

Submission to the Petitions Committee
House of Representatives | Aotearoa New Zealand

Cross-Agency OIA Analysis

ADHD Governance, Oversight, and System Coordination

In support of the petition

Launch a Public Inquiry into Systemic Harm to People with ADHD in Aotearoa

Submitted by

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ADHDInquiryNZ (grassroots volunteer initiative)

Date

27 April 2026



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Petition of Elspeth Baker-Vevers: Launch a Public Inquiry into Systemic Harm to People with ADHD in Aotearoa

Petition request

That the House of Representatives initiate a Select Committee inquiry into ADHD-related systemic harm, including misdiagnosis, stigma, and limited access to culturally safe, neuro-affirming support in health, education and employment, and establish a National ADHD Strategy and Annual Funding Plan to address lifelong harm.

Petition reason

ADHD affects about 280,000 New Zealanders who face stigma, misdiagnosis, and limited access to culturally safe, neuro-affirming support in schools, healthcare, workplaces, and communities. Other countries have held inquiries into ADHD policy and investment, but New Zealand does not yet have a coordinated plan. Evidence shows systemic harm, serious health impacts, and inequities for Māori, Pasifika, women and girls. The issues of people with ADHD have been seen as a personal problem.

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Date presented:	26 Mar 2026
Considered by:	Petitions
Presenting member:	Vanushi Walters
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Presented 26 March 2026, <https://petitions.parliament.nz/42b5c524-f57f-4c3f-eb1f-08ddcf0ec835?lang=en>

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This submission is based on Official Information Act responses and publicly available research at the time of writing.


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1. Executive Summary

Cross-Agency OIA Analysis: ADHD Governance, Oversight, and System Coordination

This submission presents findings from a cross-agency Official Information Act (OIA) analysis examining how ADHD is currently governed, monitored, and coordinated across public systems in Aotearoa New Zealand. Requests were standardised across agencies where possible to enable comparison of responses.

It examines whether a clear, coordinated cross-government framework exists for the oversight, accountability, and long-term system design of ADHD across public systems in Aotearoa New Zealand.

Key Finding

Across the responses reviewed, no single agency was identified as holding formal cross-government stewardship responsibility for ADHD.

Instead, ADHD-related activity sits across multiple portfolios, including health, education, disability, justice, employment, and social development, without a clearly defined coordinating mechanism, national strategy, or shared accountability framework.

This indicates that ADHD is not currently governed as a coordinated cross-system issue, and that no clear mechanism exists for system-level accountability or oversight.

Structural Patterns Identified

The OIA responses consistently indicate that:

- ADHD is recognised, but not governed as a distinct cross-system cohort
- Responsibility is distributed across agencies, without coordinated stewardship
- ADHD is referenced within broader categories, but not monitored or managed as a standalone population
- ADHD is considered within broader neurodiversity or disability frameworks, but is not consistently identified or governed as a distinct population group, which reduces the visibility of ADHD-specific needs, service pathways, and system-level accountability

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- National data is fragmented, with no comprehensive dataset or consistent identification pathway
- Agencies frequently confirmed that ADHD-specific policy, monitoring, or governance documentation is not held
- Cross-system analysis has occurred in isolated contexts, but does not translate into ongoing accountability or coordinated oversight

These patterns are reflected across agencies, as summarised in Appendix B.

Taken together, these findings indicate a structural gap in governance, rather than a single policy or service issue, that cannot be addressed through isolated policy or service-level changes.

Current system arrangements do not provide coordinated governance, monitoring, or accountability for ADHD at a cross-government level, and support the need for a coordinated response.

There is currently no coordinated national approach to governance or funding for ADHD across systems in Aotearoa New Zealand, despite support needs spanning multiple sectors. This submission supports a Select Committee inquiry to examine how a consistent, system-level response can be established.

Implications of Current System Gaps for People with ADHD

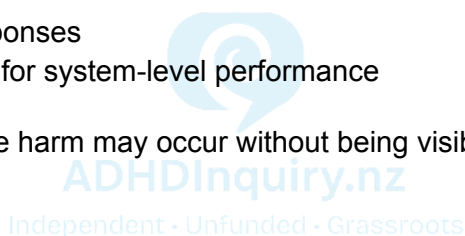
There are an estimated 280,000 people in Aotearoa New Zealand living with ADHD, with impacts spanning education, employment, health, and social systems.

These outcomes are shaped not only by the condition itself, but by how systems are designed, coordinated, and resourced to respond to it.

Current governance arrangements are organised around institutional boundaries rather than lived experience. Where a condition spans multiple systems, but no agency holds responsibility for the whole, this limits the ability to:

- monitor long-term outcomes
- identify inequities
- coordinate policy responses
- ensure accountability for system-level performance

This creates conditions where harm may occur without being visible, measured, or addressed at a system level.



Research and Lived Experience

New Zealand and international research show that people with ADHD experience a range of outcomes across education, employment, health, and social systems.

These outcomes are influenced not only by individual factors, but by how systems are designed, coordinated, and resourced to respond to ADHD.

At the same time, research is often conducted within specific domains and does not always capture how systems interact in practice.

The OIA responses, alongside lived experience, suggest that current challenges are not limited to clinical or academic questions. They relate to coordination, visibility, and accountability across systems.

Further research can continue alongside system improvement. It does not need to delay it.

The absence of complete data does not prevent identification of system-level issues, but rather highlights the need for coordinated mechanisms to assess, prioritise, and respond to them.

Consistent Signals Across Agencies and the Public

Across multiple OIA responses, agencies acknowledged that people with ADHD experience challenges that extend beyond individual services, and that further work is needed to improve support across systems.

These observations are consistent with existing research and with the experiences described by individuals, families, and advocates across Aotearoa New Zealand.

The petition calling for a public inquiry into ADHD has been signed by more than 1,800 people, reflecting sustained public concern and lived experience.

Taken together, these sources point to a consistent position. The need for improved coordination and support is already recognised.

What remains is the absence of a coordinated, system-level response to issues that are already widely recognised. Coordinated national strategies and dedicated funding approaches are used elsewhere to address complex, cross-sector issues.

No equivalent national strategy for ADHD has been identified.


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Why a Public Inquiry Is Appropriate

The issues identified relate to:

- cross-portfolio stewardship
- data architecture and cohort visibility
- monitoring and accountability
- coordination across multiple public systems

These are system-level governance questions that sit across agency boundaries.

A public inquiry would allow for a structured examination of how ADHD is currently governed across health, education, disability, employment, and justice systems. It would enable evidence to be gathered in a consistent way, including from agencies, researchers, and people with lived experience.

It would also provide a basis for assessing whether current arrangements are sufficient, or whether a coordinated national strategy and funding approach are required.

Conclusion

The evidence gathered through cross-agency OIA responses indicates that ADHD is currently treated as a shared issue in principle, but without clearly defined ownership in practice.

Where responsibility is distributed, data is fragmented, and accountability is unclear, a system-level examination is warranted.

This submission supports a public inquiry to determine whether current arrangements are sufficient, or whether a coordinated national governance framework is required to support equitable and effective outcomes for people with ADHD in Aotearoa New Zealand.

Summary of System-Level Findings

- No clearly identified cross-government stewardship
- ADHD recognised across systems but not governed as a cohort
- Fragmented data and limited visibility
- No consistent monitoring or accountability framework
- Repeated confirmation that key information is not held


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2. Introduction

This submission supports the petition calling for a public inquiry into systemic harm experienced by people with ADHD in Aotearoa New Zealand.

It presents a cross-agency view of how ADHD is currently recognised, governed, and monitored across public systems. The analysis is based on information provided by government agencies under the Official Information Act 1982.

A series of OIA requests were submitted to multiple agencies across the health, education, and social sectors. These requests followed a consistent structure and sought information on:

- leadership and responsibility for ADHD-related policy or oversight
- data collection, monitoring, and outcomes
- funding allocated to ADHD-specific initiatives
- use of linked data, including the Integrated Data Infrastructure
- alignment with rights-based frameworks

This was a deliberate, structured approach designed to enable comparison across agencies and identify system-level patterns.

The purpose of this submission is not to evaluate individual agency performance. It is to examine how the system operates as a whole. This includes how responsibilities are distributed, how information is collected, and whether coordination exists across sectors.

The responses indicate that ADHD does not sit clearly within a single area of responsibility, despite its impact across health, education, employment, and social systems.

The findings presented in this submission are drawn directly from agency responses and are used to identify systemic gaps, fragmentation, and areas where coordination appears limited or absent.

This submission identifies system-level gaps in governance, data, and coordination that cannot be resolved through existing structures alone.



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3. Scope of OIA Analysis

A series of Official Information Act requests was submitted across multiple government agencies to examine how ADHD is currently recognised, categorised, resourced, monitored, and governed across public systems.

In total, 36 OIA requests were issued across central government agencies and related entities, covering approximately 28 distinct agencies. In some cases, where a request was refused, required refinement, or addressed a different aspect of ADHD-related system activity, follow-up or additional requests were submitted.

The requests covered agencies across health, education, disability, justice, social development, workforce policy, research, and central government coordination.

The requests followed a consistent structure to enable comparison across agencies. They sought information on:

- leadership, ownership, and responsibility for ADHD-related policy, coordination, governance, or oversight
- policies, frameworks, strategies, guidance, and service design relating to ADHD
- data collection, coding, categorisation, monitoring, and outcome reporting
- use of linked data systems, including the Integrated Data Infrastructure
- funding, resourcing, commissioning, and investment relating to ADHD-specific work
- equity, rights, and compliance, including whether Māori, Pacific peoples, gender, and rainbow and takatāpui community considerations were reflected
- cross-agency coordination, accountability, and oversight mechanisms
- confirmation where ADHD-specific information was not held, did not exist, or was grouped under broader categories.

This was a deliberate, structured approach designed to enable comparison across agencies and identify system-level patterns.

The purpose was not to assess individual agency performance. It was to examine how the system operates as a whole, including how responsibilities are distributed, how information is captured, and whether coordination exists across sectors.

Table 1 provides an overview of the agencies contacted, response status, and key areas covered.



Table 1: Overview of OIA Requests by Agency and Focus Area

Some agencies received more than one request. In these cases, each request focused on a different aspect of ADHD-related policy, data, services, or system responsibilities. This reflects the cross-sector nature of ADHD and the need to examine different parts of the system separately.

OIA #	Agency	Sector	Primary Focus of Request	Response Status
1	Manatū Hauora (Ministry of Health)	Health	National health policy, data visibility, rights oversight	Partial response
2	Te Whatu Ora	Health	ADHD services, access pathways, national data	Partial response
3	Stats NZ	Data	ADHD visibility in IDI datasets	Partial response
4	Treasury	Central government / Economic	Fiscal analysis, investment modelling, IDI feasibility	Response received
5	Social Investment Agency	Social investment / Data	ADHD social investment modelling and unpublished 2024 report	Partial response
6	DPMC	Central government	Cross-agency governance or strategy for ADHD	Response received
7	Pharmac	Health	ADHD medicines funding, criteria, equity	Partial response
8	Ministry of Education	Education	ADHD in education policy, PLD, data, learning support	Response received
9	NZQA	Education	Special Assessment Conditions for students with ADHD	Response received

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10	Teaching Council	Education	Teacher standards, ITE expectations, PLD on ADHD	Response received
11	Whaikaha	Disability	ADHD inclusion in disability policy and supports	Partial response
12	Ministry of Health	Health	Follow-up on Hui actions, data survey, coordination	Response received
13	Ministry of Health	Health	Māori, Pacific, and Rainbow equity in ADHD clinical frameworks	Information not held
14	Ministry of Justice	Justice	ADHD recognition in justice data and fair-process issues	Information not held
15	NZ Police	Justice	ADHD in police contact, training, vulnerability flags	Partial response
16	Department of Corrections	Justice	ADHD screening, data, programmes, and prison supports	Partial response
17	Oranga Tamariki	Social / Justice	ADHD in care, youth justice, data, supports	Overdue, no response
18	MBIE	Employment	ADHD and employment rights, accommodations, policy gaps	Refused (s18(e): information does not exist or cannot be found)
19	Public Service Commission	Public sector workforce	ADHD in public-sector workforce inclusion	Response received
20	WorkSafe	Employment / Health and Safety	ADHD in psychosocial risk and worker wellbeing	Response received

21	Human Rights Commission	Rights	ADHD discrimination and rights monitoring	Response received
22	Health Research Council	Research	ADHD research funding and research equity	Response received
23	Te Puni Kōkiri	Māori development	Māori equity and ADHD	Refused (s18(e): does not exist or cannot be found)
24	Ministry for Pacific Peoples	Equity	Pacific communities and ADHD	Refused (s18(e): information requested does not exist)
25	Ministry for Women	Equity	Gender equity and ADHD, especially women and girls	Refused (s18(g): information is not held)
26	Ministry for Ethnic Communities	Equity	Ethnic communities and ADHD	Response received
27	Ministry of Social Development	Social development	ADHD within employment, income, and disability supports	Refused (s18(e): information does not exist or cannot be found)
28	Ministry of Youth Development	Youth policy	ADHD in youth policy and participation barriers	Partial response
29	MBIE	Employment	Positive duty and proactive employer obligations	Refused (s18(e): information does not exist or cannot be found)
30	Te Whatu Ora	Health workforce	Supports and recognition for staff with ADHD	Partial response
31	Ministry of Health	Health workforce	Internal supports for staff with ADHD	Response received

32	Ministry of Education	Education workforce	Supports for Ministry staff and teachers with ADHD	Partial response
33	Ministry of Disabled People	Disability workforce	Internal supports for employees with ADHD	Response received
34	Manatū Taonga	Culture / Public representation	ADHD in New Zealand narratives and cultural identity frameworks	Refused (s18(f): requires substantial collation and research)
34B	Manatū Taonga	Media policy / public media reform	“Sense of inclusion” KPI (public media business case)	Partial response
35	Ministry of Health	Health / Reform implementation	Governance and rollout of ADHD Clinical Framework	Response received
36	Health NZ	Health / Reform implementation	Service readiness for 2026 ADHD reform	Partial response

Pattern Definitions

For the purposes of this analysis, the following patterns were identified across OIA responses:

- **No cross-government stewardship:** No single agency identified as responsible for coordinating ADHD policy, strategy, funding oversight, or system-level outcomes across sectors.
- **ADHD embedded but not governed:** ADHD is recognised within existing services, policies, or datasets, but without a dedicated governance framework, coordinated national approach, or clearly defined system ownership.
- **Fragmented data and limited visibility:** ADHD cannot be consistently identified across datasets, or data is incomplete, unlinked, or organised in a way that limits system-level insight or population-level analysis.
- **Absence of monitoring and accountability:** No established mechanisms for tracking outcomes, reporting performance, or assigning responsibility for ADHD-related system outcomes across agencies or over time.
- **“Information not held” responses:** Agencies explicitly stated that requested ADHD-related information (e.g. policy ownership, monitoring, strategy, or data) was not held.

