RE-EXAMINING THE BEST INTERESTS OF THE CHILD PRINCIPLE

Can this help tamariki and rangatahi Māori achieve the highest attainable standard of mental health?

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Abstract

This thesis explores how a re-examination of the best interests of the child principle can assist tamariki and rangatahi Māori to achieve the highest attainable standard of mental health. Although New Zealand has ratified the United Nations Convention on the Rights of the Child 1989, which enshrines the "best interests of the child" principle, significant disparities in mental health outcomes remain between tamariki and rangatahi Māori and non-Māori children and young people. Drawing on international human rights law, domestic legislation, case law, and Māori concepts of health and wellbeing, this thesis develops a theoretical and practical framework for reducing these mental health disparities. It explores whether New Zealand can utilise the best interests principle in a way that recognises and incorporates the unique cultural identity and collective rights of tamariki and rangatahi Māori. The flexible nature of the best interests principle is leveraged to integrate collective cultural rights and Māori worldviews into mental health law and policies. By doing so, it aims to facilitate greater recognition of Māori collective rights and practices within NewZealand's legal and healthcare systems.

This research proposes that a culturally-informed interpretation of the best interests principle, aligned with Māori worldviews and values, is important for fulfilling New Zealand's international obligations and the achievement of the highest attainable standard of mental health for tamariki and rangatahi Māori. The thesis contends that decisions concerning the best interests of tamariki and rangatahi Māori in mental health should be guided by a "by Māori, for Māori" approach, which informs and shapes the broader application of the best interests principle. Through this analysis, the thesis seeks to contribute to the improvement of mental health outcomes for tamariki and rangatahi Māori.

Dedication

For my parents – *Lakshman Karunaratne and Anoma Karunaratne*

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Glossary

The following definitions are taken from the online Māori dictionary. Associate Professor Robert Joseph has also provided assistance with formulating this glossary.[1]

Hapū	Tribe, kinship group, clan, tribe, subtribe
Iwi	Nation, extended kinship group, tribe, nation, people, nationality, race - often refers to a large group of people descended from a common ancestor and associated with a certain territory
Kaupapa Māori	Māori approach, Māori topic, Māori customary practice, Māori institution, Māori agenda, Māori principles, Māori ideology - a philosophical doctrine, incorporating the knowledge, skills, attitudes and values of Māori society
Māori	The Indigenous Peoples of Aotearoa/New Zealand
Mātauranga	Knowledge, wisdom, understanding, skill
Mokopuna	Grandchildren
Rangatahi	Youth and young adult generations of a Māori community
Tamariki	Children
Te Ao Māori	Māori world views
Te Reo Māori	The Māori language
Tikanga	Correct procedure, customary laws and institutions, the Māori legal system
Tipuna	Ancestors, grandparents

[1] All definitions taken from www.maoridictionary.co.nz; and Associate Professor Robert Joseph

Whakapapa	Genealogy, genealogical table, lineage
Whanaungatanga	relationships, kinship, sense of family connections and belonging
Wairua	The spiritual realm, the metaphysical world which is fundamental to Māori world view

List of Acronyms

Acronym	Full Term
AAAQ	Availability, Accessibility, Acceptability, and Quality
NZBORA	New Zealand Bill of Rights Act 1990
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CESCR	Committee on Economic, Social and Cultural Rights
COCA	Care of Children Act 2004
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
DHB	District Health Board (now disestablished)
ESCR	Economic, Social and Cultural Rights
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
NZFC	New Zealand Family Court
OHCHR	Office of the High Commissioner for Human Rights
OT Act	Oranga Tamariki Act 1989
Pae Ora Act	Pae Ora (Healthy Futures) Act 2022

Acronym	Full Term
UN	United Nations
UNCRC	United Nations Committee on the Rights of the Child
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
WHO	World Health Organization

Chapter One

Introductory Remarks

> *"Around the world, in rural and urban areas alike, indigenous children frequently constitute one of the most disadvantaged groups, and their rights – including those to survival and development, to the highest standard of health, to education that respects their cultural identity, and to protection from abuse, violence and exploitation – are often compromised. At the same time, however, indigenous children possess very special resources:*
>
> *They are the custodians of a multitude of cultures, languages, beliefs and knowledge systems, each of which is a precious element of our collective heritage…[t]he most effective initiatives to promote the rights of indigenous children build upon these very elements. Such initiatives recognize the inherent strength of indigenous communities, families and children, respect their dignity and give them full voice in all matters that affect them."*[2]

1.1. Overview

The mental health crisis facing tamariki and rangatahi Māori in New Zealand is a matter of deep concern that demands urgent attention. Despite New Zealand's ratification of international conventions like the Convention on the Rights of the Child 1989 ("CRC")[3] which enshrine principles such as the "best interests of the child", alarming disparities persist in mental health outcomes between Māori and non-Māori youth. This thesis examines how the best interests principle under international law can be re-examined and appropriately applied in the New Zealand context to improve mental health outcomes for tamariki and rangatahi Māori. This research explores whether New Zealand can utilise the best interests principle in a way that recognises and incorporates the unique cultural identity, collective rights, and customary practices of Māori. It argues that decisions regarding the best interests of tamariki and rangatahi Māori in mental health should be

[2] United Nations *Children's Fund Ensuring the Rights of Indigenous Children* (UNICEF Innocenti Digest, No 11, 2004) at 33.

[3] United Nations Convention on the Rights of the Child 1577 UNTS 3 (Adopted and opened for signature, ratification and accession November 1989, entered into force 2 September 1990).

made using a "by Māori, for Māori" approach that informs and shapes the broader application of the best interests principle.

Drawing on international human rights law, domestic legislation and case law, and Māori concepts of health and well-being, this thesis develops a theoretical and practical framework for reducing mental health disparities. The research examines how the flexible nature of the best interests principle can be leveraged to integrate collective cultural rights and Māori worldviews into mental health law and polices. By doing so, the thesis aims to facilitate greater recognition of Māori collective rights and practices within New Zealand's legal and healthcare systems. Ultimately, this research seeks to address a critical gap in existing legal and healthcare systems by exploring how the best interests principle can be interpreted in a culturally grounded way to better serve tamariki and rangatahi Māori. It proposes that a culturally-grounded interpretation of best interests, aligned with Māori worldviews and values, is essential for fulfilling New Zealand's international obligations and achieving the highest attainable standard of mental health for Māori youth. Through this analysis, the thesis aims to contribute to improving mental health outcomes and advancing the rights of tamariki and rangatahi Māori.

This introductory chapter begins by outlining the problem that this research aims to address. After these parameters are established, the research question and sub questions are introduced. Subsequently, the rationale for the choice of the best interests principle is presented, notably its promotion in international law and the recognition of its capacity to accommodate collective rights. The implications for the mental health rights of the Indigenous child are introduced, followed by a summary of the literature, research methodology and overview of the thesis structure.

1.2. The Problem – How bad is it really?

> I entered the mental health system when I was about 15. I wasn't told a damn thing. The main tool they used to keep me in place was medication, but the side effects were horrendous. I vividly remember shaking and frothing at the mouth and not being able to move, sleeping all the time. It was chronic. What I remember most is the lolly trolley, three times a day. Every day it seemed that my pills had changed colour or they'd added another one. No one told me what was going on… I just did what they told me to do. One time I questioned the nurse when she gave me my pills and I asked, "What's this one? " because

> I knew it was a different colour. She said, 'Just take it!' So I took it, got up and walked down the corridor and fell over flat on my face….[4]

Worldwide, there is a concerning rise in mental health issues and suicides among young people. Mental disorders affect approximately one in seven young people aged 10-19, contributing to 15 percent of the global disease burden within this age bracket.[5] This is the average percent prevalence globally with some countries experiencing rates as high as 40 percent.[6] The World Health Organisation reports that amongst adolescents, depression, anxiety and behavioural disorders rank as primary contributors to illness and disability.[7] Among individuals aged 15-29 years, suicide ranks as the third most prevalent cause of mortality.[8] Mental health conditions manifest in approximately one-third of cases prior to children and young people reaching 14 years of age.[9] This crisis has been described as "a silent pandemic of psychological distress".[10] Despite the concerning statistics, there is a notable absence of effective preventive measures addressing the

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[4] Mental Health Commission Recovery Series "Four Māori Korero About Their Experiences of Mental Illness" (March 2000, Series one) at 19-22.

[5] World Health Organization "Mental Health of Adolescents" (10 October 2024) World Health Organization <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>; see also Christian Kieling, Helen Baker-Henningham, Myron Belfer, Gabriella Conti, Ilgi Ertem, and Olayinka Omigbodun "Child and Adolescent Mental Health Worldwide: Evidence for Action" (2011) 378 The Lancet 1515 at 1515-1525.

[6] Kieling, Baker-Henningham, Belfer, Conti, Ertem, and Omigbodun, above n 5, at 1515-1525.

[7] World Health Organization "Mental Health of Adolescents" (10 October 2024) World Health Organization <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health; see also Kylie Sutcliffe "Rapid and Unequal Decline in Adolescent Mental Health and Well-being 2012-2019: Findings from New Zealand Cross-sectional Surveys" (2023) 57 Australian & New Zealand Journal of Psychiatry 6; R Peiris-John, J Ball, T Clark, T Fleming and the Adolescent Health Research Group *Youth Mental Health Needs and Opportunities: Leveraging 25 Years of Research from the Youth2000 Survey Series* (The University of Auckland and Victoria University of Wellington, Report, 2024); *The Right to Health and Indigenous Peoples, with a Focus on Children and Youth: Draft Study* UN Paper No 1611639 (7 July 2016); *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* UN Doc A/HRC/35/21 (28 March 2017); *Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* UN Doc A/HRC/44/48 (15 April 2020); *Study by the Expert Mechanism on the Rights of Indigenous People* UN Doc A/HRC/33/57 (2016).

[8] World Health Organization "Suicide" (25 March 2025) World Health Organization < https://www.who.int/news-room/fact-sheets/detail/suicide>.

[9] United Nations "1 in 7 Children and Teens Impacted by Mental Health Conditions" (9 October 2024) UN News Global perspective Human Stories <https://news.un.org/en/story/2024/10/1155536>.

[10] Eleisha Foon "New Zealand Young People Facing Silent Pandemic of Psychological Distress" (4 September 2020) RNZ <https://www.rnz.co.nz/news/national/425172/new-zealand-young-people-facing-silent-pandemic-of-psychological-distress>.

underlying causes of youth mental health problems.[11] Regrettably, factors such as poverty, ethnicity, and living in "fragile and vulnerable settings" continue to play a crucial role in determining mental health and well-being. [12] These factors, combined with "intergenerational trauma, marginalisation and disadvantage",[13] are particularly prevalent in Indigenous communities, placing Indigenous children and youth at the epicentre of this mental health crisis.[14]

The circumstances in New Zealand mirror this trend, with mental health issues doubling in prevalence over the past 20 years.[15] The latest statistics from Te Whatu Ora suicide website show that for Māori youth aged 15-24 years, the confirmed suicide rate was 27.3 per 100,000 and for non-Māori youth it was 14.8 per 100,000.[16] Among OECD nations, New Zealand ranks amongst the highest for suicide rates in the 15-19 age group.[17] Regrettably, tamariki and rangatahi Māori are disproportionately affected. Compared to their counterparts, young Māori individuals exhibit lower overall well-being (10.5 percent

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[11] *Report of the United Nations High Commissioner for Human Rights on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health* UN Doc A/HRC/23/59 (29 April 2013) at [61]-[65]; See also World Health Organisation "Adolescent Mental Health" (28 September 2020) World Health Organization <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>Often these mental health issues include depression, anxiety, self-harm, psychological trauma as a result of violence or abuse. Suicide is described as being at the forefront of the problem and is the third leading cause of death in 15-19 year olds.

[12] Rochelle Menzies, Sir Peter Gluckman and Richie Poulton *The University of Auckland "Youth Mental Health in Aotearoa New Zealand: Greater Urgency Required* (online ed, The University of Auckland: The Centre for Informed Futures, September 2000) at 2.

[13] At 5.

[14] Ministry of Health *Overview of Youth Health: Briefing* (Ministry of Health, 2024) at 15-18; In particular note the comments that young Māori who report depressive symptoms (28 percent in 2019 compared to 14 percent in 2012); Ministry of Health "Annual Data Explorer 2021/22: New Zealand Health Survey" (2022) Ministry of Health < https://minhealthnz.shinyapps.io/nz-health-survey-2021-22-annual-data-explorer/>; Mental Health Foundation of New Zealand "Statistics on Schools and Youth Mental Health" <https://mentalhealth.org.nz/statistics-on-schools-and-youth-mental-health#references>; Menzies, Gluckman and Poulton, above n 12, at 5.

[15] Menzies, Gluckman and Poulton, above n 12, at 3 ; see also OECD "New Zealand Country Highlights Doing Better For Children" OECD (2009) <https://www.oecd.org/newzealand/43589854.pdf>; Kate Sutcliffe, Jude Ball, Terryann Clark, Donna Archer, Roshini Peiris-John, Sue Crengle, Terry Fleming and Sally Merry, "Rapid and Unequal Decline in Adolescent Mental Health and Well-being 2012–2019: Findings from New Zealand Cross-Sectional Surveys" (2023) 57 Australian and New Zealand Journal of Psychiatry 264.

[16] Health New Zealand, Te Whatu Ora "Suicide Data Web Tool" Health New Zealand <Suicide data web tool> ; see also Peiris-John, Ball, Clark, Fleming and the Adolescent Health Research Group, above n 7; Hiran Thabrew, David Chinn and Krinn Isherwood "Navigating Youth Mental Health" (23 September 2023) He Ako Hiringa Learning Always <Navigating youth mental health | He Ako Hiringa>.

[17] Te Ohonga Ake "The Health Status of Māori Children and Young People in New Zealand" (Series Two, April 2017) at 99.

for Māori, 6.8 percent for NZ European).[18] According to a recent report by the Controller and Auditor General, a persistent challenge is the absence of current mental health data.[19] The most recent nationwide youth mental health prevalence survey in New Zealand, titled Te Rau Hinengaro was conducted in 2006 – now almost 20 years old.[20] The majority of available information is derived from concise screening instruments, such as the Youth2000 surveys, which utilise brief questionnaires.[21]

Within the available data there are specific youth mental health statistics that reveal concerning trends. The prevalence of depressive symptoms amongst rangatahi Māori has seen a significant increase, with 28 percent reporting such symptoms in 2019, up from 14 percent in 2012.[22] The Youth19 survey highlighted a "concerning equity gap between rangatahi Māori and Pākehā and other European youth".[23] The findings revealed that rangatahi Māori exhibited a higher rate of significant depressive symptoms (28 percent) in comparison to their Pākehā and other European counterparts (20 percent). Moreover, the survey indicated that a larger proportion of rangatahi Māori had attempted suicide within the past 12 months (13 percent) when compared to Pākehā and other European youth (3 percent).[24]

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[18] Jock Phillips "Suicide" (26 January 2025) Te Ara – the Encyclopedia of New Zealand <https://pmc.ncbi.nlm.nih.gov/articles/PMC6243073/#B1>; see also Sue Crengle, Terryann Clark, Elizabeth Robinson, Peter Bullen, Barry Dyson, Simon Denny et al *The Health and Wellbeing of Māori New Zealand Secondary School Students in 2012: Te Ara Whakapiki Taitamariki – Youth'12* (The University of Auckland, Adolescent Health Research Group, 2013); Terry Fleming, Sue Crengle, Roshini Peiris-John, Jude Ball, Sarah Fortune, Esther Yao, Cinnamon Lindsay Latimer, Analosa Veukiso-Ulugia and Terryann Clark "Priority actions for improving population youth mental health: An equity framework for Aotearoa New Zealand" (2024) 34 Mental Health & Prevention 200339.

[19] Controller and Auditor- General *Meeting the Mental Health Needs of Young New Zealanders* (Office of the Auditor-General, Report, February 2024) at 5.

[20] Mark Oakley Browne, J. Elisabeth Wells and Kate M. Scott (ed) *Te Rau Hinengaro: The New Zealand Mental Health Survey* (Ministry of Health, Wellington, 2006).

[21] Controller and Auditor- General, above n 19 at 5.

[22] Theresa Fleming, J. Tiatia-Seath, Roshini Peiris-John, Kylie Sutcliffe, Dan Archer, L. Bavin, Sue Crengle, Terryann Clark and Youth19 Research Group Youth19 Rangatahi Smart Survey, Initial Findings: Hauora Hinengaro/ Emotional and Mental Health (The University of Auckland and The University of Wellington, Youth2000 Survey Series, 2020); see also Theodore, Bowden, Kokaua, Ruhe, Hobbs, Hetrick, Marek, Wiki, Milne, Thabrew, and Boden, above n 2.

[23] Fleming, Tiatia-Seath, Peiris-John, Sutcliffe, Archer, Bavin, Crengle, Clark and Youth19 Research Group, above n 22, at 7.

[24] At 7.

Young Māori individuals were found to have a 56 percent more likely chance of hospital admission due to self-harm compared to their non-Māori and non-Pacific counterparts.[25] Moreover, studies have revealed significant disparities in depression rates among secondary school students, with 38 percent of Māori females experiencing depression, compared to 24 percent of Pākehā female youth.[26] The recent Youth2000 study revealed a consistent pattern of disadvantages for Māori compared to Pākehā, including neglected healthcare, symptoms of depression, and experiences of racial discrimination.[27] Research by Baxter noted that one in four Māori aged 16 to 24 years had experienced a mood disorder, and at least one anxiety disorder.[28] To compound the severity of this, Māori youth are less likely to use mental health services than non-Māori and face considerable barriers to health care such as racial discrimination and mental health stigma.[29]

These statistics present a bleak outlook that emphasises the urgent need to address what has been described as a "matter of deep concern that has received insufficient attention for far too long"[30] and can no longer be disregarded.

1.3. Research Question

The primary research question of this thesis is:

How can a re-examination of the best interests of the child principle assist tamariki and rangatahi Māori to achieve the highest attainable standard of mental health?

Investigating this subject prompted an examination of the right to health and the flexible nature of the best interests principle, along with its potential application in fulfilling the mental health rights of tamariki and rangatahi Māori. The research hypothesises that the

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[25] Theodore, Bowden, Kokaua, Ruhe, Hobbs, Hetrick, Marek, Wiki, Milne, Thabrew, and Boden, above n 2, at 87.

[26] Menzies, Gluckman and Poulton, above n 12, at 3.

[27] Peiris-John, Ball, Clark, Fleming and the Adolescent Health Research Group, above n 7, at 8; see also John Fitzgerald and Cate Curtis 'Non-suicidal self-injury in a New Zealand student population: Demographic and self-harm characteristics' (2017) 46(3) New Zealand Journal of Psychology 156.

[28] Joanne Baxter *Māori Mental Health Needs Profile: A Review of the Evidence* (Ministry for Health, TRM/05/27, 2008).

[29] Ake, above n 17, at 93; see also Ashlea Williams, Terryann Clark and Sonia Lewycka "The Associations between Cultural Identity and Mental Health Outcomes for Indigenous Māori Youth in New Zealand" (2018) 6 Frontiers in Public Health 319.

[30] Menzies, Gluckman and Poulton, above n 26, at 3.

current inequalities in mental health outcomes for tamariki and rangatahi Māori might indicate that New Zealand is not meeting its international obligations. In order to answer the research question, a series of secondary research questions have also guided the inquiry. They are as follows:

- How is the best interests of the child principle interpreted in international and national legislation?
- What considerations are made for the best interests of Indigenous children?
- What are the implications of the right to mental health in international and domestic legal frameworks?
- In what ways do collective cultural rights interact with health-related rights and are they relevant when assessing the best interests of the Indigenous child?
- Are New Zealand's mental health laws and policies effective for tamariki and rangatahi Māori?
- What measures can be taken to improve New Zealand's laws and policies on mental health for tamariki and rangatahi Māori?

1.4. Why the Best Interests Principle?

The CRC is guided by four guiding principles, one of which is the "best interests of the child".[31] Although the CRC does not provide a precise definition of best interests, the Committee on the Rights of the Child ("the Committee") has issued a General Comment elucidating it as a three-pronged notion. The concept encompasses a substantive right, an interpretative legal principle, and a procedural rule.[32] In essence, the best interests principle guarantees children the right to have their best interests evaluated and prioritised

[31] United Nations Convention on the Rights of the Child, above n3; The four guiding principles are non-discrimination, best interest of the child, the right to survival and development and the views of the child.
[32] *General Comment No. 14 The Right of the Child to Have His or Her Best Interests Taken as a Primary Consideration (Article 3, Paragraph 1)* UN Doc CRC/C/GC/14 (2013) at [6].

in all decision-making processes.[33] Over recent decades, the implementation and interpretation of this principle have evolved, significantly influencing the landscape of children's rights.

New Zealand's ratification of the CRC in 1993 obligates the country to consider the CRC's guiding principles in accordance with its international commitments, which include applying the best interests principle. However, it is important to recognise that New Zealand lacks explicit domestic legislation incorporating children's rights and/or the CRC. The Mana Mokopuna – Children and Young People's Commission is tasked with advancing and monitoring the application of the Children's Convention by governmental bodies and making reports to the United Nations.[34] Additional responsibilities encompass promoting awareness of the CRC within the country and championing its progress at the national level.[35] Beyond these duties, there are no further provisions for children's rights in domestic legislation.[36] The Care of Children Act 2004 and the Oranga Tamariki Act 1989 are the only two statutes that incorporate the best interests principle, but their scope is narrow and limited to custody cases and state care.[37] Despite the absence of explicit references to the best interests principle or children's rights in broader domestic legislation, New Zealand's international obligations cannot be disregarded.[38] The nation faces the challenge of applying these broad international standards to the specific mental health issues confronting tamariki and rangatahi Māori.

Global consensus supports the notion that the best interests principle allows decision-makers to customise decision making according to a child's specific circumstances.[39] Importantly for the current research and the mental health needs of Māori youth, the CRC Committee has endorsed this principle, stating that the concept of a child's best

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[33] *General Comment No. 14*, above n 32, at [6].

[34] Children and Young People's Commission Act 2022; See also Children's Commissioner "Our Role in the Children's Convention" OCC <https://www.occ.org.nz/childrens-rights-and-advice/uncroc/uncroc-role/>.

[35] Children and Young People's Act 2022, s 22.

[36] Children's Commissioner "Our Role in the Children's Convention" OCC <https://www.occ.org.nz/childrens-rights-and-advice/uncroc/uncroc-role/>.

[37] State care has failed dismally as per the 2024 Report on Abuse in State Care. Royal Commission of Inquiry Abuse in Care *Whanaketia- Through Pain and Trauma, from Darkness to Light* (July 2024).

[38] Ministry of Justice "International Human Rights" <https://www.justice.govt.nz/justice-sector-policy/constitutional-issues-and-human-rights/human-rights/international-human-rights/>.

[39] John Eekelaar and John Tobin *The UN Convention on the Rights of the Child* (Oxford University Press, UK, 2019) at 74 - 105.

interests is adaptable and flexible, accommodating both individual needs and the collective rights of Indigenous communities.[40] This flexibility enables the best interests principle to incorporate the collective cultural rights of Indigenous groups. In General Comment No. 11, the Committee emphasised that the best interests of the child encompasses both individual and collective aspects.[41] Consequently, when applying this principle, consideration should be given to how it relates to collective cultural rights.[42] The Committee urged legislative bodies to consider not only the cultural rights of Indigenous children, but also their need to exercise these rights collectively with their community when determining their best interests.[43] The following excerpt from General Comment No. 11 is particularly significant:[44]

> The Committee considers there may be a distinction between the best interests of the individual child, and the best interests of children as a group. In decisions regarding one individual child, typically a court decision or an administrative decision, it is the best interests of the specific child that is the primary concern. However, considering the collective cultural rights of the child is part of determining the child's best interests.

The observations made by the Committee align with the notion that the collective interests of Indigenous groups and the individual rights of children are closely linked. It is not sufficient to examine the child's best interests in isolation; one must also take into account the collective cultural rights. This interconnectedness is the very reason why special consideration is necessary when applying the best interests principle to children from Indigenous backgrounds.

The CRC underscores the significance of preserving a child's cultural identity and the crucial role of the family unit. The CRC's Preamble acknowledges that the "…inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world".[45] Articles 5 and 18 highlight the importance of a whānau-centred approach in child-related decision-making and the social and cultural context in which the child

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[40] At 74 -105.

[41] *General Comment No. 11 Indigenous Children and their Rights under the Convention* UN Doc CRC/C/GC/11 (12 February 2009) at [28]-[30].

[42] At [25]-[30].

[43] At [33].

[44] At [32].

[45] United Nations Convention on the Rights of the Child, above n 3, Preamble.

lives must be taken into account.[46] Notably, Article 30 of the CRC explicitly safeguards the rights of Indigenous children to maintain their cultural practices within their communities.[47] Given the CRC's focus on collective cultural rights and the family unit's importance, the best interests principle is well-suited to underpin this research. In General Comment No. 11, when the Committee discussed best interest of Indigenous children, the best interests principle's flexible and adaptable nature allows for consideration of each child's specific context, particularly in the case of tamariki and rangatahi Māori.[48] With this in mind, this thesis explores how the best interests principle can be utilised at a practical level to combat the current mental health crisis for tamariki and rangatahi Māori.

This thesis focuses on the best interests principle because it operates as a central, guiding principle within child-related decision-making. It is not simply one consideration among many; rather, it provides the overarching framework through which other principles are interpreted and applied. Concepts such as safety, participation, cultural identity, and wellbeing ultimately flow back to, and are determined through assessments of what is said to be in a 'child's best interests'. For that reason, the principle has significant structuring power: it shapes how competing rights and interests are balanced. By interrogating and reframing the content of the best interests standard, particularly in the context of tamariki and rangatahi Māori mental health, this thesis engages with a legal principle that has the capacity to influence the wider legal landscape, ensuring that other principles and rights are applied in a manner that is relational, culturally grounded, and consistent with both international human rights law and Indigenous worldviews.

Before proceeding further, it is important to note that this thesis is framed from an international human rights law perspective because it asks a distinct question (as stated above): given the current mental health crisis affecting tamariki and rangatahi Māori, how

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[46] Assuming a functional whānau exists; Article 5 provides: "States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention"; Article 18(1) provides: "States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern"; see also Eekelaar and Tobin, above n 39, at 74-105.

[47] United Nations Convention on the Rights of the Child, above n 3, at Article 30.

[48] *General Comment No.* 11, above n 41, at [32].

can international law strengthen domestic responses? This approach does not seek to replace or reinterpret Te Tiriti o Waitangi, which remains fundamental to New Zealand's constitution. Rather, it considers international human rights instruments as complementary tools that can provide additional guidance to address the current mental health crisis for tamariki and rangatahi Māori. In this sense, international law offers an additional pathway to support tamariki and rangatahi Māori in achieving the highest attainable standard of mental health, particularly by informing how domestic law is applied in practice in the mental health framework. A core argument of this thesis (as will become apparent is) where State obligations are better aligned with the collective rights and wellbeing of tamariki and rangatahi Māori, this can have a flow-on effect by reducing legal and structural barriers and creating greater space for Māori decision-making in practice in the mental health space. In this sense, the research engages with Māori self-determination as an internal manifestation - concerned with how authority, participation, and decision-making are exercised within the State. The contribution of this research is therefore not to define Māori self-determination itself, but to demonstrate how existing legal tools can be interpreted and applied in ways that are less constraining and more supportive of Māori self-determination, consistent with both international law and Te Tiriti.

With this in mind, the next section will explore the right to health and its intersection with the best interests principle.

1.5. The Right to Health

In addition to the support for the utilisation of the best interests principle, international declarations also establish the right to health and the standards that need to be implemented, including for Indigenous peoples. These international obligations establish New Zealand's responsibilities with regard to health and mental health, and the necessity for these to be considered in conjunction with the best interests principle. The universal right to health has been recognised for a significant period, as evidenced by the Universal Declaration of Human Rights 1948 ("UDHR").[49] Article 25 of the UDHR specifically states that every person has the right to a standard of living adequate for their health and

[49] *Study by the Expert Mechanism on the Rights of Indigenous People The Right to Health and Indigenous Peoples with a Focus on Children and Youth* UN Doc A/HRC/33/57 (2016) at [7].

well-being, including access to food, clothing, housing, medical care, and necessary social services.

The United Nations Declaration on the Rights of Indigenous Peoples ("UNDRIP") additionally acknowledges the connection between Indigenous peoples' right to self-determination and their health rights.[50] Moreover, UNDRIP underscores the significance of preserving the collective rights of Indigenous people.[51]

UNDRIP's Article 24 mirrors the language found in Article 12 of the International Covenant on Economic, Social and Cultural Rights ("ICESCR"),[52] an international binding agreement that establishes the right of all individuals to attain the highest possible standard of mental and physical well-being.[53] This comprehensive right encompasses both healthcare and social factors influencing health, and includes freedoms and entitlements.[54] Key components include non-discrimination and equal treatment, with certain elements subject to gradual implementation due to resource limitations.[55]

However, obligations such as non-discrimination are to be implemented immediately by states.[56] It is important to note that this right does not simply mean "being healthy".[57] Rather it includes freedoms and entitlements. The freedoms include the ability to make decisions about one's own body and protection from unwanted interference or intrusion. Conversely, the entitlements involve the right to access a health protection system that

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[50] See generally *Study by the Expert Mechanism on the Rights of Indigenous* People, above n 49; Examples include: Article 21 which upholds the right of Indigenous groups to enhance their economic and social circumstances without prejudice; Article 23 which acknowledges Indigenous Peoples entitlement to establish and formulate priorities and approaches for exercising their right to progress, particularly in actively engaging in the development and determination of health initiatives affecting them, and where feasible, managing such programmes through their own establishments; and Article 24 which recognises the right of Indigenous Peoples to their customary remedies, to sustain their health practices, and to obtain social and health services without discrimination.

[51] At [8].

[52] International Covenant on Economic, Social and Cultural Rights 993 UNTS 3 (opened for signature 16 December 1966, entered into force 3 January 1976).

[53] *The Right to Health and Indigenous Peoples with a Focus on Children and Youth,* above n 49, at [9].

[54] At [9].

[55] At [8].

[56] At [8].

[57] *General Comment No. 14 The Right to the Highest Attainable Standard of Health* UN Doc E/C.12/2000/4 (11 August 2000) at [8]-[9].

offers equal opportunities for individuals to achieve the highest possible standard of health.[58]

The right of the child to health is recognised under Article 24 of the CRC. Article 24(1) provides that, "States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilitate the treatment of illness and rehabilitation of health. State Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services".[59] A General Comment issued by the Committee states that this right is inclusive which means children are not simply entitled to appropriate health care, children also have a right to "grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health".[60] Importantly, the Committee states that in order to achieve this standard, a holistic approach to health must be used, including [their] biological, social, cultural and economic environments.[61] For Indigenous children, the CRC accommodates the acknowledgement of collective rights through Articles 5 and 18. These articles emphasise the significance of family, extended family, community, and local customs in implementing children's rights.[62] Such an approach exemplifies the CRC's aforementioned flexibility, which enables the accommodation of cultural diversity in relation to children.[63] Consequently, despite being outside Western traditions, the collective rights and corresponding duties of Indigenous children can be addressed within the CRC's flexible framework.[64]

The Committee on Economic, Social and Cultural Rights ("the CESCR") elaborates on the right to health for Indigenous peoples in its General Comment No. 14 (2000).[65] It emphasises that Indigenous communities are entitled to targeted initiatives aimed at

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[58] At [8]-[9].

[59] United Nations Convention on the Rights of the Child, above 45, Article 24.

[60] *General Comment No. 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health* UN Doc CRC/GC/15 (2013) at [1]-[2].

[61] At [2]-[4].

[62] Steve Macbeth "The Application of the Best Interests Principle to Māori Children's Collective Cultural rights: A Conceptual Shift for the New Zealand Family Court?" (LLM Dissertation, University of Waikato, 2015) at 13.

[63] At 27.

[64] At 13.

[65] *The Right to Health and Indigenous Peoples with a Focus on Children and Youth* UN Doc, above n 49, at [10]; see also *Committee on Economic, Social and Cultural Rights Right of everyone to take part in Cultural life (Article. 15, Paragraph 1 (a), of the International Covenant on Economic, Social and Cultural Rights)*, UN Doc E/C.12/GC/21 (2009) at [36].

enhancing their access to health services and care.[66] These measures should be culturally sensitive and consider traditional medicinal practices.[67] Furthermore, the Committee stipulates that nations should allocate resources to enable Indigenous peoples to create, implement, and oversee their own health services. The collective nature of health for Indigenous populations is, moreover, acknowledged by the Committee, which also recognises the adverse health impacts resulting from the displacement of these communities from their ancestral lands and environments due to development activities.[68]

The Committee noted that Indigenous children often experience poorer health outcomes compared to their non-Indigenous counterparts, attributing this disparity to obstacles in accessing suitable healthcare services.[69] Nations were urged to develop and implement services that respect the cultural heritage and the identities of Indigenous communities. These recommendations have received support from the Office of the United Nations Commissioner for Human Rights ("OHCHR") and the World Health Organisation ("WHO"). A joint report by these organisations emphasised that achieving the right to health necessitates a multifaceted approach.[70] The report outlines three key obligations for States regarding the right to health:

(i) Respecting the right by refraining from direct or indirect interference;

(ii) Protecting the right by preventing third-party interference; and

(iii) Fulfilling the right through appropriate, non-discriminatory measures.[71]

The Committee further emphasised that Indigenous populations should be provided with culturally appropriate healthcare resources and access. Moreover, nations should allocate resources for Indigenous peoples to design, deliver and control services aimed at

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[66] *The Right to Health and Indigenous Peoples with a Focus on Children and Youth* UN Doc, above n 49, at [10].
[67] At [10].
[68] *The Right to Health and Indigenous Peoples with a Focus on Children and Youth* UN Doc, above n 49, at [10].
[69] At [1]-[12]; *Committee on Economic, Social and Cultural Rights Right of Everyone to Take Part in Cultural life,* above n 67, at [36]-[37].
[70] *Office of the United Nations High Commissioner for Human Rights and World Health Organisation the Right to Health: Fact Sheet no 31* (United Nations) OCHR/WHO, 2008) at 25.
[71] At 25.

improving their mental and physical well-being.[72] Additionally, the Committee on the Elimination of Racial Discrimination ("CERD Committee") has offered insights on this topic, particularly in its concluding observations regarding New Zealand's combined twenty-first and twenty-second periodic reports. The Committee advised New Zealand to bolster its accountability for the health of Māori communities by ensuring their equal representation and active involvement in decision-making processes concerning the planning, implementation and assessment of health services.[73] In a more recent development, the Special Rapporteur noted in 2019 that states have an obligation to "facilitate, provide and promote conditions in which mental health and well-being can be realised".[74] Consequently, it is imperative to ensure that national laws, practices and policies are promoted, particularly for those in vulnerable or disadvantaged circumstances, such as Indigenous communities.

Regrettably, Indigenous populations encounter substantial obstacles in accessing healthcare and mental health support. Despite higher reported rates of mental health issues amongst Māori in New Zealand, there are disparities in treatment compared to non-Māori individuals. It is young Māori that face unique challenges in obtaining emotional support services or experience barriers within these services. Prior research has indicated that for Māori, factors including colonisation, racism, Western healthcare models, limited access to primary care, and a lack of culturally appropriate services contribute to persistent inequalities.[75] Given these barriers and the statistics presented, it is evident that the mental health of tamariki and rangatahi Māori is a pressing issue for New Zealand. This research aims to address this critical situation by applying the best interests of the child principle, with the goal of improving the current circumstances for tamariki and rangatahi Māori mental well-being. While the focus is on improving outcomes for Māori youth, any implementations or policy changes are likely to have positive flow-on effects for young people of New Zealand generally given that it is not

[72] *General Comment No. 14 The Right to the Highest Attainable Standard of Health*, above n 57, at [27].

[73] *Concluding Observations on the Combined Twenty-first and Twenty-second Periodic Reports of New Zealand* UN Doc CERD/C/NZL/CO/21-22 (2017).

[74] *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* UN Doc A/HRC/41/34 (12 April 2019) at [20].

[75] Theodore, Bowden, Kokaua, Ruhe, Hobbs, Hetrick, Marek, Wiki, Milne, Thabrew, and Boden, above n 2, at 79-80.

possible to isolate interventions solely for one group without impacting the wider youth population.

1.6. The Right to Mental Health

Of particular relevance to this thesis is that the right to health includes the right to mental health. International expectations in this respect provide a framework for evaluating New Zealand's mental health provisions and for providing a way forward for meeting the mental health needs of Māori youth. A pivotal report released by the Special Rapporteur in 2019 revealed that the current mental health framework exhibits "combined improvements and failures in evidence-based and ethical care".[76] The report identified three global deficiencies in mental health systems: an overemphasis on biomedical interventions, imbalanced power dynamics in services, and inherent biases.[77] The Special Rapporteur emphasised that neglecting mental health is both unacceptable and alarming, with many individuals' mental health needs going unmet, constituting a human rights breach that requires immediate action.[78] In a follow-up report in 2020, the Special Rapporteur reaffirmed that "there is no health without mental health" and the report asserted that optimal mental well-being is inextricably linked to human rights.[79] Despite heightened global awareness, he noted "there remains a global failure of the status quo to address human rights violations in the mental health care system" and implored nations to transcend beyond a "biomedical understanding of mental health".[80] To disrupt this cycle, actions must be grounded in rights, comprehensive, and informed by the lived experiences of those most marginalised by harmful geopolitical systems, institutions, and practices.[81]

Integrating international health rights principles into national laws and policies can provide a robust framework for addressing the mental health needs of Māori children and youth in New Zealand. International human rights law establishes standards for legal accountability in progressively realising health-related human rights. It connects individual

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[76] *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* above n 74*,* at [88]-[92] and [20].

[77] At [94].

[78] At [94].

[79] *Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, above n 7, at [3].

[80] At Summary.

[81] At Summary.

rights holders and their entitlements with corresponding state obligations. Realising human rights requires the State to respect, protect, or fulfil specific rights through governmental actions, including legislative reforms, budget allocations, and programme assessments.[82] Notably, the human rights framework necessitates a rights-based approach in drafting mental health legislation. Thus, incorporating health rights into domestic law would enable the government to more effectively pursue a rights-based approach to mental health for children and young people. As Palmer and Geiringer note, a consistent rights-based approach also requires appropriate policy frameworks and the incorporation of rights-based analysis into policy development.[83]

In developing and implementing a rights-based approach to human rights, international examples can offer valuable guidance and established principles. These fundamental principles provide a framework for national governments to ensure fair distribution of health-related benefits. Gruskin and Tarantola emphasise the importance of examining synergies and trade-offs between health and human rights, working within a framework of transparency and accountability, and focusing on principles of non-discrimination, equality, and community participation.[84] Green and Titti's observation is pertinent, highlighting two essential factors in adopting a rights-based approach. Firstly, policy, programme, or project objectives must reflect relevant human rights. Secondly, implementation must adhere to human rights principles. This approach involves examining goals and processes at all levels of activity in the light of human rights, including needs assessment, planning, implementation, monitoring, and evaluation.[85]

With this in mind, the guidance provided by the United Nations ("UN") on reducing disparities in global mental health is crucial. It advocates for a comprehensive approach to addressing mental health issues. Consequently, when assessing mental health outcomes for Indigenous children, it is essential to consider their collective cultural rights and unique

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[82] Lawrence Gostin, Matiangai Sirleaf and Eric Friedman "Global Health Law: Legal Foundations for Social Justice in Public Health" in Lawrence Gostin and Benjamin Mason Meier (eds) *Foundations of Global Health & Human Rights* (Oxford University Press, London, 2020) 45 at 48.

[83] Claudia Geirigner and Matthew Palmer "Human Rights and Social Policy" (2007) 12 Social Policy of New Zealand 12 at 38.

[84] Flavia Bustreo and Curtis Doebbler "The Rights-Based Approach to Health" in Lawrence Gostin and Benjamin Mason Meier (eds) *Foundations of Global Health & Human Rights* (Oxford University Press, London, 2020) 89 at 94.

[85] Maria Green and Titti Mattsson "Health, Rights and the State" (2017) 62 Scandinavian Studies in Law 177 at 185.

health determinants. This raises the question of how the right to mental health intersects with the principle of best interests for the Indigenous child.

1.7. The Intersection of the Best Interests Principle Including the Right to Health (and Mental Health) for tamariki and rangatahi Māori

As noted above, the right to health includes the right to mental health. The best interests principle and the right to health are closely interconnected when it comes to children's well-being, particularly for Indigenous children. This interconnection is particularly pertinent for mental health. The right to mental health for Indigenous children must be understood holistically, taking into account cultural conceptions of well-being and collective cultural rights. As noted by the Special Rapporteur on the right to health, achieving good mental health for Indigenous peoples requires "culturally appropriate care that respects their traditions, cultures and practices."[86]

The CRC Committee has emphasised the importance of considering the collective cultural rights of Indigenous children when evaluating their best interests, particularly in matters of health. In General Comment No. 11 on Indigenous Children, the Committee asserted that the assessment of an Indigenous child's best interests should encompass their cultural collective rights and the necessity to exercise these rights collectively with their community members. [87] Regarding legislation and policies affecting Indigenous communities, these groups should be consulted and afforded the opportunity to engage in the process of determining how the best interests of Indigenous children can be established in a culturally appropriate manner.[88] Therefore, the best interest principle necessitates that governments implement proactive measures across their legislative, administrative, and judicial frameworks to systematically apply this principle,[89] which should involve evaluating the impact of their decisions and actions on children's rights and interests throughout these systems.[90]

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[86] *Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental,* above n 7, at [3].
[87] *General Comment No.* 11 *Indigenous Children and Their Rights Under the Convention,* above n 41, at [30]-[33].
[88] At [30]-[33].
[89] At [33].
[90] At [30]-[33]; See also *General Comment No. 5 on General Measures of Implementation* UN Doc CRC/GC/2003/527 (November 2003) at [12].

As previously noted, the right to health (including mental health) for Indigenous children is considered holistically, encompassing collective rights and acknowledging the interrelation between the individual and their collective cultural rights in the community. This holistic view provides an important rationale for the application of the best interests principle in considering the mental health rights of Indigenous children because the best interests principle is adaptable and can incorporate collective cultural rights when making decisions about children.

The convergence of the right to health (including mental health) and the best interests principle occurs when this adaptability is used to integrate Indigenous perspectives on health and well-being, as well as collective cultural rights. By implementing the best interests principle in this culturally appropriate manner, it can be an effective instrument for promoting the right to health for Indigenous children, ensuring that health services and interventions are culturally appropriate and efficacious. Indeed, it is recognised that when assessing the best interests of an Indigenous child, their collective cultural rights must be taken into consideration.[91] The thesis aims to explore how the best interests principle can be applied to the health of tamariki and rangatahi Māori with a greater emphasis on collective rights and Māori conceptions of health and well-being.

It is argued that the intersection of the best interests principle and the right to health provides a framework for improving mental health outcomes for tamariki and rangatahi Māori. It requires holistically considering their individual and collective rights, cultural identity, and Indigenous understandings of well-being when determining their best interests in relation to mental health care and policies. Properly applying this intersectional approach could help reduce disparities and uphold the rights of tamariki and rangatahi Māori to achieve the highest attainable standard of mental health.

There is a gap in the existing literature in New Zealand given that the best interests principle has not been considered as a way to reduce the disparities in mental health outcomes for tamariki and rangatahi Māori. This will be discussed further in the literature review included in this introductory chapter. This gap adds further to the significance of this research and the findings obtained from this research will go towards clarifying how

[91] *General Comment No. 11 Indigenous Children and Their Rights Under the Convention,* above n 41, at [33]; see also United Nations *Children's Fund Ensuring the Rights of Indigenous Children*, above n 2, at 8.

New Zealand can reform its law and processes to achieve the highest attainable standard of mental health for tamariki and rangatahi Māori.

1.8. The Best Interests Principle and Collective Cultural Rights

The thesis argues that the best interests principle can incorporate collective rights. In support of this proposition, this section expands on the intersection of the best interests principle and collective cultural rights below.

This relationship between the best interests principle and collective rights has often been overlooked. Instead, the best interests of Indigenous children are more frequently viewed through a normative lens, separating them from their families, communities, and cultures.[92] This perspective reflects the dominant norm and fails to account for Indigenous children's kinship, cultural structures, and practices when determining their best interests. Such normative policies and practises are out of kilter with international expectations. For example, the CRC Committee has stressed that when evaluating the best interests of Indigenous children, states should consider their cultural rights and the need to exercise these rights collectively within their group.[93] As a guiding principle of the CRC, the best interests principle enables the assessment of both collective cultural rights and responsibilities, as well as individual rights and responsibilities, when determining what is in the best interest of a particular Indigenous child.[94]

From a Māori perspective, collective rights are understood as the inseparable connection between individual and group rights, encompassing whānau, iwi, and hapū.[95] There are reciprocal obligations for both the individual and the collective group. These obligations are predominately founded on "precedent handed down by tipuna".[96] The group assumes responsibility for individual actions, reinforcing reciprocal obligations through kinship ties.[97] This societal structure, based on collective accountability, contrasts sharply with

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[92] Bruce Valentine and Mel Grey "Keeping them home: Aboriginal out of home care in Australia" (2006) 87 Families in Society 537 at 537-545.

[93] *General Comment No. 11 Indigenous Children and their Rights Under the Convention,* above n 41, at [10].

[94] Macbeth, above n 62, at 62.

[95] Waitangi Tribunal *He Pāharakeke, He Rito Whakakīkinga Whāruarua Oranga Tamariki Urgent Inquiry* (Wai 2915, 2021) at 62.

[96] Macbeth, above n 62, at 27.

[97] At 24.

Western ideologies that prioritise the individual.[98] In child-rearing, a similar principle applies. Children are considered to belong not only to their immediate family but also to all whānau connected through their parents. This sense of belonging is rooted in identity rather than ownership and stems from whakapapa.[99] The term "tātou tamariki" is commonly used, signifying that children belong to many. Whanaungatanga, which encompasses kinship duties, responsibilities, and values arising from close familial, friendship, or reciprocal relationships, supports a collective rights perspective.[100] Consequently, when determining the best interests of tamariki and rangatahi Māori, their collective cultural rights must be taken into account. It is impossible to consider one without the other, as they are intrinsically linked. The details of collective rights and responsibilities will be explored in Chapter Four.

As has been noted, the statistics suggest there is a major concern that needs addressing. The legislation in New Zealand is limited. The Pae Ora Act 2022 ("the Pae Ora Act") serves as the primary legislation governing the structure and provision of health services in the country, while the Mental Health Act 1992 is the sole legislation overseeing mental health and psychiatric care in New Zealand. However, the latter's applicability is restricted, as it focuses only on compulsory treatment for individuals in dire need of intervention. The Pae Ora Act and the Health Act 1956 ("the Health Act") are the main health laws in New Zealand. The Health Act seeks to establish the wider framework for New Zealand's health system and the Pae Ora Act is designed to tackle health disparities and enhance overall well-being for New Zealanders, potentially improving access to healthcare services. The Pae Ora Act demonstrates concerted efforts aiming to deliver culturally appropriate healthcare and foster Māori engagement and participation. While these are positive developments, and as Breen notes, a "welcome effort", they alone are insufficient to fully recognise New Zealand's right to health as stipulated by international law for tamariki and rangatahi Māori.[101] It is argued that there is insufficient recognition of the collective cultural rights and practices of Māori in mental health law and policy, with the best

[98] Macbeth, above n 62, at 27.
[99] Macbeth, above n 62, at 27.
[100] At 29.
[101] Claire Breen "A Major New Law Aims To 'Improve The Health Of All New Zealanders'- So Why Doesn't It Include The Basic Human Right To Health?" (15 June 2022) The Conversation < https://theconversation.com/a-major-new-law-aims-to-improve-the-health-of-all-new-zealanders-so-why-doesnt-it-include-the-basic-human-right-to-health-184842 >.

interests of the child not appearing in health law. This is a clear shortcoming, given New Zealand's commitments to international agreements. Given the flexible and malleable nature of the best interests principle, this thesis argues that the principle could be a vehicle for change that allows outcomes to be provided through employing a by Māori and for Māori approach. The incorporation of collective cultural rights and Māori customary practices will not doubt assist in the progression of what Joseph stated in "*Re-Creating Legal Space for The First Law of Aotearoa-New Zealand"* as:[102]

> The future of Aotearoa-New Zealand must lie in a single legal system which nevertheless recognises and respects the world views, values, customary laws and institutions of the two great founding cultures of this country.

As this thesis progresses, it will become more evident how crucial it is to employ the best interests principle and its adaptable nature to address the unique needs of Indigenous children in the mental health space. Consequently, it is hoped this approach will lead to improved mental health outcomes for tamariki and rangatahi Māori.

To guide this research there is a need to examine what has been written about the best interests both domestically and internationally, especially as it relates to Indigenous children. These are presented in the following sections along with the methodology and structure of the thesis.

1.9. Methodology Section

This section outlines the research methodology of this thesis, and is divided into three main parts: positioning the researcher as a non-Māori (tauiwi) researcher studying Māori communities, the qualitative research approach employed, and the doctrinal aspect of the research.

As a non-Māori researcher investigating Māori communities, initial hesitation was natural. The researcher consulted supervisors Associate Professor Robert Joseph (a leading Māori scholar) and Professor Claire Breen regarding the appropriateness of undertaking this

[102] Robert Joseph "Re-creating Legal Space for the First Law of Aotearoa-New Zealand" (2009) 17 Waikato Law Review 74 at 96.

research. The researcher was reminded by the supervisory panel that other non-Māori researchers have conducted studies involving Māori communities and more will follow. Therefore, the researcher looked to those that have conducted research before, and considered how they navigated the cultural tension.[103] The researcher acknowledges the inclusiveness towards non-Māori researchers in this area and expresses gratitude for the wealth of available scholarship on Māori concepts that facilitated this research.

Before discussing the challenges in this research, it is important for the writer to provide a positioning statement outlining her motivation for undertaking this research. The writer identifies as Sinhalese, an ethnic group originating from Sri Lanka. She migrated to New Zealand with her family in the late 1990's. Approximately fifteen years ago, her father became unwell, marking her family's first encounter with mental health services in New Zealand. This experience was particularly challenging due to the limited availability of culturally appropriate services and support. Navigating the system was difficult and emotionally demanding. These personal experiences have significantly shaped the writer's interest in exploring this topic and her commitment to undertaking this research.

Another reason why the writer has focused on tamariki and rangatahi Māori is because as an aspiring scholar, the writer could not overlook the statistical reality demonstrating that Māori young people experience disproportionately high levels of mental health outcomes. To adopt a broad, generalised focus on young people as a whole would risk overlooking the severity and specificity of those inequities. The statistics presented at the outset of this thesis make clear that there is a particular group in urgent need of focused attention. Focusing on tamariki and rangatahi Māori is therefore a deliberate choice, grounded in both evidence and a commitment by the writer to addressing inequitable outcomes present in the mental health context for tamariki and rangatahi Māori.

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[103] Fiona Cram "Rangahau Māori: Tona Tika, Tona Pono- The Validity and Integrity of Māori Research" in Martin Tolich (ed) *Research Ethics in Aotearoa New Zealand* (Parson Education New Zealand Limited, Auckland, 2001); Fiona Cram "Developing Partnerships in Research: Pakeha Researchers and Māori Research" (1997) 35 Sites 44; Mark Tolich "Pakeha "Paralysis": Cultural Safety for Those Researching the General Population of Aotearoa" (2002) 19 Social Policy Journal of New Zealand 167; Vicki Carpenter and Colleen McMurchy-Pilkington "Cross-cultural Researching: Maoir and Pakeha in Te Whakapakari" (2008) 8 Qualitative Research Sage 179; Paul Woller "A Culturally Responsive Methodology of Relations: Kaupapa Māori Research and the Non-Māori Researcher" in Mere Berryman, Suzanne SooHoo and Paula Hassinger (eds) *Culturally Responsive Methodologies* (Emerald Group Publishing Limited, United Kingdom, 2013).

1.9.1. The Challenges

There are key challenges for non-Māori engaging in Māori research.[104] Cram and Lyons say that Pākehā researchers must critically examine their "preconceptions, values, and priorities", and consider how these influence their research design, execution, and interpretation.[105] This involves recognising the underlying assumptions, ideologies, and power dynamics that shape their research approach. According to Cram and Lyons, the rise of inquiry paradigms and methodologies requiring self-reflection has allowed more Pākehā researchers to gain a deeper understanding of their own perspective.[106] This increased self-awareness enables productive conversations between Pākehā and Māori researchers, empowering them to challenge a colonial status quo.[107]

However, Cram and Lyon also argue that navigating the boundaries of Kaupapa Māori research can present challenges.[108] The departure from Western epistemologies as the dominant perspective may induce feelings of alienation and disempowerment among Pākehā researchers accustomed to controlling research methodologies. This scenario can lead to what Tolich terms "Pākehā paralysis", a state in which some Pākehā researchers find it difficult to distinguish their role in Māori-centred research from conventional research methods.[109] This paralysis can hinder "researcher agency", potentially resulting in inaction where "expertise and resources" are not utilised, or in severe instances, complete withdrawal from the research endeavour.[110] This paralysis renders non-Māori researchers incapable of interacting with Māori communities due to their inability to navigate the intricacies and obstacles associated with identity politics.[111] Nevertheless,

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[104] Vanessa Simonds, and Suzanne Christopher "Adapting Western Research Methods to Indigenous Ways of Knowing" (2013) 103 American Journal of Public Health 2185 at 2185; see also generally Linda Tuhiwai Smith *Decolonizing Methodologies: Research and Indigenous People* (University of Otago Press, Dunedin, 1999).

[105] Fiona Cram and Henry Lyons "He Rangahau Whiria: A Research methodology for Both Parties to the Treaty of Waitangi" in Angus Macfarlane, Melissa Derby and Sonja Macfarlane (eds) *He Awa Whiria: Braiding the Knowledge Streams in Research Policy and Practice* (eBook ed, Canterbury University Press, 2024) at 231.

[106] At 234-244.

[107] At 234-245; See also Marlene Brant Castellano "Ethics of Aboriginal Research" (2004) Journal of Aboriginal Health 98.

[108] Cram and Lyons, above n 105 at 234-249.

[109] Cram and Lyons, above n 105; see also Tolich, above n 103 at 167-169.

[110] Alex Hotere-Barnes "Generating "Non-Stupid Optimism": Addressing Pakeha Paralysis in Māori Educational Research" (2015) 50 New Zealand Journal of Education Studies 39 at 39-53; Cram and Lyons, above n 105, at 23-236.

[111] Rachael Fabish "Pākehā Working with Māori – Activists and Academics" (2019) 2 Commoning Ethnography 132; Tolich, above n 103, at 167-170.

researchers who are not Māori, but recognise this responsibility and are willing to genuinely embrace Indigenous research methods may potentially offer significant contributions to high-quality studies within Māori communities.[112] As Cram and Lyon say, "Kaupapa Māori can hold space for Māori, at the same time, become a beacon and effective tool for Pākehā to better meet their guest responsibilities with respect to the Treaty".[113]

With the above in mind, the researcher had to carefully consider their position as a tauiwi (non-Māori) embarking on a thesis about tamariki and rangatahi Māori. This research is situated within a broader context of strengthening Māori self-determination, the right to health in the mental health space, and aligns with the goals of a human rights framework. As a non-Māori researcher, it was crucial to acknowledge the complexities and potential implications of conducting research involving Māori communities (given the discourse stated above). Therefore, this necessitated a critical examination of the researcher's role, responsibilities, and understanding of Kaupapa Māori before embarking on the research.[114] Nakamara emphasises the importance of researchers with Western training approaching Indigenous communities as learners. They must have sensitivity, open-mindedness, and readiness to tackle unforeseen challenges whilst endeavouring to prevent misrepresentation and exploitation of Indigenous knowledge.[115] According to Mcintosh, "Non-Indigenous researchers who are starting to learn Indigenous methodologies may get lost; they will have no idea where to start".[116] As implied in Mcintosh's views (which the writer shares) it would have been easy to give up altogether and abandon the research. Instead, the decision was made to proceed while being explicit about the political implications and specifically addressing the implications of the researcher's position as a tauiwi. As Bishop says there is a place for non-Māori researchers and their expertise and calls Māori to be open to Pākehā researchers who are willing to work within Māori

[112] Hannah Mackintosh "Another tool in the kete': Māori Engaging with International Human Rights Framework" (Masters in Development Studies thesis, University of Wellington, 2011) at 37.
[113] Cram and Lyons, above n, 105; see also Rachael May Fabish "Black Rainbow: Stories of Māori and Pakeha Working Across Difference" (PhD Thesis, Victoria University of Wellington, 2014).
[114] The researcher drew heavily on the work done by Hannah Mackintosh and other non-Māori researchers have undertaken research involving Māori communities; see generally Claire Bowing "The Woven Treaty" (PhD in Philosophy thesis, University of Otago, 2022); Fabish, above n 111; Fiona Cram "Developing Partnerships in Research: Pakeha Researchers with Māori Research" (1997) 35 Sites 44.
[115] Naohiro Nakamura "Indigenous Methodologies: Suggestions for Junior Researchers" (2010) 48 Geographical Research 97.
[116] At 98.

controlled context because to exclude them only serves to alienate a supportive and skilled group of professionally trained researchers.[117]

1.9.2. Guided by Kaupapa Māori : Ensuring Cultural Sensitivity and Respect in Research

There is much written about the harmful impact of research on Indigenous populations, which may often serve as a tool for colonisation, which has led to research becoming a focal point for contention, opposition, and defiance.[118] Numerous Indigenous scholars and communities have called for a transformation in research methodologies, advocating for decolonisation of research.[119] The concept of decolonising research represents an approach to conducting studies with Indigenous communities that prioritises Indigenous perspectives and knowledge systems, positioning them at the core of the research process.[120] Such an approach critically evaluates the foundational premises underlying research and questions widely accepted notions.[121] It challenges the prevalent belief that Western methodologies and epistemologies are the sole objective and scientifically valid approaches. Such perspectives marginalise Indigenous knowledge systems and methodologies by dismissing them as mere "folklore or myth".[122] Smith argues that decolonising research requires researchers to prioritise Indigenous values and adhere to Indigenous protocols.[123] This does not necessitate a wholesale rejection of Western methods and theories, but rather their adaptation when deemed suitable and advantageous by the local community.[124]

Consequently, Indigenous methodologies and theories have developed. Studies involving Indigenous communities should be conducted in a manner that is respectful and ethically

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117 See generally Mackintosh, above n 112; See also Alan Bishop "Collaborative Research Stories: Whakawhanaungatanga" (PhD in Philosophy thesis, University of Otago, 1995).

118 At 35; See also Controller and Auditor-General "Meeting the Mental Health Needs of Young New Zealanders" (Office of the Auditor-General, February 2024); Russell Bishop *Kaupapa Māori: An Indigenous Approach to Creating Knowledge* (Paper presented to Māori and Psychology: Research and Practice, Hamilton, 26 August 1999).

119 See generally Smith, above n 104; Renee Louis "Can You Hear Us Now? Voices from the Margin: Using Indigenous Methodologies in Geographic Research" (2007) 45 Geographical Research 130.

120 See generally Vanessa Simonds, and Suzanne Christopher "Adapting Western Research Methods to Indigenous Ways of Knowing" (2013) 103 American Journal of Public Health 2185.

121 See generally Simonds and Christopher, above n 104, at 2185.

122 At 2185.

123 Simonds and Christopher, above n 104, at 2185; see also generally Smith, above n 119, at 20-35.

124 Simonds, and Christopher, above n 104, at 2185; see also generally Smith, above n 123.

appropriate from an Indigenous point of view.[125] In this regard Indigenous methodologies represent a framework of guiding principles and beliefs crafted by native communities. These methodologies stem from and reflect their unique perspectives on existence and their distinctive cultural practices. They are a response to, and expression of, Indigenous peoples' particular ways of understanding the world and conducting their lives.[126] Indigenous methodologies defy a singular definition, but researchers have identified several recurring themes. These include the importance of cultivating respectful, reciprocal relationships, adopting a holistic approach that incorporates spiritual elements, and grounding the research within a specific temporal and spatial context.[127]

In New Zealand, Indigenous methodologies are known as 'Kaupapa Māori'. The term "Kaupapa" encompasses concepts of foundation, plan, philosophy, and strategies. Consequently, Kaupapa Māori represents a distinctly Māori perspective on these elements. It encompasses Māori philosophies, worldviews, and operational approaches, reflecting the fundamental beliefs and values that underpin Māori culture and understanding of the world.[128] As Smith states, Kaupapa Māori approach to research is "for, by and with Māori".[129] Kaupapa Māori epistemology confronts the established power structures and the prevalence of conventional individualistic research methodologies. As a result, Kaupapa Māori represents a self-determined approach to research that prioritises Māori aspirations and desires within Māori cultural framework.[130] Kaupapa Māori is

[125] Louis, above n 119.

[126] The University of Sydney "Indigenous Methodologies" The University of Sydney < https://music-hdr-Indigenous-methods.sydney.edu.au/?page_id=340>; see also Rigney Lester-Irabinna "Internationalization of An Indigenous Anticolonial Cultural Critique of Research Methodologies: A Guide to Indigenist Research Methodology and Its Principles" (1999) 14 Wicazo Sa Review 109 at 109-121; Bernard Huber "Negotiating the Political Ecology of Aboriginal Resources Management: How Mi'kmaq Manage Their Moose and Lobster Harvest in Unama'ki, Nova Scotia, Canada" (Master of Science in Geography Dissertation, University of Wellington, 2009); Smith, above n 119.

[127] Mackintosh, above n 112, at 36; Louis, above 119; Huber, above n 126; Deborah Williams and Gerhard Shipley "Indigenous Research Methodologies: Challenges and Opportunities for Broader Recognition and Acceptance" (2023) 11 Open Journal of Social Sciences 467.

[128] Leonie Pihama "Kaupapa Māori Theory: Transforming Theory in Aotearoa" in Leonie Pihama, Sarah-Jane Tiakiwai and Kim Southey (eds) *Kaupapa Rangahau: A Reader* (Te Kotahi Research Institute, Hamilton, 2015) at 5-6.

[129] Smith, above n 123, at 193.

[130] Alayne Mikahere-Hall "Constructing Research from An Indigenous Kaupapa Māori Perspective: An Example of Decolonizing Research" (2017) 15 Psychother Politics Int 1428.

characterised by its communal philosophy and methodology.[131] This methodology challenges the dominance of the Pākehā viewpoint in scholarly research and aims to address inequality within Aotearoa.[132] According to Smith, "[t]ransforming the mode and the institution is not sufficient. It is the political context of unequal power relations that must be challenged and changed".[133] Kaupapa Māori presents a direct challenge to the traditional Western approach to research, questioning the fundamental concepts, methodologies, and validation processes employed by academic institutions rooted in Western thought.[134]

Proponents of Kaupapa Māori emphasise the importance of Māori ownership and control in this research approach.[135] There is a perspective that research involving Māori should be conducted only by Māori.[136] This viewpoint further implies that non-Māori researchers should avoid conducting studies involving Māori communities. Alternative perspectives exist on this matter, however.[137] The challenges associated with non-Māori conducting research involving Māori communities have been discussed by scholars. For example, Spoonley has highlighted the challenges inherent in cross-cultural research, particularly

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131 Catherine Savage, Sonja Macfarlane, Angus Macfarlane, Letitia Fickel and Hēmi Te Hēmi "Huakina Mai: A Kaupapa Māori Approach to Relationship and Behaviour Support" (2014) 43 The Australian Journal of Indigenous Education 165.

132 Bishop "Kaupapa Māori: An Indigenous approach to creating knowledge" (Paper presented to Māori and Psychology: Research and Practice, Hamilton, 26 August 1999); see also Mackintosh, above n 112, at 35.

133 Mackintosh, above n 112, at 36; see also Graham Hingangaroa Smith "The Development of Kaupapa Māori: Theory and Praxis" (PhD in Philosophy Thesis, University of Auckland,2000) at 273.

134 Mackintosh, above n 112, at 36; Anaru Eketone "Theoretical underpinnings of Kaupapa Māori directed practice" (2008) 1 Mai Review 11.

135 Alison Jones "Dangerous liaisons: Pākehā, Kaupapa Māori, and Educational Research" (2012) 47 New Zealand Journal of Educational Studies 100 at 101; See also Linda Tuhiwai Rina Mead "Ngā Aho O Te Kākahu Mātauranga: The Multiple Layers of Struggle by Maori in Education" (Doctoral Thesis, Univeristy of Auckland, 1996); Fiona Cram "Rangahau Māori: Tona Tika, Tona Pono- The Validity and Integrity of Māori Research" in Martin Tolich (ed) *Research Ethics in Aotearoa New Zealand (*Parson Education New Zealand Limited, Auckland, 2001); Huia Jahnke and Julia Taiapa "Māori Research" in Carl Davidson and Martin Tolich (eds) *Social Science Research in New Zealand: Many Pathways to Understanding* (Pearson Education New Zealand Limited, Auckland, 1999).

136 Cram, above n 103, at 234-249; Jahnke and Taiapa, above n 135; Mere Roberts, Waerete Norman, Nganeko Minhinnick, Del Wihongi and Carmen Kirkwood "Kaitiakitanga: Māori Perspectives on Conservation" (1995) 2 Pacific Conservation Biology at 8; see also Carpenter and McMurchy-Pilkington, above n 103, at 188; Mackintosh, above n 112, at 36; Bowing, above n 114, at 30.

137 Mackintosh, above 112, at 37; see also Jay Johnson, Garth Cant, Richard Howitt and Evelyn Peters "Creating Anti-colonial Geographies: Embracing Indigenous Peoples' Knowledges and Rights" (2007) 45 Geographical Research 117 at 117-120; Karma Benner "Pakeha Research with Māori: Exploring the Experiences of Pakeha Researchers in Social Science Research Projects with Māori" (Masters in Social Science Thesis, University of Wellington, 2002).

due to its tendency to be driven by specific epistemological perspectives that can have significant implications for the communities being studied.[138] These dominant understandings of knowledge often shape the research process and outcomes, potentially leading to misrepresentations or oversimplifications of complex cultural dynamics. Such approaches may inadvertently perpetuate power imbalances and fail to adequately capture the nuanced realities of the communities involved, emphasising the need for more reflexive and culturally sensitive research methodologies.[139] Bishop emphasises that all researchers should critically examine their position on Māori self-determination and challenge methodologies that blame Māori for their marginalisation. Instead, researchers should adopt approaches that promote self-determination and power-sharing for Māori people.[140]

Smith's Kaupapa Māori methodologies offer valuable principles for conducting research amongst Māori families and communities. They are:[141]

- Aroha ki te tangata (a respect for people).
- Kanohi kitea (present yourself to people face to face).
- Titiro, whakarongo…korero (look, listen…speak).
- Manaaki ki te tangata (be generous).
- Kia tupato kaua e takahia te mana o te tangata (do not trample over the mana of people).
- Kaua e mahaki (do not flaunt your knowledge).

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138 Paul Spoonley, "'The Challenge of Cross-Cultural Research', in Carl Davidson and Martin Tolich (eds) *Social Science Research in New Zealand. Many Paths to Understanding* (Longman, Auckland, 1999); See also Carpenter and McMurchy-Pilkington, above n 103, at 183-187.

139 Similar comments are made by Cram and Lyons, above n 105.

140 Alan Bishop "Collaborative Research Stories: Whakawhanaungatanga" (PhD in Philosophy thesis, University of Otago, 1995) at 33.

141 Linda Tuhiwai Smith "On Tricky Ground: Researching the Native in the Age of Uncertainty" in Norman Denzin and Yvonna Lincoln (eds) *The Sage Handbook of Qualitative Research* (3rd ed, Sage Publications, California, 2005) at 98.

The examples mentioned above illustrate manaakitanga, a concept Mead describes as "nurturing relationships, looking after people, and being careful how others are treated".[142] Smith suggests that these principles serve as valuable guidelines for research and are also Māori practices that contribute to the effective functioning of tribal activities. Interpersonal relationships characterised by mutual respect and understanding are essential in this context.[143] With these principles in mind, the researcher should position themselves as a learner, open to listening and learning from the shared knowledge. Those who contribute to the research should be viewed not as participants but as true carriers of knowledge. These contributors are those with knowledge and wisdom.[144]

With these Kaupapa Māori values in mind, particularly manaakitanga and the emphasis on nurturing relationships, the researcher embarked on the study. These principles served as a guiding framework, informing the approach to participant interactions, data collection, and interpretation. By prioritising mutual respect, understanding, and careful treatment of all involved, the research process aimed to align with Māori cultural practices and contribute positively to the community.

The research process was designed to create a reciprocal relationship between the researcher and participants, reflecting the importance of collective knowledge and shared experiences in Māori culture. The researcher expresses profound gratitude for the time, knowledge, and dedication contributed by all participants. Every effort was made to conduct the research ethically and in strict adherence to Kaupapa Māori principles. The valuable prior work of both Māori and non-Māori scholars is acknowledged with respect, as their contributions have been instrumental in shaping this research. Additionally, the researcher recognises the crucial role of available scholarships in facilitating this study,

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[142] Woller, above n 103, at 294; Hirini Moko Mead *Tikanga Māori: Living by Māori Values* (Huia Publishers, Wellington, 2003) at 6.

[143] Linda Tuhiwai Smith "Nga Aho o te Kakahu Matauranga: The Multiple Layers of Struggle by Māori in Education" (Ph.D. Thesis, University of Auckland, 1996); Smith, above n 119; Woller, above n 103, at 294-295; Leonie Pihama "Kaupapa Māori Theory: Transforming Theory in Aotearoa" in Leonie Pihama, Sarah Jane Tiakiwai and Kim Southey (eds) *Kaupapa Rangahau: A Reader* (Te Kotahi Research Institute, Hamilton, 2015).

[144] Adopted from Mackintosh, above n 112, at 43.

expressing appreciation for these resources and their significant impact on the research's execution.[145]

Associate Professor Joseph advised the researcher to consistently ponder two key questions: what is the ultimate objective of your work, and how does your research topic align with that goal?[146] The researcher's aim is to contribute to the existing literature in this field through a novel perspective - specifically, a Māori-led approach in the domain of mental health for tamariki and rangatahi Māori. The researcher aspires to maintain ongoing work in this area to ultimately achieve positive changes in addressing the mental health crisis. It is hoped this study serves as a platform to amplify the voices of tamariki and rangatahi Māori, foster new relationships with potential long-term advantages and open up discourse and communication amongst many to move towards achieving the highest attainable standard of mental health for tamariki and rangatahi Māori.[147]

1.10. Doctrinal Research: Comprehensive Analysis of Legal Texts

The remaining data for this thesis has been gathered by examining international human rights legislation, legal principles, and national laws to reassess the best interests principle and its application to the right to health for tamariki and rangatahi Māori. In other words, doctrinal research has been conducted. As Hutchinson says, "doctrinal research lies at the heart of any lawyer's task because it is the research process used to identify, analyse and synthesise the context of the law".[148] This research aims to enhance mental health outcomes by examining how the flexibility of the best interests of the child principle can incorporate the collective cultural rights of Indigenous children. The study will mainly draw data from international law, utilising both primary sources (domestic legislation, jurisprudence, and international conventions) and secondary sources (scholarly articles and texts). The research incorporates Indigenous scholars' contributions and examines

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[145] See generally Mackintosh, above n 112; Bowing, above n 114; Graham Hingangaroa Smith "Protecting and Respecting Indigenous Knowledge" in Marie Battiste (ed) *Reclaiming Indigenous Voice and Vision* (UBC Press, Vancouver, 2000); Graham Hingangaroa Smith "Kaupapa Māori Theory: Theorizing Indigenous Transformation of Education and Schooling" (Paper presented to Kaupapa Māori Symposium NZARE/AARE Joint Conference, Auckland, 2003).

[146] Bishop, above n 140, at 87.

[147] Adopted from Mackintosh, above n 112.

[148] Terry Hutchinson "Doctrinal Research" in Dawn Watkins and Mandy Burton (eds) *Research Methods in Law* (2nd ed, Routledge, London, 2018) at 13.

all sources through an Indigenous lens in accordance with the values detailed above, challenging Western-centric interpretations and seeking to decolonise legal and health concepts. Where possible, Western ideologies that challenge Indigenous concepts have been examined.

The following section reviews some of the prominent work which specifically focuses on the area of mental health for tamariki and rangatahi Māori in New Zealand. As already discussed, the legal instruments in this area are largely international. The bulk of the New Zealand material which goes beyond raw statistical data is in secondary resources such as texts and reports. The first part of this literature review examines existing New Zealand material and the second part explores the key work done internationally in relation to the best interests principle and the right to mental health.[149]

1.10.1. New Zealand Statistics

Until the 2000s, much of the information that was provided about Māori mental health was part of routinely collected health data. Additional research or reports were limited. Some of the early reports that attempted to highlight the growing problem in mental health for Māori were *Hauora: Māori Standards of Health III*[150] and two reports completed by Te Puni Kōkiri (Ministry for Māori Development), which highlighted the increasing rate of hospitalisation in Māori particularly for psychotic illness.[151] A key document that changed the landscape for mental health for Māori was the *Te Rau Hinengaro, Mental Health*

[149] The literature review serves to provide insight into current discussions and investigations within a field. It enhances one's comprehension of the subject matter and illuminates how researchers communicate their findings. See generally Western Sydney University "Literature Review Purpose" (2024) Western Sydney Edu <https://www.westernsydney.edu.au/__data/assets/pdf_file/0006/1254786/Literature_review_purpose.pdf>.

[150] Eru Pomare, Vera Keefe-Ormsby, Clint Ormsby, Neil Pearce, Paparangi Reid, Bridget Robson and Naina Watene-Haydon *Hauora: Māori Standards of health III: A Study of the Years 1970-1991* (Eru Pomare Māori Health Research Centre 1995); see also Ministry of Māori Department *Ngā ia o te Oranga Hinengaro Māori. Trends in Māori Mental Health* (1993).

[151] Te Puni Kōkiri *Ngā Ia o Te Oranga Hinengaro Māori: Trends in Māori Mental Health 1984–1993* (Report, Te Puni Kōkiri, Wellington, 1996); Te Puni Kōkiri *Ngā Ia o Te Oranga Hinengaro Māori: Trends in Māori Mental Health – A Discussion Document* (Report, Te Puni Kōkiri, Wellington, 1993); Baxter, above n 28; see also Joanne Baxter "Mental Health: Psychiatric Disorder and Suicide" (2000) 2005 Hauora: Maori Standards of Health IV. A Study of the Years 121.

Survey conducted in 2003-2004.[152] The survey has been labelled as the "first survey to measure the prevalence of mental disorders within the Māori population".[153] The survey found that mental health disorders were common for Māori and contact with relevant health services was far from adequate. It highlighted that Māori were more likely to suffer from mental health illnesses than non-Māori.[154]

While these statistics were coming to light, they did not specifically focus on Māori children or youth until much later when the *Child and Youth Mortality Database* revealed the alarming suicide rates for Māori youth as being twice as much those for non-Māori youth.[155] Since that time, some further research has been completed, albeit not on a large scale. Two primary research series provide statistical information: *Te Ohonga Ake and Youth2000* surveys, respectively. These studies examine national trends based on ethnic groups (Māori, Pacific, and non-Māori/non-Pacific) and offer valuable statistical insights. In particular, the Youth2000 survey series collects statistics specifically related to youth health. Several reports have been published, with the latest revealing concerning statistics about the mental health of Māori youth, both female and male, in comparison to non-Māori. Regrettably, there remains a scarcity of community-based research focusing on tamariki and rangatahi Māori.[156] As stated above, a report by the Auditor and Controller General has highlighted a significant issue: the absence of current and comprehensive data on mental health conditions, especially among children and adolescents. This lack of data has been identified as a concern, as it hinders agencies from making well-informed decisions. The report emphasises the need for improved data collection and analysis in this area.[157]

In the context of this thesis, the existing statistical data shows the concerning mental health outcomes and challenges faced by tamariki and rangatahi Māori. This information

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[152] Joanne Baxter, Te Kani Kingi, Rees Tapsell, Mason Durie, Magnus A. McGee "Prevalence of Mental Disorders Among Māori in Te Rau Hinengaro: The New Zealand Mental Health Survey" (2006) 40 Australian and New Zealand Journal of Psychiatry 914 at 914-923.

[153] Joanne Baxter "Mental Health: Psychiatric Disorder"(2007) Otago University <https://www.otago.ac.nz/wellington/otago067746.pdf at 123> at 135.

[154] At 135-136.

[155] At 135-136.

[156] Ministry of Health *Te Ohonga Ake: The Health Status of Māori Children and Young People in New Zealand* (2017) at 99; see also Fleming, Tiatia-Seath, Peiris-John, Sutcliffe, Archer, Bavin, Crengle, Clark and Youth19 Research Group, above n 22.

[157] Controller and Auditor- General, above n 19, at 15-17.

emphasises the pressing need for research in this area and the importance of identifying strategies to enhance the current circumstances for tamariki and rangatahi Māori.

In the available scholarship (which is still quite scarce), a strong theme is the link between cultural identity and mental health. There are scholarly works which examine the disparities in mental health outcomes for Māori and non-Māori youth, explore the reasons for these disparities and propose strategies for combating them. Most of the work that exists stems from psychology literature completed by health professionals. For example, recently, Williams, Clark and Lewycka from the School of Nursing at the University of Auckland conducted research to "explore the relationship between Māori cultural identity, ethnic discrimination and mental health outcomes for Māori youth in New Zealand".[158] They concluded that ethnic discrimination "has a serious negative impact on Māori youth mental health".[159] Positive cultural identity resulted in better mental health outcomes.[160] Other authors such as Brougham have also concluded that increased cultural identity would lead to better mental health outcomes.[161] A similar conclusion was reached by Coupe in 2005 in a thesis which specifically addressed Māori suicide prevention. Coupe found that "secure Māori identity, healthy connections to social groups and a sense of belonging"[162] could prevent suicide. In another study that looks at identity and mental health, Hamley and Le Grice discuss the effects of colonisation on mental health in Māori male youth and how the current mental health structures in place are largely designed

[158] Ashlea Williams, Terryann Clark and Sonia Lewcyka "The Associations between Cultural Identity and Mental Health Outcomes for Indigenous Māori Youth in New Zealand" (2018) 6 Frontiers in Public Health 319.

[159] At 319.

[160] Williams, Clark and Lewcyka, above n 164.

[161] David Brougham and Jarrod Harr "Collectivism, Cultural Identity and Employee Mental Health: A Study of New Zealand Māori" (2013) 114 Social Indicators Research 3 at 60.

[162] Nicole Coupe "Whakamomori; Māori Suicide Prevention" (PhD, Massey University, 2005); see also Lisa Arleen Ferguson *'Health Reform and the Impact on Māori 1983–1997'* (PhD Thesis, University of Waikato, 2002); Tahlia Erana Te Ao Mihi Kingi *'Ko ngā pūtake o te mātānawe ki tā te rangatahi: An Exploration of Self-Injury in Rangatahi Māori'* (PhD thesis, Victoria University of Wellington, 2018).

from Western therapies and such "approaches are ill-equipped to address the intergenerational and structural issues at the root of mental health disparities".[163]

Similar findings have been made by the Waitangi Tribunal in the recently published report, *Wai 2575 Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry.*[164] Liu from Massey University has also written extensively about historical trajectories and Māori mental health.[165] It is also worthy to note that *Te Atawhai o Te Ao* (Independent Māori Institute for Environment & Health) is conducting various research projects, including Māori experiences of institutional racism.[166] This thesis does not extensively explore the underlying causes of the disparities, acknowledging previous research in this field. The existing studies and prevalent statistics clearly demonstrate a significant issue regarding mental health outcomes, with tamariki and rangatahi Māori being particularly affected. In particular, these studies highlight the importance of cultural identity for mental health. This research centres on utilising cultural identity to improve mental health outcomes for tamariki and rangatahi Māori. The thesis argues that this objective can be realised by utilising the best interests of the child principle, which is adaptable enough to incorporate the collective cultural rights of tamariki and rangatahi Māori. This principle can then serve as a foundation for attaining the highest possible standard of mental health.

1.10.2. The Best interests principle

New Zealand's legal framework for children's welfare emphasises the centrality of the best interests principle, particularly in care, protection, and custody cases. This principle is enshrined in the Care of Children Act 2004 and the Oranga Tamariki Act 1989, which

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[163] Logan Hamley and Jade Le Grice "He Kakano Ahau- Identity, Indigeneity and Wellbeing for Young Māori (Indigenous) Men in Aotearoa/New Zealand" (2021)31(1) Sage Journals 62 at 62-80; Keri Lawson Te Aho *'Whāia Te Mauriora, In Pursuit Of Feeling: Theorising Connections Between Soul Healing, Tribal Self-determination And Māori Suicide Prevention In Aotearoa/New Zealand'* (PhD Thesis, University of Wellington, 2013); Casey Alexandra Mendiola *'He koha aroha ki te whānau: Deliberate Self-harm and Māori Whānau'* (PhD Thesis, University of Auckland, 2011).

[164] Timothy Gassin Waitangi Tribunal *A Report Commissioned by the Waitangi Tribunal for the Wai 2575 Health Services Outcomes Kaupapa Inquiry* (Wai 2575, B26, August 2019).

