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RESEARCH ARTICLE

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The potential of a rights-based approach to refugee-focused mental health policy in Aotearoa New Zealand

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ABSTRACT
In accordance with international human rights commitments, individuals with a refugee background have the right to mental health services that are available, accessible, acceptable, and of good quality. However, refugee-background individuals living in Aotearoa New Zealand experience a myriad of barriers at the individual, community, and policy level that impede access to appropriate mental health services. This commentary puts forward the argument that the incorporation of a human rights-based approach to mental healthcare service at a policy level is essential for reducing barriers to care and increasing the accessibility of mental health services. The article provides key recommendations for reforming the current New Zealand Refugee Resettlement Strategy (NZRRS) to include rights-based indicators for children and youth, to monitor accessibility relative to geographic location, to disaggregate data, to extend the 12-month monitoring period and to extend monitoring beyond one mental health visit. Further research is needed to understand how best to implement these recommendations and develop insight into how Aotearoa New Zealand can more effectively uphold the rights of refugee-background individuals with the ultimate goal of developing a mental health system that is more inclusive and responsive to their needs.

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Introduction: addressing refugee-focused mental health policy

As conflicts around the world continue and the impact of climate change increases, the world is facing a global humanitarian crisis of unparalleled proportions. As of June 2024, over 117 million individuals were displaced – with an estimated 37.46 million recognised as refugees and 6.9 million as asylum seekers (United Nations High Commissioner for Refugees [UNHCR] 2024b). These are numbers of record proportion, and the United

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Nations High Commissioner for Refugees (UNHCR) projects that these numbers will continue to rise (UNHCR 2024a). The issue of human displacement has become a global political focus. Governments must grapple with their commitment to human rights obligations, their national capacity for providing resettlement, and the political climate of their constituents as they navigate how to address the growing displacement (Salehyan and Savun 2024; Solodoch 2024). As a member of the United Nations (UN) and signatory to the 1951 Convention Relating to the Status of Refugees and the 1967 Protocol, Aotearoa New Zealand resettles refugees via four pathways: the Quota pathway (in partnership with UNHCR), the Convention pathway (for asylum seekers), the Refugee Family Support Category, and the Community Organisation Refugee Sponsorship (CORS) programme (Immigration New Zealand [INZ] 2024c). The core policy document guiding resettlement is the New Zealand Refugee Resettlement Strategy (NZRRS), which outlines targets for successful integration as per the UNHCR (INZ 2024b).

Resettlement is one of the UNHCR's three long-term solutions for displaced people, alongside voluntary repatriation to one's country of origin and local integration into the country of initial asylum (UNHCR 2016). While it is the primary pathway of arrival for refugees in Aotearoa New Zealand, globally it is the least frequently offered, with less than 1% of the refugee population selected (UNHCR 2020). The effectiveness of resettlement as a solution has been widely questioned (Chimni 2004; Ineli-Ciger 2022) with a growing body of evidence highlighting the challenges faced during resettlement and the impact on mental health and well-being (Chen et al. 2017; Fazel 2018; Giacco et al. 2018; Hamrah et al. 2021).

In refugee communities, pre-migration risk factors for experiencing psychological distress are well established (e.g. exposure to war, violence, persecution, and time spent in a refugee camp) (Bogic et al. 2015; Chen et al. 2017; Silove et al. 2017; Giacco 2020). However, emerging literature indicates that *post-migration* factors such as separation from family, social isolation, discrimination, economic stress, poor housing and unemployment are most critical in impacting the long-term mental health and well-being outcomes of refugee-background individuals (Chen et al. 2017; Fazel 2018; Giacco 2020). In the first 5 years following resettlement, refugee-background individuals are more likely to experience post-traumatic stress disorder (PTSD), depression, anxiety and severe mental health symptomatology (Bogic et al. 2015; Chen et al. 2017; Giacco et al. 2018; Giacco 2020; Hamrah et al. 2021; Ali-Naqvi et al. 2023).

Elevated rates of mental health conditions are compounded by the barriers refugee-background individuals face when accessing mental healthcare. Globally, refugee-background individuals of all ages have lower rates of mental health service use due to difficulty navigating a new healthcare system, cultural differences in the conceptualisation of mental health, experiences of discrimination, linguistic barriers, and stigma (De Anstiss and Ziaian 2010; Satinsky et al. 2019; Byrow et al. 2020; Van Der Boor and White 2020; DeSa et al. 2022). In Aotearoa New Zealand, refugee-background individuals report a sense of 'otherness', difficulty navigating a new health system, fragmented care, high direct costs, unavailability of interpreters, and a lack of culturally competent service providers as factors contributing to decreased service use (Shrestha-Ranjit et al. 2020; Sherif et al. 2022; Cassim, Ali, et al. 2022; Cassim, Kidd, et al. 2022; Kanengoni-Nyatara et al. 2024). While it is imperative to dismantle the misinformed narrative that all refugee-background individuals need mental healthcare due to being 'traumatised, helpless, or vulnerable', it remains imperative that appropriate and accessible

mental healthcare is available to those who require it during the resettlement process (Silove et al. 2017; Ryu and Tuvilla 2018).

This impetus that appropriate and accessible mental healthcare be available to refugees is grounded in human rights obligations. Access to mental healthcare is a universal and incontrovertible right and entitlement of all individuals (UN General Assembly [UNGA] 1948). As a member of the UN, Aotearoa New Zealand has an enduring commitment to welcoming and resettling refugees and a responsibility to protect, promote and fulfil their rights – including the right to good mental healthcare. As such, this commentary explores what the universal right to access mental healthcare means, politically and practically, for refugee-background individuals resettled in Aotearoa New Zealand across three sections. The first section explores the entitlements of refugee-background individuals to mental healthcare. The second section examines the influence international commitments have on domestic policy and practice in Aotearoa New Zealand, situating the provision of mental healthcare within the local socio-political context. The third section provides recommendations for applying a rights-based and evidenced-informed approach to the NZRRS and the implications for service provision and refugee-background service users in Aotearoa New Zealand.