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4. Cross-Agency Structural Findings

The OIA responses were reviewed collectively to identify whether consistent patterns were present across agencies, rather than focusing on individual responses in isolation.

To support cross-agency analysis, responses were systematically reviewed and coded for recurring structural patterns. Pattern tagging was applied where gaps were explicitly evidenced in responses, including refusals under section 18(e) confirming that information was not held.

While the level of detail varied between agencies, a number of common themes emerged. These were not limited to a single portfolio, but appeared across multiple parts of the system, including health, education, disability, and data functions.

Table 2 summarises the structural patterns identified across OIA responses based on this analysis. These patterns are then discussed in more detail in the sections that follow.

Taken together, these patterns indicate structural characteristics of how ADHD is currently recognised and managed across systems, rather than isolated gaps within individual agencies.

Table 2: Cross-Agency Structural Pattern Summary

Structural Pattern	Agencies where pattern was identified
No cross-government stewardship	Across multiple agencies (see Appendix B)
ADHD not governed as a system issue	Across multiple agencies (see Appendix B)
ADHD not clearly identifiable in data	Across multiple agencies (see Appendix B)
No consistent monitoring or accountability identified	Across multiple agencies (see Appendix B)
“Information not held” responses	Widespread across multiple agencies (see Appendix B)

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Patterns reflect themes identified across OIA responses based on pattern tagging detailed in Appendix B. Not all patterns apply to every agency.

4.1 No Cross-Government Stewardship

This is reflected in OIA responses from the Ministry of Health (OIA #1) and Health New Zealand (OIA #2). The Ministry of Health confirmed that it does not hold information identifying a responsible team, policy framework, governance structure, or oversight role for ADHD. Health New Zealand responses similarly did not identify a national framework for workforce roles, monitoring, or system-level coordination.

The Department of the Prime Minister and Cabinet advised that it was not aware of any cross-agency ADHD strategy work and did not hold information on oversight responsibility. As the central agency supporting Cabinet and coordinating government priorities, this is a system-level indication that no centrally visible governance or coordination mechanism for ADHD was identified (OIA #6).

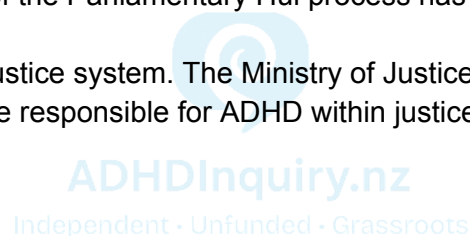
The transfer of this request from DPMC to the Ministry of Health reflects how ADHD is currently positioned within government systems as a health issue rather than a cross-sector responsibility. While diagnosis and treatment sit within the health system, the impacts of ADHD extend across education, employment, justice, and social development, without a corresponding cross-sector governance structure.

This is consistent with the Ministry of Health (OIA #1) response, which confirmed that responsibility for ADHD policy is distributed across multiple agencies and that no cross-agency evaluation or accountability framework exists.

This is further reinforced by the Ministry of Disabled People (Whaikaha), which explicitly confirmed it does not hold a coordinating role for ADHD and that cross-agency work has been limited to a time-limited interagency group that is no longer in operation.

This is also supported by Ministry of Health responses indicating that no ongoing coordination mechanism or continuation of the Parliamentary Hui process has been established (OIA #12).

This pattern extends to the justice system. The Ministry of Justice confirmed that it does not identify any unit, team, or role responsible for ADHD within justice policy or court accessibility functions (OIA #14).



These findings reflect structural gaps in coordination and governance, rather than limitations in the individuals affected, whose outcomes are strongly influenced by the level of support available across systems.

4.2 ADHD Embedded but Not Governed

OIA responses indicate that ADHD is supported within existing service structures, but without a coordinated governance framework.

This is also reflected in the New Zealand Qualifications Authority response (OIA #9), which confirmed that ADHD is recognised within the Special Assessment Conditions system but is not treated as a distinct category. Instead, ADHD is grouped within broader condition types and is not structured as a standalone dataset for governance or analysis purposes.

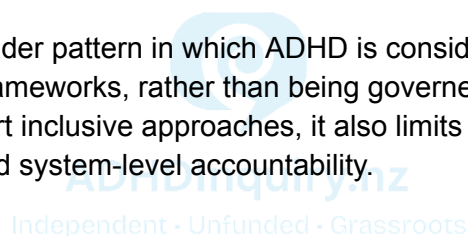
Health New Zealand (OIA #2) confirmed that clinical guidance is provided through locally developed HealthPathways, which support service delivery but do not include responsibility for system design, workforce planning, or national coordination.

This is also reflected in the Treasury response, which indicated that ADHD appeared in cohort selection work using the Integrated Data Infrastructure, but that this analysis was undertaken by the Social Investment Agency rather than as part of a coordinated Treasury-led approach (OIA #4).

This pattern is also reflected in the Teaching Council of Aotearoa New Zealand response (OIA #10), which confirmed that ADHD is not explicitly referenced in Initial Teacher Education requirements or teaching standards. While expectations refer broadly to supporting diverse learners, no ADHD-specific guidance, capability framework, or professional learning was identified. This indicates that ADHD is positioned within general inclusion frameworks rather than governed as a distinct area of professional capability.

A similar pattern is reflected in the disability system. Whaikaha (OIA #11) confirmed that ADHD is considered within broader neurodiversity work, but is not treated as a distinct policy, governance, or monitoring category.

This is consistent with a broader pattern in which ADHD is considered within general neurodiversity or disability frameworks, rather than being governed as a distinct population group. While this may support inclusive approaches, it also limits the visibility of ADHD-specific needs, service pathways, and system-level accountability.



A similar pattern is evident in youth policy. The Ministry of Youth Development (OIA #28) identified that ADHD and neurodiversity are referenced within Youth Plan activity and supporting literature, including recognition that neurodivergent young people may experience different expectations and treatment. However, no ADHD-specific policy, data, analysis, or monitoring was identified, and detailed information was not held. This indicates that ADHD is acknowledged within youth frameworks but is not governed or structured as a distinct policy cohort.

This is also evident within the public service workforce. The Public Service Commission (OIA #19) confirmed that ADHD is addressed within broader disability and neurodiversity frameworks, including inclusion initiatives, training, and employee-led networks. However, it does not hold any ADHD-specific workforce strategies, policy guidance, or accommodation frameworks, and ADHD is not identified as a distinct category within workforce design or governance. This indicates that ADHD is recognised within general inclusion activity but is not governed as a distinct workforce consideration.

The Ministry of Health response (OIA #12) also identified that ADHD-related actions are being progressed within existing workstreams, including clinical guidance and prescribing changes, but without a defined governance structure, monitoring mechanism, or coordinated system oversight.

The Ministry of Health (OIA #35) further confirmed that while the *New Zealand Clinical Principles Framework for Attention Deficit Hyperactivity Disorder (ADHD)* is owned and published at a national level, it does not mandate new requirements and is not linked to commissioning, service delivery, or dedicated funding. No documentation was identified relating to planning or implementing changes to ADHD service delivery. This indicates that clinical guidance exists, but is not supported by system-level governance, delivery mechanisms, or accountability structures.

The Ministry of Health (OIA #13) confirmed that no documentation was identified within scope relating to Māori, Pacific, or broader equity involvement in the development of ADHD clinical frameworks. While limited early engagement with Māori researchers was noted, broader engagement was not undertaken. This indicates that equity is referenced within guidance but is not demonstrably embedded in system design.

This is also reflected in the Ministry for Women (OIA #25), which confirmed that no information was held relating to ADHD in women or girls across policy, research, collaboration, or monitoring, and indicated that ADHD sits within another agency's mandate. This indicates that known gender-based differences in ADHD are not currently reflected within the systems responsible for women's outcomes.

A similar pattern is observed in the New Zealand Police response (OIA #15), which identified some operational guidance and training relating to neurodivergence, including interaction guidance and interview protocols. However, Police confirmed that no ADHD-specific policies exist across key operational areas such as frontline response, custody, or risk assessment. This indicates that while ADHD may be recognised in practice, it is not governed as a distinct operational or policy category.

This pattern is also present in the employment system. The Ministry of Business, Innovation and Employment confirmed that ADHD in the workplace is considered an emerging area of focus, but that no ADHD-specific employment policy, workplace guidance, data, analysis, or monitoring exists. All parts of the request were refused on the basis that the requested documents do not exist (OIA #18). This indicates that ADHD is not currently governed as a distinct policy or workforce category within employment systems.

A similar pattern is evident within employment and income support systems. The Ministry of Social Development confirmed that ADHD is included within a broad disability definition and may be recorded in individual client notes, but is not identified, reported, or monitored as a distinct category. It does not hold information on ADHD-specific employment policies, programmes, or outcomes, and refused the request on the basis that this information is not held (OIA #27). This indicates that ADHD is present within service delivery but is not structured or governed as a distinct cohort within employment or income support systems.

This is also evident in workplace health and safety systems. WorkSafe New Zealand confirmed that ADHD is not incorporated into regulatory policy, guidance, or system design, and is not explicitly considered within psychosocial risk frameworks or worker wellbeing approaches (OIA #20).

4.3 Fragmented Data and Limited Visibility

OIA responses from both the Ministry of Health (OIA #1) and Health New Zealand (OIA #2) confirm that ADHD cannot be consistently identified across national datasets. Agencies stated that there is no single national dataset capturing all ADHD diagnoses, and that available data is organised by care setting rather than condition. This means ADHD diagnoses across primary care, outpatient, and private settings cannot be reliably identified or linked at a system level.

A later Ministry of Health response (OIA #12) confirmed that national ADHD prevalence data is not currently available and is being developed through a future Child and Youth Mental Health and Addiction Prevalence Survey, with results expected in 2027.

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This indicates that current system visibility relies on future data development rather than existing, established datasets.

The Ministry of Education (OIA #8) confirmed it does not hold ADHD-specific policy ownership, data, monitoring, evaluation, or funding information, and does not track ADHD as a category within its systems.

This pattern is also reflected in the New Zealand Qualifications Authority response (OIA #9). While ADHD is recorded within Special Assessment Conditions applications, it is not captured as a distinct category. NZQA confirmed it does not record whether ADHD is the primary or contributing reason for applications, and does not produce ADHD-specific analysis. It also confirmed that no documentation is held explaining why ADHD-specific SAC data is not collected.

A similar limitation is evident in the employment system. The Ministry of Business, Innovation and Employment confirmed that it does not hold any ADHD-related labour market data, analysis, or modelling within scope, and no information was provided linking ADHD to employment outcomes, disputes, or workforce participation (OIA #18).

A similar limitation exists within workplace health and safety systems. WorkSafe New Zealand confirmed that it does not collect or hold ADHD-related data within investigations, assessments, or regulatory reporting, and does not categorise ADHD within its systems (OIA #20). This limits the ability to identify or analyse workplace risks, psychosocial harm, or safety outcomes experienced by workers with ADHD.

This limitation is also present within the public service workforce. The Public Service Commission (OIA #19) confirmed that ADHD is not captured as a standalone category within workforce reporting and is instead included within a broader neurodiversity question in the Public Service Census. This limits the ability to identify, analyse, or monitor workforce outcomes for public servants with ADHD.

Information relating to employees with ADHD is not captured within the Ministry of Health workforce, and is not reported as a distinct category within employee data or reporting (OIA #31).

Workforce data within Health New Zealand also does not capture information relating to employees with ADHD, neurodiversity, disability, or mental health, and therefore cannot identify or report on this group (OIA #30).

Within Whaikaha, ADHD is also not captured as a distinct category in workforce data and would only be recorded under a broader disability classification (OIA #33).

The same limitation is evident within the Ministry of Education workforce, where information relating to employees with ADHD is not captured within employee data or reporting, including within broader categories (OIA #32).

A similar limitation is evident within publicly funded research. The Health Research Council (OIA #22) identified ADHD-relevant research activity through keyword-based searches of proposal data, rather than through a distinct research classification. Between 2015 and 2025, 46 unsuccessful applications relevant to ADHD were identified, alongside four funded research projects between 2020 and 2022 that referenced ADHD-related topics.

However, ADHD is not treated as a distinct research category, and funded research is classified under broader health issue groupings such as mental health, neurological conditions, or human genetics. No ADHD-specific prioritisation criteria, research gap analysis, or equity analysis was identified.

This indicates that, even where research activity exists, ADHD is not structured as a population for analysis, limiting the ability to identify evidence gaps, monitor research investment, or inform coordinated policy development.

This is further reflected in the Statistics New Zealand response, which confirmed that ADHD is not consistently identifiable as a standalone category within the Integrated Data Infrastructure and relies on specific datasets for identification (OIA #3).

This reinforces that ADHD-related data is not only fragmented across service systems, but also difficult to identify consistently within national linked data infrastructure.

This limitation extends to youth policy. The Ministry of Youth Development (OIA #28) confirmed that ADHD-specific data or analysis is not held, indicating that ADHD cannot be identified or examined within youth system data or reporting.

This is also reflected in the disability system, where Whaikaha (OIA #11) confirmed it does not collect or monitor ADHD-specific data. ADHD is instead identified indirectly through broader datasets or grouped categories, including within Integrated Data Infrastructure code modules that combine multiple neurodevelopmental conditions rather than treating ADHD as a standalone cohort.

