**REPORT**

**TO THE SPECIAL RAPPORTEUR ON**

**THE RIGHTS OF PERSONS WITH DISABILITIES**

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**by Dr Heather Barnett**

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# Introduction

**New Zealand has a wide range of legislation and policies governing mainstream and specific social protection programmes for disabled people. There is, however, a significant disconnection between legislation and government policies, and resultant funding and practice.** **New Zealand also has specific legislation, policies and practices that violate the UNCRPD.**

The Disabled Persons Assembly is New Zealand’s (DPA) national, pan-disability, disabled persons’ led organisation. The Disabled Persons Assembly has a membership of approximately 900 disabled people, and parents or guardians of disabled people. We also have some 200 corporate members who represent or deliver services to disabled people. The DPA operates at a national level and has a network of regional assemblies throughout Aotearoa New Zealand.

The DPA works closely with six other Disabled Persons Organisations (DPOs).[[1]](#footnote-1)The six other DPOs are disability-specific and include both disabled and non-disabled members. Altogether, the seven DPOs are represented on New Zealand’s Convention Coalition Monitoring Group and work systemically to promote and monitor the implementation of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

The Disabled Persons Assembly acknowledges the immense and complex work associated with the oversight of social protections for disabled people and implementation of UNCRPD. This work is being led by the Ministerial Committee on Disability Issues, with support from the Chief Executives Group on Disability Issues. We also acknowledge the importance of having a Minister of Disability Issues and the pivotal role of the Office for Disability Issues. The Office works across diverse portfolios. In conjunction with a range of government agencies it supports the social protections system for disabled people and the implementation of the UNCRPD. We also highlight the importance of the Human Rights Commission’s, Disability Commissioner, and the importance of retaining this dedicated disabled person led position in future.[[2]](#footnote-2)

While it is often the case that legislation and policies are fairly sound, funding is inadequate and insecure, and practice is often poor. The lack of funding and good practice has led to significant disparities in the social, economic and health outcomes of disabled people compared with non-disabled people. These adverse outcomes are accentuated for indigenous and Pasifika disabled people, and disabled people living in high deprivation areas.

Our response to the request from the special rapporteur reflects some of this disjuncture. It also reflects the complex relationships between social, economic and cultural factors that adversely affect disabled people’s quality of life, our ability to participate as equal members of society, and our full citizenship. We acknowledge that these issues are complex.

Nonetheless, we draw your attention to the importance of ensuring a whole-of-government approach to effectively ensure a social protections system that is able to deliver on the implementation of the UNCRPD.

The questionnaire sent to New Zealand stakeholders by the special rapporteur is comprehensive. It potentially covers an extensive body of information that is well beyond our capacity to provide. We note that the government’s Office for Disability Issues would be best placed to provide information on the range of mainstream and disability-specific social protections available to disabled people. However, we understand that the Office does not have sufficient resources to respond.

The resource and time necessary to provide a response to all questions contained in the questionnaire is prohibitive for our organisation. We note that there is no centralised list of all forms of social protection available, mainstream or disability-specific, as these are highly fragmented and sit across different government agencies and local bodies.[[3]](#footnote-3) We have therefore noted various places this information can be found and instead focused our attention on highlighting the key issues, concerns and difficulties that exist in relation to social protections for disabled people and implementation of the UNCRPD.

## Disability statistics

Approximately 24 percent or 1.1 million New Zealanders identify as having one or more disabilities. The latest Statistics New Zealand Disability Survey 2013 highlights key disparities between disabled and non-disabled citizens.

Disabled people’s social and economic outcomes are less favourable than non-disabled people’s outcomes across every indicator (i.e. labour force status and paid employment; income; education; safety, crime and discrimination; social contact and community participation, and overall wellbeing).[[4]](#footnote-4) The following statistical data from the New Zealand Disability Survey 2013 highlights the position of disabled people in Aotearoa.

* The labour force participation rate for disabled people was 50 percent (compared with 76percent for non-disabled people).
* 55percent of disabled adults were unemployed compared with 28 percent of non-disabled adults.
* 64 percent of disabled adults had an annual gross income of $30,000 or less.
* 67 percent of disabled adults held a school or tertiary qualification compared with 85 percent of non-disabled people.
* 38 percent of disabled adults reported feeling lonely compared with 29 percent of non-disabled adults.
* Disabled adults felt much less safe and were discriminated against more than non-disabled adults.
* Disabled adults and children were less likely to participate in many popular leisure activities than non-disabled people.
* Most disabled adults report a life satisfaction score that is considerably lower than non-disabled adults.
* Poverty is directly linked to disability.
* Poverty is directly linked to ethnicity (i.e. Māori and Pasifika).[[5]](#footnote-5)
* 250,000 New Zealand children live in poverty; most of these children live in one-parent households that rely on state income support; disabled children are overrepresented in poverty statistics.[[6]](#footnote-6)
* Children are invisible in child poverty and abuse; for disabled children this situation is heightened.[[7]](#footnote-7)
* 11percent of children under age 15 were disabled.
* 52 percent of disabled children had difficulty learning.
* Māori had a higher-than-average disability rate (26 percent) that is disproportionate to the total Māori population (15percent) and the younger median age of the Māori population.
* Pasifika had a higher than average disability rate (19 percent) that is disproportionate to the total Pasifika population (7 percent) and the younger median age of the total Pasifika population.
* The disability rate for people who identified as European was 25 percent, despite this group making up 74 percent of New Zealand’s population.
* 64 percent of disabled adults reported physical impairments.
* 53 percent of disabled people had more than one type of impairment.
* The most common cause of disability for adults was disease or illness (42 percent).[[8]](#footnote-8)
* The most common cause of disability for children was a condition that existed at birth (49 percent).
* The following geographic regions have a higher than average rate of disability: Bay of Plenty; Manawatu-Whanganui; Northland; Taranaki.[[9]](#footnote-9)

## Disability related health statistics

* New Zealanders have a high rate of psychosocial disability.[[10]](#footnote-10) [[11]](#footnote-11)
* One in six New Zealand adults (16 percent) had been diagnosed with a common psychological disorder at some time in their lives.[[12]](#footnote-12)
* Rates of diagnosed mental health conditions are rising.[[13]](#footnote-13)
* Rates of psychological distress are high among Māori and Pasifika adults, and adults living in the most deprived areas.[[14]](#footnote-14)
* 13 percent of the disabled population who participated in the New Zealand Health Survey, reported psychological/psychiatric disability as either their only impairment or the most limiting of their impairments.[[15]](#footnote-15)
* A total of 549 people died by suicide in 2012.[[16]](#footnote-16)
* There at least 2500 admissions to hospital for intentional self-harm injuries every year.[[17]](#footnote-17)
* Māori report higher rates of most health conditions.[[18]](#footnote-18)
* Pasifika have many health conditions that result in disability.[[19]](#footnote-19)
* Unmet need for health care is more common among Māori and Pasifika adults and children, and those living in the most deprived areas.[[20]](#footnote-20)
* People who experience learning/intellectual disability, and people who experience psychosocial disability have poorer health outcomes than any other group, and have up to a 23 years shorter life expectancy. [[21]](#footnote-21) [[22]](#footnote-22)

# Institutional framework in charge of implementation

An overview of the New Zealand institutional framework for the implementation of the United Nations Convention on the Rights of Disabled People, New Zealand’s Disability Strategy 2001,[[23]](#footnote-23) and the Disability Action Plan 2014-2018[[24]](#footnote-24) is provided below.[[25]](#footnote-25)These documents set out the strategic context of social protections for disabled people.

To date the government has not ratified the Optional Protocol on the UNCRPD. Although it has intimated that the Protocol will be ratified in future, the government has no current plans to ensure this occurs. Until the Optional Protocol is ratified, New Zealand individuals and groups have no international mechanism through which to lodge complaints relating to violations of UNCRPD, nor the option of having the Committee investigate, report on and make recommendations about violations of the UNCRPD.

## Ministerial Committee on Disability Issues

The New Zealand government ratified the UNCRPD in 2008. In 2009 the government established the Ministerial Committee on Disability Issues (the Committee) led by an exceptionally progressive former Minister for Disability Issues, Dame Tariana Turia. The Committee is now led by a new Minister for Disability Issues and consists of ministers who have diverse portfolio areas. The Committee provides leadership and accountability for the government’s implementation of New Zealand’s Disability Strategy 2001,[[26]](#footnote-26) the Disability Action Plan 2014-2018,[[27]](#footnote-27) and the UNCRPD. The Committee is ultimately responsible for the institutional framework relating to social protections for disabled people. The intention is that the Committee takes a whole-of-government approach and works with disabled people’s organisations, the disability sector, providers of health and disability services, and other stakeholders that have an integral role in upholding disabled people’s human rights.

## Chief Executives Group on Disability Issues

The Ministerial Committee on Disability Issues is supported by the Chief Executives Group for Disability Issues (the Group) which is chaired by the Minister of Social Development.[[28]](#footnote-28) This Group is tasked with leading and coordinating government agencies’ implementation of the Ministerial Committee’s priorities on disability issues.[[29]](#footnote-29) The DPOs meet regularly with the Chief Executives Group. The Chief Executives’ Group also meets regularly with the Independent Monitoring Mechanism (discussed later in this section).

At an operational level, the Ministry of Social Development and the Ministry of Health have a primary role in terms of decisions about the provision of, and funding for, disability and mental health services, and various forms of social protection for disabled people.

Other ministries (such as the ministries of Labour, Education, Justice, Transport) have a less influential role, despite having an important part to play in implementing a whole-of-government approach to the implementation of the UNCRPD, the Disability Strategy 2001, and the Disability Action Plan 2014-2018. This also means that funding from these ministries is limited.

## The Office for Disability Issues

The Office for Disability Issues (the Office) is a government agency and subsidiary of the Ministry of Social Development. The Office reports to the Minister for Disability Issues and supports the Ministerial Committee on Disability Issues. The Office is charged with ‘promoting, guiding, leading, informing and advising on disability issues’.[[30]](#footnote-30) The Office also coordinates functions in relation to the implementation of the Disability Action Plan 2014-2018. However, the Office is not responsible for monitoring or implementation of the New Zealand Disability Strategy 2001 or the UNCRPD.[[31]](#footnote-31)

An overview of the roles of central government, local government and independent commissions, as they relate to disabled people and UNCRPD, can be found on the website of the Office for Disability Issues <http://www.odi.govt.nz/about-us/government.html>.