[165] Simon Bennett and James Liu "Historical Trajectories for Reclaiming an Indigenous Identity in Mental Health Interventions for Aotearoa/New Zealand-Māori Values, Biculturalism and Multiculturalism" (2018) 62 International Journal of Intercultural Relations 93 at 93-102.

[166] Te Atawhai o Te Ao *Whakatika* "He Kokonga Ngakau: Māori Ways of Healing, Recovery and Well-being Research Programme" (2017) Te Atawhai o Te Ao < https://teatawhai.maori.nz/research-projects/he-kokonga-ngakau-maori-ways-of-healing-rcovery-and-well-being-research-programme/>.

prioritise familial relationships, cultural rights, and holistic well-being in determining a child's best interests. Case law demonstrates the courts' flexible interpretation of this principle. For instance, *Kacem v Bashir* illustrates how factors like family dynamics and environmental stability are considered in determining a child's best interests.[167] While these laws do not directly address mental health, they demonstrate the incorporation of the best interests principle into New Zealand's legal and policy framework. The courts have broadly interpreted the principle to implicitly incorporate children's psychological and emotional well-being.

Courts consistently consider each child's unique circumstances when applying this principle. Child safety, encompassing both physical and psychological well-being, is paramount in these considerations, as evidenced in *Lowe v Way* and *Henderson v Henderson.*[168] In cases such as *Re WH* and *Atkinson v Ministry of Social Development*,[169] courts have shown consideration for both immediate and long-term impacts on a child's development. These cases also highlight the significance of psychological attachment and stability as key factors in determining best interests. While biological ties are considered important, they are not determinative in best interest considerations, as illustrated in *B v Department of Social Welfare.*[170] This approach allows for a more comprehensive assessment of a child's needs and circumstances.

Although not always explicitly framed as mental health considerations, courts implicitly consider psychological well-being, emotional needs, and long-term developmental impacts when applying the best interests principle. This suggests potential for more direct application to mental health contexts for tamariki and rangatahi Māori as will be discussed in Chapter Three.

For tamariki and rangatahi Māori, the courts recognise collective cultural rights, emphasising familial responsibilities, whakapapa, whanaungatanga, and the role of whānau, hapū, and iwi. Cases such as *McHugh v McHugh* and *Chief Executive of Oranga Tamariki v A*R highlight this approach, suggesting potential for extending the best

[167] *Kacem v Bashir* [2010] NZSC 112.
[168] *Lowe v Way* [2015] NZHC 93; *Henderson v Henderson* [2019] NZFC 9936.
[169] *Re WH* [2021] NZFC 4090; *Atkinson v Ministry of Social Development* HC Auckland CIV-2008-404-6888, 9 April 2009.
[170] *B v Department of Social Welfare* [1998] 16 FRNZ 522 (CA).

interests principle to mental health contexts for tamariki and rangatahi Māori.[171] The application of the best interests principle in New Zealand courts, particularly in determining a child's well-being, supports the argument for its potential use in mental health contexts. Additionally, guardianship cases related to medical procedures provide insight into how courts have applied the best interests principle in health-related matters.[172]

Tobin discusses how the best interests principle is applied in case law and what should be considered by the judiciary.[173] In a detailed analysis of the best interests principle, Zermatten argues for a more holistic interpretation of it.[174] Detrick's commentary offers insight into how the courts interpret the best interest principle, especially international courts.[175] These are useful sources for examining the flexibility of the best interests principle, in particular for Indigenous communities/children. In addition, the CRC Committee issued General Comment No. 14 which identifies the best interests principle as being a substantive right; a legal principle and a rule of procedure,[176] thus demonstrating its flexibility and multiple usage.

1.10.3. New Zealand Law and Policy

Another focus in the existing literature is on mental health policy and legislation and its evolution in New Zealand. For example, Gassin prepared a report for the Waitangi Tribunal Health Inquiry,[177] in which he highlighted substantial deficiencies in New Zealand's mental health systems for Māori, as well as obstacles hindering access to good healthcare services. O'Brien and Kydd have examined the transition from institutional care to community-based treatment, highlighting key legislative milestones

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171 *McHugh v McHugh* [2022] NZHC 1174; *Chief Executive of Oranga Tamariki v AR* [2020] NZFC 4046.

172 *Auckland District Health Board v Z* (2007) 26 FRNZ 596; R*e J (An Infant): B and B v Director-General of Social Welfare* [1996] 2 NZLR 134 (CA).

173 John Tobin "Judging the Judges: Are They Adopting the Rights Approach in Matters Involving Children?" (2009) 33(2) Melbourne University Law Review 579 at 579-62.

174 Jean Zermatten "The Best Interests of the Child Principle: Literal Analysis and Function" (2010) 18(4) International Journal of Children's Rights 483 at 484-499.

175 Sharon Detrick A Commentary on the United Nations Convention on the Rights of the Child (Martinus Nijhoff Publishers, Boston, 1999).

176 *General Comment No. 14,* above n 32, at [6].

177 Timothy Gassin *A Report Commissioned by the Waitangi Tribunal for the Wai2575 Health Services Outcomes Kaupapa Inquiry* (Waitangi Tribunal, Wai2575#B26, August 2019 at 10-25 and 103-119.

and their implications for patient care.[178] They suggest that these changes reflect the historical importance of family and community in mental health care provision while also representing a formalisation of their role in patient treatment. This perspective underscores the complex interplay between legislative changes, community involvement, and family roles in mental health care.[179]

In an historical overview of Māori mental health care in New Zealand, there are some important trends to highlight.[180] In the early 1900s, Māori were underrepresented in mental health institutions, most likely due to cultural factors and unfamiliarity with Western psychiatric treatment.[181] From the 1960s onward, there was a significant increase in Māori admissions to mental health facilities, possibly linked to urbanisation and societal changes.[182] The 1980s-1990s saw a shift towards deinstitutionalisation and community-based care, which had both positive and negative impacts on Māori mental health services. This period also marked the beginning of government initiatives to develop culturally appropriate services for Māori, including the establishment of Kaupapa Māori mental health units in some hospitals.[183] Kingi's work highlights that the 1990s-2000s emphasised greater Māori participation in mental health policy development and service provision.[184]

The literature on New Zealand's mental health legislation reveals a complex interplay between institutional and community-based approaches, reflecting the evolving landscape

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178 Anthony O'Brien and Robert Kydd "Compulsory Community Care in New Zealand Mental Health Legislation 1846-1992" (2013) 3 SAGE Open 1.

179 O'Brien and Kydd, above n 184, at 1.

180 Te Kani Kingi "Introduction" in Te Kani Kingi, Mason Durie, Hinemoa Elder, Rees Tapsell, Mark Lawrence and Simon Bennett (ed) *Maea Te Toi Ora: Māori Health Transformations* (Huia Publishers, Wellington, 2018; Amohia Frances Boulton "Provision at the Interface: The Māori Mental Health Contracting Experience" (PhD Thesis, Massey University, 2005); Gassin, above n 183; Helen Robinson, 'Te Taha Tinana: Māori Health and the Crown in the Te Rohe Pōtae Inquiry District, 1940- 1990', (Waitangi Tribunal, 2011), Wai 898 A31; O'Brien and Kydd, above n 184; Marie Primrose, 'Society and the Insane: A Study of Mental Illness in New Zealand, 1867-1926 With Special Reference to the Auckland Mental Hospital' (MA Thesis, University of Auckland, 1968).

181 Derek Dow *Maori Health and Government Policy 1840-1940* (Victoria University Press, 1999) at 13.

182 Mason Durie and Te Kani Kingi *A Framework for Measuring Māori Mental Health Outcomes* (Massey University, Research Report TPH97/5, December 1997); Robinson, above n 186.

183 Boulton, above n 186; Kingi, above n 186; Warwick Brunton and Peter McGeorge "Grafting and Crafting New Zealand's Mental Health Policy" in Harry Minas and Milton Lewis (eds) *Mental Health in Asia and the Pacific: Historical and Cultural Perspectives* (Springer, New York, 2017).

184 Te Kani Kingi "Mental Health Services for Maori" in Te Kani Kingi, Mason Durie, Hinemoa Elder, Rees Tapsell, Mark Lawrence and Simon Bennett (eds) *Maea Te Toi Ora: Māori Health Transformations* (Huia Publishers, Wellington, 2018).

of mental health care delivery. Scholars have examined the shifting roles of medical professionals, families, and the broader community in this context. Historical analyses have documented a gradual shift towards incorporating family involvement in decision-making processes and promoting community integration.

The evolution of New Zealand's mental health legislation and policies has been characterised by significant developments aimed at addressing inequities and improving outcomes for Māori. The Mental Health (Compulsory Assessment and Treatment) Act 1992, a cornerstone of psychiatric assessment and treatment, has been subject to scrutiny regarding its effectiveness in supporting improved mental health outcomes, particularly for Māori. The *He Ara Oranga* Report emphasised the necessity for reform in the Mental Health Act.[185] Additionally, the discussion paper "*Transforming our mental health law*" provided valuable insights into potential legislative changes.[186] A number of key strategies (discussed in further detail in Chapter Seven) were formulated to address the overrepresentation of Māori in mental health statistics and promote culturally appropriate care.[187] The Waitangi Tribunal Report Wai 2575 underscored the importance of incorporating Te Tiriti o Waitangi principles and Māori worldviews into healthcare delivery.[188] Another significant investigation into Māori mental health is the Mason Inquiries (discussed in Chapter Seven). These inquiries were designed to enhance Māori participation in mental health development and promote culturally appropriate treatment. These reports are valuable for examining the government's past efforts to address this issue and for presenting recommendations to improve the current situation.[189]

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[185] Ron Paterson, Mason Durie, Barbara Disley, Dean Rangihuna, Jemaima Tiataia-Seath and Josiah Tualamali'I *He Ara Oranga Report of the Government Inquiry into Mental Health Addiction* (Government Inquiry into Mental Health and Addiction, Report, November 2018).

[186] Ministry of Health *Transforming our Mental Health Law: A Public Discussion Document* (2021).

[187] Ministry of Health *Looking Forward: Strategic Directions for the Mental Health Services* (1994); Ministry of Health *Moving Forward: The National Mental Health Plan for More and Better Services* (1997); Ministry of Health *Te Puawaitanga: Maori Mental Health National Strategy* (2002).

[188] Waitangi Tribunal *Hauora Report on Stage One of the Health Service and Outcomes Kaupap Inquiry* (Wai 2575, 2019).

[189] Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on leave of certain classes of Patients *Report of the Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on leave of certain classes of Patients* (Wellington: The Committee, 1988); Ministry of Health *Inquiry Under Section 46 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services'* (Ministry of Health, 1996) at 140.

In response to these findings, legislative actions have been taken. The Pae Ora Act aims to address health inequities by incorporating Te Tiriti o Waitangi principles and establishing new health entities to enhance Māori participation in the health system. This Act represents a significant step towards aligning healthcare policies with Māori cultural values and needs.[190] These initiatives demonstrate a concerted effort to create a comprehensive framework for addressing mental health issues, particularly for Māori. The Mental Health Act is also under review currently. These are in general the two main pieces of mental health law in New Zealand and are discussed extensively in Chapter Seven.

Despite these legislative and policy efforts, statistical evidence suggests that health disparities for tamariki and rangatahi Māori persist, especially in mental health. The literature suggests that while progress has been made in recognising the unique needs of Māori in mental health legislation and policy, there is still a considerable way to go in achieving equitable health outcomes.

1.10.4. Collective Cultural Rights : International and National

The scholarship on collective rights theory is extensive and crucial to understanding collective cultural rights. This body of work challenges Western individualist notions and emphasises the importance of examining these theories. Internationally, prominent theorists in this field include Kymlicka, Van Dyke, and Raz.[191] Their work emphasises the significance of cultural context and argues that focusing solely on individual autonomy fails to acknowledge the complex relationship between individual identity and cultural background. Kymlicka and Raz's views on group rights highlight the need to balance individual freedoms with the collective interests of cultural communities. They suggest that recognising collective rights can help safeguard the unique cultural practices,

[190] See generally Minister of Health *New Zealand Health Strategy: Roadmap of Actions 2016* (2016). It is now the Ministry of Health *New Zealand Health Strategy* (2023); Ministry of Health *He Korowai Oranga – Māori Health Strategy* (2014); Ministry of Health *Child and Youth Wellbeing Strategy* (2020). This has been updated recently to Ministry of Health *Child and Youth Wellbeing Strategy 2024-2027* (2024).

[191] Will Kymlicka Contemporary Political Philosophy (Oxford, Oxford University Press, 2002); Joseph Raz *The Morality of Freedom* (Oxford University Press, Oxford, 1986); Vernon Van Dyke "Collective Entities and Moral Rights: Problems in Liberal Democratic Thought" in Judith Stapleton (eds) *Group Rights: Perspectives Since 1900* (Routledge, London, 1995) 57.

languages, and traditions of minority groups, which may be at risk in societies that prioritise individual rights alone.[192]

Justice Durie and other scholars including Toki, Jackson and Charters have explored Māori collective rights within New Zealand's legal and constitutional framework, emphasising several key points.[193] They stress the importance of recognising Māori collective rights alongside individual rights in the legal system, with the Treaty of Waitangi serving as a foundational document which established the basis for these rights.[194] The discourse also addresses Māori collective rights in relation to land, water, and other natural resources, as well as the importance of protecting and promoting Māori language, traditions, and cultural practices. These discussions aim to foster a more inclusive and culturally responsive legal system that recognises and protects Māori collective rights.

Justice Eddie Durie has contributed significantly to the discourse on group rights nationally.[195] Durie argues for a collective rights approach and the importance of the recognition of these rights for marginalised groups. Additionally, Mackintosh's dissertation explores how Māori engage with human rights, supporting the argument that Western individualist notions are inadequate for Indigenous communities.[196] Mackintosh discusses the importance of concepts such as whakapapa, tikanga, and whanaungatanga, which emphasise the interconnectedness of individuals within their communities.

The interconnectedness of individual and collective rights in Indigenous communities, particularly concerning the right to health, has been a subject of significant scholarly attention. There is scholarly work which recognises that health in Indigenous communities is more holistic and collective than in mainstream society, and academics argue that collective rights are essential to fulfil individual rights to health, especially in the era of globalisation.[197] Academics such as Mazel suggests that focusing solely on

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[192] Kymlicka, above n 197; Raz, above n 197, at 165-216.

[193] Claire Charters and Andrew Erueti (eds) *Māori Property Rights and the Foreshore and Seabed: The Last Frontier*(Victoria University Press, Wellington, 2007); Moana Jackson *The Māori and the Criminal Justice System: A New Perspective - He Whaipaanga Hou* (Department of Justice, Wellington, 1988); Valmaine Toki *Indigenous Courts, Self-Determination and Criminal Justice* (Routledge, Oxford, 2018).

[194] Charters and Erueti, above n 199.

[195] Justice Eddie Durie "Constitutionalising Maori" in Grant Huscroft & Paul Rishworth (eds) *Litigating Rights: Perspectives from Domestic and International Law* (Hart Publishing, Oxford, 2002) 241.

[196] Mackintosh, above n 112.

[197] Douglas Sanders "Collective Rights" (1991) 13 Human Rights Quarterly 368.

individual access to healthcare can neglect collective rights, potentially undermining overall health outcomes.[198] Ananya says the law has evolved to create space for collective rights within the liberal framework of individual human rights, Indigenous peoples have used human rights frameworks to advance cultural integrity and autonomy while maintaining engagement with larger social structures.[199] Scholars like Meir argue that collective and individual rights to health are interconnected and mutually supportive, rather than conflicting.[200] Nelson and Wilson have published work stating that collective rights are crucial for achieving justice and equity in healthcare for Indigenous individuals.[201] Litalien emphasises that collective self-determination rights in health matters are vital for realising the right to health among Indigenous peoples. However, balancing collective and individual rights can be challenging, as they may sometimes conflict.[202]

The significance of collective cultural rights was discussed by the Committee on Economic, Social, Cultural Rights in General Comment No. 21.[203] The Committee stated that limitations should only be placed on cultural rights where there are "negative practices that infringe upon other human rights".[204] Another useful report is that of the Secretary General on the "Status of the Convention on the Rights of the Child".[205] That report stated that Indigenous children enjoy both individual and collective rights and freedom as do their wider communities.[206]

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198 Odette Mazel "Indigenous Health and Human Rights: A reflection on law and culture" (2018) 4 Int J Environ Res Public Health 789.

199 S James Anaya *Indigenous Peoples in International Law* (Oxford University Press, Oxford, 1996).

200 Benjamin Meir "The highest attainable standard: advancing a collective human right to public health" (2005) 37 Columbia Human Rights Law Review 100.

201 Sarah Nelson and Kathi Wilson "Rights and health Versus Rights To Health: Bringing Indigenous Peoples' Legal Rights into the Spaces of Health Care Services" (2021) 85 Political Geography 1.

202 Éliot Litalien "Understanding the right to health in the context of collective rights to self-determination"(2021) 8 Bioethics 725.

203 *General Comment No. 21 Right of Everyone to Take Part in Cultural Life (Article 15, Paragraph 1(a), of the International Covenant on Economic, Social and Cultural Rights)*, UN Doc E/C.12/GC/21 (2009) at [35].

204 At [35].

205 *Secretary-General Status of the Convention on the Rights of the Child* UN Doc A/74/231 (2019), at [53].

206 *Secretary General Status of the Convention on the Rights of the Child* UN Doc A/67/225 (2012), at [11].

1.10.5. Māori Health Models

In the context of health, there is research by New Zealand Indigenous researchers who have drawn attention specifically to the intergenerational trauma Indigenous communities have suffered and the impact this has on health outcomes, and argue that solutions cannot be found in Western psychiatry. In his book *Whaiora: Māori Health Development,* Durie discusses the Māori well-being model and explains how it is starkly different to the Western view. This book is valuable for discussing collective rights and how these can be implemented into New Zealand's mental health framework.[207] In terms of the goals of this thesis, Durie's model can inform ways of reframing the best interests principle so as to accommodate collective rights. Durie proposed Te Whare Tapa Whā health model, which is a four-sided concept (one of the earliest models of Māori Health). The four aspects are te taha wairua (spiritual) te taha hinengaro (the mind), te taha tinana (physical) and te taha whānau (extended whānau).[208] All components are deemed to be essential for an individual's health and well-being, which contrasts with Western health concepts that often prioritise physical well-being above other aspects.[209]

Furthermore, Durie elaborates on the goal of health as "promoting security of identity"[210] because for Māori, cultural identity is a critical determinant and "deculturalisation has been associated with poorer health outcomes".[211] Durie has also written extensively on how to measure Māori well-being and public health strategies for Māori.[212] These key indicators will be relevant for looking at ways in which the current situation can improve.

The principle of grounding health care in a Māori worldview is also developed by Kingi who advocates for greater cultural competence within health services.[213] In explaining

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[207] Mason Durie *Whaiora: Maori Health Development* (Oxford University Press, Oxford, 1994); Diana Kopua, Mark Kopua and Patrick Bracken "Mahi A Atua: A Māori Approach to Mental Health" (2020) 57 Transcultural Psychiatry 375 at 375-383; See generally Sarah Rosenfield "Triple jeopardy? Mental Health at the Intersection of Gender, Race, and Class" (2012) 74 Social Science and Medicine 1791 at 1791- 1801.

[208] Mason Durie "A Māori Perspective of Health" (1985) 20 Soc Sci Med 483 at 483.

[209] See generally Adele Vuki, David Gregory, Ruth Martin-Misener and Josephine Etowa "Aboriginal and Western Conceptions of Mental Health and Illnesses" (2011) 9 A Journal of Aboriginal and Indigenous Community Health 65.

[210] Mason Durie *An Indigenous Model of Health Promotion* (Massey University, 27 April 2004).

[211] At 20-25.

[212] Mason Durie "Alignment of clinical and cultural perspectives: Innovation at the interface" (Paper presented at Te Manu Ao Seminar Series, Palmerston North, 2007).

[213] Kingi, above n 186.

how the Treaty can be applied to Māori health care, Kingi argues there are two ways: through the text and through the Treaty Principles.[214] More recently, this argument has been elaborated on by King, Cormack, and Kōpua in what they term a "Tangata whenua rights-based approach to health and wellbeing", an approach which could inform the application of the best interests of Māori children in mental health contexts.[215] Their approach aligns with the Māori worldview, which emphasises collective rights and holistic well-being. The proposed framework, based on the fan-shaped harakeke plant emphasises the full realization of te ao Māori in recognising tangata whenua rights for the health and well-being of mokopuna Māori.[216]

As this review of the domestic literature indicates, there are some key works that can inform a culturally appropriate model for mental health provision for Māori, but there is a gap in the literature in relation to the specific application of these principles to mental health provision for tamariki and rangatahi Māori.

1.10.6. The Right to Health and Best Interests Principle: The UN's Perspective

This thesis primarily relies on the abovementioned General Comment No. 14, issued in 2000 by the CESCR. This document offers a thorough interpretation of the right to health as outlined in Article 12. Scholars have noted that the General Comment substantially clarifies the previously unclear aspects of the right to health, which had impeded its effective application in both legal and policy contexts.[217] Furthermore, in its General Comment No. 11 on Indigenous children and the CRC, the CRC Committee emphasises Indigenous children and their collective cultural rights. In discussing the best interests of the child, the Committee affirms that the standard is flexible and dynamic and accordingly has enormous scope to take into account cultural differences.[218] Whilst the child's individual needs remain of utmost importance, the Comment accentuates that cultural rights and community connections must also be considered in decision-making

[214] Durie and Kingi, above n 188.
[215] Paula King, Donna Cormack, Mark Kōpua "Oranga Mokopuna A Tāngata Whenua Rights-based Approach to Health and Wellbeing" (2018) 7 Mai Journal 186 at 187.
[216] At 187.
[217] Lisa Forman "Decoding the Right to Health: What Could it Offer to Global Health?" (2015) 8 Bioethica Forum 91 at 92.
[218] Macbeth, above n 62, at 61; *General Comment No. 11*, above n 41, at 19.

processes.[219] Furthermore, the Comment elucidates that this approach requires substantial consultation with Indigenous communities and, where feasible, the inclusion of Indigenous children themselves in policy formulation.[220]

The Expert Mechanism on the Rights of Indigenous Peoples (EMRIP) has made comparable observations, particularly regarding Indigenous peoples and health. This document emphasises the difficulties which Indigenous communities encounter in obtaining suitable healthcare, whilst also shedding light on the obligations of states to ensure the right to health for Indigenous peoples.[221] In 2016, the Expert Mechanism produced a report on the right to health and Indigenous peoples, emphasising children and youth. This report elaborated on the concept of cultural appropriateness in healthcare for Indigenous peoples, including children, by analysing the right to health and "reviewing legal obligations of States and others in fulfilling that right".[222] Other bodies, such as the CERD Committee, have released relevant documents, including General Recommendation XXII concerning Indigenous peoples. This document addressed the discrimination faced by Indigenous communities, with the CERD Committee noting that "in many regions of the world, Indigenous peoples have been and continue to be discriminated against and deprived of human rights and fundamental freedoms".[223]

These key documents from the United Nations bodies reflects a growing recognition of the unique challenges and considerations involved in safeguarding the rights of Indigenous communities, including children. They provide a framework for decision-makers to navigate the complex interplay between individual rights, cultural preservation, and community interests when determining the best interests of Indigenous children.

In addition to the work done by the United Nations, several prominent scholars have contributed significantly to the discourse on the right to health and mental health. Tobin's

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[219] *General Comment No. 11*, above n 41, at [30]-[33].

[220] At [80], [48], [55].

[221] *Study by the Expert Mechanism on the Rights of Indigenous People Right to Health and Indigenous Peoples with a Focus on Children and Youth*, above n 50, at [7]-[19].

[222] *Study by the Expert Mechanism on the Rights of Indigenous People Right to Health and Indigenous Peoples with a Focus on Children and Youth*, above n 50; see generally Bustreo Flavia and Curtis Doebbler "Making Health an Imperative of Foreign Policy: The Value of a Human Rights Approach" (2010) 12 Health and Human Rights 47 at 47-59.

[223] *General Recommendation No. 23 on the Rights of Indigenous Peoples S XXIII* (8 August 1997).

book chapter on international health law explores the concept of the 'highest attainable standard of health'. In his chapter, Tobin examines the meaning and definition of health, critiquing the limitations of a narrow biomedical approach.[224] Hunt and Mesquita have expanded on the elements of health discussed by the United Nations, with a particular emphasis on vulnerable individuals.[225] Their work provides valuable insights into how health rights apply to marginalised populations. Donders has focused on the cultural dimensions of the right to health, highlighting the importance of considering diverse cultural perspectives in health-related policies and practices.[226] These scholarly contributions enhance the understanding of the right to health beyond the framework established by the United Nations, offering perspectives on its definition, scope, and application especially for Indigenous communities.

The literature discussed above shows that internationally, it is recognised that the best interests principle is flexible and can incorporate the collective cultural rights of Indigenous peoples. Health is understood as a holistic concept for Indigenous peoples. This international understanding provides a strong foundation for arguing that the best interests principle can be adapted to improve mental health outcomes for tamariki and rangatahi Māori by incorporating their collective cultural rights and unique health determinants.

1.11. Thesis Structure

To address the research question and sub-questions, this thesis has a particular structure. The structure and sequence of the remaining chapters is set out in the following sections.

The second chapter examines the theoretical framework of this thesis. In this section, the researcher reflects on her position as a non-Māori conducting research about Māori

[224] John Tobin "The Meaning of the Highest Attainable Standard of Health" in John Tobin (ed) *The Right to Health in International Law* (Oxford University Press, 2011).
[225] Yvonne Donders "Exploring the Cultural Dimensions of the Right to the Highest Attainable Standard of Health" (2015) 18 PELJ 180.
[226] Paul Hunt and Judith Mesquita "Mental Disabilities and the Human Right to the Highest Attainable Standard of Health" (2006) 28 HRQ 332.

communities. The researcher situates herself within Kaupapa Māori and relationship-based theories, which serve as guiding principles for this research.

The third chapter examines the principle of best interests, tracing its historical development. It will examine the various theoretical frameworks through which the best interests principle has evolved. The theoretical framework this thesis uses is primarily relational theory given that it emphasises dependency on others and the importance of nurturing one's relationships with others.[227] Additionally, this chapter will analyse the best interests principle as it is incorporated in New Zealand's legislative framework. Case law under these Acts will also be evaluated to determine the common law understanding and interpretation of the best interests principle.

The fourth chapter examines collective cultural rights, including their international legal foundation. The latter section of this chapter explores the interpretation of health from a Māori perspective and Māori well-being frameworks will be discussed. The chapter will analyse these frameworks in relation to mental health and the well-being of tamariki and rangatahi Māori.

Chapter Five examines the discussion on the legal foundations of the right to health at both international and national levels. This section focuses particularly on the implications of the right to health for Indigenous children, outlining crucial components that countries should address to progressively fulfil this right.

Chapter Six investigates the evolution of mental health legislation and its impact on Māori mental health outcomes in New Zealand. The chapter scrutinises historical records to address the origins of the current situation.

Chapter Seven delves into New Zealand's existing mental health framework, including current policies. This chapter poses questions regarding Māori autonomy in decision-making, particularly in the design, implementation, and delivery of mental health services for tamariki and rangatahi Māori. Crucially, the chapter evaluates whether the current

[227] Ruth Zafran "Children's Rights as Relational Rights: The Case of Relocation" (2010) 18 Journal of Gender, Social Policy and The Law 163.

practices in New Zealand align with the best interests of tamariki and rangatahi Māori and comply with the right to health as stipulated by international law.

Chapter Eight makes a number of recommendations about how the best interests principle can be used to achieve the highest attainable standard of mental health for tamariki and rangatahi Māori. This section outlines areas necessitating legislative modifications and suggests specific legal reforms. It also addresses potential obstacles, such as opposition to change within the judicial system, and offers suggestions for surmounting these challenges. This analysis seeks to provide a blueprint for implementing conceptual transformation in New Zealand's legal system, which can ensure greater conformity with international obligations and reduce inconsistencies in the application of the best interests principle and the right to health for tamariki and rangatahi Māori.

Finally, Chapter Nine provides some concluding remarks, notably whether the questions posed at the beginning of this thesis have been answered and suggesting avenues for future research.

1.12. Summary

This thesis examines the best interests of the child principle and its role in facilitating improved mental health outcomes for tamariki and rangatahi Māori. The inherent flexibility of the best interests principle allows for the incorporation of collective cultural rights. Within a local context, this research posits that the adaptable nature of the best interest principle can be utilised to encompass Māori collective cultural rights, thereby addressing mental health disparities among tamariki and rangatahi Māori. This approach facilitates a "by Māori, for Māori" position integrating Māori cultural identity and collective rights into the best interests principle's implementation in New Zealand.

Chapter Two

Theoretical Framework

> *"Relationships are central to people's lives- to who we are, to the capacities we are able to develop, to what we value, what we suffer, and what we are able to enjoy."*[1]

2.1. Introduction

This chapter explores the theoretical framework underpinning this research, focusing on relational theory and collective rights as the primary theoretical framework. Relational theory "is sensitive to interpersonal ties, works to facilitate their formation, seeks to protect those that already exist, and emphasises one person's caring and dependable response to another".[2] In a nutshell, relational theory recognises the importance of nurturing relationships and community connections for an individual. Collective rights are also important. While traditional Western liberal philosophy has focused on individual rights, many Indigenous cultures, such as Māori, adopt a more collectivist perspective that emphasises group identity, relationships, and shared responsibilities. This chapter will show that the theoretical framework of relational theory and collective rights provides a suitable foundation for examining the mental health rights of tamariki and rangatahi Māori. This is because this theoretical approach aligns well with Indigenous perspectives on health and well-being, which emphasise the interconnectedness of individuals with their wider family and community and collective rights.

Key aspects of relational theory in this context include a focus on relationships, recognising individuals as part of a network of relationships, and reflecting the importance of whānau , hapū, and iwi in Māori culture. Relational theory also offers a holistic perspective that aligns with Māori views of health as a concept encompassing, inter alia, physical, mental, social, and spiritual aspects.[3] For children's rights, relational theory is

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[1] Jennifer Nedelsky *Law's Relational Theory of Self, Autonomy, and the Law* (Oxford University Press, New York, 2011) at 3.

[2] Ruth Zafran "Children's Rights as Relational Rights: The Case of Relocation" (2010) 18 Journal of Gender, Social Policy and The Law 163 at 192.

[3] Mason Durie "Transforming Mental Health Services in Aotearoa New Zealand" in Te Kani Kingi, Mason Durie, Hinemoa Elder, Rees Tapsell, Mark Lawrence and Simon Bennett (eds) *Maea Te Toi Ora: Māori Health Transformations* (Huia Publisher, Wellington, 2018).

useful as it acknowledges the crucial role of relationships and community connections in a child's well-being.

By using this theoretical framework, the research can address the collective rights of tamariki and rangatahi Māori and incorporate them into the understanding and realisation of mental health rights. By using relational theory as the theoretical framework, the research can better address the collective nature of rights for tamariki and rangatahi Māori, taking into account their relationships with whānau, hapū, and iwi. This approach provides a strong foundation for examining mental health rights in a way that respects and incorporates Māori cultural values, worldviews and perspectives.

Research has shown that children's relationships are crucial for developing their autonomy and individuality.[4] As a result, children's rights cannot be viewed through the lens of individualistic rights that often dominate human rights law. This is because perceiving a child as an individual "misses the fundamental interdependent context of a child's life".[5] An approach centred on individual autonomy and rights fails to adequately represent children's experiences and their reliance on nurturing relationships during their growth and development.[6] For children from Indigenous communities, collective rights are more relevant due to their interdependence with others.[7] Consequently, the commonly advocated individualist rights theory and autonomy are ineffective for collective groups. As mentioned in the preceding chapter, the CRC acknowledges and provides for collective rights,[8] which is further reinforced by UNDRIP.[9] The recognition of collective rights in international instruments indicates a shift away from a purely individualistic approach to recognising collective rights in international law.

With the above references and theories in mind, the next section will discuss relational theory in more detail, including some of the early proponents of it.

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[4] Pamela Laufer-Ukeles "The Relational Rights of Children" (2016) 48 Connecticut Law Review 741 at 778.
[5] At 769.
[6] At 778.
[7] At 778.
[8] United Nations Convention on the Rights of the Child 1577 UNTS 3 (opened for signature 20 November 1989, entered into force 2 September 1990), Articles 30, 29(1)(c), 8, 12, 31.
[9] United Nations Declaration on the Rights of Indigenous Peoples GA Res 61/295, A/Res/61/295 (2007).

2.2. Relational Theory – What is it?

The foundation of relational theory rests on the notion that human beings are inherently relational in nature.[10] This theoretical perspective has been employed across various fields, which share the principle that the subject under examination should be understood in connection with others.[11] As outlined by Downie and Llewellyn, a relational concept of the self encompasses several essential attributes which are that it is "socially connected, interdependent, socially encumbered, emotional, relationally constructed, socially constituted and embodied".[12]

This framework posits that individuals are fundamentally shaped by their relationships and social contexts, rather than existing as isolated entities. At its core, the relational self is shaped and continually transformed by the interplay of numerous connections with both individuals and organisations.[13] This viewpoint emphasises the fluid and interlinked character of human life and the significant role that social encounters and institutional frameworks play in moulding and evolving one's sense of self. Building upon the relational concept of self, researchers have explored various methods to characterise autonomy as relational. For instance, they have examined the precise implications of asserting that the self is social or relational in nature.[14] Feminist academics have explored the concept of the social self and its ramifications to salvage the idea of autonomy from its individualistic and rationalistic interpretations.[15] Essentially, they approach autonomy from a relational perspective.[16]

Minow moves beyond simple individual-based explanations to explore how social structures make differences significant.[17] Her key concept is the "dilemma of difference" which occurs when attempts to help people by categorising them as different can actually

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[10] Jocelyn Downie and Jennifer Llewellyn "Relational Theory and Health Law and Policy" (2008) Special Edition Health Law Journal 193 at 196-197.
[11] At 196-197.
[12] At 196-197.
[13] At 196-197; see also Catriona Mackenzie and Natalie Stoljar (eds) *Relational Autonomy: Feminist Perspective on Autonomy, Agency and the Social Self* (Oxford University Press, New York, 2000).
[14] Downie and Llewellyn, above n 10, at 198.
[15] At 196-210.
[16] At 196-210.
[17] Martha Minow *Making All the Difference* (Cornell University Press, United States, 1990) at 19-48; see also Judith McMullen "Book Review: Making All the Difference by Martha Minow" (1991) 74 Marquette Law Review 253 at 253-260.

worsen their situation and do harm.[18] According to Minow, the legal system perceives differences as inherent qualities rather than recognising their relative nature.[19] For instance, labelling a child with a disability might provide access to special education but also lead to stigma.[20] The decision between separate and inclusive education for a deaf child highlights a significant dilemma. Minow questions how we came to accept that current institutional arrangements, which categorise some individuals as normal and others as different, are inherently natural and beneficial.[21] Minow argues that this approach is based on unspoken societal norms and assumptions about difference. She highlights the complexities and potential negative effects of well-intentioned efforts to address disadvantage through legal and social systems.[22] Minow advocates for a paradigm shift, urging to view differences "as a function of relationships" instead of innate individual traits.[23] This perspective offers enhanced flexibility in addressing challenges. From this standpoint, difference can be viewed as relational. Minow further suggests that an alternative approach to resolving the difference dilemma is to genuinely consider the viewpoint of those who have historically been marginalised. From their own perspective, women, minority group members, and individuals with disabilities might not perceive themselves as abnormal.[24] Instead, they may introduce more diverse and comprehensive definitions of what constitutes normality.[25] Minow suggests that those who possess the authority to define terms and consider themselves the standard are responsible for creating the concept of difference.[26] Minow says "[t]hough the difference does not reside in any one person, the comparison is drawn by some to distinguish themselves from others".[27] Regarding familial connections, Minow dismisses purely individualistic and contractual frameworks of rights, asserting that "a political theory that disregards

[18] Minow, above n 17, at 19-20.
[19] At 49-75.
[20] At 79-89.
[21] At 83 and 97.
[22] At 79-97.
[23] At 80.
[24] At 95.
[25] At 95-98.
[26] At 111.
[27] At 111.

relationships of care and connection amongst people cannot sufficiently address numerous themes and issues confronting families".[28]

Minow critiques the liberal focus on personal autonomy as overly restrictive, arguing that considering rights as belonging to individuals without regard to their social environment and connections is not particularly advantageous, especially for those who rely on others or can only attain independence with external assistance.[29] The liberal perspective fails to account for the contextual nature of human experiences and relationships, as well as the intricate and often intertwined connections between individuals and their broader communities.[30] Minow argues that the introduction of rights to family dynamics has not successfully altered relationship patterns within or outside the family unit, but rather imposed existing power structures on the "most vulnerable members".[31] Moreover, Minow contends that the liberal concept of rights, which assumes self-determining, autonomous individuals, neglects to recognise that autonomy itself is "socially constructed" and reliant on relationships with others.[32] Whilst traditional rights discourse provides a rich "vernacular for the claims an individual may make against a collective", it is "impoverished as a means of expressing individuals" needs for the collectivity.[33] A perspective on relational rights and responsibilities would draw attention to the claims that arise out of human interdependence.[34] It would not consider rights as individualistic stemming from the need for self-preservation.[35] Instead, it would view rights as rooted in and emerging from human interactions.[36] This approach enables individuals to investigate various relationships and, in doing so, derive support from the broader community.[37]

Minow further contends that the traditional liberal rights framework falls short for vulnerable groups, particularly children, who are often perceived as lacking the necessary

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[28] Martha Minow and Mary Shanley "Revisioning the Family: Relational Rights and Responsibilities" in Mary Shanley and Uma Narayna (eds) *Reconstructing Political Theory: Feminist Perspectives* (Pennsylvania State University Press, United States, 1997) at 99.
[29] Minow, above n 17, at 215-224.
[30] At 267-311.
[31] At 267.
[32] At 301.
[33] At 306.
[34] Minow and Shanley, above n 28, at 101-102.
[35] At 101-102.
[36] At 101-102.
[37] At 101-102.

autonomy to be rights holders.[38] This fails to consider the reality of human interdependence for children.[39] As an alternative, it is suggested that children be viewed as reliant on others, such as their families and educational institutions. By recognising that children exist within an intricate network of relationships, a relational approach offers a more appropriate framework for implementing children's rights.[40]

Overall, the social relational theory proposed by Minow presents several benefits in addressing rights issues compared to a liberal individualistic approach. This theory argues against the notion that differences are innate, instead focusing on how societal structures in fact create and sustain these disparities.[41] For Minow, "the appropriate way to address questions of exclusion…is not to label difference…[i]t is to expose the unstated norms" and reevaluate them.[42] Rather than merely extending rights to individuals, the social relational approach advocates for a reimagining of social structures to foster greater inclusivity.[43] This would pave the way for more adaptable and responsive rights frameworks.[44]

Likewise, Nedelsky argues that human interactions are significant not merely due to potential conflicts of interest, but because individuals are fundamentally shaped by their relational networks.[45] These networks span relationships from close personal connections to broader societal interactions, including those between citizens and the State.[46] Nedelsky asserts that human interdependence and reliance on others are core aspects of a relational view of personhood, describing them as inherent to being human.[47] People depend on others not only for physical necessities but also for social and emotional needs, such as love and creativity.[48] Nedelsky argues that Western liberal theory does not sufficiently consider this interdependence, resulting in an uneven allocation of the duties, challenges,

[38] Minow, above n 17, at 283.
[39] At 300-302.
[40] At 288-289.
[41] Katherine Bartlett "Minow's Social -Relations Approach to Difference Unanswering the Unasked" (1992) 17 Law and Social Inquiry 437 at 439.
[42] At 440.
[43] At 437- 470.
[44] At 437- 470.
[45] Nedelsky, above n 1, at 19-72.
[46] At 27-35.
[47] At 27.
[48] At 27.

and rewards associated with caregiving.[49] Whilst emphasising the importance of relational selfhood, Nedelsky maintains that relationships are "constitutive" rather than "determinative".[50] She posits that the "concept of relational autonomy presupposes that autonomy is possible for the relational selves".[51] Thus, relationships cannot completely define an individual's identity, actions, or potential, as this would negate genuine autonomy.[52] Nedelsky says that rights and law shape relationships, and their relational impact is essential for understanding their consequences.[53] Instead of perceiving rights as individual entitlements, they ought to be viewed as mechanisms for structuring relationships.[54] Nedelsky proposes a four-step analysis for a relational approach to rights, which addresses the following key questions:[55]

1. In what way does current legislation structure the relationships that have given rise to the issue?

2. Which values are at stake in the rights dispute?

3. What types of relationships would promote those values?

4. How would different interpretations of a right structure relationships in distinct ways?

To demonstrate this approach, Nedelsky uses as an example of same-sex couples. The issue at hand is the exclusion of same-sex couples from marriage. Those in support emphasise the values of equality and dignity, whilst opponents stress societal stability and traditional marriage institutions.[56] Nedlesky's approach then examines the types of relationships that would promote these values and how various interpretations of marriage rights would influence social interactions.[57] Nedlesky asserts that by emphasising the importance of legal frameworks reflecting societal norms (such as the normalcy of

[49] At 231-270.
[50] At 31.
[51] At 31.
[52] At 31.
[53] At 75-82.
[54] At 231-245.
[55] At 236.
[56] At 236.
[57] At 236.

"heterosexual marriage"), it becomes evident that many social debates centre around determining the appropriate form of this unavoidable societal influence.[58] Fundamentally, a relational approach does not negate individual rights but reframes them in terms of how they structure relationships.[59]

2.3. Why is Relational Theory Beneficial for Children?

As mentioned above, the relational rights framework expands the traditional understanding of rights by emphasising the responsibilities humans have towards those with whom they share caring relationships.[60] Minow and Lyndon argue that these rights are not personal possessions or driven by self-preservation instincts.[61] Instead, they originate from and are shaped by our interpersonal connections. This perspective is influenced by Gilligan's "ethics of care" theory, which posits that humans are fundamentally relational and responsive creatures.[62] According to this view, human interactions are characterised by interdependence and interconnectedness, highlighting the importance of relationships in shaping our rights and responsibilities.[63] According to Minow and Shanley, the ethics of care significantly impacts the relational model as a legal framework, shaping its essential characteristics. The integration of these two elements allows for the protection of rights even within the context of relationships.[64] In line with care ethics, this model acknowledges the importance of personal connections, encourages their development, safeguards existing relationships, and emphasises individuals' caring

[58] At 237-240.

[59] At 74-78.

[60] Marit Ursin, Camila Langfeldt and Ida Lyså "Relational Rights and Interdependent Wellbeing: Exploring the Experiences of An Ethnic Minority Girl with Norwegian Child Welfare Service" (2022) 12 Global Studies of Childhood 27 at 30-34.

[61] At 30-34.

[62] At 30-34; see also Ruth Zafran "Children's Rights as Relational Rights: The Case of Relocation" (2009) 18 The American University Journal of Gender, Social Policy and the Law 163 at 163-217; Martha Minow and Mary Lyndon "Relational rights and Responsibilities: Revisioning the family in liberal political theory and law" (1996) 11 Family and Feminist Theory 4 at 4-29; Carol Gilligan *In a Different Voice: Psychological Theory and Women's Development* (Harvard University Press, Cambridge (Mass), 1982).

[63] Gilligan, above n 62, at chapter 3 and 4; Ursin, Langfeldt and Lyså, above n 60, at 30-34.

[64] Zafran, above n 62, at 192-194.

and reliable responses to others.[65] This perspective defines care as comprehending those with whom one shares a significant relationship and striving to ensure their well-being.[66]

In terms of children, relational theory is particularly relevant. The fundamental principle of this theory is that children should be supported in their diverse and evolving relationships, which reflect their ongoing needs and development. [67] The relational theory acknowledges children as holders of rights and adopts a comprehensive approach, considering the child's entire relational network rather than solely focusing on their interests.[68] Relational theory does not abandon children to the care of their parents or guardians; rather, it underscores that children are not isolated individuals and that the centrality of their relationships is crucial to their well-being and growth.[69] Proponents of relational theory advocate for recognising and embracing different levels of closeness in care relationships. [70] They argue that care is provided through various methods and structures, necessitating a more nuanced understanding. Instead of focusing solely on individual entitlements, which often leads to conflicts between parental and children's rights or among different caregivers, a relational perspective allows for the simultaneous support of multiple relationship tiers. This approach moves beyond the traditional emphasis on competing rights and acknowledges the intricate network of care-based connections that exist in reality.[71]

This theory maintains that the State is responsible for protecting and supporting relationships to safeguard and assist children who rely on each other as well as their families.[72] In essence, children's rights should be manifested as support for the care

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[65] At 192-194; Martha Minow and Mary Lyndon Shanley "Revisioning the Family: Relational Rights and Responsibilities" in Mary Shanley and Uma Narayna (eds) *Reconstructing Political Theory: Feminist Perspectives* (Pennsylvania State University Press, United States, 1997) at 22.

[66] Zafran, above n 62, at 192-194.

[67] Laufer-Ukeles above n 4; See generally Leif Weinar "Rights" (March 2021, The Standford Encyclopaedia of Philosophy)< https://plato.stanford.edu/entries/rights/>.

[68] Ruth Zafran "Children's Rights as Relational Rights: The Case of Relocation" (2010) 18 Journal of Gender, Social Policy and The Law 163 at 194-195.

[69] Laufer-Ukeles, above n 4, at 749.

[70] At 797; see also Minow and Lyndon, above n 62, at 23.

[71] Laufer-Ukeles, above n 4, at 797. The influential research conducted by Goldstein, Freud, and Solnit supports the significance of fostering a child's relationships to facilitate their effective transition into adulthood; Joseph Goldstein, Anna Freud and Albert Solnit *Beyond the Best Interests of the Child* (Free Press, New York, 1973).

[72] Laufer-Ukeles, above n 4, at 788-816.

relationships that benefit them.[73] This approach enables children to safeguard and sustain the nurturing relationships within their community. Scholars have noted that the relationship-based theory is distinctive because it prioritises the protection of relationships rather than promoting individual rights in isolation. By placing relationships at the centre, this theory redefines rights as the entitlement to have these relationships supported, as opposed to rights to personal freedoms.[74] Nedelsky's statement is pertinent in this context:[75]

> [I]f we ask ourselves what actually enables people to be autonomous it is not isolation but relationships-with parents, teachers, friends, loved ones that provide the security, education, nurturing and support that make the development of autonomy possible.

Zafran outlines three consequences of relational theory for children's rights. Firstly, it offers a new interpretation of rights in decision-making processes, that encapsulates both children's and other family members' rights.[76] This view diverges from conventional legal discourse.[77] According to Nedelsky, the notion of a right is redefined from being a shield against others' involvement to being an element that fosters, mirrors, and enhances the interaction between an individual and their relationship with others.[78] Essentially, a right in line with relational theory "will be understood not as something that promotes separation between individuals, but as something that embodies and advances elements of ongoing responsibility and mutual concern for those with whom one is in a meaningful relationship".[79] Secondly, this approach may result in the creation of "new rights", such as the right to significant family relationships, development, and paternal care.[80] Thirdly, it would shape the application of rights within "legal decision-making".[81] Implementation should consider the reciprocal responsibilities that underpin relational rights. This method takes into account the desires of all parties, aiming to minimise harm whilst balancing "the preservation of family relationships and individual rights".[82] In situations where conflicts

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[73] At 788- 816.
[74] At 788-816.
[75] At 788- 816.
[76] Zafran, above n 68, at 190-198.
[77] At 194.
[78] Jennifer Nedelsky "Reconceiving Autonomy: Sources, Thoughts and Possibilities" (1989) 7 Yale Journal of Law and Feminism 7, at 7 and 12.
[79] Minow and Shanley, above n 65, at 6; Zafran, above n 68, at 195.
[80] Zafran, above n 68, at 195-197.
[81] At 195-198.
[82] At 196.

are unavoidable, precedence should be given to the interests of the person that is most reliant on the relationship.[83]

2.4. Collective Rights

In this thesis, relational theory is appropriate because it aligns closely with the holistic worldview and emphasis on interconnectedness of collective rights. Collective rights also challenge the strictly individualistic liberal paradigm, paving the way for understandings of human rights that acknowledge the relational nature of human experience. The understanding of rights as collective is a core value in Indigenous cultures. Indigenous cultures view individuals as being inseparable from their relationships with the family and community and well-being is tied to the connectedness with others. Given that relational theory closely links to the concept of relational well-being and emphasises the interconnectedness of human existence, knowledge, culture, and belonging[84] it is an appropriate theoretical framework to underpin this research. The next part of this chapter will discuss some of the early work of collective rights pioneers and the implications for Indigenous cultures.

2.4.1. Some Pioneers for Collective Rights: Will Kymlicka, Joseph Raz and Vermon Van Dyke

The issue of safeguarding minority groups has been a longstanding concern, dating back to medieval times. Religious considerations formed the foundation for these protections; for instance, during the 1600s and 1700s, legal documents were crafted to include clauses that shielded religious communities. Subsequently, in the aftermath of World War I, numerous agreements were formulated to ensure the protection of minority populations.[85]

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[83] At 195-198.

[84] Tamara Mackean, Madison Shakespeare and Matthew Fisher "Indigenous and Non-Indigenous Theories of Wellbeing and Their Suitability for Wellbeing Policy" (2023) 19 International Journal of Environmental Research and Public Health 11693; Matt Wildcat and Daniel Voth "Indigenous Relationality: Definitions and Methods" (2023) 19 AlterNative: An International Journal of Indigenous Peoples 475; Pat Dudgeon and Abigail Bray "Indigenous Relationality: Women, Kinship and the Law" (2019) 3 Genealogy 23; see also Marcellus Mbah, Megan Bailey and Ayesha Shingruf "Considerations for Relational Research Methods for Use in Indigenous Contexts: Implications for Sustainable Development" (2023) 27 International Journal of Social Research Methodology 431 at 431-446.

[85] Joel Oestreich "Liberal Theory and Minority Group Rights" (1999) 21 Human Rights Quarterly 108 at 110-111.

The academic landscape in the field of collective rights is intricate and extensive. Notably, the contributions of Vernon Van Dyke, Will Kymlikca and Joseph Raz warrant acknowledgement.[86] Van Dyke contended that the liberal perspective on human rights, which focuses on individuals is overly narrow and fails to address human diversity adequately. He proposed that ethnic communities and other collectives should be recognised as entities with their own rights and responsibilities, and that the relationships between these groups should be examined.[87] Referencing John Rawls' work, Van Dyke, in a series of articles, pointed out that Rawls' theory overlooked the issue of "distributive justice between groups".[88] Instead, Van Dyke advocated for a theoretical framework that acknowledges that groups "in fact have status and rights at an intermediate level between the individual and the state".[89] He stressed the crucial and foundational nature of individuals' affiliations with specific groups, which are integral to their sense of self. Furthermore, Van Dyke posited that cultures themselves can possess rights, not only for equitable distribution but also for self-preservation and, in many instances, to restrict individual freedoms. Such restrictions can be justified by the critical importance of these rights for the welfare of the group's members. According to Van Dyke, cultures themselves acquire rights, not just to a form of distributive justice but also to self-preservation. In many instances, these rights may impose restrictions on individual freedom due to their crucial significance for the well-being of the community members.[90] Such concepts are dismissed by liberals and frequently criticised because liberal theory is centred on individuals and suggests that the notion of a group as a rights holder is incompatible with the Western conception of human rights.[91]

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[86] Cambridge University Press "Vernon Van Dyke" (September 1998) Cambridge University Press <https://www.cambridge.org/core/services/aop-cambridge-core/content/view/21C901D3F3025C3B751E4C8E0EE7BD0C/S1049096500055062a.pdf/vernon-van-dyke.pdf> at 652; see also Michael Braund "Will Kymlicka" (28 January 2015) The Canadian Encyclopedia <https://www.thecanadianencyclopedia.ca/en/article/will-kymlicka>; Faculty of Philosophy "In Memoriam: Joseph Raz" (2 May 2022) University of Oxford <https://www.philosophy.ox.ac.uk/article/memoriam-joseph-raz-1931-2022>.

[87] Vernon Van Dyke "The Individual, the State, and Ethnic Communities in Political Theory" (1977) 29 World Politics 343 at 343; Oestreich, above n 85, at 110-111.

[88] Oestreich, above n 85, at 115; Vernon Van Dyke "Justice as Fairness: For Groups" (1975) 69 American Political Science Review 607 at 613-614; Dyke, above n 87.

[89] Van Dyke, above n 88, at 614; See also Oestreich, above n 85, at 115.

[90] Van Dyke, above n 88, at 614; See also Oestreich, above n 85, at 115-116.

[91] Oestreich, above n 85, at 116; Rawls' theory of justice is a popular and influential theory of liberalism; John Rawls *A Theory of Justice* (Oxford University Press, Oxford, 1972).

Another early theorist was Will Kymlicka whose essay on the "liberal theory of minority right" was published in 1995.[92] This theory is considered liberal because it acknowledges that whilst citizens value their autonomy, collective rights may be essential for individual self-governance.[93] Kymlicka argues that recognising collective rights is crucial for safeguarding individual freedom and personal dignity. He argues that humans are inherently social beings who exist within groups, rather than in isolation.[94] Consequently, communities are not secondary to individuals but are fundamental to their very formation.[95] Kymlicka introduces the concept of "societal culture",[96] which provides community members with meaningful ways of life across various domains, including social, educational, and religious spheres, both privately and publicly. He references Steven Lukes as follows:[97]

> In contrast to the individualist picture of individuals as like onions which, once their outer, culturally-relative skins are peeled off, are 'much the same in all times and places', the sociological apperception reveals society as irreducibly constitutive of or built into the individual in crucial and profound ways. His distinctively human qualities, even his very capacity (and of course opportunities) to achieve autonomy and self-development are in large measure socially determined...As George H. Mead...acutely observed, 'a person is a personality because he belongs to a community, because he takes over the institutions of that community into his own conduct.' The individual self is not merely essentially social in its formation and nature; its very individuality is to be seen as formed of social elements.

Kymlicka advocated strongly for the protection and granting of rights to Indigenous peoples, albeit on individualistic grounds. What is interesting is that Kymlicka defends liberalism but curates it to advance his position and locates it within an understanding of collective identity. Kymlicka contends that belonging to a cultural community is a fundamental aspect of an individual's identity.[98] He further asserts that Indigenous

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[92] Will Kymlicka *Multicultural Citizenship: A Liberal Theory of Minority Rights* (Oxford Clarendon Press, 1995).
[93] Will Kymlicka *Politics in the Vernacular: Nationalism, Multiculturalism and Citizenship* (New York: Oxford, 2001), at 193; see also Nicolas Lopez Calera "The Concept of Collective Rights" (2003) 34 Rechtstheorie 351 at 359; Will Kymlicka *Liberalism, Community and Culture* (New York, Clarendon Press, 1991).
[94] Oestreich, above n 85, at 116; Kymlicka, above n 92, at 26–35.
[95] Kymlicka, above n 92, at 1-10.
[96] At 76; Oestreich, above n 85, at 116.
[97] Kymlicka, above n 92, at 627-628.
[98] At 11-15; see also Beth Singer *Pragmatism, Rights, and Democracy* (Fordham University Press, New York, 1999) at 99.

identity is a crucial good, providing access to a rich context of choice.[99] According to Kymlicka, individuals possess an innate connection to their cultural community that is not easily broken. Even when given the opportunity to acquire a new language and culture, people typically remain attached to their heritage. He argues that a person's upbringing is an indelible part of their identity that cannot be simply erased.[100] Cultural membership, he posits, profoundly influences one's sense of personal identity and capabilities.[101] Kymlicka's emphasis is not so much on individual traits, but rather a sense of identity as part of one's community.[102] He further explains "[t]he primary good being recognized is the cultural community or its traditional ways of life which people are free to endorse or reject".[103]

It is crucial to consider the context of choice, as highlighted in Kymlicka's primary argument regarding the significance of cultural identity. This contrasts with the views of other philosophers like Rawls who emphasise the importance of diverse options for individuals,[104] which explains why fundamental, anonymous civil liberties are given priority in mainstream liberalism.[105] Kymlicka contends that our ability to choose from a range of options is limited. He argues that although we make our own life decisions, these choices involve selecting what we deem most valuable from the available options, which are influenced by our cultural heritage.[106] Kymlicka states "[m]y proposal claims that cultural community enters our self-understandings by providing a context of choice within which to choose and pursue our conception of the good life."[107] The context Kymlicka refers to is not the culture of the community itself, but rather the group of people with whom the individual identifies and is situated. This community is inextricably

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[99] Kymlicka, above n 92, at 11; see also Keakaokawai Varner Hemi "Everyone, Non-one, Someone and the Native Hawaiian Learner: How Expanded Quality Narratives Might Account for Guarantee/Reality Gaps, Historical-legal Context and An Admission Policy Which is Actually Levelling the Playing Field" (PhD Dissertation, University of Waikato, 2016) at 176.

[100] Will Kymlicka *Liberalism, Community and Culture* (Clarendon Press, New York, 1991) at 175; See also Singer, above n 98, at 98-100.

[101] Kymlicka, above n 93, at 75-106; see also Singer, above n 98, at 99-100.

[102] Kymlicka, above n 93, at 174-175.

[103] At 172.

[104] Rawls, above n 91 at 76-77, 84; See also John Rawls *Political Liberalism* (New York, Columbia University Press, 1993); John Rawls Justice as Fairness: A Restatement in Erin Kelly (ed) (Cambridge MA, Belknap Press, 2001).

[105] Kymlicka, above n 93, at 164-189; Hemi, above n 99, at 176.

[106] Kymlicka, above n 93, at 164; Hemi, above n 99, at 176.

[107] Kymlicka, above n 93, at 101.

linked to the "attitudinal and cognitive context provided by its nature".[108] Kymlicka asserts that liberalism does not exclude the existence of collective rights; in fact, he argues that protecting these rights is essential to uphold liberal principles.[109]

In particular, Kymlicka expresses concern about the rights of Indigenous peoples. He says that special measures for distinct minority cultures need to be established as "differential citizenship rights may be needed to protect a cultural community from unwanted disintegration".[110] Kymlicka proposes his recommendations in the context of minority rights, characterising these as "special" or "differential" rights, which he distinguishes from "equal citizenship rights" that are "specified to apply to every Canadian citizen" regardless of their race or ethnicity.[111] In a strictly liberal sense Kymlicka says that such special rights are distinct from equal rights and may be viewed by some as discrimination or privilege. However, Kymlicka states that "the special measures demanded by Aboriginal people serve to correct an advantage that nonaboriginal people have before anyone makes their choices".[112] His argument is that to safeguard the cultural community from erosion by external decisions, special protection is necessary. The imbalance in power between the cultural community and those outside of it calls for rectification, which forms the basis for advocating for Aboriginal rights and minority rights through affirmative action.[113] Whilst Kymlicka does not provide a precise definition for collective rights he notes that the term "Aboriginal rights" typically implies that Aboriginal peoples have rights to the protection of their culture, which are considered claims that must be respected even if another policy might better serve the interests of the broader Canadian political community.[114]

Specifically, Kymlicka proposes two categories of collective rights: internal restrictions and external protection. He says that collective rights can encompass a group's ability to constrain the freedom of its members in the name of group cohesion or cultural preservation (internal restrictions), or a group's right to curtail the economic or political influence exerted by the broader society over the group, ensuring that the minority's

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[108] Singer, above n 98, at 99-101.
[109] Calera, above n 93, at 359.
[110] Kymlicka, above n 93, at 164-189; Singer, above n 98, at 103.
[111] Kymlicka, above n 93, at 75-106; Singer, above n 98, at 104.
[112] Kymlicka, above n 93, at 75-106; Singer, above n 98, at 104.
[113] Singer, above n 98, at 104; see also Kymlicka, above n 93, at 75-189.
[114] Singer, above n 98, at 105; see generally Kymlicka, above n 93.

essential resources and institutions are safeguarded from majority decisions (external protection).[115] Kymlicka identifies two types of group demands. The first form of external protection involves a more dominant group requiring conformity from its members, whilst the second form entails a group seeking acknowledgement and safeguarding of its collective identity in relation to a larger or more influential group, as a fundamental right.[116]

Kymlicka expresses reservations about the concept of collective rights, suggesting that the term inadequately captures the nuances of various group-based forms of differentiated citizenship. He contends that this terminology creates an inaccurate dichotomy with individual rights.[117] Furthermore, Kymlicka argues that the notion of balancing collective and individual rights offers limited practical value.[118] Despite these criticisms, he recognises the inherent national aspect of political life. Kymlicka asserts that for liberalism to gain traction in developing nations, it must address the concerns and requirements of ethnic and national minority groups.[119] Singer takes this further and says that "I would take an even stronger position than he does, namely, that without cultural communities, individuals of our species would not be human… It is on these grounds that I would argue that cultural communities should be entitled to protection".[120]

Raz's work offers further insights into collective rights. Raz's conception of group rights is that they occur when "a number of individuals provide sufficient justification for imposing duties upon others even though, if we were to consider the interest of only one of those individuals, that single interest would not provide the necessary justification".[121] Raz outlined specific conditions that constitute a group right:[122]

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115 Calera, above n 93, at 362; see also Kymlicka*,* above n 92, at 58-195.

116 Calera, above n 93, at 362; see also Kymlicka*,* above n 92, at 58-195.

117 Calera, above n 93, at 362; Kymlicka, above n 92, at 58-195.

118 Calera, above n 93, at 362; Kymlicka, above n 92, at 58-195; see also Jeremy Waldron "Minority Cultures and the Cosmopolitan Alternative" in Will Kymlicka (ed) *The Rights of Minority Cultures* (Oxford University Press, Oxford, 1995) 93 at 114.

119 Calera, above n 93, at 362; Kymlicka, above n 92, at 58-195.

120 Singer, above n 98, at 103.

121 Peter Jones "Human Rights, Group Rights, and Peoples' Rights" (1999) 21 Human Rights Quarterly 80, at 83 and 84; Joseph Raz *The Morality of Freedom* (Oxford University Press, Oxford, 1986) at 208 and 165-216; For general discussion please see Raz at 245-263.

122 Raz, above n 121, at 208; See also Jones, above n 121, at 84; Joseph Raz "Multiculturalism: A Liberal Perspective" in Joseph Raz *Ethics in the Public Domain: Essays in the Morality of Law and Politics* (Clarendon Press, Oxford, 1994) 155 at 163.

> First, it exists because an aspect of the interest of human beings justifies holding some person(s) to be subject to a duty. Second, the interests in question are the interests of individuals as members of a group in a public good and the right is a right to that public good because it serves their interest as members of the group. Thirdly, the interest of no single member of that group in that public good is sufficient by itself to justify holding another person to be subject to a duty.

According to Raz, a group right is distributed amongst the group's members, without requiring a distinct moral standing for the group beyond its individual members.[123] The group holds these rights, yet the interests supporting them are distinct and equivalent to the group's interests.[124] Raz asserted that "[c]ultural, and other, groups have a life of their own. But their moral claim to respect and to prosperity rests entirely on their vital importance to the prosperity of individual human beings".[125] In essence, collective rights are typically rights to collective goods.[126]

Considering that the central thesis of this work argues for the adaptability of the best interests of Indigenous children to include their collective cultural rights in the context of mental health, it is important to acknowledge the inevitable resistance from liberalists. This will be the subject of the following section of this chapter.

2.5. Liberalism vs Collective Rights

It is well-established that Western societies are founded on the principle of individual rights.[127] Some argue that as Western ideologies tend to emphasise the existence of the individual as distinct from his or her community, the stance "focuses extensively on the relationship of the individual to the state".[128] Individual rights are perceived as

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123 Raz, above n 122, at 163; See also Raz, above n 121, at 165-216; Jones, above n 121, at 85.
124 Raz, above n 121, at 208; See also Jones, above n 121, at 84-85.
125 Raz, above n 122, at 163; See also Jones, above n 121, at 85-86;
126 Raz, above n 121, at 207; See also Calera, above n 93, at 363.
127 Robert Clinton "The Rights of Indigenous Peoples as Collective Group Rights" (1990) 32 Arizona Law Review 739 at 740; This phenomenon is unsurprising, given the principles of liberalism that emerged in the 17th, 18th, and early 19th centuries in Europe. These ideologies travelled to other regions of the world through colonisation, including to non-Western territories. Western philosophical thought posits that individuals relinquish a portion of their sovereign power and self-determination to the state in exchange for the peace, security, and individual welfare provided by a structured society. It is said the origins of this concept can be traced to biblical narratives.
128 Clinton, above n 127, at 741.

constraining state action or as limitations on an organised society and the government.[129] As Clinton asserted, "such social compact theories have been the dominant fountainhead of thinking about rights and the relationship of the individual to the state for many centuries".[130] Locke posited that every individual possessed a set of natural rights, and that the government was only legitimate if it was predicated on the consent of the governed and safeguarded the rights of all.[131] Fundamentally, the predominant Western themes concerning human rights originate from the notion that individual human rights emerge from the relationship between the individual and the state. The following passage is pertinent to an understanding of this position:[132]

> Human rights adhere to the human being by virtue of being human, and for no other reason. Every human being ought to have human rights, regardless of status or achievement… Human rights are claims by the individual against society and the state, that furthermore "trump" other considerations… Human rights are private, individual, autonomous…

Individualist philosophy continues to shape contemporary discourse, sparking extensive debates about the compatibility of collective rights with the emphasis on individual rights and human rights within liberalism. An alternative formulation of this question is to inquire whether collective rights can coexist with the principles of liberalism.[133] Therefore it is pertinent to note some common criticisms from liberalism about collective rights to demonstrate some of the ongoing challenges to the implementation of collective rights. For instance, one argument is that the recognition of collective rights can potentially undermine individual rights.[134]

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[129] Some of the works of the notable writers include John Rawls *A Theory of Justice* (Oxford University Press, Oxford, 1972); John Rawls *The Law of Peoples: With "The Idea of Public Reason Revisited* (Cambridge MA, Harvard University Press, 1999); John Locke discussed in Eric Mack and John Meadowcroft *John Locke* (Continuum International Publishing, New York, 2009); Jean-Jacques Rousseau *The Social Contract* (Penguin Classics, London, 1968); Ronald Dworkin "What is Equality: Part I: Equality of Welfare" (1981) 10(3) Philosophy and Public Affairs 185.

[130] Clinton, above n 127, at 741.

[131] Michael Freeman "Are There Collective Rights?" (1995) 43 Political Studies 25 at 26.

[132] Richard Thompson "Ethnic Minorities and the Case for Collective Rights" (1997) 99 American Anthropologist 786 at 787.

[133] At 787.

[134] Daniel Weinstock "How Can Collective rights and Liberalism Be Reconciled" in Rainer Baubock and John Rundell (eds) *Blurred Boundaries: Migration, Ethnicity, Citizenship* (1st ed, Routledge, Oxfordshire, 1998) 281 at 281.

Many common concerns expressed about collective rights by proponents of liberalism stem from the foundational tenets of Liberal philosophy. The core focus of liberalism is on individual rights rather than group rights. Some liberal thinkers consider collective rights to be superfluous and potentially detrimental to established individual rights. For example, Donnelly contends that the right to self-determination is unnecessary, arguing that when individual rights are upheld, self-determination is effectively guaranteed. He posits that the rights of peoples should be interpreted as fundamentally individual rights, as any other interpretation could jeopardise all other human rights. However, Donnelly acknowledges that this perspective is challenging when applied to Indigenous cultures that do not conceptualise individuals as autonomous entities.[135] Donnelly says that we ought not to succumb to the paternalistic urge of withholding human rights from traditional societies on the basis that these rights are not beneficial for them.[136] Despite potential discomfort, human rights are compatible with the established frameworks of Indigenous communities and provide robust safeguards for the rights and interests of traditional societies.[137]

There exists a dichotomy in the discourse on human rights by Donnelly. Firstly, there is an explicit acknowledgement that advocating for individual human rights in certain societies may disrupt cultures where collective rights are of paramount importance. Conversely, Donnelly contends that these potentially disruptive human rights actually safeguard traditional communities, despite anthropological evidence suggesting otherwise.[138] Notably, it is the very Indigenous groups Donnelly refers to who are spearheading the inclusion of group rights in the international rights agenda. They assert that individual rights alone are insufficient for their protection and have historically been used by states to force assimilation and erode cultural identity. Although Donnelly acknowledges this, he does not fully explore the concept that some groups require collective safeguarding, irrespective of human rights considerations.[139]

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[135] Jack Donnelly "Human Rights, Individual Rights and Collective Rights" in Jan Berting, Peter Baeher, J Herman Burgers, Cees Flinterman, Barbara de Klerk, Rob Kroes, Cornelis van Minnen and Koo Vanderwal (eds) *Human Rights in a Pluralist World: Individuals and Collectivities* (Meckler, London, 1990) 39 at 39-62; Richard Thompson "Ethnic Minorities and the Case for Collective Rights" (1997) 99 American Anthropologist 786 at 788.

[136] Donnelly, above n 135, at 39-62.

[137] At 39-62; Thompson, above n 135, at 788.

[138] Donnelly, above n 135 at 39-62.

[139] At 39-62; Thompson, above n 135, at 788.

A more substantial liberal critique of group rights is the view that collective rights in some instances might condone infringements on individual liberties, potentially endorsing illiberal customs such as infanticide or widow immolation, which could be defended as essential for preserving cultural heritage and identity. Does this mean that liberals should address illiberal elements in collective cultures? Kymlicka proposes that liberals ought not to aim for the dissolution of non-liberal nations, but instead strive to liberalise them and argues that to presume that any culture is inherently illiberal and resistant to change is both "ethnocentric and ahistorical".[140] The process of liberal reform remains unfinished in all societies, and it would be absurd to suggest that only purely liberal nations deserve respect, whilst others should be assimilated.[141]

In contrast, with the liberal position, many Indigenous groups hold a distinct view on the essential nature of human rights and their legal associations with them. These groups maintain strong connections to tribal structures and ancestral customs, and they do not perceive themselves as isolated from their community. From their perspective, "individuals are born into a complex network of family, kinship, social, and political relationships".[142] Consequently, Indigenous or native populations generally regard rights as communal privileges. Clinton concisely expressed this notion in his article as follows:[143]

> Certain rights exist within each social group and other rights and responsibilities are attendant to their relations with members of other groups within the web of associations that forms the tribe or the state. For them, the tribe or state is merely composed of interlinked group associations and affiliations.

Clinton tackles the query of how one can establish notions of fundamental human rights or dignity if these rights are rooted in communal relationships. In response, he suggests that an individual's right to autonomy is not in opposition to society, as Western doctrines

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139 Thompson, above n 135, at 788.

140 At 788; Kymlicka, above n 92, at 94.

141 Kymlicka, above n 92, at 94; Thompson, above n 135, at 788-789; see generally Michael McDonald "Should Communities Have Rights? Reflections on Liberal Individualism" in Abdullahi An-Na'im (ed) *Human Rights in Cross-Cultural Perspectives: A Quest for Consensus* (University of Pennsylvania Press, Philadelphia, 1992) 133.

142 Robert Clinton, The Rights of Indigenous Peoples as Collective Group Rights (1990) 32 Arizona La Review 739 at 742.

143 At 742.

might imply, but rather stems from their membership in family and extended kinship groups.[144]

In stark contrast to the advocacy for collective rights, orthodox liberalism endorses individual autonomy. Critics challenge what they perceive to be a narrow conception of autonomy and neglect of cultural values in orthodox liberalism.[145] Critics contend that this restricted viewpoint fails to acknowledge the intricate relationship between individual identity and cultural background. It is argued that by concentrating exclusively on individual rights and liberties, orthodox liberalism neglects the crucial influence of cultural affiliation in moulding personal autonomy and self-determination.[146] This oversight results in a partial understanding of how individuals interact with their social and political environments, potentially compromising the very autonomy that liberalism aims to safeguard.[147] Kymlicka contends that orthodox liberalism operates within an oversimplified, monolithic model of the nation-state, disregarding the reality of cultural diversity in contemporary states. This notion of the nation-state as a uniform entity fails to consider the varied cultural, ethnic, and linguistic groups that coexist within most modern societies. By clinging to this outmoded model, orthodox liberalism struggles to tackle the challenges and prospects presented by multicultural societies, potentially intensifying tensions between different cultural groups and impeding social cohesion.[148]

Instead of the notion of a simplified dichotomy between individual rights and collective rights, Kymlicka, argues for the interplay between these rights. As mentioned above, according to Kymlicka, the conventional liberal focus on individual rights falls short in addressing the complexities of multicultural societies and the significance of cultural identity in shaping personal autonomy and well-being.[149] By overlooking the importance of cultural membership, traditional liberalism may unintentionally undermine the very autonomy it seeks to protect, as it fails to provide individuals with the necessary cultural context for making informed and meaningful decisions about their lives.[150] Kymlicka

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144 At 741-742.

145 Ogr Uyesi "Liberal Multiculturalism and Human Rights Discourse: The Contribution of Will Kymlicka" (2021) 26 Ravza Altuntas Cakir 85 at 89-92.

146 At 89-92.

147 At 89-92.

148 At 89-92; See also Will Kymlicka "Do We Need a Liberal Theory of Minority Rights? Reply to Carens, Young, Parekh and Forest" (1997) 4 Constellations 72 at 75.

149 At 89-92.

150 At 89-92; Kymlicka, above n 92, at 145-168.

contests the conventional liberal stance that minority rights conflict with individual rights and liberal equality, asserting that this view stems from a narrow interpretation of liberal principles in practice. Correspondingly, he proposes a reimagined understanding of liberalism that works together with the recognition of collective rights. Kymlicka posits that by acknowledging and accommodating minority rights, liberal societies can actually bolster individual freedom and equality by offering members of minority groups the cultural context necessary for meaningful choice and self-determination.[151] He suggests that liberal theory should recognise the normative significance of cultural membership and incorporate this understanding into its framework for addressing issues of justice and equality.[152] This broadened conception of liberalism would acknowledge that cultural rights are not contrary to liberal principles but can be fundamental to their realisation. Kymlicka contends that by integrating cultural considerations into liberal theory, societies can develop more effective and equitable approaches to managing diversity in multicultural societies, fostering social cohesion whilst respecting individual rights and cultural differences.[153]

It must be noted here that while the distinction between Kymlicka and Raz is conceptually significant, this thesis does not adopt either position in a definitive sense. Kymlicka's framework is helpful in explaining how collective claims can be accommodated within liberal legal systems, but it ultimately treats collective rights as serving individual autonomy (as discussed above). Raz, in contrast, grounds rights more firmly in the value of collective interests themselves. Rather than aligning exclusively with one theory, the writer has adopted a middle-ground position that recognises the strengths and limits of both. International human rights law provides space for this approach. Although instruments such as the CRC are framed primarily in terms of individual rights, international law (including the CRC) particularly in relation to Indigenous peoples and children, acknowledges that rights are exercised both individually and collectively. In other words, they are interconnected. In this way, the international framework accommodates the interdependence of individual and collective dimensions. For tamariki and rangatahi Māori, mental health and well-being are relationally constituted and

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151 At 89-92; Will Kymlicka *The Politics of Reconciliation in Multicultural Societies* (Oxford University Press, Oxford, 2010) at 101.

152 At 89-92; Will Kymlicka *Multicultural Odysseys: Navigating the New International Politics of Diversity* (Oxford University Press, Oxford, 2007) at 92-95 and 107.

153 At 89-92; Kymlicka, above n 151 at 101.

inseparable from the continuity of whānau, hapū, and iwi (this will be explored more in chapter four). This research therefore reflects a deliberate positioning which is that one does not privilege either theoretical account but instead draws on international law to support an integrated and interdependent understanding of rights that better reflects Indigenous realities and worldviews.

This section has explored the common view of a tension between a liberal focus on individual rights and collective rights, and has also examined a broader conception of liberalism which argues that individual rights are shaped by cultural identity and that both sets of rights should be understood together. The next section looks at collective rights and relational theory.

2.6. The Alignment of Relational Theory and Collective Rights

Despite the critique of collective rights discussed above, there is also a strong pushback from relational theorists and collective rights proponents who argue that individual rights can be harmonised with collective rights. This research contends that relational theory aligns closely with Indigenous concepts of collective rights, which is particularly significant for understanding and promoting health in Indigenous communities. This alignment is important because health, for many Indigenous peoples, is a holistic concept that encompasses not only individual well-being but also the collective well-being of the community.[154] Consequently, health decisions for Māori need to align with collective values.[155] Meir argues that individual and collective health rights are interconnected and mutually supportive. He terms this the "harmonization process" where both rights work together.[156] Based on this argument, recognising collective rights is vital for achieving healthcare equity for Indigenous people, as their identities are grounded in group settings. This discussion is relevant for examining the right to health and the best interests of Indigenous children in mental health, and highlights the need for a better interpretation of health rights that includes both individual and collective rights. The relational approach

[154] Mason Durie "Transforming Mental Health Services in Aotearoa New Zealand" in Te Kani Kingi, Mason Durie, Hinemoa Elder, Rees Tapsell, Mark Lawrence and Simon Bennett (eds) *Maea Te Toi Ora: Māori Health Transformations* (Huia Publisher, Wellington, 2018).

[155] See generally Adele Vuki, David Gregory, Ruth Martin-Misener and Josephine Etowa "Aboriginal and Western Conceptions of Mental Health and Illnesses" (2011) 9 A Journal of Aboriginal and Indigenous Community Health 65.

[156] Benjamin Meir "The Highest Attainable Standard: Advancing a Collective Human Right to Public Health" (2005) 37 Columbia Human Rights Law Review 100.

recognises that individuals, especially children, are deeply interconnected with their families, communities, and cultural contexts. This perspective also resonates with Indigenous worldviews, which often emphasise the interdependence of individuals with their social and environmental surroundings.

In particular, this understanding is important for Indigenous children whose well-being and development is intrinsically linked with their cultural and wider familial links. As stated above, central to relational theory is the notion that "connection to others is the precondition to autonomy and individualisation".[157] For tamariki and rangatahi Māori the bonds with their whānau, hapū, and iwi are crucial for their growth and welfare. Therefore, when considering the rights of tamariki and rangatahi Māori, it is not possible to consider them as individuals in isolation, but their collective rights must be taken into consideration. This has been recognised under international law and various reports from the United Nations.[158] Chapter Four will elaborate on Māori collective rights, contrasting them with Western liberal ideology that emphasises individualism.

2.7. Conclusion

This chapter has explored relational theory as the primary theoretical framework for examining the mental health rights of tamariki and rangatahi Māori. Relational theory emphasises the importance of relationships and community connections for individual well-being. This approach focuses on an individual's network of relationships and the relational self. Early proponents of relational theory, including Martha Minow and Jennifer Nedelsky, challenge individualistic approaches to rights and contend that it is not appropriate, given that individuals do not live in isolation, but rather are interdependent with other people. This perspective is particularly beneficial for children as it reflects their wider relationships and evolving needs. For tamariki and rangatahi Māori, bonds with whānau, hapū, and iwi are crucial for growth and development, necessitating consideration of collective rights. Correspondingly, relational theory has been chosen for

[157] Laufer-Ukeles, above n 4, at 816.

[158] *General Comment No. 11 Indigenous Children and Their Rights under the Convention* UN Doc CRC/C/GC/11 (2009); *Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* UN Doc A/HRC/44/48 (15 April 2020).

this research because it emphasises the wider network of relationship. Importantly, relational theory aligns with a Māori view of health, which is holistic.

The next chapter will build upon this theoretical foundation to explore how the best interests principle, a key principle in this research inquiry, has been applied, if at all, in New Zealand.

Chapter Three

The Best Interests Principle in New Zealand

"The future of Aotearoa-New Zealand must lie in a single legal system which nevertheless recognises and respects the world views, values, customary laws and institutions of the two great founding cultures of this country."[1]

3.1. Introduction

Article 3 of the United Nations Convention on the Rights of the Child ("CRC") establishes the best interests principle as a guiding principle in all child-related decisions. As a signatory to the CRC, New Zealand is obligated to uphold its provisions. This chapter explores the application of the best interests principle in New Zealand's domestic legislation and case law, focusing on the Care of Children Act 2004 ("COCA") and the Oranga Tamariki Act 1989 ("OT Act").[2] While these laws do not directly address the mental health of children, they demonstrate the incorporation of the best interests principle into New Zealand's legal and policy framework, albeit in a limited scope. The analysis reveals that New Zealand's laws and policies concerning children are already influenced by the best interests principle. Consequently, examining the case law provides valuable insights into how the best interests principle has been interpreted in relation to decision making about children in New Zealand.