The Pharmac response (OIA #7) indicates that ADHD-related pharmaceutical data is held, but only partially provided. A dataset covering January 2024 to June 2025 was released, consisting of aggregate dispensing volumes by medicine and formulation. The dataset provided does not include breakdowns by age, sex, ethnicity, or region. Broader data requested was either deferred for later response or refused on the basis of substantial collusion. The response also

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indicates that no monitoring or evaluation of ADHD medicine use has been undertaken, and that Pharmac does not hold information on data gaps or decisions not to collect ADHD-related data. This indicates that while medicine use is recorded, it is not currently reported in a way that enables population-level or equity analysis.

The Treasury response (OIA #4) indicated that it does not hold its own ADHD-specific fiscal, employment, or IDI-related analysis within scope. It also showed that ADHD appeared in limited contexts, such as cohort selection work using the IDI, but that this analysis was undertaken by the Social Investment Agency rather than held or coordinated by Treasury. This indicates that relevant analysis may exist in parts of the system, but is not consistently held, shared, or coordinated across agencies.

Data visibility constraints are not limited to national health and linked data systems. Similar structural limitations are also observed in sector-specific systems such as education assessment.

This lack of data visibility extends to the justice system. The Ministry of Justice confirmed that it does not collect or report any ADHD-specific data, and that ADHD is not captured in reporting systems or court user surveys. Any reference to ADHD may only be recorded in individual court files, which are not accessible under the Official Information Act (OIA #14).

This pattern is also reflected in the New Zealand Police response (OIA #15), which confirmed that ADHD is not specifically captured, coded, or searchable in Police systems. Police stated that they do not track ADHD-related contact, do not undertake ADHD-specific analysis or reporting, and do not hold classification standards for identifying ADHD-related needs within operational data systems. This indicates that ADHD-related interactions with Police are not visible at a system level.

This pattern is further reflected in the Department of Corrections response (OIA #16), which confirmed that ADHD is not tracked as a reportable category within Corrections systems. ADHD diagnoses are recorded only within individual health files, and determining prevalence would require manual review of those records. This means ADHD cannot currently be identified or analysed at a system level, and in some cases may only be identifiable through manual review of unstructured information.

This limitation is not confined to operational or administrative systems. The Ministry for Culture and Heritage (OIA #34) advised that identifying whether ADHD is referenced within its work would require a broad manual search across websites, funded projects, and public content, and could not be determined through existing systems. This indicates that ADHD is not structured, indexed, or retrievable as a category, even where it may be present in practice.

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Table 3: ADHD Data Visibility Constraints

Table 3 summarises data visibility constraints identified across OIA responses reviewed for this submission.

Data Source	ADHD Identifiable?	Limitations
NMDS ²	Partial	Not consistently identifiable as a standalone condition
PRIMHD ²	Yes (limited and inconsistent)	Partial coverage and inconsistent data completeness
Primary care ²	No (nationally)	Not captured or standardised within national data collections
Outpatient services ²	No (nationally)	Not consistently coded or captured in national datasets
Private diagnosis ^{1,2}	No	Not routinely captured in national datasets
Pharmaceuticals ⁴	No (diagnosis not identifiable)	No direct diagnosis linkage; limited reporting and no routine monitoring or evaluation of access or use
IDI ³	Partial	No consistent standalone ADHD category; identification relies on proxy variables across datasets

¹ Ministry of Health (OIA #1), response regarding system-level data availability and monitoring limitations

² Health New Zealand (OIA #2), response regarding national data systems, service-level data capture, and dataset use

³ Statistics New Zealand (OIA #3), response regarding IDI data structure and ADHD identification limitations

⁴ Pharmac (OIA #7), response regarding pharmaceutical data, monitoring, and evaluation

The existence of project-based research using linked administrative data demonstrates analytic capability. However, individual research outputs do not establish ongoing cross-government stewardship, routine monitoring, or clearly assigned accountability. Analytic capability and institutionalised governance are distinct functions, and one does not substitute for the other.

In the absence of consistent identification and monitoring, population-level outcomes for people with ADHD cannot be reliably measured or compared across systems.

4.4 Absence of Monitoring and Accountability

The Ministry of Health (OIA #1) response indicated that no established monitoring framework or ongoing population-level reporting for ADHD has been identified. Health New Zealand (OIA #2) response indicates that consistent national monitoring, outcome tracking, or accountability mechanisms are not currently established across services.

This is reinforced by the Ministry of Health response (OIA #12), which confirmed that no ongoing monitoring or accountability mechanisms are in place for actions arising from the 2024 ADHD Parliamentary Hui, indicating that system-level initiatives are not supported by structured follow-through or evaluation.

Across responses, this indicates that monitoring, evaluation, and accountability functions are not assigned or coordinated at a system level, and are absent across multiple domains.

Statistics New Zealand (OIA #3) also confirmed that only limited ADHD-related research has been undertaken using the IDI, and that it does not hold records of broader ADHD-specific research activity or coordinated monitoring, indicating limitations in system-level data visibility.

Even where national initiatives exist, they do not operate within a coordinated or monitored system. The Ministry of Health response (OIA #35) confirmed that monitoring and evaluation approaches for recent ADHD policy changes are still being developed, with no formalised framework or system-level accountability mechanisms in place).

Whaikaha also confirmed that no ADHD-specific monitoring, reporting, or outcome tracking is undertaken within the disability system, further indicating that accountability mechanisms for ADHD do not exist across key service domains.

The Pharmac response explicitly stated that no monitoring or evaluation of ADHD medicine uptake or access has been undertaken. This is notable in a system where funding decisions, prescribing controls, and supply management are actively administered, but outcomes are not monitored. While baseline prescribing work and future evaluation activity were referenced, no

ADHD-specific monitoring or evaluation outputs were identified in the response (OIA #7).

This is also evident in policy development contexts. The Ministry for Culture and Heritage confirmed that while a “sense of inclusion” KPI was identified within the Strong Public Media business case, no measurement framework, methodology, or reporting approach was established, and the KPI was not monitored or reported on. Parts of the request relating to measurement, population coverage, and monitoring were refused on the basis that the information is not held (OIA #34B). This indicates that high-level outcomes may be defined without corresponding systems to measure, track, or evaluate them.

The Teaching Council response further reinforces this pattern, confirming that no information is held on teacher preparedness or capability to support learners with ADHD, and that no ADHD-related professional learning has been funded, commissioned, or endorsed. This indicates that teacher capability in relation to ADHD is not currently monitored or evaluated at a system level (OIA #10).

This pattern is also reflected in the employment domain. The Ministry of Business, Innovation and Employment confirmed that no monitoring, evaluation, or reporting relating to ADHD in employment contexts has been undertaken, and no information was identified within scope (OIA #18).

This pattern is also reflected in workplace health and safety regulation. WorkSafe New Zealand confirmed that no ADHD-specific monitoring, analysis, or reporting is undertaken in relation to worker wellbeing, workplace experiences, or psychosocial harm (OIA #20).

This pattern is also reflected in the public service workforce. The Public Service Commission (OIA #19) did not identify any ADHD-specific monitoring, reporting, or evaluation of workforce outcomes, including recruitment, retention, or workplace experience. While broader inclusion activity exists, no ADHD-specific monitoring or accountability framework was identified.

This pattern is also reflected in the Human Rights Commission response, which identified ADHD-related complaints within its enquiries system but did not identify any ADHD-specific monitoring, reporting, or analysis of discrimination or rights-based outcomes (OIA #21).

The Ministry of Justice response further indicates that no monitoring or analysis of ADHD exists within the justice system. No ADHD-specific data, reporting, or evaluation relating to court processes, participation, or outcomes was identified (OIA #14).

Similarly, New Zealand Police (OIA #15) confirmed that it does not track or report on ADHD-related interactions, and does not undertake ADHD-specific analysis or monitoring. While a Disability and Special Considerations noting has been introduced, the content is not tracked or

reported at a system level. This indicates that monitoring of ADHD-related interactions within policing is not established.

The Department of Corrections response also confirmed that no ADHD-specific studies, reporting, or outcome analysis have been undertaken in relation to people under its management (OIA #16). This indicates that monitoring of outcomes for people with ADHD within prison and community-based sentence settings is not established.

4.5 Repeated “Information Not Held” Responses

Across multiple OIA responses, agencies confirmed that information relating to ADHD was not held, not identified within scope, or did not exist. This included information relating to policy ownership, workforce roles, monitoring, and equity analysis.

This includes central agencies such as the Department of the Prime Minister and Cabinet (OIA #6), which advised that it was not aware of cross-agency ADHD strategy work and did not hold information on oversight responsibility.

This pattern is also reflected in the Whaikaha response (OIA #11), where no ADHD-specific rights analysis, advisory group material, or monitoring documentation was identified as being held.

The repetition of “information not held” responses across these areas indicates that key elements of governance, oversight, and system responsibility are not centrally documented or assigned.

This is illustrated in the Ministry of Education response, which confirmed that ADHD-specific policy ownership, data, monitoring, evaluation, and funding information is not held (OIA #8).

This pattern is also reflected in the Ministry of Business, Innovation and Employment response, which refused all parts of the request on the basis that the requested ADHD-related employment policy, guidance, data, and analysis do not exist (OIA #18).

This pattern is also reflected in the Ministry of Health response (OIA #13), which stated that no information was identified within scope relating to Māori, Pacific, or equity involvement in ADHD-related clinical frameworks, and noted that the Clinical Principles Framework project had a narrow consultation scope.

This pattern is also reflected across population-focused agencies. The Ministry for Ethnic

Communities (OIA #26) confirmed that it has not undertaken ADHD-specific work and does not hold information across the areas requested, including policy, research, engagement, or analysis. Similar responses were received from other agencies responsible for population-level policy, including Māori, Pacific, and women (OIA #23–#25).

Statistics New Zealand also advised that it does not hold records documenting decisions not to collect ADHD-related variables (OIA #3).

This is also reflected in the Teaching Council response, which confirmed that no specific information is held on teacher capability, professional learning, or preparedness to support learners with ADHD (OIA #10).

Some responses relied on 'not aware' statements in relation to coordination mechanisms, monitoring, and future planning, indicating that key elements of system oversight are either not held or not established.

A similar pattern is evident in the Ministry of Justice response, which refused all parts of the request on the basis that ADHD-specific policy, data, funding, and rights-related analysis are not held (OIA #14).

This is also reflected in the Department of Corrections response, which confirmed that no internal advice, reports, or documentation are held identifying barriers or limitations in recognising or supporting ADHD within prison settings, community-based sentences, or programme delivery (OIA #16).

Oranga Tamariki has not provided a response to OIA #17. As a result, no information was provided by Oranga Tamariki in response to this request regarding ADHD recognition, support, or monitoring within care and protection or youth justice systems.

These patterns are consistent with broader concerns raised in lived-experience and sector advocacy, which describe ADHD as a cross-system issue without coordinated ownership.



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5. System-Level Implications

People with ADHD experience impacts across multiple parts of the public system, including health, education, disability, employment, and justice.

Non-government organisations and community providers also play a role in supporting people with ADHD and their whānau. However, they are not funded or mandated to provide system-level coordination, monitoring, or long-term service design.

ADHD may be recognised across systems, but without coordinated stewardship it is not consistently governed, monitored, or owned as a cross-sector issue.

This includes the disability system, where ADHD is acknowledged within broader frameworks but is not monitored, analysed, or governed as a distinct population, limiting visibility of outcomes and system response.

Responsibility for coordination, monitoring, and long-term system design remains distributed across agencies without a clearly defined cross-government framework.

5.1 System Fragmentation

Across the system, ADHD is often named, but not governed; acknowledged, but not monitored; embedded, but not owned.

Fragmentation is not inherently a system failure. However, where impacts span multiple sectors and no mechanism exists to coordinate oversight, monitor outcomes, or assign accountability, fragmentation becomes a structural limitation rather than a neutral characteristic of the system.

Current system design is organised around institutional boundaries rather than lived experience. Where a condition spans multiple systems, but no agency holds responsibility for the whole, coordination, monitoring, and accountability become structurally limited.

5.2 Lack of Clear Accountability

Where responsibility is distributed across multiple agencies without a coordinating framework, no single entity holds visibility of overall outcomes. This limits the ability to assign accountability for system-level performance or to respond to issues that emerge across service boundaries.

The responses also suggest that ADHD is positioned within existing institutional boundaries

rather than treated as a cross-system issue, with central coordination functions not clearly identified even where impacts span multiple sectors.

Across Ministry of Health responses, a consistent pattern emerges where ADHD-related activity is undertaken, but without a corresponding system for coordination, monitoring, or sustained oversight. This creates a structural disconnect between policy development and system-level implementation.

A similar pattern is evident within the public service workforce. The Public Service Commission (OIA #19) identified inclusion initiatives, training, and employee-led networks, but did not identify any ADHD-specific workforce policy, data collection, or monitoring. This reflects a broader system pattern where activity occurs without clearly assigned ownership or accountability.

A similar pattern is also evident within the lead health agency itself. The Ministry of Health confirmed that ADHD is not identified or tracked within its own workforce policies, data collection, or reporting, and is instead considered within broader disability frameworks, with support determined on an individual basis rather than through defined or consistent policy (OIA #31).

This suggests that even within the agency responsible for national health policy, ADHD is not treated as a distinct or visible category. This reinforces the absence of system-level accountability, leadership, and coordinated recognition across sectors.

A related pattern is evident within Health New Zealand, where training, resources, and internal support activity relating to neurodiversity and ADHD were identified, including guidance materials and e-learning. However, these are not supported by corresponding workforce data, formal policy recognition, or structured monitoring. This indicates that activity is occurring without system-level visibility, coordination, or accountability (OIA #30).

This pattern is also evident within the education system. The Ministry of Education confirmed that no internal policies specifically reference ADHD, and that ADHD is not captured within workforce data or reporting. While general neurodiversity activity has occurred, no ADHD-specific training, communication, or monitoring was identified, and key parts of the request were refused on the basis that the requested information does not exist (OIA #32).