## Disabled Persons Organisations

Article 4(3) of the UNCRPD obliges States to ensure that the authentic voice of disabled people can be present alongside government agencies developing legislation, policy and services impacting on disabled people. This is achieved through involving Disabled Persons Organisations (DPOs).[[32]](#footnote-32)

There are seven DPOs which are defined as organisations that:

* are governed and led by disabled people
* focus on representing the lived experience of disability in one or more impairment areas
* have members who are disabled people.[[33]](#footnote-33)

Disabled Persons Organisations have distinct criteria for membership. They differ from other disability organisations that provide specific services and/or are led and governed by non-disabled people. For example, NZDSN,[[34]](#footnote-34) IHC,[[35]](#footnote-35) CCSDisabilty Action,[[36]](#footnote-36) HealthCareNZ,[[37]](#footnote-37) Mash Trust.[[38]](#footnote-38) While these organisations are not DPOs they are vitally important to ensuring a robust social protections system for disabled people. They have a primary role, from the front-line to a strategic level, for implementing the UNCRPD, the Disability Action Plan 2014-2018 and the Disability Workforce Action Plan 2013-2016.[[39]](#footnote-39)

The DPOs include:

1. Association of Blind Citizens of New Zealand Incorporated
2. Balance NZ Incorporated
3. Deaf Aotearoa New Zealand Incorporated
4. Deafblind (NZ) Incorporated
5. Disabled Persons Assembly (New Zealand) Incorporated
6. Kāpo Māori Incorporated (see Ngāti Kāpo o Aotearoa Incorporated)
7. People First New Zealand Incorporated Nga Tangata Tuatahi

All of these organisations are governed by disabled people, although some also include non-disabled people in leadership roles. The Disabled Persons Assembly is a pan-disability organisation. The other DPOs are impairment-specific organisations. We note that the seven DPOs include a psychosocial disability specific organisation called Balance NZ. The inclusion of this organisation in the UNCRPD institutional framework is an important more recent development, as it represents a structural shift in terms of ensuring the inclusion of psychosocial disability within the disability framework.

**Disability Action Plan 2014-2018**

The DPOs meet regularly with the government’s Chief Executives’ group, and work together with the government on the Disability Action Plan 2014-2018 Working Group, via its four work streams. These include:

* + - 1. Increasing employment and economic opportunities
			2. Ensuring personal safety
			3. Transforming the disability support system
			4. Promoting access in the community.

Building a genuinely people-driven system requires disabled peoples participation at every level of decision making throughout government and non-government organisations. It also requires a range of supports, services and adequate funding that promote and can ensure disabled people’s self-determination, autonomy, choice, and control.

To date the government has developed three prior Disability Action plans. However, for the first time, the current disability Action Plan 2014-2018 has been developed by the government in consultation with DPOs. Disabled Persons Organisations have therefore had a central role in identifying priorities, outcome areas and shared results.

The government’s Disability Action Plan 2014-2018 has five clearly articulated person-directed outcomes. These include:

1. safety and autonomy
2. wellbeing
3. self-determination
4. community, and
5. representation.

The Plan also has four shared results areas. These include:

1. employment and economic participation
2. personal safety
3. transforming the disability support system, and
4. promoting access in the community.[[40]](#footnote-40)

## New Zealand Convention Coalition Monitoring Group

The New Zealand Convention Coalition Monitoring Group (the Convention Coalition) consists of representatives of all seven DPOs. The DPOs work together on the Convention Coalition to monitor New Zealand’s implementation of the UNCRPD and the Disability Action Plan 2014-2018. As monitors of the Convention, the DPOs collect information to see how well the Convention is being implemented and if it is making a difference to the everyday lives of disabled people.

This group operates in accordance with Disability Rights Promotion International (DRPI) guidelines. The DRPI is an international collaboration working towards developing a global disability rights monitoring system. The approach to monitoring is based on the following system:

* all monitoring activity is led by disabled people
* human rights principles are considered when monitoring specific human rights
* a holistic approach is used that monitors individual experiences, systems, and societal attitudes.[[41]](#footnote-41)

The Convention Coalition is responsible for undertaking research each year about various aspects of life relating to the individual experiences of disabled people (e.g. youth, media, poverty, participation, acceptance in society).[[42]](#footnote-42) This research, which is published annually, informs the Convention Coalition’s monitoring of how well the New Zealand government is implementing the UNCRPD and the Disability Action Plan 2014-2018.

The government has committed $275,000 annually for three years to enable the Convention Coalition to undertake research, participate in monitoring, attend the IMM meetings and contribute to the IMM’s monitoring reports. This funding will finish in June 2016. Further, the government directed the Convention Coalition to no longer focus on systemic monitoring or the media, two of the three stages in the DRPI process. Rather, only to focus on undertaking research with individuals. The Convention Coalition is a member of the Independent Monitoring Mechanism.

## Independent Monitoring Mechanism

New Zealand has an Independent Monitoring Mechanism (IMM) developed in accordance with Article 33 of the UNCRPD. It consists of New Zealand’s Human Rights Commission, the Ombudsman, and the Convention Coalition Monitoring Group. The group is independent from government. However, the IMM is dependent on continued government funding which is not secure.

The IMM is responsible for:

* developing a framework for monitoring and reporting on the implementation of the Disability Convention
* reporting to the United Nations on the overall implementation of the Disability Convention and on specific issues
* advocating for specific issues important to disabled people

 providing advice on legislation, policy and practice affecting disabled people, and

* producing an annual report to Parliament. [[43]](#footnote-43)

The IMM has identified five broad areas that require particular attention to promote social protections for disabled people and the implementation of the UNCRPD. These include:

* + - data
		- accessibility
		- building a people-driven system
		- violence and abuse, and
		- education.[[44]](#footnote-44)

These areas are discussed later in this report in conjunction with a range of other issues identified as significant gaps in available social protections for disabled people, the implementation of the New Zealand Disability Strategy 2001, the Disability Action Plan 2014-2018 and the UNCRPD.

## Māori Disability Leadership Group

A Māori Disability Leadership Group was established as part of the process of developing the Māori Disability Action Plan 2012-2017 within the Ministry of Health. However, this group does not appear to have a key role on disability issues nor has it been involved in shaping or identifying priorities in the Disability Action Plan 2014-2018

## Faiva Ora National Leadership Group

Faiva Ora is a national group under the auspices of the Ministry of Health, consisting of influential Pasifika leaders who represent Pasifika disability issues on behalf of Pasifika disabled people. The group advises on the implementation of the Faiva Ora National Disability Plan 2014-2016, provides advice to the Ministry of Health and its Disability Support Services (DSS), and supports community initiatives to reduce stigma and negative attitudes towards Pasifika disabled people.[[45]](#footnote-45)

# Consultation and involvement - design, implementation & monitoring social protection programmes

In 2012 the Independent Monitoring Mechanism advised the Chief Executives Group on Disability Issues of the need to work more closely with DPOs, pursuant to Article 4(3). This led to the development of an agreement signed between DPOs and the Chief Executives’ group. A collaborative model has since been applied for the first time in the development of the Disability Action Plan 2014-2018. In addition, four separate working groups, consisting of government officials, DPOs and allied organisations, have been established to provide governance in relation to the four shared results in the Disability Action Plan 2014-2018.

While the new system is, overall, working well, traditional ‘top down’ models continue in other areas of the health and disability sector. For example, Councils and District Health Boards, have ‘consumer advisory groups’, but not co-leadership. Members of the advisory groups are often not members of a DPO or an organised disability group.

The Ministry of Social Development currently has a Health and Disability Long-Term Reference Group which includes DPOs, disability service providers, a range of government agencies, medical practitioners, and a beneficiary action group.  This group focuses on improvements to the social protections programme.

The Ministry of Health has a Consumer Consortium that consists of representatives from a variety of disability sector organisations.[[46]](#footnote-46) The Consortium provides input and advice to Disability Support Services on planning, policy and service development.[[47]](#footnote-47)

**Legislation**

There are 15 key Acts that have a direct impact on disabled people’s human rights and access to social protection programmes (see Appendix 1). Some of New Zealand’s legislation grossly breeches the UNCRPD (e.g. Mental Health Act 1992; Intellectual Disability Act 2003) and there are urgent calls from DPOs for the government to review legislation so that disabled people’s human rights – irrespective of impairment type – are upheld. While some legislation requiring review or amendment is included in the Disability Action Plan 2014-2018, other legislation warranting attention is yet to be included.

# Institutional framework - areas for improvement

## Government Ministers and Chief Executives - knowledge and commitment

Government ministers and chief executives knowledge and understanding of disability, the human rights approach and UNCRPD is typically limited. Each time the government changes, or there is a cabinet reshuffle (as occurred in 2014), a new Minister of Disability issues and Minister of Social Development is appointed; likewise, other cabinet Ministers are also changed. Ministers typically have little or no knowledge of disability and UNCRPD. This means the responsibility for educating each new Minister rests with the Office for Disability Issues. The protection and promotion of disabled peoples human rights, and the provision of an adequate social protections system, is ultimately reliant on willing ministers. It also means that government officials’ commitment to, and the prioritisation of, social protections for disabled people, and the implementation of UNCRPD, is always precarious.

**Example**

The Disabled Persons Assembly, with support from Te Pou, recently designed and developed a UNCRPD education programme for the disability support workforce (DSS) and disabled people.[[48]](#footnote-48) UNCRPD education of the DSS workforce and disabled people are stated objectives in the Disability Workforce Action Plan 2013-2016. Although a series of pilot workshops were highly successful and resulted in a positive evaluation of this programme by the disability sector, funding for UNCRPD education is not currently available. This insecurity of funding, and the political pressures that influence funding decisions, means there is an absence of adequate UNCRPD education for the government and non-government workforce. There is an urgent need to effectively fund the nation-wide implementation of this UNCRPD education programme.

## Funding insecurity and inadequacy

The process of government funding, and contracting with providers and non-government agencies, means that each Ministry (e.g. Health, Social Development, Education, Justice) contests funding. The tenuous commitment by government officials also means that funding to enable a whole of government approach to the implementation of the UNCRPD, social protections for disabled people, and the transformation of the disability support system, is insecure. Further, funding for disabled people, like tangata whenua and Pasifika, is always discretionary. This means that the existence of programmes and projects are subject to termination at any time.

**Examples**

Te Pou, the national non-government organisation responsible for workforce development across the disability and mental health sectors, is currently required to retender to secure ongoing government funding. This organisation is well established, well respected by the mental health and disability sectors, and has a proven track record of delivering to a high standard. However, the entire organisation is currently unsure whether it will be funded in future and in turn means that non-government organisations that depend on Te Pou for contracts also have an uncertain future.