Part one: the universal right to mental healthcare

Internationally, the right to good health is protected under several universal and refugee-specific treaties and conventions. The World Health Organization (WHO) Constitution is well-known for stating that 'the enjoyment of the highest attainable standard of health is a fundamental right of every human being without distinction of race, religion, political belief, economic or social condition' (World Health Organization [WHO] 1946, p. 1). The WHO recognises health and healthcare access to be a fundamental right of refugee-background individuals and an integral component of good migration governance (WHO 2019). However, the WHO also acknowledges that refugee-background individuals face significant disparities in actualising the right to health and emphasises that a lack of healthcare access contributes to adverse mental health outcomes (WHO 2019).

The most explicit enumeration of the right to health is articulated in Article 12.1 of the International Covenant on Economic, Social and Cultural Rights (ICECSCR) (UNGA 1966), which recognises the right to physical and mental health and the right to access preventative, curative, and rehabilitative healthcare. Individuals are entitled to equal opportunity within a healthcare system, equal and timely access to basic health services, and participation in health-related decision-making (UN Office of the High Commissioner for Human Rights [OHCHR] 2008). Furthermore, under the AAAQ framework, individuals have the right to healthcare services that comprise four core interrelated components. First is *availability*, which seeks to ensure the provision of a sufficient quantity of services for people of all ages, sexes, genders, locations, and socio-economic statuses. Second, *accessibility* mandates that healthcare services be physically available, affordable, non-discriminatory, and provide accessible information. Third, *acceptability* requires services to be people-centred, adhere to international ethical standards, provide culturally appropriate care, and be sensitive to an individual's gender. Finally, *quality* wherein services should provide safe, effective, timely, equitable and efficient care (UN

Economic and Social Council 2000). The UN Committee on Economic Social and Cultural Rights (2017) articulates that states are to unequivocally apply the ICESCR to all refugees, asylum seekers, and migrants within their state, 'even when their situation in the country concerned is irregular' (p. 1) (e.g. individuals seeking asylum on arrival).

Cross-cutting human rights principles inform how the right to health is to be implemented at a policy level with four principles critical to effective health policy (UN Economic and Social Council 2000; Bustreo and Doebbler 2020). *Participation* prioritises the inclusion and active participation of the population in health-related decision-making and policy development. *Transparency* ensures accessibility to health-related information and policies, visibility in the pathway between policy development and resource allocation, and equity in decision-making. *Accountability* calls for the inclusion of health indicators by which healthcare policy can be effectively monitored, and *non-discrimination* requires the explicit prohibition of discrimination, the promotion of equitable access to healthcare services, the prioritisation of groups who face barriers to care, and the disaggregation of data to identify inequities.

The principle of non-discrimination is considered one of the core obligations of the ICESCR which stipulates that States must protect the 'right of access to health facilities, goods, and services on a non-discriminatory basis, especially for vulnerable or marginalised groups' (p. 25) with non-discrimination being recognised as critical to the enjoyment and fulfilment of the right to health (OHCHR 2008). Under Article 5 e (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (CERD), signatory states must strive to 'prohibit and eliminate all forms of racial discrimination' to ensure equitable fulfilment of the right to public health, medical care and social services (UNGA 1965). For refugee-background individuals, experiences of discrimination have been linked to poor mental health outcomes, a decreased sense of belonging, and a barrier to accessing and engaging with healthcare (De Anstiss and Ziaian 2010; Edge and Newbold 2013; Szaflarski and Bauldry 2019; Ziersch et al. 2020).

For populations identified as more susceptible to experiences of discrimination, the right to mental healthcare is further protected by specific principles and conventions – namely the Convention on the Rights of the Child (CRC) (1989) and the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Healthcare (1991). Article 24 of the CRC articulates that children have the right to enjoy the highest attainable standard of health including the right to access healthcare facilities (UNGA 1989). Enumerations of Article 24 specify that this includes the need for increased focus on the 'mental health, psychosocial wellbeing and emotional development' (p. 10) of children, including the development of mental health-focused preventative care (UN Committee on the Rights of the Child (CRC) 2013). Children of refugee-background or currently seeking refuge are further supported under Article 22 which outlines the obligations of States to ensure their protection and assist in the reunification of children with their families – a key protective factor for positive mental health outcomes (UNGA 1989; Choummanivong et al. 2014).

Similarly, the Principles for the Protection of Persons with Mental illness and the Improvement of Mental Healthcare (1991) stipulate that all individuals with mental health conditions have the right to the best available mental healthcare, the right to freedom from discrimination on the basis of mental illness, the right to treatment suited to cultural background, the right to informed consent, the right to freedom of

religion and belief, and the right to information (UNGA 1991). For refugees and asylum seekers with mental health conditions, this indicates a commitment to provide culturally appropriate, accessible mental healthcare that is available regardless of legal status and to ensure agency in health-related decisions.

While the application of human rights regarding the mental health of refugees and asylum seekers is confirmed by the indivisible and interdependent nature of all human rights documents, the perennial, refugee-specific rights agreement is the 1951 Convention Relating to the Status of Refugees and the 1967 Protocol. The Convention defines a refugee as someone who is unable to return to their country 'owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion' (UNGA 1951, p. 14). Ratified by Aotearoa New Zealand in 1960 and 1973 respectively, the overarching aim of the 1951 Convention and the 1967 Protocol is to establish international standards for refugee protection and outline the standards by which nations are to treat refugees and asylum-seekers. Although there is no explicit inclusion of the right to health within the Convention, Article 23 states that 'contracting States shall accord to refugees lawfully staying in their territory the same treatment with respect to public relief and assistance as is accorded to their nationals' (UNGA 1951, p. 24–25) wherein public relief includes the provision of all social and medical assistance as available to individuals residing within their country (Grahl-Madsen 1997). Most recently, the New York Declaration for Refugees and Migrants (UNGA 2016) and the Global Compact on Refugees (UNGA 2018) reinforced States commitments to the 1951 Convention and reiterated the right of refugee-background individuals to mental healthcare. In particular, the Global Compact on Refugees provides nations with a framework of implementation, outlining how all rights are to be protected, respected and fulfilled, and to 'galvanise action for an improved response to refugee situations' (UNGA 2018, p. lll). Importantly, the Compact reiterates State obligations to develop health systems – policies and practices – that support the mental health of resettled individuals with particular consideration of the mental health needs of children and adolescents.