This indicates that ADHD is not structured or visible within education workforce systems. Responsibility for recognising and supporting ADHD within teaching contexts is not clearly reflected in Ministry-level policy or oversight.

This pattern is also evident within agencies with an explicit focus on population wellbeing and equity. Te Puni Kōkiri (OIA #23) confirmed that it holds no information relating to ADHD across

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policy, research, engagement, resources, or monitoring, and positioned ADHD as a specialist health matter. Similarly, the Ministry for Pacific Peoples (OIA #24) confirmed that it has not undertaken any work relating to ADHD and that no such information exists. The Ministry for Women (OIA #25) also confirmed that no information was held relating to ADHD in women or girls and indicated that ADHD sits within another agency's mandate. The Ministry for Ethnic Communities (OIA #26) similarly confirmed that it has not undertaken ADHD-specific work and does not hold information across policy, research, engagement, or analysis. Together, these responses indicate that ADHD is not currently reflected within Māori, Pacific, women and girls, or ethnic communities policy, analysis, or wellbeing work at a system level, based on the information held by these agencies.

5.3 Limited Visibility of Outcomes

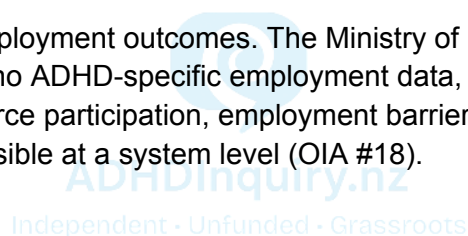
Where ADHD-related impacts occur across multiple systems over time, including education, health, employment, and justice, the absence of coordinated oversight creates conditions where cumulative harm may occur without being fully visible within any single system.

Data provided by the New Zealand Qualifications Authority (OIA #9) shows a substantial increase in Special Assessment Conditions applications involving ADHD, rising from 216 in 2018 to 1,878 in 2025. This indicates increasing system demand and learner need over time. However, as ADHD is not structured as a distinct category within SAC data, this growth cannot be clearly monitored, analysed, or linked to outcomes at a system level.

This limitation is particularly evident in the justice system, where the Ministry of Justice confirmed that ADHD is not captured in any structured or reportable form. As a result, participation barriers, procedural fairness issues, or outcome disparities for people with ADHD cannot be identified or monitored at a system level (OIA #14).

A similar limitation exists in policing. The New Zealand Police response confirms that ADHD is not captured in operational data systems and is not used as a category for analysis or reporting. This means that patterns of Police interaction, including repeat contact or escalation pathways involving people with ADHD, cannot currently be identified or assessed at a system level (OIA #15).

This limitation extends to employment outcomes. The Ministry of Business, Innovation and Employment confirmed that no ADHD-specific employment data, analysis, or monitoring is undertaken, meaning workforce participation, employment barriers, and dispute outcomes for people with ADHD are not visible at a system level (OIA #18).



The Human Rights Commission response provides a particularly significant system signal. The Commission identified 195 ADHD-related complaints and enquiries, including 122 relating to unlawful discrimination, across areas such as education, employment, and government activity (OIA #21).

This indicates that people with ADHD are raising concerns about their experiences within a national human rights framework, including potential discrimination and barriers to equitable participation across multiple parts of the system.

However, ADHD is not tracked as a standalone category and is not supported by a structured monitoring or analysis framework. This means that even where rights-related issues are formally reported, there is no consistent mechanism to identify patterns, assess systemic issues, or inform a coordinated response.

This reflects a broader system limitation where signals of potential harm and unmet need exist within oversight systems, but are not translated into system-level visibility, monitoring, or accountability.

A similar limitation is evident within the research system. The Health Research Council (OIA #22) identified ADHD-relevant research applications over time through keyword searches of proposal data, rather than through a structured classification framework. Between 2015 and 2025, 46 unsuccessful applications relevant to ADHD were identified, alongside four funded projects between 2020 and 2022 that referenced ADHD-related topics.

However, ADHD is not analysed or reported as a distinct research population, and research is instead aggregated under broader health issue categories. In the absence of structured classification, prioritisation, or analysis, it is not possible to determine whether research investment reflects population need, whether evidence gaps exist, or how research findings translate into system design or policy.

5.4 Barriers to Coordinated Policy Responses

Policy development occurs within sector boundaries, which makes it difficult to design responses that reflect how ADHD is experienced across the system as a whole. Without shared data definitions, coordinated monitoring, and cross-agency governance, policy responses are likely to remain fragmented.

This reflects a broader issue in policy implementation, where intentions or frameworks without clear funding, accountability mechanisms, and cross-sector delivery structures are unlikely to result in meaningful system change.

This is particularly significant for populations whose needs are less visible within standard service models, where the absence of dedicated funding and coordinated delivery mechanisms increases the risk that needs remain unmet.

Recent health system changes also illustrate the challenge of implementing policy across mixed public and primary care settings, where coordination responsibility is not clearly assigned across the system. This is reflected in the Ministry of Health response (OIA #35), which indicates that implementation of recent ADHD policy changes relies on coordination across multiple stakeholders, without clearly assigned responsibility for service delivery, workforce development, or funding.

5.5 Risk of Ongoing Systemic Harm

ADHD may be recognised across systems, but without coordinated stewardship it is not consistently governed, monitored, or owned as a cross-sector issue. Where this persists over time, there is a risk that systemic harm continues without being visible, measured, or addressed.

In practical terms, this means people with ADHD can experience barriers, exclusion, or inequitable treatment across multiple systems that are not consistently recognised, recorded, or responded to at a system level.

The Ministry of Justice response highlights this risk clearly. It confirmed that no ADHD-specific analysis has been undertaken in relation to fairness, accessibility, or rights within court processes, and that no data is collected to assess how people with ADHD experience the justice system (OIA #14). In the absence of visibility, any barriers to participation, comprehension, or procedural fairness cannot be identified or addressed at a system level.

A similar limitation exists within Corrections. The Department of Corrections confirmed that ADHD is not routinely screened, not tracked as a system-level category, and not subject to outcome monitoring or analysis (OIA #16). This means that experiences and outcomes for people with ADHD within custodial and community-based sentence settings are not visible at a system level. In the absence of visibility, unmet needs, inequities, or risks cannot be identified or addressed at a system level.

In high-impact systems such as care and protection and youth justice, no response has been received from Oranga Tamariki for OIA #17. As a result, this submission was unable to obtain information on how ADHD is recognised, monitored, or supported within these settings.

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This risk is also evident at earlier stages of system interaction. The Ministry of Youth Development (OIA #28) identified that while neurodiversity is acknowledged within youth wellbeing frameworks, no ADHD-specific policy, data, or monitoring exists, and detailed information is not held. In the absence of structured visibility at this stage, differences in how young people with ADHD experience expectations, participation, or support cannot be identified or addressed at a system level.

This risk is also evident in workplace systems. WorkSafe New Zealand confirmed that ADHD is not recognised within regulatory frameworks and that no data, analysis, or monitoring is undertaken in this area (OIA #20). In the absence of visibility, any patterns of burnout, workplace strain, or psychosocial harm experienced by workers with ADHD cannot be identified or addressed at a system level.

This risk is also evident within employment and income support systems. The Ministry of Social Development confirmed that it does not hold information on ADHD-specific employment policies, programmes, or outcomes, and that ADHD is not identified or reported as a distinct category within its systems (OIA #27). In the absence of targeted policy, service design, or monitoring, it is not possible to assess how people with ADHD are supported to access, retain, or succeed in employment, or whether inequities exist. This creates a condition where individuals with ADHD may be assessed and supported in practice, but the system has no mechanism to understand patterns of access, outcomes, or inequity at a population level over time.

The Pharmac response (OIA #7) demonstrates that decisions affecting access to ADHD medicines are actively being made, including funding changes, supply management, and prescribing restrictions. However, the same response confirms that no monitoring or evaluation of access, uptake, or outcomes has been undertaken. While dispensing data exists, it is not reported in a way that enables population-level or equity analysis. This creates a condition where system decisions are made without a clear mechanism to assess their impact over time. Where treatment access is shaped by funding and supply constraints, but outcomes are not monitored, there is a risk that inequities or unmet need persist without being visible at a system level.

This risk is also evident within the health system. The Ministry of Health confirmed that it has developed the ADHD Clinical Principles Framework, which describes expected standards of clinical care within health services. However, the framework is not mandated, not supported by dedicated funding, and relies on clinician awareness and voluntary uptake. Monitoring and evaluation mechanisms are still under development (OIA #35).

The framework is limited to clinical guidance and does not extend to broader system design, cross-sector coordination, or policy development across areas such as education, employment, or justice.

In the absence of mandated implementation, resourcing, and monitoring, there is no mechanism to ensure that expected standards of care are consistently delivered in practice. This creates a condition where system improvement is articulated but not operationalised, and where inequities in access, quality, and outcomes may persist without visibility or accountability.



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Petition: Launch a Public Inquiry into Systemic Harm to People with ADHD in Aotearoa,
Presented 26 March 2026, <https://petitions.parliament.nz/42b5c524-f57f-4c3f-eb1f-08ddcf0ec835?lang=en>

6. Evidence from Research and System Analysis

The findings from Official Information Act responses are consistent with a broader body of research and system analysis relating to ADHD in Aotearoa New Zealand.

This section summarises key evidence that reflects similar patterns of access barriers, fragmented support, inequities, and system-level gaps. See Appendix D for full references.

6.1 Cross-Sector Developmental Impacts in Aotearoa

Recent New Zealand research confirms that neurodevelopmental conditions, including ADHD, are associated with impacts that extend beyond health services.

The 2026 *Kanorau ā-roro* research presentation (Tustin et al., 2026), drawing on linked administrative data from the Integrated Data Infrastructure (IDI), examines outcomes for children and young people in Aotearoa.

A 2026 study examining Asian populations in Aotearoa, also using Integrated Data Infrastructure (IDI) data, highlights limitations in national data on neurodevelopmental conditions. It notes that primary care data is not included and that ADHD identification often relies on proxy measures such as medication dispensing. This suggests that current system-level data likely underestimates true prevalence and does not fully capture diagnostic pathways or unmet need. The study also indicates that observed differences in ADHD prevalence across population groups may reflect underdiagnosis rather than true variation, influenced by access barriers, referral pathways, and service availability (Panther et al., 2026).

The research identifies impacts across education, school participation, peer relationships, mental health, and interaction with health and social systems. It notes that without timely and equitable supports, long-term effects may include school disengagement, mental health difficulties, unemployment, and increased interaction with social and justice systems.

These findings show that ADHD-related impacts sit across multiple parts of the system. The OIA responses reviewed in this submission did not identify a corresponding cross-government stewardship or monitoring framework responsible for coordinating oversight across these domains.

The availability of linked data through the IDI demonstrates that cross-system analysis is possible. The question is whether current governance arrangements provide oversight that reflects the nature of these impacts.

6.2 Mortality and Health Vulnerability Evidence

A 2026 nationwide birth cohort study (Bowden et al., 2026) examined mortality risk among young people with neurodevelopmental conditions in Aotearoa New Zealand using population-level administrative data.

The study found significantly elevated mortality risk among this group compared with those without such conditions, including for those with ADHD.

The findings also identified variation in outcomes by sex and condition type, and highlighted the need for improved access to services and attention to structural barriers.

This evidence does not prescribe a specific governance model. However, it demonstrates that neurodevelopmental conditions, including ADHD, are associated with measurable population-level vulnerability.

The OIA responses did not identify a clearly defined cross-government mechanism responsible for monitoring such outcomes across systems.

6.3 Labour Market Trajectories and Policy Design

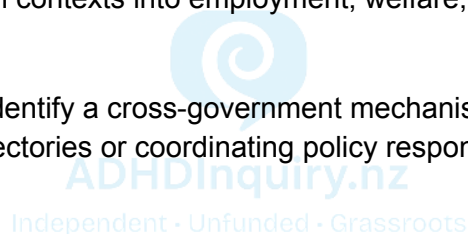
Economic and labour market outcomes are also relevant to system design.

NZIER Insight 124 (Hogan, 2026) highlights persistently poorer labour market outcomes for disabled people in New Zealand and notes that, while trajectory studies are well established internationally, no comparable studies have been undertaken in New Zealand. It identifies the Integrated Data Infrastructure (IDI) as an opportunity to better understand employment pathways over time and to inform more effective policy design.

International research in this area includes cohorts involving people with ADHD and indicates increased risk of long-term labour market marginalisation.

While NZIER's analysis is broader than ADHD alone, it reinforces that outcomes extend beyond childhood health or education contexts into employment, welfare, and long-term economic participation.

The OIA responses did not identify a cross-government mechanism responsible for monitoring ADHD-related economic trajectories or coordinating policy responses across these domains.



6.4 Structural Implications

Taken together, recent New Zealand evidence shows that ADHD and related neurodevelopmental conditions:

- affect educational participation and achievement;
- intersect with mental and physical health outcomes;
- influence interaction with social and justice systems;
- have implications for labour market participation.

These impacts are supported by national data and research within Aotearoa.

The OIA findings indicate that policy, monitoring, and accountability functions relating to ADHD are distributed across multiple portfolios without a clearly identified cross-government stewardship mechanism or coordinated national strategy.

Where impacts span multiple parts of the system, and where the capability exists to measure outcomes at a population level, the absence of clearly defined cross-sector governance becomes a matter appropriately considered by Parliament.

6.5 Equity and Lived Experience Considerations

Existing research highlights inequities in how ADHD is experienced, identified, and supported across different population groups in Aotearoa New Zealand. Māori, Pasifika, women and girls, and rainbow and takatāpui communities experience disparities in identification, diagnosis, and access to culturally appropriate care. Clinical literature also recognises that ADHD remains underdiagnosed in some groups, particularly among adults and women. Barriers to accessing healthcare can result in individuals not reaching assessment or support services (Kristensen et al., 2023).

Recent Māori-led research further identifies gaps in both evidence and system design. A 2026 Kaupapa Māori research report (McKee & Rangiwai, 2026), developed through Ngā Pae o te Māramatanga, notes that Māori adults with ADHD are under-served within existing systems and that there is limited research examining their experiences across education, employment, mental health, and physical health domains. It also highlights that this evidence gap constrains service planning, clinical guidance, and policy development.