The ‘Think Differently’ campaign is a relatively recent initiative designed to promote positive attitudes and behaviours towards disabled people nationwide. However, in the May 2015 budget the government announced that funding would no longer be available for this campaign.

In May 2015, the government also suddenly terminated funding of Relationship Services; a long standing, national service for people experiencing relationship difficulties. No transition time was permitted to enable the service to find clients alternative support.

The New Zealand budget announcements in May this year are an example of the way government funding can be allocated or withdrawn depending on the political interests and priorities of those in power at any given time. The social protections of disabled people are always at heightened risk under governments that favour a free-market economic ideology.

Independent Commissions - insecurity

The existence and continuation of independent commissions responsible for the monitoring of disabled people’s human rights (such as the Human Rights Commission, and the now defunct Mental Health Commission) is precarious.[[49]](#footnote-49)

In 2014 the New Zealand Prime Minister publicly threatened the Human Rights Commission with withdrawal of funding. This followed the Commission’s public stance against proposed legislative changes that would increase the government’s powers of surveillance and impinge citizens’ rights.[[50]](#footnote-50)This legislation has since come into force.

In 2014, the government also terminated funding for the Problem Gambling Foundation, following the Foundation’s public stand against the government’s industry-centred stance in support of gambling and casinos.

In 2012 the current government disestablished the Mental Health Commission. The Commission had approximately 30 staff and considerable influence in protecting and promoting the human rights of people who experience psychosocial disability. Although one mental health commissioner (from the former Mental Health Commission) is now employed within the Health and Disability Commission, this role has a narrow mandate and (as would be expected) has much less impact in terms of promoting and protecting the human rights of people who experience psychosocial disability.

Commissioners in any commission are appointed by government ministers who may, or may not, understand a human rights approach to disability or the complexity of social, economic and cultural factors that impact on disabled people’s participation, quality of life and citizenship.

## The United Nations Declaration on the Rights of Indigenous Peoples and the Treaty of Waitangi

New Zealand ratified the United Nations Declaration on the Rights of Indigenous Peoples (the Declaration) in 2010. The Treaty of Waitangi is New Zealand’s founding document and first human rights agreement. The Treaty sets out a partnership between the government[[51]](#footnote-51) and tangata whenua.[[52]](#footnote-52) Under the Treaty and Declaration, the government and its agents (including non-government organisations that receive funding from the State) are required to work in partnership with indigenous leaders. This means that the Ministerial Committee on Disability Issues, the Chief Executives’ group, the IMM, the Convention Coalition, and the DPOs should be operating in partnership with indigenous leaders and organistions. This is not the case.[[53]](#footnote-53)

There are longstanding and significant disparities between the health, social, educational and economic outcomes of the indigenous population (especially indigenous disabled people) compared with non-indigenous people. These disparities are of such significance that they are now addressed on the international stage, at the United Nations, the World Health Organisation, and at the World Conference on Indigenous Peoples.

Government initiatives relating to the implementation of UNCRPD and social protections affecting disabled people need to urgently adopt a government-indigenous leaders partnership at all levels of the institutional framework. This would give genuine effect to the human rights of disabled tangata whenua, as well as whānau,[[54]](#footnote-54)hapu,[[55]](#footnote-55) and iwi,[[56]](#footnote-56) in accordance with the United Nations and New Zealand human rights instruments.

## Māori specific strategies and action plans

The New Zealand Disability Strategy 2001 is a high level strategy that is supposed to be used in conjunction with Whāia Te Ao Mārama: The Māori Disability Action Plan 2012-2017,[[57]](#footnote-57) and He Korowai Oranga, a Māori-specific health and disability strategy reflecting the worldviews, values, and priorities of tangata whenua.[[58]](#footnote-58) [[59]](#footnote-59) The Disability Action Plan 2014-2018, Whāia Te Ao Mārama, and He Korowai Oranga are supposed to be the responsibility of the whole of the health and disability sector, as well as other sectors across government.

Whāia Te Ao Mārama: The Māori Disability Action Plan 2012-2017[[60]](#footnote-60) aims to establish priority areas of action to enable indigenous disabled people to achieve self-defined aspirations. It also aims to reduce barriers that impede Māori disabled people and whānau from gaining better outcomes. The four priority areas include:

1: Improved outcomes for Māori disabled

2: Better support for whānau

3: Good partnerships with Māori

4: Monitoring and reporting on the implementation

 of Whaia Te Ao Marama.[[61]](#footnote-61)

Further, He Korowai Oranga, New Zealand’s Māori Health Strategy, was intended to support the Ministry of Health and district health boards (DHBs) to improve Māori health by being used alongside the New Zealand Health Strategy, the New Zealand Disability Strategy, and the New Zealand Public Health and Disability Act 2000.

As New Zealand’s Māori Health Strategy, He Korowai Oranga sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. The strategy has been updated to reflect increasing moves towards supporting whānau, hapū, iwi and community development; supporting Māori participation at all levels of the health and disability sector; and ensuring effective health service delivery and working across sectors.[[62]](#footnote-62)

## Pasifika specific Disability Action Plan

Many of the issues identified in relation to indigenous people are applicable to Pasifika peoples. Pasifika hold a unique position in New Zealand’s history and in relation to the government’s relationships with Pacific nations and territories. This means that Pasifika have a position in Aotearoa that is different from all other migrant groups.

Faiva Ora, the National Pasifika Disability Action Plan 2010-2013[[63]](#footnote-63) is a Ministry of Health plan that sets out priorities for improving the training and career path for Pasifika disability workers, ensuring support services meet the needs of Pasifika disabled people and their families, and increasing the number of services delivered locally in the community. A Ministry of Health Pasifika leadership group was established to lead the implementation of this Plan.

The Plan was a response to widespread recognition that Pasifika have a low uptake of disability support services due to a range of barriers to access. The most important issue is a lack of culturally responsive and appropriate disability services, and accessible information in diverse Pasifika languages.[[64]](#footnote-64) Pasifika people’s views about disability and psychosocial disability in particular, can also be a barrier that prevents the use of disability support services. There do not appear to be any current initiatives to update the Pasifika Action Plan or to ensure Pasifika voices at every level of decision making throughout the institutional framework.

While the Disabled Persons Assembly is in the early stages of establishing a Pasifika caucus, this is likely to have limited impact on the pending revision of the Disability Strategy 2001 or update of the Disability Action Plan 2014-2018.

A change at the DPO level to enable the inclusion of Pasifika disabled people is urgently needed to ensure Pasifika voices are well represented at every level of the social protections institutional framework and are adequately conveyed to the United Nations Committee on the Rights of Persons with Disabilities through the IMM and Convention Coalition. There is also an onus on the New Zealand government to fulfil its obligations to Pacific nation states and territories in relation to Pasifika disability and development across the Pacific region.

## Government-DPO structure

The government-DPO system is mono-cultural and currently marginalises indigenous worldviews, values, interests and priorities, as well as a whānau ora approach.[[65]](#footnote-65)

During the process of developing and implementing the New Zealand Disability Action Plan 2014-2018 and UNCRPD there has been a dominance of Pākehā[[66]](#footnote-66) at every level of decision making. The Ministerial Committee on Disability Issues, the Chief Executives’ Group, the Convention Coalition, the IMM, and all DPOs except one, are Pākehā led and dominated.

The current DPO structure means that only organisations governed by disabled people can participate. This approach aims to ensure disabled people’s leadership and self-determination. However, it does not necessarily ensure indigenous leadership and self-determination, or an indigenous - non-indigenous partnership model of practice afforded under the Treaty of Waitangi.

At present there is one Māori-specific disabled persons’ organisation, Kāpo Māori, that is funded for people who are blind or have visual impairments.[[67]](#footnote-67) Given the comparatively small population of Māori disabled people, the voices of indigenous disabled people are not well represented at any level of New Zealand’s institutional framework for implementation or monitoring of the UNCRPD. This means indigenous disabled people’s voices are not adequately conveyed to the United Nations Committee on the Rights of Persons with Disabilities.

The current approach means the representation of disabled tangata whenua at the DPO level is limited. This has a significant negative impact on the way in which issues important to disabled tangata whenua are represented on the Convention Coalition and the IMM, and heard by the UNCRPD committee.

There is an urgent need to ensure change to the government-DPO structure to give effect to a Treaty based partnership and ensure appropriate representation of tangata whenua at every level of the institutional framework. The current situation means that tangata whenua do not have a partnership position in the UNCRPD implementation process, as is accorded under the Treaty of Waitangi and endorsed through the United Nations Declaration on the Rights of Indigenous Peoples. It is imperative that the changes are made at the government-DPO level to ensure a Treaty of Waitangi partnership approach and enable the rightful representation of indigenous disabled people.

At present there is no Pasifika disabled persons Disabled Persons Organisation. Although Pasifika can belong to any DPO, the voices of disabled Pasifika are typically marginalised. There is significant potential to apply the principle of Reasonable Accommodation to ensure the worldviews, values, interests and priorities of Pasifika peoples are effectively represented at the government-DPO level.

The Disabled Persons Assembly is currently in the process of establishing a Māori caucus, and a Pasifika caucus, to ameliorate some of the issues associated with the lack of representation of tangata whenua and Pasifika peoples among the DPOs, on the Convention Coalition and on the IMM. However, given the recency of this development it is likely to have limited influence on the institutional framework for some time to come. Disabled Persons Organisations are currently also fostering a wider dialogue about who is and is not represented at the DPO level.

Given the pending review of the New Zealand Disability Strategy 2001 and update of the Disability Action Plan 2014-2018, the issue of ensuring an

partnership approach between indigenous and non-indigenous peoples, and appropriate representation of Pasifika, is a matter of urgency.

# Disability specific social protections - good practice

## Enabling Good Lives

Enabling Good Lives (EGL) is a new, cross-government initiative to support disabled people that commenced in 2013 in Christchurch.[[68]](#footnote-68) The government has committed funding for three years during the EGL trial phase. The programme offers greater choice, control and decision-making about what disabled people regard is needed to live ‘a good everyday life, in everyday places.’[[69]](#footnote-69) This initiative attempts to demonstrate whether shifting power, choice and control to disabled people (and families or whānau) can lead to better outcomes for disabled people. It is anticipated that the success of this model will ultimately contribute to the transformation of the disability support system. Enabling Good Lives includes funds and services from the Ministries of Education, Social Development and Health, and has the potential to integrate services and supports provided by ACC.

Enabling Good Lives is a collaboration including disabled people, families and whānau, disability sector providers and government agencies. It is overseen by a national Enabling Good Lives Leadership Group that reports to the Ministerial Committee on Disability Issues.