This chapter argues that this existing foundation can be used in the context of mental health for tamariki and rangatahi Māori. The chapter will reveal that courts have interpreted the best interests principle broadly, tacitly incorporating a child's psychological welfare, which aligns with mental health considerations and human rights terminology. This broad interpretation is significant as it showcases New Zealand's adherence to its international legal obligation (although this is limited to COCA and OT Acts) Under international law, states possess the autonomy to determine the implementation of their international obligations.[3] The responsibility of the judiciary to implement these

[1] Robert Joseph "Re-creating Legal Space for the First Law of Aotearoa-New Zealand" (2009) 17 Waikato Law Review 74 at 96.
[2] Care of Children Act 2004, s 4; Oranga Tamariki Act 1989, s 4.
[3] United Nations Convention on the Rights of the Child 1577 UNTS 3 (Adopted and opened for signature, ratification and accession November 1989, entered into force 2 September 1990), Article 4.

international obligations has been highlighted by the CRC in their advocacy for extensive measures known as general measures of implementation.[4] As Tobin reminds us, whilst the judiciary's role may not be the sole or most significant factor in enforcement measures, it nonetheless provides a robust indication of how international norms have been internalised and actualised within a domestic legal system. Judges play a crucial role in adapting international human rights to domestic contexts.[5]

The analysis in this chapter will reveal several key themes that demonstrate how New Zealand's judiciary has interpreted the best interests principle in cases under the OT Act and COCA legislation. These themes include flexibility, prioritising child safety as paramount, emphasising the maintenance of familial relationships and cultural identity, and weighing both immediate and long-term effects on a child's development. These central themes bolster the thesis's main argument that the current legal framework and judicial interpretation offer a basis for broadening the best interests principle to encompass mental health contexts for tamariki and rangatahi Māori.

This chapter begins by examining the historical development of the best interests principle, emphasising its Western roots whilst demonstrating its capacity to accommodate cultural diversity and acknowledge Indigenous peoples' collective cultural rights alongside their individual rights. This background is crucial as it contextualises the best interests principle for the reader, and illustrates its evolution towards a contemporary interpretation particularly in relation to Indigenous peoples. Furthermore, this historical overview showcases the principle's adaptability in considering the collective cultural rights of Indigenous children, which forms a central argument of this thesis.

[4] Milka Sormunen "The Best Interests of the Child in Human Rights Practice: An Analysis of Domestic, European and International Jurisprudence (PhD Dissertation, University of Helsinki, 2021) at 79; See also *General Comment No. 5 (2003): General Measure of Implementation of the Convention on the Rights of the Child* UN Doc CRC/GC/2003/5 (27 November 2003).

[5] John Tobin, "Judging the Judges: Are They Adopting the Rights Approach in Matters Involving Children" (2009) 33 Melbourne University Law Review 579 at 580.

3.2. The Best Interests Principle

Under Article 3(1) the best interests principle is stated as:[6]

> In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

Historically, the concept of the best interests principle is deeply rooted in Western ideology, particularly in the notion of safeguarding childhood innocence.[7] The best interests principle originated in the 18th century with the evolving recognition that children are innocent and require protection. This paternalistic notion justified intervention in family life to safeguard 'at risk' children in the 19th century.[8] By the early 20th century, the principle had evolved to encompass children's well-being and rights. The principle's evolution can be conceptualised as progressing through three phases: from paternal supremacy, to balancing parental rights, to greater interventionism in family life. The rise of democracies and egalitarian ideals in the 20th century led to increased state intervention in child-rearing based on children's best interests.[9] The best interests principle's roots in international law go back to the 1924 Geneva Declaration, and the 1959 UN Declaration on the Rights of the Child that preceded the CRC.[10] Despite its Western origins, the best interests principle has evolved to a point where it can now encompass the cultural rights

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[6] United Nations Convention on the Rights of the Child, above n 2, Article 3(1).

[7] Steve Macbeth "The Application of the Best Interests Principle to Māori Children's Collective Cultural Rights: A Conceptual Shift for the New Zealand Family Court?" (LLM Dissertation, University of Waikato, 2015) at 9; See generally Michael King, and Christine Piper *How the Law Thinks of the Child* (2d ed, Aldershot, UK, 1995); see also Jeroen Dekker, "Children at Risk in History: A Story of Expansion" (2009) 45 Paedagogica Historica: International Journal of the History of Education 17; Paula Fass "A Historical Context for the United Nations Convention on the Rights of the Child" (2011) 633 Annals of the American Academy of Political and Social Science 17.

[8] See Claire Breen *The Standard of the Best Interests of the Child: A Western Tradition in International and Comparative Law* (Kluwer Law International, The Hague, 2002); Aron Degol and Shimelis Dinku "Notes on the Principle Best Interest of the Child: Meaning History and Its Place Under Ethiopian Law" (2011) 5 Mizan Law Review 319 at 321; Macbeth, above n 7, at 10-21; Philip Alston "The Best Interests Principle: Towards a Reconciliation of Culture and Human Rights" (1994) 8 *International Journal of Law and Family* 1; A An-An'ain "Cultural Transformation and Normative Consensus in the Best Interests of the Child" (1994) 1 International Journal of Law and Family 62; Dominique Marshall, "The Construction of Children as an Object of International Relations: The Declaration of Children's Rights and the Child Welfare Committee of the League of Nations, 1900-1924" (1999) 7 International Journal of Children's Rights 108.

[9] Breen, above n 8, at 35-45; Degol and Dinku, above n 8, at 321; Macbeth, above n 7, at 10-21

[10] Breen, above n 8, at 35-45; Degol and Dinku, above n 8, at 321; Macbeth, above n 7, at 10-21; See also Jack Donnelly "International Human Rights: A Regime Analysis" (1986) 3 International Organization 40.

and needs of Indigenous children.[11] This development supports the core argument of this thesis that the best interests principle can be utilised to improve the circumstances for tamariki and rangatahi Māori in the mental health domain. This will be discussed further below.

The best interests principle has been labelled complex and adaptable, requiring case-by-case determination.[12] It has been described by scholars as having "vague, indeterminate and subjective standards".[13] Despite difficulties, this principle has been codified as binding within human rights legislation, and the Committee on the Rights of the Child ("CRC Committee") deems it one of the core tenets in the CRC.[14] As articulated by the Committee, the best interest principle "establishes an inherent duty for States, is directly applicable (self-executing), and may be invoked in a court of law".[15] The Committee says the best interest principle is a three-fold concept as follows:

(i) a substantive right – that is a "the right of the child to have his or her best interests assessed and taken as the primary consideration… and the guarantee that this right will be implemented whenever a decision is being made about a child";[16]

(ii) a legal principle – that is if there is scope for interpretation, then the interpretation that "effectively serves the child's best interests should be taken";[17] and

[11] See generally Patrick Thornberry *Indigenous Peoples and Human Rights* (Manchester University Press, 2002); see also John Tobin *The UN Convention on the Rights of The Child* (Oxford University Press, Oxford, 2019) at 1156.

[12] Committee for the Rights of the Child *General Comment No. 14 (2013) on the Right of the Child to Have His or Her Best Interests Taken As A Primary Consideration (Article 3, Paragraph 1)* UN DOC CRC/C/GC/14 (2013) at 9.

[13] Ursula Kilkelly "The Best Interests of the Child: A Gateway to Children's Rights?" in Elaine Sutherland and Lesley-Anne Barnes Macfarlane (eds) *Implementing Article 3 of the United Nations Convention on the Rights of the Child: Best Interests, Welfare and Well-Being* (Cambridge University Press, Cambridge, 2016) 51 at 51; see also Joseph Goldstein, Anna Freud and Albert J. Solnit *Beyond the Best Interests of the Child* (Free Press, New York,1973); Robert Harris Mnookin, "Child-Custody Adjudication: Judicial Functions in the Face of Indeterminacy" (1975) 39 Law and Contemporary Problems 226.

[14] Kilkelly, above n 13, at 56.

[15] Committee for the Rights of the Child, above n 12, at [6].

[16] At [11]-[20].

[17] At [11]-[20].

(iii) a rule of procedure – that is when a decision is being made that affects a child, "the decision-making must include an evaluation of possible impact on the child concerned".[18]

The Committee's framing of the best interests principle implicitly asserts the rights-based nature of the best interests principle. By describing it as a substantive right, the Committee forcefully articulates the principle from a rights perspective.[19] This stance is further reinforced by the Committee's aim to "promote a real change in attitudes leading to the full respect of children as rights holders".[20] Essentially, the Committee's choice of language underscores its commitment to positioning the best interests principle within a rights-based framework. Moreover, Kilkelly [21] points out that, according to the interpretative guidelines of the Vienna Convention on the Law of Treaties, treaty provisions should be understood within their context and consider the overall purpose of the Convention.[22] Consequently, examining the best interest principle in relation to the CRC as a whole strengthens the portrayal of the best interest principle as a right.[23] If there is a right, another question that arises is whether there is an obligation that is "disputable" and, if so, who the duty bearer is.[24] Scholars contend that Article 3(1)'s mention of "public or private social welfare institutions, courts of law, administrative authorities or legislative bodies" as state entities implies that the state is the duty bearer.[25] In fact, the "precise pinpointing of the duty bearer gives added strength, clarity and reach to Article 3(1) which other provisions [within the CRC] does not have".[26] The Committee has clarified that legislative, administrative, and judicial bodies must apply the best interests principle and recommended that states entrench the best interests principle in their domestic law.[27] This, coupled with the explicit guidance from General Comment No. 14, provides a clear

[18] At [1].
[19] Kilkelly, above n 13, at 55-57.
[20] At 55-57.
[21] At 56-58.
[22] Vienna Convention on the Law of Treaties 1155 UNTS 331 (opened for signature 23 May 1969, entered into force 27 January 1980), Article 31.
[23] Kilkelly, above n 13, at 56-58.
[24] At 58.
[25] At 56-59; See also Committee on the Rights of the Child *General Comment No. 5 (2003) General Measures of Implementation of the Convention on the Rights of the Child,* UN Doc CRC/GC/2003/5 (2003) at [22].
[26] Kilkelly, above n 13, at 58.
[27] At 58; See also Committee on the Rights of the Child, above n 25, at [22].

articulation of the duty stemming from Article 3(1), implies it is the State that is the duty bearer.[28]

The Committee also directs the best interests principle as a procedural rule, "to ensure that decision-making in matters that affect the child is informed by what is in the child's best interests".[29] As Kilkelly points out, scholars that criticise the best interests standard have turned to this concept, -i.e. procedural rule, to address the limitations of the best interests principle by refining the process of determining what is in a child's best interests.[30] They have done this by incorporating Article 12 (the voice of the child) into the best interests principle. Woodhouse contends that the best interests principle can be interpreted as a procedural rule to ensure fair and just promotion of children's rights.[31] The Committee supports and endorses this perspective and has compiled a non-exhaustive, non-hierarchical catalogue of factors to consider when assessing a child's best interest, which will be discussed below.[32] As stated by the Committee, "the ultimate aim of the child's best interests should be to guarantee the full and effective enjoyment of the rights recognised in the Convention".[33]

Finally, the Committee has characterised the best interests principle as an interpretive tool. This implies that the best interests should serve as a framework through which children's rights can be applied and understood.[34] As stated by the Committee, "when a legal provision is subject to multiple interpretations, the one that most effectively upholds the child's best interests should be selected".[35]

The aforementioned comments are relevant for the purposes of this thesis. The Committee's conceptualisation of the principle as a tripartite concept, encompassing a substantive right, a legal principle, and a procedural rule, reflects a child-centric and child-

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[28] Kilkelly, above n 13, at 56-58; See also Committee on the Rights of the Child, above n 25, at [12].

[29] Kilkelly, above n 13, at 59-60.

[30] At 59-60; see also Barbara Bennett Woodhouse "Out of Children's Needs, Children's Rights: The Child's Voice in Defining the Family"(1993) 8 BYU Journal of Public Law 321 at 321-323; John Eekelaar "The Interests of The Child and the Child's Wishes: The Role of Dynamic Self- Determinism" (1994) 8 International Journal of Law and the Family 42.

[31] Woodhouse, above n 30, at 321-323; Kilkelly, above n 13, at 59-60.

[32] Kilkelly, above n 13, at 59-60.

[33] At 59-60; see Committee for the Rights of the Child, above n 12, at [43]–[45]; Committee on the Rights of the Child, *General Comment No. 12 The Right of the Child to be Heard* (2009)) CRC/C/GC/12 at [70]–[72].

[34] Kilkelly, above n 13, at 61; See also Committee for the Rights of the Child, above n 12, at [6].

[35] Committee for the Rights of the Child, above n 12, at [6].

focused approach to decision-making. Furthermore, the principle's adaptability and evolution to incorporate the collective cultural rights and needs of Indigenous children is particularly pertinent for tamariki and rangatahi Māori, as it enables the consideration of collective cultural rights in decision-making processes that honour their unique cultural context. Moreover, the emphasis on the State's duty to implement the best interests principle provides this thesis with a solid foundation for asserting that New Zealand has a legal obligation to consider and apply the best interests principle in domestic contexts to aid children in fully realising their rights under the CRC. Essentially, the best interests principle provides a solid theoretical and practical basis for the argument that it can and should be used as a vehicle to assist tamariki and rangatahi Māori to achieve the highest attainable standard of mental health.

When determining a child's best interests, the Committee has identified several key elements to be considered. The child's views are paramount, as children have the right to express their opinions in decisions affecting them, with these views given due weight according to their age and maturity.[36] The child's identity, including characteristics such as national origin, religion, cultural identity, and the desire to ensure the child grows up in his or her own culture, is also crucial.[37] Preservation of the family environment and relationships is emphasised, as the family is considered the fundamental unit of society, and maintaining family unity is crucial.[38] Family is construed broadly to include wider family members or the community.[39] Care, protection, and safety of the child are essential, and involve ensuring the child's well-being and development, including protection from all forms of physical or mental violence.[40] Emotional care is recognised as a basic need for a child, and consideration must be given to future/risk of emotional harm and the child's right to health is important to assessing the child's best interests.[41] The right to health is also listed as being "central to a child's best interests".[42] Lastly, the child's right to education, including access to quality education and early childhood education, is an

[36] Committee for the Rights of the Child, above n 12, at [13]-[17].
[37] Committee for the Rights of the Child, above n 12, at [13]-[17].
[38] At [55]-[59].
[39] At [55]-[59].
[40] At [71]-[74].
[41] At [13]-[17] .
[42] At [77].

important factor in determining the child's best interests.[43] The Committee is clear when assessing best interests, all relevant elements should be considered, with the weight of each element depending on the others. The purpose is to ensure the full and effective enjoyment of the rights recognised in the CRC and the holistic development of the child.[44]

The elements outlined by the United Nations in assessing a child's best interests, particularly the right to health, mental health/emotional well-being, and preservation of identity and family relationships, all converge to highlight importance of a child's mental health. These factors collectively underscore the need to consider a child's mental health and well-being when applying the best interests principle. This interpretation is highly relevant to this thesis as it supports the argument that the best interests principle can be utilised as a vehicle for change in mental health. By recognising the centrality of mental health in determining a child's best interests, this principle can be a vehicle for improving the right to mental health for tamariki and rangatahi Māori.

A natural concern arises regarding the applicability of the best interests principle to Indigenous children, given its origins are "tied to a European colonial ideology". [45] As Cleland notes, the rights of Māori children necessitate the application of concepts and principles from te ao Māori lens as "Māori children, being taonga, should be viewed as indivisible from their cultural collective".[46] Furthermore, she contends that the CRC fails to incorporate Māori perspectives on children and family structures.[47] Thus, some academics question whether the best interests principle can be reconciled with the collective cultural rights of Indigenous communities.[48] Breen, for instance, states:[49]

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[43] At [13]-[17]. There is scholarly work done that shows positive effect on a child's well being from having their right to education met; see for example Hanne Bjørnsen, Geir Espnes, Mary-Elizabeth Eilertsen, Regine Ringdal and Unni Moksnes "The Relationship Between Positive Mental Health Literacy and Mental Well-Being Among Adolescents: Implications for School Health Services" (2019) 35 The Journal of School Nursing 107; Ministry of Education "Support Your Child's Wellbeing and Mental Health" (18 December 2023) Ministry of Education <https://www.education.govt.nz/parents-and-caregivers/schools-year-0-13/health-safety-and-wellbeing/support-your-childs-wellbeing-and-mental-health>

[44] Committee for the Rights of the Child, above n 12, at [17]-[18].

[45] Amanda Tesarek "Making the "Best" Better: Transferring Best Interests Determinations to Tribes as A Solution to the Ongoing Post-colonial Indigenous Child Welfare Crisis" (2021) 30 Minnesota Journal of International Law 165 at 178.

[46] Alison Cleland "Realising Māori Children's Rights Unconventional Thinking Required" (2023) 31 The International Journal of Children's Rights 3 at 22.

[47] At 32.

[48] See generally Cleland, above n 46; See also Alston, above n 8; Tesarek, above n 45.

[49] Breen, above n 8, at 22.

> [m]any of the difficulties and criticisms concerning the tradition of the best interests of the child relate to the conflict of the best interests tradition with other traditions…[s]uch difficulties are emphasised by a conflict with traditions that are non-Western in nature and which have a different tradition of the relationship between the family and the child, where the protection and the rights of the latter in particular are often subsumed in the common good. As such, it is arguable that the validity of the standard of the best interests of the child, as an international mechanism for the protection of the welfare of the child that has failed to take account of such different traditions, is questionable.

However, this point has been addressed by the CRC Committee which emphasises that special consideration is required when applying the principle of the child's best interests to Indigenous children.[50] It notes that the best interest principle is understood as both a collective and individual right, and its application necessitates examining how it relates to collective cultural rights.[51] When evaluating the best interests of an Indigenous child, states should take into account the child's cultural rights and their need to exercise these rights collectively with other members of their Indigenous community. This consideration is essential in the assessment process.[52] The Committee urges States to consider Indigenous children's cultural rights and involve Indigenous communities in decision-making processes.[53] The Committee distinguishes between individual and group best interests, emphasising that collective cultural rights are part of determining a child's best interests. States are required to systematically apply this principle across their legislative, administrative, and judicial systems, considering the impact of decisions on children's rights.[54]

In contemporary discourse, scholars discussing the welfare of Indigenous children refer to the UNDRIP, and the principle of self-determination therein,[55] which encompasses cultural rights, and contends that Indigenous communities should be empowered to define what constitutes the child's best interests within their cultural context, whilst still

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[50] Committee on the Rights of the Child *Indigenous Children and Their Rights Under the Convention* UN Doc CRC/C/GC/11 (2009) at [30]-[33].

[51] At [30]-[33].

[52] Te Puna Rangahau o te Wai Ariki Aotearoa New Zealand Centre for Indigenous Peoples and the Law Auckland *The Rights of Tamariki Māori in Aotearoa New Zealand* (The University of Auckland, Thematic Report) at 10.

[53] Committee on the Rights of the Child, above n 50, at [30]-[33].

[54] At [30]-[33].

[55] United Nations Declaration on the Rights of Indigenous Peoples GA Res 61/295, A/Res/61/295 (2007), Article 3.

adhering to this guiding principle.[56] As a proposed solution, these scholars advocate for the transfer of child welfare jurisdiction to Indigenous groups, thereby enabling a culturally appropriate application of the "best interests" concept whilst honouring their rights to self-determination.[57] Others have proposed reconceptualising the best interest principle from an individualistic to a relationship-based approach, placing the child within a broader family and community context.[58] This comprehensive approach views the child as an integral part of a larger familial group and society, taking into account both individual and collective rights.[59] It emphasises cultural competence, particularly in collectivist societies where children's well-being is often inextricably linked with their family and community.[60] This approach moves away from a strictly individualistic interpretation towards a more comprehensive understanding of a child's well-being, considering the complex web of relationships and cultural factors.[61] It aims to provide a more culturally appropriate and nuanced framework.[62]

In this regard, the CRC Committee's General Comment No. 11, emphasises the adaptability and capacity of the best interests principle to incorporate collective cultural rights.[63] This development has expanded the principle from a narrow protective focus to a more comprehensive consideration of children's welfare, rights, and cultural context.[64] The Committee's guidance emphasises that the best interests principle should be understood as both an individual and collective right for Indigenous children. This interpretation allows for the consideration of cultural rights and the need to exercise these rights collectively within Indigenous communities.[65] This approach can reconcile the best interests principle with the collective cultural rights of Indigenous peoples, making it more culturally appropriate and responsive to the needs of Indigenous children. The ability of the best interest principle to be flexible and responsive to collective cultural rights

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[56] See generally Tesarek above n 45; Nancy With "The Ambiguity of Culture as a Best Interest Factor: Finding Guidance in the Indian Child Welfare Act's Qualified Expert Witness"(2012) 35 Hamline Law Review 729.

[57] See generally Tesarek above n 45; With, above n 56, at 729.

[58] Admark Moyou "Reconceptualisng the 'Paramountcy Principle': Beyond the Individualistic Construction of the Best Interests of the Child" (2012) 12 African Human Rights Law Journal 142 at 142-177.

[59] At 142-177.

[60] At 142-177.

[61] At 142-177.

[62] At 142-177.

[63] Macbeth, above n 7, at 19.

[64] See generally Macbeth, above n 7.

[65] Committee on the Rights of the Child, above n 50, at [23]-[29].

supports the core argument of this thesis that it can be used to assist tamariki and rangatahi Māori in achieving the highest attainable standard of health. This internationally obligated right, which New Zealand is required to uphold under its international law obligations demonstrates adaptability in recognising collective cultural rights. Consequently, the flexibility of the best interests principle allows it to recognise the unique culture and Māori worldview, making it applicable for tamariki and rangatahi Māori. The General Comment already includes the right to health within its scope and considerations when assessing best interests which adds weight to its relevance to this thesis. Subsequent chapters will explore this in more detail.

The Committee also emphasises that the best interests principle is interconnected with three other key principles in the CRC: non-discrimination (Article 2), right to life, survival, and development (Article 6), and right to be heard (Article 12).[66] The Committee is clear that these principles inform the best interests standard. For Indigenous children, including Māori, these principles are particularly relevant. Eliminating discriminatory conditions and ensuring equal enjoyment of CRC rights are crucial for their best interests. The Committee urges nations to provide culturally appropriate services in health, education, housing, and juvenile justice.[67] To illustrate, the non-discrimination principle ensures that Māori children have equitable access to mental health services, free from prejudice, thereby addressing potential systemic inequities that might contribute to poor mental health outcomes. The right to life, survival, and development is directly linked to suicide prevention and the promotion of mental well-being, calling attention to the State's duty to safeguard children's lives and support their development, including mental health.[68] The Committee says that child development needs to be viewed holistically, encompassing physical, mental, spiritual, moral, psychological, and social growth. [69] These guiding principles are relevant to addressing the mental health crisis among tamariki and rangatahi Māori. Similarly, the right to be heard, both individually and collectively, is essential for children's participation in matters affecting them.[70] Facilitating the effective participation of tamariki and rangatahi Māori in decisions that affect their mental health

[66] Committee on the Rights of the Child, above n 50, at [23]-[29]; See also Committee for the Rights of the Child *General Comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (Article 3, Paragraph 1),* CRC/C/GC/14 (2013).
[67] Committee on the Rights of the Child, above n 50, at [23]-[29].
[68] Committee for the Rights of the Child, above n 12, at [42].
[69] Committee on the Rights of the Child, above n 50, at [23]-[29].
[70] At [23]-[29].

can result in culturally appropriate interventions, legislation and policies being devolved. Indeed, the Committee urges nations to collaborate closely with Indigenous children in the creation, implementation, and execution of policies and strategies aimed at fulfilling the CRC.[71] By considering mental, spiritual, and social aspects alongside physical health, this holistic approach aligns with Māori cultural perspectives on well-being, potentially enhancing mental health outcomes,[72] as elaborated in Chapter Four.

The preceding section has provided an overview of the best interests principle as it has been elaborated within the context of the CRC, its adaptability in incorporating collective cultural rights, and the Committee's emphasis on factors to consider when evaluating a child's best interests. Building upon this foundation, the subsequent portion of this chapter will examine the application and interpretation of the best interests principle in New Zealand law. This analysis is pertinent as it will demonstrate that New Zealand law and policy (albeit to a limited extent) are already utilising this principle. This observation strengthens the thesis argument that the best interests principle can serve as a mechanism to aid tamariki and rangatahi Māori in attaining the highest possible standard of mental health.

3.3. New Zealand Legislation

New Zealand possesses two main legislative instruments that explicitly employ the best interests principle as the paramount consideration in all decisions concerning children.[73] These statutes are the COCA and OT Acts. The best interests principle is referred to as the paramount principle in both pieces of legislation, signifying that when decisions about a child are being made, the Court must prioritise the subject child's best interests and well-being/welfare.[74] Although these laws do not directly address mental health, examining

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[71] At [39].

[72] Mason Durie "Pūmau Tonu te Mauri Living as Māori Now, and in the Future"(Ministry of Maori Development, Discussion Paper, 2017); See also Mason Durie "Transforming Mental Health Services in Aotearoa New Zealand" in Te Kani Kingi, Mason Durie, Hinemoa Elder, Rees Tapsell, Mark Lawrence and Simon Bennett (eds) *Maea Te Toi Ora: Māori Health Transformations* (Huia Publisher, Wellington, 2018).

[73] David Archard and Marit Skivenes "Deciding Best Interests: General Principles and the Cases of Norway and the UK" (2010) 5(4) Journal of Children's Services 43. While not an article on New Zealand Courts, this article discusses in general terms the problems encountered by the Courts in applying the best interests principle.

[74] Care of Children Act 2004, above n 2, s4; See also Oranga Tamariki Act 1989, s 4. See generally Peter Boshier "The Care of Children Act 2004: Does it Enhance Children's Participation and Protection Rights" (2005) 9 Journal of Children's Issues Centre 7 at 7-12; Nicola Taylor, Pauline Tapp, and Mark Henaghan

them is essential as they demonstrate that New Zealand's legal and policy framework already incorporates the best interests principle, albeit in custody and care and protection cases specifically. Moreover, these cases demonstrate that New Zealand courts have experience in applying this principle and judicial decisions provide some important insights into the understanding and application of the best interests principle from a legal perspective. Consequently, a thorough examination of these Acts and related case law is valuable for this thesis as it supports the central argument that the best interests principle can be utilised to enhance the mental health of tamariki and rangatahi Māori in New Zealand.

Before turning to the case law, the following paragraphs outline the key provisions of the COCA and the OT Act that speak to what a Court must consider when determining the best interests and well-being of a child. The predecessor to the COCA (the Guardianship Act 1968) was considered to be challenging because it was "premised upon a traditional nuclear family model that does not reflect the diversity of family arrangements that now exist in New Zealand".[75] This challenge is further compounded "when the varied cultural dimensions of families are considered".[76] As a result there was a push for legislation that recognises and supports all types of family units that care of children, for example, single parent households, extended families, reconstituted families, and de facto relationships (including those of the same sex).[77] The Care of Children Bill 2003 identified as one of its key objectives the recognition of diverse familial arrangements and also advocating for children's rights in accordance with UNCROC.[78] According to the commentary, the addition of "best interests" appeared to be motivated by a desire to align the Act more closely with CRC.[79] In assessing and applying what is in a child's best interests and welfare, the legislation requires the courts to look at principles outlined in s 5.

"Respecting Children's Participation in Family Law Proceedings" (2007) 15 The International Journal of Children's Rights 61; Nicola Taylor, Megan Gollop and Mark Henaghan *Relocation Following Parental Separation: The Welfare and Best Interests of Children* (Centre for Research on Children and Families and Faculty of Law, University of Otago, June 2010).

[75] Robert Ludbrook and Lex de Jong *Care of Children in New Zealand Analysis and Expert Commentary* (Brookers, Wellington, 2005) at 6.

[76] Macbeth, above n 7, at 90; Care of Children Bill 2003, (54-2) (Select Committee Report) NZ Parliamentary Library, Bills Digest No 978.

[77] Macbeth, above n 7, at 90; Care of Children Bill 2003, above n 76.

[78] Ludbrook and de Jong, above n 75, at 6; Macbeth, above n 7, at 89; see also Care of Children Bill, above n 76, at 12 and 3.

[79] Westlaw Commentary *Child law* (looseleaf ed, Westlaw NZ) at CC4.02.

Section 5 of the COCA sets out six principles. These six principles relate to a child's safety; their care and development and upbringings being the responsibility of parents/guardians; a child's care and development should be facilitated by ongoing consultation and co-operation; continuity in care, development and upbringing sustaining a relationship with parents and family group, whānau, hapū or iwi which need to be preserved and strengthened, and a child's identity including cultural and language should be preserved and strengthened. As the Select Committee Report says, "[t]he principles are also structured in recognition of the fact that an integral part of the context of a child's best interests is the child's family and culture which may include members of the child's wider family".[80] The judiciary has been clear that these principles are a non-exhaustive list and has gone on to provide guidance on best interests and 'welfare'. For example, in *Director-General of Social Welfare v L,*[81] the Court of Appeal referred to welfare as the basic duties to feed, clothe and nurture. "Interests" have been referred to as the wider considerations affecting the chid, including the child's ongoing relationship with parents and family members.[82] In more recent times, this has been reaffirmed. For example, in *C v W,* the Family Court observed:[83]

> The addition of the term 'best interests' in s 4 COCA underlines that a decision must focus not only on the immediate day-to-day welfare of the child such as care and nurture, but also the long-term interests of ideally maintaining relationships with both parents. The inclusion of 'best interests' in the new legislation highlights the importance of the Court looking at the longer term developmental, educational, cultural, and familial needs of a child.

In *N v N,*[84] the Court observed that "welfare" as defined by the Concise Oxford Dictionary is "health, happiness and fortunes of a person", and "interests" means "advantage of benefit of someone".[85] Taking these definitions into consideration, Judge Burns affirmed that "Parliament intended there to be a significant change by adding

[80] Care of Children Bill 2003, above n 76, at 3.
[81] *Director-General of Social Welfare v L* [1989] 2 NZLR 314.
[82] At 324 and 325.
[83] *C v W* (2005) 24 FRNZ 872, [2005] NZFLR 953 at [24].
[84] *N v N* (2006) 25 FRNZ 356.
[85] At [44].

the words best interests. The range of factors that the Court can take into account have, in my view, considerably widened".[86]

At first glance these comments from the judiciary do not explicitly discuss the connection between best interests and mental health. However, it is argued that, despite a lack of explicit mention of mental health, there are some important inferences that can be made from their statements. The judicial comments clearly show the far reaching and broader considerations that can determine a child's best interests and welfare, which may in turn have a ripple effect on a child's mental health. An individual's overall wellness and ability to function are fundamentally linked to their mental health.[87] Therefore, good mental health is likely to be an implicit part of the "best interests" concept. The United Nations has emphasised that for Indigenous peoples, health is not only defined by individuals but is strongly connected to their community, land, and the natural environment.[88] Therefore when considering the right to health, a holistic assessment is necessary (this will be discussed in further detail in Chapter Four).[89]

The comprehensive approach to best interests by the judiciary, which includes factors such as ongoing relationships, long-term developmental needs, educational needs, cultural needs, familial needs, preparation for the future, teaching life skills, and role modeling, all contribute to a child's overall sense of well-being. These elements are interconnected and can significantly impact a child's mental health. The United Nations has emphasised that attaining good mental health is intricately linked to other human rights and social determinants including children's rights to healthy development, education, play, and creativity,[90] all of which impact their health.[91] Therefore, when considering the best

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[86] *N v N* , above n 84 at [44]; See also *M v O* FC Te Awamutu FAM-2005-072-185, 29 June 2007.

[87] *Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* UN Doc A/HRC/44/48 (15 April 2020) [1]-[2]; See also Shiv Gautam, Akhilesh Jain, Jigneshchandra Chaudhary, Manaswi Gautam, Manisha Gaur and Sandeep Grover "Concept of Mental Health and Mental Well-being, Its Determinants and Coping Strategies" (2024) 66 Indian Journal Psychiatry 231.

[88] For example in General Comment No. 21, the CESCR commented that the essential communal aspect of Indigenous peoples' cultural life is crucial for their survival, well-being, and complete development; Committee on Economic, Social and Cultural Rights *Right of Everyone to Take Part in Cultural Life (Article. 15, Paragraph 1(a), of the International Covenant on Economic, Social and Cultural Rights),* UN Doc E/C.12/GC/21 (2009) at [22].

[89] Government Inquiry into Mental Health and Addiction '*He Ara Oranga' Report of the Government Inquiry into Mental Health and Addiction* (Government Inquiry into Mental Health and Addiction, Wellington, 2018) at 16-17.

[90] *Report of the Special Rapporteur,* above n 87, at [23]-[25].

[91] At [35].

interests of the Indigenous child, States should take into account cultural rights and the need to exercise these rights collectively within the child's wider family group.[92] As a guiding principle within the CRC, the best interests principle enables the assessment of both collective cultural rights and responsibilities, as well as individual rights and responsibilities, when determining what is in the best interest of a particular Indigenous child.[93] When applying the best interests principle to children and young people, the United Nations acknowledges and declares that "nurturing and supportive family environments are essential for adolescents to reach their full potential and achieve optimal health as they transition into adulthood".[94] This is particularly crucial for both the physical and mental well-being of children.[95] For instance, strong, positive relationships with family members can provide emotional support and stability, fostering good mental health. Meeting long-term developmental needs ensures proper cognitive and emotional growth, which are crucial for mental well-being. Appropriate education can boost self-esteem and provide a sense of accomplishment, positively affecting mental health. Cultural and familial needs, when met, can provide a sense of belonging and identity, contributing to emotional stability. Preparation for the future and teaching life skills can reduce anxiety about adulthood and increase confidence, supporting good mental health. Positive role models can influence a child's self-concept and aspirations, contributing to their overall mental and emotional development. Essentially, the ripple effect of addressing these broader factors would be likely to result in improved mental health outcomes for the child, as illuminated by the United Nations.[96] In New Zealand while not explicitly stated by the judiciary, the holistic nature of the "best interests" concept implicitly includes consideration of a child's mental health.

There are some criticisms of the COCA and its applicability to tamariki and rangatahi Māori. Cleland argues the COCA does not align with Māori family structures and values, perpetuates the cultural assimilation that began with colonial guardianship laws,[97] and that it is a monocultural law that privileges the Western nuclear family model and parental

[92] Committee on the Rights of the Child, above n 50, at [10].
[93] Macbeth, above n 7, at 62.
[94] *Report of the Special Rapporteur on the Right of Everyone to the Highest Attainable Standard of Physical and Mental Health* A/HRC/32/32 (4 April 2016) at [46] .
[95] At [46].
[96] At [40]-[46].
[97] Cleland, above n 46, at 669-670.

rights, while marginalising te ao Māori and tikanga Māori.[98] In this view, the legislation's limited references to culture, whānau, hapū, and iwi are insufficient to address the importance of these entities in Māori child-rearing practices and decision-making processes.[99] Court decisions applying COCA principles tend to prioritise parental rights over tikanga Māori values such as whakapapa and whanaungatanga.[100] Consequently, the law fails to adequately recognise and respect Māori family structures and collective decision-making processes, rendering it unsuitable for a bicultural Aotearoa New Zealand. This misalignment between COCA and Māori families underscores the need for transformative reform to develop family law principles and processes that are truly reflective of Aotearoa's bicultural nature.[101] The writer has shared these criticisms to demonstrate that the there is room for improvement in the application of the COCA, but, nonetheless, the best interests principle remains important and useful because it is flexible enough to meet Cleland's concerns and be adapted to take cognisance of collective rights.

Similar to the COCA, the OT Act also encompasses the best interests principle and a wider array of principles that must be taken into consideration when determining a child's best interests and well-being.[102] It is important to note that the two Acts are not mutually exclusive.[103] The philosophy of the 1989 Act is underpinned by the view that the well-being of children is best assured if the responsibility for their care resides primarily with their family or whānau with minimum State intervention.[104] The Court has been clear that in order to determine best interests and well-being, the principles stated in ss 5 and 13 must be kept in mind. These sections echo the paramountcy principle (the best interests and well-being principle) and the need to protect children and young persons from harm and promote the need for decisions to be made in a holistic manner. Sections 5 and 13 describe a framework for considering the best interests of tamariki. These principles emphasise child participation, a holistic approach and recognition of Māori cultural concepts such as mana tamaiti, whakapapa, and whanaungatanga. The OT Act stresses

98 At 669-670.

99 Cleland, above n 46, at 669-671.

100 At 669-670.

101 At 697.

102 This legislation served as the fundamental statute concerning state intervention for several decades for children and young people who were or could be at risk. The origins of the Act can be traced back to the Puao-Te-Ata-Tu Report 1988; Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare *Puao-te-Ata-tu: Daybreak* (Department of Social Welfare, Wellington, 1988).

103 See *TWA v HC* [2016] NZCA 459.

104 Oranga Tamariki Act, above n 74, ss 5, 14.

the importance of maintaining the child's sense of belonging, involving family and community in decision-making, and incorporating a rights-based approach based on the UNCROC.[105] The principles also focus on ensuring decisions and interventions are culturally sensitive, timely and age appropriate.[106] In particular, s 5(1)(b)(iii) provides that the court must be guided by the principles including respecting and upholding a child's rights under the UNCROC. The judiciary has expressed the view that ss 4A, 5 and 13 highlight that the "well-being of the child is entwined with that of his or her family; the child's well-being is to be promoted and the child is to be severed from the family to the least extent necessary, and only as a last resort".[107] Arguably, the importance placed by both Acts on family involvement and participation in decision-making can be applied in other contexts too such as decision making frameworks in mental health.

Prior to delving into case law analysis, it is important to address the removal of s 7AA of the OT Act,[108] which mandated Treaty of Waitangi obligations for the Chief Executive to collaborate with iwi. This has now been passed into law, which means that the obligation is no longer in force. Chapter Seven will further examine the presence of Treaty principles in national legislation but for this chapter's purposes, it is essential to note s 7AA's importance for tamariki Māori. Those obligations required "recognising and providing a practical commitment to the principles of TOW".[109] Fulfilling those obligations necessitated considering "the whakapapa of Māori children and young persons and the whanaungatanga responsibilities of their whanau, hapu and iwi".[110] That approach necessitated viewing the child within their cultural context rather than in isolation.[111] The removal of s 7AA has been criticised as lacking justification and sufficient evidence to support the government's claims that s 7AA negatively impacted tamariki Māori.[112] Eliminating s 7AA, will undoubtedly influence how best interests are interpreted and

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105 Oranga Tamariki Act, above n 74, s 5(1)(b)(iii) says that a child's rights must be respected and upheld.
106 Oranga Tamariki Act, above n 74, ss 5 and 13.
107 *Re DM FC Greymouth* FAM-2008-018-95 3 September 2019 at [23] J; *Chief Executive of the Ministry of Social Development v Ingham* [2014] NZFC 5529 at [15]-[16].
108 Oranga Tamariki (Repeal of Section 7AA) Amendment Bill 2024 (43–2).
109 Westlaw Commentary, above n 79, at NT1.2.03.
110 Oranga Tamariki Act, above n 74, s 7AA(2)(b).
111 Oranga Tamariki Act, above n 74, s 7Aa(2)(C)(i)-(vi).
112 Kendra Cox "What's Really Behind the Repeal of Section 7AA?"(13 June 2024, University of Auckland) <https://www.auckland.ac.nz/en/news/2024/06/13/whats-behind-repeal-of-Section-7aa.html>.

applied in future case law under the OT Act, and may have a broader effect on realising the right to mental health of tamariki and rangatahi Māori.

In developing a best interests framework for tamariki and rangatahi Māori rights to mental health, it is important to consider the application (albeit limited) of the best interests principle in New Zealand. It can be argued that the best interest frameworks in the COCA and OT Act could be modified and applied to address the mental health needs of tamariki and rangatahi Māori. This approach is supported by the fact that the judiciary already employs the best interests principle when making decisions about children and young people.

Bearing these observations in mind, the subsequent sections will analyse judicial interpretations of the best interests principle in OT Act and COCA cases, with particular emphasis on the judges' statements. Given the extensive nature of case law, this thesis has concentrated on significant cases and those from superior courts.

3.4. Common Themes in OT Act and COCA Cases

The analysis of the case law below, where the Court had to consider what was in the best interests of children in OT Act and COCA cases reveals some common themes. They can be coalesced as follows:

- Recognition that best interests principle currently applied in New Zealand laws is flexible;
- Child's safety is paramount;
- Emphasis on maintaining relationships with family, whānau, hapū, and iwi;
- Acknowledgment of cultural identity as crucial to a child's well-being; and
- Consideration of both immediate and long-term impacts on a child's development.

Although the case law does not frequently address mental health explicitly, it is clear that the judiciary places significant emphasis on a child's psychological welfare. For the purposes of this thesis, it is argued that here is a strong relationship between psychological well-being and mental health.[113] Certain language in these Acts alludes to psychological well-being. For instance, the phrase "continuity and stability in care" implies that a child's emotional and psychological welfare is a crucial factor in determining their best interests. The implementation of the best interests principle in these statutes, although narrow, provides insight into the principle's application and key emerging themes, such as its inherent flexibility. With this groundwork laid, the writer can now delve into specific legal cases. This investigation will shed further light on how the principle of best interests might be applied to mental health situations involving tamariki and rangatahi Māori.

A seminal case in family law is *Kacem v Bashir*[114] which involved a mother's request to relocate two children to Australia. This was denied by the Court of Appeal and subsequently upheld by the Supreme Court. Chief Justice Elias provided a distinct perspective on the interpretation of the COCA's s 5 principles. Her Honour held that the s 5 principles are not rigid rules but flexible guidelines that should be considered holistically, framing the assessment of a child's best interests within the broader context of family relationships, continuity, and stability.[115] The Court held that: [116]

> Everything will depend on an individualised assessment of how the competing contentions should be resolved in the particular circumstances affecting the particular children. If, on an examination of the particular facts of a relocation case, it is found that the present arrangements for the children are settled and working well, that factor will obviously carry weight in the evaluative exercise.

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[113] There is a body of medical literature that discusses the interconnectedness of psychology and mental health. See Hans-Ulrich Wittchen, Susanne Knappe and Gunter Schumann "The Psychological Perspective on Mental Health and Mental Disorder Research: Introduction to the ROAMER Work Package 5 Consensus Document" (2014) 23 International Journal of Methods in Psychiatric Research 15 at 27; Natalie Harrison "Book Review: Promoting Psychological Well-being in Children and Families" (2016) 18 Social Psychological Review 50; Isabelle Savoye, Nathalie Moreau, Marie-Christine Brault, Alain Levêque and Isabelle Godin "Well-being, Gender, and Psychological Health in School-aged Children" (2015) 73 Archives of Public Health 52.

[114] *Kacem v Bashir* [2010] NZSC 112. See also *Justice v HJ* [2006] NZSC 97. See generally Mark Henaghan "Relocation cases – the Rhetoric and Reality of a Child's Best Interests – A View From The Bottom Of The World" (2011) 23 Child and Family Quarterly 226.

[115] *Kacem v Bashir*, above n 114, at [1] – [9].

[116] At [24]; see also *Justice v HJ*, above n 114 , at [24].

Similarly, in *Justice v HJ*, the Supreme Court commented that when determining a return "the judge should consider whether return would or would not be in the best interests of a child who has necessarily already have been found to be settled in his/her new environment. That very settlement implied than an order of return may very well not be in the child's best interests".[117]

The flexible and context-specific interpretation of the best interests principle by the Supreme Court has profound implications for children's mental health. The Court acknowledges the unique nature of each child's situation and recognises that their well-being is closely intertwined with various factors, including family dynamics, consistency, and environmental stability. This approach enables a more sophisticated assessment of a child's best interests, taking into account their present mental condition, emotional bonds, and the potential consequences of disrupting their established surroundings. The Court's position in *Kacem v Bashir* and *Justice v HJ* highlights the significance of considering a child's adjustment and acclimatisation to their current circumstances, recognising that removing a child from a stable environment could potentially be detrimental to their mental health and overall welfare.

Another key aspect when considering best interests is safety. In s 5(a), a child's safety *must* be protected. In *Lowe v Way*, his Honor Priestley J concludes that s 5 principles must be read in context in the light of the purpose of the Act and the paramountcy principle.[118] It is important to note that the judiciary has interpreted safety as a comprehensive concept encompassing a child's physical health and emotional well-being. This is exemplified in *Henderson v Henderson* where the Court determined that psychological abuse may involve isolating children from their families and professionals, abducting them, or failing to protect them from community harm.[119] Another more recent example is in *Re WH* where the Court evaluated the most suitable orders for WH's welfare and best interests.[120] The non-relative caregivers sought a special guardianship order, which if granted, would sever a child's biological parents' right to make applications in the Family Court, without the leave of the Court. The Judge concluded that changing the child's living situation could cause confusion, distress, and potential psychological harm, highlighting the importance

[117] *Justice v HJ*, above n 114, at [86].
[118] *Lowe v Way* [2015] NZHC 93 at [34].
[119] *Henderson v Henderson* [2019] NZFC 9936 at [40] and [60]; See also *Nikau v Tatchell* [2018] NZFC 1239.
[120] *Re WH* [2021] NZFC 4090.

of early childhood attachments. The Court found such risks detrimental to a child's best interests.[121] This is a useful example of what the courts perceive as having a detrimental effect on a child's mental health. When evaluating safety and risks, the psychological impacts on a child's well-being are crucial, and safety is prioritised, whether it concerns physical or psychological well-being, including disrupting any emotional attachment the child may have already formed in their lives.

Similar comments about psychological well-being were made in *Atkinson v Ministry of Social Development*, which concerned a mother seeking increased access to her child.[122] The Family Court commented when a child has formed bonds and is already part of a family, and experiencing a sense of belonging, it is crucial to reunite the child with that family to preserve this connection, as long as the child's safety is ensured. In *Atkinson*, the key difference is that the child was taken at birth and had never formed an attachment to his mother.[123] On appeal, the Court had to decide between the mother's claim that it was in the child's interest that she had frequent access and the Ministry's claim that the child's psychological attachment to his new family must be nurtured and would be seriously impaired if access was too frequent.[124] In deciding for the latter, the Court determined that the child's psychological attachment should remain intact, and they must be able to cultivate and sustain a sense of belonging. Permitting or encouraging developments that could disrupt this new family environment may compromise the child's sense of security and belonging.[125] The Family Court, in *Hughes v Ministry of Social Development*, echoed these sentiments, asserting that when faced with a choice between safe non-kin and kin placements, the legal principles still lend substantial weight to kin placement. This preference is backed by well-established social science research that observes that "Children in non-kin foster care are exposed to heightened risks of instability, transience, and loss of personal and cultural identity".[126] While these risks may not always materialise, the consistent documentation of these elevated risks over the years has informed the underlying policy of the legislation. Two noteworthy aspects of this statement are relevant and these are the courts' recognition of factors that jeopardise mental health outcomes

[121] *Re WH*, above n 120, at [72]-[76].
[122] *Atkinson v Ministry of Social Development* HC Auckland CIV-2008-404-6888, 9 April 2009.
[123] At [12].
[124] At [64].
[125] At [58].
[126] *Hughes v Ministry of Social Developmen*t [2014] NZHC 3093 at [51].

and the measures that can be implemented to safeguard the child's best interests, both generally and specifically in relation to mental health.

These comments by the judiciary demonstrate that judges are considering children's psychological attachments and any long-term implications for psychological and emotional well-being in their decision-making process. The courts' emphasis on maintaining a child's sense of belonging, nurturing psychological attachments, and considering long-term impacts on development indicates an implicit recognition of mental health factors. This judicial approach aligns with the broader interpretation of the "best interests" principle, encompassing various aspects of a child's well-being, including mental health. Judicial interpretation aligns with the comments made by the United Nations namely that the best interests of the child be viewed holistically, encompassing physical, mental, spiritual, moral, psychological, and social growth.[127] It supports the argument central to this thesis, that the best interests principle could be used effectively to improve the mental health situation of tamariki and rangatahi Māori in New Zealand. The existing judicial practice of considering psychological well-being, even when not explicitly mandated, suggests potential for more direct application of the best interests principle to the mental health context for tamariki and rangatahi Māori.

There are other aspects to the determination of the best interests of the child by the Court and that is the need to maintain a child's identity, and familial relationships. General Comment No 14 has acknowledged the significance of a child's existing relationships with family members and other key individuals as a crucial factor in determining their best interests. These connections are fundamental to the child's socialisation process and play a vital role in developing and maintaining their psychological stability.[128] Regarding familial relationships, the legislation affords parents a privileged position. As Tipping J stated in *B v Department of Social Welfare* (1998) 16 FRNZ 522 (CA):[129]

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[127] Committee on the Rights of the Child, above n 50, at [23]-[29]; United Nations High Commissioner for Refugees *Guidelines for Determining the Best Interests of the Child* (UNHCR, Guidelines, May 2008) at 70; United Nations High Commissioner for Refugees *Guidelines on International Protection No. 1: Gender-Related Persecution within the Context of Article 1A (2) of the 1951 Convention and/or its 1967 Protocol Relating to the Status of Refugees* (2002).

[128] *General Comment No. 14,* above n 12 at [59].

[129] *B v Department of Social Welfare* (1998) 16 FRNZ 522 (CA) at 525-526.

> …the Act reflects the way in which the New Zealand Parliament has given effect to the [United Nations Convention on the Rights of the Child]. We must not be thought to be downplaying the importance which biological ties have in the principles underlying this area of the law. Ordinarily the interests and welfare of children are best served by their being in the custody of their biological parents, or at least one of them; that is to do no more than state the obvious and to recognise the fundamental role of the biological family in our society.

This principle is reflected in both the OT Act and COCA illustrating the courts' recognition of the importance of inclusive family-based decision-making processes. Essentially, this approach highlights the value placed on familial involvement and strengthening those relationships in matters concerning children's well-being. As Chapter Four will show in more detail, when considering the right to health for the child, maintaining familial ties for the child's psychological well-being is important. Reports have shown that intergenerational trauma stemming from the separation of children from their families has manifested in mental illness, abuse, suicide, and self-harm for Indigenous children.[130]

Although legislation grants parents a favoured status, legal rulings and laws clearly indicate that this cannot be the main factor when determining a child's best interests in particular cases. In these cases, the child's well-being and concerns are what the courts are guided by and, while maintaining and preserving the biological connection is important, it does not mean that this will always take precedence. In fact, the biological relationship is one of the principles the law requires judges to look at when determining what is in the best interests of a child.[131]

From the case law analysis above, it is clear that in making decisions about children's best interests and well-being , the judiciary needs to encompass a wide array of considerations. The determination of best interests is confined to the consideration of the s 5 principles in the COCA, and relevant sections in the OT Act. This is important to mention as at the

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[130] *Study by the Expert Mechanism on the Rights of Indigenous People The Right to Health and Indigenous Peoples with a Focus on Children and Youth* UN Doc A/HRC/33/57 (2016).

[131] See also *Department of Social Welfare v W* [1994] NZFLR 179; and *B Children* FC Palmerston North CYPF054/025/92 29 June 1993. Both cases address familial ties. The Courts found that the biological parents had subjected the children to abuse and the child must be protected from harm must take priority over maintaining the family unit. See also *D v W* (1995) 23 FRNZ 336.

core of this thesis is the argument that the best interests principle under international law is flexible and malleable to incorporate the collective cultural rights of Indigenous children and can be used as a vehicle for change to assist tamariki and rangatahi Māori to achieve the highest standard of mental health. It appears from the discussion that the judiciary are already doing this in the context of care and protection and custody cases.

In addition to the reliance on the best interests principle, New Zealand courts appear to be adopting a human rights approach or interpretation as stipulated under the UNCROC. The international human rights language surrounding the best interests principle, as articulated by the CRC Committee in General Comment No. 14, encompasses a range of elements to be considered when assessing a child's best interests.[132] To recap these elements include the child's views, identity (including cultural identity), preservation of family involvement and relationships, safety and care (including emotional care and needs), and the child's right to health and education. While courts may not explicitly use such human rights terminology, an examination of key themes emerging from their decisions reveals that they are, in fact, adopting a human rights approach. The courts consistently consider factors such as emotional needs, safety, and preservation of family relationships. Importantly, the core themes in the case law discussed above suggest a similar flexibility and malleability is present in the use of the best interest principle by the courts as envisaged under international law.[133] Given that the New Zealand courts have already demonstrated their willingness to incorporate human rights language this provides a strong foundation for extending the best interests principle to other areas, such as mental health.

To recap, the purpose of this chapter is to examine the use and application of the best interests principle in domestic law. The analysis of New Zealand's legal framework demonstrates that the best interests principle is already in use, albeit in a limited capacity within two specific pieces of legislation. This implementation provides valuable insights into the principle's application and key emerging themes, such as its inherent flexibility. Judicial interpretation of the best interests principle in New Zealand has been broad. While not explicitly mandated, courts have shown a tendency to consider a child's psychological well-being, which closely aligns with mental health considerations. This

[132] *General Comment No. 14,* above n 12, at [1]-[4], [32]-[35].
[133] *General Comment No. 14,* above n 12, at [9].

existing judicial approach provides a foundation for expanding the principle's application to mental health contexts. What this chapter shows is that the application of the best interests principle in mental health law can have a legal grounding. Given the courts' current interpretation and application, this extension is not a significant departure from existing practice. In fact, it can be argued that New Zealand is already moving in this direction, albeit indirectly. Common factors considered by courts and legislators when determining a child's best interests often include psychological and emotional well-being. This existing consideration of mental health-related factors supports the thesis's proposal to apply the principle explicitly in mental health contexts.

With this in mind, the next section will examine collective cultural rights. As elucidated at the beginning of this chapter, understanding of the best interests of Indigenous children encompasses collective cultural rights and their relationship with other concerns. Recognising the significance of collective rights in evaluating the best interests of the child, the next section examines how the judiciary has applied the principle of best interests and collective cultural rights.

3.5. Collective Cultural Rights

The OT Act contains provisions and concepts relating to children's cultural rights, particularly in ss 2, 5, 13, and 7AA.[134] It defines important concepts such as mana tamaiti, which denotes the inherent worth and dignity derived from a child's whakapapa and their connection to a whānau, hapū, iwi, or family group, in line with tikanga Māori and its cultural equivalents.[135] Additional concepts like whakapapa and whanaungatanga are also addressed in the Act.[136] Throughout these sections, there is a strong focus on acknowledging and reinforcing a child's familial responsibilities within their family, whānau, hapū, and iwi.[137] For this chapter's purposes, these cultural considerations are referred to as "collective cultural rights" (which will be examined more thoroughly in the

[134] In other areas of the law, such as *Takamore v Clarke* [2012] NZSC 116, the Judiciary has been confronted with Māori customary practices and its presence in the common law. It is interesting to note that in this case the Supreme Court noted the importance of Māori custom and tikanga. While this case is not related to family law, the discussion is still significant to show the integrating of Māori customary law into New Zealand's common law requires balancing values that reflect both collective and individual perspectives.

[135] Oranga Tamariki Act, above n 74, s 2.

[136] Oranga Tamariki Act, above n 74, s 2.

[137] Ss 5, 79.

following chapter).[138] Balancing the legislative mandate to prioritise children's welfare and best interests with the Court's duty to acknowledge and uphold Māori principles has been labelled as a difficult challenge for the judiciary.[139] The examination of cases outlined subsequently illuminated several themes concerning the judicial interpretation of collective cultural rights when considering best interests and well-being of a child. These can be summarised as:[140]

- Strong emphasis on familial responsibilities and obligations;
- Recognition of the importance of whakapapa, whanaungatanga, and the role of whānau, hapū, and iwi in decision-making processes;
- Consideration of cultural harm alongside physical harm;
- Interconnectedness of individual and collective well-being for tamariki Māori; and
- The weight given to collective cultural rights remains unclear and can differ from case to case.

An early precedent for considering the collective cultural rights of Māori children was established in the case of *B v Director-General of Social Welfare*.[141] In this instance, a child's grandmother sought custody. The High Court determined that for tamariki Māori, the practice of child-rearing within a whānau context was crucial, encompassing not only the spiritual significance of the child's lineage but also their connection to the land.[142] The Court recognised "the importance of a child within a whanau and obligations and responsibilities of members of the whanau to that child, together with the advantages which that brings of the child being nurtured within a group".[143] These family structures and bonds warrant protection, such as under the Treaty of Waitangi and the Draft Treaty

[138] Douglas Saunders "Collective Rights" (1991) 13 Human Rights Quarterly 368.
[139] Te Puna Rangahau o te Wai Ariki Aotearoa New Zealand, above n 52, at 8.
[140] At 8.
[141] *B v Director-General of Social Welfare* [1997] 3 NZLR 179.
[142] At 18; See also *Re T* (2000) 19 FRNZ 11.
[143] *B v Director-General of Social Welfare,* above n 141, at 19.

on Indigenous Peoples' Rights, as it was then, "both of which formalise at least to some extent, what might otherwise be seen as vague generalities".[144]

In terms of determining the best interests of tamariki Māori in custody disputes, the Court pays strong attention to the views of the family and the need to preserve and strengthen these relationships. Similarly, when securing best interest of the child, the need to strengthen familial relationships, including encouraging the family's participation in decision-making, is a consistent theme across cases, such as *Chief Executive of Oranga Tamariki-Ministry for Children v LS*.[145] The Court held that continued whānau involvement should be maintained, and efforts should be made to promote a Māori child's mana through whanaungatanga and whakapapa.[146] It cannot be a "tick box exercise", rather steps are required to re-establish relationship with whānau.[147] Even if there are no whānau caregivers/placements available, this does not mean whānau are excluded, because their ongoing involvement is important as, "[t]here is still an obligation that the mana of a Māori child needs to be enhanced and promoted and maintained and this can only be done through the recognition and practical promotion of whanaungatanga and whakapapa".[148] In *McHugh v McHugh*, the Court reiterated similar sentiments, ruling that Oranga Tamariki has an obligation to conduct a comprehensive investigation into a child's whakapapa and exhaust all possibilities to secure a whakapapa placement.[149] It is required to search extensively for potential caregivers within the child's extended family network to ensure that "best efforts had been made on behalf of the child to promote the child's long term sense of identity and whakapapa".[150] This approach aims to safeguard the child's connection to their cultural heritage and familial roots and is in line with the international law commentary on securing the best interests of the child.[151] Indeed, New Zealand seems to be adhering to international norms through its robust focus on preserving collective cultural rights given the significant emphasis placed on Indigenous

[144] At 19; Ultimately the Court held that it would not be in the best interest of the child to place her with her grandmother (who did not raise her children) against the wishes of the mother.
[145] *Chief Executive of Oranga Tamariki-Ministry for Children v LS* [2020] NZFC 3632.
[146] At [32].
[147] At [32].
[148] At [32] See also *Chief Executive of Oranga Tamariki-Ministry for Children* [2020] NZFC 4271.
[149] *McHugh v McHugh* [2022] NZHC 1174.
[150] At [113] and [117].
[151] *General Comment No. 14,* above n 12, at [1]-[7].

familial connections when determining what is in the best interests of the child.[152] For example, in *B v Ministry of Social Development*[153] the Court had to determine whether a 15 months old child was placed in non-kin care or a kin placement. With the kin placement a genogram showed that "five generations ago an ancestor of the proposed female caregiver was a sibling of the child's ancestor eight generations previously".[154] The Court was clear that when considering whānau, hapū, and the wider family group, priority should be given to immediate family members (parents, siblings, grandparents, uncles, aunts, and first cousins) before more distant blood relatives.[155]

Understanding the interplay between an Indigenous child's individual and collective rights is crucial, as Māori identities are deeply embedded in communal contexts, rendering personal and group well-being inseparable. Collective cultural rights and the right to health are also inextricably linked (this will be explored further in the next chapter).[156] Therefore, this acknowledgement of collective cultural rights by the judiciary when assessing the child's best interests is particularly valuable for this thesis, as it shows that courts are indirectly considering the Māori child's right to mental health. By acknowledging the importance of cultural identity and community connections, courts are indirectly promoting Indigenous children's mental health and overall well-being. This holistic approach which recognises the interconnectedness of individual and collective rights, has the potential to significantly enhance mental health outcomes for tamariki and rangatahi Māori.

As discussed above, the courts also consider the stability in the current placement and the long-term impacts of a change for the child. This was the situation in *Chief Executive of Oranga Tamariki-Ministry for Children v MQ* where the judge had to make a decision about

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[152] Henry Kha and Marica Ratnam "The Right of Indigenous Children to Cultural Safety in the Family Laws of Australia and New Zealand" (2022) 45 University of New South Wales Law Journal 1367. There is a high number of tamariki and rangtahi Māori in State care. There is public concerns about the uplift and reverse uplift cases as well. The disproportionate and disparity of tamariki and Māori in State care is under the spotlight and a matter of deep concern. See generally Teuila Fuatai "State Law is Failing Tamariki Māori" (17 August 2022) The University of Auckland <.https://www.auckland.ac.nz/en/news/2022/08/17/state-law-is-failing-tamariki-maori.html>.

[153] *B v Ministry of Social Development* [2008] NZFLR 1012 (FC).

[154] At [61].

[155] At [136].

[156] Paul Whitinui "The Treaty and "Treating" Māori Health: Politics, policy and partnership" (2011) 7 AlterNative An International Journal of Indigenous Peoples 138; McBeth, above n 7, at 70-89.

placing a Māori child with non-Māori caregivers when the child had lived for three years with the child's iwi who at the time also had care of the child's younger sibling.[157] The Court stated that a holistic assessment analysis should take place and, in this particular case, and the potential impact on the child's psychological and emotional health from separating her from her current caregivers was both significant and uncertain. While the Court did not explicitly mention mental health, the consideration of a child's psychological and emotional well-being implies that the Court is in fact giving considerable weight to the potential impact a change in placement would bring to a child's mental/emotional well-being.[158] Similar comments have been made in *Ministry of Social Development v An* where the child had formed a strong bond with the caregivers.[159] The Court identified them as the "psychological parents" and the fact that they are not the biological parents did not justify a change in the circumstances. If the Court were to do that, "that ignores the significant of the psychological attachment which has developed virtually from birth between K [the child] and each of P and Sg [the caregivers]".[160] To this end, the courts deem that existing relationships formed by the child are important factors these include substantial relationships developed with foster parents and grandparents and maintaining the child's connection to their established family group. The Court is clear that decisions should avoid disconnecting the child from their established family relationships.[161]

The judicial interpretation of the best interests principle and collective cultural rights is important for this thesis.[162] By examining how courts have applied this principle in other areas of law, it is possible to draw insights for mental health interventions in law and policy as this thesis progresses. What the above analysis shows is that the courts are in fact already considering collective cultural rights of tamariki Māori in their decision

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157 *Chief Executive of Oranga Tamariki-Ministry for Children v MQ* [2021[NZFC 9089.

158 Similar comments made in *Ministry of Social Development v An* [2011] NZFLR 990 (FC).

159 *Ministry of Social Development v An,* above n 158.

160 At [79]; See also *Re NC* FC Porirua FAM-2010-091-364, 15 July 2011.

161 *Ministry of Social Development v An*, above n 158, at [101]-[103].

162 For further discussion on application of Māori concepts in Court see Natalie Ramarihia Coates "Me Mau Nga Ringa Maori I Nga Rakau A Te Pakeha? Should Maori Customary Law be Incorporated into Legislation?" (LLB (Hons) Dissertation, University of Otago – Te Whare Wananga o Otakou, 2009); Ani Mikaere "How Will the Future Generations Judge Us? Some Thoughts on the Relationship Between Crown Law and Tikanga Māori" (Paper Presented at the Ma te rango te Waka ka Rere: Exploring a Kaupapa Maori Organisational Framework, Te Wananga o Raukawa, Otaki, 2006); Some dissenting views are from Moana Jackson, "The Treaty and the Word: The Colonization of Māori Philosophy" in Graham Oddie and Roy Perrett (eds) *Justice Ethics and New Zealand Society* (Oxford University Press, 1992).

making. There is a strong emphasis on Māori cultural values, worldview and the importance of family in collaborative decision making, which is directly linked to positive mental health outcomes something which been recognised by the courts, and internationally.[163]

Although collective cultural rights are emphasised, a recent publication by Te Puna Rangahu o te Wai Ariki ("the report") highlights a discrepancy in judicial perspectives.[164] The Court faces challenges in balancing te ao Māori principles with the best interests principle when making decisions for tamariki Māori. Moreover, there is a lack of consensus among judges regarding the significance or weight that should be attributed to te ao Māori principles in determining "best interests of tamariki Māori".[165] According to the report, one of the most challenging issues faced by judges is balancing two key aspects of the OT Act legislation: the mandate to prioritise a child's welfare and best interests as the primary consideration, and the requirement to acknowledge and uphold te ao Māori principles. Reconciling these two directives has proven to be a complex task for the judiciary.[166]

Yet there are nuances in the application of the law, and the judge's application of the law can be subjective. For example, in *Moana's Mother v Smith & Chief Executive of Oranga Tamariki Ministry for Children & Taipa*[167] and *Re WH*,[168] the Judge argued against prioritising te ao Māori principles over other principles in the OT Act.[169] However, other judges emphasise the importance of these principles in determining the best interests of tamariki Māori. This was evident in *Chief Executive of Oranga Tamariki v BH*, where Judge Otene highlighted the significance of considering children's well-being in connection with their whānau. Her Honour stated that Māori principles and concepts "weigh with heft in favour of well-being of children being entwined with the well-being of their whanau and best assured when responsibility for their care rests primarily with their family, whanau, hapu

163 *Study by the Expert Mechanism*, above n 130, at [4]-[5].
164 Te Puna Rangahau o te Wai Ariki Aotearoa, above n 52, at 8.
165 At 8.
166 At 8.
167 At 9; See also *Moana's Mother v Smith & Chief Executive of Oranga Tamariki Ministry for Children & Taipa* [2022] NZHC 2934.
168 Te Puna Rangahau o te Wai Ariki Aotearoa, above n 52, at 9; see also *Re WH*, above n 120.
169 Te Puna Rangahau o te Wai Ariki Aotearoa, above n 52, at 8.

or iwi".[170] In cases involving significant impacts on a child's mana, whakapapa, and whanaungatanga, these principles should be given greater weight.[171] Additionally, cultural harm is considered alongside physical harm when assessing a child's protection, as enunciated by the Court in *Chief Executive of Oranga Tamariki v AR*.[172] Again, despite the different views amongst the judiciary as to the weight that must be given to cultural considerations, it is clear is that the Court gives weight to cultural considerations and the Māori child's place within her whānau . The courts recognise the interconnectedness of individual and collective well-being in Māori culture, and acknowledge that the child's identity and welfare are intrinsically linked to her cultural heritage and the broader community. This approach reflects an understanding of the importance of maintaining cultural connections and the role of extended family in Māori society. By considering these factors, the Court implicitly acknowledges the collective nature of Māori cultural rights, even if not explicitly framed as such. The decision demonstrates a nuanced understanding of how individual and communal interests are intertwined in Māori culture, and how this impacts the child's overall well-being and development when considering the best interests of tamariki Māori.

The report accurately highlights the High Court's endorsement of the *BH* approach in *McHugh,*[173] underscoring the importance of substantively applying te ao Māori principles. In that case Justice Doogue elaborated that the principles within the OT Act are intended to assist the Court in determining what serves a child's best interests and well-being. The indivisible connection between the physical, social and spiritual welfare of tamariki Māori is paramount. By maintaining this ongoing link between tamariki Māori and their extended whānau, the Court simultaneously fosters their well-being and best interests.[174] Justice Cull in the *Moana* case expressed comparable views, stating that the connection between Māori children and their extended family should be preserved and enhanced whenever

[170] Te Puna Rangahau o te Wai Ariki Aotearoa, above n 52, at 9; See also *Chief Executive of Oranga Tamariki v BH* [2021] NZFC 210.
[171] At [39]; Te Puna Rangahau o te Wai Ariki Aotearoa, above n 52, at 9.
[172] *Chief Executive of Oranga Tamariki v AR* [2020] NZFC 4046 at [241]; Te Puna Rangahau o te Wai Ariki, above n 52, at 9.
[173] *McHugh v McHugh*, above n 149, at [94]-[112].
[174] At [94]-[112].

feasible[175] noting "A Māori child's safety and her wellbeing… must be assessed with a te ao Māori lens by giving preference to her kinship and whanau connections".[176]

In cases about the care and protection of Māori children, the courts look at what is best for the children by considering their cultural rights and the importance of making decisions together with family and the community. By doing this, the courts show that cultural identity and wider family involvement are important for a child's well-being. This approach sees a child's best interests as more than just individual needs; it includes cultural and family ties. This idea supports the main argument of this thesis, which contends that that the best interests principle can include Indigenous children's cultural rights, especially in mental health.

It must be noted here that in the New Zealand context, particularly over the past 80 years, the care and protection system has demonstrated how a constrained understanding of "best interests" can cause significant harm to tamariki and rangatahi Māori. Reviews into the uplifting of Māori children, as well as findings of the Waitangi Tribunal in more recent times have highlighted how the best interests principle has been applied in ways that privileged short-term risk avoidance over whakapapa connections, collective wellbeing, and Māori decision-making authority. This should be noted here because in the writer's view if the best interests principle is to guide decision-making in the mental health context, New Zealand must be mindful of the pitfalls already identified in care and protection, including cultural dislocation, over-intervention, and the marginalisation of whānau voice.

Despite the past, the writer maintains that the best interests principle can still serve as a vehicle for change. There is reason to hope that the significant scrutiny, inquiry, and reform efforts in the care and protection space have generated a deeper understanding of past harms. In addition, international human rights law guidance now provides clearer direction on the application of the best interests principle for Indigenous children. When interpreted consistently with those developments, and learnings from the past, the best

[175] *Moana's Mother v Smith & Chief Executive of Oranga Tamariki Ministry for Children & Taipa* , above n 167, at [36].
[176] At [68].

interests principle has the potential to operate as a tool capable of supporting Māori-led approaches and more holistic understandings of well-being in the mental health context.[177]

As mentioned before, the collective aspect is key when looking at an Indigenous child's best interests. The courts' ability to use this method in care and protection and custody cases shows they can consider many factors when deciding what is best for a child. This suggests that the legal system can similarly also use a broad view in mental health cases, including the cultural rights of Māori children and youth. Since decision-makers are already making these kinds of decisions, they can use a similar approach in mental health and best interests cases. This means looking at many factors, like cultural rights, and recognising the importance of community and cultural ties. It also means respecting Māori views and understanding the connection of all living things. For Māori children, this could mean including the idea of extended family in decisions, recognising the cultural importance of mental health, and using traditional healing methods along with Western ones. This will be discussed more in Chapter Six.

3.6. Medical Treatment and Best Interests for Children and Young People

The next part of this chapter briefly explores medical situations for children as this is the area where the legislation most clearly addresses the well-being of children and adolescents.

The best interests principle has also been addressed in other sections of the COCA and OT Act, namely guardianship matters relating to medical procedures.[178] In guardianship matters concerning medical treatment, judges are required to make more explicit decisions about a child's health. This represents the closest the legislation comes to discussing health matters. Consequently, it is relevant to recognise these cases and examine how the judiciary has interpreted or commented on what constitutes a child's best interests and welfare in health/medical cases.[179]

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[177] Royal Commission of Inquiry into Abuse in Care *Whanaketia – Through Pain and Trauma, from Darkness to Light* (Royal Commission, 2024); Crown Response Office *Crown Response to the Royal Commission of Inquiry into Abuse in Care* (2024) < https://www.abuseinquiryresponse.govt.nz>; Office of the Ombudsman *Children in care: complaints to the Ombudsman 2019–2023* (Ombudsman, February 2024); Waitangi Tribunal *He Pāharakeke, he Rito Whakakikinga Whāruarua: Oranga Tamariki Urgent Inquiry* (Wai 2915, 2021).

[178] Oranga Tamariki Act, above n 74, at s 110; Care of Children Act, above n 2, s 46.

[179] Care of Children Act 2004, above n 2, s 46.

Where the courts have had to consider urgent and necessary medical treatment for a child or young person, the Court has been cognisant of the tension that this could create among the child's guardians. This was illustrated by Baragwanath J's comment in *Auckland District Health Board v Z*[180] that, undoubtedly, a parent's role as guardian encompasses making decisions about their child's medical care. However, the law emphasises that the Court's primary consideration is the child's welfare and best interests, which may supersede parental rights at times. This does not diminish the significance of parents' views and desires; rather, there is an assumption that these will be honoured. To the extent that they cannot be fully accommodated, the Court will acknowledge them as much as possible within the framework of the child's paramount interests. This approach recognises that a child should not be viewed as an isolated entity separate from their parents, but rather, as far as feasible, as an integral part of the family unit comprising both the child and the parents.[181]

While these cases do not directly relate to mental health, they are important to note. The cases demonstrate that when considering what is in the best interests and for the well-being of a child, the Court undertakes an assessment that places significant weight on the views and positions of the child's family. However, if there is a risk that could imperil the life or health of the child, this overrides parental rights, and the Court would likely make the sought orders.[182] For example, in situations involving a conflict between parent's religious beliefs and the medical need for the child to have blood transfusion, or other necessary medical treatment, the courts, after a careful assessment, have found that it is in the best interests of the child to have the treatment. Again, the case law notes that while the views of the parents were important, it could not only be the determining factor. For instance, in *Re J*, concerning an urgent blood transfusion for a child whose parents did not consent due to religious beliefs, the Court of Appeal held that while parents have the freedom to practise their religion, this cannot extend "to imperil the life or health of the child".[183] This case and the other cases examined demonstrate that in relation to medical treatment, religious beliefs or views of parents do not prevail in instances where failure to

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[180] *Auckland District Health Board v Z* (2007) 26 FRNZ 596.

[181] At 20; See also *Chief Executive of Dept of Child Youth and Family v C S C-M* (2005) 25 FRNZ 736. In *Chief Executive of Dept of Child Youth and Family v C S C-M* the Ministry sought to provide a course of therapeutic counselling to X without the consent of the guardians. The Judge held that counselling was a guardianship decision and the child's guardians should be consulted. Guardians are generally biological parents.

[182] For example see *Re J (An Infant): B and B v Director-General of Social Welfare* [1996] 2 NZLR 134 (CA).

[183] *Re J (An Infant): B and B v Director-General of Social Welfare,* above n 181, at [61].

administer a medical treatment would be detrimental to the child's life. The courts have repeatedly stated that this approach is in the best interests of the child. Therefore, while family views are important, best interests in medical cases primarily concern physical well-being and the risk to a child's life.

The court's recognition of family participation in a child's well-being aligns with the principles of children's rights and welfare outlined in UN documents.[184] This approach is particularly relevant for the mental health of tamariki and rangatahi Māori, as it acknowledges cultural sensitivity, and encourages collaborative decision-making. The judiciary's current use of human rights language lends support to this thesis's central argument. It posits that the best interest principle can be applied in mental health settings to aid tamariki and rangatahi Māori in attaining the highest possible standard of mental health. This assertion is bolstered by the fact that the judiciary is already employing such language, albeit in limited areas. However, this approach can be readily expanded to encompass broader applications, such as mental health.

3.7. Summary

New Zealand's legal framework, particularly the COCA and OT Act, employs the best interests principle as the paramount consideration in decisions concerning children. While these laws do not directly address mental health, they demonstrate that New Zealand's legal and policy framework incorporates the best interests principle, albeit in a limited scope. Judicial interpretation of the best interests principle has been broad, with courts implicitly considering a child's psychological well-being, which aligns with mental health considerations. Key themes emerging from the analysis include:

1. Recognition that the best interests principle is flexible.

2. Child's safety is paramount.

3. Emphasis on maintaining relationships with family, whānau, hapū, and iwi.

4. Acknowledgment of cultural identity as crucial to a child's well-being.

[184] See generally United Nations High Commissioner, above n 127.

5. Consideration of both immediate and long-term impacts on a child's development.

Regarding collective cultural rights of Māori children, the courts emphasise familial responsibilities, the importance of whakapapa, whanaungatanga, and the role of whānau, hapū, and iwi in decision-making. Cultural harm is considered alongside physical harm, and the interconnectedness of individual and collective well-being in Māori culture is acknowledged. However, there are challenges in balancing te ao Māori principles with the best interests principle, with differing judicial views on their application. Nevertheless, the existing legal framework and judicial interpretation provide a foundation for extending the best interests principle to mental health contexts for tamariki and rangatahi Māori. By incorporating elements such as a comprehensive view of well-being, culturally appropriate interventions, family involvement, and active collaboration, a framework for mental health decision-making can be developed that aligns with the current legal framework and judicial interpretation and participation of children and their families in mental health decisions. By incorporating these elements, a framework for mental health decision-making can be developed that aligns with the existing legal framework and judicial interpretation This will be explored further in Chapter Six.

The next chapter will focus on collective cultural rights and what collective cultural rights looks like for Māori, in particular in the context of health.

Chapter Four

Collective Rights, Indigenous Communities and Health

"Ki te tapepa te tāhū, ka horo te whare
If the ridge-pole is not balanced, the house will collapse"[1]

4.1. Introduction

The previous chapter focused on the principle of the best interests of the child, the relationship between the international obligations to meet this principle and its domestic application. The key New Zealand statutes were noted and relevant case law was examined. A significant point that was highlighted in the previous chapter was the role of collective rights in determining the best interests of the child. This chapter examines how collective rights can be applied to the right to health and explains why this is important.

The concept of collective rights has gained increasing recognition, particularly in relation to Indigenous peoples. While traditional Western liberal philosophy has emphasised individual rights, many Indigenous cultures, including Māori, have a collectivist worldview that prioritises group identity, relationships, and shared responsibilities. This chapter explores the nature of collective rights, their importance for Indigenous communities, and how they relate specifically to the right to health. The reemergence of collective rights in this context emphasises its importance in understanding how Indigenous communities approach human rights. Chapter Two provided the theoretical framework, analysing human rights through the lens of collective and relational rights. This chapter extends that discussion, emphasising the holistic view of rights and specifically the right to health. This approach aligns with the scholarship and international instruments that embed these rights both internationally and domestically. This chapter aims to demonstrate how this understanding of rights is particularly relevant and crucial for the right to health (mental health) of tamariki and rangatahi Māori.

[1] Waitangi Tribunal *He Pāharakeke, He Rito Whakakīkinga Whāruarua Oranga Tamariki Urgent Inquiry* (Wai 2915, 2021) at 47.

The chapter begins by recapping some key ideas about collective rights that were introduced in previous chapters. It then examines what a collective right to health might look like in general terms, before focusing on Māori conceptualisations of collective health rights. Central to this discussion are Māori concepts such as whakapapa, tikanga and whanaungatanga which emphasise the interconnectedness of individuals, communities, and the natural world. The chapter then explores how these collectivist values shape Māori approaches to health and well-being, which tend to be more holistic than Western biomedical models. It examines frameworks like the Te Whare Tapa Whā model that views health holistically as encompassing physical, mental, spiritual and family dimensions. The implications of these collective, holistic health concepts for Māori children and youth are considered. Finally, the chapter considers what a collective rights-based approach to health for Māori might look like in practice in the New Zealand context. By examining these issues, the chapter aims to demonstrate the importance of understanding collective rights and Māori cultural concepts for developing more effective, culturally-responsive approaches to improving the right to mental health for tamariki and rangatahi Māori.

4.2. Overview of Collective Rights vs Liberalism

The debate between liberalism and collective rights has a long history, as discussed in Chapter Two. Liberal theorists argue that equal treatment of individuals requires protecting certain rights and liberties.[2] Liberal theorists assert that uniformly distributed civil and political rights serve as a safeguard against potential tyranny from both government and other individuals.[3] Such a protective constitutional framework primarily consists of negative rights surrounding the rights holder, enabling individuals to pursue their own conception of the good.[4] Liberals aim to maximise individuals' inherent

[2] Will Kymlicka *Contemporary Political Philosophy* (Oxford, Oxford University Press, 2002) at 53.

[3] David Morrice "The Liberal-Communitarian Debate in Contemporary Political Philosophy and Its Significance for International Relations" (2000) 26 Review of International Studies 233 at 236; Ronald Dworkin "Rights as Trumps" in Jeremy Waldron (ed) *Theories of Rights* (Oxford University Press, Oxford, 1984) 153 at 153-163; Keakaokawai Varner Hemi "Everyone, Non-one, Someone and the Native Hawaiian Learner: How Expanded Quality Narratives Might Account for Guarantee/Reality Gaps, Historical-legal Context and An Admission Policy Which is Actually Levelling the Playing Field" (PhD Dissertation, University of Waikato, 2016) at 145.

[4] Hemi, above n 3, at 145; see also Eric Mack and John Meadowcroft *John Locke* (Continuum International Publishing, New York, 2009).

freedom to choose their own life paths.[5] Western societies predominantly emphasise individual rights, viewing them as constraints on state action and limitations on organised society and government. Prominent Western thinkers, such as social contract theorists, Locke, Rawls, Rousseau, and Dworkin, have contributed to the concept of human rights based on the individual-state relationship. Liberal philosophy typically focuses on individual rights, often considering collective rights unnecessary or potentially harmful to established individual rights.[6]

On the other hand, the origins of collective rights can be traced back to philosophers including Van Dyke, Kymlicka, and Raz. These scholars challenged the strictly individualistic liberal paradigm, paving the way for an understanding of human rights that acknowledges the relational nature of human experience. Their work emphasises the importance of group membership, cultural context, and collective interests in shaping individual identity and autonomy. Kymlicka argues that recognising collective rights is crucial for safeguarding individual freedom and personal dignity. He introduces the concept of "societal culture" and advocates for the protection of Indigenous peoples' rights, albeit on individualistic grounds.[7]

Kymlicka highlights the importance of culture, arguing that it is valuable because it offers a "meaningful" array of choices for how people live their lives and serves as the framework for individuals to create a "life plan".[8] Consequently, groups with distinct cultures that are not in the majority or hold power in society should be granted group rights to help preserve their unique cultures.[9] Kymlicka proposes a broader conception of liberalism that incorporates collective rights, arguing that recognizing minority rights can

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[5] Hemi, above n 3, at 145; see also Christopher Heath Wellman "Liberalism, Communitarianism, and Group Rights" (1999) 18 Law and Philosophy 13 at 13.

