

HĀPAITIA

**Supporting & Strengthening
Māori Mental Health Specialist
Services**

Final report

May 2025

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Mihimihi

*Mate atu he tētēkura, ka ara mai he tētēkura
Ko ngā ringa raupā e takoto ana te manuka o
mua, o nāianeī tonu
Kia ū tonu tātou ki ngā mokopuna e kokiri ai ki
mua*

*“To the many Rangatira who have paved the way for
new leadership to come forth, and to those with
chaffed hands of hard work past and present, we
remain resilient for the next generation to move
forward”*

*Ko ngā tētēkura o te motu nei, tūtū mai rā
Ko ngā tētēkura o te kainga, tūtū mai rā
Ko ngā tētēkura o te whānau, tūtū mai rā i tō
mana motuake!
Kia Kotahi ai tātou mā te whānau
Mauri tū, mauri ora!*

*“To all the leaders across this whenua and within the
safety realms of our home and whānau, continue to
stand with strength as we stand as one people. For
the breath of life sustains us and brings it to life!”*

*Kāti ki tēnā, kei te mihi nunui ki ngā manu
taupua o te motu rā. Koutou mā hai whāngaia
e o mātou wairua, hinengaro, tinana, me te
whānau hoki. E hōrapa atu i ngā kōrero mai i
tēnā rohe, mai i tēnā rohe o Aotearoa. Kua kī
te puku, te whakaaro, me te wairua rānei.
Tēnā koutou mō o koutou koha ki a mātou,
ara, ngā manu taikō a Te Whatu Ora. Ko te
mea nui, hai huaki ai te tatou o tō koutou
whare hauora, ki a pai ai te tauritetanga o ia
tangata, o ia tangata. Ara, ko te kōrero hai
whakatū i o tātou purongo a Hāpaitia!
Hāpaitia ki a koutou, Hāpaitia ki a tātou
katoa.*

*“In our endeavour to improve access and equity for
Māori, we extend our deepest gratitude to all who
support the Hāpaitia project team. Your contribution,
especially in providing the nourishment to our spirit,
mind, body, and family is invaluable. The wealth of
knowledge, experiences, and thoughts you shared
fills our minds and strengthens our resolve. We
acknowledge the gifting of this information to Te
Whatu Ora. Hāpaitia will rise to benefit us all!*

He Mihi Acknowledgements

He mihi nunui, he mihi maioha nei ki ngā tangata mātau-ā-wheako me ngā tini whānau hai tukuna mai i ō rātou nei kōrero me ngā pūkenga hoki.

We pay particular attention to thanking tangata mātau-ā-wheako (lived experienced of mental distress) and the many whānau from the respective places we visited. Those who shared pūrākau (stories) and welcomed the opportunity to influence change across the kaupapa (sector) to ensure that whānau Māori have better experiences within inpatient units.

Kāti rā, kai a koutou ngā kaimahi o Te Whatu Ora, hai whakatau mai, hai kōrerotia e o koutou mātauranga hohonu ki a mātou. Ka nui te tino mihi atu ki a koutou katoa kei raro i te manaakitanga.

Finally, thank you to Te Whatu Ora for welcoming us into your space and sharing your extensive knowledge and deep understanding in a safe place.

He mihi mahana ki a koutou katoa.

Hāpaitia

Kaua he kōrero nahenahe, he kōrero ki a tātou katoa

“Nothing about us without us.” (Lived Experience community)

The name Hāpaitia was gifted by Māori Lived Experience leader Egan Bidois, *Director Lived Experience, Oranga Hinengaro*. It means to uplift the mana of tāngata whaiora, whānau, people with lived experience of mental distress, and kaimahi (the workforce). Hāpaitia was intended to identify a potential pathway of support with the aim being enhancing services' ability to provide more positive outcomes for Māori. Hence the selection of the name Hāpaitia, which translates to *'lift up, raise, elevate'*.

Executive Summary

Introduction

Māori experience worse mental health outcomes, as highly evidenced, within publications such as *He Ora Aranga: Report of the Government Inquiry into Mental Health and Addiction 2018* and *Office of the Director of Mental Health Addiction Services Regulatory Report 1 July 2021 to 30 June 2022*.

There have been many approaches taken to address the inequitable health needs of Māori. However, they have varied in their outcomes due to their dependency on the capacity and capability of the mental health workforce and the structure of the mental health system.

Hāpaitia: Supporting and Strengthening Māori Mental Health Specialist Services in Aotearoa New Zealand, was a project intended to understand the state of specialist mental health care and identify areas for improvement. It was carried out by the Oranga Hinengaro team within Te Aka Whai Ora prior to its disestablishment in June 2024. This report details the findings and recommendations arising from Hāpaitia.

Project Overview

The purpose of Hāpaitia was to review the state of specialist mental health services and their provision of care for Māori. Its primary objectives were to:

- Understand how specialist mental health and forensic services are delivering care to Māori, including the functions of Māori models of care.
- Meet with key stakeholders (Māori cultural staff, clinicians, managers, tāngata whaiora, lived experience and whānau) and hauora Māori partners to understand service delivery, pressures, plans, pathways and moemoeā (aspirations).
- Develop recommendations that will support the strengthening of existing services, improve equity, and grow workforce capacity and capability.

The project's focus was adult acute mental health and forensic inpatient units. Face-to-face engagement was the key information gathering approach. A total of 34 facilities were visited, involving approximately 400 staff across various roles and levels, as well as 50 tāngata whaiora.

Findings

The information gained through the engagement process was compiled and analysed. The following themes emerged:

- Inconsistencies in the delivery of Māori models of care and cultural responsiveness across mental health and addiction services.
- Workforce shortages, resource constraints, and an aging infrastructure impact on the quality of care delivered.
- Systemic inconsistencies in integrating whānau, lived experience and peer support at all levels of decision making.

- Insufficient Māori staffing at all levels directly impeding progress in reducing seclusion and restraint, perpetuating harm and inequity for Māori.
- A lack of support and increased difficulty in dealing with alcohol and other drug (AOD) cases.