The same research emphasises the importance of culturally grounded frameworks, drawing on mātauranga Māori and pūrākau to support more meaningful understanding and engagement.

However, such approaches remain largely conceptual and are not yet embedded within national policy, service design, or clinical guidance.

These findings are consistent with broader evidence presented in this submission, which shows that ADHD-related impacts span multiple systems, while governance, accountability, and service design remain fragmented across them.

These gaps are particularly relevant in the absence of a national ADHD strategy or clearly defined cross-sector stewardship.

Taken together, this indicates that current system settings do not consistently reflect the diversity of lived experience in Aotearoa and that equity considerations, including culturally grounded approaches, are not yet integrated within a coordinated, cross-government response.



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7. Why a Parliamentary Inquiry Is Needed

The findings from the OIA responses point to a consistent pattern across agencies. ADHD is recognised across multiple parts of the public system, but there is no clear cross-government stewardship, no unified monitoring approach, and no consistent way of identifying or tracking the population affected.

Existing initiatives and programmes demonstrate that ADHD is recognised across different parts of the system. However, these sit within individual sectors and do not provide coordinated cross-government stewardship, monitoring, or accountability.

This includes the ADHD Clinical Principles Framework developed by the Ministry of Health, which sets out expected standards of clinical care, alongside recent changes to expand prescribing authority for ADHD diagnosis and treatment. These changes represent a regulatory reform intended to improve access. However, implementation is not mandated, is not supported by dedicated funding, and relies on voluntary uptake by clinicians, with monitoring still under development (OIA #35). Supporting information released by the Ministry of Health indicates that services will develop gradually and depend on local workforce capacity and funding. In the absence of coordinated implementation, workforce development, and monitoring mechanisms, recognition and reform do not consistently translate into system delivery or accountability.

This includes youth policy, where the Ministry of Youth Development (OIA #28) identified that ADHD and neurodiversity are referenced within Youth Plan frameworks and supporting literature. However, no ADHD-specific policy, data, or system-level monitoring was identified, and detailed information is not held. This further demonstrates that recognition does not consistently translate into governance, visibility, or accountability.

The absence of a clearly identified central agency with oversight or coordination responsibility, including at the level of the Department of the Prime Minister and Cabinet, indicates that current system arrangements do not provide a clear mechanism for addressing cross-sector issues of this nature.

Recognition and awareness are important steps. However, without corresponding system design, coordination, and accountability, awareness alone does not ensure consistent outcomes or effective support across the system.

This pattern is also reflected within the public service workforce. The Public Service Commission (OIA #19) identified neurodiversity training, awareness initiatives, and employee-led networks, but did not identify any ADHD-specific workforce strategy, policy, or data collection. This indicates that recognition does not consistently translate into structured governance or accountability, even within central government systems.

Evidence obtained through Official Information Act responses indicates that ADHD is recognised within government systems, analysed using national data, and considered in policy development. However, this recognition does not consistently translate into coordinated governance, monitoring, or prioritised investment.

This limitation is also evident in policy development pathways. The Ministry of Business, Innovation and Employment (OIA #29) confirmed that proactive employer duties, neuroinclusion approaches, and relevant international policy models have not been formally considered in relation to ADHD. This indicates that, even where ADHD is recognised and analysed, there is no consistent mechanism for translating this into structured policy responses or system-level solutions.

This pattern is also evident in how ADHD is approached within publicly funded research. The Health Research Council (OIA #22) identified ADHD-relevant research activity through keyword-based searches of proposal data, rather than through a distinct research classification. Between 2015 and 2025, 46 unsuccessful applications relevant to ADHD were identified, alongside four funded research projects between 2020 and 2022 that referenced ADHD-related topics.

However, ADHD is not treated as a distinct research category and is not supported by specific prioritisation, equity analysis, or research gap monitoring. This indicates that, even where ADHD is considered within investment decision-making, it is not consistently translated into structured system-level visibility, prioritisation, or accountability.

This includes the justice system, where the Ministry of Justice confirmed that it does not hold ADHD-specific policy, data, or analysis relating to court participation, fairness, or rights. This means there is currently no system-level visibility of how people with ADHD experience legal processes or whether existing arrangements meet obligations under rights frameworks (OIA #14).

This limitation extends beyond court processes into frontline policing. The New Zealand Police response confirmed that ADHD is not captured, coded, or searchable within Police systems, and is not used as a category for analysis or reporting (OIA #15). This means that interactions between Police and people with ADHD, including situations involving vulnerability, escalation, or repeat contact, cannot currently be identified or assessed at a system level. As a result, there is no visibility of how policing practices may affect people with ADHD, or whether current approaches are appropriate or effective. This reflects a broader system pattern where high-impact interactions occur without corresponding visibility, oversight, or accountability.

This pattern extends beyond policing into custodial settings. The Department of Corrections

confirmed that ADHD is not systematically identified, monitored, or analysed within prison or community-based sentence populations (OIA #16), reinforcing that high-impact parts of the system operate without corresponding visibility or oversight.

This pattern is not limited to justice settings. WorkSafe New Zealand also confirmed that ADHD is not recognised within workplace health and safety systems, and that no data, analysis, or monitoring is undertaken in this area (OIA #20).

Given that neurodevelopmental conditions such as ADHD fall within the scope of disability in many policy and human rights contexts, this raises questions about whether people with ADHD are receiving equitable consideration within public systems. This is particularly relevant in light of New Zealand's obligations under the Human Rights Act 1993, the New Zealand Bill of Rights Act 1990, and the United Nations Convention on the Rights of Persons with Disabilities, which emphasise non-discrimination and equitable access to support and services.

This limitation is also reflected in the Human Rights Commission response (OIA #21), which confirmed that ADHD-related complaints and enquiries are present within its system, including matters relating to education, employment, and government activity.

However, ADHD is not tracked as a standalone category and is not supported by a structured monitoring or analysis framework.

This indicates that even within a national body responsible for monitoring discrimination and rights, there is no consistent mechanism to identify patterns or assess systemic issues affecting people with ADHD.

These issues are not new. Similar concerns relating to coordination, data visibility, accountability, and system responsiveness have been identified repeatedly across research, community advocacy, and sector engagement over time, including in earlier policy work and system reviews. Parliamentary records also reflect sustained awareness of ADHD-related issues across health, education, justice, and social systems over more than two decades, without corresponding system-level coordination or response (see Appendix E)

Despite this, recent Official Information Act responses indicate that these system characteristics remain largely unchanged, with no consistent ownership, monitoring, or coordinated strategy in place across key sectors.

These are system-level characteristics. They sit across portfolios, data systems, and service boundaries. They are not confined to a single agency, programme, or policy area.

Current mechanisms are not well suited to addressing issues of this nature. Agency-level responses operate within defined mandates. Data systems are structured around services

rather than conditions. Policy development tends to occur within sector boundaries. This makes it difficult to examine how ADHD is experienced across the system as a whole, or to assess whether current arrangements are effective.

While this activity demonstrates recognition of ADHD in some areas, the OIA findings indicate that it does not operate within a coordinated framework for implementation, monitoring, or accountability, and therefore does not resolve the system-level gaps identified.

Previous petitions relating to specific conditions, including ADHD, have resulted in evidence-gathering and stakeholder engagement, but have not led to coordinated, system-level responses. This reinforces the need for a formal inquiry mechanism where cross-agency accountability and implementation can be examined.

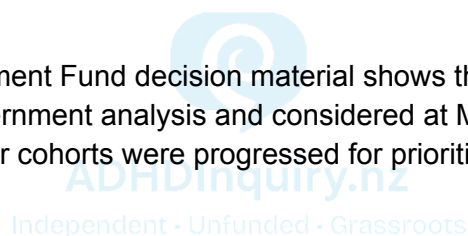
The OIA responses provide a cross-agency snapshot of how ADHD is currently recognised, recorded, and governed across parts of the public system. This work does not examine systems in depth, test evidence through formal processes, or incorporate structured lived experience and frontline perspectives. The findings highlight areas where information is fragmented, responsibility is unclear, or visibility is limited. These point to broader system-level questions that sit beyond the scope of OIA requests.

As reflected in Appendix B, these patterns are not isolated to a single agency, but occur consistently across multiple parts of the system.

Taken together, the evidence shows a consistent system pattern. ADHD is identifiable within national datasets and has been subject to cross-government analysis. However, no clear system ownership was identified, data remains fragmented across agencies, and while ADHD has been considered within investment decision-making, it has not consistently translated into prioritised action. This suggests that breakdowns are occurring at multiple points across the system pathway (from recognition through to implementation) rather than at a single point of failure.

Where responsibility is distributed across multiple agencies without a coordinating framework, accountability for system-level outcomes becomes unclear. Information is often partial, held in different formats, or not available in a way that supports system-level visibility. This limits the ability to understand long-term outcomes, identify inequities, or coordinate responses across sectors.

Evidence from Social Investment Fund decision material shows that children with ADHD were identified through cross-government analysis and considered at Ministerial level as a cohort of interest. However, while other cohorts were progressed for prioritised investment, ADHD was



not clearly advanced in the same way, and no rationale for this distinction was provided in the released documentation.

A public inquiry provides a mechanism to examine questions of this kind. It would allow for a structured examination of how ADHD is currently governed across health, education, disability, employment, and justice systems. It would enable evidence to be gathered in a consistent way, including from agencies, researchers, and people with lived experience.

The OIA findings indicate that these issues cannot currently be examined through existing system mechanisms, as the necessary data, oversight, and accountability structures are not in place.

A coordinated inquiry process would also provide an opportunity to incorporate lived experience in a structured way, ensuring that system design reflects how ADHD is experienced across different parts of the system.

A public inquiry would also provide a basis for assessing whether current arrangements are sufficient, or whether changes are needed to improve coordination, accountability, and outcomes. This includes consideration of whether a national strategy, supported by a clear funding approach, would provide a more coherent framework for addressing ADHD across the life course.

The patterns identified through the OIA process indicate that these system-level issues are unlikely to be resolved through incremental or agency-specific changes alone.

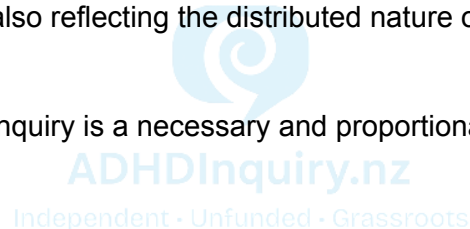
The issue is not the absence of evidence, but the absence of a coordinated system response.

A coordinated, system-level examination is required.

The OIA findings suggest that ADHD is treated as a shared issue in principle, but without clearly defined ownership in practice.

Correspondence with the Minister for Mental Health and the Ministry of Disabled People (Appendix F) reflects a similar pattern, with responsibilities described across multiple portfolios and ongoing initiatives, but without clearly defined cross-government stewardship or coordinated oversight. These responses acknowledge areas where improvement is needed and identify unmet needs, while also reflecting the distributed nature of current approaches across the system.

For these reasons, a public inquiry is a necessary and proportionate next step.



8. Recommendation

The OIA findings identify a consistent absence of cross-government stewardship, coordinated monitoring, and clearly assigned accountability across multiple agencies.

A public inquiry is therefore a necessary and proportionate mechanism to assess the adequacy of current system arrangements.

Given that ADHD-related responsibilities sit across multiple portfolios without clearly defined cross-government stewardship, referral to a single Minister is unlikely to address the system-level issues identified.

It is recommended that the House of Representatives initiate a public inquiry into systemic harm experienced by people with ADHD in Aotearoa New Zealand, which appropriately reflects the experiences of affected individuals and communities, as set out in the petition.

The inquiry should assess the impact of current system design, service access, data visibility, and cross-sector coordination on outcomes for people with ADHD across the life course.

It should also assess whether existing governance arrangements are sufficient or whether a coordinated national ADHD strategy is required, supported by a clear and sustained approach to annual funding.



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9. Conclusion

Across multiple Official Information Act responses, a consistent pattern is evident. Information relating to governance, monitoring, workforce planning, equity, and system accountability is frequently not held, not tracked, or not assigned to any agency.

These gaps are not confined to a single sector. Similar patterns are present across health, education, employment, disability, and population-focused agencies. While ADHD is recognised within existing systems, it is not supported by a coordinated governance framework, consistent data visibility, or cross-agency accountability.

This does not reflect a lack of need. Rather, it reflects a system that is not currently designed to understand, support, or respond effectively to people with ADHD.

In the absence of monitoring, ownership, and structured oversight, it is not possible to assess whether supports are accessible, equitable, or effective. This limits the ability of the government to improve outcomes, reduce harm, or ensure that people with ADHD are appropriately supported across different areas of life.

This submission does not attempt to quantify the full extent of harm experienced by people with ADHD. However, the evidence presented demonstrates that current system structures do not support consistent monitoring, data collection, or cross-agency accountability. As a result, the scale, distribution, and drivers of harm cannot be reliably identified or addressed at a system level.

In the absence of system-level monitoring, harm cannot be assumed to be absent.

There are an estimated 280,000 people in Aotearoa New Zealand living with ADHD. In the absence of system-level visibility and coordination, outcomes for a population of this size cannot be reliably understood, monitored, or improved.

This aligns with wider government acknowledgement that people with ADHD experience unmet needs and fragmented supports, including disproportionate impacts across Māori, Pasifika, women and girls, and rainbow and takatāpui communities.

These issues also engage broader equity and rights considerations, including access to appropriate support and protection from systemic disadvantage.

Taken together, the evidence indicates that while individual factors play a role, current challenges experienced by people with ADHD are significantly shaped by system-level gaps in coordination, accountability, and design.

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A Select Committee inquiry is therefore necessary to support a more effective and coordinated response.

This includes:

- clarifying system ownership and governance
- improving data visibility and outcome monitoring
- strengthening equity-informed policy and service design
- enabling a joined-up, cross-agency approach to supporting people with ADHD

An inquiry would provide the structure needed to establish the extent of harm, understand its drivers, and ensure that people with ADHD are better supported across health, education, employment, and community settings, with progress able to be measured over time.