[6] John Rawls *A Theory of Justice* (Oxford University Press, Oxford, 1972); John Rawls *The Law of Peoples: With "The Idea of Public Reason Revisited* (Harvard University Press, Cambridge MA, 1999); Jean-Jacques Rousseau *The Social Contract* (Penguin Classics, London, 1968); Ronald Dworkin "What is Equality: Part I: Equality of Welfare" (1981) 10 Philosophy and Public Affairs 185.

[7] Kymlicka*,* above n 2 , at 18-20; Vernon Van Dyke "Justice as Fairness: For Groups" (1975) 69 American Political Science Review 613; Joel Oestreich "Liberal Theory and Minority Group Rights" (1999) 21 Human Rights Quarterly 108 at 116.

[8] Maria Bakalova "The Concept of Group Rights from Universalist-Particularist Perspective and Beyond" (2021) 1 Yearbook of the University of National and World Economy 173 at 184; Will Kymlicka "Liberalism and the Politicization of Ethnicity" in Judith Stapleton (ed) *Group Rights: Perspectives Since 1900* (Routledge, London, 1995) 175 at 233-257.

[9] Bakalova, above n 8, at 184.

strengthen individual freedom and equality.[10] Such an expanded view suggests that collective rights are not contrary to liberal principles but can be fundamental to their realisation, especially in multicultural societies.[11] Kymlicka argues that our choices are limited by our cultural context, which provides the framework for our decision-making. He asserts that liberalism should protect collective rights, especially for Indigenous peoples, through "special" or "differential" rights. These rights aim to correct imbalances and protect minority cultures from erosion. Kymlicka proposes two categories of collective rights: internal restrictions and external protection. He also identifies two types of group demands: one where a dominant group requires conformity from its members, and another where a group seeks recognition and protection of its rights and responsibilities in relation to a larger or more influential group.[12]

In support of a collectivist understanding, Van Dyke asserts that "…in a state of nature, individuals are part of communities that are not just collections of individuals but collective entities with moral rights separate from those of individual members".[13] Adding precision to a collective understanding, Bakalova identifies two key aspects of group or collective rights.[14] The first point is that group rights play a vital role in shaping the identities, viewpoints, and decisions of their members.[15] These rights are not just collections of individuals with certain characteristics but are connected to a collective identity.[16] The second point is that the liberal tradition's emphasis on individuals tends to ignore the level between the individual and the State, thus distorting the true picture.[17] Similarly, Raz's concept of 'collective' rights posits that group rights occur when the combined interests of group members provide sufficient justification for imposing duties on others, even if a single member's interest would not.[18] Raz's theory of collective rights

[10] Kymlicka, above n 2, at 1-10; See further Chapter Two footnotes from 82 to 103.
[11] See Chapter Two footnotes from 126 to 152.
[12] Nicolas Lopez Calera "The Concept of Collective Rights" (2003) 34 Rechtstheorie 351 at 362; see also Will Kymlicka *Multicultural Citizenship: A Liberal Theory of Minority Rights* (Clarendon Press, Oxford, 1995) at 58-195.
[13] Bakalova, above n 8, at 184; Vernon Van Dyke "Collective Entities and Moral Rights: Problems in Liberal Democratic Thought" in Judith Stapleton (ed) *Group Rights: Perspectives Since 1900* (Routledge, London, 1995) 57.
[14] Bakalova, above n 8, at 184.
[15] At 184.
[16] At 184.
[17] At 184.
[18] Jeremy Waldron *Liberal Rights: Collected Papers 1981-1991* (University of Cambridge, Cambridge, 1993); Jeremy Waldron "Human Rights: A Critique of the Raz/Rawls Approach" (2013) New York University Public Law and Legal Theory Working Papers 405.

posits that rights are justified by interests that are sufficient to impose duties on others. Group rights arise when the combined interests of individuals as group members justify imposing duties, even if a single member's interest would not suffice. These rights are distributed among group members and relate to public good serving the group's interests. Raz emphasises that while groups have their own existence, their moral claim to respect stems from their importance for individual well-being, and collective rights typically pertain to collective goods.[19]

Collective rights scholars argue that a narrow focus on individual autonomy fails to acknowledge the complex relationship between individual identity and cultural background.[20] In contrast with individualist thinking, Indigenous groups often view rights as communal privileges, emphasising the interconnectedness of individuals within their communities. These theorists contend that many of the essential positive and negative experiences people have as humans are shared collectively rather than experienced individually.[21] Consequently, if we assert that human rights must be rights held solely by individuals independently, our understanding of human rights will not align with the social reality of human existence.[22]

The interconnectedness of Indigenous cultures is understood and acknowledged by the United Nations. For example, the Special Rapporteur's 1993 Report observes that the prevailing international legal view on culture does not align with the understanding of culture held by Indigenous peoples.[23] Indigenous communities perceive all human mental and emotional creations as interconnected, originating from a common source: their relationship with the land, their connection to other living beings inhabiting that land, and their bond with the spiritual realm. Consequently, it is considered more straightforward and appropriate to refer to each Indigenous people's collective heritage, rather than

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[19] Joseph Raz *The Morality of Freedom* (Oxford University Press, Oxford, 1986) at 165-216; For general discussion please see 245-263; see also Peter Jones "Human Rights, Group Rights, and Peoples' Rights" (1999) 21 Human Rights Quarterly 80 at 83; See further Chapter Two footnotes from 82 to 103.

[20] See Chapter Two footnotes from 126 to 140.

[21] Rakesh Chandra "Collective Rights vs. Individual Rights" (2017) 4 International Journal of Multidisciplinary Research and Development 51 at 53.

[22] At 53.

[23] *Report of the Special Rapporteur of the Sub-Commission on Prevention of Discrimination and Protection of Minorities and Chairperson of the Working Group on Indigenous Population on the Study on the Cultural and Intellectual Property of Indigenous Peoples* UN Doc E/CN.4/Sub.2/1993/28 (1993) at [21]; See also Alison Cleland "Realising Māori Children's Rights Unconventional Thinking Required" (2023) 31 The International Journal of Children's Rights 3 at 12.

drawing distinctions between cultural property and intellectual property.[24] The Human Rights Council describes the connection between the exercise of collective rights and the indivisible collective rights of the group. The Human Rights Council highlights an ongoing debate in international human rights law concerning the collective aspect of cultural rights.[25] The central question is whether these rights are individual rights exercised collectively or if they are unique group rights.[26] Although "cultural life" suggests a collective nature and several international documents acknowledge collective cultural rights, the CESCR asserts that these rights can be practiced both individually and collectively. Recognising collective rights does not diminish individual cultural rights, which encompass freedoms such as joining or leaving communities, forming multiple identities, accessing cultural heritage, and engaging in cultural creation.[27]

4.2.1. Summary

The concept of collective rights challenges the traditional individualistic liberal paradigm, with philosophers like Van Dyke, Kymlicka, and Raz emphasising the importance of group membership and cultural context in shaping individual identity. Kymlicka argues that recognizing collective rights is crucial for safeguarding individual freedom and personal dignity, introducing the concept of "societal culture" and advocating for Indigenous peoples' rights. Van Dyke asserts that communities are collective entities with moral rights separate from those of individual members, while Raz proposes that group rights arise when combined interests of group members justify imposing duties on others.[28] The United Nations acknowledges the centrality of interconnectedness for Indigenous communities and recognises the debate on whether cultural rights are individual rights exercised collectively or unique group rights. Collective rights address the complex relationship between individual identity and cultural background, reflecting the social reality of human existence where many experiences are shared collectively.

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[24] *Report of the Special Rapporteur,* above n 23, at [21]; See also Cleland, above n 23, at 12.
[25] Human Rights Council *Report of the Independent Expert in the Field of Cultural Rights, Ms Farida Shaheed*, A/HRC/14/36 (2010) at [10]; Macbeth, above n 25, at 65.
[26] Human Rights Council, above n 25, at [10].
[27] At [10]; Macbeth, above n 25, at 65.
[28] See footnotes from 1-25.

4.3 United Nations Declaration on the Rights of Indigenous Peoples ("UNDRIP")

The development of international instruments, such as the UNDRIP, which recognises Indigenous collective rights is important.[29] The recognition of collective rights in the international framework marks a departure from the traditional Western liberal emphasis on individual rights, echoing the theoretical critiques of liberalism discussed earlier in the chapter. The theoretical arguments for safeguarding collective cultural identities and practices are reflected in the acknowledgement of the Indigenous peoples' right to self-determination and cultural rights. The international framework offers a practical means to implement the theoretical concepts of collective rights, including the rights of Indigenous communities to participate in decision-making processes that affect them. Consequently, it is beneficial to briefly examine the international framework that advocates for and supports collective rights.

The development of the UNDRIP has been characterised as "the emergence of a multicultural model of political ordering that challenges Western conceptions of the culturally homogenous and legally monolithic state".[30] The Declaration encompasses over twenty provisions that affirm the collective rights of Indigenous peoples in decision-making processes.[31] Article 18, in particular, underscores the right of Indigenous people to participate in decision-making matters that affect their rights through representatives chosen in accordance with their own procedures, as well as to maintain and develop their own Indigenous decision-making institutions.[32] As Toki points out, the UNDRIP does

[29] United Nations Declaration on the Rights of Indigenous Peoples GA Res 61/295, A/Res/61/295 (2007); United Nations Convention on the Rights of the Child 1577 UNTS 3 (opened for signature 20 November 1989, entered into force 2 September 1990); and International Covenant on Economic, Social and Cultural Rights 993 UNTS 3 (opened for signature 16 December 1966, entered into force 3 January 1976).

[30] James Anaya "International Human Rights and Indigenous Peoples: The Move Toward the Multicultural State" (2004) 21 Arizona Journal of International and Comparative Law 13 at 15.

[31] Human Rights in Aotearoa "Human Rights and Te Tiriti o Waitangi" Tikatangata <https://tikatangata.org.nz/human-rights-in-aotearoa/human-rights-and-te-tiriti-o-waitangi>.

[32] Valmaine Toki *Constitutional Frameworks – The Treaty of Waitangi* (1st ed, Taylor & Francis Group, Abingdon, 2018) at 141; Valmaine Toki "Indigenous Peoples' Rights" in Margaret Bedggood and Kris Gledhill (eds) *Law Into Action Economic, Social and Cultural Rights in Aotearoa New Zealand* (Thomson Reuters, Wellington, 2011) 260.

not create new rights but is the only international instrument that views Indigenous rights through an Indigenous lens, citing James Ananya as follows:[33]

> The Declaration... will go a long way in consolidating gains made by indigenous peoples in the international arena toward rolling back inequities and oppression. It builds upon numerous decisions and other standard setting measures over recent decades by a wide range of international institutions that are favourable to indigenous peoples' demands... There should not have been a Declaration on the Rights of Indigenous Peoples, because it should not be needed. But it is needed. The history of oppression cannot be erased, but the dark shadow that history has continued to cast can and should be lightened.

Indigenous peoples' right to participate in decision-making is closely linked to their right to self-determination, which includes their right to self-govern, as stated in Articles 4 and 5. These rights include the government's duty to consult Indigenous peoples on matters affecting them, following the principle of free and prior informed consent in Article 19. According to the Declaration, these legal principles are essential for protecting Indigenous peoples' participation in decision-making and must be strictly followed by governments.

In relation to children, the UNDRIP affirms the collective entitlement of Indigenous peoples to participate in their children's upbringing and welfare, connecting this to the children's rights outlined in the UNCROC. The UNDRIP preamble emphasises that Indigenous families and communities have the right to share responsibility for the upbringing, training, education and well-being of their children, in line with the rights of the child.[34] Such an approach emphasises the importance of considering the UNCROC and UNDRIP in tandem, as noted in General Comment No. 11.[35] It is noted that the best interests of the child is viewed as both an individual and collective right, and applying this right to Indigenous children as a group necessitates examining how it relates to collective cultural rights.[36]

As will be discussed in Chapter Five, the CRC Committee has emphasised that the best interests of the child requires careful consideration of their cultural collective rights and

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[33] Toki *Constitutional Frameworks*, above n 32, at 148.
[34] United Nations Declaration, above n 29, Preamble.
[35] *General Comment No.* 11 *Indigenous Children and Their Rights under the Convention* UN Doc CRC/C/GC/11 (12 February 2009) at [82].
[36] At [7] and [82].

of their need to exercise such rights collectively with their community.[37] Therefore when assessing the best interests of an Indigenous child, consideration of various factors are necessary to ensure they fully enjoy their rights under the UNCROC and are given support for their overall development.[38] The Committee emphasises that the child's best interests are viewed as both an individual and collective entitlement. It notes that when applying this right to Indigenous children as a group, it is necessary to consider how the consideration of best interests interacts with collective cultural rights. [39]

The principles enshrined in the UNDRIP are also evident at the domestic level in New Zealand. [40] At the national level, there are additional legal frameworks that specifically support the collective rights of Māori. These include the Crown's responsibilities under Te Tiriti o Waitangi and the broader requirement to interpret legislation in line with Treaty principles.[41] Nevertheless, these mechanisms and their implementation in healthcare (including mental health) appear to be ineffective, which is evident from the statistics indicating poor mental health outcomes among tamariki and rangatahi Māori discussed in Chapter One.

In summary, the UNDRIP provides international legislative support for recognising collective rights, a core principle when considering the best interests of Indigenous children. Within the context of the exploration of collective rights, international obligations and their significance for decisions about Māori, the specific question is how understanding collective rights relates to the right to health, which is the focus of discussion in the next section.

4.4. Collective Rights and the Right to Health

The United Nations has acknowledged the interconnectedness of individuals in Indigenous communities, particularly concerning the right to heath. For instance, the EMRIP highlights that health and well-being in Indigenous communities are "broader

[37] *General Comment No.* 11, above n 35, at [30].
[38] Macbeth, above n 25, at 72.
[39] Committee for the Rights of the Child *General Comment No. 14 (2013) on the Right of the Child to have His or Her Best Interests Taken as a Primary Consideration (Article 3, Paragraph 1)* CRC/C/GC/14 (2013) at [24].
[40] The Hon Dame Susan Glazebrook "The Declaration on the Rights of Indigenous Peoples and the Courts" (2020) 7 Te Tai Haruru: Journal of Māori and Indigenous Issues at 65 at 65-76.
[41] At 65-76; Macbeth, above n 25, at 106.

and more holistic" compared to the perception of them in mainstream society.[42] Health is perceived as both an individual and collective right, which is heavily influenced by the community. As noted by the Permanent Forum on Indigenous Issues ("PFII"), "the right to health is realised through the well-being of an individual as well as the social, emotional, spiritual, and cultural well-being of the whole community".[43]

When discussing the right to health, there must be a recognition of collective rights, because simply viewing the right to health through an individualist lens is insufficient.[44] The CRC Committee has stated that in the era of globalisation, collective rights and their corresponding collective mechanisms are essential to fulfil the individual right to health.[45]

In an increasingly interconnected world, tackling health disparities will require a renewed focus on shared societal factors and will require comprehensive public health systems that go far beyond an individual-focused approach to medicine. In this situation, the focus on individual health is insufficient.[46] Central to this thesis is that for Indigenous communities, considering their holistic and interconnected worldview is vital. As mentioned in this chapter merely examining health from an individualistic perspective is inadequate and is failing Indigenous communities.

Research suggests that there is often an emphasis on individual access to healthcare services, which can lead to neglecting collective rights.[47] However, scholars argue that disregarding collective rights can undermine the right to health, and these rights should be explicitly incorporated into healthcare planning and execution.[48] Indeed Nelson and Wilson concluded, "[c]ollective rights need to be recognized overtly in the planning and delivery of health care services, if justice and equity for individuals accessing health services are to be achieved."[49] Mazel noted the process of accommodation and adaptation

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[42] *Permanent Forum on Indigenous Issues Report on the Twelfth Session (20-31 May 2013)* UN Doc E/2013/43-E/C.19/2013/25 (2013) at [4]; *Study by the Expert Mechanism on the Rights of Indigenous People The Right to Health and Indigenous Peoples with a Focus on Children and Youth* UN Doc A/HRC/33/57 (2016) at [4].

[43] At [4].

[44] *General Comment No.* 11, above n 35, at [12]-[33].

[45] At [7]; Douglas Sanders "Collective Rights" (1991) 13 Human Rights Quarterly 368.

[46] Benjamin Meir "The Highest Attainable Standard: Advancing A Collective Human Right to Public Health" (2005) 37 Columbia Human Rights Law Review 100 at 134-137.

[47] Sarah Nelson and Kathi Wilson "Rights and Health Versus Rights to Health: Bringing Indigenous Peoples' Legal Rights into the Spaces of Health Care Services" (2021) 85 Political Geography 1 at 1-2.

[48] At 3-10.

[49] At 2.

has meant the law itself has been contested and transformed so that a space for collective rights has been opened in the liberal framework of individual human rights.[50]

Merry contends that culture plays a crucial role in shaping power structures and legal systems, particularly when discussing the health rights of Indigenous peoples.[51] If culture is seen as a collection of evolving practices and ideas influenced by historical events, then the law should also be viewed as dynamic rather than fixed.[52] Such adaptability in law allows it to evolve and creates opportunities for challenging dominant authorities. The engagement of Indigenous peoples with human rights law and discourse illustrates this legal evolution through ongoing acts of resistance.[53] In the absence of other viable options, Indigenous communities have navigated existing legal systems to redefine themselves as creators and influencers of law, rather than mere subjects.[54] This adaptive process has not only challenged but also transformed the law, making room for collective rights within the traditionally individual-focused human rights framework.[55]

The system's previous emphasis on group differences has now shifted to embrace diversity and multiplicity, especially in the context of health.[56] In this regard, Anaya's comments are insightful. He states that Indigenous peoples' use of the human rights framework has advanced cultural integrity and autonomy, and on the other, participatory engagement. Such a dual thrust reflects the view that Indigenous peoples are entitled to be different but not necessarily to be considered a priori unconnected from larger social and political structures.[57]

Comparable observations have been made by Nelson and Wilson, who emphasise the importance of respecting collective rights in healthcare to achieve justice and equity for individuals accessing health services.[58] These authors highlight the need to address colonial structures, which are ongoing systemic and institutional practices stemming from

[50] Odette Mazel "Indigenous Health and Human Rights: A Reflection on Law and Culture" (2018) 4 International Journal of Environmental Research and Public Health 789 at 792.
[51] Sally Merry "Law, Culture and Cultural Appropriation" (1998) 10 Yale J. Law Humanit 575–603 at 603.
[52] Mazel, above n 50, at 789-794.
[53] At 789-794.
[54] At 789-794.
[55] At 789-794.
[56] At 789-794.
[57] S James Anaya *Indigenous Peoples in International Law* (Oxford University Press, Oxford, 1996) at 111-112.
[58] Nelson and Wilson, above n 47, at 2.

the colonial relationship between Indigenous peoples and the Canadian settler-colonial state.[59] These structures, along with existing health systems, significantly impact the healthcare services provided to Indigenous people. In this scenario, while collective Indigenous rights might appear to be distinct from these situations, neglecting to respect collective rights affects Indigenous rights on an individual level.[60]

Similar emphasis on the importance of collective rights has been made by Meir, who maintains that individual and collective human rights are interconnected, especially when it comes to health.[61] He contends that there does not always have to be a conflict between individual rights and a collective right to health.[62] If we believe in an individual's right to health, then society as a whole must have a right to public health.[63] In this argument, these approaches to rights work together and depend on each other. In this view, discussion about collective rights can help support individual rights and emphasise that all people are equal and connected. Public health, as a collective right, can work alongside individual health systems to ensure everyone can achieve the best possible health. Meir argues that collective rights are crucial for guaranteeing public benefits that cannot be attained through individual rights alone, which is particularly significant in public health, where interventions like vaccination programs or sanitation improvements benefit entire communities or societies. The objectives of individual and collective health rights frequently overlap and support each other, indicating that the traditional emphasis on individual curative interventions is insufficient for addressing broader health disparities intensified by globalisation.[64] Meir terms this recommended process as the 'harmonization process' which acknowledges that individual and collective health rights are interconnected and interdependent, rather than mutually exclusive.[65]

Litalien, on the other hand, argues that collective rights, particularly those concerning self-determination in health matters, are vital for realising the right to health among Indigenous peoples.[66] Litalien says that to enable individuals to lead lives they can truly

[59] Nelson and Wilson, above n 47, at 3-7.
[60] At 2.
[61] Meir, above n 46, at 134-137.
[62] At 100-101; Meir understands collective rights to be social units smaller than the state itself.
[63] At 134-137.
[64] At 112- 137.
[65] At 112- 137.
[66] Éliot Litalien "Understanding the Right to Health in the Context of Collective Rights to Self-Determination" (2021) 8 Bioethics 725 at 732.

call their own, it is essential to allow them to engage in communities that hold significance for them and possess the ability to accomplish objectives and acquire resources that their members might not be able to achieve or obtain on their own.[67] Indigenous communities view the world in a holistic and interconnected manner, placing great importance on the well-being of the group as a whole. Consequently, any significant health-related changes must incorporate and respect this perspective. Litalien articulated that these rights empower communities to pursue meaningful ways of living, determine how health-related rights are fulfilled according to their cultural values, and can lead to better health results through culturally appropriate healthcare.[68] It is crucial for the State to fulfill its responsibilities in a manner that "align[s], as much as possible, with the values or ways of life of the sub-state communities".[69] Implementing such policies would require the State to offer health-related products, services, and protections that are specifically adapted to the distinct needs and cultural traditions of these communities. Such a strategy is vital because it acknowledges the unique health issues Indigenous peoples face and understands that standard healthcare methods may not always be culturally appropriate or effective for them.[70]

According to Litalien, recognising collective rights can greatly affect individuals on a personal level, and achieving healthcare equity for Indigenous people necessitates explicitly acknowledging these collective rights when planning and delivering health services. It is his view that the scope of Indigenous rights should be broadened to include a wider array of concepts, such as place and health, which are deeply ingrained in Indigenous customs and traditions. This expanded understanding of Indigenous rights acknowledges the connections between these concepts and the overall well-being of Indigenous communities.[71] Litalien further argues that the objectives of the right to health and collective self-determination rights are aligned, stating that safeguarding an individual's health enhances their agency in a manner consistent with the promotion of agency through collective self-determination.[72] He emphasises the importance of acknowledging that, in cases where certain groups have or should be granted self-determination rights, meeting the obligations associated with the human right to health

[67] Litalien, above n 66, at 730.
[68] At 732.
[69] At 732.
[70] See generally Litalien, above n 66, at 732; Nelson and Wilson, above n 47, at 2.
[71] Nelson and Wilson, above n 47, at 2.
[72] Litalien, above n 66, at 733.

should be a joint endeavour. The government should develop policies and initiatives that aim to strike a balance between preserving the essential components of agency necessary for collective self-determination rights and upholding the right to health.[73] Some challenges with harmonising individual and collective rights have been highlighted, such as the "tension that exists between collective rights to self-determination and individual human rights especially the right to health".[74] Litalien contends that this relationship is marked by conflict as the collective rights, which prioritise the welfare of the larger community or group, tend to clash with individual rights that aim to protect essential human interests. Litalien argues that the conflict stems from the fact that collective rights, including the right to self-determination, may not always coincide with individual interests. Thus, it is important to carefully balance the rights.[75]

However, emphasising collective rights is important for many Indigenous communities, and health cannot be achieved solely through an individualistic lens. By recognising these collective rights, the legal system can more effectively address the unique health needs and challenges faced by Indigenous groups by considering their holistic approach to health, which often encompasses physical, mental, spiritual, and environmental well-being at the community level.[76]

The preceding discussion highlights the relationship between individual and collective rights in health contexts, particularly for Indigenous people and Indigenous communities. This connection is vital, as Indigenous identities are firmly grounded in group settings, making personal and communal well-being indivisible. This view is relevant for this thesis, especially when examining the right to health and the best interests of Indigenous children in the mental health space. As previously mentioned, it is understood that when assessing a child's best interests under Article 3(1), their collective cultural rights must be considered. The Secretary General has supported General Comment No. 11 regarding the application of the best interests principle to the collective cultural rights of Indigenous children.[77] The intertwining of collective rights and the right to health serves as a powerful indicator that

[73] Litalien, above n 66, at 733.
[74] At 725.
[75] At 727-732.
[76] Mason Durie "A Māori Perspective of Health" (1985) 20 Social Science and Medicine 483 at 483.
[77] *Report of the Secretary General Status of the Convention on the Rights of the Child* UN Doc A/67/225 (2012).

could potentially mould and enhance the mental health and well-being of tamariki and rangatahi Māori to improve mental health outcomes.

It has been demonstrated that the Western approach often prioritises individual autonomy which clashes with Indigenous perspectives that value community cohesion and interconnectedness. This contrast emphasises the necessity for a better interpretation of health rights that encompasses both individual and communal viewpoints. The United Nations has consistently highlighted in General Comments the necessity for Indigenous communities to have authority over the planning, delivery, and execution of healthcare services to ensure their relevance.[78] These elements are discussed in greater detail in the following chapter. Nonetheless, it is crucial to recognise that collective rights and the right to self-determination are interlinked and essential, as acknowledged by the UN.[79] The subsequent chapters will explore and demonstrate that such an understanding is lacking in New Zealand's mental health services for tamariki and rangatahi Māori and a transformed understanding is needed to improve the situation in mental health for tamariki and rangatahi Māori.

4.5. Māori Collective rights

Building on the above understanding of collective rights (and the discussion in Chapter Two), and their importance for Indigenous communities, it is important for this research to examine how Māori collective rights are conceptualised. This research shows that to achieve meaningful change in mental health outcomes for tamariki and rangatahi Māori, the underlying rights must be understood and implemented in a manner which acknowledges the interconnectedness of physical, mental, spiritual and cultural well-being in the context of Indigenous rights.

The foundational principles of Māori society contrast with traditional Western liberal ideology, which has a marked emphasis on individualism. Consequently, Western liberal concepts have often failed to align with the collectivist perspectives held by Māori and

[78] *General Comment No.* 11, above n 35, at [55]; *Study by the Expert Mechanism on the Rights of Indigenous People,* above n 42, at [15]-[28].
[79] See *General Comment No. 21: Right of Everyone to Take Part in Cultural Life (Article 15(1)(a)) of the Covenant on Economic, Social and Cultural Rights* UN Doc E/C.12/GC/21 (2009) at [1] and [36].

other Indigenous peoples.[80] Justice Edward Taihakurei Durie (as he was then) addresses this misalignment, referring to it as the 'individual rights v group rights debate'.[81] The discussion is pertinent to Indigenous groups who have resided or continue to dwell in tribal communities. Indigenous communities' survival hinges on group cohesion and individual commitment to the group, resulting in a distinct view of rights.[82] Justice Durie's perspective can be encapsulated by noting that, traditionally, Indigenous communities have neither formally endorsed nor participated in the creation of UN treaties, as States typically undertook this role on their behalf. The objectives of the State disregarded those of Indigenous groups, including Māori.[83] The repercussions of this persist to this day, rendering Māori land difficult to manage, vulnerable to alienation, and depriving the community of a shared resource.[84] This is important to mention in this thesis because it shows the impact of such action and its consequences on Indigenous communities. Consequently, any approach to tackle challenges such as those related to the mental health of tamariki and rangatahi Māori, must be implemented in a culturally appropriate manner.

Justice Durie does not take the view that, even though there are conspicuous differences between individual rights and collective rights, that this distinction would invalidate "the search for universal standards".[85] He contends that whilst Māori have encountered challenges due to the imposition of unsuitable frameworks, it is a separate matter to claim that cultural differences negate the pursuit of universal standards. As an example, one would not expect severe punishment of an offender to be justified in modern society merely because such treatment is customary in the offender's cultural background. This position recognises that contemporary societies no longer operate in seclusion but as elements of a worldwide global community.[86] To achieve global harmony and individual satisfaction, the contention is that it remains essential to encourage universal benchmarks

[80] Macbeth, above n 25, at 26; other New Zealand scholars that talk about collective rights, include Claire Charters, Moana Jackson and Valmaine Toki; Claire Charters and Andrew Erueti (eds) *Maori Property Rights and the Foreshore and Seabed: The Last Frontier* (Victoria University Press, Wellington, 2007); Moana Jackson *The Māori and the Criminal Justice System: A New Perspective - He Whaipaanga Hou* (Department of Justice, Wellington, 1988); Valmaine Toki *Indigenous Courts, Self-determination and Criminal Justice* (Routledge, Oxford, 2018).

[81] Justice Eddie Durie "Constitutionalising Maori" in Grant Huscroft & Paul Rishworth (eds) *Litigating Rights: Perspectives from Domestic and International Law* (Hart Publishing, Oxford, 2002) 241 at 253.

[82] At 253.

[83] At 253.

[84] At 253.

[85] Durie, above n 81, at 253.

[86] Durie, above n 81, at 253.

that all societies should strive to meet. The key issue lies in ensuring the prudent implementation of norms, considering the unique context of each situation. This adaptable approach to Indigenous peoples' endeavours requires a sophisticated understanding rather than "a strict bureaucracy".[87]

In advancing a more nuanced and sophisticated understanding of collective rights and their relationship to individual rights, it needs to be recognised that cultures are dynamic entities capable of evolving without compromising their fundamental tenets and beliefs. Justice Durie argues that we must not forget cultural rights include both collective and individual aspects.[88] He proposes that there is a viable middle ground between universalism and cultural relativity that can foster the creation of a framework that acknowledges cultural diversity while promoting a high level of human rights protection, an approach which involves working within the underlying value systems of each culture.[89] Durie proposes this approach to reconcile individual and Indigenous rights.

To adequately protect Māori rights within New Zealand's legal framework, it is crucial to analyse the Māori value system and to identify structural elements that could be incorporated into the country's legal system to effectively safeguard the rights of Māori as Indigenous people.[90] As a starting point, it needs to be recognised that Māori collectivism emphasises relationships between individuals grounded in shared values rather than strict rules.[91] The theoretical framework, as outlined in Chapter Two, has already addressed this topic. Whilst it might appear to be a repetition of previous discussions, the distinction lies in this chapter's aim to explore the manner in which Māori perceive 'rights'. An integral aspect of this perception is the holistic understanding of the right to health, which will be examined in greater detail later in this chapter.

Still, according to Justice Durie, Māori society is governed by fundamental principles known as "conceptual regulators" that shaped behavior in traditional Māori communities.[92] A key principle of Māori communities is the focus on relationships

[87] Durie, above n 81, at 253.
[88] At 253.
[89] At 253.
[90] At 258.
[91] Macbeth, above n 25 at 23.
[92] Durie, above n 81, at 258.

between individuals and values, rather than rules,[93] which is described as being "agent-centered rather than act centered". Conduct is guided by the desire to align with those of great mana, rather than by a set of regulations,[94] a model which has some resemblance to Aristotle's virtue ethics.[95] Virtue-centered morality necessitates a moral community that views life as a shared endeavour, which the Māori value system provides.[96]

The concept of whanaungatanga promotes collective responsibility over individual accountability. It has been suggested that the desire or need to connect people and strengthen kinship ties is such a powerful cultural value that whanaungatanga can only be effective if its members recognise it.[97] Therefore, in Māori culture, the concept of whanaungatanga, which emphasises collective responsibility, blurs the line between self-interest and altruism, because actions which benefit the group are viewed as serving one's own interests.[98] As explained by Durie, the principle of muru is an example of how individual and shared responsibility merge; "Muru is a mechanism that was used to restore balance. It is a form of utu, which aims to contain retribution from escalating to harmful levels within close kin groups".[99] The practical application of muru demonstrates the fundamental principles of whanaungatanga. The entire kin group bears responsibility for its members' actions, and when conflicts arise between different tikanga (proper principles), a balancing process determines which principle should take precedence in a given context.[100] The collective accountability of extended family and tribal groups for a member's misconduct is viewed as reinforcing the mutual obligations within the community. Such as adaptable approach to applying tikanga practices can play a crucial role in safeguarding individual rights whilst upholding cultural values.[101]

In considering collective rights, it is essential to acknowledge the role of customary law or tikanga within Māori culture, which Durie describes as conceptual regulators of

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[93] Durie, above n 81, at 258.
[94] At 258.
[95] At 258.
[96] At 258.
[97] At 258.
[98] At 258; See also Edward Taihakurei Durie "Custom Law"(Treaty of Waitangi Research Unit, Wellington, 1994) at 104; See also John Patterson *Exploring Māori Values* (Dunmore Press, Palmerston North, 1992).
[99] Durie, above n 81, at 258.
[100] At 258 -259.
[101] At 258-259; See also Christopher Joyner and John Dettling "Bridging the Cultural Chasm: Cultural Relativism and the Future of International Law" (1990) 20 California Western International Law Journal 275 at 288.

tikanga.[102] Many Māori continue to value the conceptual foundations of their customary law. As Durie notes the expression of these principles in contemporary society differs from their historical manifestation prior to the Treaty of Waitangi over 160 years ago, and will likely evolve further in the coming 160 years.[103] While Māori society has introduced new guidelines deemed suitable for the present day, the core values of the system remain constant. Tikanga Māori, while adaptable, maintains its underlying values. For instance, according to Durie, equality can now be considered a Māori value and may sometimes take priority over other principles. Consequently, it is feasible for Māori cultural practices to adapt to changes, such as gender non-discrimination rights, without violating the rights of Māori as Indigenous people or compromising the essential aspects of Māori society.[104]

The emphasis on collective Indigenous rights further highlights the importance of protecting Indigenous cultures and ways of life, rather than assimilating or integrating them with other groups.[105] As discussed above, human rights have traditionally been viewed as the rights of individuals in relation to the State. However, for many Indigenous communities worldwide, collective rights differ, as Justice Durie explains:[106]

> …indigenous peoples who lived or live a tribal life in districts occupied by small but autonomous and competitive bands, clans or hapu without allegiance to a central regime depend on group integrity and individual loyalty for survival. As a result indigenous people's perspective on rights is different.

Clearly, collectivism is a crucial element of Māori culture, playing a fundamental role in how Indigenous communities interact with human rights. Research has been undertaken to analyse what this interaction may look like in practice. One example of research to examine this reconciliation is Mackintosh's dissertation, entitled "Another tool in the kete': Māori engaging with the international human rights framework",[107] which identifies "3 dimensions within the Māori cultural framework that the research contributors used to engage with human rights".[108] These dimensions are kaupapa Māori, tikanga, and

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[102] Durie, above n 81, at 259.
[103] At 259.
[104] At 259.
[105] Alexander Xanthaki "Collective rights: the case for indigenous peoples" (2000) 25 Amicus Curiat 7 at 7.
[106] Macbeth, above n 25, at 23.
[107] Hannah Mackintosh "Another Tool in the Kete': Māori Engaging with the International Human Rights Framework" (Masters in Development Studies Thesis, University of Wellington, 2011) at 50.
[108] Mackintosh, above n 107, at 50.

whakapapa. The ways in which each of these dimensions can be connected with human rights is discussed in the following sections.

4.5.1. Intersection of human rights and Māori Cultural values

Kaupapa Māori

Kaupapa Māori, representing the Māori worldview, "in the broader sense encapsulates the culturally specific ways that Maori view, interpret and understand the world".[109] Generally, these values are mirrored "by the human rights framework such as respect, inclusiveness and building relationships based on reciprocity and shared knoweldge".[110]

Tikanga Māori

Tikanga, loosely translated as "the rights", encompasses the values, principles, and norms "developed by Māori to govern themselves". [111] It offers "tools of thought and understanding... [t]hey help us differentiate between right and wrong in everything we do and in all the activities we engage in. There is a right and proper way to conduct oneself".[112] As Mikaere states, tikanga "operated as the first law of the land"[113]. While it has adapted to new contexts over time, its underlying principles have endured (including whakapapa [genealogy], whanaungatanaga [relationship], mana [authority], manaakitanga [hospitality], aroha [love], wairua [spirituality] and utu [reciprocity]). [114] Tikanga is transmitted from one generation to the next.

In her work, Mackintosh states:[115]

> ... so if Kaupapa Māori is the view that's held within a community, then ... the processes you use to achieve that worldview are tikanga, or the right things. Within that tikanga process are inherent the values of tika, pono and aroha. Tika once again is the right things; pono is that you believe in what you're doing, and aroha is empathy. So these high level

[109] Mackintosh, above n 107, at 50.
[110] At 51.
[111] At 51.
[112] At 51.
[113] Ani Mikaere "Seeing Human Rights Through Māori Eyes" (2007) 10 Yearbook of New Zealand Jurisprudence 53 at 54.
[114] At 54.
[115] Mackintosh, above n 107, at 51.

> values are inherent within the processes that we use to achieve Kaupapa Māori or the Māori worldview.

As Mackintosh states in her research, tikanga "defines the pathway through which human rights enter the community, the way that they are lived and the relationships that are formed."[116]

Whakapapa

The third element is whakapapa, which has been described in the following manner:[117]

> It is to do with that sense of being essentially at one with nature and our environment, rather than at odds with it. As tangata whenua we are people of the land – who have grown out of the land, Papatūānuku, our Earth Mother. Having knowledge of whakapapa helps ground us to the earth. We have a sense of belonging here, a sense of purpose, a raison d'être which extends beyond the sense of merely existing on this planet.

Whakapapa allows human rights to extend past genealogy and land to "the connection of those people to a particular concept or idea". [118] Examining human rights through a Māori worldview allows individuals to engage with human rights to understand the origins of the concept and its significance to Māori people.[119]

The three concepts explained above have been explicated as follows:[120]

> These three concepts are inextricably connected. Kaupapa Māori is a distinct cultural worldview. This forms the foundation for how human rights are engaged with and the values inherent within human rights are viewed as consistent with those in Kaupapa Māori. Tikanga is the waka. It defines the pathway through which human rights are carried and experienced based on the governing principles that define that community. Finally, whakapapa provides a vehicle for interpreting and understanding human rights. Through whakapapa, connections can be made between the Māori worldview and the international framework of human rights. Kaupapa Māori, tikanga and whakapapa

116 Mackintosh, above n 107, at 51.
117 At 52.
118 At 52.
119 At 52.
120 At 53.

> therefore are all essential elements used by Māori as a way to relate to the international framework of human rights.

Whānau

As previously elaborated, collectivity can be considered the cornerstone of Māori culture and is a crucial aspect of how Indigenous peoples interact with human rights. Central to this idea is the concept of whānau which roughly translates and implies extended family and forms a vital component of Māori social structure.[121] The whānau concept is linked to the aforementioned ideas and encompasses rights, responsibilities, commitments, and obligations, as well as essential support systems that contribute to the collective welfare.[122] It represents a mutual relationship between the individual and the community, which is characterised by individuals expecting support from both close and distant relatives, while the collective group also anticipates assistance from its members.[123] Mackintosh's research highlighted clear connections between the collective and individuals for Māori:[124]

> Human rights work is mostly, in reality, human responsibilities work... Rights and responsibilities link us with each other in a network of rights and responsibilities: my rights require responsibilities of others; the rights of others impose responsibilities on me.

Likewise, whakapapa imposes obligations on its individual members. As Mackintosh states, "[p]articipation within the whanau activates the connection between the rights of the individual as they are passed down through whakapapa to the responsibility as a member of the collective".[125] Whakapapa does not negate personal rights. Instead, communal and individual rights are complementary.

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[121] Mackintosh, above n 107, at 53.
[122] At 53.
[123] At 53.
[124] At 53.
[125] At 53.

Community significance : A vital pillar

In essence, "a collective approach to the protection of the rights of individual community members is essential".[126] Mikaere offers the following insightful view:[127]

> ... Maori concepts of land tenure did not include the notion of individual ownership: rather that land was considered to be held by the collective, in trust for present and future generations. While there is nothing incorrect in such a statement, focusing merely on the individual-collective contrast that a comparison with Western land law invites results in the omission of a vast amount of material about the true significance of land; the role of Papatuanuku as a spiritual being, as ancestress, as the ultimate nurturer of her human descendants: the dual meaning of the term "whenua" (meaning both land and afterbirth) and the significance of returning the whenua to the whenua after a child is born to the hapū; the profound importance of land to the question of hapū identity; and so on.

Mikaere's acknowledgement of collective rights is essential for Indigenous groups, because it embodies their core values of identity, dignity, and connection through shared lineage and mutual obligations within whānau, hapū, and iwi.

In Māori culture, whakapapa and whanaungatanga illustrate these values.[128] Mikaere states, "our sovereign authority in Aotearoa is sourced in the simple fact of our having been here for over a thousand years, in our having developed an intimate connection with this environment, and an intricate web of relationships to regulate our place within it".[129]

The question of sovereign authority is particularly pertinent to the topic of children's rights; for Māori children, the right to self-determination regarding their home and community is vital. The Waitangi Tribunal highlighted that Te Tiriti o Waitangi ensures Māori autonomy in organising and living according to their cultural practices,[130] which suggests that Māori should make decisions affecting their children's welfare without external interference that could jeopardise their cultural connections to family, tribe, or

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[126] Mackintosh, above n 107, at 53.

[127] Macbeth, above n 25, at 26; see also Di Pitama, George Ririnui and Ani Mikaere "Guardianship, Custody and Access: Māori Perspectives and Experiences" in *Māori Concepts of Guardianship, Custody and Access: A Literature Review* (Department for Courts, August 2002) at [7.2].

[128] Cleland, above n 23, at 13.

[129] At 14.

[130] Ministry of Health *Health and Disability System Review - Interim Report. Hauora Manaaki Ki Aotearoa Whānui – Pūrongo Mō Tēnei Wā* (Wellington, 2019) at 30.

language. An intervention in this decision-making would contravene tikanga Māori principles and undermine the protection of their genealogical and communal ties.[131]

4.6. Health and Māori Collective Rights

Health decisions for Māori also need to align with their collective values. Recognising this priority, Durie proposed the Te Whare Tapa Whā health model, which is a four-sided concept, and one of the earliest models of Māori health. The four aspects are 'te taha wairua (spiritual) te taha hinengaro (the mind), te taha tinana (physical) and te taha whanau (extended whanau)'.[132] All components are deemed to be essential for an individual's health and well-being, which contrasts with Western health concepts that often prioritise physical well-being above other aspects.[133] Again, this model aligns with the collective rights framework discussed earlier, emphasising the interdependence of the individual and community well-being. Over time, there have been several models of Māori health developed. Research undertaken by Wilson and others aptly captures these models.[134] Whilst this thesis does not examine these models further, it is important to recognise that collective values underpin all of them.

The centrality of collective values in Māori health models has particular implications for issues relating to the health of Māori children including their mental health. In this regard, the framework proposed by King, Cormack, and Kōpua titled "Tangata whenua rights-based approach to health and wellbeing" is valuable for understanding the best interests

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[131] Cleland, above n 23, at 14.

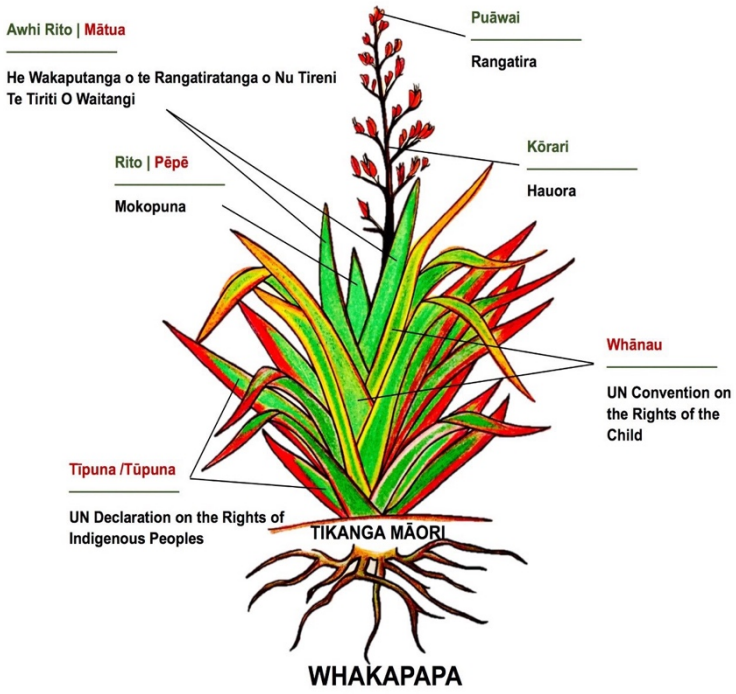
[132] Durie, above n 76, at 483; See generally Wiremu NiaNia, Mana Rangi, Allister Bush and David Epston "Restoring Mana and Taking Care of Wairua: A Story of Māori Whanau healing" (2017) 38 Australian and New Zealand Journal of Family Therapy 72 at 72-97; Peter Caccioppoli and Rhys Cullen *Māori Health* (1st ed, Kotahitanga Community Trust, Auckland, 2005); Hannah Mooney, Andrea Watson, Paule Ruwhiu and Awhina Hollis-English *Māori social work and Māori Mental Health in Aotearoa New Zealand* (1st ed, Springer, Singapore, 2020).

[133] Adele Vuki, David Gregory, Ruth Martin-Misener and Josephine Etowa "Aboriginal and Western Conceptions of Mental Health and Illnesses" (2011) 9 A Journal of Aboriginal and Indigenous Community Health 65.

[134] Denise Wilson, Eleanor Moloney, Jenny Parr, Cathleen Aspinall and Julia Slark "Creating an Indigenous Māori-centred Model of Relational Health: A Literature Review of Māori Health Models" (2020) 30 Journal of Clinical Nursing 3539 at 3545-3546.

of Māori children in mental health contexts.[135] Their approach aligns with the Māori worldview, which emphasises collective rights and holistic wellbeing.

In te ao Māori, the concept of "mokopuna" represents the continuity of generations and the interconnectedness of past, present, and future.[136] The proposed framework, based on the fan-shaped harakeke plant (image shown below), emphasises the full realisation of te ao Māori in recognising tangata whenua rights for the health and well-being of mokopuna Māori.[137] Such a perspective is crucial when considering the best interests of Māori children in mental health, because it acknowledges the importance of cultural identity, collective rights, and the broader context of whakapapa.[138]



This image is taken from the article by Paula King, Donna Cormack, Mark Kōpua "Oranga Mokopuna A tāngata whenua rights-based approach to health and wellbeing".[139]

[135] Paula King, Donna Cormack, Mark Kōpua "Oranga Mokopuna A Tāngata Whenua Rights-based Approach to Health and Wellbeing" (2018) 7 Mai Journal 186.
[136] King, Cormack, Kōpua, above n 135, at 188.
[137] At 187-190.
[138] At 190.
[139] At 190.

The conceptual model based on Māori principles illustrates the interconnectedness of various elements, emphasising the holistic nature of the Māori worldview. At its core is whakapapa, representing the inherent rights of future generations. The model's foundation, Pakiaka – Tikanga Māori, forms the roots, providing guiding principles and practices. At the heart of society lies Rito-Mokopuna, symbolising children, while Awhi Rito/Mātua represents parental lines and legal instruments. The innermost leaves, Whānau-UNCROC, reference health and collective rights, while the outermost leaves, Tīpuna/Tūpuna-UNDRIP, emphasise self-determination. The stem, Kōrari-Hauora, represents holistic well-being, and Pūawai-Rangatira symbolises thriving future leaders. This interconnected model encapsulates the essence of Māori philosophy, highlighting the intricate relationships between generations, principles, rights, and well-being.[140] Also, pertinent is the explicit reference to the UNDRIP which the framework indicates is naturally interwoven with te ao Māori.

In considering the best interests of Māori children, an understanding of collective rights, Māori health frameworks and societal structures consequently need to be key determinants in the decision-making process. As demonstrated, the Māori worldview emphasises the interconnectedness of individuals with their whānau, community, culture, and environment. Therefore, promoting the best interests of Māori children necessitates protecting and upholding their collective cultural rights and identities.

By recognising the centrality of collective rights for Indigenous peoples, a more culturally appropriate and effective approach to promoting the health and well-being of Māori children, particularly in the mental health sector, can be developed. Such an approach is relevant to this thesis because when addressing the mental health needs of Māori children, it is crucial to adopt a rights-based approach that incorporates whakapapa, whānau, and places mokopuna and tikanga Māori at its core. This framework is vital for fulfilling collective rights, as it aligns with the Māori perspective on rights.

While this discussion has highlighted the importance of te ao Māori and a collective world view in decision-making about the health of Māori children, there have been challenges to the view that there is constructive alignment between individual and collective rights.

[140] King, Cormack, Kōpua, above n 135, at 196.

4.7. A Rights Based Approach to Health in New Zealand

New Zealand is a signatory to the UNCROC and the UNDRIP, both of which recognise cultural collective rights consistent with international human rights law,[141] which means that New Zealand has international obligations that must be discharged. Canvassed above are the high-level theories about what collective rights are and how collectivity and rights generally are interpreted for Māori. It was also shown that Indigenous concepts of health embrace a collective and individual perspective and a comprehensive understanding. Consequently, the right to health for Indigenous communities cannot be considered in isolation from rights to indigeneity, self-determination, culture, language, land, and the natural environment.

Based on an understanding of the collective rights of Māori and New Zealand's international obligations, it is essential to examine how these rights can be realised in practical terms within New Zealand's national context, where legislation does not explicitly recognise a right to health. It is acknowledged that there are various laws that can be interpreted as (partially) affirming the right to health such as the Human Rights Act 1993, which prohibits discrimination in health-related matters (these are discussed in detail in Chapter Six). However, the reality is that the statistics documented in this research highlight the particularly concerning state of mental health among tamariki and rangatahi Māori. This situation demands urgent attention and improvement, particularly in the light of the increasing disparities between Māori and non-Māori youth in mental health outcomes. The ineffectiveness of current initiatives in addressing this issue is demonstrated by these deteriorating trends.

Up to this point in time, in the absence of a specific statutory right to health, the approach to addressing the issue has been through social policies (which will be discussed in Chapter Six). Some policy responses have been implemented to support Māori collective cultural rights and responsibilities regarding health.[142] However, it is argued that appropriate legislation could be much more efficacious. As White and Ladley say, if such rights were enshrined in domestic law, they would be "hard edged, and the holder of the

[141] Macbeth, above n 25, at 33; See also Terri Libesman "Can International Law Imagine the World of Indigenous Children?" (2007) 15 The International Journal of Children's Rights 283.
[142] Paul Whitinui "The Treaty and "Treating" Māori Health: Politics, Policy and Partnership" (2011) 7 AlterNative An International Journal of Indigenous Peoples 138.

duty will be held legally accountable in some way for their performance. Legal rights are not soft feel-goods, to be acknowledged or given by a cabinet or parliament in the ebb and flow of political influence".[143] Although a firm right to health is not established in domestic law, the government appears committed to tackling the existing disparities in mental health for Māori. Such a commitment is demonstrated through various initiatives and strategies that have been developed. A detailed explanation of these initiatives and strategies is provided in Chapter Six and will not be elaborated upon here.

Still, a holistic rights-based approach in healthcare (including mental health) that encompasses collective rights and highlights Māori concepts such as whānau, whakapapa, and tikanga Māori, alongside the UNCROC and the UNDRIP, needs to be adopted in the development, execution, evaluation, and supervision of strategies, policies, systems, and interventions aimed at improving health outcomes for tamariki and rangatahi Māori.[144]

This collective rights perspective on the right to mental health for tamariki and rangatahi Māori comprises several crucial components. This perspective acknowledges the interrelation between individual and collective well-being, and employing Māori health frameworks like Te Whare Tapa Whā. Emphasising cultural connection and identity is vital, as is promoting Māori autonomy in mental health services and policies. The approach stresses whānau-centred interventions, utilising mātauranga Māori and traditional healing methods alongside Western approaches. Ongoing consultation with Māori communities and comprehensive outcomes measures are fundamental to this approach. By respecting the collective nature of Māori identity and well-being, a collective rights framework aims to support both individual tamariki and rangatahi and their communities, recognising that upholding collective cultural rights is essential for mental health. When planning a health rights approach that aligns with Māori collective values, it imperative to acknowledge that Māori concepts often do not align precisely with Western concepts.

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[143] Nicola White and Andrew Ladley "Claims to Treaty and Other Rights: Exploring the Terms of Crown-Māori Negotiation" (2005) 1 Policy Quarterly 3 at 6; see also Whitinui, above n 142, at 141.

[144] King, Cormack, Kōpua, above n 135, at 196; See also Kiri Toki "Ko Nga Take Ture Māori: What a Difference a 'DRIP' Makes - The Implications of Officially Endorsing the United Nations Declaration on the Rights of Indigenous Peoples" (2010) 16 Auckland University Law Rev 243; Pita Sharples "Supporting UN Declaration Restores NZ Mana" (press release, 20 April 2010).

Over time, some efforts have been made by the Crown to enhance the role of Māori in health matters.[145] However, despite the Crown's efforts to promote Māori representation in health governance, policymaking, and consultation, concerns have been raised about the level of influence Māori have on health policies and the gap between policy statements and actual practices.[146] The principles outlined in the Treaty of Waitangi and a dedication to Māori health are emphasised in the policy document, He Korowai Oranga. The New Zealand Health strategy aims to achieve equitable health outcomes for all while recognising the unique relationship between the Crown and Māori.[147] As Came asserts, there have been attempts to consult and involve Māori in policy making, including the requirement of DHBs to consult Māori, and develop and report on annual Māori health plans. Māori input has been facilitated in DHB planning processes as a result of these initiatives.[148] It must be noted that DHBs have now been replaced under the Pae Ora Act and the Māori Health Authority, a new creation of the Pae Ora Act has also been disestablished.[149]

Despite these initiatives, as Came correctly identifies in her research, there are ways in which Māori voices can be marginalised or overlooked in health policy, including their "numerical minority status within both the population and decision-making bodies, the limited political will of governments to prioritise policies for Māori, the preference for Western knowledge and research over Māori evidence and analysis, the inadequate cultural competence of managers and policymakers, and flawed consultation processes".[150] To illustrate further, Came provides some of the concerns raised by Māori

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[145] See for example *Whanau Ora: Report of the Taskforce on Whanau-Centered Initiatives* (Ministry of Social Development 6 April 2010) at 10; The Māori Reference Group for the Taskforce for Action on Violence within Families "E Tu Whānau Programme of Action for Addressing Family Violence 2013 – 2018" <www.familyservices.govt.nz>.

[146] Timothy Gassin, Waitangi Tribunal *A report Commissioned by the Waitangi Tribunal for the Wai2575 Health Services Outcomes Kaupapa Inquiry* (Waitangi Tribunal, Wai2575, B26, August 2019) at 91.

[147] Heather Came and Keith Tudor "Unravelling the Whāriki of Crown Māori Health Infrastructure" (2017) 130 NZMJ 42 at 42; see also Heather Came, Clare Doole, Barbara McKenna and Tim McCreanor "Institutional Racism in Public Health Contracting: Findings of a Nationwide Survey From New Zealand" (2018) 199 Social Science and Medicine 132.

[148] Came and Tudor, above n 147, at 42-43.

[149] Ministry of Health *Disestablishment of the MHA: Next Steps Hauora Māori Bundle* (Wellington, 2024).

[150] Gassin, above n 146, at 91; As stated in the report at 91, "These problems were identified through a series of interviews with individuals who had experience working in the health sector and were in many cases mirrored in a later study by Came and others examining the experiences of Māori and Pacific people serving on health advisory groups. Given the small sample size for these studies and the sourcing of informants from the existing networks of the researchers and their close associates, caution needs to be

leaders about the consultation process. Some of the concerns include "tight (and therefore disrespectful) timeframes, the (biased) framing of questions, the restriction of who was included in the consultation process… how consultation was conducted (i.e., along lines decided by Pākehā, and not observing Māori tikanga… and critically what happened to contributions afterwards)".[151]

As with the consultation and policy making process, at a practical level, putting policy implementation issue into practice does not always occur effectively".[152] Wano pointed out that Māori health plans, developed independently of other planning processes, are often cited and referenced without leading to any significant improvement in terms of outcomes.[153] However, as Gassin points out, the failure to implement changes that are widely recognised as necessary and included in government policies suggests that the problem is more extensive than just "dismissive attitudes or poor engagement with Māori".[154] The issue is not only about whether "Māori voices are heard less strongly than others in policy-making",[155] but also the fact that the "general failure to transform services in line with recommendations of both Māori and others has likely had a disproportionately negative impact on Māori, given the higher rates of mental illness amongst Māori"[156] and the higher proportion of Māori who use mental health services.

A further view on improving Māori health outcomes is offered by Whitinui. He argues that simply duplicating mainstream health strategies is not enough to bridge the gap between Māori and non-Māori in health.[157] Rather, a curated approach incorporating Māori health concepts and frameworks, leveraging Māori health service provides, optimising the use of Māori culture and use of Māori evidence-based best practice are just some of the things required to cultivate a positive health relationship with Māori.[158]

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exercised in considering the extent to which the experiences and perceptions recorded reflect those of Māori in the health sector more broadly".

[151] Whitinui, above n 142, at 142.

[152] Gassin, above n 146, at 92.

[153] Gassin, above n 146, at 92.

[154] At 92.

[155] At 92.

[156] At 92.

[157] Whitinui, above n 142, at 142.

[158] At 144-145.

Durie has proposed five crucial theoretical considerations to keep in mind when navigating cultural factors in the health care sector for the benefit of Māori, which are:[159]

1. Foundational: validates and legitimises Māori ways of knowing, doing and being that aim to benefit Māori health in all areas of society (Māori knowledge and health perspectives).

2. Engagement: allows opportunities for all Māori to fully engage and participate in their health and well-being equally (cultural customs and whānau).

3. Assessment: develops a greater cultural profile or portfolio of evidence about the health benefits, gains and outcomes by and for Māori (relationships and cultural intervention plan).

4. Interventional: cultural practices and principles that underpin Māori health and well-being.

5. Outcomes: Improving the health and well- being of Māori to be able to function to their potential in all areas of society.

Together, these frameworks provide a comprehensive and culturally sensitive approach to addressing Māori health disparities. They emphasise the importance of integrating Māori cultural values, practices, and knowledge into health interventions. These strategies and considerations would help to build a strong foundation for developing and implementing effective health programs that are tailored to the specific needs and cultural context of Māori communities.

When determining the right to health and mental health for Indigenous children, collective rights are critical because health for Indigenous communities is a holistic concept that encapsulates the collectivity and indivisibility of the individuality from their kinship, and the natural environment. Such a holistic view of health is relevant because it concerns collectivity, and the right to health for Indigenous communities cannot be

[159] Whitinui, above n 142, at 144-145; At 146; See also Mason Durie *Alignment of Clinical and Cultural Perspectives: Innovation at the Interface* (Te Manu Ao Seminar Series, Massey University, Palmerston North, 2007).

viewed in isolation as being individualistic or conceptualised in the Western liberal sense, rather it is a collective right. As Durie stated, "[t]he challenge is to adopt and support policies and programmes that foster a secure cultural identity so that Māori might live as well as non-Māori".[160] Therefore, a rights-based approach that recognises the unique cultural needs and rights of Māori people, ensuring that health initiatives are not only accessible but also culturally appropriate and empowering is vital. As the thesis progresses towards recommendations for improving the outcome in mental health for tamariki and ragatahi Māori, this rights-based approach will be revisited.

4.8. Conclusion

The chapter explores the concept of collective rights and its significance for Indigenous communities, particularly Māori. Collective rights, which prioritise group interests over individual rights, are crucial for understanding Indigenous perspectives. Theorists such as Kymlicka and Raz have advocated for recognising these rights, especially for minority and Indigenous groups. Māori culture emphasises collectivism and interconnectedness, reflected in concepts such as whakapapa, tikanga, and whanaungatanga. International instruments such as the UNDRIP also affirm collective rights for Indigenous peoples, including self-determination and participation in decision-making. In health contexts, there is a significant relationship between individual and collective rights for Indigenous peoples, as Indigenous identities are rooted in group settings. To summarise, a rights-based approach to Māori health should incorporate collective rights perspectives and Māori concepts alongside individual rights frameworks. While challenges remain to fully implementing collective rights approaches in New Zealand's health policies for Māori, recognising these collective rights is a crucial step towards addressing the physical and mental health needs of tamariki and rangatahi Māori in culturally responsive ways. The chapter emphasises the importance of understanding and incorporating collective rights to develop effective, culturally-appropriate approaches to Māori health.

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[160] Mason Durie "Pūmau Tonu te Mauri Living as Māori Now, and in the Future" (Ministry of Māori Development, Discussion Paper, 2017) at 9.

Further to the discussion of collective rights and their importance for Indigenous communities, particularly Māori, it is crucial to now turn to examine how these concepts intersect with the principle of the best interests of the child. To this end, the following chapter examines the interpretation and application of the best interests and the right to health standard under international law.

Chapter Five

The Child's Right to Health and Mental Health

5.1. Introduction

The previous chapter examined the principle of collective cultural rights, their development, and common objections to them. It also explored the potential attributes of a Māori collective right to health. The chapter established the importance of cultural rights from a rights-based perspective. Correspondingly, the analysis bolstered the thesis argument that the child's best interests principle is flexible enough to incorporate the Indigenous child's collective cultural health, an approach which aligns with Indigenous communities' holistic understanding of health. Building upon this foundation, this chapter elucidates the right to physical health and mental health, examines the components of this right and its interpretation by the United Nations.

The human right to the highest achievable level of health is codified in various international legal instruments and treaties. According to Tobin, these international declarations have established the "normative foundation of global health law".[1] All countries have endorsed at least one international human rights treaty that includes the right to health, making it binding under international law. As a result, all States are legally bound by international human rights norms to 'progressively realise' the right to health. The WHO Constitution describes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[2] It is important to recognise that the right to health does not guarantee perfect health. Numerous factors beyond governmental control, including natural elements, educational attainment, income levels, and individual choices can significantly influence a person's well-being.[3] However, the primary obligation of nations regarding the right to health is to create conditions that optimise the potential for good health among their citizens. Such an obligation extends

[1] John Tobin and Damon Barrett "The Right to Health and Health-Related Human Rights" in Lawrence Gostin and Benjamin Meier (eds) *Foundations of Global Health & Human Rights* (Oxford University Press, Oxford, 2020) 67 at 67.

[2] *Constitution of the World Health Organization* 14 UNTS 185 (New York, 22 July 1946, entered into force 7April 1948), Preamble.

[3] Yvonne Donders "Exploring the Cultural Dimensions of the Right to the Highest Attainable Standard of Health" (2015) 18 PELJ 180 at 185-187.

beyond merely ensuring access to healthcare services and medical provisions. What has been established is that the right to health encompasses essential health determinants, such as sufficient nutrition, appropriate housing, safe drinking water, adequate sanitation facilities, secure working environments, and a healthy ecosystem.[4] Therefore when States are considering how to fulfil their obligations, these determinants must be considered. The key message remains clear: "there can be no good health without human rights".[5]

Particularly pertinent to this thesis are mental health rights. In recent years, there has been increasing acknowledgement that mental health is a crucial aspect of overall health and well-being, and that without good mental health, the right to health is not fully achieved.[6] Correspondingly, mental health has gained increased recognition as a human rights issue.[7] Despite increasing recognition of mental health within the human rights framework, there are some persistent difficulties. In particular, there has been debate around what the right to mental health means because it has suffered from imprecise standards.[8] The UN has remedied this defect in the 21st century by issuing a raft of reports and comments on this area.[9] Academics have labelled this as a "dramatic development in the global understanding of the meaning and scope of the international human right to health".[10] Not only is there increased awareness of the importance of mental health in overall health and well-being, but it is also evident that globally, there is a growing mental health crisis.[11] International human rights law has a crucial role in addressing this crisis for two main reasons, as signalled by Gostin in 2004 (but remaining valid today). Firstly, it is the only

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[4] Donders, above n 3, at 185-187.

[5] *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* UN Doc A/HRC/44/48 (2020) at [1].

[6] At [3]-[6]; *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* UN Doc A/HRC/35/21 (28 March 2017); Office of the United Nations High Commissioner for Human Rights "Right to Mental Health" (2023) United Nations Human Rights Council <https://www.ohchr.org/en/special-procedures/sr-health/right-mental-health>.

[7] World Health Organization "Mental Health is A Universal Human Right" (10 October 2023) <https://www.who.int/news-room/questions-and-answers/item/mental-health-promoting-and-protecting-human-rights>.

[8] Tobin and Barrett, above n 1, at 67.

[9] *General Comment No. 11 Indigenous Children and Their Rights under the Convention on the Rights of the Child*, UN Doc CRC/C/GC/11 (12 February 2009); *General Comment No. 14 The Right to the Highest Attainable Standard of Health* UN Doc E/C.12/2000/4 (11 August 2000); *Expert Mechanism on the Rights of Indigenous Peoples Study on the Right to Health and Indigenous Peoples with a Focus on Children and Youth*, UN Doc A/HRC/33/57 (25 July 2016).

[10] Tobin and Barrett, above n 1, at 67.

[11] William Bor, Angela Dean, Jacob Najman and Reza Hayatbaksh "Are Children and Adolescent Mental Health Problems Increasing in the 21st Century? A Systemic Review" (2014) 48 Australian and New Zealand Journal of Psychiatry 606 at 606-616.

tool available to "legitimize international scrutiny" of mental health policies in a State. Secondly, it continues to afford citizens with protections which cannot be taken away "by the ordinary political process".[12]

As noted earlier, the right to health has been codified in international human rights documents which set the baseline for compliance by individual States and which include the right to and scrutiny of mental health. Within this context, this chapter examines the relevant international documents and the expectations of health rights that they establish, in particular mental health rights. This chapter begins by outlining the key international instruments that establish the right to health, including the Universal Declaration of Human Rights ("UDHR"), and the International Covenant on Economic, Social and Cultural Rights ("ICESCR").[13] The discussion then examines how the right to health has been interpreted and elaborated upon by UN treaty bodies and special procedures, including the ESCR's General Comment No. 14 which sets out the framework of availability, accessibility, acceptability and quality ("AAAQ").[14] In keeping with the focus on the best interests of the child, and the significance of collective rights, the chapter then considers mental health rights for the Indigenous child.

At this point, it is important to clarify the terms of mental disabilities and mental health, as some may draw a distinction. This research primarily focuses on improving mental health outcomes for tamariki and rangatahi Māori. Although the terms mental health and mental disabilities are often used interchangeably, they represent related but distinct concepts.[15] Mental health encompasses a person's overall emotional, psychological, and social well-being, which can vary based on their surroundings and experiences.[16] On the other hand, mental disabilities, sometimes called psychosocial or psychiatric disabilities,

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[12] Lawerence Gostin "The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health" (2004) 63 Maryland Review 20 at 20-21.

[13] International Covenant on Economic, Social and Cultural Rights 993 UNTS 3 (opened for signature 16 December 1966, entered into force 3 January 1976); Universal Declaration of Human Rights U.N. Doc A/810 (adopted by the United Nations General Assembly 10 December 1948)

[14] *General Comment No. 14,* above n 9; Universal Declaration of Human Rights U.N. Doc A/810 (adopted by the United Nations General Assembly 10 December 1948).

[15] A Sen and PS Mohanraj, "Mental Health and Disability: Understanding the Complex Interplay" in G Bennett and E Goodall (eds), *The Palgrave Encyclopedia of Disability* (Palgrave Macmillan, Cham, 2024) 1 at 1-15; Jamie Elmer "Mental Health vs Mental Illness: Understanding the Differences" (18 April 2023) Healthline <https://www.healthline.com/health/mental-health/mental-health-vs-mental-illness>

[16] At [5].

are long-term mental health conditions that hinder the ability to function in everyday life.[17] While poor mental health does not mean a person has a disability, both conditions necessitate appropriate support and protection within a rights-based framework. Although there is a distinction between the two, this research treats them as synonymous for its purposes.

5.2. International Instruments

The importance of health as an aspect of international law can be seen by the references to health in the United Nations Charter 1945 and the Covenant of the League of Nations 1919, both of which refer explicitly to health.[18] Nowadays, the right to health, alternatively referred to as the highest attainable standard of health (the standard adopted under international law) is enshrined in numerous international instruments. For example, the UDHR 1948 is a significant initial reference point. Article 25 stipulates the comprehensive right for "everyone ..to a standard of living adequate for the health and wellbeing of themselves and their families including food, clothing, housing and medical care and necessary social services".[19] Prior to this declaration, the World Health Organisation's ("WHO") Constitution in 1946 had asserted that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being".[20] Substantial evidence suggests that the drafters of the WHO Constitution did not intend to guarantee an individual's health.[21] Rather, there was consensus, as articulated in the preamble of the WHO Constitution, that "Governments have a responsibility for the health of their peoples, which can be fulfilled only by the providing of adequate health and social measures".[22] As United States President Truman's delegate stated at the Proceedings and Final Acts of the International Health Conference in 1946, (the conference aim was to establish the constitution), "[t]he right to adequate medical care and the opportunity to

[17] Elmer, above n 15, at [5].

[18] *Charter of the United Nations* 1 UNTS XVI (opened for signature 26 June 1945, entered into force 24 October 1945); *Covenant of the League of Nations* (opened for signature 28 June 1919, entered into force 10 January 1920). The League of Nations was established after the First World War.

[19] Universal Declaration of Human Rights, above n 14, at Article 25.

[20] *Constitution of the World Health Organization*, above n 2, at Preamble.

[21] John Tobin "The Meaning of the Highest Attainable Standard of Health" in *The Right to Health in International Law* (Oxford University Press, Oxford, 2011) 121 at 123-124.

[22] *Constitution of the World Health Organization*, above n 2, preamble.

achieve and enjoy good health should be available to all people".[23] During this conference, delegates were reminded of the statement made by President Roosevelt in 1939, "The health of people is a public concern; ill health is a major cause of suffering, economic loss and dependency; good health is essential to security and progress".[24] As Tobin observes, this perspective is mirrored in the WHO Constitution's preamble, which states that "the health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States" and that "the achievement of any State in the promotion and protection of health is of value to all".[25] Significantly, however, nations were driven by more than these pragmatic considerations and recognised that the highest attainable standard of health was, in itself, a sufficient basis for establishing a fundamental human right.[26] States have accepted that health is a significant interest to be entrenched as a human right and to be bound by international law.

Complementing these early international iterations, health as a human right appears in various subsequent international instruments. Of these instruments, as the WHO states, "the most authoritative interpretation of the right to health is outlined in Article 12 of the ICESCR.[27] Article 12 provides:[28]

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
>
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
>
> (b) The improvement of all aspects of environmental and industrial hygiene;

[23] Official Records of the World Health Organization "No 2: Proceedings and Final Acts of the International Health" (UN WHO Interim Commission Conference, New York from 19 June to 22 July 1946) at 31.
[24] Official Records of the World Health Organization, above n 23, at 31.
[25] Tobin, above n 20, at 124; *Constitution of the World Health Organization*, above n 2, preamble.
[26] Tobin, above n 20, at 124; See also *Constitution of the World Health Organization*, above n 2, preamble.
[27] World Health Organization *The Right to Health in the Constitutions of Member States of the World Health Organizations South-East Asia Region* (World Health Organization, 2011) at 2.
[28] International Covenant on Economic, Social and Cultural Rights, above n 13, Article 12.

…

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

The right to health is further embedded in various UN human rights agreements.[29] CEDAW (Article 12) advocates for the removal of discrimination against women in healthcare, ensuring they have equal access to medical services. The CRC (Article 24) ensures children's right to the best possible health standards and access to healthcare services. The Convention on the Rights of Persons with Disabilities (Article 25) affirms the right to the highest attainable health standards. The Declaration on the Rights of Indigenous Peoples (Article 24) acknowledges the right to health and healthcare access without discrimination, while also recognising Indigenous peoples' rights to traditional medicines and health practices. Although it does not explicitly reference the right to mental health, the CRPD addresses psychological well-being and protects the rights of individuals with mental health conditions under the broad umbrella of long term psychological disabilities.[30] It emphasises complete and equal rights, including respect for dignity, autonomy, and societal participation of persons with long term disabilities. The treaty prohibits disability-based discrimination and requires states to provide reasonable accommodations, ensuring equal exercise of rights for people with disabilities.[31]

Each of these UN treaties are supported by an independent panel of experts that functions as a monitoring body to oversee the implementation of the treaties and the overall adherence to international obligations by states.[32] Each State Party is required to

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[29] Convention on the Elimination of All Forms of Discrimination Against Women 1249 UNTS 13 (opened for signature 18 December 1979, entered into force 3 September 1981); Convention on the Rights of the Child 1577 UNTS 3 (opened for signature 20 November 1989, entered into force 2 September 1990);Convention on the Rights of Persons with Disabilities 2515 UNTS 3 (opened for signature 30 March 2007, entered into force 3 May 2008); United Nations Declaration on the Rights of Indigenous Peoples GA Res 61/295, A/Res/61/295 (2007).

[30] Oliver Lewis and Soumitra Pathare "Chronic Illness" in Lawrence Gostin and Benjamin Meier (ed) *Foundations of Global Health & Human Rights* (Oxford University Press, New York) 285 at 292; see also Convention on the Rights of Persons with Disabilities, above n 29, Article 1.

[31] Lewis and Pathare, above n 30, at 292; see also Convention on the Rights of Persons with Disabilities, above n 29, Article 5.

[32] Each Treaty has a monitoring body that obligates states to report regularly; For example the CRC has the Committee on the Rights of the Child; CEDAW has the Committee on the Elimination of Discrimination Against Women; CRPD has the Committee on the Rights of Persons with Disabilities; Donders, above n 3, at 186; See also *Committee on the Rights of the Child Treaty-Specific Guidelines Regarding the Form and Content of Periodic Reports to be Submitted by States Parties under Article 44, Paragraph 1(b), of the Convention on the Rights of the*

submit a report to the relevant treaty body, delineating how they have implemented the treaty. Subsequently, the treaty bodies conduct a dialogue with the State Party, encompassing both written correspondence and oral discussions.[33] The monitoring body issues Concluding Observations, which elucidate positive developments, ongoing challenges, and concerns regarding the treaty's implementation.[34] These Concluding Observations are considered to be recommendations and do not carry legally binding force. These treaty monitoring bodies also issue General Comments, which provide detailed interpretations of specific treaty provisions.[35]

While the international frameworks provide for the right to health, these instruments do not offer sufficient clarity and specificity regarding the scope and interpretation of this right, which is crucial for understanding how it can be effectively implemented in practice. Consequently, the subsequent discussion will address the definition and interpretation of the right to health. In this discussion, specific focus is placed on the observations made by the treaty monitoring bodies.

5.3. Interpretation of Health and the Right to Health

Defining health, let alone mental health, is challenging due to the breadth of the concept and the various interpretations of the term. In an effort to provide greater specificity, Daniels has attempted to define health as the absence of deviation from normal biological functioning. While this definition provides a more nuanced articulation of health, it still falls short when it comes to understanding and addressing disabilities.[36] The limitations of Daniels' approach are apparent when considering the diverse range of human experiences and the varying degrees of functionality across different individuals and contexts. As commentators have suggested, the concept of normal functioning is problematic and subjective.[37] Traditionally, and in a narrow understanding, health might

Child UN Doc CRC/C/58/Rev.2 (25 November 2010); Dianne Otto, "Gender Comment": Why Does the UN Committee on Economic, Social and Cultural Rights Need a General Comment on Women?" (2002) 14 Canadian Journal of Women and the Law 1; Matthew Craven "The International Covenant on Economic, Social, and Cultural Rights: A Perspective on its Development (Clarendon Press, Oxford, 1998) at 91; Henry Steiner and Phillip Alston *International Human Rights in Context: Law, Politics, Morals* (2nd ed, Oxford University Press, 2000) 265.

[33] Donders, above n 3, at 186.

[34] At 186.

[35] At 186.

[36] Tobin, above n 20, at 125-126.

[37] Tobin, above n 20, at 125-126.

be viewed as the absence of physical or mental ailments. However, as Tobin notes, this definition is inadequate because it fails to account for other issues such as congenital conditions or functional limitations.[38] Turning to international law, the WHO Constitution defines health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[39] This description has faced criticism for being overly broad and impractical for application in human rights, policy, and legal contexts.

The International Classification of Functioning, Disability and Health (ICF) was adopted by the World Health Assembly in 2001.[40] The WHO, in its report, striving for a common language for functioning, disability and health, provides a biopsychosocial model of disability which is based on an integration of traditional medical and social models. This classification system represents a significant departure from previous models by moving away from notions of normalcy.[41] The ICF provides a more nuanced and comprehensive framework for understanding health and disability, recognising the dynamic interplay between an individual's health condition and their environment.[42] One of the strengths of the ICF model is its increased attention to environmental and social factors affecting health and disability. The approach acknowledges that health outcomes are not solely determined by biological factors but are also influenced by a wide range of external elements, including access to healthcare, social support systems, economic conditions, and physical infrastructure.[43] By considering these broader determinants of health, the ICF model offers a more holistic and actionable framework for addressing health disparities and promoting well-being for all individuals.[44] The model proves a valuable contribution towards a definition of health. However, it still leaves many uncertainties about the nature of the right to health and the measures required to secure its practical implementation, to ensure it is not merely a theoretical concept.

General Comment No. 14 provides a comprehensive interpretation of the right to health as enshrined in Article 12. As scholars have noted, the General Comment "goes a

[38] Tobin, above n 20, at 125-126.
[39] At 125-126.
[40] At 125-129.
[41] At 125-129.
[42] At 125-129.
[43] At 126-129.
[44] At 126-129.

significant way towards resolving the long-standing vagueness of the right to health that has plagued its enforcement in legal and policy areas".[45] The General Comment is also significant because it defines the normative scope of the right to health, outlines the entitlements it encompasses, identifies its essential elements, and delineates the obligations of States in realising this right.[46] A crucial clarification made by General Comment No. 14 is that the right to health should not be understood as a right to be healthy.[47] Instead, it encompasses the right to a system of health protection, including healthcare services and the underlying determinants of health such as safe water, adequate sanitation, safe food, healthy occupational and environmental conditions, and access to health-related education and information.[48] States are responsible and obligated to create "conditions in which everyone can be as healthy as possible".[49]

Whilst General Comment No. 14 acknowledged that the highest standard of health will undoubtedly vary in each State, it established that there are several elements which should be met, regardless of the level of resources in a country.[50] Below is a detailed discussion of the elements referred to as the AAAQ, which were introduced by the CESCR. The CESCR also provides core obligations that States must fulfil under all circumstances, precluding the utilisation of progressive realisation or resource limitations as justifications for non-compliance.[51] These core obligations aim to ensure a minimum level of healthcare, particularly for the most vulnerable populations.[52] States are required to guarantee at least the basic essential levels of each right, including non-discriminatory access to health facilities, goods, and services; access to minimum essential food, basic shelter, housing, sanitation, and safe drinking water; essential drugs as defined by the WHO; equitable distribution of health resources; and the implementation of a national public health strategy addressing the needs of the entire population, with a focus on vulnerable or marginalised groups.[53]

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[45] Lisa Forman "Decoding the Right to Health: What Could It Offer to Global Health?" (2015) 8 Bioethica Forum 91 at 92.
[46] At 92.
[47] *General Comment No. 14,* above n 9, at [8]; Forman, above n 45, at 92.
[48] *General Comment No. 14,* above n 9, at [8]; Forman, above n 45, at 92.
[49] *General Comment No. 14,* above n 9, at [8].
[50] At [11]-[13]; Forman, above n 45, at 92.
[51] *General Comment No. 14,* above n 9, at [30]-[37]; Forman, above 45, at 92.
[52] Forman, above 45, at 92.
[53] *General Comment No. 14,* above n 9, at [11]-[13], [30]-[37]; Forman, above n 45 at 92.

One of the core obligations as evident in the ICESCR for State Parties is progressive realisation. Article 2 of the ICESCR requires a State Party to take steps to achieving progressively the full realisation of the ICESCR rights.[54] In relation to health, General Comment No. 14 interprets this to mean that while full realisation of the right may be achieved progressively, States have an immediate obligation to take deliberate, concrete, and targeted steps towards this goal.[55] This interpretation aims to prevent States from indefinitely delaying action and steps towards realisation.[56] The obligation is to move as expeditiously as possible towards achieving the highest attainable standard of health. General Comment No. 14 also elaborates on the tripartite typology of State obligations: the obligation to respect (refraining from interfering with the enjoyment of the right), protect (preventing third parties from interfering), and fulfil (adopting appropriate legislative, administrative, budgetary, judicial, promotional, and other measures to fully realize the right).[57] In summary, the modern interpretation of the right to health encompasses both an entitlement and a responsibility. The entitlement refers to achieving the best possible health standards. The associated obligation, as outlined in the ICESCR, "is that states respect, protect and fulfil the right; adopt specific and appropriate measure; and progressively realize over time".[58] Progressive realisation and the obligation to respect, protect and fulfil, specifically in a health context is discussed below.

In addition to the work conducted by the CESCR, the Special Rapporteur and other various monitoring bodies, there has been a substantial body of scholarly jurisprudence in the field further elucidating the meaning of the right to health.[59] As Bustreo and Doebbler assert, implementing a human rights-based approach to health necessitates the incorporation of cross-cutting human rights principles. These obligations are based upon the human rights obligations that States have accepted under international law.[60]

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[54] International Covenant on Economic, Social and Cultural Rights, above n 13, Article 2.