The various treaties and conventions enumerated by the United Nations and ratified by Aotearoa New Zealand articulate an optimal expression of equitable, accessible and appropriate mental healthcare for refugee-background individuals. However, the realisation of rights requires the principles to be incorporated into domestic law and enforced in local practice. In this regard, critics highlight the often aspirational nature of international treaties and the many ongoing disparities between human rights ratification and human rights compliance (Hafner-Burton and Tsutsui 2005). This critique is evident in the approach taken by many nations in refugee-focused policy (Chetail 2014), and is evident in the approach to refugee-specific policy in Aotearoa New Zealand (Mahony et al. 2017).

Part two: the right to mental healthcare in Aotearoa New Zealand

International conventions and domestic law in Aotearoa New Zealand

In principle, Aotearoa New Zealand has committed to the ongoing realisation of *all* rights as afforded to *all* people. *In practice*, however, the translation of international treaties to domestic policy is not a linear process (Geiringer and Palmer 2007). Parliamentary

statute remains the highest level of legislative power in Aotearoa New Zealand, retaining the ability to override domestic and international law. This reflects an approach to international treaties under which international treaties must be converted into domestic law if they are to become legally binding (Hopkins 2011). As a result, the interpretation and incorporation of international treaties at a political and judicial level often rely on the values of treaties being imbued into domestic law rather than explicitly incorporated (Hopkins 2011).

As a measure of accountability, the UN enacts a Universal Periodic Review (UPR) of all member states – a 5-yearly assessment of a state's progression towards the full enactment of human rights. Aotearoa New Zealand has undergone three UPR cycles (2009, 2014, 2019), with the most recent identifying the need to improve mental health services for 'young people, men, ethnic communities and the LGBTIQ community' (UNGA 2019, p. 11), encompassing refugee-background communities as part of Aotearoa New Zealand's ethnic community (Ministry for Ethnic Communities – Te Tari Mātāwaka 2023). Additionally, the recent report from the United Nations Committee on the Elimination of Racial Discrimination (2017) highlighted concerns in Aotearoa New Zealand regarding 'inadequate access to social services, including mental health programmes … for migrants, asylum seekers and refugees' (p. 6) with section 32 (c) suggesting Aotearoa New Zealand must seek to 'ensure that all asylum seekers and refugees have access to adequate and appropriate services, including social work and counselling services, so as to fully enjoy their economic, social and cultural rights' (p. 6).

In Aotearoa New Zealand, there exists a noticeable disparity between the principles of rights and their practical implementation regarding the right to health for refugee-background individuals. Reviews on the implementation, protection, and fulfilment of the right highlight an urgent need for improved access to adequate, appropriate, and acceptable mental health services. This disparity does not exist in isolation but reflects the broader socio-political and mental health context of Aotearoa New Zealand.

Mental health context of Aotearoa New Zealand

Across the general population, Aotearoa New Zealand is currently experiencing an 'epidemic of mental distress and addiction', perpetuated by a discrepancy between mental health service needs and mental health service availability (Patterson et al. 2018, p. 10). Annually, one in five people living in Aotearoa New Zealand experience mental illness or significant mental distress yet estimates indicate there is one psychologist available for every 312 individuals who would benefit from treatment and one for every 145 individuals with severe mental health difficulties (Rucklidge et al. 2018). The recent mental health and well-being inquiry, He Ara Oranga (Patterson et al. 2018), identified a range of system-level shortcomings contributing to deficits in available care, namely, inaccessible services due to a fragmented mental health system, long delays in treatment delivery, arbitrary intake thresholds, a lack of available information and, a lack of culturally appropriate services. Importantly, these barriers do not impact individuals indiscriminately. Rural communities face limited access to and availability of mental health services, and for refugee-background individuals, the inquiry noted that barriers were perpetuated by language differences, a lack of qualified interpreters, poverty, cultural beliefs, and reduced knowledge of the mental health system (Patterson et al. 2018).

It is widely acknowledged that the entire mental health system in Aotearoa New Zealand needs reform, including the relevant policies, funding channels and pathways to care (Every-Palmer et al. 2024). Refugee-background individuals arriving, resettling and living in Aotearoa New Zealand are entering a system that is overburdened, underfunded, and underserving individuals in need (Patterson et al. 2018). However, this widespread need does not divert, dilute, or excuse from the rights and entitlements Aotearoa New Zealand has committed to fulfilling regarding the right to health. Rather, in a mental health system calling for reform, it creates the opportunity to ascertain how the current policies are fulfilling the rights of refugees and how these can be better informed moving forward.

Current national policy and the right to health – Tika ki te Whai Oranga

Te Tiriti o Waitangi is central to the legislative and human rights context of Aotearoa New Zealand. Signed in 1840, Te Tiriti affirmed tino rangatiratanga (absolute sovereignty) of Māori as tangata whenua (Indigenous peoples) and outlined the relationship between Māori and the British Crown (Came et al. 2023). Despite the provisions in Te Tiriti, Māori have been systemically marginalised under colonial governance, evident in the illegal dispossession of Māori-owned land and the implementation of discriminatory laws such as the Pae Ora (Disestablishment of Māori Health Authority) Amendment Act (2024) (Came et al. 2024). Current and historical inequities in the provision of mental healthcare and the inaccessibility of mental health services disproportionally impacted Māori, contributing to increased rates of mental distress (Gassin 2019). The history of Te Tiriti highlights the real and realised risk of discriminatory mental healthcare practice and policy and demonstrates the grave reality of failing to enact a human rights-based healthcare system. This history provides impetus to the necessity of prioritising non-discriminatory, culturally safe, and equitable healthcare services (Berghan et al. 2017) – a necessity that is applicable to refugee-focused mental healthcare policy and practice.

Additional rights-imbued legislation in Aotearoa New Zealand includes the New Zealand Bill of Rights Act (1990) and the Human Rights Act (1993). Neither of these Acts (nor any other Act in Aotearoa New Zealand) explicitly mentions the 'right to health', rather, each are embedded with rights-based language – protecting and promoting the rights of individuals to enjoy equal opportunity, freedom from unfair treatment, and freedom from discrimination – rights which extend to healthcare provision. The absence of an explicit 'right to health' reflects the political approach in Aotearoa New Zealand wherein economic, social and cultural rights are recognised, but only incorporated implicitly, indirectly and often imprecisely into domestic law and statues (Geiringer and Palmer 2007; McDougall 2015).