Recommendations

Based on our findings, six recommendations are proposed:

1. Develop and implement a comprehensive specialist mental health workforce strategy.
2. Establish and operationalise an equitable, holistic model of care framework.
3. Embed whānau and lived experience voice as a key strategic priority.
4. Strengthen workforce competency in dual diagnosis, specifically AOD.
5. Develop a monitoring, accountability and equity framework.
6. Task an expert panel with assessing delivery by December 2026.

In addition to these recommendations, we identify two current initiatives which are critical to addressing the issues in the findings:

- Mental Health Infrastructure Programme (MHIP) – this is a series of projects refurbishing, rebuilding, or upgrading 16 mental health units across the motu (country), incorporating kaupapa Māori design principles and features.
- Mental Health Bill – this is intended to replace the Mental Health (Compulsory Assessment and Treatment) Act 1992, shifting compulsory mental health care towards a rights-based and recovery approach. It includes measures to improve supported decision-making, involve whānau, and ensure culturally appropriate care.

Conclusion

Our review of specialist mental health services and their provision of care for Māori highlighted a range of challenges as well as exemplars of services. We have proposed six recommendations aimed at addressing those challenges and building on some of the work already being done across the system. By developing key competencies in our workforce and promoting culturally responsive models of care, we can achieve equitable and needs-based mental health care for all individuals in Aotearoa New Zealand.

Background

Māori experience worse mental health outcomes than non-Māori. Despite making up about 17% of the population, Māori account for 28.4% of all mental health service users.¹ They are:

- most likely to access mental health and addiction services, with 5,920.2 clients accessing services for every 100,000 Māori population;²
- 4.0 times more likely than other ethnicities to be subjected to a community treatment order and 3.6 times more likely to be subjected to an inpatient treatment order;³
- 2.9 times more likely to be subjected to indefinite community treatment orders and 4.1 times more likely to be subjected to indefinite inpatient treatment orders;⁴
- 5.5 times more likely to be secluded while in inpatient care;⁵
- more likely to complete suicide (especially Māori men, who are twice as likely as non-Māori men to complete suicide)⁶.

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction 2018 (He Ara Oranga) highlighted the factors contributing to these outcomes, including barriers to accessing culturally appropriate services, systemic racism, demand on cultural and clinical expertise, inconsistencies in models of care, a lack of lived experience and whānau voice in decision making, and inequitable resourcing.

Specialist mental health services have a critical role in the continuum of care

Across specialist care facilities in Aotearoa, there are approximately 604 adult acute beds and 308 forensic inpatient beds. Around 180,000 individuals access these services annually (3.7% of the population). Māori make up a third of this population.

As outlined above, much of the mental health inequity Māori experience occurs in specialist services, through higher rates of compulsory treatment orders and the use of restrictive practices like seclusion.

Evidence also shows that efforts to improve mental health outcomes generally are not proving effective for Māori. For example, the number of people who experienced seclusion while receiving mental health treatment in an adult inpatient service has decreased by 26.9% since 2009 (when seclusion reduction policies were introduced in Aotearoa). However, the number of Māori in seclusion has increased by 47% over the same period **Error! Bookmark not defined..**

¹ Source: Office of the Director of Mental Health and Addiction Services Regulatory Report 1 July 2021 to 30 June 2022.

² Source: Te Whatu Ora Mental Health and Addiction: Service Use web tool

³ Source: Office of the Director of Mental Health and Addiction Services Regulatory Report 1 July 2021 to 30 June 2022.

⁴ Source: Office of the Director of Mental Health and Addiction Services Regulatory Report 1 July 2021 to 30 June 2022.

⁵ Source: Office of the Director of Mental Health and Addiction Services Regulatory Report 1 July 2021 to 30 June 2022.

⁶ Source: Te Whatu Ora suicide web tool

There are measures in place aimed at addressing the inequitable mental health needs of Māori

The Pae Ora (Healthy Futures) Act 2022 (the Pae Ora Act) set a new foundation for the health system. Its purpose includes achieving equity in health outcomes among New Zealand's population groups, particularly for Māori, and it contains specific measures to give effect to the principles of Te Tiriti o Waitangi.

Following its establishment under the Act, Te Whatu Ora | Health New Zealand, in partnership with Te Aka Whai Ora | the Māori Health Authority, released Te Pae Tata | the Interim New Zealand Health Plan 2022. Te Pae Tata included several actions aimed directly at better mental health outcomes for Māori, including the design and expansion of te ao Māori mental health service solutions.

But more must be done to improve Māori mental health outcomes

The critical role that specialist mental health services play in the continuum of care means they have significant potential to improve Māori mental health outcomes. This requires an understanding of services, their provision of care for tāngata whaiora Māori, the pressures they face, and the opportunities for improvement.

This understanding will also need to evolve with our aging population growth. As many as 1-2 in every 6 older persons experience mental health or substance use problems⁷, and this number could be expected to grow into the future with a correlating growth in the proportion of older Māori persons requiring specialist mental health care.

Hāpaitia: Supporting and Strengthening Māori Mental health Specialist Services in Aotearoa New Zealand (Hāpaitia) was a project intended to achieve that understanding. It was carried out by the Oranga Hinengaro team within Te Aka Whai Ora, in service of its obligations under the Pae Ora Act and the associated actions of Te Pae Tata. As will be outlined in the following sections, Hāpaitia aimed to understand adult mental health and forensic inpatient units and make recommendations to enhance the way these services provide care for Māori.

The context has changed, but the need has not

Between the completion of Hāpaitia and the writing of this report, Te Aka Whai Ora was disestablished and its functions transferred to Te Whatu Ora. However, the basis for the project remains. Māori continue to experience greater mental health needs than anyone else. The findings of Hāpaitia and its recommendations remain relevant and necessary in addressing that inequitable need.

The Government Policy Statement on Health identifies five specific targets related to mental health and addiction:

⁷ Source: Te Pou, 2019.

- **Faster access to specialist mental health and addiction services** – 80% of people accessing specialist mental health and addiction services are seen within three weeks.
- **Faster access to primary mental health and addiction services** – 80% of people accessing primary mental health and addiction services through the Access and Choice programme are seen within one week.
- **Shorter mental health and addiction-related stays in emergency departments** 95% of mental health and addiction related emergency department presentations are admitted, discharged, or transferred from an emergency department within six hours.
- **Increased mental health and addiction workforce development** – train 500 mental health and addiction professionals each year.
- **Strengthened focus on prevention and early intervention** – 25% of mental health and addiction investment is allocated towards prevention and early intervention.

