Te Aka Whai Ora
Māori Health Authority

Ki te Whaiao

Understanding kaupapa Māori approaches to compulsory mental health care

Final report

May 2024

Mai i te Pō, ki te Whaiao, ki te Ao Mārama

The whakataukī above describes Māori creation narratives. They tell that the universe began in darkness, from which emerged the potential for being, eventually leading to life, consciousness, and knowledge. It evokes a transition – from darkness to light, from ignorance to enlightenment.

For many tāngata whaiora, their experiences under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (**the Mental Health Act**) may be likened to te Pō – a place of darkness, fear, and uncertainty. Often, they have experienced harm and trauma under the Mental Health Act and within mental health inpatient settings. This is especially true for tāngata whaiora Māori.

While providing support to Manatū Hauora on the repeal and replacement of the Mental Health Act, one of the key themes we heard from lived experience voices, whānau, and kaimahi Māori in the mental health sector was that restrictive practices such as seclusion and restraint are harmful and must be eliminated. We also heard that kaupapa Māori approaches are used in inpatient settings around the motu, and that they do not rely on the use of restrictive practices.

We set out to understand whether, and how, kaupapa Māori approaches might provide for the elimination of restrictive practices under the Mental Health Act. While our focus was initially on inpatient settings, and how kaupapa Māori approaches are used there, our analysis showed that tāngata whaiora – particularly Māori – don't just experience inequitable outcomes in the use of seclusion and restraint. There are failings in other parts of the mental health system, even other sectors, that contribute to negative experiences under the Mental Health Act.

This report presents our findings and proposals to change those experiences. Its name and structure draw from the whakataukī above, with each section represented by a stage of that transition from darkness to light, ignorance to enlightenment. It covers the context and reasons for our exploration of the issues, the approach we took and the conclusions we made, and the findings we make for improvement. These findings are targeted at mental health legislation, but our findings are also intended to provide insights that will be relevant across the mental health sector. For this reason, the report should be read in its entirety, not just for its findings.

As our report shows, there are many changes needed across legislative, regulatory, and operational mechanisms, including the Mental Health Act itself and Tiriti o Waitangi compliance. But they will require collaboration and investment across the mental health sector, and between sectors, to achieve. It will take a significant, concerted effort not just to eliminate the use of seclusion and restraint, but to take the experiences of tāngata whaiora broadly under the Mental Health Act from a place of harm and uncertainty to one of care and understanding.

Mai i te Pō, ki te Whaiao, ki te Ao Mārama.

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- Kāhui o te Ihi, Auckland City Hospital
- He Puna Waiora, North Shore Hospital
- Waiatarau, Waitakere Hospital
- Te Awhina, Whanganui Hospital
- Stanford House, Whanganui Hospital
- Te Whare Oranga Tangata o Whakaue, Rotorua Hospital
- Te Toki Maurere, Whakatāne Hospital
- Te Whare Maiangiangi, Tauranga Hospital
- Henry Rongomau Bennett Centre, Waikato Hospital
- Regional Rangatahi Adolescent Inpatient Service, Kenepuru Community Hospital
- Tāwhirimātea Regional Rehabilitation Service, Rātonga-Rua-o-Porirua
- Te Whare o Matairangi, Wellington Regional Hospital
- Te Awakura, Wāhi Oranga, Te Whare Manaaki, Te Whare Hohou Roko, and Te Whare Mauriora, Hillmorton Hospital

We also acknowledge the many organisations we met with, who have worked and advocated in the mental health sector for many years. Their work has informed our own and we thank them for it:

- Te Hiringa Mahara | Mental Health and Wellbeing Commission
- Te Tāhū Hauora | Health Quality and Safety Commission
- Te Rau Ora
- Mental Health Foundation
- Te Pou
- Kāhui Tū Kaha
- Helen Hamer & Associates Ltd
- Safer Care Victoria

Kuputaka | Glossary

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

Tangata whaiora (singular) **Tāngata whaiora (plural)**	"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".
Seclusion	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) For the purposes of this report, seclusion is a practice used to control or compel behaviour rather than for any therapeutic benefit. This is not a clinical definition but our own based on our observations and findings.
Restraint	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) Different forms of restraint include: • **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 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. This is not a clinical definition but our own based on our observations and findings.

Mai i te Pō

Background to the repeal and replacement of the Mental Health Act

"You know, it's all very well to put something down on paper, but that can be used coercively, or it can be used to support the individual. You want to have legislation that's enabling and supportive and not damaging." (Lived experience)[1]

The Mental Health (Compulsory Assessment and Treatment) Act 1992 (**the Mental Health Act**) sets out the specific circumstances in which people may be subject to compulsory mental health assessment and treatment. It is intended to enable compulsory mental health care for people experiencing severe mental distress while defining and protecting the rights of those people.

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (2018) made several important recommendations to improve Mental Health outcomes in Aotearoa. One of these recommendations was to repeal and replace the Mental Health Act. The report stated that the Mental Health Act is out of date and does not reflect best practice or align with our international commitments. It also said that any new law needs to reflect a human rights-based approach, align with modern models of mental health care, and minimise the use of compulsion, seclusion, and restraint.[2]

In 2019, the government agreed with this recommendation. At the direction of the then-Minister of Health, Manatū Hauora are leading the work programme to repeal and replace the Mental Health Act. This involved a public consultation process between 22 October 2021 and 28 January 2022 and the establishment of a Mental Health Act Expert Advisory Group.