[55] Forman, above 45, at 92.

[56] At 92.

[57] *General Comment No. 14,* above n 9, at [30]-[37]; Forman, above n 45, at 92.

[58] Tobin and Barrett, above n 1, at 72; *General Comment No. 14,* above n 9 at [30]-[37].

[59] Bustreo Flavia and Curtis Doebbler "Making Health an Imperative of Foreign Policy: The Value of a Human Rights Approach" (2010) 12 Health and Human Rights 47; John Tobin "Article 24" in John Tobin (ed) *The UN Convention on the Rights of the Child* (Oxford University Press, Oxford, 2019); Forman, above n 45, at 91.

[60] Bustreo and Doebbler, above n 59 at 95.

Several key principles can be deduced from interpreting the right to health. As the UN Commissioner for Human Rights stated, "fulfilment of the right to health, including mental health, can empower and restore individual dignity and contribute to more tolerant, peaceful and just societies".[61] The right to health, as outlined in General Comment No. 14 and the reports of the Special Rapporteur, includes several fundamental principles. Like General Comment No. 14, these principles include non-discrimination, availability, accessibility, acceptability, quality, participation, accountability, progressive realisation, core obligations, international cooperation, respect for cultural diversity, and a focus on vulnerable groups.[62] Together, these principles strive to ensure that health facilities, goods, and services are accessible to everyone, particularly marginalised communities, without any form of discrimination. These principles are discussed below in relation to the right to health generally, and where applicable, reference is made to mental health and Indigenous peoples.

Examining the framework for the right to health and its cross-cutting principles is important for understanding legal obligations regarding Indigenous children's health and mental well-being. The analysis provides a foundation for exploring how international standards align with Māori cultural perspectives on health and whether New Zealand is meeting its obligation under international law. Additionally, the analysis helps to identify gaps in New Zealand's current policies and practices, allowing for an evaluation of how the best interests principle can apply to tamariki and rangatahi Māori mental health rights. The following section examines these frameworks/principles as understood under international law.

5.3.1. Freedoms and Entitlements

The right to health is made up of freedoms and entitlements. The concept of 'freedom' within the context of the right to health encompasses several critical aspects. At its core, this right incorporates the fundamental freedom to control one's health and body including the right to make decisions over one's health, and to exercise informed consent which is particularly difficult for individuals suffering from mental health illnesses who

[61] OHCHR "Bachelet Calls for Mental Health Care to be Based on Human Rights" (Press release,15 November 2021).
[62] *General Comment No. 14*, above n 9; *Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health Report to the General Assembly* UN Doc A/61/338 (13 September 2006).

can be vulnerable. The situation is compounded where there is stigma and discrimination "surrounding mental disabilities and expediency or indifference on the part of staff".[63] In this context, concerns have been raised about decisions to administer medication and pernicious treatments without informed consent from the patient. Whilst there is international and national legislation that provides for treatment for psychiatric patients, it must be exercised with extreme caution, given the potential for significant breaches of the right to make informed decisions. Unfortunately, there is ample case law that shows the failure of countries to use such provisions in a respectful and proper manner.[64] The freedom element in the right to health is thus a complex and multifaceted concept, balancing individual autonomy with societal concerns and protections.[65]

Entitlements include the right "to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health",[66] which includes "culturally appropriate health services".[67] In terms of mental health, entitlement is an important principle as it ensures the health and dignity of vulnerable people. General Comment No. 5 on persons with disabilities emphasises the principle of non-discrimination in healthcare access. It stipulates that individuals with disabilities should receive medical care of the same quality and within the same system as other members of society. The principle highlights the importance of inclusive healthcare systems that cater to the diverse needs of all individuals, regardless of their abilities.[68]

In this regard, there is an onus on States to provide health care services that are inclusive, and uphold the dignity of the patient. The expectation is that the "full package of community-based physical and mental healthcare and support services" should be

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[63] Paul Hunt and Judith Mesquita "Mental Disabilities and the Human Right to the Highest Attainable Standard of Health" (2006) 28 Human Rights Quarterly 332.

[64] At 332-334; *Varbanov v Bulgaria* App No 31365/96 Eur Ct H.R (2000); *Purohit and Moore v Gambia* (2003) African Comm'n on Hum and Peoples' Rts Comm No 241/2001.

[65] Hunt and Mesquita, above n 63, at 343.

[66] *General Comment No. 14,* above 9, at [8].

[67] Helen Potts *Participation and the Right to the Highest Attainable Standard of Health* (Human Rights Centre, University of Essex, 2008) at 12.

[68] Committee on Economic, Social and Cultural Rights *General Comment No. 5: Persons with Disabilities* UN Doc E/C.12/1994/13 (1994) at 34; Hunt and Mesquita, above n 63, at 345.

offered.[69] In a similar vein, for the provision of such health services, there must be training and adequate health professionals involved.[70]

5.3.2. AAAQ framework - with a focus on Indigenous peoples

For spelling out the practical implications of core principles, the AAAQ framework provides specific criteria that need to be met. These criteria will be examined in the following sections.[71] The ensuing discussion supports the central argument of this thesis, which is that the best interests principle can enhance the right to health for tamariki and rangatahi Māori.

Accessibility

Accessibility is a multifaceted concept but its underlying premise is simple: health services need to be "accessible to everyone".[72] There are four criteria that fall under this element which includes "non-discrimination, physical accessibility, economic accessibility and information accessibility".[73] Each of these components will be discussed in the following sections.

Non-discrimination is a crucial dimension of accessibility. The basic principle is that no individual should face discrimination when accessing the healthcare system. As the CESCR states, healthcare, goods and services "must be accessible to all, especially, the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prescribed grounds".[74] The OHCHR and the WHO have interpreted these grounds as those provided for in Article 2 of the ICESCR, which include religion, language or race.[75]

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[69] Hunt and Mesquita, above n 63, at 345.

[70] *Office of the United Nations High Commissioner for Human Rights and World Health Organisation the Right to Health: Fact Sheet no 31* OCHR/WHO (2008) at 7; Hunt and Mesquita, above n 63, at 345- 347.

[71] *Report of the Special Rapporteur,* above n 62*,* at [17]–[20]; *General Comment No. 14,* above n 9*,* at [11]-[12]; *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* UN Doc A/HRC/7/11 (31 January 2008) at [25]–[28]; *Expert Mechanism on the Rights of Indigenous Peoples*, above n 9.

[72] *Expert Mechanism on the Rights of Indigenous Peoples* , above n 9 at 13; See also *Report of the Special Rapporteur* above n 6*,* at [50]-[58].

[73] *General Comment No.* 14, above n 9, at [11]-[12].

[74] *General Comment No.* 14, above n 9, at [12].

[75] *Office of the United Nations High Commissioner,* above n 70, at 7.

Recent research conducted by Yates demonstrated that Indigenous peoples are less likely to receive access to certain healthcare due to discrimination based on their race.[76] As the Special Rapporteur asserts, the need to ensure that there is no discrimination is amplified for Indigenous peoples with disabilities and discrimination, and can lead to disparities in the treatments patients receive and possibilities of misdiagnosis, constituting a clear breach of their right to health.[77] Regarding mental health, individuals with mental health illnesses should receive the same standard of healthcare as other individuals and should not be subject to discrimination. However, this is often not the case, and mental illness is frequently seen as a reason to deny patients essential treatments, and "such reasoning is inherently incompatible with the right to access care on the basis of non-discrimination".[78]

Physical accessibility is paramount to ensuring that individuals have access to relevant mental healthcare. However, the Special Rapporteur has identified that this often presents a challenge for vulnerable groups who, due to colonisation or urbanisation, are isolated from society, thus restricting their physical accessibility to essential healthcare.[79] For individuals suffering from mental illness, the situation is exacerbated as treatment centres or community-based care facilities are frequently located away from residential areas. The accessibility challenge is problematic because it impedes such individuals from continuing to live, work, and be supported by their communities. To ameliorate this situation, community-based treatments are essential and significant. The WHO has emphasised the importance of community-based care and its integration into primary healthcare settings to safeguard the principle of "least restrictive environment".[80]

Another key attribute of accessibility is economic accessibility which refers to the affordability of healthcare for all citizens. This is not axiomatic and remains problematic especially for Indigenous communities. In this regard, the Special Rapporteur asserted that economic accessibility remains a prevalent issue for Indigenous communities, as they

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[76] Karen Yates "Indigenous People in Australia, Canada, New Zealand and the United States are Less Likely to Receive Renal Transplantation" (2009) 76 Kidney International 6; see also Dale Bramley, Peter Herbert, and Rod Jackson "Indigenous Disparities in Disease-Specific Mortality: A Cross-Country Comparison" (2004) 117 New Zealand Medical Journal 1215.

[77] *Report of the Special Rapporteur on the Right of Indigenous Peoples* UN Doc A/HRC/57/47 (22 July 2024) at [24]-[45].

[78] Hunt and Mesquita, above n 63, at 347.

[79] *Report of the Special Rapporteur ,* above n 6, at [24].

[80] Hunt and Mesquita, above n 63, at 347.

frequently represent "the most socioeconomically marginalized groups in society".[81] Furthermore, mental health care and medication are often not subsidised, rendering them unaffordable for economically disadvantaged communities.[82] Consequently, these communities are precluded from accessing mental healthcare.

The final cornerstone for accessibility is information accessibility which encompasses "the right to seek, receive and impart information and ideas concerning health issues".[83] The right has also been shown to be problematic for Indigenous communities. The United Nations has observed that for Indigenous or marginalised communities, information accessibility is frequently limited due to various factors, including "health information being unavailable in Indigenous languages, higher rates of illiteracy amongst Indigenous peoples, lack of contact with health care providers, and discriminatory or paternalist attitudes amongst healthcare providers".[84] Consequently, there is often inadequate provision of crucial information that would assist individuals and communities in comprehending mental illness. For individuals with mental health disorders, the situation is exacerbated as they are frequently denied information, including diagnosis and treatment, due to being perceived as lacking capacity to make informed decisions.[85]

Acceptability

Acceptability has been defined by the CESCR to include "[m]ental health services [that are] respectful of medical ethics and human rights, as well as culturally appropriate, sensitive to gender and life-cycle requirements and designed to respect confidentiality and empower individuals to control their health and well-being".[86] Of particular relevance to this thesis is the requirement that healthcare facilities, goods and services must be culturally 'appropriate and acceptable' to all individuals, free from inappropriate practices

[81] *Expert Mechanism on the Rights of Indigenous Peoples ,* above n 9, at [25].
[82] Lihong Zhang, Zianf-Yo Hou, Yan Liu "Measuring Mental Health Service Accesiility for Indigenous Populations: A Systematic Reveiw" (2024) 12 Journal of Racial and Ethinc Health Disparitites 1; See also Carol Davy, Stephen Harfield, Alexa McArthur, Zachary Munn and Alex Brown "Access to Primary Health Care Services for Indigenous Peoples: A Framework Synthesis" (2016) 15 International Journal for Equity in Health *1*63.
[83] Courtland Robinson "The Right to Health and Basic Services" (2010) 41 Studies in Transnational Legal Policy 207 at 218.
[84] *Expert Mechanism on the Rights of Indigenous Peoples ,* above n 9, at [8].
[85] Hunt and Mesquita, above n 63 at 347.
[86] *Report of the Special Rapporteur ,* above n 6 at [58].

or stereotyping.[87] The Permanent Forum on Indigenous Issues ("PFII") has emphasised the necessity of culturally appropriateness and the importance of good physical and mental health for Indigenous children's growth and development.[88] As Robinson asserts, healthcare systems that do not accommodate diversity will result in negative outcomes or cause disparities in healthcare.[89] The Special Rapporteur has stated that frequently "interpersonal and structural racism"[90] occurs in healthcare systems, alongside "policies and practices that marginalize or exclude"[91] Indigenous communities, preventing the development of culturally acceptable facilities and services. The Report notes that there is a dearth of acceptable and high-quality interventions based on trust and respect and that mental health legislation and practices "still allow the proliferation of non-consensual measures".[92] Negative stereotyping of Indigenous groups and, the subsequent internalisation of these stereotypes by the Indigenous communities themselves and a lack of cultural competency of healthcare professionals all exacerbate the situation.[93] Collectively, these factors impact on the 'acceptability' of the healthcare system for Indigenous communities. In order to create a mental health care system that nurtures Indigenous communities, the Special Rapporteur posits further that Indigenous communities must be consulted and included in the development of policies, strategies and initiatives. The CESCR has further elucidated this matter in General Comment No. 21:[94]

> Appropriateness refers to the realization of a specific human right in a way that is pertinent and suitable to a given cultural modality or context, that is, respectful of the culture and cultural rights of individuals and communities, including minorities and Indigenous peoples… The way in which rights are implemented may also have an impact on cultural life and cultural diversity…

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87 *Report of the Special Rapporteur ,* above n 6*,* at [58].

88 *Permanent Forum on Indigenous Issues Report on the Second Session* UN Doc E/2003/43–E/C.19/2003/22 (23 May 2003) at [4], [5], [17].

89 Robinson, above n 83, at 221.

90 *Report of the Special Rapporteur ,* above n 6 at [50]-[58].

91 *Report of the Special Rapporteur* above n 6 at [50]-[58].

92 *Special Rapporteur ,* above n 5, at [64]; *Report of the Special Rapporteur ,* above n 6, at [50]-[58].

93 Expert Mechanism, above n 9, at [26].

94 *General Comment No. 21 Right of Everyone to Take Part in Cultural Life (Article 15, Paragraph1(a)) of the International Covenant on Economic, Social and Cultural Rights* UN Doc E/C.12/GC/21 (2009) at [16]- [17].

Within the context of mental health care, it is pivotal that healthcare and support services be culturally appropriate and respectfully undertaken.

Availability

The criterion of availability is defined as the "presence of core social and underlying determinants that are essential to the promotion of well-being"[95] for individuals and the broader community. The situation encompasses access to functional public and healthcare facilities, goods and services.[96] In addition to these conventional criteria, availability also includes "access to health [as] related information, education, and [the promotion of] healthy and positive relationships between individuals based on trust, respect and tolerance".[97] The Special Rapporteur asserts that when factors such as housing, food, social security and community integration are supported, this facilitates the promotion of healthy and positive relationships.[98] With regard to mental health, availability necessitates an "adequate supply of essential medicines" as well as the presence of trained health professionals.[99]

Quality

Quality requires that health services should be of good quality.[100] The WHO stipulates that good quality mental healthcare requires evidence-based practices to support prevention, promotion and recovery.[101] While this may appear idealistic, as Robinson and Peabody elucidate, poor quality is a factor that "can obviate all the implied benefits of good access, and effective treatment"[102] in mental health.

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[95] *Report of Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* UN Doc A/HRC/41/34 (12 April 2019) at [25]; *Report of the Special,* above n 6, at [55]; see also *General Comment No. 4 Adolescent Health and Development in the Context of the Convention on the Rights of the Child* UN Doc CRC/GC/2003/4 (1 July 2003) at [41(c)].

[96] Hunt and Mesquita, above n 63, at 347.

[97] *Report of Special Rapporteur*, above n 95, at [25]; See generally Mohit Varshney "Violence and Mental Illness: What is the True Story?" (2016) 70 Journal of Epidemiology & Community Health 223.

[98] *Report of Special Rapporteur,* above n 95, at [7].

[99] Hunt and Mesquita, above n 63, at 346.

[100] *General Comment No. 14 ,* above n 9*,* at [18]; *Report of the Special Rapporteur,* above n 6, at [60].

[101] World Health Organization *Mental Health Action Plan 2013-2020* (WHO Document Production Services, Action Plan, 2013) at [49].

[102] Robinson, above n 83, at 221; See also John Peabody, Dean Jamison, Joel Berman "Improving the Quality of Care in Developing Countries" in Dean Jamison, Joel Breman, Anthony Measham, George

Furthermore, Peabody provides an interpretation of what 'good quality' entails. He posits that good quality means providers are able to manage an individual's or a population's health care by the timely, skilful application of medical technology in a culturally sensitive manner within the existing constraints.[103] Ultimately, good quality transcends the notion of users of mental health services as "mere recipients of care",[104] instead recognising them as active holders of rights.[105] In essence, this necessitates skilled health professionals, "evidence-based psychological interventions, scientifically approved and unexpired drugs, appropriate hospital equipment, safe and portable water and adequate sanitation".[106] In the context of mental health, health professionals should be adequately trained, and additional support for patients, including sanitary facilities and psychiatric institutions, should be provided.[107]

5.3.3 Respect, protect, and fulfil

The ICESCR establishes a legally enforceable framework for the right to optimal health which is further supported by legal standards, including the AAAQ framework.[108] Furthermore, governments are obligated to honour, safeguard and implement the right to health known as the responsibility to respect, protect and fulfil obligations. These are a comprehensive set of measures that can assist governments in transforming the abstract duty to acknowledge the right to health into tangible and implementable components.[109] The framework provides a structured approach for governments to fulfil their responsibilities in ensuring the realisation of the right to health for their citizens. By breaking down the abstract concept into specific categories, the respect, protect and fulfil typology offers a practical roadmap for policy-makers and legislators. It enables them to identify and implement targeted interventions across various domains of healthcare provision, access, and quality. Each of the components will be elaborated on in the following sections. As the Special Rapporteur highlighted, particularly regarding mental health, "States must create, offer, and encourage conditions that allow for the

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Alleyne, Mariam Claeson, David Evans, Prabhat Jha, Anne Mills and Philip Musgrove (eds) *Disease Control Priorities in Developing Countries* (2nd ed, Oxford University Press, New York, 2006).

[103] Robinson, above n 83, at 221.

[104] *Report of the Special Rapporteur* , above n 9 , at [67].

[105] At [67].

[106] Hunt and Mesquita, above n 63 at 348; *General Comment No. 14 ,* above n 9*,* at [30]-[37].

[107] Hunt and Mesquita, above n 63, at 348.

[108] *Report of the Special Rapporteur*, above n 6, at [35]-[37]; *General Comment No. 14 ,* above n 9 at [30]-[37].

[109] Hunt and Mesquita, above n 63, at 348; *General Comment No. 14,* above n 9 at [30]-[37].

achievement of health and well-being".[110] To uphold the right to mental health, it is essential to provide not only fair healthcare (and alternatives to biomedical care) but also public mental health initiatives that can shield populations from significant risk factors associated with poor mental health.[111]

Respect

The principle of respect incorporates a number of aspects. In accordance with this principle, states are obligated to refrain from impeding access to healthcare services and health determinants. The CESCR asserted that the obligation to respect extends to the underlying determinants of health,[112] for instance, States must not contaminate the air, water or conduct detrimental activities on Indigenous land. Regarding individuals with mental illness, states are required to ensure that they are not denied access to support services and underlying health determinants.[113]

Protection

In addition to respect, State Parties have a responsibility to protect the right to health by preventing third-party interference and rectifying discrimination, particularly for vulnerable groups such as people with mental disabilities and Indigenous communities. Specifically, States should endeavour to rectify existing discrimination and to ensure equitable treatment and access to healthcare facilities, particularly for vulnerable individuals with mental disabilities. Consequently, attention must be directed towards "workforce awareness-raising activities and campaigns" to address racist and other discriminatory behaviour exhibited.[114] Given the vulnerability of Indigenous communities, this obligation necessitates States to include ensuring protection for these communities from private companies to safeguard their medicinal plants, and prevent the commodification of Indigenous knowledge and practices.[115] States are also encouraged to collaborate with Indigenous communities to develop preventative programmes as well as plans to ensure access for Indigenous communities to mainstream and traditional

[110] *Report of the Special Rapporteur,* above n 95*,* at [20].
[111] At [20].
[112] See generally *General Comment No. 14 ,* above n 9 at [30]-[37].
[113] Hunt and Mesquita, above n 63, at 348.
[114] *Expert Mechanism, above n 9,* at [32]; *General Comment No. 14 ,* above n 9*,* at [30]-[37].
[115] *Expert Mechanism,* above n 9*,* at [32]-[36]; *General Comment No. 14,* above n 9, at [*30*]-[37]; *Permanent Forum,* above n [88].

medicine.[116] Moreover, redress and remedy mechanisms should be available for infringements on the right to health.[117]

Fulfil

The third dimension, the obligation to fulfil, necessitates that States implement measures (including within their respective legislative and administrative systems) to ensure the realisation of citizens' right to health.[118] Mental health legislation, regulations, and initiatives should incorporate human rights principles and empower individuals with mental disabilities to make decisions about their own lives. These measures should provide legal safeguards concerning the establishment of and access to high-quality facilities and support services.[119]

States are encouraged to develop and implement a national strategy that requires indicators for oversight and monitoring.[120] The principle applies equally to mental health because States are obligated to ensure accurate recognition of individuals with mental disabilities in national health strategies. Such projects and/or strategies should "embody human rights and empower people with mental disabilities to make choices about their lives; give legal protection… establish robust procedural mechanisms… and promote mental health throughout society".[121] Such an approach includes "the immediate obligation to create a national health plan …to make provision for Indigenous peoples needs in a mainstream plan".[122]

The next section unpacks some further crosscutting principles established by international law that guide states to implement the right to health and mental health. These crosscutting principles are non-discrimination and equality, participation, progressive realisation and resource constraints and accountability which are discussed below. These principles are relevant to this thesis because it is important to understand the international frameworks to fully understand New Zealand's international law obligations. From there,

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116 *Expert Mechanism,* above n 9*,* at [32]-[36]; *General Comment No. 14,* above n 9, at [30]-[37].
117 *Expert Mechanism,* above n 9*,* at [32]-[36]; *General Comment No. 14,* above n 9, at [30]-[37].
118 *Expert Mechanism,* above n 9*,* at [37]; See also *Report of Special Rapporteur,* above n 5, at [67].
119 Hunt and Mesquita, above n 63, at 349-350.
120 *Expert Mechanism,* above n 9*,* at [37].
121 Hunt and Mesquita, above n 63, at 349; See also *General Comment No. 14,* above n [9].
122 *Expert Mechanism,* above n 9*,* at [38].

an assessment of mental health law and policy and its conformity to required principles in New Zealand for tamariki and rangatahi Māori can be made, which will be discussed in Chapter Six.

5.3.4. Non-discrimination and Equality in Mental Health

As previously mentioned, discrimination and inequality amongst marginalised and vulnerable groups constitute a fundamental challenge to realising the right to health. Human rights treaties provide everyone with the right to be free from discrimination which has been taken to apply to health care services and determinants of health.[123] This is applicable to mental health rights, but in this area discrimination still persists, thus preventing individuals from utilising health care services and a range of other rights, including the rights to refuse treatment, to legal capacity and to privacy, and other civil and political rights.[124] The PFII has expressed concern that "[t]he health gap between Indigenous peoples and others is clear evidence of the discriminatory structures that are in conflict with human rights and Indigenous peoples' rights in particular".[125] This concern highlights the necessity for governments and the United Nations entities to redirect their strategies to fulfil their obligations to Indigenous peoples more effectively.[126]

Compounding this issue is discrimination within the health care services themselves, including attitudes of staff which discourage individuals from seeking assistance, or may result in segregation and isolation.[127]

Furthermore, a "one size" model is not compliant with the right to health; rather, there should be established a "diverse package of options for people seeking care and support".[128] Such an approach includes measures such as providing adequate training to health professionals to ensure equitable access. It has been demonstrated that models that

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123 *Report of Special Rapporteur ,* above n 5, at [61]-[62]; *Report of the Special Rapporteur* , above n 6*,* at [40]-[48].
124 *Report of Special Rapporteur ,* above n 5, at [61]-[62].
125 *Permanent Forum on Indigenous Issues Report on the Twelfth Session* UN Doc E/2013/43–E/C.19/2013/25 (20–31 May 2013) at [4].
126 At [4].
127 *General Comment No. 5 Persons with Disabilities* UN Doc E/C/12/1994/13 (1994); Hunt and Mesquita, above n 63, at 349 ; See also *General Comment No. 14 ,* above n 9*,* at [12].
128 *Report of Special Rapporteur*, above n 5, at [14]; See also *Report of the Special Rapporteur ,* above n 6*,* at [45]-[48].

are adaptable, flexible, "peer-led" and "co-produced" are significantly more effective in "facilitating flexible, non-discriminatory and respectful therapeutic alternatives".[129]

Not only do States have an obligation to prohibit discrimination, but they are also obligated to provide equality of care. Regarding mental health, individuals, whilst entitled to the right to health generally, are also entitled to equal access to mental health services and social services that "promote their independence and autonomy",[130] are preventive, and supportive of social integration.

Furthermore, in this regard, services relevant to specific communities or groups should be made available. For instance, the CRC Committee has emphasised that services concerning children and adolescents should be tailored and appropriate to their needs. Support must also be provided to the individual's family. However, it is frequently observed that inappropriate resource allocation contributes to discrimination and impedes equality of opportunity.[131]

5.3.5. Participation

Participation is a crucial aspect for realising the right to health, including mental health, particularly for Indigenous communities. Active involvement in the design, implementation, and governance of health services by marginalised and Indigenous communities is essential;[132] this is acknowledged by international human rights law, that advocates for active and informed participation from all individuals. The participation principle extends to the mental health context.[133] Involvement is vital at all levels, including the "development, implementation and monitoring of legislation, policies, programs, and services relating to mental health and social support and to broader policies and programmes, such as poverty reduction strategies, that affect them".[134] Furthermore, it is noteworthy that participation also encompasses family members, because they too can provide valuable input which is significant, and for many individuals, "being heard is

[129] *Report of Special Rapporteur,* above n 5, at [15].
[130] Hunt and Mesquita, above n 63, at 350.
[131] *General Comment No. 4,* above n 95, at [41]-[43].
[132] *Expert Mechanism,* above n 9, at [15]-[28]; See also *Report of the Special Rapporteur,* above n 6, at [10].
[133] Hunt and Mesquita, above n 63, at 350; *Report of the Special Rapporteur,* above n 6, at [10].
[134] Hunt and Mesquita, above n 63, at 350-351.

pivotal to healing".[135] The Special Rapporteur in recent times has echoed these views particularly in the context of mental health, noting the need for "inclusive engagement" with users of mental health services, particularly for those in vulnerable situations.[136]

5.3.6. Progressive realisation and resource constraints

As noted previously, governments have a responsibility to take measures towards progressively realising full implementation of international law obligations. Nations are obligated to act to enhance both the volume and standard of resources allocated to fulfilling the right to health. These obligations are discussed below.

The first of these obligations is the obligation to adopt expeditious measures. The concept of progressive realisation mandates that nations swiftly and efficiently work towards fully implementing the right to health. Evaluating a country's adherence to this progressive obligation will be contextual, and take account of the prevailing conditions within a particular nation.[137] Implementation efforts may range from ensuring proper training for healthcare professionals to increasing financial allocations for health initiatives. The principle of progressive realisation establishes a framework for accountability, requiring countries to justify their progress in adopting measures to secure the right to health.[138] The justification should be informed by several factors, the extent to which measures were specific and targeted, whether resource allocation decisions were made without discrimination or arbitrariness, the timeframes involved, and crucially, whether the actions taken considered the needs of the most disadvantaged and marginalised individuals.[139] The assessment also examines whether a country's discretion in resource allocation was exercised fairly and reasonably.[140]

Importantly, the Special Rapporteur on health emphasises that governments must ensure their policies and practices do not obstruct the advancement of mental health or well-being, particularly for marginalised groups.[141] To safeguard mental health, proactive

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135 *Report of the Special Rapporteur ,* above n 5*,* at [15].
136 *Report of the Special Rapporteur,* above n 6, at [42].
137 Tobin and Barrett, above n 1, at 76.
138 At 76.
139 At 76.
140 At 76.
141 *Report of the Special Rapporteur*, above n 95, at [18]-[21], [31]-[32].

measures from the State are essential.[142] Across many regions, power disparities, insufficient investment in rights-based policies, and an over-reliance on medicalised approaches highlight a failure to uphold the right to health, a lack of political commitment to support, replicate, and sustain evidence-based social interventions that enhance well-being, prevent discrimination, and encourage community inclusion.[143] To achieve progressive realisation, States should undertake "deliberate, concrete, and targeted actions towards fulfilling the right to mental health in all its forms, including the promotion of mental health."[144] By focusing on the conditions necessary for individuals to thrive, benchmarks can not only bridge the "treatment gap"[145] but also aid in developing indicators that emphasise upstream protective factors, such as a sufficient "standard of living and social inclusion".[146]

Furthermore, the State has a fundamental duty to ensure the minimum core of the right to health, irrespective of national resources, which underpins the obligation of progressive realisation.[147] Despite ongoing debate surrounding this concept, the notion of minimum core obligation, has been established to safeguard essential provisions at all times. These include basic foodstuffs, equitable access to primary healthcare, fundamental shelter and housing, social security or assistance coverage, protection for families, and elementary education.[148] In General Comment No. 14, the requirement was broadened to encompass accessibility to healthcare facilities, crucial medications, and the formulation and execution of a public health strategy and plan of action grounded in epidemiological evidence.[149] The notion aligns with the protective measures outlined in the aforementioned typology of obligations.[150] The Special Rapporteur on health has observed that immediate action also involves ensuring non-discriminatory access to services that promote mental well-being and equitable access to interventions for individuals in marginalised situations.[151]

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142 *Report of the Special Rapporteur*, above n 95, at [21]-[23].
143 At [21]-[23].
144 At [22].
145 At [23].
146 At [23].
147 Tobin and Barrett, above n 1, at 77.
148 At 76.
149 *General Comment No. 14,* above n 9, at [43]; Tobin and Barrett, above n 1, at 77.
150 Tobin and Barrett, above n 1, at 77.
151 *Report of the Special Rapporteur*, above 95, at [22].

Responsibilities extend beyond national boundaries, including a provision for international support. According to Article 2(1) of the ICESCR and Article 4 of the CRC, there is a requirement to undertake measures of international assistance and cooperation to achieve the right to health.[152] The right includes respecting and not interfering with the enjoyment of health rights, protecting against third-party interference, and providing international assistance to help other States achieve minimum essential health levels.[153] Unfortunately, mental healthcare has often been neglected in international assistance efforts, with some funding supporting inappropriate programs that prolong outdated approaches (such as building psychiatric facilities).[154]

Instead, scholars argue that donors should support the development of community-based care and support services, advocacy by persons with mental disabilities and their representatives, provision of policy and technical expertise on rights-based mental health approaches, and to ensure all programmes promote equality and non-discrimination.[155] International assistance should prioritise promoting equality and non-discrimination in mental health care.[156]

5.3.7. Accountability

The final cross-cutting principle is accountability, which has been recently characterised by the Special Rapporteur as a "core normative principle for supporting rights-based implementation".[157] Just as human rights impose obligations on States, there must be accountability for actions and inactions for those obligations. Consequently, in the context of the right to health, all duty bearers are held accountable. The accountability principle is particularly relevant in the domain of mental health, because the vulnerability of individuals with mental disabilities necessitates a greater degree of "effective, transparent, and accessible monitoring and accountability arrangements are available and accessible".[158]

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[152] Hunt and Mesquita, above n 63, at 352.
[153] Hunt and Mesquita, above n 63, at 353.
[154] At 353.
[155] At 352-353.
[156] At 352.
[157] *Special Rapporteur,* above n 5*,* at [16].
[158] Hunt and Mesquita, above n 63, at 353.

Accountability facilitates enhanced participation, contributing to anti-discrimination efforts and the prevention of human rights violations.[159] Safeguards must be established for involuntary admission and treatment, including an independent monitoring body to periodically review such cases, conduct investigations, and address complaints.[160]

Frequently, there is inadequate accountability at the national level, thus obscuring breaches of the right to health. Moreover, a lack of monitoring and surveillance exacerbates the situation, because individuals with mental health conditions often face difficulties in accessing "independent and effective accountability mechanisms" when their rights have been infringed upon.[161] An effective accountability system requires several key components, as detailed by Hunt and Mesquita.[162] Firstly, an independent review body must be established, accessible to persons with mental disabilities or their representatives.[163] The independent body should periodically review cases of involuntary admission and treatment, possess the authority to overturn inappropriate or unnecessary involuntary admissions, and consider cases where admission has been sought but denied.

Secondly, procedural safeguards must be in place to ensure that all protections outlined in the MI Principles[164] are provided to persons with mental disabilities.

Thirdly, a national human rights institution should be established as an independent body with a mandate to promote and protect the rights of persons with mental disabilities. In this article Hunt and Mesquita use the "umbrella term mental disabilities".[165] This includes major mental illness and psychiatric disorders, minor mental ill health and disorder.[166] The institution should have wide investigative powers, the ability to conduct public inquiries, and determine complaints. It must be properly resourced, conform to the Paris Principles, and report annually to the national legislature.[167]

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159 Hunt and Mesquita, above n 63, at 352-353.
160 At 352.
161 Hunt and Mesquita, above n 63, at 352.
162 At 352.
163 At 352.
164 *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* GA Res 46/119 (1991).
165 Hunt and Mesquita, above n 63, at 336.
166 At 352-354, and 336.
167 At 352; Principles Relating to the Status of National Institutions (The Paris Principles) GA Res 48/134, A/RES/48/134 (1993).The Principles Relating to the Status of National Human Rights Institutions set out

To address these challenges, States should improve national monitoring and accountability in mental healthcare, enhance independent monitoring to prevent unnoticed abuses, fulfil obligations to respect, protect, and fulfil the right to health both domestically and internationally, and prioritise mental healthcare in international assistance.[168]

5.3.8. Summary

The preceding section presented a summary of the international frameworks regarding the right to health, with specific reference to mental health where appropriate. It is evident from this analysis that safeguards for the right to health exist at an international level. However, the implementation of these safeguards internationally and domestically remains a significant challenge. Outlining these essential international frameworks on the right to health is pertinent and helpful to this thesis because it demonstrates New Zealand's international obligations and will aid in identifying existing gaps in mental health law and policy for tamariki and rangatahi Māori. To these ends, the next section of this chapter explores what the right to health and mental health of the Indigenous child looks like under international law.

As noted above, in contemporary society, the concept of health rights encompasses mental well-being. Nevertheless, mental health remains "among the most grossly neglected element of the right to health". [169] Hudson attributes this neglect to misconceptions, insufficient interventions for mental disorders, and the evolution of treatments. [170] Although the right to mental health has historically lacked definition and focus, there is a discernible trend towards addressing the global mental health crisis.[171]

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the minimum standards that NHRIs must meet in order to be considered credible and to operate effectively.

168 Hunt and Mesquita, above n 63, at 352.

169 Christopher Hudson "Social Progress, Globalization, and the Development of Mental Health: A Human Rights Perspective" in Joseph Zajda and Yvonne Vissing (eds) *Discourses of Globalisation, Ideology, and Human Rights* (Springer Nature, Switzerland, 2022) at 181.

170 At 182.

171 Vikram Patel, Shekhar Saxena, Crick Lund, Graham Thornicroft, Florence Baingana, Paul Bolton, Dan Chisholm, Pamela Collins, Janice Cooper, Julian Eaton, Helen Herrman, Mohammad Herzallah, Yueqin Huang, Mark Jordans, Arthur Kleinman, Maria Medina-Mora, Ellen Morgan, Unaiza Niaz, Olayinka Omigbodun, Martin Prince, Atif Rahman, Benedetto Saraceno, Bidyut Sarkar, Mary De Silva, Ilina Singh, Dan Stein, Charlene Sunkel, JÜrgen UnÜtzer "The Lancet Commission on Global Mental Health and Sustainable Development" (2018) 392 The Lancet 1553 at 1571.

The interconnection between socio-economic rights and mental health is now acknowledged. Mental well-being cannot be considered in isolation; rather, it is dependent on an individual's ability "to enjoy and exercise a range of human rights".[172] "The notion that mental health is a fundamental human right suggests that conditions undermining it, such as unequal access to health determinants, housing, and potable water, should be confronted". [173] Essentially, individuals "have the right to enjoy the shared conditions that allow for the attainment of mental health, including access to quality mental health care".[174]

5.4. The Right to Health for an Indigenous Child

There are references to Indigenous children under the CRC, which according to the UN, is illustrative of the special measures Indigenous children may require to fully enjoy their rights.[175] In particular, Article 30 states that Indigenous children should not be denied the right, in community with his or her group, to enjoy his or her own culture. [176] The CRC Committee has provided further useful commentary about Indigenous children and health, which is referred to below. In essence, "State Parties' [have] a positive obligation to recognise and protect indigenous children's rights against denial or violation…".[177] The Committee recognised that particular groups require specific measures to safeguard their health rights and access to services, specifically mentioning children and Indigenous populations as needing such protections. These measures can be described as addressing the cultural requirements for health-related goods and services, implementing special actions to eliminate cultural obstacles to healthcare access, or safeguarding individuals from detrimental practices.[178]

Regarding Indigenous peoples, the Committee further emphasises that "States should provide resources for Indigenous peoples to design, deliver and control... so they may

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[172] World Health Organization *Promoting Mental Health* (World Health Organization, 2005) at 81.
[173] Patel and et al, above n 171, at 1571.
[174] Patel and et al, above n 171, at 1571.
[175] *General Comment No. 4*,, above n 95, at [41(c)].
[176] United Nations Convention, above n 29, Article 30.
[177] Steve Macbeth "The Application of the Best Interests Principle to Māori Children's Collective Cultural Rights: A Conceptual Shift for the New Zealand Family Court?" (LLM Dissertation, University of Waikato, 2015) at 60 ; See also *Human Rights Committee General Comment No. 23: Article 27 (Rights of Minorities)*, UN Doc CCPR/C/21/Rev.1/Add.5 (1994) at [6.1].
[178] Donders, above n 3, at 188.

enjoy the highest attainable standard of physical and mental health".[179] Additionally, nations are urged to allocate resources enabling Indigenous communities to create, implement, and oversee their own health services, ensuring they can attain the best possible physical and mental well-being.[180] The Committee further asserts that Indigenous children should "…have access to culturally appropriate services" and that "…all health facilities, goods and services should respect cultural values…and be acceptable to both adolescents and communities in which they live".[181]

The EMRIP has noted the concept of cultural appropriateness in the context of health for Indigenous peoples, including children, by providing an analysis of the right to health and "a review of legal obligations of States and others in terms of fulfilling that right".[182] The Expert Mechanism emphasises the inextricable link that Indigenous peoples have with health. It is important that for Indigenous peoples, health is not only defined by individuals but is strongly connected to their community, land, and the natural environment.[183]

Similar observations were articulated by the PFII, stating that "the right to health materialises through the well-being of an individual, as well as the social, emotional, spiritual and cultural well-being of the whole community".[184] Significantly, it was also noted that the right to health is intertwined with the realisation of other rights, including self-determination, culture, and the natural environment.[185]

The Expert Mechanism draws upon relevant articles in the UNDRIP that support such a realisation, including Article 21, that recognises the right to the improvement of Indigenous peoples' economic and social conditions without discrimination, and Article 24, that recognises the right to traditional medicines, to maintain health practices and access to social and health services without discrimination, and affirms the equal right

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[179] *General Comment No. 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health* UN Doc CRC/GC/15 (2013); see also *General Comment No. 14,* above n 9, at [27].
[180] At [27].
[181] *General Comment No.4,* above n 95*,* at [41(c)].
[182] *Expert Mechanism on the Rights of Indigenous Peoples ,* above n 9*,* at [3].
[183] For example, the CESCR stated that "[t]he strong communal dimension of Indigenous peoples' cultural life is indispensable to their existence wellbeing and full development …"; *General Comment No. 21* E/C.12/GC/21 (2009) at [22].
[184] *Permanent Forum on Indigenous Issues*, above n 124, at [4]; *Expert Mechanism,* above n 9, at [3].
[185] *Permanent Forum on Indigenous Issues*, above n 124, at [4]; *Expert Mechanism,* above n 9*,* at [3]-[4].

to health. The Expert Mechanism has discussed how the AAAQ framework applies to Indigenous peoples. Their findings are summarised below.[186]

Accessibility: Healthcare provisions, including goods and services, ought to be obtainable in adequate quantities.[187] However, this is not always the reality for Indigenous populations, where resources are often limited. Moreover, facilities and services are frequently situated in populated regions, but are understaffed and lack sufficient medicines and equipment, often rendering them non-operational.[188]

Accessibility: Indigenous communities are facing increasing challenges in meeting the four dimensions of accessibility.[189] This is due in part to prejudiced attitudes and behaviours of healthcare professionals, that exacerbate the situation and generate fear and mistrust in medical facilities. Such bias can often result in incorrect diagnoses and improper treatment. Regarding physical accessibility, this poses a problem for Indigenous groups residing in remote areas.[190]

In terms of economic accessibility, Indigenous communities, are often among the most socioeconomically disadvantaged groups, hence they frequently struggle with affordability of healthcare services.[191] Finally, information accessibility is also hindered for Indigenous populations due to factors such as a scarcity of information in Indigenous languages, limited opportunities, "a lack of contact with health-care providers owing to unavailability; and discriminatory or paternalistic attitudes among health-workers".[192]

Acceptability: Cultural appropriateness is also essential for healthcare facilities, goods, and services. Nevertheless, Indigenous populations face systemic discrimination in policies and practices, which results in the internalisation of stigma, creating obstacles to access.[193] The frequent occurrence of negative attitudes, such as holding Indigenous communities responsible for their poor health, exemplifies the lack of cultural sensitivity

[186] *Expert Mechanism,* above n 9*,* at [22] –[27].
[187] At [22]-[27].
[188] *Expert Mechanism,* above n 9*,* [22]-[27].
[189] The four dimensions are: non-discrimination, physical, economic and information accessibility.
[190] Often by displacement of their lands.
[191] *Expert Mechanism,* above n 9*,* at [22]-[27].
[192] *Expert Mechanism,* above n 9*,* at [25].
[193] At [22]-[27].

and unfavourable disposition towards these groups. These factors contribute to the barriers experienced by Indigenous peoples in accessing appropriate healthcare.[194]

Quality: A divide often exists between conventional medical practices and the traditional healing methods of Indigenous peoples.[195] The division creates friction, where Indigenous communities frequently encounter difficulties internally as they strive to harmonise traditional and modern health approaches whilst addressing various social concerns.[196]

The CERD Committee released General Recommendation XXII concerning Indigenous peoples. This document addressed the discrimination faced by Indigenous communities, noting that in "many regions of the world Indigenous peoples have been and are still being discriminated against and deprived of human rights and fundamental freedoms".[197] Focusing on Article 5 that safeguards "the right to public health, medical care, social security and social services",[198] the CERD Committee elaborated that these rights must be exercised without racial discrimination, and State Parties are required to outlaw and eradicate racial discrimination in the realisation and enjoyment of these rights.[199] Specifically, Indigenous peoples, their cultural heritage, linguistic traditions, and lifestyle must be recognised and respected. The Special Rapporteur has recently published a report on Race and Health that notes the barriers Indigenous Peoples face in having access to preventative healthcare.[200] Indigenous groups should, moreover, be granted equal rights free from any form of discrimination, particularly regarding their Indigenous identity. Moreover, Indigenous peoples ought to be guaranteed equal involvement in all spheres,

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194 At [22]-[27].

195 At [22]-[27].

196 *Expert Mechanism* above n 9, at [9].

197 *General Recommendation No 23 on the Rights of Indigenous Peoples S XXIII* (8 August 1997).

198 International Convention on the Elimination of All Forms of Racial Discrimination 660 UNTS 195 (opened for signature 21 December 1965, entered into force 4 January 1969) Article 5; See also *Committee on the Elimination of Racial Discrimination General Recommendation No. 23 on Indigenous People* UN Doc A/52/18 Annex V (1997).

199 *Committee on the Elimination of Racial Discrimination General Recommendation XX on Article 5 of the Convention* UN Doc A/51/18 (1996) 124 at [31].

200 *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health Report to the General Assembly: Racism and the Right to Health* UN Doc A/77/197 (20 July 2022) at [8]-[14].

including public affairs, and no decisions affecting them should be made without their prior informed consent. [201]

As previously stated, the CESCR has affirmed that the cultural dimension is significant in the interpretation of the right to health. Specifically, General Comment No. 14 acknowledges the inseparable link between Indigenous peoples, the collective dimension, and the natural environment, including land. The Committee urges States to protect "medicinal plants, animals and minerals".[202] The Committee further asserts that "...all health facilities, goods and services must be...culturally appropriate"[203] and that staff or health professionals should be trained to recognise and respond appropriately to the specific needs of vulnerable or marginalised groups.[204] The Committee emphasises the importance of States taking into account culture and corresponding values when addressing health services. In this context, the Committee specifically stated, States should provide resources for Indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health.[205]

The preceding discussion demonstrates that international treaties have highlighted the critical role of cultural dimensions in considering the right to health and the mental health of Indigenous children. Such recognition has subsequently been affirmed by the United Nations and their respective reporting bodies. With regard to Indigenous children, the protections afforded under the CRC are pertinent to this thesis. As previously noted, the CRC has emphasised the connection between culture and the right to health. In General Comment No. 4, the Committee asserted that health for adolescents entails that "...all health facilities, goods and services should respect cultural values...and be acceptable to both adolescents and the communities in which they live".[206] The importance of non-discrimination and culturally appropriate health services has also been noted by the CRPD Committee [207]

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[201] *Committee on the Elimination of Racial Discrimination General Recommendation XXIII on the Rights of Indigenous Peoples* UN Doc A/52/18, Annex V (1997).
[202] *General Comment No. 14,* above n 9, at [27].
[203] *General Comment No. 14,* above n 9, at [12(c)].
[204] At [37].
[205] At [27].
[206] *General Comment No. 4,* above n 95, at [30].
[207] *General Comment No. 6 Equality and Non-Discrimination* UN Doc CRPD/C/GC/6 (2018).

The preceding discussion suggests that there are two types of cultural dimensions pertaining to the right to health, which Donders elucidates as follows. The first thread is the "promotion of cultural dimensions",[208] which is derived from the cultural concepts relating to cultural appropriateness and sensitivity for health services and goods and services. To elaborate, this dimension encompasses the notion that health services are respectful of cultural differences, and health services, including treatment and medication, are protected. Additionally, it is pertinent to note the collective nature of Indigenous communities and the active promotion of participation of Indigenous communities in the design, delivery and control of health services.[209] As stipulated earlier, everyone is entitled to equal health and services. However, special measures are necessitated for certain groups and communities to ensure that health services can be delivered in a manner that meets their respective cultural needs.

The CRC Committee recommended that State Parties enhance access to health care for certain groups, including Indigenous peoples and children. Nevertheless, it must be observed that there is a paucity of guidance on the precise meaning of cultural appropriateness or cultural sensitivity. While these terms are frequently employed, there is neither a definitive meaning nor clarity regarding who determines what is culturally appropriate. The UN has delegated this responsibility to each State Party and the cultural communities concerned. One might reasonably infer that a key attribute to such determination is the involvement and active participation of Indigenous communities themselves in the design, delivery and control of health services, which approach is advocated amongst all UN bodies.

The second aspect highlighted by Donders is the "protection of the right to health against certain cultural approaches or practices".[210] She refers to undertaking efforts to safeguard the right to health by eliminating cultural discrimination or stereotypes that impede individuals from exercising their right to health. The CEDAW Committee has also emphasised the discrimination faced by Indigenous women and its impact on their access

[208] Donders, above n 3, at 192.
[209] At 192.
[210] Donders, above n 3, 192.

to healthcare.[211] It is noted with concern that such discrimination is perpetuated by underlying beliefs and stereotypes.[212]

While Donders has elucidated two aspects of cultural dimensions, a third dimension can be inferred. The additional and interrelated dimension pertains to the involvement and active participation of Indigenous communities in the design, implementation, and governance of health services. The concept has been advocated by UN bodies which emphasise that meaningful and effective participation promotes social and behavioural changes.[213] Consequently, the involvement of Indigenous communities at higher levels, including the formulation of policies and health legislation, is critical. Such an approach does not diminish the obligations imposed on States but facilitates changes that are meaningful and relevant to cultural communities. Furthermore, participation is essential to respecting the cultural dimensions because Indigenous community involvement ensures culturally appropriate decisions and practices for meeting the right to health. Active participation can moreover contribute to the development of health services that align with cultural rights. Furthermore, by engaging effectively in consultation with Indigenous communities, States can work towards achieving equal access to health services, goods, and "in the determination of those traditional health goods and services that deserve recognition and protection".[214]

In addition, for Indigenous peoples, the right to health is crucial to their very existence and constitutes a fundamental component of their self-determination, which is enshrined in both Article 24 of the UNDRIP and Article 12 of the ICESCR.[215] All human rights, including those pertaining to health and self-determination, are interconnected.[216] Self-determination provides Indigenous peoples, in consideration of their historical context and present circumstances, the right to maintain autonomy over their lands, resources, governmental and decision-making bodies, and cultural practices.[217] The principle of self-determination encompasses several key aspects: non-discrimination, preservation of

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[211] This also includes eradiating harmful practices; Donders, above n 3, at 192.

[212] Convention on the Rights of the Child: Concluding Observations on Niger UN Doc CRC/C/NER/CO/2 (2009) at [55]-[56].

[213] Donders, above n 3, at 21.

[214] Donders, above n 3, 212.

[215] *Expert Mechanism on the Rights of Indigenous Peoples,* above n 9*,* at [18].

[216] At [18].

[217] Carol Verbeek "Free, Prior, Informed Consent: The Key to Self-Determinator: An Analysis of the Kichwa People of Sarayaku v Ecuador" (2012) 37 American Indian Law Review 263 at 269-270.

cultural integrity, security of lands and natural resources, and entitlements to social welfare and development.[218] Consequently, the complete realisation of health-related rights is unattainable without self-determination, which is an inviolable right.[219] As the EMRIP states, achieving self-determination brings about related advantages in health and other sociocultural rights, potentially resulting in enhanced eating habits, greater physical exercise, and a restored link to traditional economic foundations.[220]

The present discussion would not be complete without consideration of Free, Prior and Informed Consent ("FPIC"). Ensuring informed consent is a crucial aspect of honouring an individual's 'autonomy, self-determination, and human dignity'.[221] It is an "integral part of respecting, protecting and fulfilling the enjoyment of the right to health".[222] FPIC encompasses various interconnected and inseparable aspects of human rights "that are indivisible, interdependent and interrelated." [223] Alongside the right to health, it incorporates the right to self-determination, protection from non-consensual experimentation, and liberty of thought and expression.[224] FPIC is inextricably linked to the right to self-determination (as recognised in Article 1 of the ICESCR and the ICCPR and Article 4 of UNDRIP). The FPIC concept posits that individuals and groups have an equal entitlement to shape their own futures and exist within governance structures designed accordingly. Indigenous peoples, scholars, and advocates often consider the principle of self-determination as fundamental to the evolution and promotion of FPIC.[225] FPIC acknowledges the pre-existing rights of Indigenous peoples to their territories and resources, whilst advocating for equitable and respectful relationships with third parties based on informed consent.[226] In practice, FPIC necessitates processes that enable and support meaningful decision-making by Indigenous communities regarding their developmental path.[227]

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[218] Verbeek, above n217, at 269-270.
[219] *Expert Mechanism on the Rights of Indigenous Peoples,* above n 9*,* at [18].
[220] At [18].
[221] At [18].
[222] At [18].
[223] *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* UN Doc A/64/272 (10 August 2009) at [19].
[224] *Report of the Special Rapporteur* , above n 223, at [19].
[225] Phillippe Hanna and Frank Vanclay "Human Rights, Indigenous Peoples and the Concept of Free, Prior and Informed Concept" (2013) 31 Impact Assessment and Project Appraisal 146 at 146-147.
[226] At 146-147.
[227] FPIC can be found explicitly under Articles 10, 19, 29, 32 of UNDRIP.

The cultural dimension of the right to health for Indigenous peoples includes promoting cultural appropriateness in health services, protecting health rights against harmful cultural practices, and ensuring participation of Indigenous communities in health policy and services. FPIC and the right to self-determination are important principles related to Indigenous health rights. However, Indigenous peoples face barriers in realising this right, including discrimination, lack of culturally appropriate services, and socioeconomic disadvantages.[228] For Indigenous children, the CRC emphasises access to culturally appropriate health services and community participation.

States have obligations to respect, protect, and fulfil the right to health for Indigenous peoples, including taking special measures to improve access and providing resources for Indigenous-controlled health services. The challenge remains in implementing these rights and determining culturally appropriate approaches to health, especially mental health, for Indigenous communities which provides a foundation for examining Māori mental health outcomes in New Zealand.

As stated earlier, when discussing the best interests of a child, collective cultural rights are important. The United Nations has affirmed that "indigenous peoples are entitled to enjoy both their individual and collective rights as individuals and as a group free from any discrimination of any kind".[229] The importance of collective rights is highlighted in the following paragraphs eloquently:[230]

> 11. Indigenous children enjoy both individual and collective rights and freedoms as do their wider communities. Indigenous peoples' collective freedoms are specifically guaranteed under article 27 of the International Covenant on Civil and Political Rights, in the International Labour Organization (ILO) Indigenous and Tribal Peoples' Convention, 1989 (No. 169) and in the United Nations Declaration on the Rights of Indigenous Peoples.
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> 12. Rights guaranteed by the Convention on the Rights of the Child are applicable to all children irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status. The Convention is underpinned by the principles of equality and non- discrimination (article 2); the

[228] *Expert Mechanism ,* above n 9*,* at [13].
[229] *Report of the Secretary General Status of the Convention on the Rights of the Child* UN Doc A/67/225 (2012) at [12].
[230] At [11]-[13]; *General Comment No. 14,* above n 9, at [6].

best interests of the child (article 3); the right to life, survival and development (article 6); and the right to be heard and to participate (article 12). The principle of equality and non-discrimination are also reinforced in ILO Convention No. 169 and the United Nations Declaration on the Rights of Indigenous Peoples which stress that Indigenous peoples are entitled to enjoy both their individual and collective rights as individuals and as a group free from discrimination of any kind. The rights of Indigenous children are underpinned not only by the principles of the Convention on the Rights of the Child but also by the principles of self-identification, and respect for cultural identity, as espoused under the Declaration.

13. The United Nations Declaration on the Rights of Indigenous Peoples contains child-sensitive provisions: recognizing the right of Indigenous families and communities to retain shared responsibilities for the upbringing, training, education and well-being of their children, and protection of the child from forceful removal from its group to another group (article 7); the right of the child to all levels and forms of education of the State without discrimination (article 14.2); and the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development, taking into account the special vulnerability of children and the importance of education for their empowerment (article 17.2).

Recognising the intersection between the best interests principle and collective cultural rights in fulfilling children's rights under the CRC is crucial, as it bolsters this thesis's argument that the best interests principle can aid tamariki and rangatahi Māori to attain the highest possible standard of mental health. While all children have the right to the highest attainable standard of mental health, for Indigenous children, it is essential to consider collective cultural rights when applying the best interests of the child principle, acknowledging that a child's best interests encompass both collective and individual rights.[231]

5.5. Indigenous Children and the Right to Mental Health

In terms of achieving mental health rights, the United Nations has acknowledged that the primary barrier is the structural, political, and systemic impediments resulting from outdated and dysfunctional mental health frameworks. These antiquated systems pose a significant global challenge to the realisation of mental health as a fundamental right.[232] Acknowledging mental health as a fundamental human right, by extending the definition

[231] *General Comment No. 14,* above n 9, at [24] and [82].
[232] *Report of the Special Rapporteur ,* above n 5*,* at [18]-[19].

and scope of the right to health, is crucial for vulnerable populations who are at the epicentre of the mental health crisis. In 2020, the Special Rapporteur reiterated the significance of mental health and stressed the necessity to highlight the unique and interdependent connection between mental health and the complete realisation of all human rights.[233] Despite this recognition, the current situation is far from optimal, with numerous obstacles hindering the advancement and safeguarding of the right to health, including mental health. Such a dismal situation is particularly evident for children and adolescents who lack the authority and capability to make decisions for themselves. The circumstances are further complicated for Indigenous children.[234]

As previously discussed in Chapter Four in relation to Indigenous communities, health and well-being are defined more comprehensively than merely the absence of disease or physical health. Such a conceptualisation is holistic, comprising four elements: mental, spiritual, emotional, and physical. These four interconnected elements represent a holistic approach to health.[235] With this conceptual framework in mind, the subsequent section of this chapter will examine the international framework for the right to health for Indigenous peoples in general, and specifically for Indigenous children. At this point in time, there exists no specific international instrument dedicated to promoting and protecting Indigenous children's right to health. The most relatable instrument is the UNDRIP which has been discussed in the previous chapter. As a reminder, Article 24 of the UNDRIP affords Indigenous peoples the highest attainable standard of physical and mental health and access to health services without discrimination. The preamble recognises "the right of Indigenous families, and communities to retain shared responsibility for the upbringing, training, education and well-being of their children, consistent with the rights of the child".[236]

Notwithstanding the assurances under international law concerning the health of Indigenous peoples/children, it is regrettable that Indigenous children infrequently experience the equivalent level of well-being or possess similar opportunities to access

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[233] *Report of the Special Rapporteur ,* above n 5, at [1].

[234] See generally Kylie Sutcliffe "Rapid and Unequal Decline in Adolescent Mental Health and Well-being 2012-2019: Findings from New Zealand Cross-sectional Surveys" (2023) 57 Australian & New Zealand Journal of Psychiatry 6.

[235] See generally Mason Durie *Alignment of Clinical and Cultural Perspectives: Innovation at the Interface* (Te Manu Ao Seminar Series, Massey University, Palmerston North, 2007).

[236] United Nations Declaration, above n 29.

healthcare facilities as their non-Indigenous counterparts.[237] Such a disparity is attributed to multiple factors, and promoting the right to health necessitates complex and careful consideration. Primarily, it is essential to elucidate the nature of the right to health for the Indigenous child. As Douglas and Douglas stated in 1995:[238]

> The rights of the child are not incidental to the rights of Indigenous peoples. They are central human rights and freedoms and are in many ways the key to wider acknowledgment of human rights and in the future because children are seen as our future, our hopes and our joys. For many, if not all Indigenous peoples, the bearing, nurturing and raising children, the next generation is the purposeful essence of our social, cultural and political activity…we strive to do this to enable them to carry on the culture and beliefs of earlier generations in the ways of the ancestors.

Nearly two decades later, The Lancet's editor, Richard Horton, echoed similar sentiments, emphasising the need to bring visibility to Indigenous peoples.[239] Indigenous communities, including their children, face persistent violations of their rights to health and mental well-being. A Lancet series highlighted common factors contributing to this issue, such as inadequate data, the application of Western health concepts, and socio-political influences.[240] In fact, the PFII as far back as 2013, recommended states to gather data on Indigenous health and "to conduct a study on the perveance and causes of suicide among Indigenous youth and on efforts being made, including culture-based approaches, to prevent suicide and promote mental health and wellness".[241] The United Nations has acknowledged further the significant disparities in child health indicators between Indigenous and non-Indigenous populations worldwide.[242] Another influence that contributes to mental health in Indigenous populations is the ongoing intergenerational

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237 See generally Rochelle Menzies, Sir Peter Gluckman and Richie Poulton *The University of Auckland "Youth Mental Health in Aotearoa New Zealand: Greater Urgency Required* (online ed, The University of Auckland: The Centre for Informed Futures, September 2000) at 2.

238 Rahera Barrett Douglas & Edward Te Kohu Douglas "The Rights of the Indigenous Child: Reconciling the United Nations Convention on the Rights of the Child and the (Draft) Declaration on the Rights of Indigenous People with Early Education Policies for Indigenous Children" (1995) 3 International Journal of Children's Rights 197 at 199.

239 Vivian Vrivelli, Juan Hautecouer, Coll Hutchison, Ana Lamas, Carolyn Stephens "Improving Indigenous Maternal and Child Health" in Beth Walker (ed) *State of the World's Minorites and Indigenous Peoples* (Minority Rights Group, London, 2013) 24 at 24-36.

240 Vrivelli, Hautecouer, Hutchison, Lamas, Stephens, at 24-36.

241 *Permanent Forum on Indigenous Issues*, above n 125, at [5],[9].

242 *Expert Mechanism,* above n 9*,* at [51]-[52].

trauma stemming from the separation of children from their families which manifests in mental illness, abuse, suicide, and self-harm.[243]

Moreover, Indigenous children are often denied rights related to family, identity, and community. Combined with intergenerational trauma and a lack of progressive improvement, the denial of rights like these severely impacts Indigenous children, leading to mental health issues and suicide. Three key areas that exacerbate social and economic disadvantages of Indigenous children are education, family and community integrity, and mental health.[244] Focusing on mental health, the Expert Mechanism described the rates of mental illness and suicide as "alarming".[245] The situation remains dire for Indigenous children, who experience poorer health outcomes than their non-Indigenous counterparts in virtually every context.[246] Protecting Indigenous children's right to health is crucial, raising the question of what the right to health means for an Indigenous child. Research for this study showed a scarcity of resources addressing this question. Consequently, much of the information presented here has been sourced from United Nations documents.

5.6. Conclusion

This chapter has provided an account of the international legal framework that focuses on mental health and Indigenous children's rights. The right to health is enshrined in various international instruments, including the ICESCR and the UNDRIP. General Comment No. 14 from the CESCR elaborates further on the right to health, introducing the AAAQ framework and outlining state obligations to respect, protect and fulfil the right. Mental health is recognised as an integral part of the right to health, although it has historically been neglected. For Indigenous peoples, health is viewed holistically and connected to community, land, and culture. Despite such efforts, Indigenous children

243 At [50]-[53].

244 At [54].

245 *Expert Mechanism,* above n 9, at [58].

246 Zhong-Cheng Luo, Russell Wilkins, Maureen Heaman, Janet Smylie, Patricia Martens, Nancy McHugh "Birth Outcomes and Infant Mortality Among First Nations Inuit, and Non-Indigenous Women by Northern Versus Southern Residence, Quebec" (2012) 66 Journal of Epidemiology and Community Health 328 at 328-333; see also Vrivelli, Hautecouer, Hutchison, Lamas, Stephens, above n 239, at 24-36.

continue to face significant health disparities and barriers in realising their right to health, including discrimination and lack of culturally appropriate services.

Key principles for Indigenous children's health rights include cultural appropriateness of health services, protection against harmful cultural practices, participation of Indigenous communities in health policy and services, self-determination and FPIC rights and responsibilities. Challenges remain in implementing these rights and determining culturally appropriate approaches, especially for mental health. However, the international legal framework provides a touchstone for examining Māori mental health outcomes in New Zealand in subsequent chapters, highlighting the need to consider cultural dimensions and Indigenous perspectives when applying the right to health.

Chapter Six

An Historical Overview of Māori Mental Health Care in New Zealand

6.1. Introduction

The previous chapter looked at the international legal frameworks which establish expectations and obligations about health rights. The chapter also canvassed the topic of the rights of Indigenous children including their mental health rights. This overview provides a framework for evaluating the mental health rights of Indigenous children in New Zealand. As a precursor to this evaluation, a historical perspective on mental health legislation in New Zealand and its impact on Māori provides important insights. This is the focus of the current chapter.

This chapter explores the historical development of mental health legislation in New Zealand and examines Māori interactions with the mental health system. It traces the evolution of mental health laws and documents the increasing recognition of Māori mental health issues since the 1970s. The chapter emphasises the importance of understanding this historical context to address current disparities in mental health outcomes for tamariki and rangatahi Māori. It examines early mental health interventions, which were based on societal norms of separating the mentally unwell from the public. The discussion notes the initially low percentage of Māori patients in asylums and the subsequent shift to higher involvement in the 1990s. While cautioning against using historical data as a definitive measure of Māori mental health, the chapter acknowledges its relevance to the legal focus of the thesis.[1]

Examining the history of mental health legislation and Māori experiences with the mental health system is imporant for understanding the context and challenges surrounding Māori generally, and tamariki and rangtahi Maori. Past legislation and policies have significantly shaped current disparities and inequities in mental health outcomes for Māori. Looking at this history reveals how Western approaches to mental health care have often

[1] Timothy Gassin *A Report Commissioned by the Waitangi Tribunal for the Wai2575 Health Services Outcomes Kaupapa Inquiry* (Waitangi Tribunal, Wai2575#B26), August 2019 at 1-3.

conflicted with Māori cultural perspectives and failed to adequately serve Māori communities.

This historical perspective highlights longstanding systemic issues that continue to impact Māori communities. Correspondingly, understanding this historical context is essential for identifying effective approaches and proposing culturally responsive solutions to improve mental health outcomes for tamariki and rangatahi Māori.

6.2. Historical Mental Health Legislation

Historical legislation shows that mental health legislation was founded on an English/Western approach focused on institutional care for the mentally unwell and the principle of keeping the mentally unwell away from the public. Legislation was based on an "imported English system of mental health care that focused on building insitutions for the mentally ill".[2] These instutions were referred to as psychiatric hospitals, lunatic asulyums, and mental hosptials/boarding houses. These instutions were separated socially, and administratively from other health servics.[3] While there was movement from the 1960s onwards with the closures of these institutions and towards more community-based care, the Western/English approach continued to dictate the mental health sphere until the latter part of the 20th century, an approach that evolved similiarly in other Commonwealth countries.[4] This inherited tradition of mental health care engendered many problems for Māori. The following sections aim to offer a contextual backdrop for mental health legislation as it existed in the past, avoiding unnecessary duplication of existing scholarship.

Legislation relating to mental health can be traced back to 1846. Since then, New Zealand has implemented five iterations of mental health legislation, each providing alternatives

[2] Gassin, above n 1, at 16; see generally Ministry of Health *Achieving Equity in Health Outcomes: Summary of a discovery process* (Ministry of Health Wellington, Report, August 2019); see also Mental Health Commission *Te Haererenga Mo Te Whakaōranga 1996-2006 The Journey of Recovery of the New Zealand Mental Health Sector* (The Mental Health Commission, April 2007).

[3] Warwick Brunton "The Place of Public Inquiries in Shaping New Zealand's National Mental Health Policy 1858-1996" (2005) 2 Australian and New Health Policy Bio Med Central 1, at 1-16.

[4] Warwick Brunton "A Choice of Difficulties: National Mental Health Policy in New Zealand, 1840-1947" (PhD Thesis, University of Otago, 2001).

to institutional care outside of hospital settings.[5] The Lunatics Ordinance 1846 comprised 15 parts. Section 2, in particular, provided for an insane person's relatives or friends to assume "their own care or protection" of the individual, "provided they guaranteed to two Justices of the Peace or a Judge, the person's peaceable behaviour".[6] A similar provision existed in s 4, allowing relatives, guardians or friends to remove an insane person from an asylum with the same guarantee to a Justice of the Peace or a Judge.[7] These provisions were significant as they demonstrated that while an individual could be diagnosed as a lunatic, there was a role for and recognition of compulsory care outside of hospital settings. Furthermore, the provisions established the concept that an individual did not need to be cured to be discharged; rather, "safe containment was paramount over treatment".[8] In 1854, the first lunatic asylum was established, and the number of detained individuals began to increase from the 1860s onwards.[9]

The second legislation was the Lunatics Act 1868. This legislation was precipitated by the 1858 Select Committee revision of lunacy law and was a more refined piece of legislation than its predecessor. The roles of families and communities were further addressed in four sections of the Act. Additionally, ss 48-50 allowed for single lunatics to reside in what was termed a "licensed house" which was a place of residence with medical oversight, a resident keeper, and reporting accountabilities.[10] Section 64 of the Act permitted patients to have "trial leave", allowing them to be absent if they were under control from a licensed house or asylum.[11] Furthermore, s 66 enabled a friend or relative to file an application for custody of an insane person, provided they could be cared for safely and would not cause harm to themselves or others. Of significance in this legislation was the definition of lunatic. This was defined in s 2 as an individual "of unsound mind and incapable of managing himself or his affairs".[12] Authority was granted to constables pursuant to s 21 to present individuals who were "addicted to the habitual excessive use of intoxicating

[5] Anthony O'Brien and Robert Kydd "Compulsory Community Care in New Zealand Mental Health Legislation 1846-1992" (2013) 3 SAGE Open 1 at 2.
[6] O'Brien and Kydd, above n 5.
[7] At 6.
[8] At 6.
[9] Superintendent's Office "Reports on Lunatic Asylums in New Zealand" [1870] I AJHR D-29 at 14.
[10] O'Brien and Kydd, above n 5, at 4.
[11] At 10.
[12] Lunatics Act 1868, s 2.

drinks" before a magistrate to ascertain detention.[13] In 1871, concerns were raised regarding the poor standards in facilities by a committee established to report on the facilities and level of care. The recommendations stipulated that a higher level of care be provided and the facilities be administered by medical superintendents, there should be better classifications of the detained and that a national inspectorate and central asylum be created.[14] Another significant development during this period was the agreement that individuals with alcohol dependency could not be placed in asylums in confinements.[15] Moreover, the Criminal Code Act 1892 (and the Crimes Act 1908) made attempted suicide punishable by up to two years' imprisonment, and anyone aiding and abetting suicide could be sentenced to life with hard labour.[16]

The Mental Defectives Act 1911, the third mental health statute, reinforced these provisions whilst emphasising the medical aspect. A difference was that this Act prohibited magistrates from allowing friends or relatives to care for insane individuals. Additionally, s 20 mandated that single patient householders be medical practitioners, and house placements required medical approval.[17] Notably, this Act introduced the concept of "voluntary boarders", challenging the notion of asylums as solely for compulsory confinement. Moreover, the Act removed the ability of relatives or friends to request discharge, transferring this authority to medical practitioners.[18] As highlighted by Gillespie and Breen, there were four significant aspects of this legislation: the introduction of voluntary admissions, a shift from lunacy to mental defective, the exclusion of drunkards from the mentally defective category (with specific processes for those under 21), and expanded care and treatment regulations, including mandatory quarterly visits by district inspectors with unrestricted access.[19] The 1930s saw no major amendments to the law, maintaining the status quo. However, asylum admissions continued to rise during this period. Concurrently, the suicide rate began to decline from its peak in the 1920s.[20]

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[13] Lunatics Act 1868, s 28; see also Alexander Gillespie and Claire Breen *People, Power and Law: A New Zealand Hisotry* (Hart Publishing, Oxford, 2022) at 61.
[14] Gillespie and Breen, above n 13.
[15] The Inebriate Institutions Act 1898.
[16] Gillespie and Breen, above n 13, at 157.
[17] O'Brien and Kydd, above n 5, at 4.
[18] At 17.
[19] Lunatics Amendement Act 1894; see also Gillespie and Breen, above n 13, at 157.
[20] Gillespie and Breen, above n 13, at 224-248.

A crucial issue during the 1940s was the lack of adequate staffing.[21] This shortage was tragically highlighted in 1942 when a blaze at the Seacliff Mental Facility claimed the lives of 37 patients. A subsequent Commission revealed that, like other institutions, there was a "great shortage of staff and, in our opinion, the hospital staff [was] inadequate in numbers to provide the requisite supervision of all patients at all times".[22] This understaffing meant that a nurse was not on duty in this ward at all times during the night and the supervision provided was inadequate.[23] The Commission put forth several proposals, including the repatriation of more experienced nurses from wartime duties and enhancing the hospital's status to attract younger female employees. Additionally, it was suggested that a committee be formed to examine the current conditions and report to the Director-General of Mental Hospitals.[24]

The Mental Defectives Act 1911 was superseded by the Mental Health Act 1969. This legislation emerged during a period of significant challenges and transformation, largely influenced by the Health Community Inquiry's recommendation to "increase psychiatric services provided by general hospitals, an initiative that reduces reliance on the network institutions in the provision of mental health care".[25] By the 1990s, large psychiatric hospitals had been replaced with smaller, inpatient facilities. The 1969 Act was significant as it "continued existing provisions for compulsory out-of-hospital care, including those for single patients and leave of absences".[26] Scholars have suggested that this shift demonstrates New Zealand's dedication to deinstitutionalisation compared to other Western nations at the time.[27] During this period, mental health policies began to shift towards community-based care. Out-of-hospital patients primarily received mental health services from hospital-based settings. Additionally, psychiatric home-visit services were introduced. Patients who were granted leave of absence resided in regulated boarding houses, although medical practitioners were no longer required to oversee this arrangement. The 1969 Act notably resulted in a higher number of patients being granted leave compared to the periods of previous legislation.[28]

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[21] At 20.
[22] Royal Commission "Upon Fire at Seacliff" [1943] 3 AJHR H07 at 3.
[23] At 22.
[24] Royal Commission, above n 22, at 6.
[25] O'Brien and Kydd, above n 5, at 5.
[26] At 25.
[27] O'Brien and Kydd, above n 5, at 5; see also Gassin, above n 1.
[28] O'Brien and Kydd, above n 5, at 5.

The Mental Health Act 1992 established a framework for community treatment orders. This legislation integrated provisions for mandatory out-of-hospital care and community treatment orders/inpatients on leave. According to s 29, individuals under a community order were required to attend a designated location for treatment. The regulations for inpatient leave remained largely unaltered, as per s 31. It is noteworthy that the Act does not mandate inpatient admission. Instead, a community treatment order can be issued following a period of compulsory community care which might be provided in the person's home or some other non-hospital facility.[29] Consequently, the 1992 Act enables the implementation of mental health legislation without necessitating hospital admissions.[30]

The 1992 Act, which will be examined in depth subsequently, incorporates provisions for care outside of hospitals and mandates "statutory monitor[ing]" of such care.[31] This marks a significant departure from previous legislation, where family members could serve as legal guardians of the patient. The current framework no longer legally recognises relatives' care or protection; instead, it emphasises that treatment is provided.[32] Scholars suggest this change indicates that in the 21st century, psychiatric services play a more substantial role in the lives of individuals receiving compulsory out-of-hospital care compared to the institutional era.[33] However, it is worth noting that earlier legislation allowed for a "higher degree of autonomy which has been lost within the increased medicalization of the 20th century".[34] The focus has shifted towards greater medical oversight rather than care provided by relatives or friends. Additionally, the 1992 Act introduced a requirement for family consultation, which was absent in previous legislation.[35] Academics have used the four stages put forward by Rochefort in his work titled *Policymaking cycles in mental health: Critical examination of a conceptual method* – static, progressive, discontinuous, and cyclical – to categorise the impetus for such movement. The push towards out-of-hospital care has been labelled as a being the progressive limb of Rochefort's model in policy being "consistently improved".[36] However, it could be argued that "improvement" is

[29] Mental Health Act (Compulsory Assessment and Treatment) 1992, s 28; see also O'Brien and Kydd above n 5, at 5.
[30] At 5-6.
[31] At 30.
[32] At 30.
[33] At 30.
[34] At 30.
[35] For example, Mental Health Act (Compulsory Assessment and Treatment) 1992, s 5.
[36] O'Brien and Kydd, above n 5, at 5-6.

contentious in considering the "effectiveness of community treatment order and about their place in mental health".[37]

6.3. Summary

New Zealand's mental health legislation has evolved to prioritise out-of-hospital care, with a focus on treatment in patients' homes. This shift began in 1868 with medical approval for placing patients with householders and continued through subsequent laws.[38] The 1992 Act introduced community treatment orders, formalising a historical arrangement for friends and family to take an active role in the lives of patents. This progression reflects a consistent effort to involve families and communities in mental health treatment outside traditional hospital settings.[39]

The historical background is important for understanding the changing emphasis on family roles and its specific impact on Māori patients and their whānau in mental healthcare settings. Māori culture places high importance on whānau, emphasising collective well-being and decision-making (as discussed in Chapter Four).[40] However, historical policies and practices often, did not always make room for family roles/involvement in the care of a patient. The evolution of healthcare approaches has alternately emphasised and de-emphasised family involvement, affecting Māori patients differently from non-Māori. Historical insights can be uselful to aid the formulation and development of more inclusive and culturally responsive mental healthcare policies, laws and practices. With this in mind, the next part of the chapter will turn to specifically look at Māori in the mental helath system.

6.4. Māori and the Mental Health System

For the purposes of the current research, the evolution of mental health legislation and approaches to mental health care need to be examined for their impact on Māori.[41] The next section of this chapter aims to broadly examine the historical context of mental

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[37] At 36.

[38] At 36.

[39] O'Brien and Kydd, above n 5, at 5-7.

[40] See generally Mason Durie "A Māori Perspective of Health" (1985) 20 Social Science and Medicine 483.

[41] See generally Hector Kaiwai and Tanya Allport *'Maori with Disabilities (Part Two): Report Commissioned by the Waitangi Tribunal for the Health Services and Outcomes Inquiry (Wai 2575)'* Wai 2500 B23 (Waitangi Tribunal, Wellington, 2019).

health in law and policy as it pertains to Māori. As stated above this historical and policy background is crucial for crafting future effective legislative measures that benefit tamariki and rangatahi Māori in mental health care. For effective future planning it is important to review the developments that have led to the current position. The next sections provide an overview of key phases in this history.

6.4.1. The Period From 1800-1900s

Research into Māori experiences in asylums during the 1800-1900s is very limited.[42] Historical accounts suggest that following colonisation, Māori health generally deteriorated due to exposure to foreign illnesses and altered living, economic, cultural, and social circumstances.[43] Before European arrival, there was scant documentation on Māori mental illness, although this does not indicate its absence. Māori terms such as pōrangi, wairangi, poorewarewa, haurangi and pooteetee are often used by Māori to describe individuals considered to be mad or out of thier mind.[44] Despite the lack of early data on Māori mental health rates, Māori scholar Kingi posits that two conclusions can be drawn.[45] Firstly, mental illnesses is likely to have existed in Māori communities prior to European contact, based on the understanding that mental disorders occur across all cultures and it is improbable that Māori alone could have developed biological or other means to prevent them. Secondly, the current comparatively high rates of Māori mental illness are a recent development.[46]

Reference to Māori mental health became more noticeable in the 19th century (albeit still remaining minimal). For example, in the 1900s, Māori representation in mental health institutions remained low. The Select Committee on the General Lunatic Asylum in 1858

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[42] Therese Crocker *Māori Health Services and Outcomes Inquiry (Wai 2575) Pre-casebook Discussion Paper: Part 1*(Waitangi Tribunal Unit, 2018) at 30.

[43] Lorelle Burke "The Voices Caused Him to Become Porangi: Maori Patients in the Auckland Lunatic Asylum, 1860-1900" (MA Thesis, University of Waikato, 2006) at 6; See also Registrar-General *Statistics of the Colony* (Eyre and Spottiswood, London, 1888).

[44] Te Kani Kingi "Introduction" in Te Kani Kingi, Mason Durie, Hinemoa Elder, Rees Tapsell, Mark Lawrence and Simon Bennett (eds) *Maea Te Toi Ora: Māori Health Transformations* (Huia Publishers, Wellington, 2018) at 10-12; see generally John Weaver and Doug Munro "Austerity, Neo-Liberal Economics, and Youth Suicide: The Case of New Zealand, 1980–2000" (2013) 46 Journal of Social History 771.

[45] Kingi, above n 44, at 11; Geoffrey Blake-Palmer "Māori Attitudes to Sickness" (1956) 2 Medical Journal of Australia 405.

[46] Kingi, above n 44, at 11.

was unable to ascertain whether these numbers were due to Māori exclusion or a lower incidence of mental illness among the Indigenous population.[47] The official records seldom documented mental illness among Māori, who comprised a small fraction of patients in state asylums. According to Labrum's findings, Māori admission rates in 1871 were five per 10,000 for females and four per 10,000 for males. The number of Māori patients nationwide rose from 14 out of 872 in 1877 to 21 out of 2,480 in 1898.[48] Academics have suggested various reasons for the initial low numbers, including the unfamiliar nature of Western medicine for Māori, who typically resided in rural areas. Many Māori were either dubious about or unfamiliar with these institutions and their unconventional treatment methods for the mentally ill.[49] The situation was further complicated by what Primrose describes as a prolonged period of animosity between Māori and European communities following the Māori Wars, which kept them separated for an extended time.[50] Moreover, institutionalisation in asylums typically occurred only where Māori and European lives intersected, rarely resulting from voluntary commitments by Māori families or communities.[51] For Māori living in rural areas, instances of mental illness were unlikely to be pursued by authorities.[52] Some insights can be gleaned from patient records from Auckland Asylum between 1853-1900. According to these records, Māori admissions were primarily a result of interactions with law enforcement, intermarriage with Europeans, or proximity to European settlements.[53] Māori representation in asylums was one percent of the total asylum population in 1880. By 1890, these numbers had increased slightly.[54] Many admitted Māori remained in the

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[47] Brunton, above n 39, at 48.

[48] Gassin, above n 1, at 4; see also Inspector of Asylums *Lunatic Asylums – Reports of Inspectors* [1878] I AJHR H-10 at 18; Inspector of Asylums *Lunatic Asylums of the Colony* [1899] I AJHR H-7 at 16; Bronwyn Labrum, "Looking Beyond the Asylum: Gender and the Process of Committal in Auckland, 1870–1910" (1992) 26(2) New Zealand Journal of History 125.

[49] Burke, above n 43, at 33; see also YCAA Carrington Hospital (Auckland Lunatic Asylum) Case Continuation Book, 1890–1892, Archives New Zealand, YCAA 1048/5, folio 430.

[50] Marie Primrose "Society and the Insane: A Study of Mental Illness in New Zealand, 1867-1926 with Special Reference to the Auckland Mental Hospital" (MA thesis, University of Auckland, 1968) at 263; see also Burke, above n 43, at 33.

[51] Burke, above n 43, at 33.

[52] Primrose, above n 50, at 264.