Moving to healthcare policy more specifically, the Pae Ora (Healthy Futures) Act 2022 was introduced to 'protect, promote and improve the health of all New Zealanders' (Ministry of Health 2022, s. 3A) and ensure equal and equitable access to good quality healthcare – wording that again is imbued with rights-based language and reflects the values and ideals of Article 12.1 of the ICESCR. Under Pae Ora, Te Whatu Ora (Health New Zealand) established an interim 2-year plan, Te Pae Tata (Health New Zealand (Te Whatu Ora) & Te Aka Whai Ora (Māori Health Authority) 2022). Te Pae

Tata includes mental health and well-being targets and a commitment to collaborate with refugee-background communities to develop appropriate and accessible health policies and services. In partnership with Te Whatu Ora, the Ministry of Health identified improving mental well-being as a government priority and introduced a range of high-level health system indicators to measure performance. Under this priority, the current targets are for individuals under 25 to access mental health services within 3 weeks of referral and to improve access to primary mental health and addiction services (Te Whatu Ora 2024). While Te Pae Tata includes a long-term intention to prioritise the health and well-being of refugee communities and develop more inclusive and accessible services, there is currently a notable absence of actionable goals or performance measures monitoring implementation and progress in this area.

The New Zealand Health Strategy, published by the Ministry of Health (2023b), also sits under the Pae Ora (Healthy Futures) Act 2022 and is the leading national strategy for addressing the health and well-being of all New Zealanders. A core long-term goal of the Strategy is 'to achieve health equity for our diverse communities' by prioritising aspects such as timely access to healthcare services (Ministry of Health 2023b, p. 4). Within the Strategy, refugee-background individuals are included under the umbrella term 'ethnic communities' which further includes 'asylum seekers, new and temporary migrants, long-term settlers and multigenerational New Zealanders' (p. 30). While the inclusion of refugee-background communities under the term 'ethnic communities' is noted, this term ultimately refers to a heterogeneous group of communities representing various migration backgrounds and ethnic groups with a diverse range of health needs. Using ethnicity as a proxy for refugee status is problematic in that it raises issues of specificity and diminishes the accurate identification of the health needs of a diverse group of people (Parackal et al. 2021). Thus, despite a commitment to achieving health equity for our diverse communities, there fails to be appropriate data available to subsequently inform the development of refugee-specific, actionable healthcare targets.

Similarly, Kia Manawanui Aotearoa – New Zealand's plan for transforming mental health and well-being reflects the familiar approach to healthcare policy wherein refugee-specific needs are acknowledged but not addressed. The refugee-background community are identified in Kia Manawanui Aotearoa as a population group requiring special focus, however, in the 2021 plan, there are no refugee-specific goals, merely a mention of the need to understand '"specific populations" needs and services and how better to meet their needs (eg, … [a] review of refugee mental health service provision)' (Ministry of Health 2021, p. 48). Additionally, in the subsequent 2023 update, the singular refugee-specific reference is in regard to the development of an 'Asian, migrant and refugee' competency training for health practitioners (Ministry of Health 2023a).

Evidently, there is an absence of specific targets for improving mental health service use and well-being outcomes for the refugee-background community in much of the healthcare policy implemented in Aotearoa New Zealand. The Ministry of Health is ultimately responsible for funding, implementing and auditing healthcare policy, however, current Ministry of Health policies rely on an indirect inclusion of both human-rights-based language and refugee-background-specific targets. Protection of the right to health is broadly mentioned through statements that reflect rights-based values (such as equitable and accessible healthcare) but lack specific and measurable rights-based outcomes. Moreover, there is an acute absence of refugee-specific mental health

targets in high-level health policy (e.g. the New Zealand Health Strategy 2023; Ministry of Health 2023b). Despite this absence of explicit actionable policy on refugee-background health, the Ministry of Health is responsible for providing health data to Immigration New Zealand for the New Zealand Refugee Resettlement Strategy – the primary document outlining the protection and promotion of rights at a governance level for refugee-background individuals in Aotearoa New Zealand.

Mental healthcare in the NZRRS

Developed in 2012, implemented in 2013 and refreshed in 2023, the NZRRS is the primary domestic commitment by the New Zealand government outlining resettlement targets for refugees. Prior to the refresh, the NZRRS exclusively applied to quota refugees but has now expanded to include Convention Refugees and Protected Persons, the Community Organisation Sponsorship Category, the Refugee Family Support Category, and Afghan Evacuees and Interpreters (INZ 2024b). The aim of the NZRRS is that individuals 'settle successfully, achieve their goals and thrive in Aotearoa New Zealand' as operationalised via five key pillars: participation and inclusion; health and well-being; housing; education, training, and English language; employment and self-sufficiency (INZ 2024b). Under health and well-being, the target outcome is that 'former refugees and their families achieve their health and wellbeing goals and thrive in their lives', monitored by three success indicators, one of which pertains to mental health: 'access to mental health services (at least one mental health related face to face visit)' within 12 months (INZ 2022). Following the refresh, these success indicators have yet to change from the original measures outlined in 2012, indicating that while there was a political commitment to expand the inclusivity criteria of the NZRRS, there is no tangible update on how this will be resourced, implemented, or measured.

The ongoing development of the success indicators for the NZRRS is integral to effective enactment, particularly as the NZRRS is a whole-of-government strategy meaning responsibility for fulfilling the aims and outcomes spans multiple governmental agencies. While whole-of-government approaches seek to promote inter-agency collaboration and the efficient use of resourcing, there is also the risk of agencies having diminished responsibility for the strategy and unclear expectations regarding resourcing and funding allocations (Humpage 2005; Martin 2011). Under the NZRRS, the Ministry of Health is responsible for implementing and monitoring the mental health success indicator. However, there is a notable lack of refugee-background targets within key Ministry of Health documents (Te Pae Tata, the New Zealand Health Strategy, Kia Manawanui Aotearoa). While this absence of ministry-specific targets is not a direct result of the absence of detail about mental health indicators in the NZRRS, including more depth and detail at the whole-of-government level will increase the impetus that relevant agencies prioritise refugee-background mental healthcare and reflect the aims of the NZRRS within their ministry policies.

The lack of depth and detail in the current NZRRS mental health indicator is also troubling from a human rights perspective. The current indicator only includes accessibility – one out of the four core components of rights-based healthcare (availability, accessibility, acceptability, good quality). While accessibility is a critical component of rights-based care, rights-based policy also requires an accurate operationalisation of the construct.