In December 2022, Cabinet agreed to a first tranche of policy decisions to set the foundations for the new legislation, including:

- New purposes and principles, and the inclusion of specific provisions to clarify how the legislation will give effect to the Crown's obligations under te Tiriti o Waitangi
- Updated legal criteria for compulsory mental health care, and clearer statutory processes when a person is subject to the legislation
- Placing a person's ability to make decisions about their own care at the centre of decision-making, through embedding supported decision-making approaches
- Greater recognition and involvement of whānau, hapū, and iwi in a person's care
- A more holistic and comprehensive approach to mental health care provided under legislation, promoting a broader range of care and support options
- More balanced provisions for the use of seclusion, restraint, and other restrictive practices.

In July 2023, Cabinet agreed to a second tranche of policy decisions focussed on oversight, monitoring, and accountability mechanisms, including:

- Statutory roles and responsibilities for administering and overseeing the legislation
- The rights of tāngata whaiora under legislation and associated complaint resolution procedures
- Means of reviewing and challenging statutory decisions
- Strengthen monitoring and reporting requirements

[1] *Repealing and Replacing the Mental Health Act: Analysis of Public Consultation Submissions*, Dr Michael Roguski and Fleur Chauvel, Kaitiaki Research and Evaluation, prepared for Manatū Hauora, 2022.
[2] *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*, 2018.

At the time of writing this report, we understand the Bill to replace the Mental Health Act is currently being drafted based upon these foundational decisions.

Māori experiences of the Mental Health Act

"I was thrown into a room with a toilet and a blue mattress, where staff forced me onto the floor face down, and I said I couldn't breathe. I feared for my life." (Māori lived experience, submission)[3]

Manatū Hauora received 317 written submissions during public consultation on the repeal and replacement of the Mental Health Act. Of these, 30% were by tāngata whaiora and 18% were by whānau or family members of tāngata whaiora or someone with lived experience. 13% of submitters identified as Māori (half of which also identified as NZ European).

Feedback was also gathered from over 500 people who attended over 60 online information sessions and consultation hui. As well as general sessions open to any member of the public, there were specific sessions for those with lived experience, whānau and family of people with lived experience, and Māori (including whānau, hapū, and iwi, and tāngata whaiora and people working in the health and government sectors).

Feedback from Māori was clear that the Mental Health Act has caused great harm and trauma, and is inconsistent with Te Tiriti o Waitangi. They said that compulsory treatment does not align with an ao Māori worldview, that it re-traumatises people who are already in distress, and that it should only reflect extreme and serious circumstances where no other option exists. They said that Māori are over-represented in the mental health system, experiencing inequity and racial disparities in addition to inter-generational harm and trauma already experienced elsewhere in life.

These experiences are supported by evidence

There is substantial data on the inequitable use of compulsion on Māori and findings made by various organisations over the last few years. In 2022, Māori were:[4]

- 4 times more likely to be subject to a community treatment order
- 3.6 times more likely to be subject to an inpatient treatment order
- 4.1 times more likely to be subject to an indefinite treatment order
- 5.5 times more likely to be secluded
- Secluded for longer periods than non-Māori on average.

The total number of people who experienced seclusion while receiving mental health treatment in an adult inpatient service decreased by 26.9% since 2009. However, the number of Māori who have been secluded has increased by 47% over the same period.[5]

We can infer from this data that efforts to reduce seclusion are working for non-Māori, but are having the opposite effect on Māori. This likely means a concerted effort to introduce kaupapa Māori approaches into inpatient mental health settings will be required to achieve equitable outcomes for Māori.

In 2020/21 there were 311 children and young people, aged 16 years or younger, under the Mental Health Act. Of those, 41% were Māori. There were 32 young people, aged 16 years or younger, who experienced seclusion. Of those, 50% were Māori..[6]

[3] Butler, K. 2022. *Pākarutia te Mokemoketanga – Breaking our Silence for the Repeal and Replacement of the Mental Health Act 2022*. Take Notice: Auckland.
[4] Source: Office of the Director of Mental Health and Addiction Services Regulatory Report 1 July 2021 to 30 June 2022.
[5] Ibid.
[6] Source: Office of the Director of Mental Health 2020/ 2021 seclusion dataset – obtained via request.

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (2018) found that restrictive practices are overused in Aotearoa, many seclusion rooms are in a poor state, the use of seclusion and restraint contributes to people's reluctance to seek help, and many people view seclusion as a breach of human rights.[7]

Te Huringa: Change and Transformation 2022, released by the Mental Health and Wellbeing Commission, spotlights fundamental, critical inequities for tāngata whaiora Māori under the Mental Health Act. Māori disproportionately experience higher rates of coercive practices that are restrictive and cause harm, including both solitary confinement and community treatment orders, with persistently higher applications of the Mental Health Act.

These findings reflect the criticism New Zealand has received for its high use of seclusion and restraint by the following organisations, which have called for the elimination of these practices:

- United Nations Disability Committee (2014, 2022) and Committee Against Torture (2015, 2017, 2023)
- Te Tāhū Hauora | Health Quality and Safety Commission (2019)
- Te Kāhui Tika Tangata | New Zealand Human Rights Commission (2020)
- The Office of the Ombudsman (2020)
- Mana Mokopuna | Children and Young People's Commission (2022)

Role of Te Aka Whai Ora

"Let's approach it from a te ao Māori lens right from the beginning because I think when you get the stuff right from the start, you get it right for everybody." (Lived experience, Māori)[8]

Te Aka Whai Ora was established under the Pae Ora (Healthy Futures) Act 2022 (**Pae Ora**). Our overarching objective is to ensure that Māori have the best possible health outcomes.