Achieving these targets will rely partially on addressing the disproportionate use of specialist mental health services by Māori. The findings and recommendations in this report are aimed at improving the way that services provide care for Māori and their whānau, and in doing so improving Māori mental health outcomes overall.

It should be noted that most of Hāpaitia was completed by Te Aka Whai Ora before its disestablishment. As such, references to Te Aka Whai Ora (now Hauora Māori Services within Te Whatu Ora) are maintained in this report. However, where practicable, references to Te Aka Whai Ora should be associated as applicable to the equivalent functions now upheld within Hauora Māori Services, other relevant departments of Te Whatu Ora, and the broader public sector post-disestablishment.

Overview of Hāpaitia

Purpose and Objectives

The purpose of Hāpaitia was to review the state of specialist mental health services and their provision of care for Māori, to better understand the opportunities for and barriers to service improvement. This was not a critical analysis of individual units and services, nor was it intended to takahi (trample) the mana of those services. But its aim was to identify examples of best practice and areas for improvement.

Our primary objectives were to:

- Understand how specialist mental health and forensic services are delivering care to Māori, including the functions of Māori models of care.
- Meet with key stakeholders (Māori cultural staff, clinicians, managers, tāngata lived experience, whaiora and whānau) and hauora Māori partners to understand service delivery, pressures, plans, pathways and moemoeā (aspirations).
- Develop recommendations that will support the strengthening of existing services, improve equity, and grow workforce capacity.

Areas of focus

In addition to understanding the state of specialist mental health services and their provision of care for Māori, there were several areas of particular interest that informed our approach to the project. These included:

- the use of seclusion, restraint, and the application of the Mental Health (Compulsory Assessment and Treatment) Act 1992;
- duration of occupancy within inpatient beds and the numbers of admissions for Māori compared to non-Māori;
- cultural supports utilised, whānau inclusion, and the use of mātauranga Māori;
- promotion and support of community treatment; and
- continuity of care following discharge.

Project scope and inclusion

The scope for review focussed on adult acute mental health and forensic inpatient units. Infant, Child, and Adolescent Mental Health services (**ICAMHS**), as well as specialist community services, were excluded. This was due to limitations on capacity and resource. However, it was envisaged that the excluded services would be the focus in future phases of the project.

Within the services reviewed, all aspects of care provided for tāngata whaiora Māori were in scope including, but not limited to, admission, treatment, accommodation, models of care, and discharge.

Methodology

The persistent inequities experienced by Māori within specialist and forensic mental health services underscore the need to re-centre Indigenous methodologies in health system reviews. The Hāpaitia Project sought to explore, through engagement and field review, how kaupapa Māori methodologies

could be embedded within inpatient environments to enhance equity, safety, and outcomes for Māori and non-Māori alike.

This review is grounded in Linda Tuhiwai Smith's (1999) *Decolonising Methodologies*, which provides a critical framework for reclaiming Indigenous ways of knowing, doing, and being in research and evaluation contexts. Smith's work challenges Western paradigms by emphasising Māori authority over Māori knowledge and the ethical imperatives of respect, relevance, reciprocity, and responsibility in all research involving Māori communities.

Review Approach

Review Scope and Objectives

The primary objective of the Hāpaitia Review was to examine pathways of support for Māori within specialist and forensic inpatient mental health services, identifying opportunities to enhance service delivery, strengthen whānau engagement, and embed kaupapa Māori frameworks into existing clinical systems.

The review sought to answer the question:

“How can kaupapa Māori approaches be applied to review and transform mental health inpatient services to achieve equitable and mana-enhancing outcomes for Māori?”

This objective reflects an intent not only to document system performance but to rethink the review process itself by positioning Māori voices, values, and experiences at the centre of inquiry.

Application of Kaupapa Māori Methodologies

Smith's (2021)⁸ *Decolonising Methodologies* provides both the ethical and analytical foundations for the Hāpaitia approach. The review operationalised four key principles:

- Respect (Manaakitanga): Upholding the dignity and mana of all participants through tikanga-based processes such as karakia, mihi, and kai, ensuring that engagement is safe and affirming.
- Relevance (Whai Take): Framing inquiry around Māori aspirations for oranga, equity, and system transformation, not merely compliance or performance.
- Reciprocity (Utu): Ensuring that insights gathered are returned to each region and service through playback hui, with findings co-validated and actions co-designed.
- Responsibility (Kaitiakitanga): Protecting the integrity of data and relationships, acknowledging that kōrero are taonga entrusted to the research team.

These principles shaped every phase of the review — from planning and engagement to analysis, reporting, and return of information to communities and services.

⁸ Smith, L. T. *Decolonizing Methodologies: Research and Indigenous Peoples*.

Method

Participants / Stakeholder Engagement

The review engaged with a wide network of participants and stakeholders across 20 former District Health Board (DHB) specialist and forensic inpatient units nationwide. Engagement included:

- Multidisciplinary teams and clinical staff
- Executive Leadership Teams and Group/General Managers
- Māori health representatives and cultural advisors
- Whānau facilitators, lived-experience representatives, and peer support workers
- Subject matter experts in mental health, addiction, and kaupapa Māori practice

In several regions, Māori health representatives and whānau facilitators joined multiple hui to provide continuity, ensure cultural oversight, and support relational connection across the motu.

The engagement approach ensured that tāngata whaiora, whānau, and kaimahi experienced the review as mana-enhancing and co-created, rather than extractive or evaluative in a colonial sense.

Data Collection

The primary data collection process consisted of kanohi-ki-te-kanohi (face-to-face) site visits and hui across four regions (20-34 inpatient units) — Northern, Te Manawa Taki, Central, and Te Waipounamu. At each site, the Hāpaitia Project Team applied kaupapa Māori engagement tools including wānanga, kōrero ā-whānau, and hīkoi within units to understand lived realities, successes, and areas for improvement.