Enabling Good Lives is currently at a demonstration stage and only available in Christchurch[[70]](#footnote-70) and Waikato.[[71]](#footnote-71)

## The New Model

The New Model for supporting disabled people is intended to provide greater

choice, control and flexibility over supports and budgets available to disabled people to enable greater self-determination and promote a good life.[[72]](#footnote-72) However the New Model only applies to the parts of the disability support system funded by the Ministry of Health funds.

## Enhanced Individualised Funding

Enhanced individualised funding (EIF) is administered by the Ministry of Health. It is designed to provide more choice, control and flexibility about the residential services, supports, budget and assistance disabled people require.

At present EIF is only available in the Eastern and Western Bay of Plenty. The Needs Assessment and Services Coordination (NASC) organisation assesses whether disabled people are suitable for EIF. A Local Area Coordinator can assist with the process.

Enhanced Individualised Funding can only be used for services or supports defined as ‘disability support’, activities that are part of an agreed plan to help disabled people reach self-determined goals, and does not include anything that is the responsibility of other government agencies.

## Individualised Funding

Individualised Funding (IF) is a way of paying for home and community support services which allows a disabled person to directly manage the resources they have been allocated for disability supports. The funding can be used to purchase support workers (individuals or provider organisations) to provide support with household management and personal care.[[73]](#footnote-73) The programme is administered by the Ministry of Health. An assessment is required through the National Assessment Services. A relatively small group of disabled people currently access IF.

Until recently legislation prohibited disabled people from purchasing services from family or whānau members with whom the disabled person resides. This issue has been a significant concern for disabled people who prefer people they are close to perform household and intimate care functions. The funding cannot be used for other supports related to disability such as leisure, recreation, home renovations, medical supplies, personal and family costs, or to supplement income.

Individualised funding is only available to a small minority of disabled people who have particular impairment types, and are deemed ‘capable’ of managing their finances or have someone who can do this on their behalf. Individualised funding is not available to people who experience learning/intellectual disability or psychosocial disability, despite effective models of individualised funding operating in the United States amongst people who experience psychosocial disability. Social protections that allow disabled people to purchase the type of support that will improve quality of life, enhance participation in the community, and allow autonomy, choice and control, are the only way to ensure disabled people’s human rights are genuinely upheld.

While the New Zealand Public Health and Disability Act 2000 now permits a family or whānau carers payment, to assist disabled people with household and intimate care, evidence to date indicates that barriers to family payments have resulted in a low uptake of this provision.[[74]](#footnote-74)

# Social Protections - areas for improvement

## Statistics and data collection

Statistics New Zealand is the government agency responsible for the national Census and the nation’s household, labour force, income, social, economic surveys, and disability surveys. However, there is a lack of comprehensive statistical information relating to disabled people in New Zealand and most government departments do not collect disaggregated disability data. Statistics New Zealand’s Household Labour Force Survey, and the Income Survey, do not gather data on outcomes for disabled people.

Available data about disabled people in relation to education, employment, income, poverty, physical health, mental health, housing, and justice, indicate marked disparities between disabled and non-disabled people; with little change since 2008. These disparities are greater for indigenous and Pasifika disabled people, and disabled people who live in geographic areas of high deprivation.

Statistics New Zealand is not planning to offer telephone dictation services for those with limited mobility or vision for the 2018 Census. Instead the service will only use paper forms or an online submissions process. This approach further limits data that can be collected about disabled people’s lives.

## Disability sector and Mental Health sector

The Disability sector and the Mental Health sector are regarded as separate sectors. New Zealand’s Disability Strategy 2001, and New Zealand’s mental health strategies,[[75]](#footnote-75) [[76]](#footnote-76)are distinct entities with separate funding streams, social protections, and contracts for service provision. This reflects very different definitions of disability across New Zealand legislation and policy environments, and a history of psychosocial disability not being regarded as part of the disability sector, and vice versa.

In practice, services provided in response to the Disability Strategy 2001, and services provided in response to the Mental Health Strategy 2005, are not integrated.[[77]](#footnote-77) The former is governed by a social model of disability and a human rights approach. The latter is governed by a medical model and dominated by psychiatry. The majority of services provided to people whose primary disability is psychosocial, is through District Health Boards’ (DHBs) specialist psychiatric inpatient facilities and community mental health services. While some publicly funded primary mental health services are offered, these are typically only available to people under 25 years old, or people in receipt of state income support who hold a ‘community services’ card.

## Mental Health (Compulsory Assessment and Treatment) Act 1993

Current psychiatric practice is enshrined in law through the Mental Health (Compulsory Assessment and Treatment) Act 1992. The Act violates the human rights of people who experience psychosocial disability in multiple ways. In particular, the Act contravenes Articles 12, 13, 14, 15, 16, 17, 18 of the UNCRPD.[[78]](#footnote-78)

District Health Board services for people who experience psychosocial disability are dominated by a medical model and barbaric forms of psychiatric practice. The widespread use of the Mental Health Act 1992 by psychiatrists has meant people who experience psychosocial disability are subject to comparatively high rates of state sanctioned abuses, such as forced treatment and indefinite forced treatment (with poor access to effective justice),[[79]](#footnote-79) and the continued use of seclusion and restraint.[[80]](#footnote-80) [[81]](#footnote-81) Other forms of abuse (e.g. physical and sexual abuse) also occur in state care/custody (e.g. psychiatric units, residential facilities, forensic units and prisons).[[82]](#footnote-82) [[83]](#footnote-83) The notable regional variations in the use of CTOS, seclusion and restraint are indicative of the view of individuals in positions of power within psychiatric units rather than any inherent differences amongst the people using services.[[84]](#footnote-84)

Some of the abuses of disabled people, especially people who experience psychosocial disability or learning/intellectual disability, while in care are so severe, that have recently been reported by the New Zealand Human Rights Commission to the United Nations Committee on the Convention Against Torture.[[85]](#footnote-85)

People under Compulsory Treatment Orders who reside in the community are a group who are not easily recognised, often go under the radar of human rights monitors, and do not have effective mechanisms for reporting psychiatric abuses or making complaints about CTOs (because psychiatric practice is legitimised through mental health legislation, and justice is biased in favour of the psychiatric system).[[86]](#footnote-86)

The New Zealand Convention Coalition’s work to monitor UNCRPD has meant all DPOs are working closely to uphold the human rights of all disabled people. However, real change in relation to the human rights of people with psychosocial disability requires better integration of these historically separate sectors, and urgent review of the Mental Health Act 1992 and psychiatric practice. The government currently has no plan to review the Act.

## The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 is a violation of the human rights of people who experience learning/intellectual disability and contravenes Articles 12, 13, 14, 15, 16, 17, 18 of the UNCRPD.

The Act has significant problems in terms of learning/intellectually disabled people’s liberty, freedom of movement, equal recognition before the law, access to justice, access to effective complaints mechanisms (that are not stacked in favour of traditional concepts of learning/intellectual disability), and freedom from torture, cruel, inhuman and degrading treatment.

Under the Act learning/intellectually disabled people continue to be subject to forced treatment, detention and indefinite detention, and seclusion and restraint. People who come under this Act are those who have been found guilty of a crime or who are unfit to plea in a court of law. There is an urgent need for intervention from the United Nations, and systemic advocacy from the highest level within New Zealand, to ensure this group of disabled people’s basic human rights are protected. The government has no plan to review this Act.

Other New Zealand legislation also provides for the sterilisation of young learning/intellectually disabled women without the young woman’s consent.[[87]](#footnote-87)

The New Zealand Ombudsman has recently investigated situations where learning/intellectually disabled people have been secluded for months at a time in detention facilities.

## Shorter life expectancy and poorer physical health outcomes

People who experience learning/intellectual disability, or psychosocial disability, have a life expectancy that is up to 23 years less than the general population.[[88]](#footnote-88) [[89]](#footnote-89) Likewise, both groups are at greater risk of chronic health conditions, are more likely to be dispensed many different types of prescription drugs, and significantly more likely to have an avoidable hospital admission.[[90]](#footnote-90) [[91]](#footnote-91)

Both of these groups experience stigma and discrimination within health services, from the primary health level, through to general hospital services, and including psychiatric services. Both groups also experience a poorer quality of health service than other groups of people, and are more likely to be prescribed multiple medications, many of which cause physical ill-health and contribute to premature death.

## Learning/intellectually disabled people’s access to justice

People who experience learning/intellectually disabled people face ongoing barriers to access to justice in the course of being arrested or interviewed by police, in relation to publicly assigned lawyers, and within the court system and broader legal mechanisms. Recent New Zealand research relating to learning/intellectually disabled people’s access to justice has been undertaken by the Donald Beasley Institute.[[92]](#footnote-92)

International moves to introduce the concept of an ‘appropriate adult’, akin to the current practice of a ‘responsible adult’ (that applies to young people in New Zealand), would be beneficial for learning/intellectually disabled people in terms of ensuring social protections are in place, before being interviewed by the police or progressing through the legal system.

## Complaints and appeals mechanisms

The Human Rights Commission provides a complaints process to disabled people who may have been discriminated against, and whose rights may have been breached, as per the Human Rights Act 1993. [[93]](#footnote-93) [[94]](#footnote-94)

The Health and Disability Commission provides a complaints process that is specific to the provision of health and disability services. The Code of Consumers’ Rights outlines people’s rights when using these types of services.[[95]](#footnote-95)All health and disability services are required to have complaints mechanisms.

While the legislation and complaints mechanisms are appear comprehensive, they are inadequate for dealing with the vast array of human rights breeches, discrimination and daily indignities experienced by disabled people. The threshold for discrimination or legislative breeches is high. Further, the onus is on individual disabled people (or a representative) to pursue the complaints process. For some people, lodging a complaint may exacerbate existing human rights violations, as disabled people may continue residing in the same place, or receiving the same service from the staff they are lodging a complaint about.

While the Human Rights Commission has highlighted evidence of abuse of disabled people in community settings, there is no real safety for disabled people.[[96]](#footnote-96) A very small number of complaints are taken by disabled people to the Human Rights Commission or the Health and Disability Commission. However, there is evidence of an increasing number of complaints being taken to the Ombudsman, who investigates complaints against government departments.[[97]](#footnote-97)

The complaints system also operates in the context of the Mental Health Act 1993 and the Intellectual Disability Act 2003. These Acts contravene the UNCRPD and by their very nature effectively deny people who experience psychosocial disability, and/or learning/intellectual disability, basic human rights accorded under the UNCRPD.