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10. Appendices

Appendix A: OIA Response Outcome Summary

Overview

A total of 36 Official Information Act (OIA) requests were submitted across central government agencies and related entities.

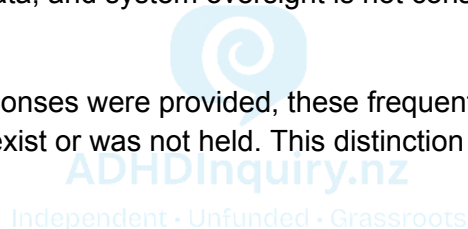
Response outcomes varied, with a substantial proportion of requests resulting in partial responses, refusals, or confirmation that requested information was not held.

Response Type	Description	Count
Response received	Complete response provided (including cases where agencies confirmed information was not held)	15
Partial response	Response provided but with gaps or limitations	13
Information not held (s18(e)) or refused	Information confirmed as not held (s18(e)) or refused under other provisions of the OIA (including s18(f) and s18(g))	7
Overdue / no response	No response received within statutory timeframe	1

Interpretation of Response Outcomes

These response patterns indicate that, across multiple agencies, key information relating to ADHD policy, governance, data, and system oversight is not consistently held, accessible, or reported.

Notably, even where full responses were provided, these frequently involved confirmation that relevant information did not exist or was not held. This distinction is important, as it indicates



that gaps identified in this submission reflect underlying system absence rather than incomplete responses alone.

The prevalence of partial responses, refusals, and “information not held” outcomes supports the identification of system-level gaps explored in Section 4.

Appendix B: Cross-Agency Pattern Table

(provided as a separate document)

Appendix C: Individual OIA Summaries

These summaries provide a consistent overview of each OIA request and response. Full response documents are available via the links provided.

OIA #1 – Ministry of Health and Health New Zealand – ADHD policy, governance, data, and oversight

Request summary

This request sought information on how ADHD is recognised, governed, monitored, and assessed across national health systems, including policy responsibility, data collection, equity analysis, and oversight.

Response summary

The response stated that the Ministry of Health does not hold information identifying a responsible team, policy framework, governance structure, or oversight role for ADHD, and several parts of the request were refused on the basis that the information is not held. It also stated that limited ADHD-related analysis has been undertaken using the Integrated Data Infrastructure, with no established monitoring framework or decisions on ongoing population-level reporting.

The Health New Zealand response stated that there is no national dataset capturing all ADHD diagnoses, and that existing data is organised by care setting, meaning ADHD cannot be consistently identified across primary care, outpatient, or private specialist settings. It also stated that medication data does not confirm diagnosis and that available diagnosis data is limited and incomplete.

Link <https://fyi.org.nz/request/33049-1-adhd-policy-governance-data-and-rights-oversight>


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OIA #2 – Health New Zealand | Te Whatu Ora – ADHD services, pathways, data and outcomes

Request summary

This request sought information on how ADHD is recognised and managed across national health services, including clinical pathways, workforce roles, data collection, monitoring, outcomes, and equity issues.

Response summary

The response stated that ADHD-related clinical guidance is provided through HealthPathways, which are locally implemented across regions and support general practitioners, but do not include responsibility for service design, workforce planning, or implementation.

It stated that national-level information on workforce roles is not held and refused that part of the request, and that ADHD referrals and diagnoses are not consistently coded or collected at a national level.

The response confirmed that there is no single national dataset capturing ADHD diagnoses across all care settings, and that available data is limited to specific services and systems. Several parts of the request, including monitoring, population analysis, and equity analysis, were refused or not held.

Link <https://fyi.org.nz/request/33050-2-adhd-services-pathways-data-and-outcomes-national>

OIA #3 – Statistics New Zealand – ADHD identification in the IDI

Request summary

This request sought information on how ADHD can be identified and analysed within Statistics New Zealand's Integrated Data Infrastructure, including available data indicators, research activity, metadata, and any known data gaps or limitations.

Response summary

The response stated that ADHD is not consistently identifiable as a standalone category across IDI datasets. Some ADHD-related information exists in specific sources such as the 2023 Household Disability Survey, but identification relies on particular datasets rather than a single comprehensive method. Statistics New Zealand identified one ADHD-related research project and confirmed that it does not hold records of additional ADHD-specific projects. It also advised that ADHD is not collected in the Census and that intersectional analysis is limited by how data is collected and linked. The response confirmed that no records are held documenting decisions not to collect ADHD-related variables, and this part of the request was refused on the basis that the information does not exist.

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Link: <https://fyi.org.nz/help/unhappy/33051-3-adhd-identification-pathways-and-data-availability>

OIA #4 - Treasury - ADHD related fiscal analysis and IDI data feasibility

Request summary

This request sought information on whether the Treasury held any analysis, modelling, advice, or correspondence about the economic, fiscal, employment, social investment, or IDI-related impacts of ADHD, including whether ADHD had been considered in linked data work or fiscal planning.

Response summary

The response stated that the Treasury did not hold any relevant information within scope of the request except for documents provided by the Social Investment Agency. In later clarification, the Treasury said those SIA documents contained discussion and analysis related to use of the IDI to select potential cohorts, one of which was children with ADHD and FASD. The Treasury said this analysis was SIA work and may be released by SIA in response to a separate OIA request. No Treasury-generated ADHD-specific fiscal, employment, or IDI analysis was identified in the response.

Link: <https://fyi.org.nz/request/33052-4-adhd-related-fiscal-analysis-and-idi-data-feasibility>

OIA #5 – Social Investment Agency – ADHD analysis and modelling

Request summary

This request sought information on ADHD-related analysis, modelling, and investment work, including an unpublished 2024 report, supporting data and methodology, and any broader work linking ADHD to outcomes across government systems.

Response summary

The response stated that the Social Investment Agency released the previously unpublished May 2024 report on ADHD, which uses IDI data to analyse outcomes and prevalence. It also stated that further ADHD-related analysis and modelling work would be made publicly available and refused part of the request on the basis that this information would soon be released. The agency declined to provide additional classification or documentation beyond the specific ADHD work identified.

Link <https://fyi.org.nz/request/33053-5-adhd-analysis-modelling-and-unpublished-2024-report>

OIA #6 – Department of the Prime Minister and Cabinet – ADHD cross-agency governance or strategy



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Request summary

This request sought information on whether there is any cross-agency coordination, governance, or national strategy for ADHD, including Cabinet-level consideration, accountability frameworks, and whether any agency holds overall responsibility.

Response summary

The Department of the Prime Minister and Cabinet transferred the request to the Ministry of Health and advised it was not aware of any cross-agency ADHD strategy work and explicitly stated that it did not hold information on oversight responsibility. The Ministry of Health identified some ADHD-related documents and interagency activity but stated that no cross-agency evaluation, performance, or accountability frameworks including ADHD outcomes exist, and confirmed that responsibility for ADHD policy sits across multiple agencies rather than a single entity.

Link

<https://fyi.org.nz/request/33055-6-adhd-cross-agency-governance-or-strategy#incoming-139252>

OIA #7 – Pharmac – ADHD medicines funding, access, and equity

Request summary

This request sought information on ADHD medicines, including funding decisions, prescribing data, equity and access analysis, data gaps, monitoring, supply issues, and how ADHD medicines are categorised within Pharmac systems.

Response summary

The response stated that some information was refused due to substantial collation, some information does not exist, and some data will be provided later. Limited dispensing data was provided for a recent period, no monitoring or evaluation of ADHD medicine access has been undertaken, and ADHD medicines are categorised under a specific pharmaceutical grouping.

Some information was refused under section 18(f), some was not held under section 18(e), and parts of the request were extended for a later response.

Link <https://fyi.org.nz/request/33090-7-adhd-medicines-funding-access-and-equity>

OIA #8 – Ministry of Education – ADHD policy, learning support and data oversight

Request summary

This request sought information on how ADHD is recognised, governed, supported, monitored,

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and funded within the education system, including policy ownership, learning support, teacher capability, data tracking, and equity considerations.

Response summary

The response stated that the Ministry does not hold documents identifying responsibility for ADHD, does not collect or track ADHD data, has not undertaken ADHD-specific monitoring or analysis, and does not hold information on ADHD-specific teacher training, evaluations, or funding. ADHD is not used as a category within Ministry systems, with supports instead delivered through a needs-based approach.

The response refused multiple parts of the request on the basis that the information does not exist or is not held.

Link

<https://fyi.org.nz/request/33057-8-adhd-policy-learning-support-pld-data-and-system-oversight>

OIA #9 – New Zealand Qualifications Authority – ADHD and Special Assessment Conditions (SAC)

Request summary

This request sought information on how ADHD is recognised, categorised, and monitored within NZQA's Special Assessment Conditions system, including policy, SAC data, equity analysis, and whether ADHD-specific data is collected or intentionally not collected.

Response summary

The response stated that ADHD is eligible for Special Assessment Conditions but is not recognised as a standalone category and is instead grouped under broader condition types. NZQA provided aggregated SAC data where ADHD is recorded, but confirmed it does not record whether ADHD is the primary or contributing reason for applications and does not produce ADHD-specific analysis. It also confirmed that ADHD-related cases are categorised as a medical condition presenting as a learning barrier within SAC records.

NZQA confirmed that it does not hold any documents explaining a rationale or decision for not collecting ADHD-specific SAC data.

Link <https://fyi.org.nz/request/33108-9-adhd-and-special-assessment-conditions>

OIA #10 – Teaching Council of Aotearoa New Zealand – ADHD in teacher education and standards



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Presented 26 March 2026, <https://petitions.parliament.nz/42b5c524-f57f-4c3f-eb1f-08ddcf0ec835?lang=en>

Request summary

This request sought information on whether ADHD is referenced in Initial Teacher Education requirements, teaching standards, or professional guidance, and whether the Teaching Council holds any information on teacher capability, professional learning, or support relating to ADHD.

Response summary

The response stated that Initial Teacher Education programmes must align with teaching standards that refer broadly to supporting diverse learners, including neurodivergence and diverse learner needs, but do not explicitly mention ADHD. It confirmed that the Council is not a provider of professional learning and does not hold any ADHD-related professional learning materials. It also stated that the Council holds no specific information on teacher preparedness or capability to support learners with ADHD.

Following clarification, the Council confirmed that ADHD is not explicitly referenced in programme requirements, that no ADHD-related professional learning has been funded, commissioned, or endorsed since 2015, and that no specific information is held on supporting learners with ADHD.

Link

<https://fyi.org.nz/request/33094-10-adhd-in-teaching-standards-initial-teacher-education-and-professional-capability>

OIA #11 – Ministry of Disabled People (Whaikaha) – ADHD recognition, coordination, and data visibility

Request summary

This request sought information on how ADHD is recognised within the disability system, including policy inclusion, advisory and consultation activity, cross-agency coordination, rights and compliance analysis, and how ADHD is identified or monitored in disability-related data.

Response summary

The response stated that Whaikaha does not hold a coordinating role for ADHD and does not conduct ADHD-specific rights or compliance analysis under the UNCRPD, Bill of Rights Act, or Human Rights Act. It confirmed that ADHD is considered within broader neurodiversity work and provided material relating to a time-limited Neurodiversity Interagency Group and Disability Strategy processes. The response also stated that Whaikaha does not collect or monitor ADHD-specific data and instead relies on external datasets such as the Stats NZ Disability Survey and health survey data. Some parts of the request were transferred to the Ministry of Social Development, and earlier material was refused on the basis of substantial collusion.

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Link

<https://fyi.org.nz/request/33058-11-adhd-recognition-policy-treatment-and-data-visibility-2022-present#incoming-138572>

OIA #12 – Ministry of Health – ADHD hui actions, survey funding, and coordination**Request summary**

This request sought information on progress following the 2024 ADHD Parliamentary Hui, including funding and progress of an ADHD data survey, cross-agency work, coordination mechanisms, monitoring, and future hui planning.

Response summary

The response stated that funding has been approved for a Child and Youth Mental Health and Addiction Prevalence Survey, which will include ADHD-related data and is expected to report in 2027. The Ministry confirmed that some ADHD-related actions have progressed, including clinical guidance and prescribing changes, and that a cross-agency stocktake has been completed.

The response also stated that there are no current plans to fund an ADHD-specific coordination mechanism, no ongoing monitoring of hui actions, and no further Parliamentary hui is scheduled.

Link

<https://fyi.org.nz/request/33059-12-adhd-hui-actions-data-survey-funding-and-coordination-progress>

OIA #13 – Ministry of Health – Māori, Pacific and equity involvement in ADHD clinical frameworks**Request summary**

This request sought information on Māori, Pacific, and equity involvement in the development, governance, and consultation processes for ADHD-related clinical frameworks, including any Te Tiriti application, equity analysis, and representation.

Response summary

The response stated that the Ministry had not identified any information within scope of the request and no documents were provided. It clarified that the ADHD Clinical Principles Framework project, referenced in the response, had a narrow scope focused on professional workforce consultation, with limited early engagement with Māori researchers and general discussions about ADHD programmes and pathways.

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Link

<https://fyi.org.nz/request/33093-13-maori-pacific-and-equity-involvement-in-adhd-related-clinical-frameworks>

OIA #14 – Ministry of Justice – ADHD policy, data, and fair process in the justice system

Request summary

This request sought information on how ADHD is recognised within justice policy, including responsibility, data collection, funding, initiatives, and any analysis relating to fairness, accessibility, or rights.

Response summary

The response stated that the Ministry of Justice does not hold any ADHD-specific information. It does not identify a responsible unit for ADHD, does not collect or report ADHD data, and does not hold ADHD-specific funding, initiatives, or analysis relating to fairness or rights. Any reference to ADHD may only be recorded in individual court files, which are not subject to the OIA.

The Ministry refused the request under section 18(g)(i) on the basis that the information is not held.

Link

<https://fyi.org.nz/request/33060-14-adhd-policy-data-and-fair-process-in-the-justice-system>

OIA #15 – New Zealand Police – ADHD and Police contact / data recognition

Request summary

This request sought information on how ADHD is recognised by Police in operational guidance, data systems, inter-agency coordination, and recruitment or medical screening policies.