Information gathered included:

- Observations of clinical and cultural interface
- Whānau and tāngata whai ora narratives
- Local service practices and innovations
- Workforce composition, training, and leadership structures
- Environmental and relational dimensions of care

Engagement

Engagement with specialist services

The review was conducted primarily through physical visits to inpatient units by the project team. The content of specific visits and any identifying details such as names and roles were kept confidential, with only general themes and findings reproduced in this report. Further details on our approach, including a full list of the units visited, a timeline, and the composition of the project team, are set out in **Appendix 1**.

A total of 34 facilities were visited, involving approximately 400 staff and 50 tāngata whaiora. Staff attending the engagements were selected by the unit's leadership based on availability. However, the project team requested representation from each unit including but not limited to:

- lived experience/peer support (Māori and Pacific representation)
- whānau voice
- unit leadership
- clinical staff
- cultural staff
- tāngata whaiora
- all others involved in tāngata whaiora care.

Units were sent the same list of questions (see **Appendix 2**) in advance of each visit. This ensured that units had sufficient time to understand the type of information sought by the project team and to arrange for the attendance of appropriate staff to respond to questions.

Each visit began with a mihi whakatau to welcome the project team, followed by whakawhanaungatanga.

Open forum discussions then commenced based on the provided questions and areas of focus. Units were also able to make presentations on areas they wished to highlight in response to our questions.

Discussions were followed by tours of the units led by various staff, allowing for more focused one-on-one and small group discussion. Tours were respectful of, and flexible with, the active operations within the unit to ensure minimal disruption for staff and tāngata whaiora. This provided an opportunity for direct observation of the units in action, including direct engagement with tāngata whaiora where appropriate.

Finally, a whakakapi (closing) process took place to formally close each engagement.

Review of engagement reports

Each engagement was recorded in a report detailing the data and insights gathered. These reports were provided to the respective unit for review and feedback, followed by an online meeting with the project team to discuss the feedback and how it could be addressed.

Compilation and analysis

Following the review process, a thematic analysis of the engagement reports was conducted. The themes and findings of this analysis are presented in the next section.

Findings

The following themes emerged from the insights gathered across the engagements. It is important to recognise that many of the identified themes are interconnected, particularly those related to workforce issues, reflecting larger issues within the broader context of the health system.

Inconsistencies in the delivery of Māori models of care and cultural responsiveness across mental health and addiction services

We found some exemplars of Māori models of care around the motu. There were also good examples of cultural responsiveness and Māori-centric approaches in some units, such as the embedding of tikanga and mātauranga Māori. In other cases, kaupapa Māori was being implemented but without sufficient support – for example, some units engaged bespoke supporting roles such as on-site kaumātua, in recognition of their importance in guiding cultural practices, but there was a lack of succession planning for these roles that has resulted in persisting role vacancies.

Additionally, consistent cultural supervision was found to be lacking across units. This impacts Māori clinical staff, who are often relied on to provide cultural support functions beyond their primary roles.

“Te Huaoranga is a diagnostic tool/Māori model of care used when admitting Māori into the services, this... allows Māori to select a Māori service pathway that is used within the specialised services”.

The impact of workforce shortages, resource constraints, and an aging infrastructure impacts the quality of care delivered

Several units highlighted issues caused by inadequate building infrastructure. The outdated and deteriorating condition of these facilities created unsafe environments for tāngata whaiora and staff, and in some cases building compliance issues.

Other factors such as overcrowding, poor design, and restricted space options were recognised as key factors contributing to an unfavourable environment for mental health recovery in many units. This was often expressed as being detrimental to the wairua of tāngata whaiora and staff.

Staff shortages and recruitment difficulties were significant challenges in almost all units visited. There are not enough staff generally, but there are also significant shortages of Māori staff in both clinical and cultural roles. This has led to high staff fatigue and as a consequence, concerns about the quality of care for tāngata whaiora.

Some units are implementing strategies to grow their Māori staff. One example included a targeted approach to recruiting Māori students. However, the rate of Māori recruitment needs to accelerate significantly to reflect the proportion of tāngata whaiora Māori in care.

“There has been a strong advocacy and commitment for the mental health division to employ Māori kaimahi both clinical and non-clinical within the services and in leadership positions. Included within the frontline leadership roles for Māori staff embedded to support the Whaiora journey and model of care systems. With the increase of Māori from leadership within the ELT (Executive Leadership Team) to frontline leadership and allied health Māori outcomes and practices within the units have improved.”

“There is an increase in the aging population with no ‘older person designated bed’ being available in acute or ATNR, this will need to be addressed and supported into fruition via future funding streams”.

“The ward requires substantial investment in infrastructure; staff have tried to make the environment as appealing as possible”.

“Recognition that the unit was often over occupancy, causing overcrowding and nowhere for whai ora within the ward to have a quiet place. Occupancy rates have been reduced and this has decreased seclusion levels”.

“Occupancy has improved under the leadership of however, it remains over 100%. This is due at times to the High and Complex needs of whaiora who are hard to place and the lack of community service available for this demographic”.

Systemic inconsistencies in integrating whānau, lived experience and peer support at all levels of decision making

There is growing recognition of the value of integrating lived experience and peer support into mental health services, yet these roles are often under-resourced and their integration inconsistent. Collaborations between clinical staff and peer support workers can be effective, but tensions may arise due to conflicting approaches and priorities. The need to increase the lived experience and peer support workforce was a consistent theme from staff.

Some successful examples of lived experience and peer support integration was observed in various regions.

From a kaupapa Māori perspective, meaningful involvement and communication with whānau is essential for quality and continuity of care, both within and outside the unit. This includes greater involvement in decision-making and care planning, as well as improved post-discharge support and referral to community-based follow-up services.

Whānau involvement was generally not evident across the units visited. Only two care models were observed that integrated whānau involvement and lived experience from admission to discharge.

“Several services provided exemplar models of cultural/clinical interface, with one not being enforced without the other. One space referred to this as “Having the uncomfortable conversations and being comfortable with this.” These services ensured that staff and tangata whai ora were aware of the Tikanga of the Iwi within the region and this was how practice was guided. “

“Peer support and whānau voice have been integrated into all service delivery, they attend leadership hui and MDT alongside the tangata whaiora, beginning at the admission process. (This has been a journey for all in learning how to work together). Weekly peer support meetings are planned to discuss all mahi including who is working with who and in what space, how this can be improved and what is working well”.