According to the WHO, the accurate operationalisation of accessibility would incorporate the assessment of four dimensions: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility (UN Economic and Social Council 2000). Yet, in the NZRRS, accessibility has been operationalised as 'at least one face-to-face visit within 12 months', which is fulfilled after one recorded event of healthcare utilisation.

From a rights-perspective, it can be argued that equating 'healthcare access' with 'healthcare utilisation' is insufficient as an accurate portrayal of access and for the protection and fulfilment of the mental health rights of refugee-background individuals in Aotearoa New Zealand. Healthcare utilisation as a proxy for access relies on unhelpful and potentially harmful assumptions. It rests on the normative belief that those who need healthcare will progress through the healthcare system in a linear fashion while excluding the impact of factors such as discrimination, affordability and access to information and more broadly the availability, acceptability, and quality of services (Goddard and Smith 2001; Dixon-Woods et al. 2006). Not only does this diminish any rights-based foundation of the NZRRS mental health indicator, but it frames the responsibility of healthcare access as an individual behaviour, disregarding the consideration of contextual and systematic factors, such as cultural beliefs, health literacy, faith backgrounds, socio-economic status, affordability, intake thresholds, and navigation of a healthcare system – all of which have been identified as relevant barriers to mental healthcare use by refugee-background individuals (De Anstiss and Ziaian 2010; Satinsky et al. 2019; Byrow et al. 2020; Van Der Boor and White 2020; DeSa et al. 2022).

Mental health service use among refugee-background individuals in Aotearoa New Zealand

The importance of rights-based policy in the mental health sector is not merely atheoretical with the restriction of measuring 'healthcare access' as 'healthcare utilisation' having tangible implications for refugee-background individuals in Aotearoa New Zealand. Data from INZ shows that from 2015 to 2021, 40%–45% of quota refugees attended at least one mental health-related appointment within the first 12 months (INZ 2022). These high rates of service utilisation are unsurprising, as quota refugees receive 12 months of government-funded settlement support, including a 5-week stay at Te Āhuru Mōwai o Aotearoa – Māngere Refugee Resettlement Centre – where mental health assessments and referrals to secondary services are made available (INZ 2024d).

Beyond the INZ data, further research has investigated contact with specialist mental health services for refugees from all four visa pathways during their first 5 years of resettlement in Aotearoa New Zealand (Petrović-van der Deen et al. 2023). For quota refugees, utilisation of specialist mental health services was similar to the results reported by INZ, with high rates of service use during the first 12 months. However, these rates dropped in the following 2–5 years, with only 2% of quota refugees accessing mental health services through the public health system 2–5 years after resettlement (excluding NGO-provided care). Similarly, for non-quota refugees, rates of service use via the public health system reflected low rates of service use. In the first 5 years post-resettlement, only 2%–3% of convention refugees contacted public specialist mental health services, 1% of family reunification refugees, and 3.9% of asylum seekers (Ferns

et al. 2022; Petrović-van der Deen et al. 2023). Due to the lack of funded settlement support for non-quota refugees, low rates of service utilisation are evident from the first year of resettlement. It is hoped that these disparities between quotas and non-quotas will minimise with the NZRRS expansion to now include refugee-background individuals from all pathways and visa categories.

Importantly, underutilisation of services is not in response to a lack of need. In Aotearoa New Zealand, access to specialist services generally requires a referral from a primary healthcare provider, such as a general practitioner. Refugee background individuals already face a number of financial, linguistic, structural, and cultural barriers to engaging with GP services (Richard et al. 2019; Sherif et al. 2022; Kanengoni-Nyatara et al. 2024), and for those who do, additional systemic barriers were identified as decreasing the likelihood of a successful referral to a secondary service (Cassim, Ali, et al. 2022). Thus, prior to even engaging with a specialist mental health service, refugee-background individuals must navigate a healthcare system fraught with issues and access-related barriers (Sherif et al. 2022; Cassim, Ali, et al. 2022).

None of these issues are adequately captured or addressed in the NZRRS as a strategy that is limited to monitoring 'healthcare utilisation' over a 12-month timeframe. While healthcare utilisation data captures whether a service was visited, it does not address whether the service was appropriate, whether there was any continuity of care, whether there were positive outcomes, or whether known barriers to receiving care were mitigated. In the absence of such information, there is limited ability to assess whether appropriate and rights-based care is being provided. To address these limitations, both an evidence-based and rights-based approach to policy development must be implemented where-in rights-based healthcare policy development evolves from strong evidence in the literature. As such, the following section outlines evidenced-based models for operationalising healthcare access and how these can be applied to develop rights-based NZRRS target outcomes and success indicators that would contribute to tangible improvements in respecting, protecting and fulfilling the right to access mental healthcare services for refugee-background individuals in Aotearoa New Zealand.

Part three: a rights-based approach to mental healthcare accessibility

Evidence-based frameworks of healthcare accessibility

Across the literature, healthcare access has been well-recognised as a complex and multi-faceted construct. Penchansky and Thomas (1981) acknowledged the difficulty of defining access, considering it the 'degree of fit between clients and the system' (p. 128), characterised by five key variables: the availability, accessibility, accommodation, affordability and acceptability of healthcare services. Andersen (1995) subsequently developed the widely used 'behavioural model of healthcare service utilisation', which emphasised healthcare access as resulting from the relationship between a person's environment, population characteristics, health behaviours, and healthcare outcomes. While these models did not overtly stem from a rights-based premise, woven throughout is the inclusion of rights-based variables such as affordability, physical accessibility and availability.

Recent models of healthcare utilisation have been developed with the aim of capturing how accessibility can be considered for a diverse range of demographic groups and incorporate a wider range of variables (Levesque et al. 2013; Davy et al. 2016; Saurman 2016; Yang and Hwang 2016; WHO 2023). For example, the WHO adapted the model by Penchansky and Thomas (1981) to consider how the five key accessibility variables would change across the refugee migration journey and life-course (WHO 2023). Similarly, an adaptation of Andersen's behavioural model considers how immigrant-specific factors such as assimilation, immigration status, cultural values and beliefs impact healthcare use (Yang and Hwang 2016). While not refugee-specific, this model considers refugee-relevant experiences such as how the context for emigration (forced migration), and the period of assimilation impact healthcare access, contextualising immigrant healthcare use to include the macrostructural social, economic, and political factors that contribute to a healthcare system. This inclusion of macrostructural factors supports the critique that many models fail to incorporate the impact of policy in facilitating equitable access and how ineffective policy will disproportionately affect those outside the majority culture (Davy et al. 2016).