As noted previously, the government has not ratified the Optional Protocol that would provide a mechanism for individuals and groups to directly lay complaints with the UNCRPD Committee.

**Example**

By OECD standards New Zealand’s rate of Compulsory Treatment Orders is high by and steadily increasing. Most other jurisdictions with rates of this kind view it as a social problem to be ameliorated.[[98]](#footnote-98) In 2011, 4181 applications for Compulsory Treatment Orders under the Mental Health Act 1993 were granted. Of 1070 applications for review by the family court/district court, 592 were granted and only 37 people were released from a CTO. Of 144 applications for review by the Mental Health Review Tribunal, only 72 were heard and of those, only 2 people were released from the Act. These are often people who have been subject to forced treatment for many years.[[99]](#footnote-99)Compulsory Treatment Orders are often used indefinitely, and effectively operative in a manner akin to preventative detention in the criminal justice system.

The current government has no current plans to address the review of the Mental Health Act 1993 or to address the high rates of CTOs. This effectively means that people under CTOS have no other avenues for redress.[[100]](#footnote-100)

## Reasonable Accommodation

New Zealand legislation does not currently provide a definition of Reasonable Accommodation in the Bill of Rights Act 1990 or the Human Rights Act 1993. There is widespread lack of understanding of Reasonable Accommodation across all spheres of society (e.g. education, employment, local government, public information). This means that judgements about what counts as Reasonable Accommodation are made by people in positions of power (e.g. employers, educators, landlords, local councils) who often lack understanding of a social model of disability, disabled people’s human rights, or the UNCRPD.

Although the Office for Disability Issues provides guidelines on reasonable and appropriate accommodations, these are not well known.[[101]](#footnote-101) In the absence of a legal definition, and the absence of legal consequences for not ensuring Reasonable Accommodation requirements are met, there is little incentive for those in positions of power to adhere to the UNCRPD.

## Housing insecurity, lack of affordability and inaccessibility

New Zealand is in dire need of an independent Housing Commission and legislative changes that adequately protect tenants from having to live in ‘sick’ open market rental housing. Housing accessibility, affordability, security and quality in New Zealand is a significant social issue that is integrally connected to poverty.[[102]](#footnote-102) [[103]](#footnote-103) [[104]](#footnote-104) Unhealthy homes, is one of the most significant social determinants of poor social and health outcomes; this issue is heightened for disabled people.[[105]](#footnote-105) [[106]](#footnote-106)

New Zealand has a large stock of open market (privately owned) rental housing that is substandard. Damp, cold, mouldy, poorly ventilated and poorly maintained housing is common and contributes to poor health outcomes.[[107]](#footnote-107) [[108]](#footnote-108) [[109]](#footnote-109) [[110]](#footnote-110) [[111]](#footnote-111)It is common practice for private landlords and property managers to rely on tenants to purchase dehumidifiers (to reduce the effects of damp and mould) and adequate forms of heating. Tenants then also have to pay the high associated costs of electricity. There is currently no requirement for rental housing to be dry and accessible, or for owners to provide safe, effective, and cost and energy efficient heating. Disabled people are typically not eligible for funding for modifications to rental housing.

The high cost of rental housing frequently forces people to live with others, often in overcrowded conditions, and this contributes to disease and illness that exacerbates disability.[[112]](#footnote-112) New Zealand has third world diseases as a result of overcrowding and poverty.[[113]](#footnote-113)

Some groups of disabled people are forced to resort to Boarding Houses or caravan parks.[[114]](#footnote-114) Boarding houses and caravan parks are run by private landlords who provide notoriously substandard accommodation, at exorbitant rates, with fines imposed for various tenant misdemeanours.[[115]](#footnote-115) Like all other open market rental accommodation, there is no effective mechanism to ensure these premises are accessible, warm, dry, insulated, or healthy environments.

There is no effective oversight of private landlords or property managers, and the complaints process is inadequate for addressing breeches of the Residential Tenancies Act 1986 while the breeches are occurring. Regulations that do exist to protect tenants are inadequate and dependent on individuals taking complaints through a formal legal process.[[116]](#footnote-116) Complaints have to be of sufficient severity to warrant going through the Tenancy Tribunal. For instance, under the Act landlords are not required to rectify, and are not penalised for letting damp, mouldy, cold, poorly maintained properties that do not have safe and adequate forms of heating or ventilation. While a Warrant of Fitness is slowly being introduced for privately owned rental properties, this is not mandatory or routine practice.[[117]](#footnote-117) Given that the majority of disabled people use rental accommodation, the issue of appropriate regulation, and proper implementation of the law, is a matter of urgency.

An accommodation supplement is sometimes available through WINZ for people receiving income support. However, the supplement is very low compared with the high market rates charged for rental housing. In effect, the accommodation supplement operates as a tax transfer for landlords. Further, it is not uncommon for WINZ to require beneficiaries to shift houses, if rent is perceived as too high. This occurs irrespective of people’s broader circumstances (such as landlords repeatedly increasing the rent), the supports people may have in their nearby community, the location of their children’s schools, and proximity of access to transport, public facilitates and social services.

## Social and emergency housing

New Zealand has a small social housing stock and very little emergency housing; both of which are unable to meet demand. The eligibility for social housing is increasingly stringent and there is often no long-term security of tenure which leads to housing insecurity and transience. The government has sold a significant number of former state owned houses and the social housing stock has been depleted over recent years.

## Poverty

Statistics New Zealand does not provide a definition or measure of poverty and does not release statistics on poverty per se. However there is widespread agreement that poverty is a critical social issue facing New Zealand. UNICEF has been outspoken on this issue. Extrapolated statistical data indicates that disabled adults are more likely than non-disabled adults to be unemployed, are more likely to live in rental accommodation, are more likely to be unable to afford the basics of living (e.g. food, groceries, utilities, going to the doctor, transport, participation in the community), and are more likely to live in households that earn under $30,000 a year.[[118]](#footnote-118) [[119]](#footnote-119) In addition, disabled people have multiple, additional costs associated with disability that are not provided for through government social protections schemes.

The majority of people who experience learning/intellectual disability are on minimum wages, or are paid below the minimum wage, due to legislation that permits minimum wage exemptions.[[120]](#footnote-120)

The government has no plans to implement a poverty reduction plan. By comparison, in the May 2015 budget the government announced expenditure of $264 million for the Defence Force; $20 million for government surveillance; $11 million conserving the kiwi bird; and $25 million for the purposes of choosing a new national flag.

## Children and young people – poverty, abuse, family violence, violence at school

**Poverty**

New Zealand has a high rate of child poverty.[[121]](#footnote-121) The New Zealand Disability Survey 2013 reported that disabled children are more likely than non-disabled children to live in poverty and to live in high deprivation areas.[[122]](#footnote-122) Thirty four percent of disabled children live in households with an income of under $50,000, 17 percent with an income under $30,000, and five percent with an income under $15,000 per year.[[123]](#footnote-123)

A recent report published by the Child Poverty Action Group, ‘It shouldn’t be this hard: children, poverty and disability,’ highlights a range of issues relating to disabled children and poverty.[[124]](#footnote-124) However the New Zealand government has no plans to ameliorate child poverty. The recent May 2015 budget is evidence of a complete disregard for the rights of all children to an adequate standard of living.

The parent/s or guardians of disabled children often are unable to work because of inadequate support, the additional costs of supporting disabled children, and the difficulties associated with accessing basic services such as education and health. This often means caregivers are reliant on income support payments through WINZ. [[125]](#footnote-125)

**Child abuse, family violence, violence in schools and sexual violence**

New Zealand has a high rate of child abuse,[[126]](#footnote-126) [[127]](#footnote-127) family violence,[[128]](#footnote-128) [[129]](#footnote-129) [[130]](#footnote-130) [[131]](#footnote-131) sexual violence,[[132]](#footnote-132) and violence in schools (bullying).[[133]](#footnote-133) [[134]](#footnote-134) There are also significant issues relating to children and young people in state care[[135]](#footnote-135) and detained youth.[[136]](#footnote-136)

There is no current provision for the protection of disabled women in community care settings under the Domestic Violence Act 1995. Most refuges are inaccessible or have policy that disallows women who experience psychosocial disability.

Coupled with poverty,[[137]](#footnote-137) [[138]](#footnote-138)all of these forms of abuse are heighted for disabled children, young people and women, whose lives, quality of life, and long term wellbeing are severely compromised by early life deprivation, adversity and trauma. Youth in New Zealand have a high rate of suicide and psychosocial disability, often resulting from negative early life experiences.[[139]](#footnote-139)

The social protections system does not cater well to disabled youth who do not fit criteria for disability-specific supports. This is especially so for disabled youth reliant on income support through WINZ.

## Employment

Disabled people have an unemployment rate that is twice that of non-disabled people.[[140]](#footnote-140) The government continues to view disabled people as a cost rather than an investment and legal provisions for Reasonable Accommodation do not function effectively.

New Zealand has long standing Equal Employment Opportunities legislation (contained in several Acts) and employers are required to eliminate policies, procedures and institutional barriers to disabled people’s employment. However, research and statistics show that this has not resulted in significant improvements in disabled people’s overall employment status, income levels, or poverty status. The relationship between low income and deprivation has long been highlighted by New Zealand academics and non-government social justice agencies.[[141]](#footnote-141) [[142]](#footnote-142)

The employment of disabled people is strongly reliant on employer attitudes and understanding of Reasonable Accommodation. As noted previously, Reasonable Accommodation is not defined in New Zealand legislation and is not well understood.

Between 1996 and 2006 the employment rate of disabled barely improved, despite a raft of legislation, policies and programmes.[[143]](#footnote-143) Even in the public service, that promotes Better Public Services to disabled people, only approximately 3.7 percent of the workforce identify as experiencing disability.[[144]](#footnote-144)

**Example**

A current review of vocational services exemplifies the employment barriers disabled people face. While the intention is that there is alignment between the Enabling Good Lives principles,[[145]](#footnote-145)employment participation, inclusive services, and policy and employment initiatives, this has not typically been the case.

The current system proposes moving away from disability community-based agencies. Instead screening would be undertaken via the government’s WINZ service. While the ‘twin track’ approach has recently been implemented to support disabled people’s employment,[[146]](#footnote-146) WINZ is known as notoriously punitive and motivated by cost-cutting.

A move to WINZ screening would be contradictory to the governments’ Disability Strategy 2001 and the Disability Action Plan 2014-2018. It would be antithetical to the Enabling Good Lives principles. This approach is likely to result in further poverty and human rights violations.