Insufficient Māori staffing at all levels directly impedes progress in reducing seclusion and restraint, perpetuating harm and inequity for Māori

We saw many units actively working to decrease the use of seclusion and restraint. There was evidence in some units that Māori support workers are effective at de-escalation and preventing seclusion and/or restraint from occurring. In most units, the presence of Māori staff had a positive

effect of reducing seclusion and restraint events. However, many Māori support staff work standard hours, and in some units' seclusion and restraint events were found to increase outside of these hours, for example during the night or on weekends. For this reason, many units expressed a desire to have more cultural support during these hours.

A lack of support and Increased difficulty in dealing with alcohol and other drug (AOD) cases

Staff told us that a significant proportion of Māori admissions were caused by substance abuse. This trend highlighted a safety concern for both staff and tāngata whaiora. The trend was reported as escalating across regions, exacerbated by insufficient access to AOD rehabilitation. Services expressed concerns about their lack of preparedness to handle the growing rate of substance-related admissions and that many staff in are not trained in AOD support.

Recommendations

Based on the findings of the review, it is evident that there are several critical areas requiring attention to enhance the delivery of mental health services for Māori, particularly in addressing cultural responsiveness, infrastructure deficiencies, workforce challenges, and gaps in service delivery.

To this end, five recommendations are proposed to guide strategic initiatives aimed at improving the overall quality and effectiveness of mental health care provision. Each recommendation is aligned with at least one of the Government's mental health and addiction targets.

1. Develop and implement a comprehensive specialist mental health workforce strategy

Relevant mental health and addiction target: [Increased mental health and addiction workforce development](#)

Staff shortages and workforce challenges are impeding the enhancement of services through measures such as the integration of culturally responsive models of care and lived experience. These developments are necessary to achieve long-term sustainable mental health outcomes.

A comprehensive strategy should be developed to tackle the longstanding and persisting workforce challenges seen across specialist mental health units. The strategy should be multi-pronged, acknowledging that many workforce challenges are compounding, dynamic, and often co-dependent on other challenges within services.

Longer-term solutions might include increasing workforce education and training opportunities, senior and kaumātua staff succession planning, and increasing pay incentives to quell international competition for specialist mental health staff. However, these will not be adequate to address our short-term concerns and avoid challenges compounding.

Therefore, innovative solutions must be used to address our short-term workforce challenges. Examples could include the transition of vacant clinical FTE to more recruitable non-clinical FTE such as peer support and cultural roles, temporary bonding schemes, and targeted recruitment of Māori staff. Exploring these innovations will be an important part of the strategy's development.

Action

Te Whatu Ora Hauora Māori Services, Workforce and Hospital Specialist Services work collaboratively to develop and implement a comprehensive *Specialist Mental Health Workforce Strategy*. This will involve engagement from key leaders and representation from inpatient units, including but not limited to, clinicians, managers, peer support/lived experience, whānau voice, cultural workers, and community.

2. Establish and operationalise an equitable, holistic model of care framework

Relevant mental health and addiction target: Increased mental health and addiction workforce development

We found several models of care that integrate lived experience, peer support, and cultural responsiveness. While implemented well, their influence is often fragmented and reliant on individual champions to deliver them. These models are also impeded by compounding workforce issues.

Further, the use of seclusion and restraint on Māori remains disproportionately high. Many units are working to reduce their usage on Māori, to varying degrees of effectiveness. As covered in our findings, factors such as workforce capacity and capability, as well as infrastructure deficiencies, hamper these efforts. However, they are not the sole cause of disproportionate use and more can be done.

There are many initiatives already aimed at reducing the use of restrictive practices. The Mental Health Bill, which is currently in the House, contains requirements to limit the use of seclusion. The Health Quality and Safety Commission's (HQSC) Māori Advisory Group, for example, have developed a cultural kete as part of the organisation's Zero Seclusion: Safety and Dignity for All change package. The kete provides advice and guidance on kaupapa Māori approaches and interventions.

A comprehensive, holistic framework of care can consolidate existing initiatives and promote new ones to ensure consistency across the system. It should be based on cultural responsiveness and Māori models of care, incorporating lived experience, peer support, and whānau voice. It should standardise reporting methods and data collection, providing for greater accountability by unit staff.

While the aim is to establish a consistent baseline of care across the motu, the framework should also provide for regional variation as appropriate – for example, incorporating tikanga from a particular rohe. The overarching purpose of this recommendation is to provide a stable foundation on which units can build their own practices.

Implementation of the framework proposed above will require building competency in several areas across the workforce.

Again, there are existing training modules to draw on or incorporate. Safe Practice Effective Communication (**SPEC**) is a national training course on least restrictive practice delivered by Te Pou, the national workforce centre for mental health, addiction and disability in Aotearoa New Zealand. Initiatives such as SPEC can be incorporated or further enhanced as part of a comprehensive training package, rolled out nationally to prepare the workforce to deliver on the new framework of care.

Action

Develop and deliver, in consultation with the workforce, lived experience, peer support communities, and Māori, an equitable, holistic model of care framework. The framework will be rolled out nationally and incorporate existing training modules such as SPEC.

3. Embed whānau and lived experience voice as a key strategic priority

Rationale

Involving whānau (extended family, lived experience, community, and cultural support networks) in decision-making and care planning processes is crucial. Whānau involvement and Lived experience ensures that care plans are culturally appropriate and sensitive to the needs, values, and preferences of the individual and their community. It also promotes holistic care by incorporating the perspectives and insights of those who are closest to the individual, potentially enhancing treatment outcomes and satisfaction with services and aftercare.

We found that involving whānau and lived experience enhances the post-discharge process for an individual ensures continuity of care and support. Discharge from mental health services can be a vulnerable period, and adequate support during this transition can help prevent relapse, promote recovery, and facilitate community integration. By providing navigators in community-based services across all regions, individuals and their whānau can receive personalised support, guidance, and connections to necessary resources. This approach acknowledges the diverse needs and circumstances of individuals and ensures that they receive ongoing support tailored to their specific needs, ultimately improving their overall well-being, and reducing the risk of adverse outcomes such as readmission or disengagement from care.