Response summary

The response stated that Police do not specifically capture or code ADHD in their systems, do not hold ADHD-specific operational policies across the requested policing contexts, and do not undertake ADHD-specific data analysis or reporting. It released broader neurodiversity guidance, identified three Police-Oranga Tamariki documents within scope, and provided a summary of a 2024 review recommending updated recruitment medical standards for applicants with ADHD.

Part of the request was refused because the information did not exist, and part was refused because identifying all inter-agency documents over the requested period would require substantial collation and research.

Link <https://fyi.org.nz/request/33061-15-adhd-and-police-contact-data-recognition>


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OIA #16 – Department of Corrections – ADHD recognition, data, programmes, and prison supports

Request summary

This request sought information on how ADHD is recognised, screened, recorded, monitored, and supported within the Department of Corrections, including policy, screening tools, data, programme delivery, inter-agency work, barriers, and classification systems.

Response summary

The response stated that ADHD is not routinely screened for at prison intake and that diagnoses, where known, are recorded within individual health files based on disclosure or existing medical records. It confirmed that Corrections does not hold ADHD-specific prevalence data, outcome data, or analysis, and advised that identifying this information would require manual review of individual files. The response also stated that no ADHD-specific programmes, coordinated initiatives, or inter-agency work were identified, and that no internal advice, reports, or documentation are held identifying barriers or limitations in recognising or supporting ADHD. ADHD is referenced within prescribing guidance and staff training materials.

Link <https://fyi.org.nz/request/33067-16-adhd-recognition-data-and-support>

OIA #17 – Oranga Tamariki (Ministry for Children) – ADHD Recognition and Support

Request summary

This request sought information on how ADHD is recognised, recorded, supported, and monitored within Oranga Tamariki's care and protection and youth justice systems since 1 January 2015. It requested policies, practice frameworks, training materials, and operational guidance referencing ADHD, as well as any data, studies, or analysis identifying ADHD among children and young people in care or youth justice settings. It also sought information on programmes or inter-agency coordination, acknowledged barriers or limitations, materials relating to high and complex needs and residential interventions, public-facing resources, and how ADHD is classified or categorised within Oranga Tamariki systems.

Response summary

No response received.

Link <https://fyi.org.nz/request/33064-17-adhd-recognition-and-support>

OIA #18 – Ministry of Business, Innovation & Employment – ADHD and employment policy / workplace rights

Request summary

This request sought information on how ADHD is recognised within employment law, workplace

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rights, labour market policy, mediation services, and employer guidance, including any policy, data, analysis, or monitoring relating to ADHD.

Response summary

The response stated that ADHD in the workplace is an emerging area of focus and that MBIE has not developed any specific employment policy or guidance relating to ADHD. All parts of the request were refused under section 18(e) on the basis that the requested documents do not exist.

Link <https://fyi.org.nz/request/33070-18-adhd-and-employment-policy-workplace-rights>

OIA #19 – Public Service Commission – ADHD and inclusion in the public service

Request summary

This request sought information on how ADHD is recognised within public service workforce policy, including strategies, workplace support, data collection, inclusion initiatives, and monitoring of workforce outcomes.

Response summary

The response stated that the Commission does not hold any workforce strategies, policies, or guidance that specifically reference ADHD. ADHD is addressed within broader disability and neurodiversity frameworks, and workforce data is collected through a general neurodiversity question in the Public Service Census rather than as a standalone category. Some information was refused on the basis that it is publicly available, and part of the request was refused on the basis that the information does not exist.

Link <https://fyi.org.nz/request/33091-19-adhd-and-inclusion-in-the-public-service>

OIA #20 – WorkSafe New Zealand – ADHD and psychosocial risk / workplace wellbeing

Request summary

This request sought information on how ADHD and neurodivergence are recognised within WorkSafe New Zealand's regulatory functions, including policy, guidance, psychosocial risk frameworks, worker impairment, data collection, investigations, and cross-agency activity.

Response summary

The response stated that WorkSafe does not hold any policy, guidance, analysis, or documentation referencing ADHD in relation to psychosocial risk, worker impairment, stress, burnout, safety outcomes, or regulatory investigations. It confirmed that ADHD is not categorised within its systems and that there is no requirement to collect or record ADHD information in investigations or assessments. The response also stated that WorkSafe has not undertaken any analysis of how ADHD or neurodivergence may affect worker wellbeing,

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participation, or experience within workplace health and safety systems, and has not been involved in any cross-agency initiatives where ADHD was the focus.

WorkSafe provided general psychosocial risk and mental health guidance but confirmed that it does not provide ADHD-specific or neurodivergence-specific guidance relating to worker wellbeing, support, or participation. Several parts of the request were refused on the basis that the information does not exist or is not held.

Link <https://fyi.org.nz/request/33069-20-adhd-and-psychosocial-risk-work-wellbeing>

OIA #21 – Human Rights Commission – ADHD and Human Rights Monitoring

Request summary

This request sought information on how ADHD is recognised, monitored, and addressed within the Human Rights Commission’s work, including complaints data, systemic reviews, policy analysis, and international reporting.

Response summary

The Human Rights Commission confirmed that ADHD is recognised within its disability-related work and is addressed under the prohibited ground of disability. It provided data indicating that ADHD-related enquiries and complaints have been recorded, but confirmed that ADHD is not tracked as a standalone category and is instead identified through keyword searches.

The response included a range of documents referencing ADHD within broader disability and neurodisability contexts, including advocacy, submissions, and reporting. However, no ADHD-specific monitoring framework, standalone inquiry, or dedicated policy or reporting mechanism was identified.

Link <https://fyi.org.nz/request/33081-21-adhd-and-human-rights-monitoring>

OIA #22 – Health Research Council – ADHD research funding and prioritisation

Request summary

This request sought information on how ADHD is recognised, prioritised, and analysed within publicly funded health research, including funding decisions, assessment criteria, equity considerations, and any analysis of research gaps or population outcomes.

Response summary

The response stated that a small number of ADHD-relevant research applications were identified through database searches, but ADHD is not treated as a distinct research category and is instead classified under broader health issue areas selected by researchers. The Health Research Council does not hold ADHD-specific prioritisation criteria, equity analysis, or research gap analysis, and reporting is undertaken at aggregated health issue levels rather than

for ADHD specifically. It also confirmed that some requested information, including unsuccessful application details and various analyses, was either withheld or not held.

Link <https://fyi.org.nz/request/33071-22-adhd-research-funding-prioritisation-and-equity-gaps>

OIA #23 – Te Puni Kōkiri – Māori equity and ADHD

Request summary

This request sought information on any policy work, research, cross-agency engagement, community resources, monitoring, or categorisation relating to ADHD or neurodevelopmental conditions in relation to Māori wellbeing and equity.

Response summary

The response stated that no information was identified within scope across the areas specified and refused the request on the basis that the information does not exist or could not be found. It also indicated that ADHD is considered a specialist health matter that sits within the health portfolio.

Link

Response provided by email; document available on request

OIA #24 – Ministry for Pacific Peoples – Pacific communities and ADHD

Request summary

This request sought information on policy work, research, cross-agency engagement, community resources, and monitoring relating to ADHD among Pacific peoples.

Response summary

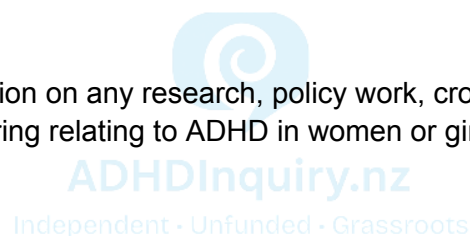
The response stated that the requested information does not exist and confirmed that no ADHD-specific information was identified. The request was refused on the basis that the information does not exist. It also noted that responsibility would sit with the Pacific Peoples with Disabilities Lead if such work were undertaken in the future.

Link Response provided by email; document available on request

OIA #25 – Ministry for Women – Women and girls / ADHD

Request summary

This request sought information on any research, policy work, cross-agency collaboration, public materials, and monitoring relating to ADHD in women or girls.



Response summary

The response stated that no information was identified within scope across all requested areas following a search of Ministry records back to 2015. The request was refused on the basis that the information is not held. It also indicated that ADHD is likely considered part of the Ministry of Health's mandate rather than the Ministry for Women.

Link Response provided by email; document available on request

OIA #26 – Ministry for Ethnic Communities – Ethnic communities and ADHD

Request summary

This request sought information on policy work, research, cross-agency engagement, public resources, and system positioning relating to ADHD in ethnic communities.

Response summary

The response stated that the Ministry has not undertaken ADHD-specific work and does not hold information across the areas requested. It identified a single instance where the Ministry was asked to provide feedback on a Cabinet paper referencing ADHD but confirmed that no substantive comments were made. The response also noted that the Ministry does not collect health-related data or maintain datasets on medical conditions, and that no ADHD-specific analysis has been conducted.

Link Response provided by email; document available on request

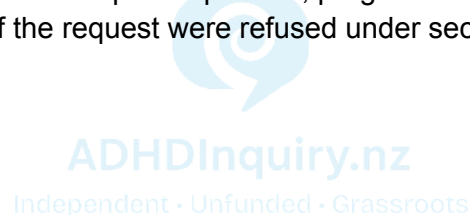
OIA #27 – Ministry of Social Development – ADHD in employment, income support, and disability services

Request summary

This request sought information on how ADHD is recognised, tracked, funded, and considered within employment support, income support, disability services, and related programmes, including any data, policy, monitoring, or equity analysis.

Response summary

The response stated that ADHD is included within a broad disability definition and may be recorded in individual client notes, but is not identified, reported, or monitored as a distinct category. ADHD is generally grouped within broader impairment categories, and the Ministry does not hold information on ADHD-specific policies, programmes, funding, monitoring, or equity analysis. Most parts of the request were refused under section 18(e) on the basis that the information is not held.



Link

<https://fyi.org.nz/request/33068-27-adhd-within-employment-income-support-and-disability-services>

OIA #28 – Ministry of Youth Development – ADHD and youth policy**Request summary**

This request sought information on how ADHD is recognised within youth policy, including any policy documents, research, funding, public-facing materials, monitoring frameworks, and categorisation used by the Ministry of Youth Development.

Response summary

The response identified three publicly available documents that partly addressed the request, including Youth Plan material and supporting literature that reference neurodiversity and youth wellbeing, and a campaign that included ADHD New Zealand. It did not identify any ADHD-specific policy, data collection, analysis, or monitoring frameworks. The remainder of the request was refused on the basis that the information does not exist or could not be found.

Link

<https://fyi.org.nz/request/33109-28-for-ministry-of-youth-development-myadhd-and-youth-policy>

OIA #29 – Ministry of Business, Innovation and Employment – Positive duty and neuroinclusion in employment**Request summary**

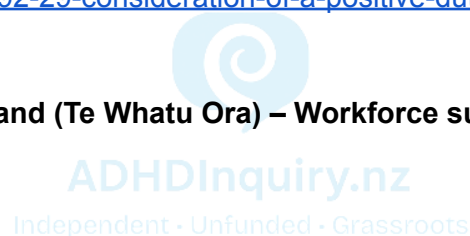
This request sought information on whether MBIE had considered introducing proactive employer duties relating to disability inclusion or neuroinclusion in employment legislation, including policy advice, international comparisons, internal guidance, and cross-agency work.

Response summary

The response stated that ADHD in the workplace is an emerging area of focus, but MBIE has not developed specific employment policy or guidance relating to ADHD. All parts of the request were refused on the basis that the documents requested do not exist or could not be found.

Link

<https://fyi.org.nz/request/33092-29-consideration-of-a-positive-duty-for-neuroinclusion-in-employment>

OIA #30 – Health New Zealand (Te Whatu Ora) – Workforce support and recognition of ADHD

Petition: Launch a Public Inquiry into Systemic Harm to People with ADHD in Aotearoa,

Presented 26 March 2026, <https://petitions.parliament.nz/42b5c524-f57f-4c3f-eb1f-08ddcf0ec835?lang=en>

Request summary

This request sought information on workplace policies, workforce data, training, and support relating to employees with ADHD.

Response summary

The response stated that ADHD is not specifically referenced in workforce policies and is instead included within broader disability and neurodiversity frameworks. Workforce data does not capture ADHD, neurodiversity, disability, or mental health, and therefore cannot identify employees with ADHD. Some general training, resources, and guidance exist, including a neurodiversity manager guide and e-learning modules.

Parts of the request relating to policies and workforce data were refused on the basis that the information is not held.

Link Response provided by email; documents available on request

OIA #31 – Ministry of Health – Internal workforce supports and ADHD

Request summary

This request sought information on Ministry of Health workplace policies, staff data, internal training, and inclusion initiatives relating to ADHD, including whether ADHD is specifically recognised, monitored, or supported within the workforce.

Response summary

The response stated that no workplace, wellbeing, inclusion, or HR policies since 2015 specifically reference ADHD. It confirmed that ADHD is not included as a category in staff surveys or diversity reporting, and that no workforce data captures ADHD either specifically or within broader categories. ADHD is not explicitly referenced in internal programmes but is considered within broader disability and neurodiversity policies, with support provided on a case-by-case basis. Some general awareness activity and training related to neurodiversity has been undertaken.

Link Response provided by email; document available on request

OIA #32 – Ministry of Education – Internal workforce supports and ADHD

Request summary

This request sought information on Ministry of Education workplace policies, workforce data, training, and inclusion activity relating to ADHD, including whether ADHD is recognised, tracked, or supported within the Ministry workforce and teacher workforce.


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Response summary

The response stated that no internal policies specifically reference ADHD, and parts of the request relating to policies and broader coverage were refused on the basis that the documents do not exist. It confirmed that ADHD is not captured in staff surveys or workforce data, including within broader categories. A general neurodiversity webinar was provided to staff, but no ADHD-specific training, communications, or monitoring was identified.

Link Response provided by email; document available on request

OIA #33 – Whaikaha (Ministry of Disabled People) – Internal workforce supports and ADHD

Request summary

This request sought information on workplace policies, workforce data, training, and internal supports relating to employees with ADHD.