One of the many functions of Te Aka Whai Ora is to provide policy and strategy advice to the Minister of Health on matters relevant to hauora Māori. It is within this function that we are working with Manatū Hauora on the repeal and replacement of the Mental Health Act. This includes reviewing and providing advice on policy proposals developed by Manatū Hauora and agreed by Cabinet, with a particular focus on how the Mental Health Act will give effect to the Crown's Tiriti o Waitangi obligations.

The call to eliminate seclusion and restraint

Feedback by Māori on this issue during public consultation wasn't universal, but we heard a resounding theme: **that seclusion and restraint must not just be reduced, they must be eliminated**.

These practices are widely regarded to be traumatic and harmful, with no therapeutic benefit. Their elimination has been called for by various organisations such as the United Nations Disability Committee and Committee Against Torture, the Health Quality and Safety Commission, the Human Rights Commission, the Office of the Ombudsman, and the Children and Young People's Commission.

We heard that the disproportionate use of these practices on Māori is inconsistent with te Tiriti o Waitangi and the Crown's obligations to provide active protection and equity for Māori. The Crown's failure to uphold these obligations across the health system was a key finding of the Waitangi Tribunal's Wai 2575 Stage One (Hauora) Report.

We also heard, through lived experience voices and kaimahi Māori working in the mental health sector, that kaupapa Māori approaches to mental health care do not involve restrictive practices and, where those approaches are used, seclusion and restraint of Māori decreases.

[7] *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*, 2018.

[8] *Repealing and Replacing the Mental Health Act: Analysis of Public Consultation Submissions*, Dr Michael Roguski and Fleur Chauvel, Kaitiaki Research and Evaluation, prepared for Manatū Hauora, 2022.

While there is clear evidence of the higher rates of seclusion on Māori, we did not have sufficient evidence about where kaupapa Māori approaches are being used in compulsory care settings, what forms they take, and how effective they are compared to Western models of care used under the Mental Health Act. We also had no evidence on the use of restraint, so were unable to determine the effectiveness of kaupapa Māori approaches as alternatives to restraint.

This is the basis for our project, *Ki te Whaiao.* **Having heard the call by Māori to eliminate the use of seclusion and restraint, we needed to understand whether this is achievable, and how kaupapa Māori approaches might provide the means to achieve it**.

In line with our objective and functions under Pae Ora, we are obligated to deliver policy advice that will ensure Tiriti o Waitangi obligations are upheld and ensure that Māori have the best possible outcomes in mental health – in this context, by exploring the feasibility of eliminating the use of seclusion and restraint and making findings that will inform ongoing work to repeal and replace the Mental Health Act.. The next section of this report sets out the approach we took to uphold this obligation.

Ki te Whaiao

Tirohanga Whānui | Project Overview

"Like that there's, you know, just with the systemic racism, with colonisation, like there is always going to be that inequity coming into the Act, so whatever happens more Māori are going to experience it as things currently stand. So rather than looking at what you can do to make sure Māori worldview and Māori are accommodated and all that kind of stuff like. How would you actually just design a Māori Act that then was for everyone…" (Lived experience, Māori)[9]

The overarching purpose of *Ki te Whaiao* was to understand whether kaupapa Māori approaches to mental health care offer a means of eliminating restrictive practices such as seclusion and restraint. This purpose was derived from the many lived experience and whānau voices, kaimahi in the mental health sector, as well as human rights and advocacy groups, calling for the elimination of these practices.

Ngā Whāinga | Objectives

Our primary objectives were to understand:

- Where and how kaupapa Māori approaches are being used in compulsory care
- The effectiveness of kaupapa Māori approaches being used in compulsory care
- The feasibility of eliminating seclusion
- The feasibility of eliminating restraint

Our exploration of each objective was led by questions including, but not limited to:

- What makes an approach "kaupapa Māori" in nature?
- How widely are these approaches currently being used?
- What are the outcomes compared to Western approaches?
- How can kaupapa Māori approaches be applied across key processes of compulsory care?
- What changes would be required across practice, services, and workforce to apply kaupapa Māori?
- What are the current barriers to eliminating or reducing seclusion and/or restraint?

We identified the following areas as within scope:

- Possible changes to the Mental Health Act, operational policy, guidelines, and training, with a focus on the four objectives above
- Budget implications and advice to assist budget processes if necessary
- Implementation planning and delivery for the new mental health legislation

We originally excluded broader changes to the mental health system that sit outside the Mental Health Act, although we expected that some insights might be shared to inform wider mental health mahi.

As our findings show, however, eliminating seclusion and restraint through kaupapa Māori approaches requires wide-ranging changes that extend beyond the Mental Health Act. We have therefore identified initiatives already underway that would greatly support implementation of our findings.

[9] *Repealing and Replacing the Mental Health Act: Analysis of Public Consultation Submissions*, Dr Michael Roguski and Fleur Chauvel, Kaitiaki Research and Evaluation, prepared for Manatū Hauora, 2022.

Te Tukanga | Approach

Ki te Whaiao was led by Te Aka Whai Ora, with support by Manatū Hauora. A project team was established, with membership from the following teams:

- Systems, Strategy, and Policy – Te Aka Whai Ora
- Oranga Hinengaro – Te Aka Whai Ora
- Mental Health and Addiction Strategy and Policy – Manatū Hauora
- Community Engagement Mental Health and Addiction – Manatū Hauora

Three phases of evidence-gathering were designed, with key deliverables for each. These are summarised below.

Phase 1: Desktop research

This involved gathering local and international literature on the use of seclusion and restraint, gathering relevant data on seclusion usage and readmission rates (particularly of tāngata whaiora Māori), and examples of kaupapa Māori approaches in compulsory mental health care. We also reviewed the feedback from those who participated in public consultation, focussing on the views of tāngata whaiora Māori, their whānau, and kaimahi Māori.