The necessity of including policy as an influencing factor in healthcare accessibility was expounded by Tzenios (2019) who applied an ecological approach to healthcare access, considering how individual characteristics (e.g. education, health literacy) exist within a structural context (e.g. availability and quality of services), all of which operate within a high-level, policy systemic context. Consideration of the systemic context is imperative for refugees who must navigate a new governance and policy space. For refugees in Aotearoa New Zealand, navigating a healthcare system is a product of developing trust in a new governance system, integrating into a new society, establishing a sense of belonging and navigating the acculturation process – emphasising the need for policy that does not frame healthcare access as an individual behaviour, but the outcome of inter-related person-, provider- and policy-specific variables (Sherif et al. 2022; Cassim, Ali, et al. 2022; Al Naasan et al. 2024). Similarly, Saurman (2016) argues that awareness – knowing and understanding what services exist, how to use them and ensuring effective communication between clinicians, patients and the community – is a necessary addition to the work by Penchansky and Thomas (1981) with research finding that for asylum seekers and refugees, awareness is a critical to minimising barriers to access (Saurman 2016; Kang et al. 2019).

Ultimately, the evidence shows that healthcare access operationalised as utilisation is a crude and reductionistic representation of the experiences of any individuals within a healthcare system and from a human rights perspective, fails to include the availability, acceptability and quality of care. Reducing healthcare access to service utilisation limits policy-makers ability to make informed decisions regarding how to best respect, protect and fulfil the right to health. While none of the aforementioned models are explicitly 'rights-based', each one reinforces the necessity of incorporating measurable rights-based variables in the operationalisation of healthcare access. As such, the remainder of this article will consider how these variables could be applied to inform what a rights-and evidence-based NZRRS would look like in regard to mental health aims and outcome measures and how this could improve mental healthcare for those providing and receiving it.

Recommendations for a rights-based NZRRS

Based on the above practical and theoretical insights into the provision of mental health care for refugee-background individuals, this article concludes with five policy-specific recommendations (Table 1). First, to develop specific mental health indicators for children and adolescents. Second, to include geographic location in NZRRS success indicators. Third, to disaggregate data under the current NZRRS 'service use' indicator. Fourth, to extend the 12-month monitoring window of the NZRRS. Fifth, to expand 'at least one mental health-related visit' to capture frequency.

Recommendation one: include specific outcomes and indicators for children and adolescents

From 2007 to 2013, 30% of Quota, Family Sponsored and Convention refugees in Aotearoa New Zealand were ages 0–14 and from 2011 to 2016, 27% of refugee-background individuals granted residence were ages 12–24 (Ministry of Business Innovation and Employment 2017; Petrović-van der Deen et al. 2023). Refugee-background children and adolescents face an increased risk of experiencing mental distress, with data showing elevated prevalence of PTSD, depression and anxiety (Fazel et al. 2005; Henley and Robinson 2011; Kien et al. 2019; Blackmore et al. 2020). Furthermore, refugee-background children report increased rates of sub-clinical symptoms of distress such as poor sleep, social withdrawal, dizziness, and difficulty eating (Henley and Robinson 2011; Pacione et al. 2013; Dangmann et al. 2022). Despite these elevated rates, there is no inclusion in the NZRRS detailing specific outcomes or indicators for child, adolescent, and youth mental health even though almost one in three refugee-background individuals were ages 0–24.

It is well established that children of any background rarely seek services for themselves (Henley and Robinson 2011), making it essential that the NZRRS addresses the need to provide appropriate mental healthcare for children and adolescents. In 2008, a Ministry of Health-funded report highlighted the inaccessibility and inappropriateness of mental health services for refugee youth in Aotearoa New Zealand noting that a lack of resourcing impacted the availability of appropriate care and highlighting the absence of data regarding refugee – child and youth mental health (Sobrun-Maharaj et al. 2008). Without system-level support in place, previous attempts at providing refugee-specific child and youth mental health interventions have been short-lived due to a lack of resourcing. For example, The Transcultural Care Centre and Intersectoral Service for Children and Young People from Refugee Backgrounds and Their Families, known as 'On TRACC', was an inter-sectoral, trans-cultural service for refugee-background youth in Auckland which showed promising outcomes and good youth engagement but was not funded to continue (Mortensen 2011).

Ultimately, to fulfil human rights commitments and overcome short-lived, underfunded and region-specific youth services, the onus for change needs to shift from being placed on over-burdened local and regional services and start at the policy and strategy level (Mortensen 2011). Under obligations to the Convention on the Rights of the Child, Aotearoa New Zealand has a commitment to develop and implement child-appropriate mental health preventative care and treatment. Expanding the NZRRS to include youth-specific target outcomes and success indicators will not only allow for

Table 1. Recommendations for a rights-based approach to mental health aims and outcomes within the New Zealand Refugee Resettlement Strategy.