Response summary

The response stated that no policies, guidance, or initiatives specifically reference ADHD, as policies are designed to be broad and inclusive rather than condition-specific. ADHD is not captured as a distinct category in workforce data and would only be recorded under a broader disability category. A general neurodiversity webinar was provided, and a reasonable accommodations policy applies to disabled employees, but no ADHD-specific training, communication, or monitoring was identified.

Link Response provided by email; documents available on request

OIA #34 – Ministry for Culture and Heritage – ADHD visibility in cultural and heritage work

Request summary

This request sought information on whether ADHD is referenced in cultural, heritage, identity, and public storytelling work, including policy, funding, guidance, and internal advice.

Response summary

The response stated that identifying any material referencing ADHD would require a broad search across large volumes of content, including websites, social media, and funded work, and that this would involve substantial collation and research. It indicated that there is unlikely to be significant relevant material, if any, but that this could not be confirmed without undertaking that work. The Ministry advised that the request would likely be refused on this basis under substantial collation and research grounds, including following refinement of the request and subsequent clarification.


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Link Response provided by email; document available on request

OIA #34B – Ministry for Culture and Heritage – “Sense of inclusion” KPI (public media business case)

Request summary

This request sought information on the definition, measurement framework, population coverage, and monitoring of the “sense of inclusion” KPI identified in the Strong Public Media business case.

Response summary

The response confirmed that a “sense of inclusion” KPI was identified, with associated measures relating to whether New Zealanders access New Zealand content that reflects people like themselves or informs their sense of national identity. However, no performance or measurement frameworks were established, and the KPI was not monitored or reported on.

Parts of the request relating to measurement methodology, population breakdown, and monitoring were refused on the basis that the information is not held by the Ministry.

Link

<https://fyi.org.nz/request/33315-sense-of-inclusion-kpi-strengthening-public-media-business-cas>
[e](#)

OIA #35 – Ministry of Health – ADHD Clinical Principles Framework governance and rollout

Request summary

This request sought information on the ownership, governance, implementation, resourcing, workforce development, monitoring, and communication relating to the ADHD Clinical Principles Framework and the February 2026 prescribing changes.

Response summary

The response stated that the Ministry of Health authored and owns the ADHD Clinical Principles Framework, which sets out expected standards of clinical care within health services. The framework was developed with input from a Clinical Reference Group.

The response indicated that implementation is supported through stakeholder engagement and guidance, with uptake dependent on clinician awareness and choice rather than mandated system delivery. Monitoring and evaluation approaches are still under development, with initial analysis expected to draw on available datasets such as pharmaceutical dispensing data. In several areas, including commissioning, workforce development, and detailed implementation planning, no comprehensive documentation was provided, or information was addressed through reference to existing or previously released material.

Petition: Launch a Public Inquiry into Systemic Harm to People with ADHD in Aotearoa,

Presented 26 March 2026, <https://petitions.parliament.nz/42b5c524-f57f-4c3f-eb1f-08ddcf0ec835?lang=en>

Link

<https://fyi.org.nz/request/33110-35-ownership-governance-and-operational-rollout-of-the-adhd-clinical-principles-framework-february-2026>

OIA #36 – Health New Zealand | Te Whatu Ora – Implementation of ADHD Clinical Framework and prescribing changes

Request summary

This request sought information on Health New Zealand's role in implementing the New Zealand Clinical Principles Framework for ADHD (2025) and preparing for the February 2026 prescribing changes, including responsibility, implementation planning, workforce preparation, funding, monitoring, and sector guidance.

Response summary

The response stated that the ADHD Clinical Principles Framework is a Ministry of Health document and that no funding was allocated to Health New Zealand for its implementation. Health New Zealand advised that it does not hold documents assigning it responsibility for implementing the Framework or preparing for the prescribing changes, and that its role is limited to updating clinical guidance through HealthPathways and supporting a webinar.

For the remaining areas requested, including implementation planning, workforce preparation, funding, monitoring, and equity, the response stated that the information is not held or would require substantial collation and research, and these parts of the request were refused under the OIA.

Link

<https://fyi.org.nz/request/33111-36-te-whatu-ora-s-role-in-implementing-the-adhd-clinical-principles-framework-and-february-2026-prescribing-changes>

Appendix D: References

Bowden, N., Schluter, P. J., Asaka, U., et al. (2026). *Mortality risk of youth with neurodevelopmental conditions: An Aotearoa New Zealand nationwide birth cohort study*. JAMA Pediatrics, 180(1), 35–44. <https://doi.org/10.1001/jamapediatrics.2025.4335>

Cruice, E. T. (2023). *A privilege or a crisis? Exploring access to adult ADHD assessment in Aotearoa New Zealand* (Master's thesis, Massey University).

Hogan, S. (2026). *Labour market trajectories of disabled people – generating insights for more effective interventions* (NZIER Insight 124). New Zealand Institute of Economic Research.

Kristensen, Z., Drinkwater, C., Johnson, R., & Menkes, D. B. (2023). *Considerations in the assessment and management of ADHD within the transgender, gender diverse and non-binary*

(TGDNB) population. *New Zealand Medical Journal*, 136(1587).

McKee, A., & Rangiwai, B. (2026). *Ngā Mata Rua ā Māui—The Two Faces of Māui: The Beginnings of a Māui-based ADHD Psychoeducation Framework*. Ngā Pae o te Māramatanga.

Ministry of Health. (2024). *Opportunities to improve support for people with ADHD* (Ministerial briefing H2024041356). Ministry of Health.

Ministry of Health. (2025). *New Zealand Clinical Principles Framework for Attention-Deficit Hyperactivity Disorder*. Ministry of Health.

Panther, N. K., Bowden, N., Chu, J., & D'Souza, S. (2026). *Prevalence and age of diagnosis of neurodevelopmental conditions among Asian populations in Aotearoa New Zealand*. *Journal of Neurodevelopmental Disorders*. <https://doi.org/10.1186/s11689-026-09695-z>

Skirrow, P., Cookson, S., & Bull, D. (2023). *Working together for change: ADHD diagnosis and treatment in New Zealand*. *Journal of the New Zealand College of Clinical Psychologists*, 33(1), 10–17.

Tustin, K., Adams, J., Bowden, N., McAnally, H., Wicken, A., Taylor, B., & Turnbull, F. (2026). *Kanorau ā-roto: Neurodevelopmental conditions in children and young people in Aotearoa*. University of Otago, New Zealand Child and Youth Epidemiology Service.

Appendix E: Parliamentary Recognition of ADHD-Related System Issues Over Time

Parliamentary records referenced in this appendix were accessed through publicly available New Zealand Parliament sources, including Hansard (debates), petitions, select committee reports, and published submissions.

This appendix provides selected examples and is not intended to be an exhaustive account of all parliamentary references to ADHD-related issues.

These records span health, education, justice, and social systems, demonstrating that ADHD-related issues have been identified across multiple domains over time, without consistent system-level coordination or response.

These records demonstrate sustained parliamentary awareness over more than two decades.


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E1: Parliamentary Debate and Official Record (Hansard)

Parliamentary debate records indicate that ADHD has been referenced across multiple domains over time, including justice, health, education, and social systems.

As early as 2003, parliamentary discussion of neurological and developmental conditions highlighted long-term impacts on education, employment, and interaction with social systems, including the importance of early identification and intervention.¹

In 2007, parliamentary questions relating to ADHD medication funding reflected tensions between cost containment and functional outcomes for children, including reported impacts on school participation when medication access changed.²

More recent parliamentary debate continues to reference ADHD within high-impact systems. In February 2024, Helen White MP noted that people within the prison system are “often... suffering from things like ADHD” alongside trauma and other challenges.³

In March 2024, Dr Tracey McLellan MP referenced ADHD in the context of addiction and comorbidity, highlighting risks associated with assumptions of rational decision-making in populations with complex needs.⁴

Parliamentary discussions have also highlighted links between ADHD, education, and system outcomes. In 2025, members referenced the importance of structured learning environments and consistent support for neurodiverse learners, including those with ADHD.⁵

ADHD has also been referenced in relation to access to treatment. In June 2025, the Minister for Mental Health acknowledged longstanding barriers to diagnosis and treatment, including cost and wait times, and the need to improve access to care.⁶

Across Hansard records, ADHD appears within broader policy discussions rather than as a consistently governed or monitored population group.

E2 – Petitions and Select Committee Processes

Public petitions and select committee processes further demonstrate that ADHD-related concerns have been formally raised within Parliament on multiple occasions over time.

In August 2022, the petition of Laura Williams requested that Parliament “acknowledge that adult ADHD is a worthy concern, and increase funding for it.” This petition was subsequently considered by the Health Committee, with a report presented to the House in May 2023.⁸

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The Health Committee report identified ongoing issues relating to access to diagnosis, workforce capacity, cost barriers, and limitations in publicly funded services, including that many individuals do not meet thresholds for access despite experiencing significant impact.⁸

Ministry of Health advice provided to the committee acknowledged systemic barriers to ADHD diagnosis and treatment, including workforce constraints, access thresholds, and financial barriers within the public and private health system.⁹

In January 2024, the petition of Jas McIntosh requested that ADHD and autism assessments be made accessible and affordable for all eligible people in New Zealand, reflecting continued concerns regarding access to diagnosis and support.¹⁰

In 2025, the petition of Casey Powell requested increased funding for teacher aide support for children with behavioural and learning needs, including ADHD, highlighting ongoing concerns regarding support within the education system.¹¹

In one case, a petition proposed allowing KiwiSaver withdrawals for mental health treatment, including ADHD, to enable access to assessment and care, indicating that access barriers may lead to consideration of solutions outside the health system.¹²

These processes demonstrate that ADHD-related concerns have been repeatedly escalated through formal parliamentary channels over time, across different contexts and presenting members.

E3 – Committee Reports

Early parliamentary committee reporting (Social Services Committee, 2003) identified attention deficit disorder as a contributing factor in youth offending and social outcomes, indicating long-standing awareness of neurodevelopmental conditions within justice and care systems.¹³

A Select Committee inquiry into learning support needs (2016) highlighted inconsistent support, lack of clear pathways, and equity barriers for students with learning differences, including ADHD as raised by submitters, and recommended improved coordination and early identification.¹⁴

A Health Committee report on an ADHD petition (2023) identified significant barriers to diagnosis, including cost and access constraints, and highlighted the need for early intervention and system-level response. However, the committee ultimately recommended that the House take note of its report, without establishing a coordinated system-level response or implementation mechanism.⁸


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E4 – Submissions

Submissions to select committees and parliamentary inquiries indicate that ADHD-related impacts are raised across multiple policy areas, including education, youth justice, health, and rehabilitation.

Submissions relating to learning support needs have highlighted gaps in identification, teacher capability, and system coordination affecting students with neurodevelopmental conditions, including ADHD.¹⁴

Subsequent submissions to parliamentary processes, including those from organisations such as ADHD New Zealand and those relating to youth justice and rehabilitation legislation, have continued to identify challenges associated with unmet ADHD needs, including links to educational disengagement, mental health impacts, and interaction with justice systems.¹⁵

Stakeholder submissions have also highlighted the impact of undiagnosed and untreated ADHD within the justice system, including reduced rehabilitation outcomes and the need for systematic screening and treatment approaches.¹⁶

These submissions consistently highlight the interaction between neurodevelopmental conditions and system outcomes, and the need for coordinated, cross-sector approaches to support.

Conclusion

ADHD-related issues have been repeatedly identified through parliamentary processes across multiple domains.

However, this recognition is typically situational and embedded within broader discussions, rather than reflected in coordinated, ADHD-specific governance, monitoring, or accountability frameworks.

This pattern is consistent with findings from Official Information Act responses, which indicate that while ADHD is visible across systems, it is not consistently governed, monitored, or addressed as a distinct population at a system level.

The combination of repeated parliamentary recognition and persistent system gaps supports the need for a coordinated, cross-sector examination through a Select Committee inquiry.

Footnotes

1. New Zealand Parliament (2003). Hansard, Volume 612.

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2. New Zealand Parliament (2007). Hansard, Volume 640.
3. New Zealand Parliament (2024). Hansard, Volume 773, 29 February 2024.
4. New Zealand Parliament (2024). Hansard, Volume 774, 19 March 2024.
5. New Zealand Parliament (2025). Hansard, Volumes 783–784.
6. New Zealand Parliament (2025). Hansard, Volume 785, 24 June 2025.
7. New Zealand Parliament (2022). Petition of Laura Williams.
8. Health Committee (2023). Petition of Laura Williams report.
9. Ministry of Health. Submission to Petition of Laura Williams.
10. New Zealand Parliament (2024). Petition of Jas McIntosh.
11. New Zealand Parliament (2025). Petition of Casey Powell: More funding for teacher aide support for children with ADHD and other issues.
12. New Zealand Parliament (2025). Petition of The Unity Party: Allow KiwiSaver withdrawals for mental health treatment (including ADHD).
13. Social Services Committee (2003). Vote Child, Youth and Family Services report.
14. Education and Science Committee (2016). Learning support inquiry.
15. New Zealand Parliament (various). Select Committee submissions referencing ADHD.
16. ADHD New Zealand (2024). Submission on Parole (Mandatory Completion of Rehabilitative Programmes) Amendment Bill.

Appendix F: Agency Correspondence

F1: Letter from the Hon Matt Doocey, Minister for Mental Health

F2: Letter from Whaīkaha – Ministry of Disabled People

Appendix G: International Evidence on the Socioeconomic Impact of ADHD

A 2019 Australian study by Deloitte Access Economics found that most economic costs associated with ADHD arise from productivity impacts, including reduced workforce participation, absenteeism, and reduced productivity while at work, accounting for approximately 81% of total financial costs. This reinforces the cross-system nature of ADHD and the importance of coordinated responses beyond the health sector.

Source: Deloitte Access Economics (2019), *The social and economic costs of ADHD in Australia*.

<https://www.deloitte.com/content/dam/assets-zone1/au/en/docs/services/economics/deloitte-au-economics-social-costs-adhd-australia-270819.pdf>



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