We identified key themes and recorded our findings.

Phase 2: Identifying gaps

Based on our findings, we identified areas that required more information or that we needed to understand more deeply. There was substantial lived experience voice heard through public consultation, many of whom gave examples of kaupapa Māori approaches that submitters preferred to Western models of care. But there was far less evidence about how kaimahi practically incorporate kaupapa Māori approaches, particularly within an inpatient setting, and their views on how effective it is.

We decided that the views of kaimahi, with both cultural and clinical experience, working in inpatient settings needed to be a focus area. We also identified various mental health advocacy groups who have undertaken their own research into similar topics that we should engage with.

Through our desktop research, we became aware of mental health legislation reform in Victoria, Australia. We identified the opportunity to compare processes and how that reform is addressing issues such as seclusion and restraint, as well as inequity for indigenous peoples.

Having clarified our areas of focus, we identified the groups we wished to engage to further our understanding of these areas.

Phase 3: Filling the gaps

We engaged with a range of groups to fill the gaps identified in the previous phase:

- Cultural and clinical staff in acute and forensic inpatient services
- Mental health and advocacy groups
- Australian officials (Victoria) working on the implementation of new mental health legislation

We also looked into:

- The experiences of tāngata whaiora, particularly Māori, that lead to inpatient hospitalisation, and factors that can reduce readmissions and suicide after discharge.
- A stocktake of kaupapa Māori mental health services to understand the nature and types of services available outside the inpatient and forensic experience.

Collaboration with *Hāpaitia*

We identified a key linkage with a separate project led by the Oranga Hinengaro team within Te Aka Whai Ora. *Hāpaitia: Strengthening Māori Mental Health and Addiction Specialist Services* engaged with Mental Health Specialist Services including Inpatient and Forensic Units, Mental Health Specialist Services within communities, as well as lived experience and whānau, to strengthen and support the services they provide to Māori.

As part of Phase 3, we collaborated with Oranga Hinengaro to engage with inpatient and forensic services. Initially, a *Ki te Whaiao* project team member accompanied Oranga Hinengaro members on visits to inpatient services as part of *Hāpaitia*. This approach was taken with the aim to minimise strain on inpatient services and the potential of engagement fatigue.

Following unavoidable disruptions to *Hāpaitia*, we concluded the remainder of our visits to inpatient and forensic units independently of Oranga Hinengaro.

Ngā Hua i Puta Mai | Conclusions

"The data shows that people, Māori adults, are less likely to have their needs met, are less likely to consult with health professionals. And that does include mental health. Because, you know, there's a distrust, there's a, you know, non-connection. So it is really important that people respect and it's basically honouring the Treaty and the participation, but allowing people to have their voice and have their say, in being part of this sort of conversation."
(Lived experience, Māori disabled person)

Below we set out the key themes that emerged across all phases of our project. Given our findings on the nature of kaupapa Māori approaches described below, there is no quantitative data available about their effectiveness compared to Western models of acute mental health care. But we have gathered extensive qualitative data about the effectiveness of kaupapa Māori approaches, which we have considered alongside relevant quantitative data that is available such as seclusion rates and Māori workforce data. This creates a strong picture about what kaupapa Māori approaches look like in compulsory care, how effective they are, and what empowers or inhibits them.

It should be noted that we have not identified specific facilities in the kōrero below. The purpose of our visits was not to critique practices within facilities but to understand how kaupapa Māori approaches are being used across the motu.

Kaupapa Māori approaches are values-based and people-driven; they are a way of being rather than a specific model of practice

One of the drivers for our project was a lack of evidence about how kaupapa Māori approaches are practically used within inpatient settings. The findings of our desktop research suggested that the reason for this lack of specificity is that "kaupapa Māori approaches" cannot be defined through any particular method or model. Rather, kaupapa Māori refers to "Māori" ways of doing things – like speaking te reo Māori and practicing tikanga – that are based on the values that underpin Māori ways of being – such as mana, tapu, and whānau. There are kaupapa Māori frameworks and models being utilised, such as Te Whare Tapa Whā, but these frameworks are not kaupapa Māori approaches in and of themselves; they are based upon kaupapa Māori practices and understandings.

These findings were validated through our engagement, particularly with kaimahi Māori working in inpatient services. In both clinical and cultural roles, kaimahi Māori naturally brought a kaupapa Māori way of working by their backgrounds and worldviews, not by any particular guidance or training.

This means that kaupapa Māori approaches are most often demonstrated in informal, day-to-day interactions between kaimahi and whaiora. Examples include:

- Sharing kai with whaiora who are distressed (manaakitanga)
- Using karakia to whakawātea or clear the energy of a tense situation (wairuatanga)

- Creating familial connections with whaiora through whakapapa (whanaungatanga)

Feedback from kaimahi also showed that "being Māori" is often enough to create a positive dynamic with whaiora. **Many examples were shared by kaimahi Māori who have been able to de-escalate situations just by entering a room**. It suggests that whaiora Māori naturally feel safer with kaimahi Māori.

Although kaupapa Māori approaches seem to be expressed most often in personal interactions, in many locations they are used in more formal or organised settings. For example:

- Mihi whakatau when whaiora and their whānau arrive at a facility
- Daily or regular karakia and waiata sessions
- Holding whānau hui

While kaupapa Māori approaches most often rely on kaimahi Māori to practice them, we also found examples where Pākehā or tauiwi staff enabled whaiora to practice kaupapa Māori for themselves. One forensic facility we visited supported a tāne Māori to mahi whakairo (Māori carving artform), which had to be sanctioned by Pākehā in leadership positions.