Actions

Facilitate meaningful involvement of whānau and lived experience in decision-making and care planning processes. Integrate the Mental Health Advance Preferences Statements, to allow individuals to have their voices heard.

Place navigators, where required, into community-based services to engage with tangata whaiora (before and after discharge) to assess needs and provide ongoing support in the community for the individual and their whānau.

4. Strengthen workforce competency in dual diagnosis, specifically AOD

Relevant mental health and addiction target: [Strengthened focus on prevention and early intervention](#)

While post-discharge support for tāngata whaiora is critical to prevent re-use and re-admission, consistency in referral pathways and support services is essential for individuals struggling with AOD issues. It ensures that individuals receive timely access to appropriate services and interventions, which is critical for addressing substance use disorders effectively. Consistent pathways help streamline the referral process, reducing confusion and delays in accessing care. They also promote continuity of care by facilitating communication and coordination between different service providers, ensuring that individuals receive comprehensive and integrated support tailored to their needs. Finally, consistent pathways contribute to equity and fairness by ensuring that all individuals, regardless of their location or circumstances, have equal access to quality care and support for AOD issues.

While we have proposed a comprehensive training package above, we consider that AOD needs are very specific and warrant a separate training package focussed on equipping staff with the necessary skills and knowledge to provide for these needs.

There also needs to be a provision of a safe physical space for tāngata whaiora coming down off meth and other complex drugs.

“There has been a growing number of meth admissions and staff are now being educated on addiction and intoxication as a number are not AOD trained, and this was placing them and the whaiora in unsafe situations”.

Action

Implement a comprehensive training programme for all staff focused on Alcohol and Other Drug (AOD) support and intervention techniques.

5. Develop a monitoring, accountability and equity framework

Māori accessing mental health inpatient units continue to have higher rates and longer periods of seclusion than non-Māori. The data suggests that despite efforts to reduce seclusion rates, Māori individuals continue to be disproportionately affected. The fact that Māori seclusion rates have increased by 47% over the same period while non-Māori rates have decreased by 26.9% is a significant concern.

It's important to note that generally seclusion is a restrictive and potentially harmful practice that can have long-term effects on mental health. It is essential to address the underlying causes of this disparity and work towards creating a more equitable and culturally responsive mental health system.

This monitoring framework should incorporate targeted approaches that integrate Kaupapa Māori methodologies, which are culturally responsive and grounded in Māori values and principles, necessary to achieve fair outcomes for Māori individuals in inpatient mental health settings.

To do this there needs to be data validity that provides acknowledgement to Kaupapa Māori approaches to reduce seclusion and restraint by kaimahi Māori.

Hua Oranga⁹ is an example of a one-page Māori health outcomes measure that can be completed in under five minutes. This tool facilitates collaborative reflections and improvement between practitioners, tangata whaiora, lived experience and whānau to adjust and improve the quality and effective approaches to well-being.

Action

Develop a monitoring, accountability and equity framework focusing on the reduction of restraint and seclusion for Māori.

⁹ Source: Te Rau Ora Strengthening Māori Health and Well-being, Hua Oranga oradatabase.co.nz

6. Task an expert panel with assessing delivery by December 2026

Relevant mental health and addiction target: Faster access to specialist mental health and addiction services

Action goes hand-in-hand with accountability. A short timeframe is proposed for initial review, to maintain momentum towards delivery and identify any barriers or gaps that require addressing.

Overall, achieving the recommendations in this report will improve the capability and efficiency of specialist mental health and addiction services. This will enable better quality of care with fewer tāngata whaiora requiring care for extended periods of time, and improved capacity to receive and treat new tāngata whaiora.

Action

Review progress against these recommendations by December 2026.

Supporting initiatives

The recommendations outlined above are intended to fill gaps or strengthen areas that require it. Some of the issues identified in our findings are already being addressed by existing initiatives. We consider these initiatives are critical in supporting our recommendations and draw attention to them below.

Mental Health Infrastructure Programme (MHIP)

This Programme links together 16 mental health and addiction infrastructure projects, including the refurbishment or rebuild of mental health units across the motu.

Designs used in the programme reflect best-practice Australasian Health Facility Guidelines. These include design principles specific to Aotearoa New Zealand, such as the incorporation of kaupapa Māori design features like ātea and whareniui that enable practices such as pōwhiri and whakatau and enable manaakitanga and connection with whānau.¹⁰ These features are critical in creating environments that are conducive to the holistic care we envision in our recommendations.

Mental Health Bill

The Mental Health Bill is intended to repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 (**the Mental Health Act**).

The Bill aims to shift compulsory mental health care towards a rights-based and recovery approach. It includes a greater focus on supported decision-making and responsive needs-based care, including culturally appropriate care.

Many of the measures included in the Bill, if passed, will help address the issues outlined in our findings. However, we note that legislation cannot effect change unless it is implemented effectively. The success of the Bill will depend on the readiness and capability of the workforce, which our recommendations aim to improve.

¹⁰ <https://www.tewhatauora.govt.nz/health-services-and-programmes/infrastructure-and-investment/mental-health-infrastructure-programme#project-snapshots>

Conclusion

This report provides an insight into acute adult and forensic inpatient services in Aotearoa New Zealand, with a specific focus on the care provided for Māori. Through extensive engagement and analysis, several key themes have emerged, highlighting areas for improvement and strategic intervention.

We understand that everyone working in mental health and addictions wants better outcomes for tāngata whaiora, whānau and lived experience, particularly for Māori who experience significant mental health inequity. We also understand that those aspirations are heavily impacted by larger issues, such as workforce shortages, infrastructure, and wider socio-economic factors.

Therefore, the recommendations in this report are not a critical reflection of units or staff. They are intended to support and strengthen Māori mental health specialist services by identifying challenges and promoting examples of best practice. By addressing sector-wide issues and implementing targeted interventions, we can achieve equitable and culturally responsive mental health care for all individuals in Aotearoa New Zealand.