[53] Burke, above n 43, at 33; see also Primrose, above n 50; The 1800's was also a period in which Māori were described as a dying race.

[54] Burke, above n 43, at 37; see also R.E Wright-St Clair *A History of the New Zealand Medical Association* (Butterworths, Wellington, 1987).

asylum until their death, with discharges typically due to transfers to other institutions or care homes.[55]

While the numbers of Māori in institutions in this early period were small, research on their experiences highlights problematic aspects of Western models of mental health provisions for Māori. In this respect, valuable insights have been provided by Barry and Coleborne's study of Māori patient case notes from the Auckland Mental Hospital between 1860 and 1900.[56] Their research demonstrates that examining Māori patients sheds light on the unequal power dynamics within colonial societies, both inside and outside settler institutions, such as mental hospitals.[57] Barry and Coleborne posit that these power imbalances have led to two lasting consequences for New Zealand and other settler colonies. Firstly they provide evidence which connects the ongoing effects of colonisation to mental illness in Indigenous populations, and secondly, they show how health services consistently fail to deliver culturally appropriate mental health care for Indigenous peoples.[58] The authors argue that a thorough analysis of patient case notes reveals forms of cultural alienation experienced by Māori, which were reinforced by institutional practices of bodily examination, description, and attempts at "civilising" or reform.[59]

The negative cultural consequences for Māori of early mental care have also been discussed by other scholars. Gillespie and Breen, for example, say the few Māori patients at the time that were in asylums were detained without any cultural understanding.[60] Consequently, Māori patients experienced cultural alienation, which, in a broader context, was also attributed to the "loss of traditional land and language in the management of Māori in the asylum".[61] Further exacerbating the situation for Māori patients was the language barrier that existed between them and medical professionals. Cultural alienation has been elucidated by Mason Durie as "enabling the onset of mate Māori, an affliction

[55] Burke, above n 43, at 43.
[56] Gassin, above n 1, at 5; see also Lorelle Barry and Catharine Coleborne "Insanity and Ethnicity in New Zealand: Māori Encounters with the Auckland Mental Hospital, 1860-1900" (2011) 22 History of Psychiatry 289 at 285-301.
[57] Gassin, above n 1, at 5.
[58] At 5.
[59] At 58.
[60] Alexander Gillespie and Claire Breen *People, Power and Law: A New Zealand Hisotry* (Hart Publishing, Oxford, 2022) at 62.
[61] Burke, above n 43, at 56.

distinctive to Māori resulting from a psychological and emotional withdrawal from their surroundings, such as the asylum".[62] Despite the inextricable link that exists between spirituality and culture in Māori patients, these concepts were not recognised as being present. As evidenced in some patient records, it was observed that Māori patients became "sullen and withdrew from asylum life in general".[63] Durie characterises such experience as being symptomatic of the continuing significance of culture to Māori where heritage dictates the ideas Māori had concerning illness.[64] In very basic terms, traditional ideas like tapu and viewing illness as a violation of tapu might account for the observed sullenness and withdrawal in some Māori patients.[65] It was likely those Māori who were experiencing mental illness were cared for by whānau and wider family groups.[66] The years to come would paint a dire picture for Māori mental health.

6.4.2 Early Twentieth Century to 1970s

It was only from the 1920s onwards that Māori numbers in asylums became slightly more prevalent. Labrum says that, in 1911, Māori admissions to asylums were 14 per 10,000 for Māori women and 23 per 10,000 for Māori men.[67] In 1909, Māori patients made up one percent of psychiatric inpatients of a total of 3,549 inpatients. By 1948, it had risen to 2.6 percent.[68] In 1958, the admission rate for Māori was 6.4 per 10,000, whereas it was 10.5 per 10,000 for Pākehā.[69] Despite the limited work that existed during this time, it became apparent that there was increasing attention to the field of Māori mental illnesses and the advent of scholarly work in this area. For example, Ernest and Beaglehole conducted one of the first studies on Māori mental health in 1946.[70] They stated that the lower numbers of Māori in mental health could be attributed to the "the tremendous value to the Māori

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[62] At 57.

[63] At 62.

[64] At 57; see also Roy MacLeod and Milton Lewis *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (Routledge, London and New York, 1988).

[65] At 57; see also MacLeod and Lewis, above n 64.

[66] Derek Dow *Māori Health and Government Policy 1840-1940* (Wellington: Victoria University Press, 1999) at 176.

[67] Gassin, above n 1, at 6.

[68] Gassin, above n 1, at 6; see also Helen Robinson "Te Taha Tinana: Māori Health and the Crown in the Te Rohe Pōtae Inquiry District, 1940- 1990" (Waitangi Tribunal, 2011), Wai 898 A31.

[69] Ernest Beaglehole *Mental Health in New Zealand* (2nd ed, Wellington: Price Milburn & Co, 1958) at I; See also Gassin, above n 1, at 6.

[70] Ernest Beaglehole and Pearl Beaglehole *Some Modern Maoris* (Oxford: Oxford University Press, 1946) at 243.

of possessing a psychological security that comes from tribal and family membership".[71] However, these statistics have also been criticised by scholars as being "meaningless".[72] McDonald was the pioneer in establishing a connection between the criminal justice system and mental health. He suggested that Māori individuals with mental illnesses were more likely to be incarcerated, as they might be perceived as criminals rather than mentally unwell.[73] In particular, McDonald's critique is worth mentioning, as cited in the Wai 2575 report:[74]

> Now it is dangerous and unjustifiable to assume that admissions to Mental Hospitals will give an adequate picture of Maori ill-health if we use the above classification. Dr Beaglehole has little or no contact with the patients in these institutions or he would realise that Maoris are very reluctant to enter them, so that the only Maoris seen there are those who are floridly and severely psychotic that even their loving and tolerant families can no longer cope with them, i.e., the wildly manic, the acutely hallucinated, the acutely suicidal… A Maori voluntary boarder is a rarity, and these are the ones who will be suffering from any of his four categories, not because these cases are rare in the Maori, but because they stay with their learnt family and tribal groups rather than enter a Mental Hospital. Staying with their families, they manage to get along somehow, seen only perhaps by the tohunga who, it must be regretfully admitted, is liable to give them a vastly better type of supportive psychotherapy than a pakeha therapist can provide. So his figures are really meaningless. He would explain them by a subtle re-statement of the myth of the noble savage, happy and relaxed with his beer, cigarettes and making love in the sunshine, untroubled by the tensions which beset the superior pakeha. And of course, it is a myth which could be exploded by general practitioners working in such places as Rotorua and Auckland.

McDonald states that "there is a great need (and the possibility) to pursue the problems of Māori mental ill health from different premises, premises more suited to the realities of Māori psychic life".[75] In this regard, Dr Robinson discussing statistics relating to Māori admissions, says that the contention Māori in asylums had a higher or more serious mental

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[71] At 244.

[72] Gassin, above n 1, at 6.

[73] Gassin, above n 1, at 7; see also Frank McDonald "Books: The Mental Health of the Māori" (1958) Te Ao Hou 50 at 58.

[74] Gassin, above n 1, at 7; see also McDonald, above n 73, at 58.

[75] Gassin, above n 1, at 7; see also McDonald, above n 73, at 50-58.

illness was based on the fact that Māori patients' duration at asylums were longer.[76] In a 1962 report, it was recorded that "the overall picture is one of increasing numbers of Māori entering mental hospitals"[77] and that the increase was not for all age groups; rather, the Māori admission rate seemed to increase for those under the age of 40.[78]

With the increase in Māori being admitted to the asylums a question posed by Foster was why there were twice as an many European as Māori mentally deficient children admitted before the age of 10 years and "what factors caused more than half the Māori cases to be admitted in their teens".[79] Some reasons articulated was that Māori families were larger, the "Māori mother does not appear to have a strong need to seek hospitalisation for a young mentally deficient child. Supervision is often no problem. There is generally more tolerance of the child than is common with Europeans, both in his family environment and as a member of the community, whether this be at a neighbourhood or village level".[80] In terms of why more than half the Māori cases to be admitted in their teens, Fraser wrote that it was "undoubtedly the resultant effect of the factors which cause European children to be admitted to mental hospitals at an earlier age than Māori children. The fact that a child needs special training, is not recognised until a later age. There is a lack of knowledge about available facilities for training and how to make use of them".[81] Fraser also commented on the increase in Māori admissions, for example first admission numbers between 1958-60 were over 10 percent higher than from 1953-57. It was also found that Māori patients tended to stay in hospital for much longer than non-Māori.[82] Elsewhere Blake-Palmer categorised the Māori medicine system as being one of "magical practices and a collection of herbal medicines"[83] and that European medicinal treatment "must mean some separation from family, and offers no comfort comparable to a credible assurance that Māori business is countered effectively by Māori methods".[84] He goes on to say that "[i]t is of some interest to inquire in the nature of any special "mental health

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[76] Robinson above n 68 at 3; Francis Foster, *Māori Patients in Mental Hospitals* (Wellington: Department of Health, 1962) at 25-26.

[77] At 25-26; see also Robinson, above n 68, at 3.

[78] At 25-26; see also Robinson, above n 68, at 3. The main forms of diagnosis were schizophrenias, manic depressive reaction, other psychoses, alcoholism all forms, psychoneurosis, pathological and immature personality.

[79] Foster, above n 76, at 14.

[80] At 14; see also Robinson, above n 68, at 3-14.

[81] Foster, above n 76, at 17.

[82] At 25-26; Robinson, above n 68, at 189-190.

[83] Geoffrey Blake-Palmer "Māori Attitudes to Sickness" (1956) 2 Medical Journal of Australia 405.

[84] At 405.

mechanism" or factors in the Maori social group which may serve to protect their mental health. That is I am convinced, very clear evidence of such mechanisms. There are so many deep-seated satisfactions which the Maori derives from the surviving elements of his culture…".[85] Blake-Palmer goes onto say that "Indeed some Europeans, including anthropologists such as Professor R. Piddington, have regarded the Māori as "the only group in New Zealand boasting a cultural and individual character distinctively their own".[86]

In this period, there were some indicators of changes in statistics about mental health based on admission rates to mental health facilities.[87] An analysis of Māori and non-Māori first admission rates from 1959 to the late 1980s showed that admission rates for both groups increased in the early 1960s, with Māori rates experiencing a more rapid rise.[88] Following this, non-Māori rates stabilised before showing a slight decline from the mid-1970s through the 1980s.[89] Conversely, Māori rates continued to climb in the late 1960s, plateaued during the 1970s, and then increased again in the 1980s.[90] Some caution should be taken about "whether these patterns reflected changing levels of mental illness, an increasing likelihood that mentally ill Māori would be admitted to psychiatric care or both, but the differing patterns for Māori and non-Māori show that it cannot simply be attributed to general mental health policy".[91] Durie says that the rise might be due to increased service utilisation and a stronger sense of ethnic identity among Māori,[92] and that the elevated admission rates likely also indicated higher levels of mental health issues among Māori.[93]

Suicide data are another indicator of the state of mental health among Māori and non-Māori in this period.[94] From the 1940s to the mid-1980s, Māori typically had markedly

[85] Blake-Palmer, above n 83, at 405; see also Gassin, above n 1.
[86] At 405.
[87] Gassin, above n 1, at 8.
[88] At 87.
[89] At 87.
[90] Note: Caution is issued that these numbers do not accurately represent the true prevalence of mental illness as discussed in Gassin, above n 1 at 8; see also Foster, above n 76; Alan Howard "Review of Māori Patients in Mental Hospitals" (1963) 72 Journal of the Polynesian Society 1.
[91] Robinson, above n 68, at 200.
[92] At 204.
[93] At 204.
[94] At 203.

lower suicide rates compared to Pākehā.[95] Between 1944 and 1968, the Māori suicide and self-inflicted injury death rate per 100,000 oscillated between 1.0 and 7.5, showing a slight decline, whilst the Pākehā rate ranged from 8.0 to 11.0. The Māori average was 4.4, contrasting with the Pākehā average of 9.6.[96] In the latter half of the 1950s, age-adjusted rates for Māori were 11.4 for males and 0.2 for females, whereas non-Māori rates were 13.5 for males and 5.5 for females. Although data is lacking for 1968-1978, statistics from 1978 to 1990 indicate that age-standardised suicide rates remained consistently lower for Māori of both genders compared to non-Māori for this period.[97] Data on youth suicide rates are limited. Robinson in her work provides some statistics, as follows.[98] In the late 1950s, suicide mortality per 100,000 for ages 15 to 24 was 9.1 for Māori males, 5.9 for non-Māori males, and 1.5 for females of both ethnicities. These small numbers, including a single death for Māori females, are insufficient for reliable conclusions.[99] From 1978 to the mid-1980s, rates per 100,000 generally stayed below 10 for all groups, except for non-Māori males, whose rate remained under 20.[100] In the mid-1980s, rates rose significantly for Māori and non-Māori males, peaking at 49.1 for Māori males in 1989 and 39.2 for non-Māori males in 1990. Notably, Māori males had the lowest youth suicide rate in 1981 but the highest by 1989.[101] Female rates did not increase significantly, with Māori females generally having slightly higher rates than non-Māori females. From 1978 to 1990, average rates per 100,000 were 16.7 for Māori males, 24.4 for non-Māori males, 7.7 for Māori females, and 5.4 for non-Māori females. The average Māori male youth suicide rate rose from 3.9 (1978-1983) to 27.7 (1984-1990), while for non-Māori males it increased from 18.6 to 29.3.[102]

In the early 1960s, the rates of self-inflicted injuries and hospitalisations were similar for both Māori and non-Māori, standing at 2 per 10,000.[103] However, between 1978 and 1990, the rates for Māori consistently became the "highest" among all ethnic groups.[104]

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95 At 94.
96 Robinson, above n 68, at 203.
97 At 94.
98 At 203-204.
99 At 204.
100 At 204.
101 At 204.
102 At 203-204; New Zealand Health Information Service *Suicide Trends in New Zealand 1978–1998* (2001) at 27.
103 Robinson, above n 68, at 204; Ministry of Health *Suicide Trends: Mortality 1921–2003, Hospitalisations for Intentional Self-Harm 1978–2004: Monitoring Report No 10* (2006) at 24.
104 Robinson, above n 68, at 204.

Typically, these rates were at least 50 percent higher than those of Pākehā', with an increase noted from 1987, possibly reflecting a rise in youth suicide rates during that period.[105] As Robinson says there had "been a significant decline in overall Māori mental health from the 1960's until at least 1990, particularly amongst those aged under 30".[106] Whilst it is difficult to ascertain an accurate picture of the situation, Robinson observes that "it does appear that rates of Māori mental crisis, manifesting itself particularly in alcoholism and youth suicide, increased sharply from the 1970's and again in the 1980's".[107] During this time frame, there appears to be a growing awareness of the increase in mental health illnesses for Māori, as noted by the Review of Māori Health.[108] As accentuated in the Wai 2575 report, the decade from 1959 to 1969 "saw a switch from a situation in which the age-standardised rate of European admissions was substantially higher than that for Māori to one in which Māori had a slightly higher age-standardised admission rate than Europeans".[109] As aptly put in this report "the increase marked the beginning of a new period in which Māori would consistently suffer mental illness at elevated rates".[110]

The pattern of decline in Māori mental health was evident in 1976 when Māori admission rates surpassed those of non-Māori for the first time.[111] Durie suggests that this shift in the trend could be attributed to various factors, including "increased utilisation of psychiatric facilities, ineffective primary health care, less support from extended families following urbanisation, changes to the methods of recording ethnicity, deculturation, socio-economic stress, risk-taking lifestyles or actual higher prevalence rates of illness".[112]

This trend was significant enough to prompt Māori communities to explore novel healthcare approaches which recognised and integrated Māori values. In 1983, a

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[105] At 204-205.

[106] Robinson, above n 68, at 205; New Zealand Health Information Service, above n 102, at 24-25.

[107] Robinson, above n 68, at 220.

[108] Māori and Polynesian Health Committee *Review of Maori Health: Report of the Maori and Polynesian Health Committee* (Department of Health, Wellington, 1971) at 17-18.

[109] Gassin, above n 1, at 9.

[110] At 109.

[111] Mason Durie "Transforming Mental Health Services in Aotearoa New Zealand" in Te Kani Kingi, Mason Durie, Hinemoa Elder, Rees Tapsell, Mark Lawrence and Simon Bennett (eds) *Maea Te Toi Ora: Māori Health Transformations* (Huia Publishers, Wellington, 2018) 35 at 42; see also Mental Health Commission, above n 2, at 162–163; see also Joanne Baxter, Te Kani Kingi, Rees Tapsell, Mason Durie and Magnus McGee "Prevalence of Mental Disorders Among Māori in Te Rau Hinengaro: The New Zealand Mental Health Survey" (2006) 40 Australian and New Zealand Journal of Psychiatry 914 at 914-923.

[112] Durie, above n 111, at 36.

Committee of Inquiry recommended incorporating Māori cultural values and spiritual beliefs into psychiatric treatment.[113] In 1982, a culturally sensitive model for understanding health and delivering healthcare to Māori was introduced.[114] This model, Te Whare Tapa Whā, (discussed in Chapter Three) presented a framework depicting health as a balanced integration of wairua, hinengaro, tinana and whānau. This approach challenged the conventional division between mental and physical health, asserting that optimal well-being depended on all four dimensions, each playing a crucial role in health interventions.[115] In keeping with this important move towards culturally compatible mental health care, another significant development occurred at Tokanui Psychiatric Hospital,[116] where a unit integrating Māori culture, values and management practices whilst adhering to clinical requirements and professional standards was created (known as the Whaiora Unit).[117] The majority of the staff, including the medical officer, were of Māori descent.[118]

These steps to recognise Māori values were one aspect of a range of changes that were happening in the 1970s both on the mental health front and in the wider society In broad terms, these developments can be categorised as the deinstitutionalisation of psychiatric facilities, various reforms in the health sector, an increase in mental health disparities between Māori and non-Māori, and a greater focus on formulating responses specifically for Māori.[119] Highly significant were developments in the broader landscape with regard to Māori as stated in the Wai 2575 report. Durie characterises this era as "a decade of Māori development", during which prominence was given to "tino rangatiratanga, the Treaty of Waitangi, iwi development, cultural advancement, economic self-reliance, and social equity".[120]

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113 At 36; see also Liam O'Sullivan "A Māori Doctor" in Nigel Beckford and Michael Fitzsimmons (eds) *Te Pāruhi a Ngā Tākuta* (Fitzbeck Publishing, Wellington, 2013) 91.

114 Te Kani Kingi "Mental Health Services for Māori" in Te Kani Kingi, Mason Durie, Hinemoa Elder, Rees Tapsell, Mark Lawrence and Simon Bennett (eds) *Maea Te Toi Ora: Māori Health Transformations* (Huia Publishers, Wellington, 2018) 22 at 27.

115 Kingi, above n 114, at 27; see generally Alun Joseph and Robin Kearns "Deinstitutionalization Meets Restructuring: The Closure of a Psychiatric Hospital in New Zealand" (1996) 2 Health and Place 179 at 179-189.

116 Joseph and Kearns above n 115, at 179-189; Kingi, above n 114, at 27.

117 Kingi, above n 114, at 27.

118 Joseph and Kearns, above n 115, at 179-189; Kingi, above n 44, at 7-10.

119 Gassin, above n 1, at 10.

120 At 10.

The following sections examine some of the broader changes that were occurring during the 1970s.

6.4.3. Māori mental health in the 1970s

A significant shift occurred in the 1970s with the deinstitutionalisation of psychiatric facilities which in turn opened the way for Māori mental health services provision. This process unfolded "with the apparent decision in 1963 to cease planning new institutions, which was followed by a 1973 decision to construct no further accommodation at institutions and culminated with the rundown and closure of institutions in the 1980's".[121] Deinstitutionalisation involves the "transfer of the locus of treatment of mental illness from large-scale, often monolithic institutions to small-scale community-based facilities".[122] During this time, the number of hospital beds decreased from 10,000 to fewer than 2,000. The closure of institutions was replaced by general hospital services and community care.[123] Durie characterises this as a move towards normalising the lives of individuals who might otherwise have spent extended periods in large institutions, often separated from families and communities and deprived of freedoms enjoyed by patients with non-mental disorders.[124] He notes, the "indigenisation of the mental health system" was a crucial evolutionary development stemming from deinstitutionalisation.[125] Similarly, Boulton asserts that "deinstitutionalisation could be regarded as one of the catalysts of Māori mental health service provision".[126] Deinstitutionalisation created opportunities for Māori organisations to "begin to deliver services to their own people".[127] According to Brunton and McGeorge:[128]

> …[T]he government transformed the Treaty of Waitangi (1840) between Maori and the Crown into an enduring bicultural partnership based on principles of protection, partnership and participation. This was important given the surge in Maori ethnic identity

[121] Gassin, above n 1, at 120.
[122] Joseph and Kearns, above n 115, at 179.
[123] Gassin, above n 1, at 10.
[124] Durie, above n 111, at 35.
[125] At 82; Gassin, above n 1, at 10.
[126] Amohia Frances Boulton "Provision at the Interface: The Māori Mental Health Contracting Experience" (PhD Thesis, Massey University, 2005) at 14.
[127] At 126.
[128] Warwick Brunton and Peter McGeorge "Grafting and Crafting New Zealand's Mental Health Policy" in Harry Minas and Milton Lewis (eds) *Mental Health in Asia and the Pacific: Historical and Cultural Perspectives* (Springer, New York, 2017) at 280.

> (now one New Zealander in seven). Maori health became a general health care priority. Maori aspirations and involvement in policy and services were recognised; culturally appropriate services were affirmed and strengthened, a Maori health workforce was nurtured and high Maori mental health admissions rates were addressed ... Maori psychiatrist, Sir Mason Durie gained widespread acceptance for an understanding of *te hauora hinengaro* (mental health) as one of the four foundations of Maori health symbolised by *Te Whare Tapa Wha* (meeting house) ... Such insights informed the increased cultural sensitivity of most psychiatric hospitals as they built relationships with *iwi* (tribes) and *whanau*, incorporated Maori values and beliefs into treatment programmes and supported Maori health professionals.

While the merits of deinstitutionalisation have been identified, critics have also pointed to negative effects. In particular, Weaver asserts that deinstitutionalisation resulted in "a shocking number of instances where the hasty deinstitutionalization of mental health care allowed young people with schizophrenia greater freedom but less protection".[129] Another consequence was the closure of Tokanui Hospital in Te Awamutu. While Durie saw this as a positive,[130] others noted that the closure of the hospital "may have added to the mental health concerns of Māori, as Māori made up a large portion of both patients and workers".[131] There was also a unit based on Māori values, but the closure meant that such services were discontinued. For some critics, "[T]he success of deinstitutionalisation often came to be measured by reduced rates of hospitalisation than improved rates of access to treatment and support".[132] For the purposes of this thesis, these aspects are noteworthy because they demonstrate past efforts to provide culturally appropriate mental health services for Māori. However, as the statistics discussed in Chapter One indicate, these efforts have not been successful, and more comprehensive action is required. But, as Durie says:[133]

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[129] Weaver and Munro, above n 44, at 771; see generally John Weaver *Sorrows of a Century: Interpreting Suicide in New Zealand, 1900–2000* (Bridget Williams Books, Wellington, 2014) at 207 and 213; John Weaver and Douglas Munro "Country Living, Country Dying: Rural Suicides in New Zealand, 1900–1950" (2009) 42 Journal of Social History 933.

[130] Gassin, above n 1, at 11-12.

[131] At 12.

[132] At 12; see also Diana Burns, Duris Barrett, Vivien Daley, Paul Duignan and Kay Saville-Smith *Towards a Post-Institutional Response to Mental Health: Consensus Statement from the Beyond Care and Control? Workshop, June 1994* (Auckland: Health Research Council of New Zealand, 1994).

[133] Mason Durie *Ngā Kāhui Pou: Launching Māori Futures* (Huia, Wellington, 2003), at 133; Mason Durie *Kaupapa Hauora Māori: Policies for Māori Health, Proceedings of the Hui Ara Ahu Whakamua* (Te Puni Kōkiri, Wellington, 1994).

> There is no single cause of poor mental health, nor a single solution ... For the most part mental health problems amongst young Māori reflect social, economic and cultural trends and any comprehensive solutions must be similarly broad.

Various researchers have explored reasons such as the troubling social and economic disparities and the gradual assimilation faced by Māori, along with the erosion of self-worth and mana due to unemployment, racial bias, and cultural belittlement.[134] Kingi notes that although many Māori might have preserved cultural connections, networks, customs, and language, being removed from ancestral lands, marae, cultural institutions, family, and sub-tribes would have posed challenges.[135] The urban migration of Māori was linked to increased interactions with the mental health system due to closer proximity. As previously mentioned, some argue that Māori were more inclined to care for family members at home. Consequently, as urbanisation progressed, 'traditional bonds and cultural expectations were inevitably weakened'.[136]

In addition to the process of deinstitutionalisation, another significant development in this period was the recognition of mental health as a primary concern for Māori, given the substantial increase in Māori admissions in the 1980s. The evidence of this trend in Dr Robinson's statistics, is reinforced by Kingi who stated that during the 1980s, "admissions were two, and in some categories, three times that of non-Māori".[137] By this juncture, issues related to alcohol and drug misuse, as well as an increasing use of admission under compulsion instead of the "conventional medical referral systems" were apparent.[138] The increase in Māori mental health numbers contrasted with the situation for non-Māori for whom there was only a marginal increase between 1960-1990; the corresponding rate for Māori over the same period was more than 200 percent.[139] Furthermore, the suicide rate concurrently increased by 162 percent for Māori males. Another area of concern was re-admission, which experienced an increase of 65 percent

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134 Eru Pomare and Gail de Boer *Hauora: Māori Standards of Health – A Study of the Years 1970–1984* (Department of Health and Medical Research Council, Wellington, 1988) at 119.

135 Kingi, above n 44, at 15-16.

136 Kingi, above n 44, at 15-16; Gassin above n 1 at 17; see generally Vera Keefe-Ormsby *Tihei Mauri Ora: The Human Stories of Whakatū* (University of Otago, Wellington, 2008); Melissa Williams *Panguru and the City: Kāinga Tahi, Kāinga Rua – An Urban Migration History* (Bridget Williams Books, Wellington, 2015).

137 Amohia Frances Boulton "Provision at the Interface: The Māori Mental Health Contracting Experience" (PhD Thesis, Massey University, 2005) at 12.

138 At 12.

139 At 12 -13.

from 1984-1994 for Māori males, which Kingi notes is "two times higher than non-Māori male rate".[140] As a result of the escalating mental health issues for Māori, in 1994, the Public Health Commission categorised mental health as a "threat to Māori health".[141] The situation was characterised as "a crisis of unprecedented proportions" a few years later by the Māori Health Commission.[142] This finding necessitated further information gathering, given the paucity of data noted by several agencies.[143] This established a foundation for additional research to be conducted in this area, with the work of Mason Durie being particularly significant.

Mason Durie proposed a paradigm regarding the development of Māori mental health services, comprising three phases: institutionalisation, deinstitutionalisation, and cultural affirmation.[144] The earlier discussion examined the institutionalisation of Māori during a period when New Zealand "followed the European trend of housing the mentally ill in large asylums or mental hospitals".[145] The rationale behind this approach was to protect the public and to "provide long-term care for those in need".[146] Deinstitutionalisation "resulted in an increased reliance by the government on local communities to support mental health consumer".[147] According to Durie, deinstitutionalisation necessitated that Māori provide "ameliorative social services" where the State had been unsuccessful. Concurrently, this created opportunities for Māori organisations to implement Māori-centred approaches for their people.[148] The final phase of cultural affirmation is discussed below.

Thus far, this chapter has examined the history of Māori mental health and the previous iterations of mental health legislation in New Zealand. This historical analysis provides essential context for current disparities and challenges, highlighting the conflict between Western approaches and Māori cultural perspectives. The analysis demonstrates long-standing systemic issues that, as the current statistics show, continue to impact Māori

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140 Kingi, above n 44, at 12.
141 Public Health Commission *Our Health, Our Future: Hauora Pakiri, Koiora Roa: the State of Public Health in New Zealand* (Wellington: Public Health Commission, 1994), at 67.
142 Māori Health Commission *Māori Mental Health, Tihei Mauri Ora! Report of the Māori Health Commission June 1998* (1998), at 14; see also Gassin, above n 1, at 13.
143 Gassin, above n 1, at 13-14.
144 Boulton, above n 137, at 14-16.
145 At 14.
146 At 14.
147 At 14.
148 At 14.

children. The history also demonstrates the impact of cultural alienation in mental health settings and the importance of Māori-led initiatives. By examining this history, the thesis can better contextualise current challenges for tamariki and rangatahi Māori to identify effective approaches and propose culturally appropriate solutions for improving mental health outcomes. Considering this, the subsequent section of this chapter will examine several significant governmental investigations into Māori health.

6.5. Government Inquiries 1984-1996

The period following the 1980s saw several government-led reforms and commissioning of reports, particularly about Māori, such as the *Raupora: Health and Māori Women* Report[149] and the "*Hui Whakaornga* held at Hoani Waititi Marae in Auckland in 1984".[150] The purpose of the hui was to consider and discuss Māori well-being and health as well as strategies and initiatives for promoting Māori health.[151] In the 1990s Māori mental health was labelled as the "number one health concern for Māori",[152] particularly following the 1988 Psychiatric Report which highlighted the overrepresentation of Māori individuals in both prisons and psychiatric hospitals.[153] The report also noted that existing health services were inadequate in terms of both accessibility and cultural appropriateness for addressing Māori needs. Emerging data indicated a rise in suicide rates among Māori males and a disproportionate number of Māori patients in acute psychiatric admissions.[154] As mentioned previously, factors such as the hesitancy to address behavioural issues with Māori individuals, even by other Māori, were contributing to these concerns.[155] The following quote is cited in full to further illustrate this:[156]

> The Western psychiatric tradition of confining people with a mental health disability was foreign to Māori's, who had always cared for those people in their communities. The

[149] Erihāpeti Rehu-Murchie *Rapuora: Health and Māori Women* (Māori Women's Welfare League, Wellington, 1984); New Zealand Department of Health *Hui Whakaoranga: Māori Health Planning Workshop, Hoani Waititi Marae, 19–22 March 1984* (Department of Health, Wellington, 1984); Boulton, above n 137, at 16.
[150] Boulton, above n 13, at 16.
[151] At 16.
[152] At 18.
[153] New Zealand Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals *Report of the Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients* (Department of Health, Wellington, 1988); Boulton above n 137, at 16-18.
[154] Kingi, above n 44, at 12.
[155] Robinson, above n 68, at 295.
[156] Kingi, above n 44, at 14.

> Mental Health system was originally established to cater for people to be taken out of society. Society had this fear of contamination from mental disease and also a massive denial that it even existed. These concepts were alien to Māori people whose whanau members suffering from trauma were always included within the whanau, hapu, iwi boundaries and given special status.

6.5.1. The Mason Inquiries

In the last 30 years, several noteworthy investigations have been conducted into the mental health system. Two of these, known as the 'Mason Inquiries', are particularly significant. The first Mason Inquiry, carried out in 1987-1988, examined procedures in certain psychiatric hospitals regarding the admission, discharge, or release on leave of specific patient groups. The second, a Ministerial Inquiry led by Judge Ken Mason, took place in 1995-1996.[157] The initial Mason Inquiry was the forerunner of 67 investigations into service inadequacies which highlighted the disproportionate representation of Māori in mental illness statistics.[158] The Mason Inquiry panel adopted a regional approach, engaging with Māori communities across different areas to gather their perspectives on psychiatric services.[159] In Wellington and Otago, they discovered a lack of facilities tailored to Māori needs, although there were plans to develop a community-based Māori facility.[160] The panel encountered a small group in Wellington that showed no tangible commitment to biculturalism and the Treaty of Waitangi, despite claims of support.[161] In Auckland, they identified three Māori mental health groups and a highly active whānau of Māori workers associated with Kingseat Hospital.[162] The Christchurch region employed a

[157] Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients *Report of the Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients* (The Committee, Wellington,1988); Ministry of Health *Inquiry Under Section 46 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services* (Ministry of Health, Wellington, 1996); Warwick Brunton and Peter McGeorge "Grafting and Crafting New Zealand's Mental Health Policy" in Harry Minas and Milton Lewis (eds) Mental Health in Asia and the Pacific: Historical and Cultural Perspectives (Springer, New York, 2017) at 281, see also Gassin, above n 1, at 14.

[158] Gassin, above n 1, at 14.

[159] Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients, above n 157, at 7.

[160] At 7 and 145; Gassin, above n 1, at 14.

[161] At 168.

[162] At 142.

Māori Health Co-ordinator at the hospital, but the panel concluded that the services in this area lacked a substantial bicultural dimension.[163]

In consolidating their findings, the panel outlined a summary of Māori concerns. It was found that there was little evidence of a commitment to the Treaty of Waitangi, and it was recommended that all planning be done in consultation with Māori groups representing all iwi.[164] Another relevant concern accentuated by the panel was that "patients [were] assessed largely in terms of Western psychiatry. There is little acknowledgement of the impact of culture, family, and spiritual beings on identity. Differences between Māori and pakeha were often neglected in psychiatric assessments".[165] In terms of education and training, the panel found that health professionals were not educated in Taha Māori or the application of Taha Māori to services. The training programmes were monocultural.[166] In conclusion, the report observed that Māori were over-represented in both psychiatric institutions and correctional facilities. It also pointed out that the services provided do not align with Māori cultural needs, and that Māori often delay seeking medical care, which results in a higher probability of requiring hospitalisation.[167]

Prior to examining the second Mason Inquiry, it is important to understand that Brunton characterises the 1990s as a period of "deinstitutionalisation" amidst budget constraints.[168] Public concerns about inadequate coordination amongst various service providers were heightened by tragic events, leading some to advocate for a return to traditional institutions.[169] These concerns were sparked by police shootings involving individuals with mental health issues. In response, a Labour MP prepared a private member's bill to initiate a comprehensive inquiry.[170] However, the Prime Minister rejected the idea of a large-scale investigation, arguing it would impede systemic improvements.[171] Following another shooting incident, a ministerial inquiry was commissioned, known as 'Mason

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163 Gassin, above n 1, at 14.

164 Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients above n 157 at 178.

165 At 178.

166 At 178.

167 At 178; Gassin above n 1, at 15.

168 Brunton, above n 3, at 10.

169 At 10.

170 Gassin, above n 1, at 15; see also Brunton, above n 3, at 10.

171 Brunton, above n 3, at 10.

Inquiry 2'. This investigation primarily focused on enhancing public safety and improving service coordination.[172] The resulting report included a brief section on Māori, highlighting the lack of culturally appropriate services to prevent hospital admissions, the inadequacy of available services in meeting Māori needs, and the unfavourable social and economic environment for Māori.[173] The inquiry suggested that the establishment of the Mental Health Commission would provide a more precise measure of what could be procured by Māori Mental Health providers. It also anticipated that the Mental Health Commission and/or advisory Board would include sufficient Māori representation, both in numbers and expertise, so as to effect meaningful change.[174] The inquiry proposed four options for the delivery of mental health services by Māori:[175]

1. By iwi.

2. By a regional organisation.

3. By a Māori Mental Health Commission which would have functions similar to those of the proposed Mental Health Commission.

4. By establishing a Māori Mental Health Advisory Group which would be one of the "core functions" of a National Mental Health Board.

As a result of the second Mason Inquiry, New Zealand saw the establishment of the Mental Health Commission, which initially became a Crown entity pursuant to the Mental Health Commission Act 1998.[176]

In addition to the Mason Inquiries, there were other significant initiatives which were designed to enhance the participation of Māori in mental health decisions and the development of more culturally appropriate mental health provision, discussed below.

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[172] Gassin, above n 1, at 16.

[173] Ministry of Health *Inquiry Under Section 46 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services* (1996) at 137.

[174] At 140.

[175] At 140.

[176] Mental Health Commission Act 1998 - note this Act was repealed on 1 July 2012. The Mental Health and Wellbeing Commission was established under the Mental Health and Wellbeing Commission 2020.

6.6. Māori Participation in the Development of Law and Policy

By the 1990s, the significance of Māori mental health had become evident, necessitating governmental action. Various reports prompted the creation of strategies and policies tailored to address Māori needs. Kingi emphasised the importance of the Health and Disability Services Act 1993, which fundamentally altered the New Zealand health sector's philosophical foundation. This legislation redefined health as a commodity rather than a right or necessity.[177] The reforms introduced five key changes: merging primary and secondary care, redefining core health services, establishing public and personal health systems, integrating funding, and separating purchaser and provider roles for Māori.[178] The primary objective was to guarantee fair and cost-effective access to healthcare and disability assistance, whilst optimising resource utilisation.[179] The underlying assumption was that the existing model, where the government acted as both purchaser and provider of health services, was inefficient.[180] It was theorised that separating these roles would foster competition, enhance efficiency, reduce costs, and lead to improved and more equitable outcomes. Additionally, guidelines were developed to address Māori health concerns and incorporate them into regional purchasing strategies.[181] The reforms also emphasised Māori participation in decision-making across all levels of the health sector, prioritised resource allocation to account for Māori health needs and perspectives, and promoted the development of culturally appropriate practices and procedures as integral components in the provision of health services.[182] These policy directives were generally well-received by Māori.

It was clear by this stage that there was development towards Māori cultural frameworks or at least a valiant attempt to work towards this goal. In this regard, Durie states:[183]

> Māori health perspectives, cultural protocols for assessment, treatment and rehabilitation and a Māori workforce comprising increased numbers of Māori health professionals as well as Māori community workers, kaumātua, and dedicated Māori services. All contributed to an approach to mental health treatment and care that recognised culture as an important component in both assessment and recovery.

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177 Kingi, above n 114, at 29.
178 Kingi, above n 114, at 29.
179 At 178.
180 At 178.
181 At 178.
182 At 178.
183 Durie, above n 111, at 82; see also Gassin, above n 1, at 18.

Although these changes above are primarily linked to care after institutional settings, some progress was also made in adopting Kaupapa Māori approaches or incorporating Māori cultural elements into the institutional framework.[184] Mason Durie proposed three methods for hospital health boards to establish culturally suitable health services for Māori: providing funds to Māori groups to create their own programmes, incorporating Māori viewpoints into current programmes, or setting up alternative programmes alongside existing ones.[185] There are two examples of the alternative programmes as proposed by Durie. These were the establishments of Te Whai Ora and Te Whare Pai psychiatric units.[186] On this point, Kingi noted that despite the widespread closure of hospitals, these initiatives demonstrated how "health and culture could be integrated without conflict or compromise".[187] Moreover, individuals engaged in these advancements stayed within the field, whilst the number of Māori with clinical qualifications continued to grow.[188]

By the mid-1990s, the final stage of Durie's three-stage model of mental health service delivery cultural affirmation was in full swing. This was evidenced by the emergence of various mental health services tailored specifically for Māori, alongside general mental health services accessible to Māori.[189] As Boulton aptly notes, "this period ha[d] been one during which practitioners have begun to acknowledge the role culture has to play in the recovery of Māori mental consumers and where the empowerment of consumers and their families is regarded as critical to the successful delivery, evaluation and governance of mental health services and systems".[190] Notably, this era saw governmental recognition of the importance and effectiveness of culturally appropriate mental health services. These services had evolved beyond Western notions "of good health".[191] This phase of cultural affirmation, as described by Durie, continues to this day and is marked by the expansion

184 Gassin, above n 1, at 18.
185 At 19; Janet Rankin "Whai Ora: A Māori Cultural Therapy Unit" (1986) 2 Community Mental Health in New Zealand 38 at 38-47.
186 At 19; Mason Durie *Whaiora: Maori Health Development* (Oxford University Press, Oxford, 1994).
187 At 19; Kingi, above n 114, at 44.
188 At 19; Kingi, above n 114, at 44.
189 Boulton, above n 126, at 30.
190 At 30.
191 At 30.

of diverse mental health service providers, including those catering specifically to Māori populations.[192]

The latter part of the 20th century and the early 21st century witnessed a surge in governmental initiatives addressing mental health emergencies. In March 2000, following a hui organised in 1998, the Mental Health Commission published a report detailing the experiences of Māori engaged with both Kaupapa Māori and mainstream mental health services.[193] This document highlighted crucial issues faced by Māori within the mental health system.[194] The Commission determined that whilst some mental health services were available to Māori, these were insufficient. Financial constraints were identified as a major concern, alongside a general scarcity of Kaupapa Māori services necessary to provide comprehensive support. The report referenced Durie, stating that "[i]f they are to be effective, mental health services must coincide with Māori realities. According to the Treaty of Waitangi principle of options, Māori should be able to access services that are geared to their own cultural expectations, if that is what they wish".[195] The Commission emphasised that Durie's Whare Tapa Wha model should be employed to evaluate outcomes for Māori opting for Kaupapa Māori, regardless of whether they are in a Kaupapa Māori or mainstream service.[196] The Whare Tapa Wha model underpins the Kaupapa Māori mental health services in Aotearoa/New Zealand.[197] Additionally, the Commission identified the need for a "strong Māori workforce, and more and better mental health services that are controlled by consumers, whanau and their community".[198]

Subsequently, the government developed several mental health strategies and polices, which Kingi states explored "the opportunities offered by the health reforms and to further refine the deinstitutionalized approach to mental health care".[199] A notable strategy was the *Looking Forward: Strategic Directions for the Mental Health Services* in 1997. This document acknowledged mental health as a serious and deep-seated issue that "can only

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192 Boulton, above 126, at 29.

193 Mental Health Commission "Four Māori Korero about their Experience of Mental Health" (Mental Health Commission: Wellington, 2000).

194 At 7-9.

195 At 9.

196 At 7.

197 At 7.

198 At 7-8.

199 Kingi, above n 114, at 26.

be addressed through a coordinated and integrated strategy".[200] The strategy's primary objectives were to "reduce the prevalence of mental illness and mental health problems within the community" and "enhance the health status and minimise the impact of mental disorders on consumers, their families, caregivers, and the wider community".[201] The report specifically highlighted Māori youth and individuals within the criminal justice system, advocating for increased Māori involvement in the health sector. It called for a decrease in mental illnesses among Māori and an expansion of the Māori health workforce. This strategy paved the way for the subsequent report, *Moving Forward, the National Mental Health Plan for More and Better Services* (1997).[202] This follow-up report recognised that while some progress had been made in mental health, further efforts were necessary to achieve the goals outlined in *Looking Forward*.[203] Once again, it emphasised the need for greater Māori participation in the design and implementation of mental health services and greater availability of Kaupapa Māori health mental health services.[204]

The 2002 *Te Puāwaitanga: Māori Mental Health National Strategy* marked the first instance of Māori mental health receiving dedicated attention in policy discussions.[205] The document's aim was to provide District Health Boards with a national framework for service planning and delivery to meet governmental mental health policy objectives for Māori.[206] The report highlighted that mental health issues had become the primary health concern for Māori, a situation that had been ongoing since 1975. Crucially, it revealed that mental illness patterns differed between Māori and non-Māori populations, emphasising that Māori required access to their societal institutions such as te reo Māori, land, marae, as well as primary healthcare, education, housing, and employment opportunities.[207] This strategy was succeeded by Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008-2015. Concurrently, other policies were implemented, including Te Tāhuhu – Improving Mental Health 2005-2015 and Te Kōkiri:

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200 Ministry of Health *Looking Forward: Strategic Directions for the Mental Health Services* (1994) at 1-3.
201 At 1-3.
202 Ministry of Health *Moving Forward: The National Mental Health Plan for More and Better Services* (1997).
203 At 15-34.
204 At 8 and 40.
205 Mental Health Commission "Te Haererenga Mo Te Whakaōranga 1996-2006: The Journey of Recovery for the New Zealand Mental Health Sector" (Wellington, Mental Health Commission, 2007); see also Gassin, above n 1, at 23.
206 Ministry of Health "Te Puāwaitanga: Maori Mental Health National Strategy" (Wellington, Ministry of Health, 2002) at 2.
207 At 2.

The Mental Health and Addiction Action Plan 2006-2015.[208] Further government initiatives and policies in the present day will be discussed in Chapter Seven.

The historical analysis of Māori mental health and mental health legislation provides essential context for understanding the government inquiries and policy responses that emerged in the late 20th century as disparities in mental health outcomes for Māori became increasingly apparent. It becomes clear that although efforts have been made in the past to enhance Māori mental health, these attempts have not been successful. This is evident from the alarming statistics affecting tamariki and rangatahi Māori. It also emphasises the necessity for any response to be culturally appropriate. This reinforces the core argument of this thesis, which is that the principle of the best interests of the child is adaptable enough to accommodate the collective cultural rights of tamariki and rangatahi Māori and can serve as a vehicle to improve their right to mental health.

6.7. Conclusion

This chapter has provided an overview of how mental health services and legislation have developed in New Zealand with a particular focus on Māori. In the early 1900s, Māori were underrepresented in mental health facilities, possibly due to cultural and social factors that made them hesitant to engage with Western psychiatric treatment.[209] Nevertheless, from the 1960s onwards, there was a marked rise in Māori admissions to mental health institutions, which scholars have suggested may be linked to urbanisation and broader changes in society. During the 1980s and 1990s, there was a transition towards community-based care and deinstitutionalisation, which brought about both advantages and drawbacks for Māori mental health services.[210] This era also saw the commencement of governmental initiatives to create culturally suitable services for Māori, including the introduction of Kaupapa Māori mental health units in certain hospitals. The subsequent decades of the 1990s and 2000s saw an enhanced emphasis on Māori participation in mental health policy creation and service provision, accompanied by the

[208] Minister of Health *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan* (Wellington, Ministry of Health, 2005); Minister of Health *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015* (Wellington, Ministry of Health, 2006); Ministry of Health *Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015* (Wellington, Ministry of Health, 2008).

[209] Gassin, above n 1, at 19-20.

[210] At 19-20.

formulation of specific Māori mental health strategies and the expansion of Kaupapa Māori services.[211]

Furthermore, this chapter has shown the progress in Māori mental health rights, noting improvements in culturally appropriate and accessible services. However, the current persistent disparities in mental health outcomes and ongoing challenges in workforce development and service provision suggest that full realisation of this right remains a work in progress. The concerning mental health statistics for tamariki and rangatahi Māori indicate that, despite efforts to provide culturally sensitive mental health services since the 1990s, New Zealand has yet to achieve optimal outcomes. This situation necessitates an exploration of methods to enhance mental health results, particularly for tamariki and rangatahi Māori, and to refine the overall approach to mental health care for these communities. As this thesis suggests, employing the best interests principle in New Zealand's mental health domain is likely to gain traction, as the best interests of tamariki and rangatahi Māori in mental health are inextricably linked to their cultural context and identity. The best interests principle has the capacity to be a vehicle for change. The potential is there for the best interests principle to serve the mental health needs of tamariki and rangatahi Māori, in a culturally appropriate way, as will be discussed in detail in Chapter Eight.

[211] Gassin, above n 1, at 19-20.

Chapter Seven

New Zealand Law on Mental Health

7.1. Introduction

The previous chapter looked at mental health provisions for Māori from an historical perspective and demonstrated the disparities between Māori and non-Māori in mental health outcomes. These disparities became very apparent in the 1990s. Alongside this, the period heralded the establishment of a number of different approaches to enhance the cultural appropriateness of mental health provision for Māori. Complementing and building on this historical overview, this chapter examines the current legal and policy frameworks governing mental health in New Zealand, with an emphasis on how they impact on Māori.

The chapter begins by outlining the key pieces of legislation that pertain to mental health in New Zealand, including the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Pae Ora (Healthy Futures) Act 2022. It then analyses how these laws align with international human rights standards on the right to health, especially as they relate to Māori and youth mental health. The chapter critically examines relevant government strategies and policies, such as He Korowai Oranga (the Māori Health Strategy) and the Child and Youth Wellbeing Strategy. The chapter evaluates the extent to which these frameworks incorporate te ao Māori perspectives and children's rights principles. Additionally, the discussion evaluates whether the current mental health system in New Zealand is meeting its international obligations under the normative right to health, and criteria such as the AAAQ framework (availability, accessibility, acceptability and quality). The analysis draws attention to the persistent inequities faced by tamariki and rangatahi Māori in mental health outcomes and access to culturally appropriate services.

The chapter concludes by identifying gaps in the existing legal and policy landscape, particularly regarding the rights of Māori children and young people to equitable mental health care. It sets the stage for further exploration of how New Zealand can better fulfil

its domestic and international commitments to upholding the right to mental health for all.

7.2. The Mental Health (Compulsory Assessment and Treatment) Act 1992

In New Zealand, the primary legislation governing mental health and psychiatric assessment and treatment is the Mental Health (Compulsory Assessment and Treatment) Act 1992 ("the Mental Health Act").[1] The Mental Health Act is being re-evaluated in the light of the He Ara Oranga Report, leading to the introduction of a Mental Health Bill.[2] This Bill transitions compulsory mental health care to a framework based on rights. For instance, it includes the right to respect for culture and identity, as well as the right to medical and other health care. Specifically, individuals under compulsory care are entitled to receive medical and other health services that are appropriate for their physical and mental health needs.[3]

The Mental Health Act, as it currently stands, is applicable to individuals of all ages, including adolescents and young people. However, it is crucial to understand that the Act's application is limited to specific circumstances. To fall within the scope of the Act, the individual concerned must meet the definition of mental disorder which is "an abnormal state of mind...characterised by delusions, or by disorders of mood, perception, volition or cognition" that poses "a serious danger to the health or safety of that person or of others" or "seriously diminishes the capacity of that person to take care of himself or herself".[4] There are a number of specifics which determine the applicability of the Mental Health Act, including in relation to diagnosis. Generally, a diagnosis "of mental illness does not itself satisfy the requirements for a compulsory treatment order".[5] In *Re PJ* and *Re RT*, it was determined that "Parliament has deliberately eschewed reference to major mental disorders as understood in the psychiatric community...[but] has set the parameters for establishing the existence of a...mental disorder according to the presence or absence of observable symptomological indices".[6] While a formal diagnosis such as

[1] A review of this Act is currently underway.
[2] Mental Health Bill 2024 (87–2).
[3] At ss 25-38.
[4] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2.
[5] Rebekah Mapson "Assessment and Treatment of Children Under the Mental Health (Compulsory Assessment and Treatment) Act 1992" (2013) 3 NZLSJ 70 at 77.
[6] At 77; see also *Re PJ* SRT 6/93, 28/93 ; *Re RT*, 12/4/96, SRT13/96.

schizophrenia may be given for a child, this alone is typically insufficient to meet the requirements of s 2 without accompanying symptoms. The symptoms of the "illness will [need to be] identified to establish the need for a Compulsory Treatment Order".[7]

Some provisions of the Act pose challenges in relation to children. For example, the definition of mental disorder as a condition which "seriously diminishes the capacity of that person to take care of himself or herself" is particularly problematic for children, as they inherently have reduced self-care abilities.[8] This evaluation poses difficulties for children.[9] Alternatively, Mapson posits that this self-care aspect could align with the CRC's best interests principle by acknowledging children's lower self-care capacity and recognising parental responsibility in seeking medical attention.[10] As the law currently stands, following a child or young person's evaluation, the possibility of a Compulsory Treatment order is considered. Section 14A mandates that order application documents be provided to caregivers, parents, or guardians of children or young persons. Section 59 stipulates that patients under an order must comply with treatment as directed by the clinician for the initial month, and subsequently, if the patient agrees or a Review Tribunal-appointed psychiatrist deems it in the patient's best interests.[11] When necessary, a child's parent or guardian may appear in court as per ss 19(6) and 20(3), unless a judge directs otherwise.

There are provisions in the Act which are designed to provide greater reliability and accuracy in the assessment of children. In this regard, Part 8 of the Act addresses children and young people through specific provisions. Section 86 stipulates that, when feasible, individuals who are under 17 should undergo assessment examinations conducted by psychiatrists experienced in child psychiatry. This addition was designed to prevent misdiagnosis of delinquent or defiant youth as mentally disordered.[12] However, meeting this requirement is difficult because of the shortage of practitioners in this field.[13] The Mason Committee identified child psychiatrists as among the most scarce medical specialists, potentially hindering the effectiveness of this safety measure nearly 30 years

[7] Mapson, above n 5, at 77-79.
[8] Mental Health Act, above n 4, at s 2.
[9] Mapson, above n 5, at 77.
[10] At 78.
[11] Mental Health Act, above n 4, at s 59(2)(b).
[12] Sylvia Bell and Warren Brookbanks *Mental Health Law in New Zealand* (3rd ed, Thomson Reuters, New Zealand, 2017)) at 92.
[13] At 92.

ago.[14] Consequently, adherence to this provision may not always be possible. Additional measures include the requirement for a child psychiatry specialist to be present when a Review Tribunal evaluates a child or young person's condition. Other conditions are that brain surgery for mental disorders is prohibited for individuals under 17, and cases involving young people must be reviewed within one month prior to their 17th birthday if they remain subject to an order under the Act. These provisions serve as protective measures for individuals under 17 years of age.[15]

There are two types of compulsory treatment orders. Pursuant to s 28(1), it may be a community treatment order or an inpatient order. The assumption under s 28(2) is that a community treatment order be made and inpatient orders changed to community treatment orders "unless the responsible clinician considers that the patient cannot be adequately treated in the community".[16] There is an expectation that under s 29(1) the patient attend and accept treatment at their residence or other community setting, as defined. A compulsory treatment order expires after six months (s 33). However, a review 14 days before expiry may progress if the clinician believes that it is necessary to do so. Upon review, it is possible to extend this order. If so, the order will be extended in order for the review to occur.[17]

This discussion of the Mental Health Act and its provisions establishes the legal framework impacting the mental health outcomes of tamariki and rangatahi Māori. The Act shapes available services and interventions, yet disparities in mental health outcomes for Māori persist, despite various governmental initiatives, and underscore the need for a more responsive approach. The analysis of current laws' alignment with international human rights standards and incorporation of te ao Māori perspectives is particularly relevant. Such an analysis helps assess whether the legal system adequately protects the best interests of Māori children in the mental health context and fulfills their right to mental health. Statistical evidence indicates that the current system is failing to meet these

[14] Ministry of Health *Inquiry under s 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley* (1996); see also Mapson, above n 5, at 77-87.
[15] Mental Health Act, above n 4, at Part 8.
[16] Section 28.
[17] *Re B and Q* [1993] NZFLR 792 (1993) 10 FRNZ 325 DC.

needs effectively. In response to these challenges, a review of the current mental health legislation is underway, as discussed in subsequent sections.

7.3. Critique of the Mental Health Act ("the Act")

In 2021 the Ministry of Health issued *Transforming our Mental Health law: A Public Discussion Document*'.[18] The importance of this paper, in part, was recognising that the earlier legislation was 30 years old and was "not adequately supporting improved mental health outcomes or the well-being of individuals and is contributing to significant inequities".[19] The aim of the discussion paper was to "create new legislation that protects and respects human rights, implements the principles of Te Tiriti and improves equity".[20] The discussion paper also criticised the 1992 Act for being "out of step" with Treaty obligations and international human rights,[21] and observed that it "is resulting in unfair, unjust and avoidable worse outcomes for Māori, Pacific, those with disabilities…".[22] It was recognised that current statistics illustrate that Māori are more likely to be subject to compulsory mental health treatment than non-Māori. The 2020 statistics for Māori were as follows:[23]

- 3.7 times more likely than non-Māori to be subject to a community treatment order.
- 3.2 times more likely than non-Māori to be subject to a hospital inpatient treatment order.
- 5.1 times more likely to be secluded than non-Māori.

[18] Ministry of Health *Transforming our Mental Health Law: A Public Discussion Document* (2021); see also Karen Brown 'Mental Health in Line for Major Reform' (28 May 2019) Radio New Zealand <https://www.rnz.co.nz/national/programmes/morningreport/audio/2018697046/mental-health-in-line-for-major-reform>.

[19] Ministry of Health, above n 18, at 3.

[20] At 3.

[21] At 1.

[22] At 4.

[23] At 11.

- In 2020, 433 children and young people aged 17 years or younger were under the Mental Health Act, and 191 were Māori (44 percent).[24]

The discussion paper acknowledges that the Act demonstrates a glaring omission in its failure to formally recognise Te Tiriti o Waitangi.[25] This omission is crucial given the Treaty's fundamental role in New Zealand's constitutional framework and its importance in addressing the disproportionate impact of mental health issues on the Māori populations.[26] This omission undermines the Act's ability to effectively respond to the unique cultural needs and perspectives of Māori people in mental health contexts.[27] Furthermore, the discussion paper noted that the Act displays insufficient cultural responsiveness across various dimensions. There are no mandatory cultural needs assessments built into the legislation, which means that the specific cultural requirements of individuals may be overlooked or inadequately addressed in their treatment plans.[28] Additionally, the Act lacks clear requirements for culturally appropriate care, leaving room for inconsistencies in the delivery of mental health services to diverse populations.[29] Considering the notable cultural and ethnic differences among the population groups affected by the Act, as well as the frequent cultural gap between those administering and receiving treatment, the current Mental Health Act's provisions may be inadequate.[30] The limited incorporation of te ao Māori perspective within the Act further accentuates its failure to reflect Māori worldviews and collective decision-making processes.[31] This omission not only disregards the holistic approach to health and well-being that is central to Māori culture but also fails to leverage the potential benefits of incorporating these perspectives into mental health care practices for all New Zealanders. The discussion paper also referenced the Waitangi Tribunal Wai 2575 inquiry, noting the recommended legislative changes aimed at implementing Te Tiriti principles with a specific goal for the health sector to achieve equitable outcomes for Māori.[32]

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[24] Ministry of Health, above n 18, at 52.
[25] At 17-22.
[26] At 17-22.
[27] At 17-22.
[28] At 47-53.
[29] At 47-53.
[30] At 48.
[30] At 47-53.
[31] At 47-51.
[32] At 20-21.

In addition to the Act's omission of Te Tiriti o Waitangi obligations the discussion paper highlighted its deficiencies in relation to international obligations. It was noted that these international obligations require special consideration for children and young people.[33] The Mental Health Act has provisions pertaining to children and young people, as discussed above but demonstrates several critical shortcomings. One of the most significant issues is the lack of age-specific provisions. The legislation applies uniformly across all age groups without substantial differentiation for the unique needs and vulnerabilities of young people at different developmental stages. This one-size-fits-all approach fails to account for the distinct developmental stages and capacities of children and adolescents, potentially leading to inappropriate or ineffective interventions. The discussion paper also notes that any new legislation should emphasise the views of the child, their entitlement to receive information that is appropriate for them and to be supported to express their views.[34]

Importantly, the discussion paper also stated that the role of family, whānau and wider family group should be included in any new legislation. Families must be at the centre of solutions.[35] Whilst there is a requirement under the Mental Health Act to consult with family and whānau pursuant to s 7A during the compulsory assessment and treatment process, in practice the implementation of this varies and is at the discretion of the health professionals. It has been found that this is not always consistent practice.[36] Therefore, it was argued that new legislation needs to "consider how to best facilitate culturally appropriate inclusion of family, whanau, aiga and carers".[37] It was argued that the legislation also falls short in ensuring appropriate family and whānau involvement in decision-making processes for children.[38] Given the crucial role that family support plays in a child's mental health journey, this gap could lead to treatment plans that are disconnected from the child's home environment and support systems. The criticism was that the Act's failure to provide for age-appropriate supported decision-making processes further compounds this issue, potentially excluding children and young people from

[33] Ministry of Health, above n 18, at 51-52.
[34] At 47-51.
[35] At 52.
[36] At 49.
[37] At 49.
[38] At 51.

participating in decisions about their own care to the extent that is appropriate for their age and capacity.[39]

Another significant concern noted in the discussion paper is the lack of child-specific safeguards under compulsory treatment provisions apart from the requirement for a child psychiatrist. Without these protections, children may be subjected to interventions that are not tailored to their developmental stage or that fail to consider the long-term impacts on their growth and well-being. This gap exposes young people to potential risks and may hinder their recovery and overall development.[40] These shortcomings in the current Mental Health Act shows the pressing need for comprehensive reforms. In addition to the discussion paper, there were other initiatives calling for legislative reform around mental health. These are discussed in the next section.

7.4. Health and Disability System Review and the Waitangi Tribunal Report Wai 2575 ("Wai 2575")

The two influential law reform reports that significantly shaped New Zealand's health system reforms were the Health and Disability System Review completed in 2020 and the Waitangi Tribunal Report (Wai 2575) Stage One completed in 2019; both addressed critical Māori health concerns and inequities. The Health and Disability System Review, conducted by an independent panel, provided a comprehensive analysis of the existing health system.[41] The panel undertook extensive consultations and received evidence highlighting the persistent disparities in health outcomes between Māori and non-Māori populations.[42] This report and Wai 2575 (discussed below) are considered instrumental in shaping the Pae Ora Act 2022. It is important to highlight that the Waitangi Tribunal recommended the creation of a Māori Health Authority,[43] which led to the formation of Te Aka Whai Ora. However, in 2024, a change in government resulted in its dissolution. In this context, the Waitangi Tribunal issued an urgent report, emphasising that the disbandment was detrimental to Māori and recommended the Government to urgently

[39] Ministry of Health, above n 18, at 51-53.
[40] At 53.
[41] Ministry of Health *Health and Disability System Review - Interim Report. Hauora Manaaki ki Aotearoa Whānui – Pūrongo mō Tēnei Wā* (2019).
[42] Ministry of Health, above n 41, at 15-20.
[43] Waitangi Tribunal *Hauora Report on Stage One of the Health Service and Outcomes Kaupapa Inquiry* (Wai 2575, 2019) at 176.

consider the development of a stand-alone Māori health authority.[44] The Treaty Principles Bill 2024 also sought to alter the interpretation of Te Tiriti o Waitangi and redefine laws and policies to acknowledge Māori rights.[45] This could have implications for health rights, such as the principles of rangatiratanga and partnership, allowing Māori to govern, design, and deliver health services.[46] However, this Bill has not passed its second reading in Parliament. [47] In April 2025, Charters, a Māori legal expert, strongly criticised New Zealand's government at the United Nations Permanent Forum on Indigenous Issues. She stated that the administration's implementation of highly regressive policies towards Māori rights was unprecedented in her experience.[48] Charters pointed out the government's refusal to accept UNDRIP and its legislative efforts a position which she believes erode Māori rights. She called for UN intervention, requesting accountability for New Zealand and suggesting a visit from the Special Rapporteur on Indigenous Rights.[49] These actions represent a notable shift from New Zealand's earlier stance on Indigenous rights and raise questions about the country's compliance with international norms in this area.

Based on the submissions it received, the interim report for Health and Disability found that the current health and disability system in New Zealand has not adequately served Māori, primarily due to its failure to recognise and incorporate different worldviews, knowledge bases, and cultural norms.[50] This oversight has resulted in significant health outcome disparities between Māori and non-Māori populations. The report emphasises the importance of Mātauranga Māori in healthcare delivery, noting a gradual increase in the incorporation of these traditional knowledge systems over the past four decades.[51] The report contends that Te Tiriti is fundamental to improving Māori health outcomes, arguing that its principles should be fully integrated into the health system to address

[44] Waitangi Tribunal *Te Aka Whai Ora (Maori Health Authority) Priority Report, Part 1* (Wai 3307, 2024).
[45] Principles of the Treaty of Waitangi Bill 2024 (94–1).
[46] Carwyn Jones, Maria Bargh, Michael Baker, and Rhys Jones "Treaty Principles Bill Threatens Public Health and Equity: It Needs Your Submission" (18 December 2024) Public Health Communication Centre <https://www.phcc.org.nz/briefing/treaty-principles-bill-threatens-public-health-and-equity-it-needs-your-submission>.
[47] Kathryn Armstrong "New Zealand Rejects Rights Bill after Widespread Outrage" (10 April 2025) BBC <https://www.bbc.com/news/articles/c8je9013m0ro>.
[48] Te Aniwaniwa Paterson "Māori Leaders Urge UN to Act on Nz's 'Regressive' Policies" Te Ao Māori News (28 April 2025) <https://www.teaonews.co.nz/2025/04/28/maori-leaders-urge-un-to-act-on-nzs-regressive-policies/>.
[49] Te Aniwaniwa Paterson, above n 48.
[50] Ministry of Health, above n 41, at 33-50.
[51] At 33-50.

historical inequities.[52] Despite some progress, the report highlights that Māori continue to experience poorer health outcomes across all life stages compared to non-Māori. This disparity is attributed to various factors, including ongoing racism and discrimination.[53]

The Health and Disability System Review report emphasises the importance of whānau in Māori health, and whānau-centered approaches in healthcare delivery.[54] The review identifies the role of Māori providers and the development of a Māori health workforce as crucial elements in improving health outcomes, while acknowledging the challenges these providers face, such as underfunding and lack of support.[55] To address these issues, the report calls for a comprehensive overhaul of the health system,[56] that also fully embraces Māori worldviews, supports Māori leadership and governance, and actively works to address institutional racism.[57] The report outlines several key areas for improvement, including the provision of culturally appropriate services, increased Māori participation in decision-making processes, and better accountability for Māori health outcomes. In conclusion, the report emphasises the need for significant changes to fully incorporate the principles of Te Tiriti o Waitangi and embrace Mātauranga Māori in the health system, presenting this as a crucial step towards achieving health equity for Māori.[58] The report found that in order to improve health equity the "system had to understand the needs of individuals better, whanau (families) and communities and to design and deliver services addressed to those identified needs"[59] such as greater access to Kaupapa Māori services. The report recognises that the health system had "evolved within a strong western medical tradition. The inequities which had arisen for Māori could not be fully addressed without ensuring that the system also embraced the Māori world view (matauranga Māori) for the future".[60]

The Wai 2575 Report should also be noted, as it was largely these two reports that were influential in the reform of the health legislation, otherwise referred to as the "blueprint".[61]

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[52] Ministry of Health, above n 41, at 39-40.
[53] At 40.
[54] At 48.
[55] At 33-50.
[56] At 50.
[57] At 33-50.
[58] At 50.
[59] Joanna Manning "New Zealand's Bold New Structural Health Reforms: The Pae Ora (Healthy Futures) Act 2022" (2022) 29 JLM 987 at 995.
[60] At 995.
[61] At 993.

The Wai 2575 Report focusing on health services and outcomes, conducted an in-depth investigation into the primary health sector.[62] The report found that the Crown had breached its Treaty obligations in this sector, failing to adequately address Māori health needs and disparities.[63] The violation of Treaty obligations resulted in Māori experiencing detrimental effects. Specifically, the long-standing and unacceptable disparity in Māori health status, which the Crown had neglected to proactively address, was identified as a primary source of harm endured by the Māori population.[64] The Tribunal recommended exploring the establishment of a stand-alone Māori Primary Health Authority to ensure more effective and culturally appropriate healthcare delivery for Māori communities.[65] This recommendation aimed to address the systemic issues that have contributed to long-standing health inequities.[66]

Furthermore, the Waitangi Tribunal report proposed updated Treaty principles to guide future health policy and service delivery.[67] It is important to note that the Tribunal revisited the Treaty principles, previously known as the 3 P's – protection, participation and partnership.[68] The Tribunal stated that guiding principles should not only be limited to these, but also include tino rangitaratanga (self-determination and mana Motuhake in the design, delivery and monitoring), equity (commitment to achieving equitable outcomes), active protection (act to the fullest extent practicable to achieve equitable health outcomes), options (Crown to provide for and properly resource Kaupapa Māori health services and provide culturally appropriate health care services), and partnership (in governance, design, delivery and monitoring. Māori must be co-designers with the Crown).[69] The inclusion of these principles emphasises the need for a more holistic and culturally responsive approach to Māori health, recognising the importance of Māori participation and decision-making in healthcare.[70] The fundamental recommendation from the Tribunal was that the Crown commit to achieving health equities for Māori and ensure that the legislative and policy framework recognises and provides for the Treaty

[62] Waitangi Tribunal, above n 43, at 161-193.
[63] At 161-193.
[64] Manning, above n 59, at 993.
[65] Waitangi Tribunal, above n 43 at 161-193.
[66] At 161-193.
[67] At 180.
[68] At 27-38.
[69] At 164 and 180.
[70] Waitangi Tribunal, above m 43, at 161-193.

and its principles. This must be at all levels and in the documentation that makeup that framework.[71]

Both reports highlighted the urgent need to address persistent health inequities affecting Māori. They emphasise that these disparities were not only a matter of health but also a reflection of broader social, economic, and historical factors that have disadvantaged Māori communities.[72] These reports are relevant to this thesis as they show the importance of considering cultural identity in healthcare approaches for Māori. There is a clear need to recognise the interconnectedness of health, culture, and social factors, for effective health care for Māori. Both reports also emphasise the importance of Māori participation, and self-determination in the design and delivery of healthcare services. This perspective reinforces this thesis's proposition that the best interests of Māori children in mental health cannot be fully served without considering their cultural identity. Effective mental health care services for tamariki and rangatahi Māori should be culturally appropriate and recognise their unique context, with Māori actively involved in shaping and delivering these healthcare services. The findings of these reports in all respects thus argue for a vision and implementation which ensures that mental health services be provided by Māori for Māori.

The *He Ara Oranga* report, a significant government inquiry into mental health and addiction in New Zealand, was initiated due to widespread concerns about mental health services and calls for change from service users and their families.[73] The report's key findings highlight that New Zealand's mental health system is "under pressure and unsustainable" in its current form, with outcomes for Māori significantly worse than for the general population.[74] The system primarily responds to people with diagnosed mental illnesses through a narrow lens, often overlooking broader needs, while the quality of services and facilities is inconsistent across the country.[75] Additionally, there is a lack of preventive measures and insufficient attention to wider social needs contributing to mental health issues.[76] The report made several important recommendations to address

[71] Waitangi Tribunal, above m 43, at 161-193.
[72] At 161-193; Ministry of Health, above n 41, 50-65.
[73] Government Inquiry into Mental Health and Addiction *He Ara Oranga: Report of the Government Inquiry into Mental Health and Inquiry into Mental Health and Addiction* (Government Inquiry into Mental Health and Addiction, Wellington, 2018) at 6.
[74] At 10.
[75] At 11.
[76] Government Inquiry, above n 73, at 35-62.

these issues. These include reforming the Mental Health Act to better align with human rights principles and modern mental health practices, placing people at the centre of mental health and addiction services, and supporting families and whānau as active participants in care and treatment.[77] The report also recommends expanding access to services for people with mild to moderate and moderate to severe mental health and addiction needs, strengthening the NGO sector to support more community-based services, and taking a whole-of-government approach to well-being. Finally, it proposes establishing a new Mental Health and Wellbeing Commission to provide leadership and oversight of mental health and well-being in New Zealand.[78] These recommendations aim to transform the mental health and addiction system in New Zealand, making it more responsive, accessible, and effective for all citizens.

7.5. Pae Ora (Healthy Futures) Act 2022

The Pae Ora Act 2022, a significant reform in public health and disability legislation, was developed with a Māori perspective to address health inequities.[79] It aims to shift from Western, medicalised approaches to mental health care, which places people and whānau at the centre. [80] The Act incorporates Te Tiriti o Waitangi principles. Section 6 of the Act requires the Minister and health entities to be guided by these principles to improve Māori health outcomes, using a defined list of ways to give effect to the Treaty principles rather than "common" treaty clauses.[81] Section 7 has embedded principles from the Wai 2575 report as health principles. These include: opportunities for Māori decision-making in health service design and delivery; equity, ensuring equitable access, service levels, and health outcomes for Māori; active protection, promoting Māori health through population health approaches and addressing wider health determinants; options, offering quality services tailored to Māori needs, including Kaupapa Māori services, culturally safe care, and a representative workforce; and partnership, engaging Māori in developing, delivering, and monitoring health services to reflect their needs and aspirations. These principles represent a significant change in the health system's approach to Māori health.

[77] Government Inquiry, above n 73, at 65 -198.
[78] At 65-198.
[79] Manning, above n 69, at 987.
[80] Ministry of Health, above n 18, at 14.
[81] Mental Health (Compulsory Assessment and Treatment) Act, above n 4, s 6.

The Pae Ora Act aims to improve health inequities, particularly for Māori, and promote overall health for New Zealanders.[82] Its primary goal is to build towards pae ora (healthy futures) for all New Zealanders, acknowledging the ineffectiveness of the current scattered approach in the health system. The Pae Ora Act seeks to redesign healthcare services, creating seamless and more accessible options tailored to diverse community needs. [83] With a strong focus on equity, the Pae Ora Act emphasises addressing health disparities, particularly those affecting Māori communities. This approach moves away from a one-size-fits-all model, acknowledging that universal services may need modification to effectively serve different populations and reduce health inequities.[84] Key elements of the Pae Ora Act include the establishment (and subsequent disestablishment due to change in political landscape) of the Māori Health Authority, the Hauora Māori Advisory Committee, Iwi-Māori Partnership Boards, Health New Zealand (consolidating 20 District Health Boards), and a new Public Health Agency. These changes aim to enhance Māori participation in the health system, address health disparities, and streamline health service delivery across the country.[85]

Some other sections of the Pae Ora Act are worth noting. Section 34 mandates the Minister to provide a Government Policy Statement on Health (GPS) every three years, outlining priorities for publicly funded health and parameters for the NZ Health Plan. The GPS must include priorities for improving Māori health outcomes and engaging with Māori. Health entities are required to implement the GPS (s 39). The Pae Ora Act also requires the formation of six national health strategies including one for Haurora Māori.[86] The Minister must consider but is not bound by these strategies (s 35(b)). The GPS (2024-2027) has been developed and priority areas identified.[87] In particular five mental health and addiction targets have been stated. These targets are: faster access to specialist mental health and addiction services; faster access to primary mental health and addicition services; shorter stays at emergency deparments; increase in workforce; and strengthened focus on prevention and early intervention.[88]

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[82] Mental Health (Compulsory Assessment and Treatment) Act, above n 4, s 3.
[83] Department of the Prime Minister and Cabinet "Our Health and Disability Building a Stronger Health and Disability System that Delivers for All New Zealanders" (April 2021) CAB 21 Sub 0092 at 4.
[84] Manning, above n 59, at 997.
[85] At 1003.
[86] Mental Health (Compulsory Assessment and Treatment) Act, above n 4, s 42.
[87] Ministry of Health Government Policy Statement on Health 2024–2027 (2024).
[88] At 4.

7.6. Code of Health and Disability Services Consumers Rights 1996 ("the Code") and the NZBORA 1990

In addition to the recent Pae Ora Act, there are two other earlier pieces of legislation that should be mentioned as they relate to the right to health.

The Health and Disability Commissioner Act 1994 established the Code of Health and Disability Services Consumers' Rights. This applies to all health and disability consumers, including children and young people.[89] The Code contains 10 rights and should be interpreted in conjunction with other legislation. Several key points are particularly relevant to Māori health. Right 1 mandates respect for consumers, specifically requiring services to consider the needs, values, and beliefs of different cultural groups, including Māori.[90] Right 2 affirms freedom from discrimination on grounds prohibited by the Human Rights Act 1993.[91] Right 4 ensures services are provided consistently with consumer needs and in a manner that optimises quality of life, taking a holistic view of consumer needs.[92] It is expected that this Code is not read in isolation but in conjuction with other legisaltion.

Secondly, there is the NZBORA 1990 which offers protection against discrimination (s 19(1)) and the right to refuse medical treatment (s 11). It has been described as a set of guidelines that provide direction for the entire process of government serving as a means of ensuring principled governance in New Zealand, and being pivotal to statutory interpretation, law and policy making.[93] Although this is a significant national legal document, it is important to note (and will be explored further in Chapter Eight) that NZBORA does not enshrine the right to the highest attainable standard of health or other ESCR rights. The government contends that these rights are already safeguarded by

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[89] Health and Disability Commissioner Act 1994, s 74(1).

[90] Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, Right 1.

[91] At Right 2.

[92] At Right 4.

[93] Geoffrey Palmer "The Bill of Rights Fifteen Years On" (Keynote Speech for the Ministry of Justice Symposium on the New Zealand Bill of Rights Act 1990, Wellington, 10 February 2006) at [28]–[29]; see Joss Opie "A Case for Including Economic, Social and Cultural Rights in the New Zealand Bill of Rights Act 1990" (2012) 43 VUWLR 471 at 471-416; Joss Opie "Economic, Social and Cultural Rights" (2014) New Zealand Law Journal 195.

separate pieces of legislation.[94] In terms of health, the prohibition of discrimination is particularly relevant to Māori health, as it protects against discrimination in healthcare services.[95]

Examining the Mental Health Act, the Pae Ora Act, the Health and Disability Code and NZBORA is important to this thesis as these pieces of legislation collectively form New Zealand's current legal framework for addressing health inequities and improving outcomes for Māori in terms of mental health. The Pae Ora Act, in particular, emphasises Māori participation in health service design and decision-making processes, as well as the development of culturally appropriate health strategies. This legislative landscape provides a critical context for assessing New Zealand's progress in meeting its normative right to health obligations. Despite these legislative efforts, statistical evidence suggests that the intended outcomes of reducing health disparities have not yet been fully realised. This discrepancy between legislative intent and practical outcomes raises important questions about the effectiveness of New Zealand's domestic laws in fulfilling the normative right to health and mental health. The latter part of this chapter evaluates whether New Zealand is in fact meeting its obligations under the right to health.

In addressing mental health challenges in New Zealand, three key strategies play a crucial role in shaping the nation's approach.[96] The New Zealand Health Strategy and the Māori Health Strategy represent comprehensive frameworks that guide policy development and implementation in the mental health sector. These strategies, while distinct in their focus, are interconnected and aim to improve mental health outcomes for all New Zealanders.

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[94] Human Rights Foundation of New Zealand *Universal Periodic Review of New Zealand 18th Session of the Working Group to the UPR* (Human Rights Foundation, Joint Stakeholders Report, 2014) at [5]; see Judy McGregor and Margaret Wilson *Fault Lines: Human Rights in New Zealand* (New Zealand Law Foundation, 2016).

[95] Rebekah Graham and Bridgette Masters-Awatere "Experiences of Māori of Aotearoa New Zealand's Public Health System: A Systemic Review of Two Decades of Published Qualitative Research" (2020) 44 Australian and New Zealand Journal of Public Health 193 at 193-200 ; see also Natalie Talamaivao, Ricci Harris, Donna Cormack, Sarah-Jane Paine and Paula King "Racism and Health in Aotearoa New Zealand: A Systemic Review of Quantitative Studies" (2020) 133 NZMJ 55 at 55-59.

[96] New Zealand has He Korowai Oranga – Māori Health Strategy, Pathways to Pacific Health and Wellbeing, Health of Older People, Primary Health Care Strategy, Rising to the Challenge of Mental Health and Addiction Service Developmental Plan, and Living Well with Diabetes: A Plan for People at High Risk or Living with Diabetes; see Ministry of Health *New Zealand Health Strategy Roadmap of Actions* (2016).

The following discussion looks at these strategies (and briefly at some other key ones) to examine their objectives.

7.6.1. New Zealand Health Strategy 2016

The Ministry of Health's Strategy is a comprehensive plan spanning a 5-year period, encompassing 27 action areas divided into two main components. The first part, "Future Direction", outlines the high-level vision for New Zealand's health system from 2016 to 2026, addressing key challenges and goals. The second part, "Roadmap", provides detailed plans for implementing the strategy through 27 specific action areas. The strategy is underpinned by eight guiding principles, which include acknowledging Treaty of Waitangi obligations, promoting optimal health for all citizens, improving health equity, and fostering collaboration across various sectors.[97] Five interconnected themes shape the strategy: people-powered, closer to home, value and high performance, one team, and smart system. Key actions within the strategy include making the health system more responsive to people's needs, enabling Māori participation in decision-making and service delivery, building cultural competence to reflect New Zealand's diversity, delivering services closer to home, increasing focus on prevention, early intervention, and rehabilitation, and improving health outcomes for children and young people.[98] Apart from these, at first glance there is no particular focus on mental health, yet it is clear the strategy envisages and targets the overall delivery of health services in New Zealand and mental health falls under that umbrella.

7.6.2. He Korowai Oranga Whakamau Māori Health Strategy and Whakamaua: Māori Health Action Plan 2020-2025

The Māori Health Strategy, formulated in 2013/2014, aims to achieve optimal health outcomes for Māori. This web-based "living strategy" is regularly updated and focuses on four key pathways: supporting whānau, hapū, iwi, and community development; promoting Māori participation in the health sector; ensuring effective health service delivery; and working across sectors.[99] The strategy's core vision, Pae Ora (healthy futures), comprises three elements: Mauri Ora (healthy individuals), Whānau Ora (healthy

[97] Ministry of Health, above n 96, at 3.
[98] At 15.
[99] Ministry of Health *The Guide to He Korowai Oranga Maori Health Strategy* (2014).

families), and Wai Ora (healthy environments). Whānau Ora emphasises supporting Māori families to achieve maximum health and well-being, recognising the central role of whānau in Māori identity and strength. Wai Ora acknowledges the importance of environmental factors, including access to housing, safe water, air, and healthy food.[100] The strategy outlines two main directions: Māori aspirations and contributions, which involves partnering with Māori in decision-making and health service delivery, and government aspirations and contributions, which focus on ensuring equitable health outcomes.[101]

The Māori Health Strategy focuses on three key threads: rangatiratanga (Māori leadership in decision-making), building on past gains, and achieving equity.[102] The strategy aims to improve Māori health outcomes through four pathways: developing Māori communities, increasing Māori participation in the health sector, providing effective and culturally appropriate services, and working across sectors. Central to this approach is the recognition of Māori support networks (whānau, hapū, iwi) in managing health and well-being. The strategy emphasises the importance of Māori providers, culturally appropriate services, and organising healthcare around Māori needs. It also highlights the need for quality ethnicity data and evidence-based practices to inform Māori health initiatives. Together, these components form the core of He Korowai Oranga, guiding the health system towards achieving Pae Ora (healthy futures) for Māori.[103]

The strategy to achieve Pae Ora comprises four pathways. Te Ara Tuatahi focuses on developing Māori communities, recognising their role in managing health and well-being. Te Ara Tuarua aims to increase Māori participation in the health sector, with DHBs obligated (despite these being disestablished now) to partner with Māori communities. Te Ara Tuatoru emphasises the provision of effective, culturally appropriate health services for Māori. Lastly, Te Ara Tuawha promotes cross-sector collaboration to ensure services are organised around Māori needs rather than provider requirements. These pathways collectively aim to improve Māori health outcomes by addressing various aspects of healthcare delivery and community involvement.[104]

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[100] Ministry of Health, above n 99, at 3.
[101] At 3..
[102] At 3.
[103] At 3.
[104] At 3.