Kaupapa Māori approaches have a demonstrable impact on the reduction of seclusion and restraint

We found extensive qualitative evidence that kaupapa Māori approaches contribute to lower rates of seclusion and restraint. In the forensic facility mentioned above where a tāne Māori was supported to mahi whakairo, tāngata whaiora also participated in kaupapa Māori such as mihi whakatau, which was used to welcome us to the unit, and in serving kai for us as a show of manaakitanga. According to kaimahi there, seclusion has not been used at this facility for seven years. Although this is not an acute facility, the timeframe of no seclusion is still significant.

Many kaimahi shared examples similar to those previously provided where kaupapa Māori approaches led to a de-escalation that would have otherwise resulted in whaiora being secluded or restrained. Often these are interpersonal engagements where kaimahi offer kai or karakia as an alternative to seclusion. However, kaimahi also emphasised the importance of kaupapa Māori approaches immediately upon arrival to a service, which is often when whaiora are most distressed; over two thirds of seclusion events occur within the first 48 hours of admission.[10] **In many locations, kaimahi shared that mihi whakatau, or at least some form of whakawhanaungatanga, for new admissions, prevents seclusion upon arrival**.

These findings are reinforced by quantitative data on seclusion rates. Some examples we encountered are described below.

The lowest seclusion rates occur when kaupapa Māori approaches are a core part of the service

One service we visited has one of the lowest seclusion rates in the country.[11] Although the number of tāngata whaiora Māori (28.6% adult acute, 37.9% rangatahi) in care, and the number of tāngata whaiora Māori secluded (23.1%), is still disproportionately high, overall the seclusion rate is very low. The service has a rangatahi unit where seclusion has been eliminated entirely.

We found that kaupapa Māori approaches were a key feature of the culture in this service. Kaimahi Māori in cultural advisor roles were obviously respected and valued by other staff, and kaupapa Māori approaches were evident in processes for welcoming and discharging tāngata whaiora, and the importance placed on whānau involvement. Pākehā and tauiwi staff

[10] Six Core Strategies service review tool, Strategy 5: Use of seclusion and restraint reduction tools (New Zealand adaptation – 2nd edition), Te Pou (2020).

[11] According to data from the PRIMHD DataMart, sourced from the KPI Programme: Mental Health and Addiction Aotearoa New Zealand.

also demonstrated comfort and capability to practice kaupapa Māori through whakawhanaungatanga and karakia.

Leadership was a key factor to the success of kaupapa Māori approaches in the service. Māori occupied roles at various leadership levels, and we heard that relationships were strong with community services and mana whenua, which ensures a continuity of care for whaiora.

We consider that the strength of kaupapa Māori approaches in this service is a significant factor in its very low seclusion rates.

When kaumātua are present, tāngata whaiora Māori are secluded less

In another facility, there are two kaumātua roles who work regular hours Monday-Friday. They told us that they felt there needed to be kaimahi Māori available for the night shifts and weekends to ensure a continuity of kaupapa Māori care.

When we reviewed seclusion data for this facility, we found that most seclusion events occur during the day. However, for Māori, the opposite is true: most seclusion events occur on the night shift.

From January – March 2023, the average seclusion event duration for Māori was highest during the night shift at 19 hours. In the previous quarter, from Oct – Dec 2022, the average seclusion event duration for Māori was even higher during the night shift at 31 hours. No other ethnicity was secluded during the night shift in this quarter.[12]

The data reflects the views of the kaumātua that kaupapa Māori continuity of care is needed. **Put simply, when the kaumātua are not present, the seclusion rates of Māori in this facility increase**.

Widely-accepted seclusion and restraint elimination practices align well with kaupapa Māori approaches – and are informed by them

Mental health organisations we engaged with have advocated for the elimination of seclusion and restraint for years. Various tools and strategies have been developed to assist services to reduce and eliminate seclusion and restraint, which many inpatient services utilise. We found that these tools reflect many of the practices and approaches used by kaimahi Māori – because they have typically been informed by kaupapa Māori.

The Six Core Strategies©

The National Association of State Mental Health Program Directors Medical Directors Council, based in the USA, originally established the Six Core Strategies© as evidence-informed approaches to reducing seclusion and restraint events. They are also used in the UK, Canada, Australia, and Finland.[13]

In 2013, Te Pou – a national workforce centre for mental health, addiction, and disability – adapted these strategies for the Aotearoa New Zealand context. They were refreshed in 2020. The six strategies are:

1. Leadership towards organisational change
2. Full inclusion of lived experience
3. Using data to inform practice
4. Workforce development
5. Use of seclusion and restraint reduction tools
6. Debriefing techniques

[12] According to data from the PRIMHD DataMart, sourced from the KPI Programme: Mental Health and Addiction Aotearoa New Zealand.

[13] Six Core Strategies service review tool, Strategy 5: Use of seclusion and restraint reduction tools (New Zealand adaptation – 2nd edition), Te Pou (2020).

We found that many facilities utilise these strategies. While they are not based on kaupapa Māori approaches, they do promote and support their usage. For example, Strategy 1 states that the inclusion of Māori leadership is pivotal in upholding Tiriti o Waitangi obligations. As stated above, in regions with the lowest seclusion rates, we found that leadership was a major factor – either through Māori in leadership positions, or Pākehā leaders enabling and empowering Māori solutions, or both. Strategy 5 recommends welcoming processes that support safe and responsive transitions into services, such as mihi whakatau.