## Education

While the Education Act 1989 provides for the right to education for all 5-19 year olds, there is no requirement for inclusive education of disabled children. This means the right to inclusive education is not legally established and has yet to be realised at a practical level.

There are ongoing issues facing disabled students at every step of school engagement. For example: enrolment; attitudes to inclusiveness by senior staff; a lack of support hours; unsuitable physical environments; an inadequate child-to-adult ratio to ensure safety; access to curriculum; and participation in ‘everyday’ school activities.[[147]](#footnote-147) Further, the reporting of disabled students’ achievement and educational outcomes is limited, and there are no measures that compare learning outcomes of disabled and non-disabled students. Current legislation has been recognised as discriminatory at a judicial level, but has not resulted in any change. The IHC[[148]](#footnote-148)continues to pursue legal proceedings against the Ministry of Education in this regard.[[149]](#footnote-149)

To obtain any form of social protections for disabled children and young people within the education system, the onus is on parent/s or guardians to initiate and justify basic requirements for accessible education. The process of obtaining supports for a disabled child or young person can involve multiple government departments and multiple agencies, is dependent on the students’ impairment type/s and needs,[[150]](#footnote-150) the different definitions of disability used by each agency and in different policies, the inclusion of particular impairment types, and an officially sanctioned ‘diagnosis’.

Navigating the social protections system, obtaining required information, knowing what is available, obtaining (and in some cases paying for) assessments, applying for supports, and repeatedly reapplying and renegotiating provisions, is extremely time consuming and costly, and takes personal toll on parents/s and guardians.

The Ministry of Education provides Ongoing Resourcing Scheme (ORS) for students with the highest level of need for special education to join in and learn alongside other students at school. However, competitive funding, and the capping of ORS budgets, means that if one student is granted funding, another student can miss out. This approach to the funding of students results in highly inequitable outcomes.

Complaints to the Ombudsman about educational access and funding for disabled children are common.[[151]](#footnote-151)

## Accessibility

Accessibility applies to diverse spheres of public and political life, and includes (but is not limited to) the physical and built environment, information and communication, media, transport, goods and services, and the broad spectrum of facilities and services that are part of any community. The private sector is also required to ensure services are accessible to the public. However, implementation and monitoring of compliance with UNCRPD accessibility guidelines, and Government website access standards, lacks rigour across government and non-government agencies, and in the provision of services and public facilities.

**Examples**

Education about disability and accessibility is not systematically or widely available, is rarely funded, and is not a legal requirement.

There is a widespread lack of access to information and communication technology, or to information and technology per se, in accessible formats.

Accessibility requirements governing earthquake strengthening of buildings are only required when this is ‘reasonably practical’ and territorial authorities are permitted to exempt alterations from the Building Code.

The public transport system is not consistently accessible, there are persistent barriers relating to electronic ticketing, online timetables and transport related information.

There is widespread lack of utilisation of audio describers for public events (e.g. theatre, civic events, parades, musical events, museums, galleries, sports).

Signs in public places are not in Easy Read or Braille.

New Zealand has yet to ratify the Marrakesh Treaty that would increase the availability of copyright material in alternative formats for print-disabled people.

NZ Sign Language is an official New Zealand language. However, there are many situations when interpreters are not provided.

Captioning is not routine practice in public places or at events, and is not consistently used in television programming.

The judicial system relies on printed material, electronic screen readers are not permitted in court, and disabled people who require reader/writer support to access materials for judicial hearings, are required to arrange and pay for this themselves.

The Total Mobility scheme (discounted taxis) is structured and implemented differently in each regional council area. This results in inequitable outcomes between regions.

## Reducing stigma and discrimination

Disabled people report that stigma and discrimination are the biggest barrier to full participation in society and upholding isabled people’s human rights. Disability related discrimination is currently the largest category of complaint to the Human Rights Commission.

The majority of New Zealanders have little or no direct contact with disabled people. The recent termination of funding for the ‘Think Differently’ campaign seriously undermines efforts to raise awareness about discrimination and to foster greater understanding of disabled people’s lives. A social change campaign involving media advertising and education that focused on psychosocial disability, ‘Like Minds, Like Mine’, led to significant change in public attitudes about people who experience psychosocial disability.[[152]](#footnote-152)

# Disability-specific programmes

Services, programmes, income support, grants, supplements, assistance, and other social protections are spread across a range of government and non-government agencies. There is no centralised organisation responsible for collating and coordinating all disability related information about the social protections available to disabled people. Likewise, there is no central agency responsible for funding all the social protections that disabled people are entitled to and the administration of social protections is spread across government and non-government agencies. The State Services Commission undertook an initiative to explore the way disabled people experience government agencies. The report, called Better Public Services, identified a raft of problems and barriers for people for dealing with government agencies.[[153]](#footnote-153)

At present, the funding of social protections for disabled people is predominantly spread across the Ministry of Social Development (MSD) and its WINZ subsidiary, the Ministry of Health (MoH), and the Ministry of Education (MoE). For an example of some of the social protections available through these three Ministries, see Appendix 2.

While there is a vast array of disability-specific programmes, there is no coherent overview of all programmes or provisions available. Furthermore, eligibility criteria vary markedly according to the government agency funding and/or administering the service, the impairment type/s, cause of impairment/s, geographic region, and the service ‘culture’ (meaning the attitudes and values of the organisation and staff members). These disparities result in inequitable outcomes for different groups of disabled people throughout Aotearoa New Zealand. As noted previously, the social protections available to people who experience psychosocial disability vary markedly from those available to other groups of disabled people.[[154]](#footnote-154)

The lack of cohesion of social protections means that it is very difficult for disabled people, and families, whānau or guardians, to navigate through the system and to obtain the social protections to which they are entitled. While new approaches have been adopted to ensure a smoother process (e.g. Enabling Good Lives) this is still a relatively new programme. If disabled people are unemployed, or unable to work, they are still dependent on WINZ for weekly income support payments. Further, while it appears that New Zealand has many social protections for disabled people, securing them is often described as a ‘nightmare’. For most disabled people, the bureaucratic processes, ‘catch-22’ situations, complexity and hurdles obtaining social protections are significant and come at a high personal cost for disabled people, families, whānau, guardians and support workers.

The move to mainstreaming through WINZ has the potential to further erode the provision of disability-specific supports.[[155]](#footnote-155) Any additional support requires knowing what to ask for (as this information is not readily provided by WINZ), being in a position to gather all the documentation the agency requires to approve applications for funding, repeatedly having to go to health practitioners for medical certificates and to pay the costs associated with consultations, and to proceed through a range of barriers that make it increasingly difficult for disabled people to obtain social protections through this service. Given that many disabled people are unemployed, these issues are paramount. Many disabled people are ‘life-long beneficiaries’ who are reliant on WINZ for basic living costs.[[156]](#footnote-156) Being a beneficiary in New Zealand typically means living in poverty.[[157]](#footnote-157)

Income support payments provided through WINZ can be suspended or terminated at any time without notice. The onus is then on the individual to seek the reinstatement of payments, which requires making contact with a call centre, obtaining an appointment (that can take several weeks), travelling into the local WINZ office, and repeating application processes that have previously been undertaken. The sudden and unannounced suspension or termination of income support has an extremely adverse impact on disabled people’s payment of rent, food, utilities, transport and other basic costs. It also contributes to debt and poverty. The WINZ system in particular, is administered in an extremely punitive and inhumane manner that adversely affects many disabled people’s wellbeing and quality of life.

While mainstreaming has been promoted for some time in Aotearoa New Zealand, there is a simultaneous need for disability-specific social protections across government and non-government agencies. Recent developments relating to social protections under the jurisdiction of the Ministry of Social Development are a significant cause for concern as they are likely to erode disability-specific social protections.

## Inequitable provisions

There continues to be deep concern about the inability of government to provide equitable and fair treatment across impairment types, age, and geographic locations. The manner in which a disability is acquired also determines the range of provisions a person is entitled to. This has a significant impact on disabled people’s social and economic outcomes.

Example

People who are born with an impairment (for example blind, Deaf, spina bifida) are eligible for income support and social assistance through the Ministry of Social Development. The weekly income support payment rate, and other financial support available, is set at a much lower rate than for people whose impairment is a result of an accident.

Although the government’s latest budget announcement will provide an increase of $25 to the generic weekly income support payment (after 30 years at an unchanged rate), the government simultaneously announced the reduction of the Child Disability Allowance by $8 million. This follows a steady decrease in the rate of Child Disability Allowance approved by WINZ over the recent years, despite a simultaneous increase in the number of disabled children.[[158]](#footnote-158)

The government has also introduced a range of harsher restrictions in access to income support irrespective of person’s circumstances (e.g. in some cases requiring lone parents to work once a child is three years old, despite the fact early childhood education is often not accessible, is expensive, and is not available in all geographic regions). Every year, there is an increase in the barriers and bureaucratic obstacles people are required to go through to obtain any type of payment from WINZ.[[159]](#footnote-159) These changes have an exponentially adverse impact on disabled people. For example, every year disabled people who are in receipt of the Supported Living Allowance have to reapply, despite having severe impairments that do not change over time or actually progressively worsen with time. Reapplying requires providing a range of documentation, takes considerable time, is unnecessarily stressful and costly.

People who have had an accident and are eligible for Accident Compensation (a form of insurance available to all citizens) typically receive a higher level of compensation than is available through the Ministry of Health or Ministry of Social Development.[[160]](#footnote-160) However, the threshold for receiving income related payments has become increasingly stringent and inequitable over time, barriers to access are increasingly rigorous and unfair, and the duration of payments has decreased based on a theoretical average time taken to rehabilitate.[[161]](#footnote-161) For example, if a person has a particular type of head injury (irrespective of the impact of the injury) then there is a fixed and standard amount of time allowed before ACC payments cease. People in this situation are then required to apply for income support through WINZ, and have to go through the whole cycle of application, and obtaining medical assessments and certificates again.

There are also inconsistencies across ACC legislation relating to psychosocial disability. If trauma is experienced while undertaking paid work people may be eligible for ACC. However, people who experience trauma, in places other than paid work, cannot access ACC.[[162]](#footnote-162)

## Disability-sensitive training and awareness-raising for civil servants and/or external partners

There is no national programme of disability-sensitive or disability awareness-raising. Most training or education of this kind is piecemeal, adhoc and reliant on inadequate and insecure funding.

The Think Differently campaign was initiated to provide a national communications strategy, national partnerships, community action projects, and research and evaluation. The campaign was funded through the Ministry of Social Development. However, the government has recently discontinued funding for this programme.