The Whakamaua: Māori Health Action Plan 2020-2025 is the implementation document for the Māori health strategy. It outlines specific actions to improve Māori health outcomes and achieve health equity. These actions include strengthening Māori-Crown partnerships by establishing formal partnerships between Māori and health sector organisations and involving Māori in decision-making processes at all levels of the health system. The plan also focuses on increasing Māori leadership by appointing Māori to leadership positions in health sector organisations and supporting the development of Māori health leaders through mentorship and training programs.[105] Developing the Māori health workforce is another key aspect, which involves increasing the number of Māori health professionals through targeted recruitment and retention strategies and providing culturally appropriate training and professional development opportunities. The plan emphasises enhancing Māori health sector development by supporting the growth of Māori health providers and organisations and investing in Kaupapa Māori services and initiatives. Expanding access to rongoā Māori services is prioritised through integrating traditional Māori healing practices into mainstream healthcare and increasing funding and support for rongoā Māori practitioners and services.[106]

The Whakamaua: Māori Health Action Plan 2020-2025 addresses racism and discrimination by implementing anti-racism training for health sector staff and establishing mechanisms to report and address instances of racism in healthcare settings.[107] Incorporating mātauranga Māori throughout the health system is emphasised by integrating Māori knowledge, values, and practices into health policies and services and developing culturally responsive health promotion and disease prevention strategies.[108] Enhancing whānau-centred services is prioritised by designing health services that consider the broader family and community context of Māori patients and supporting whānau ora initiatives that address social determinants of health. Finally, the plan focuses on improving accountability measures by developing Māori-specific health indicators and targets and regularly monitoring and reporting on progress towards achieving health equity for Māori.[109]

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[105] Ministry of Health *Whakamaua: Māori Health Action Plan 2020–2025* (2020) at 36-38.
[106] At 40-44.
[107] At 40-46.
[108] At 40-41.
[109] At 50-54.

7.6.3. Child Youth Wellbeing Strategy / Framework

In 2021, New Zealand introduced its inaugural Child and Youth Wellbeing strategy, described as "bold and ambitious".[110] The Ministry of Health recognised the challenges faced by young individuals, with particular emphasis on mental health and the swiftly rising rates of mental health disorders among youth.

The strategy comprises six outcomes, with one pertinent to mental health stating that "children and young people are happy and healthy".[111] Several indicators are associated with this outcome, including one specific to mental health: the "percentage of young people who experienced high or very high levels of psychological distress at some stage over a four-week period".[112] The development of this strategy involved consultation with children and young people. For instance, in 2018, over 6,000 children were consulted, and their perspectives obtained.[113] This consultation process stemmed from an amendment to the Children's Act 2014, mandating the involvement of children and young people in the development, implementation, and ongoing management of a child and youth strategy. According to literature, this is viewed positively and "means that large-scale engagements seeking children and young people's views may become increasingly common in future".[114] As this strategy is newly implemented, there is currently limited academic literature available on the subject.

The preceding discussion of New Zealand's strategies and legislation is pertinent, as it illustrates what is happening on the ground for mental health initiatives for Māori in general, and specifically for tamariki and rangatahi Māori. This sets the stage for the subsequent section, which examines whether these ground-level actions align with New Zealand's international commitments regarding the right to health. The next section begins with a recap of the main trends in the historical evolution of mental healthcare in

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[110] Child and Youth Wellbeing "The Strategy Framework" (29 August 2019) Ndha Deliver < https://ndhadeliver.natlib.govt.nz/webarchive/20240412190031/https://www.childyouthwellbeing.govt.nz/our-aspirations/strategy-framework>, at 1-2.

[111] At 1-2.

[112] At 1-2.

[113] Department of Prime Minister and Cabinet *Our Vision New Zealand is the Best Place in The World for Children and Young People* (Department of the Prime Minister and Cabinet, Child and Youth Wellbeing Strategy, 2019) at 5.

[114] Kelsey Brown, Luke Fitzmaurice, Kiri Milne and Donna Provoost "Engaging Children and Young People in the Policy Process" (2020) 16 Policy Quarterly 3 at 9.

New Zealand, before evaluating the current standing of these provisions in relation to New Zealand's international commitments to the right to health.

7.7. How Did we get to Where we are Now?

The previous chapter provided a comprehensive overview of the evolution of Māori mental health and mental health laws in New Zealand from 1840 to the 1970s. Initially, there was limited knowledge about Māori mental health, but two key conclusions were drawn: mental illness existed among Māori pre-European contact, and the high rates of mental illness among Māori are a recent development.[115]

The legal framework for mental health in New Zealand underwent significant changes during this period. Early legislation, such as the Lunatics Ordinance of 1846, focused on public protection by isolating those deemed insane in asylums.[116] It was based on "societal expectations to provide for the safe custody and prevention of offences by persons who were regarded to be dangerously insane and for the care and maintenance of persons of unsound reasoning".[117] This custodial approach, rooted in Georgian and Victorian English values, persisted until the mid-20th century,[118] with institutions functioning largely as sites for containment rather than active treatment.

The 1868 Lunatics Act marked a shift towards more structured oversight of care facilities and standardised care provision. The law expanded on establishing licensed institutions, including private facilities, to provide consistent care and management, distinguishing between individuals needing long-term care and those requiring temporary confinement.[119] The Mental Defectives Act 1911 introduced social control measures, targeting individuals considered "subnormal" or "undesirable" and institutionalising

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115 Te Kani Kingi "Introduction" in Te Kani Kingi, Mason Durie, Hinemoa Elder, Rees Tapsell, Mark Lawrence and Simon Bennett (ed) *Maea Te Toi Ora: Māori Health Transformations* (Huia Publishers, Wellington, 2018) at 11.

116 Te Ara "Story: Mental Health Services" (5 May 2022) Te Ara <https://teara.govt.nz/en/mental-health-services/page-2>.

117 Kirk Reed and Brian Field "Resituating Aotearoa New Zealand Mental Health Legislation in the Context of Social and Occupational Justice" (2017) 29 Aotearoa New Zealand Social Work 56 at 59.

118 At 55-58.

119 At 58.

them.[120] The tenor of the legislation reflected the view that the mentally unsound were incapable of managing their affairs, necessitating state intervention for their care.[121]

Between 1954 and 1961, legislative changes addressed mental health care service and delivery. The 1969 Mental Health Act, for instance, reviewed existing laws and responded to the Health Committee Inquiry's recommendation for deinstitutionalisation and the establishment of psychiatric care within general hospitals. This marked a significant shift from earlier legislation, which had focused on isolating mental health issues from the broader population, driven by discriminatory public attitudes and aimed at protecting the general public.[122] During the 1960s and 1970s, an increased recognition of patient requirements and the advantages of outpatient treatment led to a move towards deinstitutionalisation.

The current chapter has focused on recent law and policy development in New Zealand. The Mental Health Act 1992 endorsed a greater recognition of parents' rights, required care to be provided in the "least restrictive environment" and limited involuntary hospitalisation.[123] This legislation bolstered patients' rights to self-determination and established guidelines for mandatory treatment, particularly for individuals receiving care within their communities rather than in hospital settings. In this phase, the State became focused on the rights of patients and the legislation attempted to mirror this by taking on a rights-based approach. Essentially, the Act allows more "checks and balances and review procedures" aimed at "protecting service users' rights and ensuring that unnecessary incarceration did not take place".[124] The 1992 Act was amended in 1999, emphasising a shift from a focus on an "institutional model of mental health" to a focus on "community care" and protecting patient's rights including the right to information (s 64), respect of cultural identity (s 65), the right to treatment (s 66), the right to be informed about treatment (s 67), and right to independent psychiatric advice (s 69).[125]

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120 Reed and Field, above n 117, at 58.

121 At 59.

122 Timothy Gassin *Waitangi Tribunal A Report Commissioned by the Waitangi Tribunal for the Wai 2575 Health Services Outcomes Kaupapa Inquiry* (Wai 2575, B26, August 2019) at 5; see also Te Kani Kingi "Mental Health Services for Māori" in Te Kani Kingi, Mason Durie, Hinemoa Elder, Rees Tapsell, Mark Lawrence and Simon Bennett (eds) *Maea Te Toi Ora: Māori Health Transformations* (Huia Publishers, Wellington, 2018) at 29.

123 Reed and Field, above n 117, at 80.

124 At 60.

125 Gassin, above n 122, at 5.

The historical analysis of mental health legislation in New Zealand demonstrates its foundation in English and Western ideologies. For a long period of time, this approach prioritised societal protection by isolating those deemed mentally unfit, diverging significantly from a rights-oriented perspective. Instead, the approach emphasised maintaining mental health institutions distinct from other health and social services. The care and treatment provided to patients were inadequate and fragmented, lacking proper medical and culturally appropriate interventions. It was not until the 1960s that legislation introduced explicit medical interventions in facilities, and only towards the end of the 20th century did a semblance of a rights-based approach emerge, focusing on treating patients in the least restrictive manner possible. Notably, consideration of Te Tiriti principles and culturally appropriate treatment was largely absent from mental health legislation until recent times. It can be concluded that the initial absence of a unified te ao Māori approach, followed by intermittent efforts over the years, has undoubtedly contributed to the present situation. Furthermore, the lack of a consistent strategy that emphasises children, their rights, their welfare, and their right to health has further complicated the ability of tamariki and rangatahi Māori to access mental health services and improving mental health outcomes generally.

As stated above, historically in New Zealand, the State did not adopt a rights-based approach to mental health. However, a gradual shift towards acknowledging such an approach began in the late 20th century. Notably, the recognition of Māori in mental health was largely overlooked until around the 1970s when disparities became apparent. At that time, no legislative action was taken. Instead, only initial observations and studies on Māori mental health emerged, such as the Health Department's Medical Branch report on Māori patients in mental hospitals. It was not until the 1980s and 1990s that Māori mental health gained significant attention, prompted by a sharp rise in Māori admissions. This period saw some consideration given to Māori mental health issues. However, it was not until the mid-21st century that Māori mental health received substantial focus. Despite these changes, as the subsequent discussion will contend, New Zealand is still a long way away from fulfilling a rights-based approach to health generally, and mental health.

7.8. Is the Law and Policy We Have Working?

A recent study by the Mental Health and Wellbeing Commission, which independently monitors mental health and addiction services in New Zealand, revealed significant

challenges in addressing mental health issues, particularly for Māori. The Commission highlighted that the current system inadequately serves Māori, with a disproportionately high application of the Mental Health Act to tangata whaiora.[126] Furthermore, the inequitable outcomes experienced by Māori were attributed to colonisation, systemic racism, and a persistent disregard for Te Tiriti o Waitangi.[127] Regarding young people, the report identified substantially extended waiting periods for accessing health services and the need to prioritise youth-oriented services. The Commission emphasised the importance of maximising tangata whaiora autonomy and upholding rights on an equal basis. It was argued that the transformation of the mental health and addiction system must remain a governmental priority, with the aim of developing a holistic approach focused on meeting the mental well-being needs of all individuals.[128]

The Commission's views and the current statistics (discussed in Chapter One) demonstrate that Māori mental health is an ongoing issue and this raises the question of whether the current legal framework in mental health meets the normative right to health as envisaged by the international community. This question is important as the right to (mental) health under international law (see Chapter Five) tells us that New Zealand has legal obligations because of its endorsement of international human rights instruments.[129] These international agreements are underpinned by core principles. The principles of equality and non-discrimination, and the AAAQ framework form the foundation of the right to health (as discussed in Chapter Five).[130] The CESCR's General Comment No. 14 stipulates that countries are required to safeguard the right to health, which includes the duty to implement laws or measures which ensure equitable access to healthcare and related services.[131] The duty to meet these obligations requires state parties to clearly recognise the right to health in their domestic political and legal systems, ideally through legislative implementation, and to develop a comprehensive national health policy to

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126 Mental Health and Wellbeing Commission *Te Huringa Change and Transformation* (2022) at 6-7.

127 At 6-7.

128 At 16. New Zealand has endorsed international agreements, including UNDRIP. Such endorsements bring about responsibilities that nations must honour- see generally Harold Honju Koh "Why do Nations Obey International Law" (1997) 106 The Yale Law Journal 259 at 259.

129 Mental Health and Wellbeing Commission, above n 126, at 16.

130 Koh, above n 128, at 259.

131 *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12)* UN Doc E/C.12/2000/4 (11 August 2000) at [34]-[37]; [43]-[45] and [53]-[56].

realise this right.[132] To evaluate New Zealand's enactment of these responsibilities, its legislative framework concerning mental health is examined.

7.9. Are There Gaps in New Zealand's Law?

As discussed earlier in the thesis, the right to health in a general sense, as has been interpreted by the United Nations and "the normative content of the right to health" has been explained.[133] Obligations for states are set out in General Comment No. 14 and comprise key elements, known as the AAAQ framework. It is an "inclusive right" with freedoms and entitlements.[134] Healthcare must be accessible, acceptable, available and of good quality. Additionally, nations have a duty to respect, protect and fulfil the right to health. Adopting a rights-based approach to health, among these other cross-cutting human rights principles, demands attention to participation, non-discrimination, transparency and accountability. On this note, the principles of child centric practice as identified in the CRC should also be mentioned. The four principles are: non-discrimination, best interests of the child, the right to survival and development, and regard for the views of the child.[135] The question that arises is whether the cross-cutting principles are present in the current New Zealand mental health legal framework and, if so, in what ways are they manifested. The presence of such frameworks is important because leveraging legal frameworks to uphold human rights, specifically the right to health, can narrow the disparity between international legal obligations and national public health actualities.

In answering this question, it is contended that the current health and mental health legal framework in New Zealand is piecemeal. Whilst efforts have been made to improve New Zealand's mental health and health laws, it is evident that there are still substantial gaps and areas for improvement. The Pae Ora Act 2022 demonstrates concerted efforts

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[132] Lawrence Gostin, Matiangai Sirleaf and Eric Friedman "Global Health Law Legal Foundations for Social Justice in Public Health" in Lawrence Gostin and Benjamin Meier (eds) *Foundations of Global Health & Human Rights* (Oxford University Press, London, 2020) 46 at 62-63; *General Comment No. 14,* above n 131, at [43]-[45] and [53]-[56].

[133] Lisa Montel, Naomi Ssenyonga, Michel Coleman and Claudia Allemani "How Should Implementation of the Human Right be Assessed? A Scoping Review of the Public Health Literature from 2000 to 2021" (2022) 21 International Journal for Equity in Health 1.

[134] *Office of the United Nations High Commissioner for Human Rights and World Health Organisation The Right to Health: Fact Sheet no 31* OCHR/WHO (2008).

[135] United Nations Convention on the Rights of the Child 1577 UNTS 3, [1991] ATS 4, 28 ILM 1456 (opened for signature 20 November 1989, entered into force 2 September 1990).

to incorporate Te Tiriti o Waitangi principles and the Health Principles (as outlined in section 7, including the principle to engage with Māori to develop and deliver services that reflect their needs and ensuring Māori have access to services in proportion to their health needs) [136] in providing culturally appropriate healthcare delivery and the engagement and participation of Māori.[137] However, this alone is insufficient to recognise New Zealand's right to health under international law and there are critical gaps in the legislative provisions. One of these significant gaps in New Zealand's legal framework is the lack of an explicit recognition of the right to health. This failure to incorporate the right to health deprives individuals, who are the ultimate beneficiaries of healthcare, of a clear legal avenue to assert their entitlement to health services.[138] The United Nations has consistently urged nations to enshrine the right to health in their domestic legislation, as this approach offers distinct benefits, including a clear framework for upholding health rights.[139] As Breen notes, despite the obligations and expectations outlined in the Pae Ora Act, without a well-defined right to health in the law, it becomes challenging to assess whether these new initiatives are being implemented effectively.[140] Furthermore, having a right to health in domestic law would provide citizens with a legal avenue to hold the government and various health authorities accountable.[141] Correspondingly, the Pae Ora Act's objectives seem aspirational rather than legally enforceable. The problem of enforceability is compounded by the lack of explicit supervisory protocols in the Act. It is unclear who will be responsible for overseeing Te Whatu Ora's implementation of modifications. The transfer of duties to the board may result in a gap in accountability. In connection with this, the establishment of a legally enforceable right to health could improve governmental responsibility by offering a clear path for seeking redress.

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136 Pae Ora (Healthy Futures) Act 2022, s 7.

137 Claire Breen "A Major New Law Aims to 'Improve the Health of All New Zealanders'- So Why Doesn't It Include the Basic Human Right to Health?" (15 June 2022) The Conversation < https://theconversation.com/a-major-new-law-aims-to-improve-the-health-of-all-new-zealanders-so-why-doesnt-it-include-the-basic-human-right-to-health-184842 > The Pae Ora Act and the Māori Health Strategy, demonstrate concerted efforts to incorporate culturally appropriate approaches and Te Ao Māori perspectives into the healthcare system.

138 Anita Chung "The Right to Health and COVID-19: Lessons Learned for the New Health System" (2022) 9 PILJNZ 47; Joanna Manning "Litigating a Right to Health Care in New Zealand" in Colleen Flood and Aeyal Gross (eds) *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press, Cambridge, 2014) 240; Breen, above n 137.

139 *Concluding Observations on the Fourth Periodic Report of New Zealand* UN Doc E/C.12/NZL/CO/4 (1 May 2018) at [4]-[5]; *Consideration of Reports Submitted by States Parties under Articles 16 and 17 of the Covenant* UN Doc E/C.12/NZL/CO/3 (18 May 2012); see also Human Rights Foundation, above n 94, at 5-8; Wilson, McGregor and Bell, above n 94, at 153-155.

140 Breen, above n 137.

141 Breen, above n 137.

Accountability is vital as it ensures that governments are answerable to their citizens and the international community for their actions. Concerning mental health for tamariki, and rangatahi Māori, the absence of an enforceable right leaves them without effective means to hold the government liable for any violations.

There are other provisions in the Pae Ora Act which have the potential to improve health care for Māori, but these also have limitations, particularly in relation to the mental health of tamariki and rangatahi Māori. Furthermore, implementation is also bedevilled by challenges including scarcity of resources. The Pae Ora Act establishes entities like Te Whatu Ora to improve healthcare access and service availability across various communities, with a particular emphasis on Māori. This initiative seeks to enhance culturally appropriate healthcare provision for Māori, including tamariki and rangatahi Māori, addressing their specific needs. However, despite these intentions, the legislation does not explicitly require adequate mental health services to be accessible and available for tamariki and rangatahi Māori. A persistent lack of specialised mental healthcare services, especially in preventative care, continues to impact young Māori.[142] Apart from the narrow provisions of the Mental Health Act, the legal framework does not explicitly tackle the requirement for youth-focused and culturally sensitive services, particularly those related to mental health and preventative care for tamariki and rangatahi Māori. There is a significant need for preventative mental health services, which is not addressed by any current legislation.

The Pae Ora Act's health principles state that Māori and other population groups should have access proportionate to their health needs. Again, there are some omissions as well as challenges of enforceability. While one could argue that an objective of the Pae Ora Act is to provide culturally appropriate healthcare, neither this Act nor any other legislation mandates that all services be culturally suitable for tamariki and rangatahi Māori. Consequently, the absence of explicit mention of mental health service availability and accessibility in domestic legislation for tamariki and rangatahi Māori means that it does not meet the accessibility and availability components of the AAAQ framework. Although the author acknowledges that not every aspect needs to be detailed in legislation, the contention is that domestic law should establish a clear, measurable standard, obliging

[142] See generally Ron Paterson, Mason Durie, Barbara Disley, Dean Rangihuna, Jemaima Tiataia-Seath and Josiah Tualamali'i *He Ara Oranga Report of the Government Inquiry into Mental Health Addiction* (Government Inquiry into Mental Health and Addiction, 2018) at 22-62.

the government to realise the health rights envisioned by the UN. This topic will be explored further in Chapter Eight. While the Pae Ora Act mentions equity, it lacks enforceable provisions such as funding, wait time and competent providers.

The AAAQ framework underscores the importance of health services being culturally suitable and acceptable.[143] The Pae Ora Act acknowledges this by recognising tikanga Māori and the role of Te Aka Whai Ora in crafting health policies that reflect Māori customs and values.[144] However, the Pae Ora Act does not mandate the widespread adoption of culturally specific care practices across all health services, potentially exposing tamariki and rangatahi Māori to care that may not be in line with their cultural needs. Moreover, there is no explicit provision requiring the availability of culturally appropriate mental health services tailored to rangatahi and tamariki Māori. This absence of legislative requirements leaves cultural responsiveness dependent on policies and provider discretion rather than enforceable standards, which is problematic. This aspect aligns with the quality component of the AAAQ framework. The current mental health legislation lacks explicit, enforceable criteria to guarantee high-standard mental health services for tamariki and rangatahi Māori. No specific mechanisms exist to assess the quality of care provided to this demographic. It is worth noting the lack of a comprehensive structure to consistently ensure top-tier healthcare services that address the specific health issues encountered by Māori children and young people.

New Zealand's health legislation does not fully embody the essential cross-cutting principles required for a human rights-based approach to healthcare. Regarding equality and non-discrimination, whilst the Pae Ora Act emphasises equity, it lacks strong legal provisions to tackle systemic healthcare discrimination. The lack of clear avenues for Māori, and tamariki and rangatahi Māori particularly, to contest discriminatory practices undermines New Zealand's commitment to ensuring equitable health outcomes. This will be discussed below.

New Zealand's legislation falls short in terms of participation, another key principle. Whilst the Pae Ora Act facilitates Māori representation in health governance, its provisions are largely aspirational. For instance, s 16A mandates Health New Zealand to

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[143] *General Comment No.* 14, above n 131; *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* UN Doc A/61/338 (13 September 2006).
[144] Pae Ora (Healthy Futures) Act, above n 136, s 7.

engage with and report to Māori. Additionally, health principle 7(1)(b) stipulates that the health sector should collaborate with Māori to create and implement services and programmes that address their needs and aspirations. However, without explicit provisions ensuring the involvement of tamariki, and rangatahi Māori in the design and delivery of mental health services, their ability to meaningfully influence mental health law, policy, and service delivery is limited. Effective participation would necessitate a legal framework that empowers these groups to actively shape the mental health services they receive, which is currently lacking. Consequently, New Zealand is not fully realising the principles of participation and self-determination.

Moreover, the current legal framework lacks robust accountability measures. While the Pae Ora Act mandates reporting requirements for health organisations, it falls short in providing strong enforcement mechanisms. The Health and Disability Code offers some oversight, but it fails to provide clear legal avenues for tamariki and rangatahi Māori to seek redress or hold service providers accountable for inadequate care. There are no effective methods to ensure domestic bodies fulfil their obligations towards Māori health, especially for youth, and the lack of legal recourse for violations of the right to health undermines efforts to uphold these rights. These deficiencies indicate that New Zealand is not fully meeting its international commitments to protect, promote, and fulfil the right to health, particularly for Māori communities and their young people.

As mentioned earlier, international law sets forth four fundamental principles regarding children, which are essential for implementing a child-focused approach but examination suggests that these principles are also only partially reflected in New Zealand's health legislation.

Although non-discrimination is a fundamental aspect of international law, New Zealand's health legislation does not adequately uphold this principle at the national level. The Pae Ora Act aims to cater to Māori health needs and foster equitable outcomes, yet it lacks clear and enforceable anti-discrimination measures. This deficiency leaves Māori children and youth susceptible to both direct and systemic discrimination. There is some protection offered under the Human Rights Act and the Health and Disability Code. Yet there is a lack of specific, actionable provisions in health-related legislation.

New Zealand's health legislation also lacks explicit provisions for the best interests principle, in mental health services and health law. The Pae Ora Act, while addressing equity and health improvement, fails to mandate that decisions concerning mental health services should be guided by the best interests principle of Māori children and adolescents. This legislative gap potentially allows for decisions that may not fully consider the specific needs of tamariki and rangatahi Māori.

The right to survival and development, a fundamental principle, is inadequately safeguarded in New Zealand's health laws. Despite the Pae Ora Act's aim to enhance health outcomes, it does not establish concrete measures to ensure Māori youth receive essential mental health support for their development and well-being. The Health and Disability Code recognises the importance of developmental support[145] but does not comprehensively extend its protections to mental health services for Māori youth. Moreover, the Mental Health Act permits compulsory treatment without specific provisions safeguarding the holistic development and well-being of Māori children and youth, which contradicts international health rights obligations.

Furthermore, New Zealand's health legislation insufficiently incorporates children's and Indigenous perspectives. While the Pae Ora Act includes provisions for Māori representation in governance, it does not guarantee that Māori youth, especially those receiving mental health services, have a say in their care decisions. The Mental Health Act does not mandate that children and adolescents be given the opportunity to express their views, particularly in cases of compulsory treatment. Although the Health and Disability Code grants certain rights to individuals with disabilities, it lacks specific mechanisms to ensure children's views are prioritised in mental health or disability services. This absence of legislative guarantees for children's participation in mental health care decisions limits New Zealand's adherence to international obligations and may result in care that fails to fully respect the autonomy and unique needs of tamariki and rangatahi Māori.

Based on this evaluation of the legislation and its support for international obligations, it is contended that the existing health legislation in New Zealand fails to comply fully with international obligations, particularly concerning tamariki and rangatahi Māori. The

[145] Health and Disability Commissioner, above n 90, Right 4.

legislation inadequately addresses the AAAQ framework and other cross-cutting principles, including non-discrimination, participation, accountability and the best interests of the child. The current legal framework lacks enforceable provisions to ensure available and accessible culturally responsive and youth-specific mental health services for Māori youth. While policies exist to guide culturally appropriate care, they lack legal enforceability, resulting in inconsistent implementation and leaving Māori children and youth without robust protections or recourse, an issue that is explored further below. Furthermore, the absence of these guiding principles in enforceable health laws perpetuates inequities for Māori youth in accessing and receiving adequate mental health care, underscoring New Zealand's shortcomings in fulfilling its international human rights commitments.

7.10. The Intersection of Policy and the Law

As the discussion above shows, New Zealand has limited health legislation. Instead, there are several policies that are aimed at tackling health disparities between Māori and non-Māori. There are also strategies which target youth and children's well-being, and which extend to mental health. The convergence of law and policy plays a vital role. Legislation establishes the foundation which delineates the entitlements, responsibilities, and frameworks that dictate the functioning of healthcare systems, whilst policies set out the pragmatic methods required to realise these legal aims. Within the sphere of Māori mental health, there are policies in place. However, a considerable disparity persists between the aspirations set forth in these policies and the tangible outcomes observed in practice (as the statistics tell us).

Policies targeting the mental health of tamariki and rangatahi Māori are designed with good intentions. For example, the children and young people framework has six outcomes with one being "children and young people are happy and healthy".[146] There are several indicators associated with this outcome and in relation to mental health the indicator is the "percentage of young people who experienced high or very high levels of psychological distress at some stage over a four-week period".[147] The policy aims to provide children with good mental well-being and recovery from trauma.[148] Other

[146] Child and Youth Wellbeing, above n 110, at 1-2.
[147] At 1-2.
[148] At 1-2.

positives include initiatives promoting Kaupapa approaches to mental health care, which are grounded in Māori values. These policies and strategies often emphasise the need for holistic care models that reflect wider whānau structures (in line with the collective nature of Indigenous communities), as well as the importance of addressing the social determinants of health that disproportionately affect Māori children, such as poverty, education, and housing. However, these policies are not always effective because they lack the force of law that mandates consistent implementation, accountability and the oversight of the mental health sector.

Policies, no matter how well-designed, are only as strong as the systems that support and implement them.[149] In the absence of legislative backing, these policies can be inconsistently applied or deprioritised by local health providers. The Pae Ora Act, for instance, requires the creation of a GPS, health plan and strategy. While these are commendable aims, the absence of detailed implementation guidelines within the Pae Ora Act, or in separate legislation, results in a lack of oversight regarding enforceability and potential for ineffective implementation. Historically, various government strategies have been employed, such as the health strategy for Māori,[150] which is somewhat dated. Despite these measures, recent statistics indicate that tamariki and rangatahi Māori remain at the forefront of the mental health crisis. This highlights a discrepancy between the intended outcomes of these strategies and what is actually happening on the ground.

To address the gap between policy and practice, incorporating policy into legislation is essential. Legally mandating mental health frameworks for tamariki and rangatahi Māori could ensure a clear legal duty to provide services and establish a mechanism for accountability if these services are not delivered. Although the Pae Ora Act acknowledges the significance of equity and enhancing health outcomes for Māori, it lacks specific legislative provisions for mental health care for Māori children and youth, and fails to meet the requirements outlined in the AAAQ framework, such as measures for acceptability, accessibility, and availability. This creates a situation where policy initiatives, despite their importance, may not be consistently and sufficiently implemented across the

[149] Joel Teitelbaum, Angela McGowan, Therese Richmond, Dushanka Kleinman, Nico Pronk, Emmeline Ochiai, Carter Blakey and Karen Brewer "Law and Policy as Tools in Healthy People 2030" (2021) 27 Journal of Public Health Management and Practice 265.
[150] Ministry of Health, above n 99.

board. Furthermore, legislation possesses a distinctive capacity to establish legally binding entitlements. To illustrate, if statutory provisions were to incorporate mental health services specifically designed for tamariki and rangatahi Māori and their families would have the legal means to challenge any denial of access to culturally sensitive mental health support. Such legal requirements contrast with policy, which frequently lacks the mechanisms for individuals to hold governmental bodies or healthcare providers accountable when mental health services fail to address the particular needs of Māori communities effectively.

In summary, the preceding discussion shows that there are policies and strategies which aim to enhance and strengthen mental health services for young individuals, emphasising culturally sensitive approaches, particularly for tamariki and rangatahi Māori. However, it is also apparent that, currently, there are limited tools for enforcing these policies. Although the Pae Ora Act establishes the foundation through its Health and Treaty principles, both the policies and legislation lack concrete measures to ensure all health providers offer culturally competent, accessible, and preventative mental health services. The absence of legislative backing for these mental health service policies and plans creates deficiencies, particularly impacting Māori youth. Integrating policy objectives into legislation would reinforce obligations, establish accountability mechanisms to enforce consistent, culturally appropriate care, and hold the government directly accountable for addressing these disparities.

According to the Wai 2575 report, there seems to be a widespread discrepancy in the health sector, particularly in mental health, between policies that sound promising and the actual delivery of services.[151] The Government Inquiry into Mental Health and Addiction also expressed concern about this disparity:[152]

> Areas for action are outlined in multiple reports and strategies. Widespread agreement exists about the need for change and, in many respects, what changes should look like. Yet, despite so much consensus, the system has not substantially shifted.

[151] Gassin, above n 122 at 92.
[152] At 92.

The committee highlighted that "[w]e cannot afford to have another report that repeats the same messages but does not result in real change".[153] As the Wai 2575 report noted, minimal advancement has been achieved regarding objectives associated with "community-based assistance, preventative measures, and early interventions despite worthy policies and strategies".[154] There is a much wider problem here that needs to be addressed.

7.11. Conclusion

It is evident that there has been a substantial evolution of law and policy in the past 170 years in relation to mental health and care models as discussed in the previous chapter. The earlier part of that evolution did not recognise a human rights-based approach for the right to mental health, nor was there consideration for Māori and mental health. However, the past 40 years have witnessed the emergence of te ao Māori perspectives and recognition given to the issue of Māori mental health. The impetus for these developments was the disturbing mental health statistics, particularly for Māori. In terms of children and young people's perspectives, much of the legislative history shows there is little to no recognition in this regard, and in particular for the best interests principle for children in mental health and its use in law and policy. The Child and Young People Strategy 2019 is one of the first pieces of work done in New Zealand that required children's perspectives to be considered when drafting and implementing the strategy. Whilst New Zealand does have other health strategies and legislation such as the Pae Ora Act, there still appears to be substantial gaps, particularly for addressing the rights of Māori and tamariki and rangatahi Māori. The statistics tells us that the current mental health framework is not working for Māori communities.

This chapter discussed key legislation, including the Pae Ora (Healthy Futures) Act 2022 and the Mental Health (Compulsory Assessment and Treatment) Act 1992. It was elucidated that the Mental Health Act 1992 serves as the primary legislation for compulsory mental health treatment, containing specific provisions for children and youth, and it was also noted that the Act had some problematic aspects in its application to young people. The chapter then considered the Pae Ora Act 2022 which aimed to

[153] Government Inquiry into Mental Health and Addiction, above n 73, at 96.
[154] Gassin, above n 122, at 92.

reform the health system and address inequities by incorporating Te Tiriti o Waitangi and health principles. It was noted that this Act did not include specific mental health provisions for tamariki and rangatahi Māori. Key government strategies for mental health were noted, including He Korowai Oranga (Māori Health Strategy) and the Child and Youth Wellbeing Strategy. However, legislative gaps in the existing legal and policy landscape were identified, particularly concerning equitable mental health care for tamariki and rangatahi Māori. It was argued that without legislation that embeds the mental health needs of tamariki and rangatahi Māori within the core obligations of the health system, policies risk being little more than aspirational documents that do not translate into meaningful change. The contention is that to address the mental health disparities, effectively, New Zealand needs to move beyond policy and legislate clear, enforceable rights that mandate culturally responsive and equitable mental health services and fulfil its international obligations.

In summary, despite efforts to incorporate te ao Māori perspectives, persistent inequities for Māori remain a significant concern.[155] What can be concluded is that the current framework is insufficient to fully realise the right to mental health for Māori, and tamariki and rangatahi Māori especially. With this in mind, the next chapter examines what can be done to improve New Zealand mental health laws and particularly to address the mental health needs of tamariki and rangatahi Māori.

[155] See generally World Health Organisation "Adolescent Mental Health" (28 September 2020) World Health Organization <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>; see also OECD "New Zealand Country Highlights Doing Better for Children" OECD (2009) <https://www.oecd.org/newzealand/43589854.pdf>; see also Health New Zealand Te Whatu Ora "Suicide Data Web Tool" <https://www.tewhatuora.govt.nz/for-health-professionals/data-and-statistics/suicide/data-web-tool>.

Chapter Eight

Summary and Recommendations

8.1. Introduction

This thesis aims to explore how the best interests principle can be utilised to fulfil the right to the highest achievable standard of mental health for tamariki and rangatahi Māori in New Zealand. Statistical data reveal that tamariki and rangatahi Māori are experiencing higher levels of mental distress, with suicide rates reaching alarming proportions.[1] Despite the United Nations' robust advocacy for human rights through its conventions and New Zealand's international commitments to uphold these domestically, it is acknowledged that the practical application of these rights at the local level has not met expectations, as evidenced by the troubling statistics.[2] As emphasised by Secretary-General Kofi Annan in 2005:[3]

> For much of the past 60 years, our focus has been on articulating, codifying and enshrining rights. That effort produced a remarkable framework of laws, standards and mechanism – the Universal Declaration, the international covenants, and much else. Such work needs to continue in some areas. **But the era of declaration is now giving way, as it should, to an era of implementation. [emphasis added]**

Previous chapters have illustrated that, despite legal and policy efforts, New Zealand is not effectively implementing these mental health rights. It is argued that national legislation and policies are crucial to enhance the mental health rights of tamariki and rangtahi Māori in New Zealand and to align the country more closely with international human rights standards. This chapter suggests legislative amendments that could assist

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[1] See generally World Health Organisation "Adolescent Mental Health" (28 September 2020) World Health Organization <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>

[2] See generally OECD "New Zealand Country Highlights Doing Better for Children" OECD (2009) <https://www.oecd.org/newzealand/43589854.pdf>; see also Health New Zealand Te Whatu Ora "Suicide Data Web Tool" <https://www.tewhatuora.govt.nz/for-health-professionals/data-and-statistics/suicide/data-web-tool>.

[3] Kofi Annan, Secretary-General of the United Nations "Secretary-General's Address to the Commission on Human Rights" (61st Session of the Commission on Human Rights, Geneva, 7 April 2005); Gillian MacNaughton and Angela Duger "Translating Law into Domestic Law, Policy and Practice" in Lawrence Gostin and Benjamin Meier (eds) *Foundations of Global Health & Human Rights* (Oxford University Press, Oxford, 2020) 113 at 114.

New Zealand in progressing towards this goal. Before developing recommendations, a summary of the current situation is presented to advocate for the importance of adopting a human rights-based legislative response. This will be the focus of the subsequent section of this chapter.

8.2. Why a Human Rights Approach is Necessary?

The international human rights system that emerged in 1945 through the Charter of the United Nations[4] and subsequent human rights instruments adopted by the UN General Assembly obligates all sovereign states to respect and protect human rights. Given this, the contemporary human rights framework is unquestionably anchored in a state-centric approach. Therefore, it is paramount to evaluate how international human rights norms are internalised in national legislation, administrative procedures, and practical applications to promote the mental well-being of children, particularly that of Indigenous children. New Zealand has ratified the CRC and the ICESCR, and thus has a legal duty to uphold these rights within its jurisdiction.[5] The previous chapters discussed what is currently happening in New Zealand at a ground level and showed that whilst efforts have been made, there has been no specific legislative programme of implementation. It is argued that the time has come for implementation to start happening in a more intentional and methodical way.

A vital method of promoting international law and principles is the enactment of national legislation and policy, which serves as a tangible demonstration of a country's commitment to upholding these principles/international law.[6] The United Nations highlights the significance of such measures, emphasising their importance in advancing the cause of international law.[7] Consequently, it is essential that New Zealand acknowledges the value of legal and policy frameworks in achieving its objectives. To this

[4] Charter of the United Nations 1 UNTS XVI (opened for signature 26 June 1945, entered into force 24 October 1945.

[5] United Nations Convention on the Rights of the Child 1577 UNTS 3 (opened for signature 20 November 1989, entered into force 2 September 1990); International Covenant on Economic, Social and Cultural Rights 993 UNTS 3 (opened for signature 16 December 1966, entered into force 3 January 1976); MacNaughton and Duger, above n 3, at 113.

[6] At 119.

[7] See generally *General Comment No. 11 Indigenous Children and Their Rights under the Convention* UN Doc CRC/C/GC/11 (12 February 2009) at [80]; *General Comment No. 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health* UN Doc CRC/GC/15 (2013) at [94].

end, this chapter makes recommendations to enhance New Zealand's implementation of the right to health, particularly the right to mental health for children and young people with a particular focus on tamariki and rangatahi Māori.

In 2018, New Zealand initiated an investigation into its mental health and addiction system.[8] The report from this inquiry urgently called for reforms to improve New Zealand's approach to mental health and addiction, and to make more resources available to those in need of support.[9] A crucial finding was the overwhelming call from Māori to recognise their indigeneity and affirm their rights, particularly in determining how health services are "commissioned, delivered, and evaluated".[10] This emphasis stems from the disconnection between Western mental health models and Māori holistic health perspectives. The report identified several critical issues in the current health system, including alarmingly high youth suicide rates, described by many as a national disgrace, and significant service gaps for individuals with mild to moderate and moderate to severe needs.[11] The perceived ineffectiveness and inefficiency of the current system were characterised by an over-reliance on medication, difficulties in meeting specialist service criteria, and challenges in discharge planning.[12] Additionally, the study highlighted a lack of available services, and limited access to services for people in rural areas.[13] These findings illustrate the need for a comprehensive overhaul of the mental health system, with a particular focus on culturally appropriate services and improved accessibility across all regions and levels of care.

Since 2019, the government has implemented several measures in response to these recommendations outlined in the report. Some of these measures include the Kia Manawanui Aotearoa: Long-term Pathway to Mental Well-being (a 10-year government strategy released in 2021), the investment of $1.9 billion dollars into a mental well-being package, and the establishment of the Suicide Prevention Office and the

[8] Ron Paterson, Mason Durie, Barbara Disley, Dean Rangihuna, Jemaima Tiataia-Seath and Josiah Tualamali'i *He Ara Oranga Report of the Government Inquiry into Mental Health Addiction* (Government Inquiry into Mental Health and Addiction, 2018).
[9] At 95.
[10] At 39-41.
[11] At 35-62.
[12] At 35-62.
[13] At 35-62.

Mental Health and Wellbeing Commission.[14] Currently New Zealand is repealing and replacing the Mental Health (Compulsory Assessment and Treatment) Act 1992 to better protect individual rights and safety of those that may require compulsory treatment.[15]

Despite the initiatives implemented, the most recent statistics indicate that the mental health of young people is not improving, and it is tamariki and rangatahi Māori who are at the forefront of this issue.[16] It is evident that despite government efforts, the challenge persists and more needs to be done to address this pressing issue. One way to address this urgent issue is to refer to international human rights law which provides a framework for promoting and protecting the rights of children. By upholding the best interests of the child principle, in the context of this thesis, the best interest of the Indigenous child, it can help to ensure that all efforts to address this issue prioritise the right to mental health of the Indigenous child.

Incorporating international health rights law into domestic legislation and policy can offer a strong mechanism for addressing the mental health needs of tamariki and rangatahi Māori in New Zealand. Human rights law provides international standards to frame legal accountability for the progressive realisation of health-related human rights. International law links individual rights holders and their entitlements with corresponding state duty bearers and their obligations. The realisation of human rights necessitates a demand on the State duty bearer to respect, protect or fulfil a particular right through governmental actions, including, but not limited to, legislative reforms, budgetary allocations or programme evaluations.[17] The consistent application of a rights-based approach also requires appropriate policy frameworks. As Palmer and Geiringer say, taking a rights-

[14] The powers of the Mental Health and Wellbeing Commission are outlined in the Mental Health and Wellbeing Commission Act 2020, s 12. They are largely to report publicly, and make recommendations to the government.

[15] Sonya Russell "New Mental Health Bill – Are We There Yet?" *Te Hiringa Mahara – Mental Health and Wellbeing Commission* (20 May 2025) at [1].

[16] Health New Zealand, above n 2; See also Roshini Peiris-John, Judy Ball, Terryann Clark, Terry Fleming and the Adolescent Health Research Group *Youth Mental Health Needs and Opportunities: Leveraging 25 Years of Research from the Youth2000 Survey Series* (The University of Auckland, Victoria University of Wellington and University of Otago, 2024); Hiran Thabrew, David Chinn and Krinn Isherwood "Navigating Youth Mental Health" 23 September 2023, He Ako Hiringa Learning Always <Navigating youth mental health | He Ako Hiringa>.

[17] Lawrence Gostin, Matiangai Sirleaf and Eric Friedman "Global Health Law: Legal Foundations for Social Justice in Public Health" in Lawrence Gostin and Benjamin Meier (eds) Foundations of Global Health & Human Rights (Oxford University Press, London, 2020) 45 at 48.

based approach to human rights domestically requires the government to also "incorporate rights-based analysis into policy development". [18]

In developing a rights-based approach and implementing human rights there are international examples that can provide helpful guidance and well-established principles, and which can serve as a framework for a national government to meet their responsibility to ensure fair distribution of health-related benefits.[19] As Gruskin and Tarantola state:[20]

> …looking at synergies and trade-offs between health and human rights and working, within a framework of transparency and accountability, toward achieving the highest attainable standard of health. Central in all settings are the principles of non-discrimination, equality, and to the extent possible the genuine participation of affected communities.

Green and Titti state that adopting a rights-based approach involves two essential factors. Firstly, it is crucial that the objectives of a policy, programme or project reflect the substance of relevant human rights. Secondly, the implementation of the policy, programme, or project must adhere to human rights principles.[21] By implementing a rights-based approach, the goals and processes at all levels of the activity are examined in the light of human rights, including the assessment of needs and the planning, implementation, monitoring, and evaluation of the activity.[22]

8.3. What Does the Best Interest of the Indigenous Child within the Right to Health Look Like?

As has been argued in this thesis, there is international consensus that the best interests principle "provides a decision-maker with the flexibility to tailor a decision to a child's

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[18] Claudia Geiringer and Matthew Palmer "Human Rights and Social Policy" (2007) 12 Social Policy of New Zealand 12.

[19] Flavia Bustreo and Curtis Doebbler "The Rights-Based Approach to Health" in Lawrence Gostin and Benjamin Meier (eds) Foundations of Global Health & Human Rights (Oxford University Press, London, 2020) 89 at 94.

[20] At 95; see also Sofia Gruskin and Daniel Tarantola "Health and Human Rights: Overview" in Kris Heggenhougen and Stella Quah (eds) *International Encyclopaedia of Public Health* (Oxford Academic Press, London, 2008).

[21] Maria Green and Titti Mattsson "Health, Rights and the State" (2017) 62 Scandinavian Studies in Law 177 at 185.

[22] At 185.

individual circumstances".[23] The CRC Committee has endorsed this view and stated that "the concept of the child's best interests is flexible and adaptable"[24] to the needs of each child including the collective rights of Indigenous communities. The best interests principle is capable of integrating collective cultural rights of Indigenous communities given this flexibility. In particular, the CRC Committee emphasised that best interests of the child "is both collective and individualistic".[25] Scholars concur that the best interests principle is fundamental in ensuring that cultural sensitivity and respect for diversity underpin all rights outlined in the CRC.[26] This principle recognises that a child's well-being is intricately linked to their multifaceted environment, encompassing social, economic, cultural, political, community, and family aspects.[27] Correspondingly, the best interests principle resists abstract definition and necessitates interpretation within each child's unique cultural framework, which makes it particularly adaptable to cultural contextualisation.[28] This approach enables a more sophisticated understanding of cultural rights, acknowledging that culture is an integral and inseparable component of a child's overall well-being.[29]

In New Zealand, there has been opposition regarding the application of the best interest principle to tamariki and rangatahi Māori, on the basis that the CRC does not reflect Māori perspectives on children and families.[30] However, it is argued that when evaluating the best interests of an Indigenous child, states should take into account the child's cultural rights and their need to exercise these rights collectively with other members of their Indigenous community.[31] This consideration is essential in the assessment process.[32] Evidence of this approach is readily apparent in New Zealand's judicial system. As

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[23] John Eekelaar and John Tobin *The UN Convention on the Rights of the Child* (Oxford, Oxford University Press, 2019) at 74-105.

[24] At 74-105.

[25] *General Comment No. 11,* above n 7*,* at [28]-[30].

[26] John Tobin *The UN Convention on the Rights of the Child: A Commentary* (1st ed, Oxford, Oxford University Press, 2019) at 1156.

[27] At 1156.

[28] At 1156; see also Patrick Thornberry *Indigenous Peoples and Human Rights* (Manchester, Manchester University Press, 2002) at 22; see Chapter Three for a discussion on the interpretive and flexibility nature of the best interest principle.

[29] Tobin, above n 26, at 1156.

[30] Alison Cleland "Realising Māori Children's Rights Unconventional Thinking Required" (2023) 31 The International Journal of Children's Rights 3 at 22-32.

[31] *General Comment No. 11*, above n 7, at 30-33.

[32] Te Puna Rangahau o te Wai Ariki Aotearoa New Zealand Centre for Indigenous Peoples and the Law *Thematic Report: The Rights of Tamariki Māori in Aotearoa New Zealand* (The University of Auckland, August 2022) at 10.

discussed in Chapter Three, the application of the best interests principle in New Zealand, under the Care of Children Act ("COCA") and Oranga Tamariki Act ("OT Act") is happening, albeit in a limited scope. From that analysis, it can be concluded that the Courts give consideration to the significant impact of cultural needs and family relationships on a child's overall well-being.[33] The courts place emphasis on Māori cultural values, worldview, and the importance of family in collaborative decision-making.[34] What appears from the case law is that the courts' assessments encompass a comprehensive view of well-being, acknowledging the interconnectedness of cultural, familial, and individual factors in promoting positive outcomes for children.[35]

As canvassed in Chapter Four, there are different interpretations of what health and well-being means in the normative framework as compared to Indigenous communities' understanding of health as being "holistic, incorporating spiritual, environmental, cultural and social dimensions in addition to physical health".[36] In the context of New Zealand's healthcare landscape, Durie and Whitinui emphasise including Māori cultural elements, such as whānau, whakapapa, and tikanga Māori, in healthcare frameworks as well as advocating for the incorporation of international instruments, like the UNCROC and UNDRIP, in the design, execution, evaluation, and monitoring of health-related initiatives. This holistic perspective aims to enhance health outcomes by ensuring that policies, systems, and interventions are culturally sensitive and rights-based, particularly in areas such as mental health.[37]

It was shown that the prevalence and one-sided view of Westernised health ideologies and practices have created a significant barrier to Māori being able to fully embrace and

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[33] See generally, Care of Children Act 2004; Oranga Tamariki Act 1989.

[34] For example: *McHugh v McHugh* [2022] NZHC 1174.

[35] It must be noted that there may be disagreement in terms of Court's assessment of te ao Māori in New Zealand; *Expert Mechanism on the Rights of Indigenous Peoples Study on the Right to Health and Indigenous Peoples with a Focus on Children and Youth* UN Doc A/HRC/33/57 (10 August 2016).

[36] Steve Macbeth "The Application of the Best Interests Principle to Māori Children's Collective Cultural Rights: A Conceptual Shift for the New Zealand Family Court?" (LLM Dissertation, University of Waikato, 2015) at 23; Justice Eddie Durie "Constitutionalising Māori" in Grant Huscroft and Paul Rishworth (eds) Litigating Rights: Perspectives from Domestic and International Law (Hart Publishing, Oxford, 2002) 241 at 253.

[37] Paul Whitinui "The Treaty and "Treating" Māori Health: Politics, Policy and Partnership" (2011) 7 AlterNative An International Journal of Indigenous Peoples 138; Mason Durie "Pūmau Tonu Te Mauri Living as Māori Now, and in the Future" (Ministry of Māori Development, Discussion Paper, 2017); Paula King, Donna Cormack, Mark Kōpua "Oranga Mokopuna A Tāngata Whenua Rights-based Approach to Health and Wellbeing" (2018) 7 Mai Journal 186.

utilise their specific cultural practices in relation to health and well-being. Indigenous mental health is framed as "a complex field of inquiry"[38] and ways of addressing this issue must be developed by Indigenous communities themselves as they "experience and conceptualise mental well-being within a relational and holistic continuum"[39] and the "unique determinants of health [they experience]".[40]

Complementing this holistic view of health are collective rights.[41] Global agreements such as the UNDRIP uphold collective rights for Indigenous peoples, encompassing self-determination and involvement in decision-making processes. In healthcare contexts, a significant interplay exists between individual and collective rights for Indigenous populations, given that Indigenous identities are fundamentally rooted in communal settings. Consequently, a rights-oriented approach to the right to health for tamariki and rangatahi Māori should integrate collective rights perspectives and Māori concepts of health and well-being and collective rights.[42] The understanding is that the rights of the individual and that of the group, whānau, iwi and hapū, are "indivisible".[43] There are reciprocal obligations for both the individual and the collective group. These obligations are predominately founded on "precedent handed down by tipuna".[44] The group takes responsibility for the actions of the individual. Such kinship relationships "strengthens the reciprocal group obligations".[45] This demonstrates a society that is "based on collective responsibility of its members to the group."[46] Therefore, in order to determine the best interests of tamariki and rangatahi Māori in the mental health space, their collective cultural rights must also be considered. One simply cannot be considered without the other. These key components of the Māori worldview need to be recognised in the application of the best interests principle in domestic law, and specifically in legislation related to the mental health of Māori tamariki and young people if New Zealand is to make improvements to the mental health crisis facing tamariki and

[38] Constance McIntosh "Indigenous Mental Health: Imagining a Future Where Action Follows Obligations and Promises" (2017) 54(3) Alberta Law Review 589 at 591.
[39] At 591.
[40] At 591.
[41] Nicolas Calera "The Concept of Collective Rights" (2003) 34 Rechtstheorie 351 at 36.
[42] Will Kymlicka *Multicultural Citizenship: A Liberal Theory of Minority Rights* (Clarendon Press, Oxford, 1995) at 58.
[43] Waitangi Tribunal *He Pāharakeke, he Rito Whakakīkinga Whāruarua Oranga Tamariki Urgent* (Wai 2915, 2021) at 62.
[44] Macbeth, above n 36, at 27.
[45] At 24.
[46] Macbeth, above n 36, at 27.

rangatahi Māori. The discussion in the following sections sets out the proposed recommendations to achieve these improvements.

8.4. The Recommendations in a Visual Format

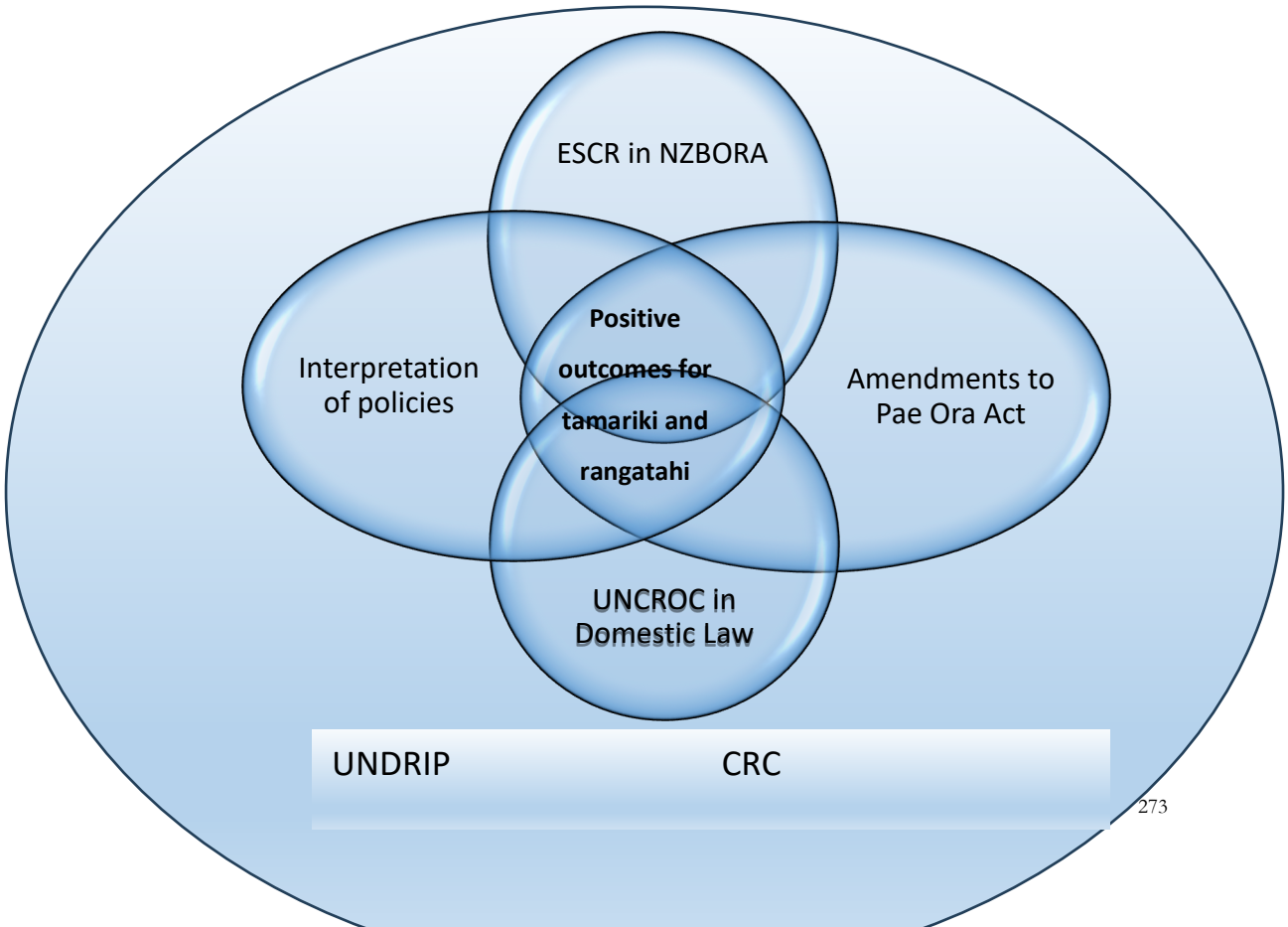
The diagram below visually represents a proposed comprehensive approach to improving mental health services for tamariki and rangatahi Māori. The diagram outlines three key areas of recommended legislative and policy changes:

(i) Incorporating economic, social and cultural rights, including the right to health, into the NZBORA;

(ii) Amending the Pae Ora (Healthy Futures) Act 2022 to include specific provisions for culturally appropriate mental health services for children, and in particular tamariki and rangatahi Māori; and

(iii) Incorporating the CRC, particularly the best interests principle, into domestic law.

These interconnected recommendations aim to create a stronger legal framework to protect the mental health rights of tamariki and rangatahi Māori and guide the development of culturally appropriate services.



The outer sphere of the diagram represents how the UNDRIP and the CRC provide a robust foundation for asserting that tamariki and rangatahi Māori have the right to culturally responsive, high-quality healthcare that aligns with Māori worldviews. As this thesis has argued, the 'best interests' principle recognises that the best interests of a child are not solely determined by Western individualistic perspectives but can encompass the child's cultural collective rights. In the context of Māori health, this flexibility allows for the incorporation of collective well-being and cultural practices into mental healthcare approaches that are culturally appropriate and meaningful for tamariki and rangatahi Māori. Based on these interconnected elements, the following proposals have been developed to establish the optimal legislative framework for integrating the child's best interests principle into national law. In the realm of mental health, these recommendations aim to encourage the government not only to consider, but also implement, measures for respecting, fulfilling, and safeguarding the right of tamariki and rangatahi Māori to achieve the highest possible standard of mental health

The following sections expand on these proposals.

8.5. A Case for Incorporating Economic Social and Cultural Rights (ESCR) into the NZBORA

The incorporation of human rights into a nation's constitution is regarded as one of the most efficacious methods for safeguarding these rights at the domestic level.[47] Consequently, constitutional provisions safeguarding fundamental rights serve as powerful legal instruments to "respect, protect and promote human rights".[48] According to Palmer and Butler, the current constitutional framework in New Zealand provides less robust legal protection for human rights than many nations with which New Zealand is typically compared.[49] New Zealand currently has a collection of legislative instruments

[47] Margaret Bedggood "Constitutionalising Rights and Responsibilities in Aotearoa/ New Zealand" (1989) 9 Otago Law Review 343 at 344; see also United Nations Good Governance Practices for The Protection of Human Rights (United Nations Publication, Report, 2007) at 4-5.

[48] Christina Murray "Protecting Human Rights in Constitution" (United Nations Development Programme, Report, 2003) at 1.

[49] Geoffrey Palmer and Andrew Butler *Towards Democratic Renewal: Ideas for Constitutional Change in New Zealand* (Victoria Press, Wellington, 2018) at 153.

that purport to safeguard certain human rights. These are mainly limited to the NZBORA and the Human Rights Act 1993.[50]

As outlined in Chapter Seven, the NZBORA is described as a set of guidelines that provide direction for the entire process of government serving as a means of ensuring principled governance in New Zealand, and being pivotal to statutory interpretation, law and policy making. However, there are some significant limitations,[51] a key one being that the NZBORA omits economic, social and cultural rights, such as the right to health.[52]

Pertinent to this thesis, this means that there is no general right to health in domestic law. As such, there is no legal requirement for the progressive realisation of ESCR, and domestic law does not prohibit retrogressive measures or unjustifiable limitations with regard to ESCR. The absence of ESCR in the NZBORA means that their influence on statutory interpretation, lawmaking, and policy formulation is significantly diminished.[53] This also pertains to the Human Rights Review Tribunal's ("HRRT") jurisdiction, including its capacity to determine that a statute is at odds with NZBORA's provision for freedom from discrimination. The key point is that "the New Zealand Courts lack the ability to test state and/or private actions against broad [ESCR] protections",[54] because "domestic law … does not recognise ESCR themselves as fundamental, justiciable rights".[55]

The need to give legislative protection to ESCR has been advocated for at an international level. In 2018, the CESCR reiterated the importance of New Zealand incorporating ESCR into its legal framework, thereby affording ESCR equal legal standing with civil and

[50] Bedggood, above n 47, at 344; see also United Nations, above n 47, at 344-351.
[51] Geoffrey Palmer "The Bill of Rights Fifteen Years On" (Keynote Speech for the Ministry of Justice Symposium on the New Zealand Bill of Rights Act 1990, Wellington, 10 February 2006) at [28]–[29]; see also Joss Opie "A Case for Including Economic, Social and Cultural Rights in the New Zealand Bill of Rights Act 1990" (2012) 43 VUWLR 471; Geoffrey Palmer "A Bill of Rights for New Zealand" (Legal Research Foundation Inc Seminar, New Zealand, 16 August 1985).
[52] Palmer and Butler, above n 49, at 152.
[53] Opie, above n 51, at 471-516; There is a requirement under the Cabinet Manuel for Minister to identify potential inconsistencies between bills and international obligations; see Cabinet Office *Cabinet Manual 2008* (Cabinet Office, Wellington, 2008)at [7.60]; see also Geiringer and Palmer, above n 18, at 37; Cabinet Office *Cabinet Manual 2023* (Cabinet Office, Wellington, 2023).
[54] Geiringer and Palmer, above n 18, at 37; see also Opie, above n 53, at 481.
[55] Opie, above n 51, at 476.

political rights.[56] Incorporating ESCR, thereby the right to health, into New Zealand domestic law is easily achieved by integrating these rights into the NZBORA, as this grants them independent legal standing as "free-standing rights that directly influence statutory interpretation, law, and policy-making".[57] Recommendations of this kind have been made previously by several United Nations bodies, including the CESCR and the UN General Assembly's Universal Periodic Review and these have been rejected by the government.[58] The government maintains that these rights are already safeguarded by individual statutes.[59] However, the Human Rights Foundation of Aotearoa presents a compelling counterargument: if these rights are indeed protected by existing legislation, there should be no objection to their inclusion NZBORA.[60]

The need to include ESCR into the NZBORA is largely driven by the relatively weak impact of international obligations on domestic implementation and the prevailing view holds that without formal domestic implementation, these international instruments are considered "soft law".[61] This term denotes quasi-legal measures that lack legally binding force, regardless of the country's signatory status and associated responsibilities.[62] On this point it must be noted that Article 27 of the Vienna Convention on the Law of Treaties stipulates that states cannot use inadequate national law as an excuse for non-compliance, while Article 26 implies an obligation on states to act in good faith.[63] Failing to incorporate international law into domestic law constitutes a breach of New Zealand's binding international obligations.[64] Should ESCR be integrated into the NZBORA, this will impose a legal duty on governmental bodies and policymakers to explicitly consider

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[56] *Concluding Observations on the Fourth Periodic Report of New Zealand* UN Doc E/C.12/NZL/CO/4 (1 May 2018) at [5].

[57] Opie, above n 53, at 503.

[58] *Concluding Observations on the Combined Twenty-first and Twenty-second Periodic Reports of New Zealand* UN Doc CERD/C/NZL/CO/21-22 (2017) at 4-5; *Consideration of Reports Submitted by States Parties under Articles 16 and 17 of the Covenant* UN Doc E/C.12/NZL/CO/3 (18 May 2012); see also Human Rights Foundation of New Zealand *Universal Periodic Review of New Zealand 18th Session of the Working Group to the UPR* (Human Rights Foundation, Joint Stakeholders Report, 2014); Margaret Wilson, Judy McGregor and Sylvia Bell "The Impact of Economic and Social Human Rights in New Zealand Case Law" (2015) 25 Australian Journal of Human Rights 143 at 153-155.

[59] Human Rights Foundation, above n 58, at 4-5.

[60] At 5.

[61] Valmaine Toki *Indigenous Courts, Self-Determination and Criminal Justice* (Routledge, London, 2018) at 143.

[62] Toki, above n 61, at 143.

[63] Law Commission *A New Zealand Guide to Ineternaitonal Law and Its Sources* (NZLC E 31X, May 1996); Vienna Convention on the Law of Treaties 1155 UNTS 331 (opened for signature 23 May 1969, entered into force 27 January 1980).

[64] Geiringer and Palmer, above n 18, at 21.

related obligations when formulating laws and policies. The phrasing of the rights could be modelled on the Covenant itself. A reference to the Covenant could be included in the preamble, in a manner akin to the mention of the ICCPR.[65]

The inclusion of ESCR in the NZBORA would augment the strength of review at the legislative stage and create stronger legislation that aligns with New Zealand's international obligations.[66] It would also mandate that Parliament explicitly notify its intention to protect ESCR, thereby fostering greater public awareness of issues surrounding the limitation of fundamental rights and increasing public pressure to protect those rights. This would also elevate the level of government accountability and oversight for its actions or inactions, compelling the government to respect, fulfil, and protect human rights, including the right to health. On this point, the comments of Opie are noteworthy:[67]

> All of these reasons providing [civil and political rights] with a special status in the NZBORA applied with equal force to ESCR (and continue to apply today) ... The inclusion of ESCR in the NZBORA could have slowed the pace of the reforms: tempered their severity by contributing to a more cautious approach from the outset; encouraged more robust and evidence-based policy; promoted ESCR through expressly requiring ESCR-consistent interpretations of legislation where such interpretations were open; and led to the identification of conduct that was inconsistent with ESCR (thereby protecting and upholding these rights). Justiciable ESCR could have provided an important and democratic check on the State's power, particularly given the context of democratic failure in which the reforms occurred.

The proposed inclusion of ESCR in the NZBORA could also advance the development of common law, mirroring the progress of New Zealand's legal system in relation to civil and political rights that has unfolded over time.[68] As evident, case law has served to clarify the intrinsic features of the prevailing NZBORA rights.[69] Such a model would provide

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[65] Daniel McDougall "The Vibe of the Thing: Implementing Economic, Social and Cultural Rights in New Zealand" (2021) 27 Auckland Law Review 21 at 86-109.

[66] At 109-112; Peter Hogg and Allison Bushell "The Charter Dialogue between Courts and Legislatures (Or Perhaps the Charter of Rights Isn't Such a Bad Thing after All)" (1997) 35 Osgoode Hall Law Journal 75 at 79.

[67] Opie, above n 51, at 501-502; See also McDougall, above n 65, at 148.

[68] McDougall, above n 65, at 109-112.

[69] Take for example *Hosking v Runting & Others* [2004] NZCA 34; see also McDougall, above n 65, at 109-112.

guidelines for Parliament and the judiciary on the content to these rights and permissible limitations. In practical terms, implementing the proposal would be facilitated by the fact that the CESCR and other United Nations bodies have conducted extensive work that can inform the Courts and Parliament on how to implement the ESCR. Likewise, it is essential to recommend that New Zealand has endorsed the Optional Protocol to the ICESCR,[70] which would enable New Zealand citizens to lodge complaints with the CESCR concerning violations of their right to health.

8.6. What is the Significance of Integrating ESCR into the NZBORA?

As has been suggested, incorporating ESCR into NZBORA can provide the foundation for firmly establishing the international right to health on the domestic level and ensuring that this right is considered in both legislative and interpretative decisions. The CRC Committee emphasises that States parties must be held responsible for fulfilling their obligations to ensure that relevant governmental bodies and service providers maintain the highest possible standards of health and healthcare for children.[71] This is in line with Article 2(1) of the ICESCR which obligates State parties to achieve progressively the full realisation of all rights recognised by the Covenant. As Article 2 is resource-dependent, the CESCR has issued a general comment stating that even when resource availability is inadequate, the State must ensure the satisfaction of the very least minimum essential levels of each of the rights.[72] The importance of having appropriate domestic legislative frameworks to support the implementation of the right to health is also highlighted in General Comment No. 14.[73]

Additionally, the obligation to fulfil (facilitate) requires States to take affirmative steps that empower individuals and communities to exercise their right to health. When individuals or groups are unable to realise a specific right contained in the Covenant due to circumstances beyond their control, States parties are also obligated to fulfil (provide) that

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[70] Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (adopted and opened for signature 10 December 2008, entered into force 5 May 2013).

[71] *General Comment No. 5 General Measure of Implementation of the Convention on the Rights of the Child* CRC/GC/2003/5 (27 November 2003).

[72] *General Comment No. 3 The Nature of States Parties Obligations* UN Doc E/1991/23 (14 December 1990); see also MacNaughton and Duger, above n 3, at 115.

[73] *General Comment No. 14 The Right to the Highest Attainable Standard of Health (art. 12)* UN Doc E/C.12/2000/4 (11 August 2000); *General Comment No. 15,* above n 7, at [94].

right.[74] The obligation to fulfil (promote) the right to health mandates that States undertake actions to establish, maintain, and restore the population's health.[75] These obligations encompass:

(i) Encouraging recognition of factors that contribute to positive health outcomes;

(ii) Ensuring culturally appropriate health services and training healthcare staff to identify and address the specific needs of vulnerable or marginalised groups;

(iii) Ensuring the State meets its obligations in disseminating relevant information about healthy lifestyles, nutrition, harmful traditional practices, and service availability; and

(iv) Assisting people in making informed decisions about their health.[76]

To ensure that these obligations are met, legislative amendments are essential for State Parties to fulfil the right to health and, as such, national legislation should impose a legal obligation on the State to deliver services, programmes, and the necessary infrastructure and resources to achieve the right to health, particularly for children. Regrettably, without the right to health enshrined in domestic law, there is no legislative foundation to necessitate or prompt government accountability as advocated by the UN.

Acknowledging the importance of establishing national frameworks to uphold the international commitment to safeguard the right to health, the NZBORA is an ideal location to integrate this right and the broader ESCR. The inclusion of all of ECSR is argued for on the basis that all aspects of ESCR are inter-related and indivisible. This is due to the interrelatedness of human rights, which stipulates that "all human rights are equal and interrelated and that human rights will not be protected if one set of rights is accorded a privileged status".[77] While numerous discussions exist on this subject, this

[74] *General Comment No. 14,* above n 73*,* at [36]-[37].
[75] At [36]-[37].
[76] At [36]-[37].
[77] McDougall, above n 65, at 95.

thesis does not explore these debates in depth. Instead, it acknowledges the principle of indivisibility.[78]

The principle of indivisibility is relevant to this thesis. As discussed in Chapter Three, it is widely recognised that a child's mental well-being is intrinsically linked to other aspects of their lives, such as education and socio-economic factors. This interconnectedness underscores the importance of a holistic approach to children's rights and well-being and stresses that the right to mental health cannot be examined in isolation.[79] This is why it is argued that all ESCR rights should be included in the NZBORA. Furthermore, the appropriateness of the NZBORA as a place to entrench these rights stems from its function as: [80]

a set of minimum standards to which public decision making must conform" and to "…educat[e] people about the significance of their fundamental rights and freedoms in New Zealand society. Citizens will have a readily accessible set of principles by which to measure the performance of the Government and to exert an influence on policy making. An awareness of basic human rights and fundamental freedoms…is a powerful weapon against any Government which seeks to infringe them.

In terms of mental health, the integration of the right to health into New Zealand's domestic legislation would influence mental health rights, especially for tamariki and rangatahi Māori. This incorporation would facilitate the alignment of New Zealand's mental health systems with the principles and language of General Comment No. 14, emphasising the importance of accessible, culturally appropriate, and non-discriminatory services. It would also provide a legal mechanism to hold the government and health authorities accountable for their implementation of the right to health, in other words, the actual delivery of appropriate mental health services that meet the elements of the

[78] Craig Scott "Reaching Beyond (Without Abandoning) the Category of Economic, Social, and Cultural Rights" (1999) 21 Human Rights Quarterly 633 at 644; see also James Nickel "Indivisibility and Linkage Arguments: A Reply to Gilabert" (2010) 32 Human Rights Quarterly 439 at 436-446; Kenneth Roth "Defending Economic Social and Cultural Rights: Practical Issues Faced by an International Human Rights Organization" (2004) 21 Human Rights Quarterly 63 at 63 ; Aryeh Neier "Social and Economic Rights: A Critique" (2006) 13 Human Rights Quarterly 1 at 1–3.

[79] Shiv Gautam, Akhilesh Jain, Jigneshchandra Chaudhary, Manaswi Gautam, Manisha Gaur and Sandeep Grover "Concept of Mental Health and Mental Well-being, It's Determinants and Coping Strategies" (2024) 66 Indian Journal of Psychiatry 231.

[80] Opie, above n 51, at 501.

right to health (as discussed in Chapter Four).[81] Likewise, this approach would concurrently strengthen the rights granted to Indigenous populations, as well as their entitlement to health and autonomy under Article 24 of the UNDRIP. This is supported by the EMRIP who asserts that the right to health is a crucial element of Indigenous peoples' existence and a fundamental component of their right to self-determination. Complete realisation of health-related rights cannot be achieved without self-determination.[82] Considering the UNDRIP's emphasis on Indigenous peoples' right self-determination, integrating the right to health into New Zealand legislation would offer Māori a robust foundation to actively participate in the development and determination of mental health initiatives affecting their communities. Such an approach would necessitate the engagement of Māori communities in shaping mental health policies and programmes, ensuring their cultural relevance and effectiveness. Ultimately, this would go towards strengthening the legal foundation for equitable health outcomes for tamariki and rangatahi Māori.

It is worth noting that objections have been raised against this proposal, which should be acknowledged here. One of the main arguments against incorporating ESCR into domestic law is the role the courts will have in influencing government decision-making and resource distribution.[83] Palmer contends that New Zealand's judiciary is not well-positioned to evaluate the broad spectrum of social policy matters involved in cases related to ESCR. He argues that social issues are best addressed through the political process.[84] More recently, Palmer and Butler reiterated their concern " about whether our courts should be the forum in which such issues are determined".[85] Yet, as McDougall highlights, both the BORA and the Human Rights Act evidently assign a part for the judiciary in scrutinising government authority, in the context of the sentencing decisions and the cost of incarcerating an inmate. It seems inconsistent to contest the judicial enforceability of ESCR merely on the grounds that courts should not encroach upon the separation of powers, as this principle is already recognised in other contexts.[86] Instead it

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[81] Claire Breen "A Major New Law Aims to 'Improve the Health of All New Zealanders'- So Why Doesn't It Include the Basic Human Right to Health?" (15 June 2022) The Conversation <https://www.waikato.ac.nz/news-events/news/a-major-new-law-aims-to-improve-the-health-of-all-new-zealanders-so-why-doesnt-it-include-the-basic-human-right-to-health/>.

[82] *Expert Mechanism on the Rights of Indigenous People*, above n 25, at 3.

[83] McDougall, above n 65, at 93.

[84] McDougall, above n 65, at 93; see generally Geoffrey Palmer, above n 51.

[85] Palmer and Butler, above n 49, at 162.

[86] McDougall , above n 65, at 95.

is argued that "…ESCR are reasonable rights, capable rights, capable of implementation and judicial enforcement".[87] While some may contend that it would be too burdensome for the judiciary to consider violations of ESCR, it is important to remember that judges are often tasked with navigating new areas of the law, just as they did when the BORA was first introduced.[88]

8.7. Justiciability

It is contended that incorporating ESCR into the NZBORA not only helps to guarantee these rights but can establish effective legal mechanisms for individuals or groups whose health rights have been violated, both domestically and internationally.[89] The UN has advocated for the inclusion of such rights into domestic legislation and even stated that "whenever a Covenant right cannot be made fully effective without some role for the judiciary, judicial remedies are necessary".[90] The integration of international agreements recognising health rights into national legal frameworks can substantially broaden and strengthen the available remedial options.[91] This incorporation would allow the courts to directly reference the Covenant when ruling on breaches of health rights, or at least its fundamental obligations.[92] The UN has encouraged judges and lawyers "to pay greater attention to violations of the right to health in the exercise of their functions".[93] The inclusion of ESCR into NZBORA provides a mechanism for individuals who have experienced violations of these rights to pursue effective legal recourse through domestic courts.[94] Currently, violations of NZBORA rights are justiciable and in addition to being

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[87] Opie, above n 51, at 195; see also Wilson, McGregor and Bell, above n 58, at 146. As Opie says there is no evidence to suggest that ESCR are inherently flawed. ESCR are acknowledged as justiciable in several constitutions such as Brazil, South Africa, and Finland. Opie says states that the courts in these countries have handled a range of cases involving ESCR. The rulings in these cases demonstrate that incorporating ESCR into a Bill of Rights or constitution does not render it unmanageable. In fact, constitutionalising ESCR in Brazil, South Africa, and Finland has served as an important means of curbing the powers of the legislature and executive branches of government and has provided a critical source of protection for those who have not been adequately served by democratic processes.

[88] Opie, above n 51, at 508.

[89] *General Comment No. 14,* above n 73, at [27]; see also *General Comment No. 3,* above n 72*,* at [1] and [2]; *General Comment No. 9 Domestic Application of the Covenant* UN Doc E/C.12/1998/24 (Draft, 3 December 1998*)* at [5].

[90] *General Comment No. 9,* above n 89*,* at [7].

[91] *General Comment No. 14,* above n 73*,* at [60].

[92] At [53]-[62].

[93] At [61].

[94] *Concluding Observations on the Sixth Periodic Report of New Zealand* UN Doc CRC/C/NZL/CO/6 (28 February 2023).

able award damages for any violation of these rights, the courts may also declare particular ordinary legislation to be inconsistent with the NZBORA.[95] This does not require Parliament to take corrective measures or grant any relief, but it may be viewed as imposing a moral or political obligation on Parliament to reconsider the legislation in question and provide a justification for any decision not to modify it.[96]

There is a specific process in place to deal with such inconsistencies and which could be pursued in relation to health rights if these were included in the NZBORA. The NZBORA Declarations of Inconsistency Amendment Act 2022, introduced a new system whereby the Attorney General must present to the House of Representatives a notice bringing the declaration to the House of Representatives' attention. Should a declaration be issued it is also mandated that the Minister responsible is to provide a report on the Government's response to the declaration.[97] In addition, the option exists to bring claims of inconsistency with the right to freedom from discrimination under the NZBORA to the attention of the HRRT. This Tribunal has the authority to identify inconsistencies and can award remedies such as damages, although these are not legally binding on the government. The HRRT may also grant other forms of relief.[98] Apart from these remedial measures (which are severely limited in the context of the right to health), there are limited options for individuals who have experienced violations of their right to health to seek redress. This process could be extended more effectively to health rights, if ESCR including the right to health was incorporated into the NZBORA. This inclusion would provide a legislative backbone and a mechanism for legal claims in domestic courts or other tribunals. It would be important for tamariki and rangatahi Māori, who could argue their rights are being violated. Depending on the responses to such claims, the affected parties could bring a communication complaint to the CRC Committee given that New Zealand has ratified the third Optional Protocol to CRC.[99]

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[95] Statements of inconsistency from the Court are formal declarations that a law is incompatible with the rights secured under the Bill of Rights Act 1990 (NZBORA).

[96] Opie, above n 51, at 480.

[97] New Zealand Bill of Rights (Declarations of Inconsistency) Amendment Act 2022, ss 7A and 7B.

[98] Opie, above n 51, at 480.

[99] Optional Protocol to the Convention on the Rights of the Child on a Communications Procedure (adopted and opened for signature 19 December 2011, entered into force 14 April 2014); see also Ministry of Social Development "Optional Protocols to the UN Convention on the Rights of the Child" Ministry of Social Development <https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/monitoring/uncroc/optional-protocols.html#OptionalProtocolonaCommunicationsProcedure1>.

In summary, it is proposed that the justiciability of the right to health in New Zealand could enhance government accountability and improve mental health outcomes for tamariki and rangatahi Māori by providing a legal basis to challenge government actions or inactions related to health services. This would compel the government to address health inequities faced by tamariki and rangatahi Māori. Justiciability enables individuals to seek legal remedies for violations of their right to health, prompting authorities to act in the best interest of those affected, particularly tamariki and rangatahi Māori. In the context of children's rights, it strengthens the best interests principle by offering a legal framework to challenge decisions compromising a child's health and well-being.

8.8. Incorporating CRC into Domestic Law

In addition to incorporating ESCR into the NZBORA, it is proposed that in order to augment the right to mental health for tamariki and rangatahi Māori, further legislative changes are required. New Zealand ratified the UNCRC in 1993 and is obligated to uphold its principles and rights.[100] In New Zealand, progress in embedding the Convention into domestic laws, policies and process has been poor. New Zealand's legal system appears to be falling behind international standards in this regard, and there is a disconnection between the procedures required to ensure the implementation of the Convention and the laws and processes currently in place.[101]

The data presented at the beginning of this thesis reveal that New Zealand is falling behind in addressing mental health concerns for its tamariki and rangatahi Māori. These data emphasise the need for revisions to laws and policies, to tackle these pervasive issues and enhance the mental health outcomes for tamariki and rangatahi Māori. This research supports the CRC Committee's recommendation that New Zealand incorporate the CRC into domestic law,[102] as a stand-alone Act.