Strategy recommendation: *Improve success indicators by including a rights-based approach and increasing mental health-related outcomes*			
Actionable step	Rights-based foundation	Evidence base	Implications
Introduce specific outcomes and indicators for children, youth and adolescents	Under the Convention on the Rights of the Child, mental health services should be accessible, available, appropriate, and of good quality to meet child and youth-specific needs and provide child and youth-specific treatment	Models of healthcare access that include age as a factor influencing accessibility: • Penchansky and Thomas (1981) • Andersen (1995) • Levesque et al. (2013) • Yang and Hwang (2016) • Tzenios (2019) • WHO (2023)	**Users:** Child and youth-specific policy will contribute to the development of more appropriate services **Providers:** Increased top-level impetus to develop and provide age-specific services. Increased resourcing would improve service continuity and longevity
Monitor mental health service access by geographic location	Physical availability is an integral part of a rights-based healthcare accessibility Relevant rights-based principles: • Accessibility and availability • Non-discrimination: geographic location should not be a discriminatory factor in determining accessibility • Transparency and Accountability: Policies should monitor the impact/role of location on determining access	Models of healthcare access that include physical/geographic location as a factor: • Penchansky and Thomas (1981) • Andersen (1995) • Levesque et al. (2013) • Davy et al. (2016) • Saurman (2016) • Tzenios (2019) • WHO (2023)	**Users:** Improved accessibility due to increased physical availability of services. Decrease in inequitable access to services based on geographic location **Providers:** Increased ability to advocate for funding in under-resourced locations, improved awareness, monitoring and transparency of where geographic disparities are influencing accessibility
Disaggregate data to increase monitoring and accountability Examples of possible data to monitor in the NZRRS regarding mental health service access: • Age • Gender • Visa status • Ethnicity	Relevant rights-based principles: • Services are to be accessible, available, acceptable, quality, and non-discriminatory for people of all ages, sexes, genders, locations, and socio-economic statuses • Policy needs to support equitable service delivery through transparency and accountability with data disaggregation providing increased ability to monitor access for specific sub-groups	Healthcare access models that incorporate monitoring individual characteristics as critical to ensuring accessibility: • Penchansky and Thomas (1981) • Andersen (1995) • Davy et al. (2016) • Yang and Hwang (2016) • Tzenios (2019) • WHO (2023)	**Users:** Assist in identifying and reducing demographic-specific barriers, increased quality of care, and decreased homogeneity in policy **Providers:** Help inform the development of tailored services for specific sub-groups based on identified barriers and increase the appropriateness of services
Extend the 12-month monitoring window	Relevant rights-based principles: • Availability: a sufficient number of services available over time • Accessibility: care is accessible for the duration of need/overtime	Evidence supporting the need for accessibility to mental healthcare services beyond 12 months for refugee-background individuals:	**Users:** a commitment to providing accessible care over time. Recognition that mental health needs may change as time since resettlement increases and ensuring care is accessible beyond the initial period

(*Continued*)

Table 1. Continued.

Strategy recommendation: *Improve success indicators by including a rights-based approach and increasing mental health-related outcomes*			
Actionable step	Rights-based foundation	Evidence base	Implications
	• Increase policy accountability to monitor the ongoing accessibility of services • Good quality: ensuring that individuals are engaged with care and satisfied with the services accessed	• Vervliet et al. (2014) • Rousseau and Frounfelker (2019) • Im et al. (2021) • Maillet et al. (2023) • Petrović-van der Deen et al. (2023): Underutilisation of services 2–5 years following resettlement in Aotearoa New Zealand. Models that include accessibility to services overtime as an aspect of healthcare accessibility: • Levesque et al. (2013) • Davy et al. (2016) • Yang and Hwang (2016) • WHO (2023)	**Providers**: an increased top-down commitment to support practitioners in providing long-term care. May lead to improvements in resourcing and the ability to provide appropriate and time-relevant care as needs shift throughout resettlement
Expand 'at least one' to capture the frequency of visits	The protection and fulfilment of rights is not time-limited. As such, a rights-based policy should reflect this nature and monitor length of engagement with services Relevant rights-based principles: • Accessibility, appropriateness, quality and non-discrimination: services should be accessible throughout the healthcare journey and not just as a one-off experience • Accountability and transparency: policy should reflect the frequency of service use to improve transparency and accountability to the provision of care	Models that conceptualise access as an ongoing engagement with care rather than a one-off use: • Penchansky and Thomas (1981) • Levesque et al. (2013) • Davy et al. (2016) • Yang and Hwang (2016) • Tzenios (2019) • WHO (2023)	**Users:** while frequency is limited in the information it provides, understanding the typical length of engagement with services is a foundation for understanding whether refugee-background individuals are engaged with services for a longer, same or shorter duration than the general population and beginning to identify and mitigate any influencing variables in service engagement **Provider:** information that aids in identifying factors or time-points which influence the duration and frequency of service engagement can help practitioners mitigate barriers and tailor service to increase appropriateness

closer alignment with human rights but allow for improved longevity and consistency in service delivery.

Recommendation two: include geographic location in NZRRS success indicators

There are well-known disparities in accessibility to mental healthcare based on geographic location across Aotearoa New Zealand (Patterson et al. 2018). Individuals in rural or smaller urban centres have reduced access to mental health services due to low availability and can face challenges to privacy and confidentiality due to the limited number of services (Patterson et al. 2018; Kulshrestha and Shahid 2022). Geographic differences in service availability are mirrored in refugee-specific mental health services. Quota refugees are currently assigned to resettle in one of 13 geographic locations (INZ 2024a); however, refugee-specific mental health services are only available in Auckland and Wellington, both of which are major urban centres.

Under the NZRRS, the service utilisation monitoring data does not provide region-specific insights nor any information on mental healthcare engagement relative to geographic location. Given that there are more services available in major urban centres – both publicly and refugee-specific – the singular nationwide statistic reported under the NZRRS monitoring creates the risk of misrepresenting patterns of service utilisation across the country. For example, it does not depict whether individuals in Auckland or Wellington are accessing services at an increased rate compared to those in smaller regions where there is reduced availability. Inequitable access due to geographic location is considered a form of systemic discrimination, contributing to disparities in health outcomes and resource allocations (Ministry of Health 2002). Refugee-background individuals already face barriers to accessing mental health services and report a higher prevalence of mental health conditions, and for those resettled outside a major urban centre, additional physical unavailability of services is not only an added barrier to care but can be considered a violation of human rights (UN Economic and Social Council 2000).

Resettlement in Aotearoa New Zealand extends to many locations outside Auckland and Wellington and therefore region-specific strategy outcomes are essential not only for effective monitoring but also for identifying and mitigating barriers to care. If people are being resettled in areas where there already exists a lack of resources and reduced availability of mental health services then they are less likely to access any mental healthcare they need. Addressing this requires effective policy and measures that are developed to ensure the right to health is respected, protected and fulfilled equitably across the nation. Furthermore, for already over-burdened service providers and staff in these regions, region-specific strategy outcomes would provide greater support in advocating for increased support and monitoring the allocation of resources.