Zero seclusion: Safety and dignity for all

This aims to support the goal of zero seclusion in adult mental health inpatient units to 5% or below by December 2023. It is led by Te Tāhū Hauora (Health Quality & Safety Commission), and includes a change package of globally recognised, evidence-based interventions to achieve zero seclusion. Many facilities we visited are actively using this change package to reduce seclusion rates.

Some of the key interventions in the change package align with kaupapa Māori approaches, such as involving whānau and a therapeutic welcome process. But the package also includes a "cultural kete" of mātauranga Māori approaches and interventions, such as:

- Māori cultural assessments
- Service coordination with kaupapa Māori mental health providers
- Cultural supervision
- Pōwhiri and mihi whakatau
- Peer support
- Rongoā Māori
- Mātauranga Māori practitioners

While many services are already utilising these tools, we heard that their effectiveness can be hampered by other factors – which also impact the effectiveness of kaupapa Māori approaches, as outlined in the next finding.

Therapeutic risk-taking and shared/supported decision-making

There is a growing movement among kaimahi to shift practice and culture away from risk aversion and towards increasing safety through shared and supported decision-making. It encourages understanding risk at varying levels of danger, and working in areas of smaller-scale risk for long-term benefit.

Shared and supported decision-making is critical to the success of this approach. It requires kaimahi to work closely with tāngata whaiora to understand their needs and provide for their autonomy in decision-making about their own care. This extends to whānau and providing for their involvement in these decisions.

This approach also aligns well with kaupapa Māori approaches, which focus on the mana of the individual and the recognition of their whānau and the collectives they belong to. Again, the example of the tangata whaiora supported to mahi whakairo is demonstrative of this; access to the tools needed to carve are a safety risk, but this is balanced against the autonomy the tools enabled for the tangata whaiora and the benefit of the mahi whakairo to them.

The effectiveness of kaupapa Māori approaches is limited by other factors

There were two recurring themes raised at every facility we engaged with that limited the effectiveness of kaupapa Māori approaches: low numbers of kaimahi Māori and a poor physical environment.

Factor 1: The Māori mental health workforce is small and strained

Noting that kaupapa Māori approaches are most often a natural way of working and being, we regularly heard that there were not enough kaimahi Māori to embed kaupapa Māori approaches as a way of working and being for the entire facility. Many kaimahi Māori –

particularly those in cultural roles – felt immense pressure to uphold kaupapa Māori when they were one of a few, or even the only, kaimahi Māori in their facility. Kaimahi often felt that they needed to be in multiple places at once, or that there needed to be more of them, to ensure kaupapa Māori approaches have a greater presence in their facility.

There is an evidenced shortage of kaimahi Māori, particularly in clinical roles. Data shows that in 2022, 11.81% of mental health inpatient nurses were Māori.[14] This is less than the estimated proportion of the total population who are Māori (17.4% as at June 2022[15]). The data also shows that the number of Māori nurses has also been in decline since 2019.

The proportion of Māori in clinical roles is even smaller. In 2022 only 5.84% of clinical psychologists were Māori.[16]

This shortage is much more striking when compared against the proportion of Māori accessing mental health services, which is 28.4%. Māori are 3.6 times more likely to be subject to an inpatient treatment order.[17] Kaimahi across different regions told us that most whaiora in their care are under the Mental Health Act.

One facility we visited had a very strong Māori workforce, which was reflected in a strong kaupapa Māori practice. When asked why there was such a large number of kaimahi Māori, compared with most other facilities who had lower numbers of kaimahi Māori, kaimahi responded that most of their Māori workforce were in non-registered roles. **Kaimahi actively utilise whakapapa connections within their hapū and iwi to encourage whānau to apply for these roles, which has grown the kaupapa Māori practice of the facility**. They also provide pathways for those kaimahi to become registered if they wish to.

Factor 2: The physical environment can limit the effectiveness of kaupapa Māori approaches

We also heard that the physical environment is often a barrier to the provision of safe and therapeutic care to tāngata whaiora. Kaimahi generally felt that the buildings they worked in were not fit for purpose; for example, many older buildings had cramped and sterile hallways, poor lighting and ventilation, dated furnishings, and few outdoor areas.

We also heard that these environments do not provide for the effective use of kaupapa Māori approaches. Many kaimahi wished to conduct mihi whakatau for tāngata whaiora and their whānau but there was no appropriate space for this. It was very common for the first encounter between tāngata whaiora and kaimahi to take place through the back entrance, often accompanied by police.

In one facility, which was based in a building so old it was at risk of not being fire and electrical compliant, none of the staff – Māori and tauiwi – felt physically or spiritually comfortable in it, or that it enabled the care that tāngata whaiora need. Cultural staff at this facility said that they regularly felt the need to whakawātea or “cleanse” the site spiritually, but that “all the karakia in the world isn’t enough” to do this.

More recently-built facilities significantly address fundamental environment issues. These facilities are designed to comply with the Australasian Health Facility Guidelines, which are supplemented by the New Zealand Health Facility Design Guidance Note. These recommend design features such as open spaces and wide corridors, natural light, appealing outdoor areas, and recreational spaces such as exercise and low-stimulus areas. In one new build, these features enabled the facility to have no seclusion room at all.

[14] Sourced from Te Kaunihera Tapuhi o Aotearoa – Nursing Council of NZ, provided by Manatū Hauora.

