the Mental Health Education and Hauora text (Fitzpatrick et al., 2018, NZCER Press) — as measurable inputs to youth mental health outcomes, with particular attention to threshold violations in sexualised content, family-displacement architecture, and the interaction between curriculum specifications and prescribed chemical agents.
4. A joint Ministry of Health / Oranga Tamariki examination of current state-arranged family separation, and of the agency's "complaint only" engagement threshold, as producers of long-term mental health and addiction caseload across all population groups, with attention to documented Māori over-representation in state care.
5. An examination of the teaching workforce's structural condition, including the consequences of the removal of The Philosophy of Education from teacher training, before further workforce demands are placed on teachers under the strategy.
6. Formal recognition of PSSD as a condition produced by treatment the system itself authorises, with appropriate clinical pathways, monitoring, and acknowledgement to affected young people.
7. An honest cost-out of upstream production and downstream management across the above patterns, made public, and used to inform allocation.

Q6. One thing for the biggest difference?

Ask the question the strategy does not ask: *what IS mental health?* Do not proceed with implementation until the answer is clear, defensible, and shared. Everything else follows from that answer or fails for lack of it.

Q7. What should be stopped, or done less of?

Stop treating "mental health" as a coherent category. Stop using "wellbeing" without defining it. Stop using "consumer" to describe a person needing care. Stop calling housing problems, poverty problems, violence problems, brain injury problems, state-separation problems, agency-refusal problems, curriculum-induced problems, and treatment-caused problems "mental health problems."

Stop the Oranga Tamariki practice of refusing help to parents in distress who ask for it before a complaint has been received.

Stop sending mental health workforce into schools to manage distress that the schools' own curriculum is producing, without first examining that curriculum.

Stop prescribing chemical agents to adolescents whose function is then specified as normal-or-abnormal by curriculum content that does not acknowledge the medication, without addressing the loop.

Stop adding wellbeing-delivery responsibilities to a teaching workforce that has already been deprofessionalised and structurally exhausted by prior policy decisions.

Stop expanding the workforce of an unclear category.

Q8. What should be measured?

Outcomes for people whose underlying condition is physical brain injury currently being treated as mental illness. Numbers of people in mental health and addiction services who have not been assessed for brain injury.

Proportion of current caseload, across all population groups and with attention to documented Māori over-representation, that is consequent on state-arranged family separation or on prior refusal of help by Oranga Tamariki.

Proportion of youth distress caseload that is consequent on identifiable curriculum content, including content delivered through the Health and Physical Education Curriculum and the Mental Health Education and Hauora text.

Number of adolescents on prescribed psychotropic, antipsychotic, and hormonal contraceptive treatments encountering curriculum content specifying the function those agents alter, and the resulting service demand.

Number of New Zealanders living with PSSD and other harms produced by treatments the system itself authorised.

Proportion of suicide and self-harm caseload locatable to identifiable upstream production: pharmacological, curriculum-induced, separation-induced, brain-injury-misdiagnosis-induced, housing-induced.

Teacher attrition rates and teacher mental health caseload as a proportion of total caseload.

Numbers of people whose distress resolved when their housing, safety, family structure, or material circumstances changed.

Numbers of people who deteriorated under treatment.

Total annual cost of downstream management compared with estimated cost of upstream prevention across each named pattern.

Q9. Other thoughts.

The strategy is one of a long series of documents (1998, 2002, 2005, 2012, 2018, 2021, 2023, and now 2026) that have re-stated the same intentions in slightly different language and produced incremental adjustments to an underlying architecture that has not changed. The list in Appendix 3 is itself evidence that the foundation is not where the work has been done. Each new strategy has assumed the categories of the last and tried to deliver them more efficiently. None has asked whether the categories are correct.

If the next strategy is to differ from the last eight, it must begin where they did not. First Principles. Clear categories. Honest naming. Recognition that other parts of the state are producing a substantial share of the caseload the mental health system is then expected to manage. Recognition that the health system alone cannot resolve what other agencies are producing — and recognition that continuing to try is producing year-on-year growth in cost without proportionate improvement in outcomes.

A more detailed structural analysis of the Health and Physical Education Curriculum, conducted over the past several months using a systematic analytical method, is available and can be made available to the Ministry on request. The findings summarised in Part 6 above are drawn from that analysis.

Closing

This submission asks the Ministry of Health to do something simple and difficult: stop, and ask what the words mean. Ask where the caseload is being produced. Ask what it costs to manage downstream versus what it would cost to prevent upstream. Ask what kind of population the country is producing, and whether that population is the basis on which a thriving economy, a thriving civil society, and a strategically robust country can rest.

Until that is done, more investment, more workforce, more services, more digital tools, more pathways, more partnerships, and more strategies will produce more activity, more expenditure, and more caseload. They will not produce the outcomes the strategy promises,

because they cannot. The foundation will not hold them. And the upstream production — by Oranga Tamariki, by the schools, by the housing system, by the prescribing pathways, by the other parts of the state whose activity generates mental health caseload — will continue.

The people the strategy intends to serve deserve better than another decade of well-meaning misnaming. They deserve to be correctly understood. From correct understanding, correct response follows. From conflated categories, no correct response can follow, regardless of how much is invested.

The first task of the next ten years is to ask what the work actually is, where the work is actually being produced, and what kind of population — and therefore what kind of country — the spending is producing.