While the Disabled Persons Assembly has designed and developed a unique, national, high quality, bicultural, UNCRPD education programme – Kia Noho Rangatira Ai Tātou – funding for the delivery of this programme is not currently available. The programme is designed to educate the Disability Support Services workforce and disabled people (to fulfil UNCRPD objectives contained in the government’s Disability Workforce Action Plan 2013-2016). This education programme has the potential to be delivered across government and non-government sectors (e.g. ACC, the judiciary, health sector) and would be an ideal national programme that is led and delivered by disabled people.

The longstanding ‘Like Minds, Like Mine’ programme, designed to provide education at a national and regional level, resulted in significant changes in attitudes towards psychosocial disability. Although this programme operated successfully for many years, and was heralded internationally as a model social change campaign, this work has become progressively less visible and funding has been significantly eroded over recent years.

Although the government initiated the Better Public Services programme to improve public services for disabled people, this has not followed with funding for an organisation to provide disability awareness education grounded in a human rights framework and UNCRPD.[[163]](#footnote-163)

**Media**

In 2013 New Zealand’s Convention Coalition Monitoring Group published a report that addresses the way disabled people are portrayed by the media. The findings highlight the lack of a human rights approach to understanding disability; negative portrayal of disability and disabled people; and the invisibility of the voices of disabled people, especially Māori and Pasifika. There is an urgent need for a systematic plan of implementation to address the way the media portrays disability and to secure funding that can sustain implementation of UNCRPD education over the long term.

## Definition of disability

The definition of disability is inconsistent across New Zealand legislation and policies. This results in inequities across different impairment types and across different government agencies.

 ‘There are various definitions of disability. The New Zealand Disability Strategy describes disability as:

 "Disability is not something individuals have. What individuals have are impairments. They may be physical, sensory, neurological, psychiatric, intellectual or other impairments... Disability is the process which happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have..."

 Statistics NZ defines disability as "any self-perceived limitation in activity resulting from a long-term condition or health problem; lasting longer or expected to last longer than six months or more and not completely eliminated by an assistive device".[2](https://www.ssc.govt.nz/node/1671%22%20%5Cl%20%22P35_3146) Statistics NZ also draws on the World Health Organisation's functional definition of disability of "...any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner of within the range considered normal for a human being".

State Services Commission[[164]](#footnote-164)

There are a range of impairments, such as specific learning disabilities (dyslexia and dyspraxia) and Autism Spectrum Disorder, that have only relatively recently been officially regarded as ‘disabilities’ within health and educational contexts. However, there is no government-wide agreement about these types of impairment which means that social protections available are inconsistent, adhoc and often not available at all.

# Appendix 1 New Zealand legislation

Accident Compensation Act 2001

Bill of Rights Act 1990

Children’s Commissioner Act 2003

Crimes of Torture Act 1989

Education Act 1989 (Amendment Act 2013)

Health and Disability Commissioner Act 1994

Human Rights Act 1993[[165]](#footnote-165)

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

Mental Health (Compulsory Assessment and Treatment) Act 1992

Minimum Wage Act 1983

Ombudsmen Act 1975[[166]](#footnote-166) (the Ombudsman is a member of the IMM)

Public Health and Disability Act 2000

Privacy Act 1993

Protection of Personal and Property Rights Act 1988

Social security Act 1964

# Appendix 2 Social protections

<http://www.msd.govt.nz/what-we-can-do/disability-services/>

<http://www.msd.govt.nz/what-we-can-do/disability-services/mainstream/index.html>

<http://www.workandincome.govt.nz/individuals/a-z-benefits/disability-allowance.html>

<http://www.health.govt.nz/our-work/disability-services>

<http://www.health.govt.nz/our-work/disability-services/about-disability-support-services>

<http://www.minedu.govt.nz/NZEducation/EducationPolicies/SpecialEducation/AboutUs/ContextOfOurWork/EducationAndDisabilityContexts.aspx>

1. Please note the two different acronyms: DPA (Disabled Persons Assembly) and DPOs (Disabled Persons Organisations). The former is a pan disability organisation. The latter are disability-specific organisations. Both DPA and DPOs are non-government organisations funded through charities and some government project-based funding. [↑](#footnote-ref-1)
2. This dedicated role is currently subject to government review. [↑](#footnote-ref-2)
3. In New Zealand local bodies are called Councils (Regional, District or City Councils). [↑](#footnote-ref-3)
4. <http://www.stats.govt.nz/browse_for_stats/health/disabilities/social-economic-outcomes-13.aspx> [↑](#footnote-ref-4)
5. <http://includingallpeople.org.nz/> [↑](#footnote-ref-5)
6. <http://www.cpag.org.nz/resources-publications/publications/> [↑](#footnote-ref-6)
7. <http://includingallpeople.org.nz/> [↑](#footnote-ref-7)
8. <http://www.stats.govt.nz/> [↑](#footnote-ref-8)
9. Northland, Whanganui, and the Bay of Plenty are also high deprivation regions. <http://www.otago.ac.nz/wellington/otago069936.pdf> [↑](#footnote-ref-9)
10. <http://www.spinz.org.nz/file/FAQs/PDFs/mental-health-survey.pdf>; [↑](#footnote-ref-10)
11. <http://www.health.govt.nz/system/files/documents/publications/mental-health-survey-summary.pdf> [↑](#footnote-ref-11)
12. <http://www.health.govt.nz/publication/new-zealand-health-survey-annual-update-key-findings-2012-13> [↑](#footnote-ref-12)
13. <http://www.health.govt.nz/publication/annual-update-key-results-2013-14-new-zealand-health-survey> [↑](#footnote-ref-13)
14. <http://www.health.govt.nz/system/files/documents/publications/mental-health-survey-summary.pdf> [↑](#footnote-ref-14)
15. <http://www.health.govt.nz/publication/annual-update-key-results-2013-14-new-zealand-health-survey> [↑](#footnote-ref-15)
16. <http://www.health.govt.nz/publication/suicide-facts-deaths-and-intentional-self-harm-hospitalisations-2012> [↑](#footnote-ref-16)
17. [www.health.govt.nz/system/files/documents/publications/suicide-facts-2011-jan14\_0.pdf](http://www.health.govt.nz/system/files/documents/publications/suicide-facts-2011-jan14_0.pdf) [↑](#footnote-ref-17)
18. <http://www.health.govt.nz/publication/annual-update-key-results-2013-14-new-zealand-health-survey> [↑](#footnote-ref-18)
19. <http://www.leva.co.nz/about> [↑](#footnote-ref-19)
20. <http://www.health.govt.nz/publication/annual-update-key-results-2013-14-new-zealand-health-survey> [↑](#footnote-ref-20)
21. <http://www.health.govt.nz/publication/health-indicators-new-zealanders-intellectual-disability> [↑](#footnote-ref-21)
22. [www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2014/vol-127-no.-1394/6126](http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2014/vol-127-no.-1394/6126) [↑](#footnote-ref-22)
23. <http://www.odi.govt.nz/resources/publications/new-zealand-disability-strategy.html#NewZealandDisabilityStrategy1> [↑](#footnote-ref-23)
24. <http://www.odi.govt.nz/what-we-do/ministerial-committee-on-disability-issues/disability-action-plan/2014-2018/index.html> [↑](#footnote-ref-24)
25. For further details about the ways in which the framework implementation is promoted, protected and monitored see the Office for Disability Issues website:

<http://www.odi.govt.nz/what-we-do/un-convention/framework/index.html> [↑](#footnote-ref-25)
26. <http://www.odi.govt.nz/what-we-do/ministerial-committee-on-disability-issues/index.html> [↑](#footnote-ref-26)
27. <http://www.odi.govt.nz/what-we-do/ministerial-committee-on-disability-issues/disability-action-plan/2014-2018/index.html> [↑](#footnote-ref-27)
28. A new Minister for Social Development was appointed in 2014. To date the Minister has demonstrated a mono-cultural, dictatorial and adversarial approach to a range of social issues that directly and indirectly affect disabled people, including indigenous people and the many disabled people who live in poverty. The Minister’s approach also reflects a free-market ideology that is antithetical to UNCRPD and social protections for disabled people. For example, the Minister recently hand-picked a panel of ‘experts’ to review New Zealand’s Child, Youth and Families Services (CYFS). The Minister did not consult iwi leaders, or appoint any indigenous leaders, despite more than 50 percent of children in CYFS care being indigenous children. This is a clear breach of the United Nations Declaration on the Rights of Indigenous Peoples and the Treaty of Waitangi. [↑](#footnote-ref-28)
29. For example from the Ministries of Health, Education, Justice, Transport, Business, Innovation and Employment, Foreign Affairs and Trade, ACC and Housing New Zealand Corporation. [↑](#footnote-ref-29)
30. <http://www.odi.govt.nz/about-us/index.html#Ourresponsibilitieswhatwedo2> [↑](#footnote-ref-30)
31. <http://www.odi.govt.nz/about-us/index.html#Ourresponsibilitieswhatwedo2> [↑](#footnote-ref-31)
32. [http://www.odi.govt.nz/what-we-do/ministerial-committee-on-disability-issues/disability-action- plan/2014-2018/we-worked-with-dpos-to-develop-the-new-plan.html](http://www.odi.govt.nz/what-we-do/ministerial-committee-on-disability-issues/disability-action-%20%20plan/2014-2018/we-worked-with-dpos-to-develop-the-new-plan.html) [↑](#footnote-ref-32)
33. Most DPOs also include non-disabled members; however only disabled members have voting rights. [↑](#footnote-ref-33)
34. <http://www.nzdsn.org.nz/> [↑](#footnote-ref-34)
35. <http://www.ihc.org.nz/> [↑](#footnote-ref-35)
36. <http://www.ccsdisabilityaction.org.nz/> [↑](#footnote-ref-36)
37. <http://www.healthcarenz.co.nz/> [↑](#footnote-ref-37)
38. <http://www.mashtrust.org.nz/> [↑](#footnote-ref-38)
39. <http://www.health.govt.nz/our-work/disability-services/disability-projects-and-programmes/disability-workforce> [↑](#footnote-ref-39)
40. <http://www.odi.govt.nz/what-we-do/ministerial-committee-on-disability-issues/disability-action-plan/2014-2018/index.html> [↑](#footnote-ref-40)
41. Article 33 Convention Coalition Monitoring Report. (2015) Disability Rights in Aotearoa New Zealand: Acceptance in Society (page 9). [↑](#footnote-ref-41)
42. For example: a) Article 33 Convention Coalition Monitoring Group (2014) Disability Rights in Aotearoa New Zealand: Participation and Poverty; b) Article 33 Convention Coalition Monitoring Group (2013) Disability Rights in Aotearoa New Zealand 2013: Youth; c) Article 33 Convention Coalition Monitoring Group (2012) Disability Rights in Aotearoa New Zealand 2012; Article 33 Convention Coalition Monitoring Group (2010) Media and disabled people. See: <http://www.odi.govt.nz/what-we-do/un-convention/framework/index.html> - section titled ‘Monitoring the rights of disabled people by the Convention Coalition’. [↑](#footnote-ref-42)
43. See Human Rights Commission (2014) Making Disability Rights Real. Wellington: New Zealand <http://www.hrc.co.nz/files/5214/2357/0956/Making-disability-rights-real-Print2.pdf> [↑](#footnote-ref-43)
44. <http://www.hrc.co.nz/files/3214/2396/7510/A-BRIEFING-FROM-NEW-ZEALANDS-CRPD-INDEPENDENT-MONITORING-MECHANISM.pdf> [↑](#footnote-ref-44)
45. <http://www.leva.co.nz/disability/faiva-ora-national-leadership-group> [↑](#footnote-ref-45)
46. <http://www.odi.govt.nz/what-we-do/ministerial-committee-on-disability-issues/disability-action-plan/2014-2018/we-worked-with-dpos-to-develop-the-new-plan.html> [↑](#footnote-ref-46)
47. <http://www.health.govt.nz/our-work/disability-services/disability-projects-and-programmes/consumer-consortium> [↑](#footnote-ref-47)
48. The programme is called Kia Noho Rangatira Ai Tātou. [↑](#footnote-ref-48)
49. In New Zealand, Commissions are independent Crown entities that are established (and disestablished) under legislation determined by the government. [↑](#footnote-ref-49)
50. GCSB Bill <http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10897315> [↑](#footnote-ref-50)
51. The official relationship is between the Crown and indigenous leaders. [↑](#footnote-ref-51)
52. The indigenous people; also called Māori. [↑](#footnote-ref-52)
53. The Declaration has yet to be comprehensively addressed across the New Zealand disability sector. [↑](#footnote-ref-53)
54. Whānau means ‘extended family, family group... and the primary economic unit of traditional Māori society. <http://maoridictionary.co.nz/> [↑](#footnote-ref-54)
55. Hapu means ‘kinship group, clan, tribe, sub-tribe... or section of a large kinship group and the primary political unit in traditional Māori society. It consisted of a number of whānau sharing descent from a common ancestor.’ <http://www.maoridictionary.co.nz/> [↑](#footnote-ref-55)
56. Iwi means extended ‘kinship group’ or ‘tribe’... and often refers to ‘a large group of people descended from a common ancestor and associated with a distinct territory.’ <http://www.maoridictionary.co.nz/> [↑](#footnote-ref-56)
57. <http://www.health.govt.nz/publication/whaia-te-ao-marama-maori-disability-action-plan-disability-support-services-2012-2017> [↑](#footnote-ref-57)
58. <http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga> [↑](#footnote-ref-58)
59. Tangata whenua are the indigenous people of Aotearoa (New Zealand). Also referred to as Māori. [↑](#footnote-ref-59)
60. <http://www.health.govt.nz/publication/whaia-te-ao-marama-maori-disability-action-plan-disability-support-services-2012-2017> [↑](#footnote-ref-60)
61. <http://www.health.govt.nz/publication/whaia-te-ao-marama-maori-disability-action-plan-disability-support-services-2012-2017> [↑](#footnote-ref-61)
62. <http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga> [↑](#footnote-ref-62)
63. <http://www.health.govt.nz/publication/faiva-ora-national-pasifika-disability-plan-2010-2013> [↑](#footnote-ref-63)
64. There are at least four Pasifika languages that are widely spoken and are a regular part of Pasifika people’s lives.  [↑](#footnote-ref-64)
65. Whānau ora is a philosophical approach and a government endorsed programme. It is based on a holistic approach and seeks to enhance the capacity and capability of the whole family; not just a disabled individual. Whānau Ora (Māori: family health) is ‘a major contemporary indigenous health initiative in New Zealand driven by Māori cultural values. Its core goal is to empower communities and extended families (whānau) to support families within the community context.’ <http://www.health.govt.nz/our-work/populations/maori-health/whanau-ora-programme> [↑](#footnote-ref-65)
66. New Zealanders of European ancestry. [↑](#footnote-ref-66)
67. <http://www.kapomaori.com/> [↑](#footnote-ref-67)
68. [www.enablinggoodlives.co.nz](http://www.enablinggoodlives.co.nz) [↑](#footnote-ref-68)
69. <http://www.odi.govt.nz/what-we-do/improving-disability-supports/enabling-good-lives/key-messages.html> [↑](#footnote-ref-69)
70. <http://www.odi.govt.nz/what-we-do/improving-disability-supports/enabling-good-lives/index.html#Christchurch4> [↑](#footnote-ref-70)
71. <http://www.odi.govt.nz/what-we-do/improving-disability-supports/enabling-good-lives/waikato.html> [↑](#footnote-ref-71)
72. <http://www.health.govt.nz/our-work/disability-services/new-model-supporting-disabled-people> [↑](#footnote-ref-72)
73. <http://www.health.govt.nz/your-health/services-and-support/disability-services/types-disability-support/individualised-funding> [↑](#footnote-ref-73)
74. <http://www.carers.co.nz/> [↑](#footnote-ref-74)
75. [Te Tāhuhu: Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan](http://www.health.govt.nz/publication/te-tahuhu-improving-mental-health-2005-2015-second-new-zealand-mental-health-and-addiction-plan); <http://www.hdc.org.nz/about-us/mental-health-and-addictions/mental-health-sector-strategy-documents> [↑](#footnote-ref-75)
76. ‘Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017’ and ‘Blueprint II How Things Need to Be’ are subsequent plans for improving mental health services and the mental health outcomes of New Zealanders.

<http://www.health.govt.nz/our-work/mental-health-and-addictions/rising-challenge>; <http://www.hdc.org.nz/media/207642/blueprint%20ii%20how%20things%20need%20to%20be.pdf> [↑](#footnote-ref-76)
77. In situations where disabled people experience psychosocial disability AND other disabilities, services can be provided through mainstream ‘Disability Support Services’ contracted via the Ministry of Health. Likewise, the Ministry of Social Development offers services to people with coexisting disabilities. [↑](#footnote-ref-77)
78. Gordon, S. & O’Brien, A. (2014) New Zealand’s mental health legislation needs reform to

avoid discrimination. New Zealand Medical Journal, Vol 127 No 1403. [↑](#footnote-ref-78)
79. This group of people are typically forced to take high doses of psychotropic drugs (often multiple different types of medication at once) that have particularly adverse health effects, shorten life expectancy, impair people’s ability to function and compromise quality of life. People can remain under CTOs in the community indefinitely, with little recourse to justice. This practice is akin to preventative detention in the criminal justice system. [↑](#footnote-ref-79)
80. New Zealand has a comparatively high rate of Compulsory Treatment Orders (i.e. forced treatment). Seclusion (including stripping) and restraint remain routine practice, despite national policy to reduce these practices. There is a substantial body of international research to show that all of these practices further traumatise people. [↑](#footnote-ref-80)
81. Gordon, S. & O’Brien, A. (2014) New Zealand’s mental health legislation needs reform to

avoid discrimination. New Zealand Medical Journal, Vol 127 No 1403.

<http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2014/vol-127-no-1403/6316> [↑](#footnote-ref-81)
82. For example: Barnett, H. & Lapsley, H. (2006) Journeys of Despair, Journeys of Hope. Young adults talk about severe mental distress, mental health services and recovery. Wellington: Mental Health Commission. <http://www.mentalhealth.org.nz/assets/ResourceFinder/journeys-of-despair-journeys-of-hope-2006.pdf> [↑](#footnote-ref-82)
83. <http://www.ombudsman.parliament.nz/system/paperclip/document_files/document_files/715/original/opcat_2013_final_report.pdf?1386810238>; <https://www.google.co.nz/webhp?sourceid=chrome-instant&rlz=1C1NCHB_enNZ574NZ574&ion=1&espv=2&ie=UTF-8#q=ombudsman+investigates+intellectually+disabled+nz>

<http://www.ombudsman.parliament.nz/resources-and-publications/latest-reports> [↑](#footnote-ref-83)
84. <http://www.health.govt.nz/system/files/documents/publications/office-of-the-director-of-mental-health-annual-report2012.pdf> [↑](#footnote-ref-84)
85. <http://www.hrc.co.nz/files/6314/3130/4434/HRC_submission_to_CAT_Final.pdf> [↑](#footnote-ref-85)
86. Gordon, S. & O’Brien, A. (2014) New Zealand’s mental health legislation needs reform to

avoid discrimination. New Zealand Medical Journal, Vol 127 No 1403. [↑](#footnote-ref-86)
87. <http://www.hrc.co.nz/files/6314/3130/4434/HRC_submission_to_CAT_Final.pdf> [↑](#footnote-ref-87)
88. [↑](#footnote-ref-88)
89. [↑](#footnote-ref-89)
90. <http://www.health.govt.nz/publication/health-indicators-new-zealanders-intellectual-disability>; [↑](#footnote-ref-90)
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150. For example a child may be being seen by a range of agencies and staff from across Special Education, a Ministry of Health funded Disability Support Service, a Child and Family Mental Health Service, a District Health Board, and a Ministry of Social Development funded services. [↑](#footnote-ref-150)
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154. For example Disability Support Services provided through the Ministry of Health are not available to people who experience psychosocial disability unless they have a coexisting impairment (as this is regarded as ‘outside the disability framework.’) [↑](#footnote-ref-154)
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160. However, if prior to an accident a person has had part-time, casual or seasonal employment, their ACC weekly payments will also be as low as WINZ payments due to the fact ACC basis weekly payments on 80% of a person’s prior annual income. [↑](#footnote-ref-160)
161. With the introduction of ACC New Zealanders gave up the right to sue for damages suffered as a result of an accident, wherever the accident occurs (e.g. workplace, sports-field, home). [↑](#footnote-ref-161)
162. The exception is that people who have experienced sexual abuse may be eligible for counselling for a limited number of therapeutic sessions. However, they are not entitled to weekly compensation payments or a lump sum payment. [↑](#footnote-ref-162)
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165. This includes the Human Rights Commission and the Disability Rights Commissioner (who is a

member of New Zealand’s Independent Monitoring Mechanism). [↑](#footnote-ref-165)
166. The powers and functions of the Ombudsman are contained in five different Acts. [↑](#footnote-ref-166)