[15] Source: Statistics New Zealand

[16] Sourced from Te Poari Mātai Hinengaro o Aotearoa – New Zealand Psychologists Board, provided by Manatū Hauora

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

Newer facilities also provide for the practice of kaupapa Māori approaches far more effectively. One facility we visited has a whare manaaki where tāngata whaiora and their whānau can be welcomed to the service through mihi whakatau. Newer builds had dedicated rooms for whānau to stay on site, and their outdoor spaces provided for māra kai (vegetable gardens) and rongoā (traditional medicinal plants) cultivation. These facilities were also designed in collaboration with mana whenua, whose influence was reflected in the design with pou and Māori artwork featured throughout.

Both of these factors impact the effectiveness of kaupapa Māori approaches

We found that, where either of these factors were compromised, the effectiveness of kaupapa Māori approaches was compromised.

Some services had high numbers of kaimahi Māori, but because the buildings they work in were not conducive to kaupapa Māori approaches, seclusion rates were still high. Others had newer builds and facilities that empowered the practice of kaupapa Māori approaches, but there were not enough kaimahi Māori to embed their usage. The facility referred to earlier where seclusion mostly occurs when kaumātua are not present is an example of this; the facility opened in 2020 and contains many of the features needed to support the practice of kaupapa Māori approaches, but this is mostly dependent on the presence of the kaumātua.

We note that some facilities have been able to successfully eliminate seclusion for periods of time, despite being older buildings. In these cases, we noted that kaupapa Māori approaches have been well-supported.

Methamphetamine is a major cause of the use of seclusion

An unanticipated issue that emerged during our engagement was the prevalence of tāngata whaiora presenting to inpatient facilities with drug-induced psychosis, suspected to have been caused by methamphetamine (**meth**). Although its prevalence varied between regions, in some locations kaimahi reported that these cases accounted for the majority of seclusion events in their facility. According to these kaimahi, seclusion is necessary to manage the highly aggressive behaviour of some tāngata whaiora in this state until the short-term psychosis subsides and they can be properly treated.

We were unable to determine how many seclusion events are related to meth usage, because seclusion data doesn't capture this information. **However, given most seclusion events occur within the first 48 hours of admission, and we heard that whaiora presenting with drug-induced psychosis is very common in some places, we consider it likely that meth is a significant contributor to seclusion events.** This assumption is potentially supported by the higher proportion of Māori entering into inpatient units via the courts/prison system[18]. Many kaimahi told us that a high number of tāngata whaiora arrive at their facility in the custody of police.

In regions where this issue is most prevalent, kaimahi felt that they could eliminate seclusion in their facility if not for meth-related seclusion events. They expressed a preference to sedate tāngata whaiora under the influence of meth rather than seclude them, because the most appropriate medical treatment for those experiencing psychosis is sleep. This is not a form of chemical restraint because it is a therapeutic intervention in the best interests of the tangata whaiora.

While this is not a kaupapa Māori issue, we have included it in our key themes because of how frequently it was raised with us and how likely it is that this issue disproportionately affects Māori. Use of amphetamines (including meth) is highly correlated to neighbourhood deprivation levels and ethnicity: Māori are 1.8 times more likely to use amphetamines than non-Māori, and those living in the poorest neighbourhoods are over seven times more likely to use amphetamines than those living in the wealthiest.[19]

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[18] Cavney, J., Skipworth, J., Madell, D., & McKenna, B. (2012). *Patterns of mental Health service contact before and after forensic mental health contact in New Zealand*. Australasian Psychiatry, 20(3), 225-227.

[19] *State of the Nation 2022: A stocktake of how New Zealand is dealing with drug use and drug harm*, NZ Drug Foundation.

Some forms of restraint will be harder to eliminate than others

There is substantial data available on the use of seclusion across the motu. However, we could not find similar data on the usage of restraint. Kaimahi we spoke to told us that restraint is reported differently from region to region, using different systems. This explains why there is no centralised source of restraint data like there is for seclusion.

This makes it difficult to understand where and how restraint is being used, and the extent to which kaupapa Māori approaches affect its usage.

One of the major arguments against eliminating seclusion and restraint is that the safety of kaimahi will be at greater risk. Seclusion and restraint are used as a means of controlling aggressive and dangerous behaviour, so many feel that removing it as an option for kaimahi to manage risk will result in more harm.

Some kaimahi we spoke to felt that, if seclusion was prohibited, then the usage of personal or environmental restraint would increase as a consequence – whether those forms of restraint are prohibited or not. They considered that situations will inevitably arise where, despite best-practice de-escalation alternatives, the actions of tāngata whaiora in an aggravated state are of such a high risk to themselves or to others that personal or environmental restraint will be necessary.

There is evidence that this may not necessarily be the case. Case studies of zero seclusion initiatives in DHBs show that, despite kaimahi concerns about safety, reducing seclusion has actually resulted in decreased rates of assault.[20] **This suggests that alternatives to seclusion – such as kaupapa Māori approaches – are also effective at reducing the need for restraint, and therefore the risk to kaimahi safety**. In the absence of consistent restraint data, however, we cannot verify this with total certainty.

There was less support for mechanical and chemical restraint, and we found less evidence of its usage. This may reflect that they are especially restrictive forms of restraint that are generally considered unacceptable and particularly affronting to tāngata whaiora dignity. There is no clear empirical evidence that either form of restraint reduces injury or assault. Risks associated with their use in mental healthcare include physical harm, increased distress, trauma, and even death with prolonged use. Qualitative research suggests that mechanical restraint is a traumatic experience that interferes with the therapeutic process and is viewed as both retraumatising and unethical.[21]

There are, however, certain interventions both medical and practical that could be mistaken for forms of chemical and mechanical restraint, such as sedation of tāngata whaiora experiencing drug-induced psychosis or mania (as in the previous finding) or the use of seatbelts when transporting tāngata whaiora by vehicle.