Recommendation three: disaggregate data under the current NZRRS 'service use' indicator

Refugee-background individuals are a heterogenous group with a wide range of needs, experiences, and cultural backgrounds. This heterogeneity is not captured within the current homogeneity of the nationally averaged service use data, rendering it unrepresentative of the population and providing little insight into whether the available care is adequately meeting the needs and entitlements of refugee-background individuals. Each of

the evidenced-based models of healthcare access emphasised how individual characteristics play an integral role in influencing healthcare access. Furthermore, fulfilment of the right to health is reliant on a health system that effectively monitors health data (Hunt 2007). The WHO highlighted meaningful data collection as essential to meeting the health needs of refugees, putting the onus on policymakers to shift from 'small-scale unrepresentative and non-comparable data sets to robust, comparable and high quality data' (WHO 2022). Accurate and representative data sets are imperative to making informed and impactful healthcare decisions, implementing policy that is meaningful and identifying healthcare inequities. Disaggregating data within the NZRRS according to age, sex, gender, and ethnicity would allow greater insight into who is accessing services and where specific barriers might exist for specific sub-groups of the population. It would also allow service providers to develop tailored interventions for specific populations, identify areas of need and reduce barriers that may be disproportionately affecting various groups. That being said, data disaggregation must occur in a manner that prioritises the safety and confidentiality of individuals and adheres to strict procedures protecting the privacy of data. In smaller communities, disaggregation of data can lead to unintended consequences including individual identification, over-generalisation, bias or over-pathologising. Protocols outlining best practices for disaggregated data collection emphasise that these risks can be mitigated and should not dissuade from the importance of disaggregating data to identify healthcare access inequities (OHCHR 2018; Yang and Sudarshan 2024). Ultimately, the lack of representative and detailed data curtails the ability to accurately monitor outcomes reflecting a healthcare system that is not responding to healthcare needs.

Recommendation four: extend the 12-month monitoring window

The limited detail provided under the current NZRRS monitoring is compounded by the 12-month monitoring window after arrival in Aotearoa New Zealand, which is too narrow to address ongoing mental health needs. Evidence-based recommendations for refugee mental healthcare suggest providing a baseline mental health assessment within the first month of arrival (as per the NZRRS), with the proviso of ongoing assessment and monitoring of access to care (Vervliet et al. 2014; Maillet et al. 2023). Many refugees experience a 'honeymoon' phase during the first 1–3 months of resettlement followed by a period of adjustment where immediate needs such as employment, financial security, housing and education are most pertinent (Im et al. 2021; Maillet et al. 2023). As such, acknowledging mental health needs are often secondary, and as the data shows, can take a period of 2–5 years following resettlement to recognise and address (Rousseau and Frounfelker 2019).

While monitoring mental health access within the first 1–12 months may be appropriate for identifying individuals who arrive with acute and immediate mental health needs, it fails to monitor long-term, sustainable access to mental healthcare. Recent data shows that 2–5 years after resettling in Aotearoa New Zealand, rates of mental health service access for refugee-background individuals are below that of the general population (Petrović-van der Deen et al. 2023). This indicates a clear gap in the current NZRRS where individuals who do not present to mental health services in the first year are not being monitored. Under obligations to the ICESCR, CERD, and CRC, access to mental healthcare should be subject to effective and regular monitoring that produces

high-quality, informative and comparable data sets (Geiringer and Palmer 2007). Thus, for the NZRRS to more comprehensively fulfill the mental health entitlements of refugee-background individuals it is imperative that the monitoring window extend beyond the initial 12-month period. While there is an absence of longitudinal research evaluating the optimal time for ongoing mental health provision (Magwood et al. 2022), the consensus is that screening should occur beyond the initial resettlement period (Maillet et al. 2023), and data evaluating refugee-background individuals mental health needs indicates accessible care should be prioritised and monitored over the first 5 years of resettlement (Petrović-van der Deen et al. 2023).

Recommendation five: expand 'at least one mental health-related visit' to capture frequency

The fulfilment of human rights is not time-limited, and as such, much like by extending the 12-month monitoring window, the governmental strategy should reflect this characteristic and monitor whether access to mental healthcare services is ongoing. Many of the evidence-based models reinforce that successful healthcare access is greater than a singular, time-limited moment of service utilisation and is the ongoing and appropriate use of services resulting in a desirable health outcome (Levesque et al. 2013; Davy et al. 2016; Yang and Hwang 2016). Under the current NZRRS success indicator, while individuals may have successfully had 'at least one visit', there are no data indicating whether the individual received ongoing care or a successful follow-up, as needed, following the initial consult.

Monitoring ongoing access to services is particularly important for supporting mental health practitioners working with refugee-background individuals who report needing increased duration and frequency of sessions to accommodate factors such as working with an interpreter and spending time establishing rapport and trust (Richard et al. 2019). Additionally, evidence shows refugee-background service users are more likely to disengage with mental healthcare due to systemic factors such as a complex referral process, navigating a new healthcare system and unclear expectations regarding what is available (Satinsky et al. 2019; Byrow et al. 2020; DeSa et al. 2022). Thus, if the NZRRS is to incorporate a rights-based approach accurately, it is recommended that the strategy monitors the frequency of visits to ascertain ongoing engagement with mental health services, continuity of care and where possible, the attainment of a desirable health outcome. While monitoring frequency alone does not provide a complete picture of the appropriateness, acceptability and quality of care received, it is an important shift towards indicating that continuity of care beyond one visit is a policy priority.

Future directions for research on mental health care for refugee-background individuals

In sum, Aotearoa New Zealand has made an international commitment to progressively realise the rights and entitlements of refugee-background individuals as they resettle and integrate into society. Beginning at the policy-level, there remains ample opportunity to implement rights-based change in order to move towards a greater fulfilment of the right to access mental health care. Refugee-background individuals face increased barriers to accessing care. Thus, while access may only be one part of equitable mental health care

provision, it must be prioritised and accurately operationalised to help mitigate access-related barriers and deliver appropriate care for those who need it.

If the above recommendations are incorporated into the NZRRS it would provide explicit and tangible rights-based measures that would more closely align with the human rights commitments made by Aotearoa New Zealand and increase accountability to the meaningful enactment of this whole-of-government strategy. At a systems level, effective policy is essential to the provision of equitable care. However, as the evidence portrays, access to healthcare is a complex dynamic between policy, provider and people-specific variables. Thus, future research is required to incorporate the perspectives and experiences of refugee-focussed mental health service providers and most importantly refugee-background individuals who have accessed mental health care.

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