Appendix 1: Full Summary of Hāpaitia project

Hāpaitia was led by Te Aka Whai Ora, with support from Te Whatu Ora, from February 2023 to March 2024. A project governance and structure were established, with membership from the following teams:

Governance/Oversight Group

- Oranga Hinengaro General Manager – Te Aka Whai Ora
- Oranga Hinengaro Lived Experience – Te Aka Whai Ora
- Hospital Specialist Services Clinical Lead Specialist Mental Health Services – Te Whatu Ora
- Hospital Specialist Services National Lead Specialist Mental Health and Addiction – Te Whatu Ora
- Pou Kaihau Hapori Māori Mental Health Leader – Te Waka Whaiora Trust

Steering Group representatives

- Project Senior Responsible Owner – Oranga Hinengaro, Te Aka Whai Ora
- Whānau Voice – Te Aka Whai Ora
- Lived Experience – Te Aka Whai Ora
- Operations Managers x2 – Te Whatu Ora
- Clinical Director – Te Whatu Ora
- Kaupapa Māori Professional Leader – Te Whatu Ora
- Whānau Leadership – Te Whatu Ora
- Clinical Advisory, Mental Health Repeal and Replace – Ministry of Health

Project team

The project team had two consistent members who attended all visits. These visits were supported by various Te Aka Whai Ora Oranga Hinengaro representatives in different regions:

- Principal Clinical Advisor Mental Health
- Te Kaihāpai Principal Advisor Lived Experience
- Principal Policy Analyst

The review was undertaken in a three-staged approach. A timeline of key activities is included below.

Stage	Mahi
1 - Planning (Feb-June 2023)	<ul style="list-style-type: none"> • Whakawhanaungatanga – forming governance and steering groups, project team. • Agreeing project scope and engagement scope • Developing project plan
2 – Engagement and insights (July-December 2023)	<ul style="list-style-type: none"> • Engagement with Te Whatu Ora Specialist Mental Health Services (unit visits) • Synopsis of visits sent to each unit for input • Virtual hui with kaimahi unable to attend unit visits
3 – Analysis and reporting (Jan-May 2024)	<ul style="list-style-type: none"> • Drafting final report • Project close

Planning Stage

Extensive consultation was conducted with Te Whatu Ora Clinical Directors network, emphasising the importance of their engagement. This step was pivotal in securing both their support and access

to the relevant units, given the valuable insights and contributions they offer to the project. Subsequently, members of this network were invited to participate in the Steering Group, ensuring diverse representation.

Additionally, the planning stage entailed the development of a comprehensive project scope and plan, an engagement strategy, and Terms of Reference (**TOR**), all of which were subject to approval by the Oversight/Governance Group.

Engagement and Insights Stage

Efforts were focused on engaging with Te Whatu Ora Specialist Mental Health Services through unit visits. These visits provided the opportunity to engage with all those involved in tāngata whaiora care, including but not limited to, operational managers and leads, clinicians, Māori staff, tāngata whaiora, and whānau. These interactions allowed for a comprehensive understanding of the dynamics and perspectives within each unit. Following each visit, a synopsis was prepared and sent to the respective units for their input and feedback. Subsequently, virtual hui sessions were organised for those units interested in sharing their insights further, fostering collaboration and enriching the depth of understanding.

Analysis and Reporting Stage

A thorough examination was conducted of all information gathered. This included the production of both a draft and final review report. Moreover, a thematic analysis was undertaken to identify recurring patterns, challenges, and opportunities across the visited units. Recommendations were formulated to address identified gaps, barriers, and challenges, alongside highlighting exemplars found during the visits. These insights were compiled and will be shared across all units to foster mutual learning and improvement.

It is important to note that this stage extended significantly due to the change in Government in November 2023 and the subsequent disestablishment of Te Aka Whai Ora in June 2024. The project faced substantial disruptions during this period due to the change in policy direction and the transfer of functions to Te Whatu Ora.

Collaboration with *Ki te Whaiao*

A key link was identified early with a separate project led by the System Policy team within Te Aka Whai Ora called “Ki te Whaiao: Understanding kaupapa Māori approaches to compulsory mental health care” (**Ki te Whaiao**). This project also involved engagement with Mental Health Specialist Services, including Inpatient and Forensic units, to develop an understanding of kaupapa Māori approaches to compulsory care, restraint, and seclusion. During Phase Two of Hāpaitia, the respective project teams visited units together, to reduce pressure on inpatient services and mitigate the risk of engagement fatigue. Following unavoidable disruptions to Hāpaitia, the Ki te Whaiao engagement visits continued independently of Hāpaitia.

Specialist Mental Health Units

The review encompassed visits to the following Specialist Mental Health services: Adult Acute, Forensics, Older Persons, and Child and Adolescent (although the latter was beyond scope for this part of Hāpaitia – the findings will be relevant for a future phase). It is acknowledged that certain units are informed by mātauranga Māori. Additionally, there were instances of overlap between categories, such as older individuals in adult acute units or those with high and complex needs.

Northern	Name
Whangārei	Tumanako Whangārei Acute Adult
Auckland, North Shore	He Puna Waiora Acute Adult
Auckland	Te Whetu Tawera Acute Adult Haumarū Ōrite Mother and Baby & Acute Child and Adolescent Fraser McDonald Unit Older Persons
Auckland, Counties Manakau	Tiaho Mai Acute Adult
Auckland, Waitakere	Waiatarau Adult Acute

Te Manawa Taki	Name
Waikato, Hamilton	Henry Rongomau Bennett Centre Acute Adult Wards 34, 35, 36
Rotorua, Lakes	Whare Whakaue Acute Adult
Taranaki	Te Puna Waiora Acute Adult
Tairāwhiti	Te Whare Awhiora Acute Adult
Bay of Plenty, Tauranga	Te Whare Maiangiāngi Acute Adult
Whakatāne	Te Toki Maurere Acute Adult

Te Ikaroa	Name
Hawkes Bay	Ngā Rau Rākau Acute Adult
Palmerston North	Ward 21 Acute Adult
Wellington Hutt Valley Wellington City Porirua	Te Whare Ahuru Acute Adult Te Whare o Matairangi Acute Adult Te Whare Ra Uta MHSOP
Whanganui	Te Awhina Acute Adult