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[100] Alastair Nicholson "The United Nations Convention on the Rights of the Child and the Need for Its Incorporation into Bill of Rights" (2006) 44 Family Court Review 5 at 19; International human rights treaties do not mandate governments to implement them into domestic law, it is largely at the discretion of the States.

[101] Children's Convention Monitoring Group *Getting It Right Building Blocks* G (UNCROC Monitoring Group, Thematic Report, 2018) at 27.

[102] *Concluding Observations on the Sixth Periodic Report of New Zealand* UN Doc CRC/C/NZL/CO/6 (28 February 2023) at [7]. The Committee has made this recommendation previously. See *Concluding Observations*

Whilst the focus on this thesis has been on the right to mental health, it must be noted that all human rights are indivisible and disregard or infringement of any right may impair the enjoyment of other rights.[103] Incorporating the UNCROC into domestic law would be a valuable asset in safeguarding all children's rights,[104] as constitutional and human rights. The incorporation of the UNCROC would also enhance its legitimacy and draw upon international best practices[105] and would mean that there is greater leverage to take the Convention into account when developing new policies or legislation.[106] It would also allow for an expanded application of the best interests principle outside the OT Act and the COCA.

When considering the best interests of the Indigenous child, particular attention must be given to collective cultural rights and their need to exercise rights collectively with their community.[107] As the UN has stated Indigenous communities should be consulted and afforded opportunities to contribute to determining how best interests can be decided in a culturally sensitive manner, with meaningful involvement of Indigenous children themselves where feasible,[108] and that culturally appropriate, acceptable, accessible, and high-quality mental health services are crucial.[109] Indigenous communities should be provided with resources to design, deliver, and manage mental health services for their children, with early intervention and preventative services co-designed with Indigenous communities. Mental health approaches should incorporate Indigenous healing practices and worldviews, and legislation and policy should require culturally appropriate mental health services and support for Indigenous children.[110] The best interests of Indigenous children are inextricably linked to their collective cultural rights. When assessing the best interests of Indigenous children, particularly in the context of their right to the highest attainable standard of mental health, it is crucial to consider their unique worldview,

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on the Fifth Periodic Report of New Zealand UN Doc CRC/C/NZL/CO/5 UN Doc CRC/C/NZL/CO/5 (21 October 2016).

[103] *Concluding Observations,* above n 94*,* at [4].

[104] Children's Convention Monitoring Group, above n 101; See also Robert Ludbrook and Andrea Jamison *Kids Missing Out* (UNICEF New Zealand Report) – This report does not list a publication date, given the report specifically discusses 20 years since CRC was ratified by New Zealand, it would likely be 2013 publication period/date.

[105] United Nations *Child Rights Mainstreaming* (United Nations, Guidance Note, July 2023).

[106] Ludbrook and Jamison, above n 104, at 25.

[107] *General Comment No. 11,* above n 7, at [30]-[33].

[108] *General Comment No. 11,* above n 7, at [30]-[33].

[109] *General Comment No. 14,* above n 73*,* at [12]-[13]; see also *General Comment No. 11,* above n 7, at [30]-[33].

[110] *General Comment No. 14,* above n 73*,* at [1]-[27].

collective cultural rights, and holistic approach to well-being. This necessitates the provision of culturally appropriate mental health services that align with Indigenous perspectives and practices. In the context of this thesis, the best interests of the child should be interpreted through the lens of Māori children's needs and rights. This approach recognises that Indigenous children's well-being is deeply connected to their cultural identity, community relationships, and collective rights. By acknowledging and respecting these collective cultural rights it can be ensured that the best interests principle is applied in a way that truly serves Indigenous children's holistic development and mental health.

Given the above considerations, strengthening recourse to the best interests principle is necessitated by the current legal and policy framework in New Zealand regarding mental health for tamariki and rangatahi Māori which has significant limitations in fully incorporating the best interests principle. For example, the Mental Health Act, while containing some specific provisions for children and young people, does not fully adopt a best interests approach. Recent initiatives like the Child and Youth Wellbeing Strategy 2021 and the Pae Ora (Healthy Futures) Act 2022 aim to improve mental health outcomes for young people, including Māori, but their effectiveness remains to be seen, especially as they lack explicit legislative provisions to ensure that children's views are prioritised in mental health care decisions. For their part, policies emphasise culturally appropriate care for tamariki and rangatahi Māori, but they often lack legal enforceability, resulting in inconsistent implementation. Consequently, there are significant gaps in protecting the mental health rights and best interests of tamariki and rangatahi Māori. This thesis calls for more robust, enforceable legislation to address mental health disparities and fulfill international obligations effectively.

8.9. What are the Child Specific Advantages for Having the CRC Incorporated into Domestic Law?

As mentioned previously, incorporating the ESCR into the NZBORA and having the CRC as a stand-alone Act in New Zealand will provide the moral force necessary to tackle mental health inequalities amongst tamariki and rangatahi Māori, as enshrining these rights in domestic legislation demonstrates a legal commitment.[111] In an analogous

[111] Julian Aguon "Other Arms: The Power of a Dual Rights Legal Strategy for the Chamoru People of Guam Using the Declaration on the Rights of Indigenous Peoples in U.S. Courts" (2008) 31 University of

manner in the context of education, Augon argues that deliberately including a specific right would establish a dual rights system based on multiple jurisdictions - both domestic and international. Consequently, this would have a substantial impact on current and future legislation.[112] A similar argument can be made regarding mental health of tamariki and rangtahi Māori, suggesting that the best interests principle (and the right to health) would significantly influence both existing and forthcoming legislation for children.

The incorporation of the CRC into domestic law would ensure the inclusion of its four general principles. Consequently, any new legislation or policies pertaining to children and young people would be subject to the principles of the child's best interests, the right to life, survival, and development, the right to have their opinion heard and non-discrimination, which would serve as a set of safeguards to guide the State and ensure alignment in all decision-making processes. As discussed in Chapter Five, the right to health of the Indigenous child encompasses several cutting-edge principles including: non-discrimination, active participation by Indigenous communities in the design and delivery of health initiatives, and recognising and giving effect to cultural dimension of Indigenous communities. These cross-cutting principles mirror the four guiding principles and incorporating these four guiding principles would have far-reaching implications for the mental health of tamariki, and rangatahi Māori. For example, the principle of non-discrimination would mandate culturally responsive mental health services that incorporate Māori worldviews, address systemic racism in mental health institutions, enforce cultural competency training for professionals, ensure language accessibility through te reo Māori services and interpreters, and establish outreach programs for underserved Māori communities. As evidenced by the Youth2000 surveys, tamariki and rangatahi Māori continue to face disadvantages due to racism and significant barriers in accessing health services.[113]

Similarly, the right to survival and development would facilitate the implementation of holistic well-being models such as Te Whare Tapa Whā, establish programmes that strengthen cultural identity, incorporate traditional Māori knowledge and practices in

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Hawi'i La Review 113; Keakaokawai Varner Hemi "Everyone, Non-one, Someone and the Native Hawaiian Learner: How Expanded Quality Narratives Might Account for Guarantee/Reality Gaps, Historical-legal Context and An Admission Policy Which is Actually Levelling the Playing Field" (PhD Dissertation, University of Waikato, 2016) at 403.

[112] Aguon, above n 111, at 113-114.

[113] See generally Peiris-John, Ball, Clark and Fleming, above n 16, at 20-35.

mental health care, and address social determinants affecting Māori mental health. Lastly, respecting the child's views would ensure participatory decision-making in mental health services and policies, establish youth advisory groups, mandate culturally appropriate communication methods, and adopt whānau-centered approaches recognising the importance of wider family and community. These legal requirements would transform the mental health landscape for Māori children and youth, ensuring culturally appropriate and responsive care, ultimately leading to improved overall well-being.

While the guiding principles discussed above are interconnected and mutually reinforcing, this thesis has chosen to focus specifically on the principle of best interests of the child. This focus allows for a more in-depth exploration of how the best interests principle can be applied in the context of mental health services for tamariki and rangatahi Māori. However, it is important to note that the best interests principle does not exist in isolation and often incorporates elements of the other guiding principles in its practical application.

In relation to the best interests principle, the CRC Committee has outlined various specific actions that nations must implement to establish a regulatory and social framework ensuring children's best interests are prioritised in all matters affecting them.[114] The most relevant ones are highlighted below:[115]

(a) **Implementing the Convention into national law** would necessitate a review of existing legislation by the State to ensure alignment with the Convention's provisions. In cases of conflict, the Convention should take precedence, as stipulated by Article 27 of the VCLT.[116] In terms of mental health of tamariki and rangatahi Māori the implementation of the CRC into national law would require a comprehensive review and potential overhaul of existing mental health law, policies and practices to ensure they align with the Convention's principles, particularly in relation to cultural sensitivity and the unique needs of tamariki and rangatahi Māori.

[114] *General Comment No. 5,* above n 71, at [27]-[29].
[115] At [3]-[73]; See generally United Nations, above n 105.
[116] Vienna Convention, above n 63.

(b) Incorporating the Convention into national legislation allows for the justiciability of ESCR and creates **opportunities for seeking redress** when violations occur. Effective mechanisms to address breaches are essential for rights to have real significance. Governments should prioritise the establishment of accessible and child-friendly procedures for young people and their representatives, encompassing the provision of age-appropriate information, guidance, and advocacy support. Additionally, they should ensure access to independent complaint systems and courts, along with the necessary legal and other forms of assistance. Unfortunately, as the previous chapter demonstrated, whilst the objectives of the Pae Ora Act are commendable, there is an apparent lack of oversight and monitoring regarding the delivery of these objectives. To this end, incorporating the CRC into domestic law will assist in addressing this gap and incentivise the government to actively meet its obligations for tamariki and rangatahi Māori to achieve the highest attainable standard of health. This point will be discussed further below.

(c) Effective implementation of the CRC requires evident and **robust coordination across various sectors.** This entails cooperation amongst all governmental departments, different levels of government, and between the government and civil society, including children and youth. Particular attention must be given to children from disadvantaged groups. The Committee stresses that the strategy should not simply be a list of noble intentions. Rather, it should delineate a viable process for actualising children's rights throughout the nation. This point has been iterated by the recent report entitled, Under One Umbrella (2023), for youth experiencing metal health and drug addictions.[117] Such a comprehensive support system addresses multifaceted needs while ensuring cultural competence by collaborating with Māori health providers and communities. Early intervention can be facilitated through coordinated efforts between schools, healthcare providers, and community organisations, leading to earlier identification and treatment of mental health issues for tamariki and rangatahi Māori. For example, improved access to services is achieved through partnerships that overcome barriers such as transportation, cost, or lack of information. A coordinated

[117] Cross-Party Mental Health and Addiction Wellbeing Group *Under One Umbrella: Integrated Mental Health, Alcohol and Other Drug Use Care for Young People in New Zealand* (Platform Charitable Trust, Report, 30 June 2023) at 36-41.

approach can also work towards addressing other social determinants such as housing, education and employment which can have a ripple effect on mental health. Finally, cross-sector data sharing leads to more informed decision-making and targeted interventions, ultimately improving mental health outcomes for Māori children.

(d) Governments will be obligated to consider the child's best interests as a primary factor and to ensure that all rights outlined in the Convention are upheld in legislative and policy-making processes across all levels of government. This requires an ongoing system of **child impact assessment** (predicting how any proposed law, policy or budget allocation might affect children and their rights) and **child impact evaluation** (examining the actual outcomes of implementation).[118] This system must be incorporated into governmental procedures at all levels and from the earliest stages of policy development. A child impact assessment could significantly improve mental health outcomes for tamariki and rangatahi Māori by ensuring cultural sensitivity, identifying specific needs, and informing resource allocation. This approach would enable early intervention, adopt a holistic perspective, and focus on equity, addressing disparities between Maori and non-Maori children. The assessment process would involve Māori communities, facilitating stakeholder engagement and ensuring their voices are heard in relevant policy development. Regular assessments would allow for continuous improvement of mental health services, encourage cross-sector collaboration, and support long-term planning by considering the potential long-term impacts of policies on Māori children's mental health. The CRC Committee emphasises that governments must prioritise budget allocation for children's rights and some fundamental principles that ought to inform public budgeting for children's rights: effectiveness, efficiency, equity, transparency, and sustainability.[119]

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[118] John Tobin "Article 4 A State's General Obligation of Implementation" in John Tobin (ed) *The UN Convention on the Rights of the Child – A Commentary* (1st ed, Oxford University Press, United Kingdom, 2019, at 12-24.

[119] Tobin, above n 118, at 122-124; Committee on the Rights of the Child *General Comment No. 19: Public Budgeting for the Realization of Children's Rights (Article 4)* UN Doc CRC/C/GC/19 (2016) at [57]-[63].

(e) The Committee has encouraged states to develop a **national strategy of action for the implementation of children's rights "rooted in the convention"**.[120] The plan should, at the very least, encompass all entitlements specified in the Convention; take into account the situations of all children, particularly those who are marginalised and disadvantaged; be developed through a participatory process involving children and youth; gain backing and approval from top governmental authorities; progress beyond mere aspirations to establish tangible and achievable targets for all rights; include sector-specific strategies for crucial areas like healthcare and education; be allocated adequate funding; be disseminated extensively; and undergo ongoing assessment and review.[121] A national strategy focused on improving Māori children's mental health could be highly beneficial. It would ensure culturally sensitive services aligned with Māori values, develop targeted interventions, and allocate resources effectively. The strategy could emphasise early detection and intervention, adopt a holistic approach considering interconnected factors, and address disparities between Māori and non-Māori children. Such a strategy would also include mechanisms for monitoring and evaluation in order to ensure its effectiveness and adaptability over time.

(f) The Committee has made it clear that States **must prioritise the rights of some children**, specifically those that are marginalised and disadvantaged. To that end:[122]

> States parties consider establishing national priorities guided by the four general principles of the Convention in the allocation of resources in their efforts to prioritise the implementation of the rights of children in their respective national contexts. These priorities should be established using rights-based approach, paying special attention to the most marginalized and disadvantaged groups of children.

This statement highlights the importance of nations maintaining their dedication to meaningful equality and prioritising the allocation of resources to achieve this goal. These targeted efforts aim to address the inequalities faced by such children and provide them

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120 *General Comment No. 5,* above n 71, at [26]-[28].

121 Tobin, above n 118, at 118-119.

122 *Day of General Discussion on Resources for the Rights of the Child-responsibility of States* UN Doc (17 September – 5 October 2007) at [41]; see also Tobin, above n 118, at 143.

with equal opportunities.[123] For tamariki and rangtahi Māori, this has several important implications for their right to mental health. It is a step in the right direction to develop a rights-based approach to mental health emphasising their entitlement to quality and culturally appropriate health care. Specific measures should be implemented to address the unique mental health challenges faced by Māori children, considering cultural, social, and historical factors. Efforts should be made to identify and remove barriers that prevent Māori children from accessing mental health services, such as cultural stigma, geographical isolation, or lack of culturally competent providers. Māori communities, including children themselves, should be actively involved in the design and implementation of mental health policies and programs. Finally, any mental health interventions should consider the broader social determinants of health, adopting a holistic approach to addressing the mental well-being of Māori children.

The above are some practical implications of what incorporation of the CRC would look like. Importantly, it would mandate the State to undertake an ongoing procedure of assessing the impact on children's rights of any proposed legislation, policy and the evaluation of the impact on children's rights. If the Convention was incorporated into domestic law, it would be integrated into all relevant external and internal procedures from the beginning and should be founded on the children's perspectives. The best interests principle, therefore, would be a primary consideration in all matters affecting children.[124] Furthermore, because New Zealand has now ratified the Third Optional Protocol,[125] children have an international avenue for redress violations of their rights, should all domestic remedies be exhausted. This would be particularly effective for tamariki and rangatahi Māori in the context of mental health.

8.10. Best Interests Principle in Domestic Law

The broader integration of the best interests principle into national law could have significant implications. As has been demonstrated, currently the best interests principle has limited scope, primarily appearing in the COCA and OT Act. Although courts consider family-related factors such as whakapapa and whanaungatanga for Māori children and young people, there appears to be a lack of broader consideration or

[123] At 144.
[124] United Nations, above n 105, at 4.
[125] Optional Protocol, above n 99.

application of collective cultural rights. If these rights were to be recognised, they could be crucial in determining outcomes, even in cases where the immediate family is unable to care for the child. The current situation is particularly problematic in the context of children's mental health. There is a need for the best interests principle to be applied comprehensively, especially in health-related matters and New Zealand has an international obligation to do so. The Committee has explicitly outlined that nations have three broad responsibilities when implementing the best interests principle. These responsibilities are:[126]

(i) That the principle is suitably incorporated and uniformly implemented in every action undertaken by a governmental body whose activities affect children (albeit directly or indirectly);

(ii) To ensure that all legal and administrative entities, as well as regulations and laws concerning children, show that the child's best interests have been considered as a primary factor; and

(iii) To make certain that the private sector, when making decisions and taking actions that involve children, evaluates and prioritises children's interests as a primary consideration.

Incorporating the CRC and, thereby, the best interests principle in domestic law would require evaluating and determining what is best for a child and necessitate procedural safeguards for children. Moreover, the rationale behind a decision would need to clearly demonstrate that the child's rights have been explicitly considered. In this context, the Committee has stated that the States parties are required to elucidate how the right has been honoured in the decision-making process.[127] This includes explaining what has been deemed to be in the child's best interests, the criteria upon which this determination is based, and how the child's interests have been balanced against other considerations, whether these are broad policy issues or individual cases.[128]

126 Eekelaar and Tobin, above n 23, at 81.
127 See generally *General Comment No. 5,* above n 71, at 4.
128 At 4.

In the context of mental health, the best interests principle can be integrated into the design, delivery, and implementation of laws and policies in the mental health sector. As a result, law and policy development and interpretation in the mental health sector would align with the CRC and the best interests principle for children. Furthermore, this would also allow clear guidelines to be developed in the application of the best interests principle and would necessitate the government's commitment to adopting a rights-based approach and consulting international jurisprudence and recommendations that elucidate the Convention.[129]

As has been discussed in Chapter Three, the best interests principle is broad and flexible enough to incorporate the collective and cultural dimensions of health and mental health of Indigenous children. Therefore, when considering best interests of the child in the realm of mental health, it must be remembered, alongside the importance of the child's cultural identity, that "states should provide resources for Indigenous peoples to design, deliver and control such services so that they may enjoy the highest attanabe stadard of physical and mental health".[130] Recognition of Indigenous cultural values requires that when the best interests of an Indigenous child are being weighed up, consideration must be given to their character and identity as an individual and as part of their community. More often than not, the best interests of the Indigenous child decisions are abstracted from a normative lens as separate and distinct from "those of their families, communities and cultures".[131] This reflects the dominant norm and denies Indigenous children the opportunity to have kinship, cultural structures and practices taken into consideration when determining the best interests. The Committee has emphasised that when the best interests of the Indigenous child is considered States should "consider the cultural rights of the indigenous child and his or her need to exercise such rights collectively of their group".[132] In this regard, Indigenous communities should be given opportunities to actively participate "in the process on how the best interest of indigenous children can be decided".[133]

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[129] Similar comments have been made about the right to education in the work by Keakaokawai Varner Hemi, above n 111.

[130] *General Comment No. 14,* above n 73*,* at [34].

[131] Bruce Valentine and Mel Grey "Keeping Them Home: Aboriginal Out of Home Care in Australia" (2006) 87 Families in Society 537 at 537-545.

[132] *General Comment No. 11,* above n 7, at [10].

[133] At [10]-[11].

In essence, cultural factors should be taken into consideration. What is happening at the moment is that children's mental health is being looked at from purely medical criteria, a health lens and an adult lens. These concerns are consistent with the views expressed by the Committee, which has long emphasised the importance of cultural appropriateness in the design, delivery, and control of health services for Indigenous children and the involvement of Indigenous communities in these processes.[134]

Clearly, there are explicit expectations in international conventions for states to recognise Indigenous values, when addressing the rights of Indigenous children, including their health rights. It has been argued that the application of the best interests principle in legislation and decision-making can accommodate these rights and that this principle can be used in cases related to mental health. To implement this approach will require a major review of existing legislation to ensure legislative backing for the application of the best interests principle and align existing legislation with the Convention, ensuring its precedence in cases of conflict. This incorporation would create opportunities for redress, including for ESCR. Governments are expected to establish child-friendly procedures for complaints and access to courts. Effective implementation necessitates coordination across government sectors and civil society, with particular attention to disadvantaged groups, namely tamariki and rangatahi Māori. The best interests principle would be recognised across all government departments, not solely those directly affecting children and Government must consider the child's best interests in all actions and implement child impact assessments. A comprehensive national strategy for implementing children's rights would also need to be developed, including specific targets and adequate funding in mental health provision. States are required to prioritise the rights of marginalised and disadvantaged children, focusing on substantive equality and allocating resources accordingly, namely to rangatahi and tamariki Māori who are at the forefront of the mental health crisis, with flow on effects into improved budgeting and resource allocation into mental health of tamariki and rangatahi Māori.

[134] See generally Lisa Forman "Decoding the Right to Health: What Could It Offer to Global Health?" (2015) 8 Bioethics Forum 91at 91-96; see also *General Comment No.* 11, above n 7, at [1]-[63].

8.11. Amendments to the Pae Ora Act

Including the right to health in NZBORA and entrenching the CRC in domestic law would grant constitutional recognition to the right to health and children's rights which is a vital step towards its realisation and enforcement. However, it is essential to note that this alone may not suffice to ensure the full realisation of the right to health in New Zealand. Additional legislative provisions are required to imbue the right with practical significance, as constitutional guarantees without accompanying legislation tend to be somewhat abstract. Building on and amending the Pae Ora Act will be an important part of an overall strategy to entrench the right to health as an enforceable right, as well as augmenting the rights under the UNDRIP.

The Pae Ora Act plays a critical role in addressing health inequities, particularly for Māori and to enhance the health of New Zealanders.[135] The Pae Ora Act requires the inclusion of the Government's priorities for engaging with, and improving health outcomes for, Māori.[136] The guiding principles require engaging with Māori and iwi-partnership boards, and providing culturally safe and appropriate responses.[137]

On the face of it, these are positive steps towards providing culturally appropriate health care for Māori and demonstrate the core ideas of what the right to health means for Indigenous communities.[138] However, the Pae Ora Act does not make any specific mention of children or young people. The government is likely to argue that the provisions included in the legislation are sufficient to capture the needs of tamariki and rangatahi Māori, but it is submitted that additional specific and explicit legislative provisions are necessary for tamariki and rangatahi Māori to fully realise their right to health. In particular, specific provisions are required that entrench the principle of the best interests of the child in all decision making and the voice of the child in all legal and administrative decisions affecting them. Currently, there is a scarcity of procedures for gathering children's perspectives on the development of legislation and policies. Furthermore, the extent to which children can participate in judicial and administrative

[135] Pae Ora (Healthy Futures) Act 2022, s 3.
[136] Sections 36, 42(1).
[137] Section 7; See the Health Principles in the Act.
[138] Chapter Four and Chapter Five discusses the significance of health rights for Indigenous populations. It emphasises the involvement of Indigenous populations in the creation and implementation of health-related policies.

proceedings varies considerably.[139] Incorporating specific provisions in the legislation would demonstrate the government's efforts to actively protect and fulfil the child's right to have the highest attainable standard of health. Incorporating the specifics of the right to health into the Pae Ora Act would not only recognise health as a constitutional and human right for individuals (including children), but also strengthen its validity and align with international best practices. This integration would serve to enhance the legitimacy of the right to health and draw upon globally recognised standards.

In addition to the absence of specific reference to the health of children or young people, there are other problematic areas in the Pae Ora Act. As several commentators have pointed out, the health reforms initiated by the Pae Ora legislation, particularly the establishment of Te Aka Whai Ora presented a rare opportunity to tackle Māori health disparities and improve health outcomes for all residents of Aotearoa.[140] The disestablishment of this initiative without any indication of its replacement is likely to result in regressive measures and fail to enhance the health and well-being of this nation's Indigenous peoples.[141] What has happened is that New Zealand has now fallen further behind in the realisation of the right to health for tamariki and rangatahi Māori. The dissolution of Te Aka Whai Ora accentuates the need for legislative reforms to tackle the disparities in mental healthcare for tamariki and rangatahi Māori. Thus, it is recommended that provisions be incorporated into the Pae Ora Act that promote culturally appropriate services for the mental well-being of children and young people. Inserting provisions into domestic law will mandate the government to work towards realising the right to health (and mental health) of the Indigenous child and will mandate the State to provide culturally appropriate preventative or early treatment services that are in line with international standards.[142]

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[139] Ludbrook and Jamison, above n 104, at 14-16.

[140] Heather Came, Clive Aspin, Nicole Coupe and Tim McCreanor "Pae Ora (Diestablishment of Maori Health Authority) Amendment Act 2024: Further Crown Breachers of Tiriti o Waitangi" (2024) 137 New Zealand Medical Jounral 94 at 97.

[141] At 97.

[142] See generally *General Comment No. 14,* above n 73; Yvonne Donders "Exploring the Cultural Dimensions of the Right to the Highest Attainable Standard of Health" (2015) 18 PELJ 180 at 185-187 at 187.

8.12. In What Ways Does Amending the Pae Ora Act Fulfil New Zealand's International Obligations Regarding the Right to Mental Health?

Chapter Five demonstrated that international standards dictate that the right to health encompasses the normative content of the right to health, which is commonly referred to as the AAAQ framework, and that nations have a duty to respect, protect, and fulfil the right to health.[143] In order to align the Pae Ora Act with New Zealand's obligations for the right to health, there are specific amendments that can be made, that derive from the General Comments and those curated by the writer. General health provisions are recommended, and as well as specific mental health provisions for tamariki and rangatahi Māori.

Availability	- Every individual shall be entitled to receive an appropriate level of healthcare, irrespective of their geographical location. - Healthcare services shall be provided in a manner that respects and accommodates the cultural backgrounds of all individuals. - Preventative health care services for tamariki and rangatahi should be available immediately, and be culturally appropriate. - A yearly report, accessible to the general public, shall be produced, outlining the availability and allocation of healthcare resources.
Accessibility	Economic accessibility - Implement measures to provide free or reduced-cost transport for rural residents to access specialised medical services not available in their local area. Ensure unrestricted access to essential healthcare, including preventive and mental health services, at no cost. This approach could be based on the existing National Travel Assistance Scheme, but with enhanced support for Māori and fewer limitations than the current system.[144] - Provide financial assistance for lodging expenses for family members accompanying patients or carers. - Offer monetary support for additional costs incurred to alleviate financial pressure on relatives who are providing support to family members experiencing health issues. - Provide complete financial support for mental health services, particularly those utilising Māori health frameworks, and allocate government funds to charitable organisations offering crucial assistance to families coping with a member's mental health challenges.

[143] See generally *General Comment No. 21 on the Right of Everyone to Take Part in Cultural Life (Article 15, [1a] of the Covenant on Economic, Social and Cultural Rights)* XLII UN Doc E/C.12/GC/21 (21 December 2009).
[144] This scheme only applies to those that are required to go see specialists.

	Non-discrimination and cultural accessibility - Allocate funding for traditional and cultural healing practices - Implement mandatory cultural sensitivity training for healthcare personnel every two years to mitigate biased and discriminatory behaviours (this is not only for doctors and nurses but to all staff working in the health sector). - Encourage private healthcare providers to develop and offer customised Māori health services through incentives. Physical accessibility - Mandate health care infrastructure in rural and underserved regions Information accessibility - Provide simple, clear language and information in a manner that is suitable for patients.
Quality	- Provide provisions for health care providers that fail to meet quality standards and provide culturally appropriate healthcare to face consequences, such as penalties, mandatory improvement plans, withholding services, and reducing funding grants for no-compliance. - Ensure quality monitoring and regular audits, increasing frequency of audits for non-compliance, implementing more rigorous reporting requirements, conducting unannounced visit.
Acceptability	- Require the incorporation of a Māori health framework and models into the public health system. This could involve conducting periodic cultural assessments of healthcare facilities to ensure adherence to standards. - Ensure essential and genuine involvement of Māori in service design is crucial. This should extend beyond a mere formality, requiring active participation. Although the disestablishment of the Māori Health Authority represents a significant setback in this regard, it is suggested that a compulsory advisory board be formed. This board would comprise Māori health experts and community representatives, such as respected elders, to offer guidance and input.

As has been discussed previously, a significant obstacle to accessing healthcare for tamariki and rangatahi Māori, including mental health services, is that there is the insufficient availability and acceptability of such services. Availability of an adequate workforce is essential, particularly ensuring sufficient competent healthcare staff for Indigenous communities. The suggested provisions under availability in the above table

aim to establish a more culturally sensitive healthcare system that is readily accessible to tamariki and rangatahi Māori. Additionally, it seeks to eliminate some of the obstacles that Indigenous communities encounter when seeking medical care, such as geographical remoteness and thus distance from available facilities and services. Having available appropriate mental health services would be in the best interests of children and young people generally, and more specifically tamariki and rangatahi Māori.

Indigenous populations face significant challenges in accessing healthcare, which aligns with the AAAQ framework. Availability issues include limited healthcare facilities in remote areas and insufficient contact with providers. Accessibility barriers encompass economic challenges due to socioeconomic disadvantage, physical barriers in remote locations, and information barriers such as language limitations. Acceptability concerns stem from discriminatory attitudes of health professionals, lack of cultural sensitivity, and systemic racism, leading to fear, mistrust, and internalised stigma.[145] Quality issues arise from incorrect diagnoses and inappropriate treatments resulting from discrimination.

To improve Māori healthcare access, several measures have been proposed in the table above. These include government funding allocation, enhancing cultural sensitivity, ensuring Māori participation in service planning, supporting traditional healing practices, and conducting cultural evaluations of healthcare facilities. These efforts aim to address the AAAQ framework components by improving the availability, accessibility, acceptability, and quality of healthcare services for Indigenous populations.

The current provisions in the Pae Ora Act do not mandate that Māori health models should be integrated into the public health sector. The proposed changes can lead to better mental health outcomes for Māori children through various interconnected mechanisms. These include improved early intervention with culturally appropriate tools, enhanced treatment effectiveness using tailored therapies, reduced stigma through

[145] See generally Jennifer Reid, Donna Cormack and Marie Crowe "The Significance of Socially-assigned Ethnicity for Self-identified Māori Accessing and Engaging with Primary Healthcare in New Zealand" (2015) 13 Sage Journals 1 at 1-8; Kay Wilson "Law Reform or Systemic Reform? Stakeholder Perceptions of Resource Constraints in Mental Health in Australia, New Zealand and Canada" (2013) 4 Psychiatry, Psychology and Law 20; See generally Rebekah Graham and Bridgette Masters-Awatere "Experiences of Māori of Aotearoa New Zealand's Public Health System: A Systematic Review of Two Decades of Published Qualitative Research" (2020) 44 Aus NZ Journal of Public Health 19 ; *Expert Mechanism,* above n 35, at [7]; As discussed in Chapter Six there are differences in the Māori worldview on health, which can often contrast with the Western view on health.

education, addressing root causes of mental health issues, improved access to culturally competent care, evidence-based practices informed by Māori-led research, holistic and continuous care coordination, and community empowerment. By addressing these multiple aspects simultaneously, these changes can contribute to improved mental health outcomes, reduced disparities, and overall well-being for tamariki and rangatahi Māori. In summary, these proposals could enable the incorporation of Māori health frameworks and models and lead to more culturally responsive mental health services, potentially improving engagement with and outcomes for Māori patients. Specific metrics and evaluation processes to assess the impact of these recommendations on Māori mental health could lead to continuous improvement in service delivery and improvement in the overall quality of the health services.[146]

In addition to the obligation to provide resources, accessibility needs to be a key focus of the Act, guaranteeing every child's right to timely, adequate, and appropriate mental health care. This approach emphasises non-discrimination and physical accessibility through community-based services, ensuring that all children, regardless of their background or location, can access the care they need.[147] By addressing accessibility, the Act can also reinforce the right to non-discrimination, as it removes barriers that might prevent tamariki and rangatahi Māori from receiving mental health support. The Act's emphasis on acceptability would be particularly important, as it would actively engage Indigenous children and communities in the design and implementation of mental health services. This approach integrates traditional practices and provides cultural competency training for health workers, ensuring that services are culturally sensitive and relevant. By involving tamariki and rangatahi Māori in the design and delivery of services, the Act would align with the guiding principle of respecting the voice of the child, empowering young people

[146] See generally for work from other scholars (while they have no used explicit human rights law language, what they are saying resonates with the argument to have culturally appropriate care for Māori) - Elana Curtis, Rhys Jones, Suzanne Tipene-Leach, Papaarangi Reid, David R Jones and Ricci Harris "Why Cultural Safety Rather Than Cultural Competency is Required to Achieve Health Equity: A Literature Review and Recommended Definition" (2019) 18 International Journal for Equity in Health 174; Graham and Masters-Awatere, above n 146, at 193.

[147] See generally Ashlea Williams, Karolina Stasiak, Matthew Shepherd, Sarah McLeod, Teresa Taylor and Sally Merry "The Associations Between Cultural Identity and Mental Health Outcomes for Indigenous Māori Youth in New Zealand" (2018) 6 Frontiers in Public Health 319; Reremoana Theodore, Nick Bowden, Jesse Kokaua, Troy Ruhe, Matt Hobbs, Sarah Hetrick, Lukas Marek, Jesse Wiki, Barry Milne, Hiran Thabrew and Joseph Boden "Mental Health Inequities for Māori Youth: A Population-level Study of Mental Health Service Data" (2022) 135 New Zealand Medical Journal 79.

to contribute to decisions that affect their mental health care. Such an approach would be in keeping with te ao Māori perspective on health and well-being.[148]

Quality assurance would be addressed through person-centred rights-based service design and Ministry oversight. This approach could ensure that mental health services are tailored to individual needs while adhering to established standards and best practices. The Ministry's oversight role helps maintain consistency and quality across different service providers and regions. The Act's comprehensive approach demonstrates a strong commitment to improving mental health services for children in line with international standards. By respecting children's views and Indigenous perspectives, protecting the right to access mental health services, and fulfilling children's mental health needs through resource allocation, early treatment, and preventative measures, the Act creates a holistic framework for addressing mental health challenges among young people.

Furthermore, the Act's focus on early intervention and preventative measures is particularly important for long-term mental health outcomes. By identifying and addressing mental health issues at an early stage, the Act aims to reduce the severity and duration of mental health problems, potentially preventing more serious conditions from developing later in life. The integration of mental health services with other aspects of child welfare, such as education and social services, could further enhance the Act's effectiveness. This holistic approach recognises that mental health is interconnected with various aspects of a child's life and development.[149]

By aligning with international standards and best practices, the Act could position New Zealand as a leader in child mental health care. This approach would not only benefit children within the country but also contribute to global efforts to improve mental health services for young people.

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[148] King, Cormack, Kōpua, above n 37, at 186; Mason Durie "A Māori Perspective of Health" (1985) 20 Soc Sci Med 483; Hannah Mackintosh "Another Tool in the Kete': Māori Engaging with International Human Rights Framework" (Masters in Development Studies Thesis, University of Wellington, 2011).

[149] *Expert Mechanism,* above n 35*,* at [4]; Éliot Litalien "Understanding the Right to Health in the Context of Collective Rights to Self-Determination" (2021) 8 Bioethics 725; Denise Wilson, Eleanor Moloney, Jenny Parr, Cathleen Aspinall and Julia Slark "Creating an Indigenous Māori-centered Model of Relational Health: A Literature Review of Māori Health Models" (2020) 30 Journal of Clinical Nursing 3539.

8.13. Government's Obligations

Based on General Comment No. 14, governments have an obligation to respect, protect and fulfil (canvassed in Chapter Four). It is clear that the New Zealand government still has areas for improvement in meeting these responsibilities as discussed in detail in the previous chapter.

The Government can utilise the Pae Ora Act to fulfil its international legal obligations **to respect and protect** the mental health rights of tamariki and rangatahi Māori. This can be achieved by incorporating specific clauses that emphasise equitable, culturally sensitive mental health care for Māori children and youth. The **obligation to protect** could be discharged by mandating a health system that promotes health equity for Māori, and could be enhanced by requiring all health entities (private and public) to collaborate with iwi and Māori health organisations in developing mental health services tailored for tamariki and rangatahi Māori. This legislative approach would help to ensure that services are non-discriminatory (a feature of the **obligation to respect**) and align with Māori collective cultural rights.[150] Under the **obligation to fulfil**, the Government also has a role to play in setting quality targets and assurance measures to ensure maintenance of standards and continuous improvement. Currently, a significant gap in the Pae Ora Act is the lack of concrete, quantifiable health targets. To address this, the legislation could mandate specific, measurable mental health objectives for Māori children and young people, thereby ensuring timely and appropriate mental health care access.

To fulfil its obligations to actively realising the right to health, the Pae Ora Act could establish a compulsory accountability framework centred on monitoring mental health outcomes. This framework would necessitate regular reports on mental health outcome disparities among tamariki and rangatahi Māori, with public tracking of progress towards equity goals.[151] Additionally, the Act could empower a designated board or entity to issue binding recommendations, ensuring that any failure to meet health equity targets results in immediate action plans. By incorporating these oversight mechanisms within the Pae Ora Act, Māori mental health services would be protected from reprioritisation, thus

[150] See generally *Expert Mechanism on the Rights of Indigenous Peoples Study on the Right to Health and Indigenous Peoples with a Focus on Children and Youth*, UN Doc A/HRC/33/57 (25 July 2016).

[151] Paul Hunt & Judith Mesquita "Mental Disabilities and the Human Right to the Highest Attainable Standard of Health" (2006) 28 HRQ 332 at 352; Refer to Chapter Five footnotes from 157 to 171.

guaranteeing the continuity of culturally appropriate care for tamariki and rangatahi Māori.

Enhancing the Pae Ora Act to emphasise the mental well-being of tamariki and rangatahi Māori could have extensive consequences. Incorporating cultural sensitivity and responsibility into mental health legislation would result in better mental health outcomes for tamariki and rangatahi Māori. This strategy could diminish youth disengagement from mental health services, aid in building trust amongst Māori communities and promote early intervention and preventative mental health services.[152] Implementing clear accountability and progress monitoring would also establish a more transparent and inclusive health system, setting a standard for equitable care that might motivate similar legislative measures across other sectors, further bolstering Māori self-determination. By integrating these obligations into the Pae Ora Act, the Government would establish a lasting foundation for Māori health rights, reinforcing its dedication to the mental health and cultural requirements of tamariki and rangatahi Māori in accordance with its international obligations.

8.14. Special Measures for Tamariki and Rangatahi

This chapter has thus far examined various proposals, including the incorporation of ESCR into NZBORA and the inclusion of CRC in domestic legislation. These can be considered high-level strategies for ensuring the right to health is embedded in national law. In addition to some of the more general proposals above, specific proposals to implement the rights of tamariki and rangatahi Māori are suggested below. Consequently, the subsequent section proposes specific measures for tamariki and rangatahi Māori that should be incorporated into the Pae Ora Act to serve the best interests of the child, particularly of tamariki and rangatahi Māori.

The first step forward is to insert a specific section into the Pae Ora Act that mandates the Government to provide culturally appropriate mental health services for tamariki and rangatahi, under the heading of Mental Health services, and a further sub-heading of tamariki and rangatahi Māori. The principle underlying the section would be "in all actions

[152] See generally Curtis, Jones, and et al, above n 146, at 174; Graham and Masters-Awatere, above n 146, at 193.

concerning children, the best interest of the child shall be the primary consideration".[153] This approach mirrors the COCA and the OT Act, which prioritise the best interests principle in all decision-making. While adopting a similar strategy here is beneficial, it would not be implemented in isolation. Additional provisions would be introduced into the Pae Ora Act to ensure access to culturally appropriate, high quality, and responsive mental health services, integrate Māori health models and worldviews, and involve Māori in the design and delivery of health services.

Proposed sub-headings to implement the right to mental health of tamariki and rangatahi are:[154]

Section [x]: Right to access mental health services

- Every child has the right to access mental health services which are timely, adequate and appropriate to their needs.

- Tamariki and rangatahi Māori and other children, as appropriate, shall be meaningfully engaged and consulted in the design and implementation of early treatment and preventative mental health services.

Section [y]: Early Treatment and Preventative measures

- Preventative treatment for tamariki and rangatahi needs to be designed to meet specific needs and integrate traditional practices as determined by Indigenous communities.

- A variety of person-centred and rights-based community-based crisis services need to be established to better support children and their families in preventative and crisis situations.

[153] United Nations Convention, above n 5, at Article 3.
[154] World Health Organization *World Mental Health Report Transforming Mental Health for All* (World Health Organization Geneva, Report, 2022) at 85.

- These initiatives need to be designed and implemented in partnership with Māori communities and be integrated into mental health treatment plans in collaboration with Māori communities.

Section [z]: Roles and responsibilities of the Ministry of Health

- The Ministry of Health will be responsible for the implementation and oversight of this Act.

- The Ministry will allocate resources and funding to support the provision of culturally appropriate mental health services for children.

- Budget allocations for mental health of children and young people will consider adequate funding for culturally appropriate mental health care initiatives for tamariki and rangatahi Māori and other relevant groups of children who may be members of a minority.

Section [xi]: Cultural competency training

- Procedures and criteria shall be adopted to provide guidance to health workers in the area of mental health care, for assessing the best interests of the child and respecting their views.

The suggested amendments to the Pae Ora Act are proposed as a holistic strategy for enhancing mental health care for young people, with a particular focus on tamariki and rangatahi Māori. These proposals align closely with the AAAQ framework, UN human rights standards, and the core principles of the CRC. Notably, the recommendations also address the fundamental tenets of the right to life, survival and development, child participation, and non-discrimination. Having the above new sections would provide a good foundation for resource allocation.

8.15. Linking Legislative Developments to Policy Development

Legislation serves as a guide to the standards that ought to be followed in a country, while policy provides direction on the specifics of these standards and how they should be

implemented. The relationship between law and policy is complex, as they serve distinct objectives. Laws are formal rules and procedures that must be adhered to by members of a society, while policies are long-term decisions aimed at addressing specific issues or problems.[155] The proposed legislative changes above are essential for the formulation and execution of effective policies. A crucial recommendation is that the policy development process must consider the interpretation of the right to mental health from a Māori perspective.

The human rights framework has provided valuable guidelines and a framework to guide the interpretation of the right to mental health. These are thoroughly examined in Chapter Five. To ensure that Indigenous peoples and children receive appropriate health care, the design, delivery, and control of health services must be culturally sensitive. The CRC Committee has emphasised the cultural aspect of the right to health for Indigenous children. The Committee asserts that Indigenous children should have access to culturally appropriate services, and all health facilities, goods, and services should respect cultural values and be acceptable to both adolescents and communities in which they reside. In other words, the CRC Committee encourages states to take special measures, including providing culturally appropriate services, to support Indigenous children's health.[156] Comments of a similar nature were expressed by the PFII and the EMPRIP which stated that "the right to health is realized through the well-being of the individual as well as the social, emotional, spiritual, and cultural well-being of the entire community".[157]

As previously noted, integrating the CRC (and by extension the best interests principle) into national legislation offers a practical benefit by necessitating a focus on disadvantaged and marginalised groups, in this case tamariki and rangatahi Māori. Codifying the Convention's four general principles in law protects children's rights and requires the government to consider cultural sensitivity in mental health programmes. This is precisely where the aforementioned legal modifications are vital, as they compel policymakers to

[155] Joel Teitelbaum, Angela McGowan, Therese Richmond, Dushanka Kleinman, Nico Pronk, Emmeline Ochiai, Carter Blakey and Karen Brewer "Law and Policy as Tools in Healthy People 2030" (2021) 27 Journal of Public Health Management and Practice 265 at 265-273.

[156] Refer to Chapter Four and Chapter Seven for further discussion.

[157] *Expert Mechanism on the Rights of Indigenous Peoples Study on the Right to Health and Indigenous Peoples with a Focus on Children and Youth* UN Doc A/HRC/33/57 (10 August 2016) at [4]; *Permanent Forum on Indigenous Issues Report on the Twelfth Session* UN Doc E/2013/43–E/C.19/2013/25 (20–31 May 2013) at [5], [9]; Refer to Chapter Five and Six for further discussion.

ensure that policy design and execution prioritise the child's best interests and align with children's right to mental health.

The following overarching guidelines must be taken into account when developing any mental health policies:

- A rights-based approach to mental health should align policies with international human rights standards, including the AAAQ framework. This approach ensures not only the availability but also the acceptability of suitable mental health services.

- Policies ought to reflect the state's obligations to respect, protect and fulfil, reinforcing its duty to actively safeguard the right to mental health.

- For tamariki and rangatahi, policies must prioritise their distinct cultural, social and health requirements.

In New Zealand, proposals have been put forward for the application of health and mental well-being for Māori and it has been shown that the existing healthcare system, inclusive of the mental health sector, is inadequate and cannot be improved without incorporating a Māori worldview.[158] This recognition can be employed to stimulate transformative change. At the very least, it is imperative that all policies pertaining to tamariki and rangatahi Māori in mental health are formulated based on the principle of the best interests of the Indigenous child.[159]

The proposed legislative amendments would significantly impact mental health policies for tamariki and rangatahi Māori in New Zealand, bringing about a comprehensive transformation in the legal and policy landscape. These changes would align the law with a human rights-based framework, incorporating ESCR into the NZBORA, entrenching the CRC in a stand-alone Act, and amending the Pae Ora Act. The reforms would elevate existing strategies from aspirational initiatives to enforceable policies, mandating the government to provide culturally appropriate mental health services for tamariki and rangatahi Māori. This shift would necessitate the application of the AAAQ framework

[158] See generally Joanna Manning "New Zealand's Bold New Structural Health Reforms: The Pae Ora (Healthy Futures) Act 2022" (2022) 29 JLM 987 at 995.
[159] Being the AAAQ framework, respect, protect and fulfil, non- discrimination and equality, participation and accountability.

and cross-cutting principles such as participation, accountability, non-discrimination, equality, and progressive realisation as discussed in Chapter Five. Essentially it would mirror the human rights language as outlined by the United Nations.

More specifically, the inclusion of ESCR would recognise healthcare as a fundamental right, requiring policy changes to address disparities in mental health outcomes between Māori and non-Māori populations. As this thesis has shown a significant area in which there are disparities for tamariki and rangtahi Māori is in mental health. Addressing disparity, would inevitably cross over into areas such as addressing accessibility issues faced by tamariki and rangatahi Māori in obtaining mental health services, including geographical, financial, and cultural barriers.

The legislative changes would also shift towards child-focused policies, considering collective cultural rights and the Indigenous worldview of well-being. This approach would involve actively engaging Indigenous communities in the design, delivery, and implementation of mental health services, promoting a "by Māori for Māori" approach. This would ensure that mental health services are not only culturally sensitive but also culturally affirming, recognising the importance of cultural identity in mental well-being. History shows that New Zealand has attempted to make policies that address the cultural dimension. The 2002 "Te Puāwaitanga: Māori Mental Health National Strategy" is one such example.[160] However, given the lack of improvement it is clear that more needs to be done.[161] Creating child-focused policies in accordance with a cultural affirmation model of health delivery as discussed by Durie is important.

For example, this would involve incorporating Māori health frameworks like Te Whare Tapa Whā, which emphasises the four cornerstones of Māori health: taha tinana (physical health), taha wairua (spiritual health), taha whānau (family health), and taha hinengaro (mental health).[162] The integration of these concepts would ensure a more holistic approach to mental health care policies that aligns with Māori cultural values and beliefs. The holistic view of health rights would address broader mental health determinants, such as poverty, discrimination, and social exclusion, while explicitly referencing Māori rights under the UNDRIP. This approach would necessitate a shift in policy development and

[160] Ministry of Health *Te Puāwaitanga: Maori Mental Health National Strategy* (2002).
[161] Paterson, Durie, Disley et al, above n 8.
[162] Mason Durie "A Māori Perspective of Health" (1985) 20 Social Science and Medicine 483 at 483.

implementation, incorporating Te Ao principles, Māori worldviews and concepts of well-being, such as mana (prestige, authority), whanaungatanga (relationships, kinship), and kaitiakitanga (guardianship). Essentially, mental health policies for tamariki and rangatahi Māori would adopt a more comprehensive view of well-being, considering individual needs within the broader context of whakapapa (genealogy) and community. This would lead to the development of culturally responsive interventions that prioritise strengthening cultural connections, family involvement, and community support in mental health care. For example, policies might encourage the use of marae-based mental health programs or incorporate traditional Māori healing practices alongside conventional mental health treatments.

The new policy framework would also emphasise early intervention and prevention strategies, recognising the importance of addressing mental health issues in tamariki and rangatahi Māori before they escalate. This could include school-based mental health programs that incorporate Māori cultural practices and values, as well as community-led initiatives that focus on building resilience and promoting positive mental health. The legislative amendments would also likely lead to changes in the training and development of mental health professionals. There would be an increased focus on cultural competency and the ability to work effectively with Māori communities. This could involve mandatory training in te reo Māori and tikanga Māori for all mental health professionals working with tamariki and rangatahi Māori.[163]

Furthermore, the new policy environment would likely emphasis the importance of data collection and research to inform evidence-based practices in Māori mental health. This could involve increased funding for Māori-led research initiatives and the development of culturally appropriate assessment tools and outcomes measures. The integration of digital health solutions would also be considered, ensuring that telehealth and e-mental health services are culturally appropriate and accessible to tamariki and rangatahi Māori,

[163] Similar themes/recommendations came out from the Mental Health and Wellbeing Commission "Improve Wellbeing for Rangatahi and Young People" (2025) <https://www.mhwc.govt.nz/our-work/advocacy/improve-wellbeing-for-rangatahi-and-young-people/>; Terry Fleming, Sue Crengle, Roshini Peiris-John, Jude Ball, Sarah Fortune, Esther Yao, Cinnamon Lindsay Latimer, Analosa Veukiso-Ulugia and Terryann Clark "Priority Actions for Improving Population Youth Mental Health: An Equity Framework for Aotearoa New Zealand" (2024) 34 Mental Health & Prevention 200339.; Ron Paterson, Mason Durie, Barbara Disley, Dean Rangihuna, Jemaima Tiataia-Seath and Josiah Tualamali'i *He Ara Oranga Report of the Government Inquiry into Mental Health Addiction* (Government Inquiry into Mental Health and Addiction 2018); Ministry of Health *Transforming our Mental Health Law: A Public Discussion Document* (2021).

particularly those in rural or remote areas. On this point, it is important to recognise that data sovereignty is crucial for Māori. Indigenous data sovereignty pertains to the "inherent rights and interests that Indigenous peoples have in relation to the collection, ownership, and application of Indigenous data".[164] Tikanga Māori can assist in addressing privacy issues to safeguard collective privacy, foster trust, and minimise harm to the group.[165]

Ultimately, these legislative amendments would create a robust, rights-based policy environment that transforms the mental health landscape in New Zealand. This would ensure that tamariki and rangatahi Māori receive equitable, culturally appropriate, and high-quality mental health care that respects their cultural identity and promotes their overall well-being within the context of their whānau and community.

8.16. Conclusion

The principle of best interests, as explored in the preceding chapters, demonstrates its adaptability and the necessity to interpret it through the lens of collective cultural rights, particularly when addressing decisions concerning tamariki and rangatahi Māori. This approach aligns with the significance of collective rights for Indigenous communities, as established in Chapter Four. That chapter emphasised that any consideration of an Indigenous child's best interests must inherently include collective rights. The importance of integrating collective cultural rights becomes especially apparent when examining the right to mental health. The stark contrast between Western individualistic health concepts and Indigenous perspectives on health and well-being underlines the need for a more inclusive approach. By incorporating collective cultural rights into the best interests principle, it can serve as a powerful catalyst for change, particularly in enhancing the right to health for tamariki and rangatahi Māori.

This chapter proposes several legislative changes to enhance mental health outcomes for tamariki and rangatahi Māori in New Zealand. These include incorporating ESCR into the NZBORA, integrating the UNCRC into domestic law, amending the Pae Ora (Healthy Futures) Act to mandate culturally appropriate mental health services for Māori,

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[164] Tahu Kukutai, Shemana Cassim, Vanessa Clark, Nicholas Jones, Jason Mika, Rhianna Morar, Marama Muru-Lanning, Robert Pouwhare, Vanessa Teague, Lynell Tuffery Huria, David Watts and Rogena Sterling "Māori Data Sovereignty and Privacy: Tikanga in Technology Discussion Paper" (Te Ngira Institute for Population Research, University of Waikato, 2023).

[165] At 3.

and adding a dedicated section on mental health services for tamariki and rangatahi Māori. These changes aim to create a stronger legal framework that protects the mental health rights of tamariki and rangatahi Māori, ensures culturally appropriate services, and improves government accountability. The chapter emphasises the importance of interpreting the right to mental health from a Māori perspective when developing law, policies and programmes. The proposed legislative changes aim to cater for the needs of tamariki and rangatahi Māori, emphasising early intervention and preventive measures, with the ultimate goal of enhancing mental health outcomes for this demographic. This is particularly crucial as statistical data indicate tamariki and rangatahi Māori are at the forefront of a mental health crisis.

Chapter Nine

Conclusion

9.1. Introduction

This thesis has examined how the best interests principle under international law can be re-examined and applied in New Zealand to improve mental health outcomes for tamariki and rangatahi Māori. The study has explored whether New Zealand can utilise the best interests principle under the CRC in a way that recognises and incorporates collective cultural rights. It argues that decisions regarding the best interests of tamariki and rangatahi Māori in mental health should be decided using a "by Māori, for Māori" approach. The research was driven by the persistent problem of poor mental health statistics among tamariki and rangatahi Māori, who are disproportionately affected, despite various government initiatives to ameliorate the situation. This thesis argues, based on international human rights law, domestic legislation, case law, and Māori health and well-being concepts, that a solution involves creating a theoretical and practical framework to address mental health disparities. This framework should employ a human rights lens and be culturally responsive, centering on Māori values and worldviews.

This thesis opened with a quote from John's story[1] to highlight the challenges that individuals encounter within New Zealand's mental health system. John's experience, while distinct, reflects the challenges and cultural dissonance encountered by many tamariki and rangatahi Māori in New Zealand's mental health system.[2] His story prompted a closer examination of how, despite initiatives and reforms, the mental health outcomes for tamariki and rangatahi Māori, like John, must be improved.

[1] Mental Health Commission *Four Maori Korero About Their Experiences of Mental Illness* (Series One, March 2000) at 19-22.

[2] Reremoana Theodore, Nick Bowden, Jesse Kokaua, Troy Ruhe, Matt Hobbs, Sarah Hetrick, Lukas Marek, Jesse Wiki, Barry Milne, Hiran Thabrew, and Joseph Boden "Mental Health Inequities for Māori Youth: A Population-level Study of Mental Health Service Data" (2022) 135 New Zealand Medical Journal 79.

It has been established that there is a clear mental health crisis impacting tamariki and rangatahi Māori in New Zealand.[3] New Zealand is among the OECD countries with the highest suicide rates in the 15-19 age group, and tamariki and rangatahi Māori are disproportionately affected.[4] This thesis seeks to address this challenge by drawing extensively on international human rights law, national legislation, relevant caselaw, and Māori views on health and well-being. The goal is to develop a theoretical and practical framework that aims to reduce mental health disparities from a human rights perspective. It specifically examines how the flexible nature of the best interests principle can integrate collective cultural rights and te ao Māori into mental health laws and policies. Grasping the concepts of collective cultural rights, the right to mental health, and the best interests principle can be challenging. To clarify these, the writer utilised a series of sub-questions for the research including:

- How is the best interests of the child principle interpreted in international and national legislation?

- What considerations are made for the best interests of Indigenous children?

- What are the implications of the right to mental health in international and domestic legal frameworks?

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[3] Health New Zealand, Te Whatu Ora "Suicide Data Web Tool" Health New Zealand <Suicide data web tool>; see also Roshini Peiris-John, Judy Ball, Terryann Clark, Terry Fleming and the Adolescent Health Research Group *Youth Mental Health Needs and Opportunities: Leveraging 25 Years of Research from the Youth2000 Survey Series* (The University of Auckland, University of Wellington and University of Otago, 2024) Hiran Thabrew, David Chinn and Krinn Isherwood "Navigating Youth Mental Health" (23 September 2023) He Ako Hiringa Learning Always <Navigating youth mental health | He Ako Hiringa>.

[4] Jock Phillips "Suicide" (26 January 2025) Te Ara – the Encyclopedia of New Zealand <https://pmc.ncbi.nlm.nih.gov/articles/PMC6243073/#B1>; see also Sue Crengle, Terryann Clark, Elizabeth Robinson, Pat Bullen, Ben Dyson, Simon Denny, Theresa Fleming, Sarah Fortune, Roshini Peiris-John, Jennifer Utter, Fiona Rossen, Jonie Sheridan, Teevale Tasileta and the Adolescent Health Research Group *The Health and Wellbeing of Māori New Zealand Secondary School Students in 2012. Te Ara Whakapiki Taitamariki: Youth'12* (The University of Auckland, Adolescent Health Research Group, 2013); Terry Fleming, Sue Crengle, Roshini Peiris-John, Jude Ball, Sarah Fortune, Esther Yao, Cinnamon Lindsay Latimer, Analosa Veukiso-Ulugia and Terryann Clark "Priority Actions for Improving Population Youth Mental Health: An Equity Framework for Aotearoa New Zealand" (2024) 34 Mental Health and Prevention 200339. Ministry of Health *Te Ohonga Ake: The Health Status of Māori Children and Young People in New Zealand* (Ministry of Health, 2017) at 99.

- In what ways do collective cultural rights interact with health-related rights and are they relevant when assessing the best interests of the Indigenous child?

- Are New Zealand's mental health laws and policies effective for tamariki and rangatahi Māori?

- What measures can be taken to improve New Zealand's laws and policies on mental health for tamariki and rangatahi Māori?

These questions quickly became central to the framework of this thesis and are discussed below.

9.2. The Findings – International Obligations and the AAAQ Framework

Persistent disparities in health outcomes between Indigenous and non-Indigenous populations, including mental health issues and high suicide rates among Indigenous youth, underscore the importance of addressing this issue.[5] The health challenges faced by Indigenous children are further intensified by intergenerational trauma and socioeconomic hardships. The principles of self-determination and FPIC are pivotal in achieving health rights for Indigenous peoples, highlighting the importance of Indigenous communities' active involvement in the planning, execution, and management of health services.[6] Nonetheless, obstacles persist in enforcing these rights and in identifying culturally suitable health strategies, particularly concerning mental health, for Indigenous communities.

The right to health, encompassing both physical and mental well-being, is enshrined in various international instruments such as the ICESCR, CRC, and UNDRIP.[7] It is now

[5] Melody Morton Ninomiya, Nicole Burns, Nathaniel Pollock, Nadia Green, Jessica Martin, Janice Linton, Jenny Rand, Laura Brubacher, Arn Keeling and Alex Latta "Indigenous Communities and the Mental Health Impacts of Land Dispossession Related to Industrial Resource Development: A Systematic Review" (2023) 7 The Lancet Planetary Health 501.

[6] *Expert Mechanism on the Rights of Indigenous People Study on the Right to Health and Indigenous Peoples with a Focus on Children and Youth* UN Doc A/HRC/33/57 (2016) at [13]; *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* UN Doc A/64/272 (10 August 2009) at [19].

[7] These instruments are discussed throughout this thesis.

well established that mental health is an integral component of the right to health.[8] The right to health for Indigenous peoples, particularly Indigenous children, is a complex issue within the international human rights framework. It encompasses a holistic view of health that includes mental, spiritual, emotional, and physical elements.[9] As a signatory to and having ratified these international agreements, New Zealand is required to uphold these human rights and fulfill these obligations.[10]

The AAAQ framework provides guidance on the meaning of the right to mental health and guides states on the obligations and expectations it entails.[11] For example, accessibility of healthcare provisions, including goods and services, should be present in adequate quantities for all populations.[12] However, Indigenous communities often face limited resources, with facilities and services frequently located in populated areas but understaffed and lacking sufficient medicines and equipment, rendering them non-operational. Indigenous communities face increasing challenges in meeting the four dimensions of accessibility due to prejudiced attitudes and behaviours of healthcare professionals, which generate fear and mistrust of medical facilities and can lead to incorrect diagnoses and improper treatment.[13] Physical accessibility poses a problem for Indigenous groups in remote areas, while economic accessibility is a challenge for these often socioeconomically disadvantaged communities.[14] Information accessibility is hindered by factors such as scarcity of information in Indigenous languages, limited opportunities, lack of contact with healthcare providers, and discriminatory attitudes among health workers.[15] Cultural appropriateness is essential for healthcare facilities, goods, and services, yet Indigenous populations face systemic discrimination in policies

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[8] World Health Organization "Mental Health: Strengthening Our Response" (17 June 2022) <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>.

[9] Estefania Bautista-Valarezo, Victor Duque, Adriana E Verdugo Sánchez and others "Towards An Indigenous Definition of Health: An Explorative Study to Understand the Indigenous Ecuadorian People's Health and Illness Concepts" (2020) 19 International Journal for Equity in Health 101; Mason Durie *Whaiora: Māori Health Development* (2nd ed, Oxford University Press, Auckland, 1999); Mason Durie "A Māori Perspective of Health" (1985) 20 Social Science and Medicine 483.

[10] Human Rights Commission "Right to Health" Tika Tangata < https://tikatangata.org.nz/human-rights-in-aotearoa/right-to-health>.

[11] *General Comment No. 14 The Right to the Highest Attainable Standard of Health (art. 12)* UN Doc E/C.12/2000/4 (11 August 2000) at [12]-[13].

[12] At [12]-[13].

[13] *Expert Mechanism on the Rights of Indigenous Peoples*, above n 6, at [22]-[27].

[14] At [22]-[27].

[15] At [22]-[27].

and practices. This results in the internalisation of stigma, creating obstacles to access. Negative attitudes, such as holding Indigenous communities responsible for their poor health, exemplify the lack of cultural sensitivity and unfavorable disposition towards these groups, contributing to barriers in accessing appropriate healthcare.[16]

States have a duty to safeguard, honour, and fulfill the right to mental health. Although the ICESCR and the CRC acknowledge resource limitations, there are several obligations that states must implement immediately, such as ensuring non-discrimination and taking deliberate, concrete, and targeted actions to fully realise the right to health.[17] Regarding the duty to respect, States are obligated to enact legislation and other measures that ensure equal access to healthcare.[18] They must adequately recognise the right to health within their national legal frameworks, ideally through legislative implementation (fulfil), and take steps to safeguard vulnerable or marginalized groups (protect).[19] Fundamentally, these components are vital for the State to uphold the mental health rights of Indigenous communities.

9.3. The Potential of the Best Interests Principle

This thesis suggests that the best interests principle can be employed to uphold the right to mental health. This principle, a key component of the CRC, mandates that all decisions concerning children prioritize their best interests.[20] Furthermore, it is linked with other CRC principles such as non-discrimination, the right to life, survival and development, and the right to be heard.[21] The CRC Committee describes it as a three-part concept: a

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[16] *Expert Mechanism on the Rights of Indigenous Peoples*, above n 6, at [27]; *Expert Mechanism on the Rights of Indigenous Peoples* above n 6, at [13]; see also Ashley Goodman, Kim Fleming, Nicole Markwick, Tracey Morrison, Louise Lagimodiere and Thomas Kerr "They Treated Me Like Crap and I know It Was Because I Was Native: The Healthcare Experiences of Aboriginal Peoples Living in Vancouver's Inner City"(2017) 178 Social Science and Medicine 87.

[17] *General Comment No. 14,* above n 11, at [30]-[37].

[18] At [30]-[37].

[19] At [30]-[37].

[20] Claire Breen *The Standard of the Best Interests of the Child: A Western Tradition in International and Comparative Law* (Kluwer Law International, The Hague, 2002); Aron Degol and Shimelis Dinku "Notes on the Principle Best Interest of the Child: Meaning History and Its Place Under Ethiopian Law" (2011) 5 Mizan Law Review 319 at 321; Steve Macbeth "The Application of the "Best Interests" Principle to Māori Children's Collective Cultural Rights: A Conceptual Shift for the New Zealand Family Court?" (LLM Dissertation, University of Waikato, 2015).

[21] *General Comment No. 11 Indigenous Children and Their Rights under the Convention* UN Doc CRC/C/GC/11 (12 February 2009) at [30]-[33].

substantive right, a legal principle, and a procedural rule.[22] Within a rights-based framework, the principle identifies the State as the primary duty bearer and the principle has evolved to include the cultural rights and needs of Indigenous children. Important factors to consider include the child's opinions, identity, family environment, care and protection, right to health, and right to education.[23] The principle can be aligned with the collective cultural rights of Indigenous communities.[24] Its adaptability and consideration of cultural rights make it suitable for addressing mental health issues among tamariki and rangatahi Māori. In New Zealand, the principle is already being applied in law and policy, indicating its potential as a tool for addressing various child-related issues.

At a local level, this thesis explored how the best interests principle is interpreted and applied within New Zealand's domestic laws, particularly the Care of Children Act 2004 and the Oranga Tamariki Act 1989. Although these statutes do not explicitly address mental health, they illustrate how the best interests principle is integrated into New Zealand's legal structures.[25] The courts have interpreted this principle broadly, often implicitly considering a child's psychological well-being, which aligns with mental health concerns (albeit within the limited scope of custody and care and protection cases).[26] The analysis of case law revealed several key themes, including the adaptability of the best interests principle, the critical importance of a child's safety, the focus on preserving family ties and cultural identity, and the consideration of both immediate and long-term effects on a child's development. The judiciary has highlighted the responsibilities of families, the significance of whakapapa, whanaungatanga, and the involvement of whānau, hapū, and iwi in decision-making processes for Māori children.[27]

In New Zealand's legal framework, the application of the best interests principle takes into account factors akin to those in these international frameworks, such as emotional needs, safety, and family dynamics, showcasing a flexible and adaptable approach. This

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[22] *General Comment No. 14 The Right of the Child to Have His or Her Best Interests Taken as a Primary Consideration (Article 3, paragraph.1)* UN Doc CRC/C/GC/14 (2013) at [11]-[20].

[23] *General Comment No. 14,* above n 22 at [55]-[59].

[24] *General Comment No. 11*, above n 2.

[25] See Care of Children Act 2004; Oranga Tamariki Act 1989.

[26] See for example *Kacem v Bashir* [2010] NZD 112; see also *Justice v HJ* [2006] NZSC 97; *Justice v HJ* [2006] NZSC 97; *Lowe v Way* [2015] NZHC 93.

[27] See generally Te Puna Rangahau o Te Wai Ariki Aotearoa New Zealand Centre for Indigenous Peoples and the Law *Determining the Best Interests of Tamariki Māori in Need of Care and Protection* (The University of Auckland, Report, December 2022) at 8.

existing methodology lays the groundwork for broadening the principle's use into mental health contexts. The thesis contends that incorporating the best interests principle into mental health law is justifiable and does not significantly deviate from existing practices, as both courts and lawmakers already consider psychological and emotional well-being when assessing a child's best interests in the context of custody and care and protection cases. This perspective bolsters the proposal to extend the principle's application to cases involving mental health.

9.4. Collective Cultural Rights

A key aspect of this thesis is the application of collective cultural rights to address the mental health needs and experiences of tamariki and rangatahi Māori. Unlike the conventional Western perspective, human rights for Indigenous communities cannot be viewed in isolation. Instead, the collectivist perspective of many Indigenous cultures, including Māori, emphasises group identity, relationships, and shared responsibilities.[28] Theorists like Kymlicka and Raz advocate for the acknowledgment of minority and Indigenous group rights, challenging the individualistic view of human rights.[29] Māori interpretations of collective rights underscore essential concepts such as whakapapa (genealogy), tikanga (customs/protocols), and whanaungatanga (kinship/relationships), which stress the interconnectedness of individuals, communities, and the natural environment.[30] The emphasis on collective values in Māori health models has significant implications for issues concerning the health of Māori children, particularly their mental health.

In the context of health, this thesis has explored that there is a significant relationship between individual and collective rights for Indigenous populations, as Indigenous identities are firmly rooted in group settings.[31] It emphasises the need for a rights-based approach to Māori health that incorporates collective rights perspectives and Māori concepts alongside individual rights frameworks. The health models put forward by Durie

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[28] *Expert Mechanism on the Rights of Indigenous Peoples,* above n 6, at [4].

[29] Will Kymlicka *Contemporary Political Philosophy* (Oxford University Press, Oxford, 2002); Joseph Raz *The Morality of Freedom* (Oxford University Press, Oxford, 1986) at 165-216; For general discussion please see 245-263.

[30] See generally Macbeth above n 20 at 26; see also Moana Jackson *The Māori and the Criminal Justice System: A New Perspective - He Whaipaanga Hou* (1988); Valmaine Toki *Indigenous Courts, Self-Determination and Criminal Justice* (Routledge, Oxford, 2018).

[31] Mason Durie "A Māori Perspective of Health" (1985) 20 Soc Sci Med 483 at 483.

and King, and Cormack and Kōpua acknowledge the interconnectedness of all aspects (spiritual, physical, extended whanau, emotional) to a person's well-being. Therefore, promoting the best interests of the Māori child requires consideration of collectivism. When addressing the mental health needs of Māori children, it is crucial to adopt a rights-based approach that incorporates whakapapa, whānau, and tikanga Māori at its core.[32] While acknowledging the challenges in fully implementing collective rights approaches in New Zealand's health laws and policies for Māori, the thesis stresses the importance of recognising these collective rights in addressing the health and mental health needs of tamariki and rangatahi Māori in culturally responsive ways.

Over time, some efforts have been made by the Crown to enhance the role of Māori in health matters[33] and to promote Māori representation in health governance, policymaking, and consultation. Yet concerns have been raised about the level of influence Māori have on health policies and the gap between policy statements and actual practices.[34] The principles outlined in the Treaty of Waitangi and a dedication to Māori health are emphasised in the policy document, He Korowai Oranga. The New Zealand Health Strategy aims to achieve equitable health outcomes for all while recognising the unique relationship between the Crown and Māori.[35] However, Māori voices can be marginalised or overlooked in health policy. Reasons include their numerical minority status both within the population and decision-making bodies, limited political will to prioritise policies for Māori, preference for Western knowledge over Māori evidence, inadequate cultural competence of managers and policymakers, and flawed consultation processes.[36] In the context of this thesis to make progress toward achieving the highest possible standard of mental health for tamariki and rangatahi Māori, the principle of best interests can be used to acknowledge the collective cultural rights of tamariki and rangatahi Māori and their significance in mental health and well-being.

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[32] Durie, above n 31, at 483; Paula King, Donna Cormack, Mark Kōpua "Oranga Mokopuna A Tāngata Whenua Rights-based Approach to Health and Wellbeing" (2018) 7 Mai Journal 186.

[33] For example the number of Māori sitting on District Health Boards, Mason Inquiries. These are discussed in Chapter Five.

[34] Timothy Gassin, Waitangi Tribunal, *A Report Commissioned by the Waitangi Tribunal for the Wai 2575 Health Services Outcomes Kaupapa Inquiry* (Wai 2575, B26, August 2019) at 91.

[35] Heather Came and Keith Tudor "Unravelling the Whāriki of Crown Māori Health Infrastructure" (2017) 130 NZMJ 42 at 42.

[36] Gassin, above n 34 at 91; Paul Whitinui "The Treaty and "Treating" Māori Health: Politics, Policy and Partnership" (2011) 7 AlterNative, An International Journal of Indigenous Peoples 138 at 142.

9.5. The Gaps

Examining the historical development of Māori mental health and related legislation in New Zealand reveals the influence of colonial legacies on health governance structures and ideologies.[37] Historically, mental health issues among Māori were not prominent in New Zealand society and Māori were not heavily represented in the mental health system, with recognition of Māori mental health concerns only emerging in the 19th century.[38] For example, during the early 1900s, Māori presence in mental health facilities was minimal. The 1858 Select Committee on the General Lunatic Asylum was unable to ascertain whether this was due to Māori exclusion or a genuinely lower incidence of mental illness among the Indigenous population.[39] Official records seldom mentioned mental illness among Māori, who constituted a small fraction of patients in state asylums.[40] Scholars have suggested various reasons for the initially low numbers, such as the unfamiliarity of Western medicine to Māori, who often resided in rural areas. Many Māori were either sceptical of or unfamiliar with these institutions and their unconventional methods of treating mental illness.[41] From 1959 to the late 1980s, data indicated that admission rates for both groups (Māori and non-Māori) increased in the early 1960s, with Māori rates rising more rapidly.[42] Māori rates continued to climb in the late 1960s, stabilised during the 1970s, and then rose again in the 1980s.[43] Although the government has implemented various initiatives and conducted inquiries, such as the Mason Inquiries, and despite efforts for Māori involvement in policy development and the creation of strategies like

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[37] Helen Moewaka Barnes and Tim McCreanor "Colonisation, Hauora and Whenua in Aotearoa" (2019) 49 Journal of the Royal Society of New Zealand 19; Bruce Cohen "Passive-Aggressive: Māori Resistance and the Continuance of Colonial Psychiatry in Aotearoa New Zealand" (2014) 1 Disability and the Global South 319.

[38] Cohen, above n 37; see also Helen Robinson Waitangi Tribunal *Te Taha Tinana: Māori Health and the Crown in the Te Rohe Pōtae Inquiry District, 1940-1990* (Wai 898, 2011) at 24; Frederick Foster *Māori Patients in Mental Hospitals* (Wellington: Department of Health, 1962); Alan Howard "Review of Māori Patients in Mental Hospitals" (1963) 72 Journal of the Polynesian Society 1 at 51-53; Mason Durie "Māori Psychiatric Admissions: Patterns and Policies" in John Spicer, Andrew Trlin and Jo Walton (eds) *Social Dimensions of Health: New Zealand Perspectives* (Dunmore Press, Palmerston North, 1994) at 328; Inspector-General "Mental Hospitals of the Dominion" [1910] 3 *AJHR* H07 at 23; Director-General "Mental Hospitals of the Dominion" [1939] 3 *AJHR* H07 at 14.

[39] Warwick Brunton "A Choice of Difficulties: National Mental Health Policy in New Zealand" (PhD thesis, University of Otago, 2001) at 48.

[40] Robinson, above n 38, at 24-25.

[41] Lorelle Burke "The Voices Caused Him to Become Porangi: Maori Patients in the Auckland Lunatic Asylum, 1860-1900" (MA Thesis, University of Waikato, 2006) at 33.

[42] Gassin, above n 34, at 8.

[43] Note: Caution is issued that these numbers do not accurately represent the true prevalence of mental illness; Gassin, above n 34, at 8; see also Foster, above n 38, at 51-53.

the 1997 "Looking Forward: Strategic Directions for the Mental Health Services", recent statistics indicate that poor mental health outcomes for Māori, particularly tamariki and rangatahi Māori, remain a significant issue.[44] The historical evolution of mental health legislation in New Zealand reveals a gradual shift towards a rights-based approach, with increased focus on Māori mental health since the 1980s and 1990s.[45] Despite this progress, significant challenges persist, particularly for tamariki and rangatahi Māori.

The current legal framework falls short in several areas. It lacks explicit recognition of the right to health in domestic law, provides limited enforceability of health objectives under the Pae Ora Act 2022, and fails to offer adequate culturally appropriate mental health services for tamariki and rangatahi Māori. Furthermore, there is insufficient implementation of cross-cutting principles such as participation, non-discrimination, and accountability. This thesis recommends that stronger legislative measures are necessary to ensure compliance with international obligations and address the specific mental health needs of tamariki and rangatahi Māori. The current health legislation does not fully meet New Zealand's commitments to protect, promote, and fulfill the right to health for Māori communities and their young people.

New Zealand's approach to addressing health disparities between Māori and non-Māori, particularly in mental health for youth and children, relies heavily on policies rather than comprehensive primary legislation. While these policies aim to promote culturally sensitive approaches and address social determinants of health, their lack of legal force results in inconsistent implementation and limited accountability.[46] The absence of legislative backing for mental health service policies creates significant deficiencies. This gap between policy intentions and actual service delivery emphasises the urgent need for substantial legislative improvements.[47] To tackle these challenges effectively, incorporating policy goals into legislation would strengthen government commitments, establish clear accountability frameworks, and make the government directly accountable for addressing health inequalities. This legislative approach would provide a stronger

[44] Ministry of Health *Looking Forward: Strategic Directions for the Mental Health Services* (1994) at 1-3.
[45] See Chapter Six for further discussion.
[46] See Chapter Eight for further discussion.
[47] Ministry of Health *Transforming Our Mental Health Law: A Public Discussion Document* (2021).

framework for ensuring consistent implementation of the right to mental health for all individuals, especially tamariki and rangatahi Māori.

9.6. A Way Forward

The best interests principle can be utilised to fulfill the right to the highest achievable standard of mental health for tamariki and rangatahi Māori in New Zealand. National legislation and policies are crucial to enhance the mental health rights of tamariki and rangatahi Māori and align the country more closely with international human rights standards (such as the AAAQ framework). This thesis has proposed legislative amendments include incorporating economic, social, and cultural rights into the New Zealand Bill of Rights Act (thereby the right to health), amending the Pae Ora (Healthy Futures) Act 2022 to include specific provisions for culturally appropriate preventative mental health services for children, and incorporating the UNCRC, particularly the best interests principle, into domestic law. Interpreting the right to mental health from an Indigenous Māori perspective is essential when developing laws and policies. These proposed changes aim to create a stronger legal framework that protects the mental health rights of tamariki and rangatahi Māori, ensures culturally appropriate services, and improves government accountability.

9.7. Final Observations

In summary, this thesis has highlighted deficiencies in the current legal and policy framework concerning the rights of tamariki and rangatahi Māori to attain the highest attainable standard of mental health. It has laid the groundwork for further investigation into how New Zealand can better meet its national and international obligations to uphold the right to mental health for everyone, especially for tamariki and rangatahi Māori, by adopting a culturally sensitive and rights-based approach that incorporates collective cultural rights and te ao Māori perspectives. The suggested legislative amendments and policy proposals present a way to bridge these gaps. By incorporating the best interests principle, recognising Indigenous viewpoints, and strengthening domestic laws, New Zealand can create a more effective system for protecting and advancing the right to mental health for tamariki and rangatahi Māori. Implementing these changes would bring the country into closer alignment with international commitments and promote more equitable, culturally aware, and efficient mental health services for Māori children

and young people. This comprehensive approach has the potential to greatly enhance mental health outcomes and overall well-being for tamariki and rangatahi Māori, contributing to a more inclusive and responsive mental healthcare system in New Zealand. The thesis establishes a foundation for future research and policy development in this vital area of health and human rights.

Te rongonui o te taniko kei roto i te whiriwhiri noa mäu tonu töna ätaahua
– The beauty of taniko (the embroided border of a fine woven cloak) is that there is more than one pattern.[48]

9.8. One Last Thought - Possible Future Research

This thesis has demonstrated that the best interests principle is adaptable and can be shaped to include collective cultural rights and perspectives that differ from mainstream or Western ideologies. It serves as an effective tool for advocating change. Although the focus has been on mental health, the best interests principle can be applied to future research in other areas concerning children and young people, such as education. Future research could examine how this principle is implemented in educational contexts, potentially exploring its impact on decision-making processes in schools, especially for students with special needs or from marginalised/vulnerable communities. Researchers could evaluate the effectiveness of policies and laws based on this principle in promoting equitable access to quality education and addressing systemic barriers faced by marginalised groups. Another possible research area could be the application of the best interests principle in early childhood education, focusing on its influence on the development of law and policy that impacts the curriculum development, teaching methods, and parental involvement in educational settings. Undoubtedly, improved education (or health) would have a positive ripple effect on other aspects of children's and young people's lives.

Finally, the emerging jurisprudence recognising tikanga Māori as a source of law in its own right signals a potentially transformative shift in Aotearoa New Zealand's legal

[48] Robert Joseph "Re-Creating Legal Space for the First Law of Aotearoa-New Zealand" (2009) 17 Waikato Law Review 74.

landscape.[49] In the mental health context, this evolution has significant implications including the reshaping how concepts such as wellbeing, and best interests are understood and applied, creating greater space for Māori decision-making authority. This is very much an area that should be explored further.

[49] *Ellis v The King* [2022] NZSC 114; *Takamore v Clarke* [2012] NZSC 116

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Appendix One

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Thilini Karunaratne

Claire Breen

Te Piringa Faculty of Law

17 June 2021

Dear Thilini

Re: **FS2021-35: Mental health of Indigenous Children**

Thank you for applying to the ALPSS Human Research Ethics Committee. We have reviewed your application and the Committee is now pleased to offer formal approval for the research activities as detailed therein.

Please contact the Committee should issues arise during your data collection, or should you wish to add further research activities or make changes to your project as it unfolds. We wish you all the best with your research. Thank you for engaging with the process of ethical review.

Kind regards,

Nathan Cooper, Chair
Division of Arts, Law, Psychology & Social Sciences Human Research Ethics Committee