Te Waipounamu	Name
Nelson	Wahi Oranga Acute Adult
Canterbury, Christchurch	Te Awakura Adult Acute Adult
Otago, Dunedin	Ward9B Acute Adult Ward 9C Acute Adult
West Coast	Manaakitanga Acute Adult
Southland	Southland Mental Health Unit Acute Adult

Forensic Services	
Midland Regional Forensic Service, Waikato	Puawai: Midlands Regional Forensic Services Puna Awhi-Rua (Ward 32) Forensic Rehab Puna Maatai (Ward 33) Forensic Acute
Whanganui	Standford House
Wellington	Rangipapa Forensic Acute (mixed gender) Pūrehurehu Forensic Acute Tāne Mahuta Forensic Rehab & Rehab Adult
Christchurch	Te Whare Manaaki Forensic Acute

	Te Whare Hohou Roko Forensic Rehab Te Whare Mauri Ora Forensic Rehab
Dunedin	Ward 9A Forensic Acute

NORTHERN REGION



Photo 1 Northern Region He Puna Waiora Inpatient Unit

- Te Tai Tokerau-Tumanako
- Waitematā-Waiatarau Waitakere
- He Puna Waiora Inpatient Unit-Takapuna
- Te Toka Tumai Te Whatu Ora
- Te Whetu Tawera Adult Mental Health unit
- Child and Family Unit
- Fraser McDonald
- Counties Manukau-Tiaho Mai

TE MANAWA TAKI



Photo 2 Te Manawa Taki - Te Whatu Ora Taranaki

- Lakes - Whare Whakaue
- Hauora a Toi Bay of Plenty - Te Whare Maiangiangi (Tauranga)
- Te Toka Maurere (Whakatane)

- Waikato – Henry Rongomau Bennett Centre
- Te Tairāwhiti – Te Whare Ahiwhiora
- Te Whatu Ora Taranaki Te Puna Waiora

CENTRAL



Photo 3 Central Te Whare O Matairangi

- Capital Coast and Hutt Valley –
- Te Whare Ahuru Acute In-patient Unit,
- Te Whare o Matairangi In-patient Unit,
- Regional Rangatahi In-Patient Unit,
- Te Whare Marie Māori Mental Health team,
- Te Korowai Whariki Regional Forensics, Purehurehu, Rangipapa, Tane Mahuta and Tawhirimatea.
- Wairapapa
- Whanganui – Te Awhi and Stanford House Forensic unit.
- Hawkes Bay -Te Matau a Maui
- Midcentral -Te Pae Hauora o Ruahine o Tararua

TE WAIPOUNAMU



Photo 4 Te Wai Pounamu Canterbury Waitaha Māori Health and Lived Experience

- Canterbury -Waitaha
- West Coast -Te Tai o Poutini
- Nelson Marlborough
- South Canterbury
- Southern-Waikari and Southern Hospital

Appendix 2: Guided Questions

The following questions were used to guide the kōrero and provide a consistent guide across all visits.

- What does the cultural interface look like? How is mātauranga Māori embedded within service delivery?
- Identified gaps in services being delivered?
- What Māori models of health are applied? What support is needed, if any?
- How does the service deliver or adapt the model to further enhance service delivery?
- Does the lived experience voice and whānau say in service improvements?
- How do services engage with whānau?
- How is data captured and utilised to change process and increase positive outcomes for tāngata whaiora Māori?
- How many kaimahi Māori are working in the sector? How are non-Māori and kaimahi Māori supported?
- What does professional development in kaupapa Māori look like? (e.g., cultural supervision, tuakana/teina)
- What does continuum of care and the interconnectedness with services and community look like?

Key points identified, but not limited to:

- The Mental Health Act including Use of seclusion and restraint.
- The duration of occupancy and numbers of admissions for Māori in contrast to non-Māori.
- Cultural supports, whānau inclusion, and the use of Mātauranga Māori.
- Identifying ways in which services promote and support community treatment.
- The referral process inclusive of the continuum of care.

Original aspirations of this project review were to support the Mental Health policy and legislation changes and to seek to put tāngata whaiora, kaimahi and whānau Māori voices at the centre of policy development. However, we identified these objectives would also support recommendations in but not limited to:

- Operational policy
- Guidelines
- Government policy
- Training (cultural competency development)
- Implementation of the Oranga Hinengaro System and Service Framework (SSF)

Appendix 3: Glossary

This report uses various terms that are important to define for the purposes of this paper.

Tāngata whaiora (singular)	“A person/people seeking health”. In this report, this term refers to a person using mental health services. It is preferred over terms such as “patient”, “service user”, and “consumer”.
Tāngata whaiora (plural)	

<p>Whānau</p>	<p>For the purposes of this report whānau is defined as a person or people who are closely connected to the tāngata whaiora either through whakapapa links or shared history.</p>
<p>Seclusion</p>	<p>A form of restrictive practice “where a person is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit.” (Ngā Paerewa Health and Disability Services (Restraint Minimisation and Safe Practice) Standards).</p> <p>For the purposes of this report, seclusion is a practice used to control or compel behaviour rather than for any therapeutic benefit, observations, and findings.</p>
<p>Restraint</p>	<p>The use of any intervention by a service provider that limits a person’s normal freedom of movement. Where restraint is consented to by a third party [for example, someone’s primary carer], it is always restraint. (Ngā Paerewa Health and Disability Services (Restraint Minimisation and Safe Practice) Standards).</p> <p>Different forms of restraint include:</p> <ul style="list-style-type: none"> • Personal – use of one’s body to limit another’s movement • Environmental – restricting access to one’s environment • Mechanical – the use of equipment to limit movement • Chemical – the use of medications <p>For the purposes of this report, restraint is a practice used to control or compel behaviour rather than for any safety or therapeutic benefit to tāngata whaiora. Chemical restraint does not include therapeutic interventions that are in the best interests of tāngata whaiora, for example, sedation of tāngata whaiora experiencing drug-induced psychosis or mania, and mechanical restraint would not include, for example, the use of seatbelts when transporting tāngata whaiora by vehicle.</p> <p>This is not a clinical definition but our own based on our observations and findings.</p>