This raises the need to clearly define the distinction between certain forms of restraint, and genuine interventions for the therapeutic or safety benefit of tāngata whaiora. Understanding this distinction is critical for the elimination of restraint.

Aotearoa New Zealand can lead the way in promoting indigenous mental healthcare practices

During our review, we found international examples where seclusion has or will be eliminated. Seclusion is prohibited in Denmark and India, and the Mental Health and Wellbeing Act 2022 in Victoria, Australia, includes a provision that aims to eliminate the use of seclusion and restraint within 10 years.[22]

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[20] *How DHBs are successfully reducing the use of seclusion*. Health Quality and Safety Commission, 2020.

[21] Newton-Howes G, Savage MK, Arnold R, Hasegawa T, Staggs V, Kisely S. (2020). The use of mechanical restraint in Pacific Rim countries: an international epidemiological study. Epidemiol Psychiatr Sci. 2020 Dec 2;29:e190. doi: 10.1017/S2045796020001031. PMID: 33261713; PMCID: PMC7737169.

[22] S12(c)(ix)(B), Mental Health and Wellbeing Act 2022 (Victoria, Australia).

We engaged with officials from Safer Care Victoria (**SCV**), an administrative office of the Victorian Department of Health. SCV works closely with the Department of Health and with clinicians and consumers to help health services deliver better and safer healthcare. We learned that SCV are leading an improvement program of work as one of a number of initiatives underway in pursuit of the elimination of restrictive practices within 10 years.

SCV acknowledged, however, that there is a gap in the involvement of indigenous voices across their work programmes, and in understanding mental healthcare from indigenous perspectives. They indicated a strong interest in learning from us in this area.

While we were unable to find strong evidence of indigenous knowledge and practices informing mental health policy in other countries, this means we have an opportunity to be world-leading in this area. We have found kaupapa Māori approaches are effective at reducing seclusion and improving Māori mental health outcomes. If we can support kaupapa Māori approaches to be as effective as possible, we can set an example for other nations to follow.

Overall Conclusions

"Whanaungatanga and tikanga Māori, is the way to go to prevent restraint and seclusion." (Lived experience, Māori)

Based on all our findings, we have concluded that kaupapa Māori approaches play a major role in de-escalation that results in seclusion and/or restraint being avoided. However, their effectiveness is compromised by other factors: primarily, a significant shortage of kaimahi Māori, in both cultural and clinical roles, and to a lesser extent the physical environment of inpatient and forensic facilities. Leadership and culture within a facility also play a major role.

We consider that, **if kaupapa Māori approaches in inpatient and forensic settings are supported to be as effective as possible, seclusion can be eliminated**. Because kaupapa Māori approaches are fundamentally about the mana and wellbeing of the person, they are effective for Pākehā and tauiwi as well as Māori.

We do not consider that eliminating all forms of restraint is currently possible. We accept that personal and environmental restraint may still be necessary in extreme circumstances. **However, we see no reason why more harmful and less practicable forms of restraint – such as chemical and mechanical – cannot be eliminated immediately.**

There are a range of actions needed to create the conditions necessary for kaupapa Māori approaches to be most effective. Some of these are beyond the scope of the Mental Health Act itself, such as workforce changes and mental health infrastructure improvements. It will take time for these actions to be implemented.

In summary, our key conclusions are:

1. **Kaupapa Māori approaches can be highly effective at de-escalation and avoiding the use of seclusion and restraint**
2. **Eliminating seclusion is possible, and kaupapa Māori approaches can play a significant role in achieving it, but it will take time for the practice and culture changes necessary to achieve it**
3. **Mechanical and chemical restraint can be eliminated immediately, but personal and environmental restraint may be necessary as a consequence of eliminating seclusion**

In the next section, we set out our findings based on these conclusions.

Ki te Ao Mārama

Ngā Tohutohu | Findings

"Starting from a place where mana enhancing practices is understood as a given would go a long way to getting us in the right direction. But again, that's a paradigm shift. I don't think you can graft it onto what you've already got." (Lived experience, Māori).[23]

The repeal and replacement of the Mental Health Act provides an opportunity for transformational change to the provision of compulsory mental health care.

As per our conclusions in the previous section, we consider that seclusion can be eliminated by supporting kaupapa Māori approaches in compulsory care. We do not consider that personal or environmental restraint can currently be eliminated, and that its usage may increase if seclusion is eliminated. But we consider mechanical and chemical restraint can be eliminated immediately, if it is clearly defined and distinguished from legitimate interventions that are therapeutic and safe for tāngata whaiora.

When our project began, we expected our findings to be limited to the Act only. However, as they have demonstrated, the barriers to utilising kaupapa Māori approaches under the Act – and the elimination of seclusion and restraint – are far broader than the Act itself. Therefore, we have also identified existing work programmes that would play a significant role in supporting our findings to be achievable.

Together, we consider our findings and broader mental health initiatives currently underway would greatly empower the provision of kaupapa Māori care for tāngata whaiora, and the elimination of seclusion and certain types of restraint. They would support the Crown to meet its Tiriti o Waitangi obligations to Māori by actively protecting Hauora Māori and ensuring equitable outcomes for Māori under compulsory mental health legislation. Overall, we consider that our findings would have a positive impact on tāngata whaiora, their whānau, hapū, iwi, and hāpori, and their experiences with mental health inpatient facilities.

A phased approach to eliminating seclusion within five years

As per our conclusions, we consider that **eliminating seclusion is possible, and kaupapa Māori approaches can play a significant role in achieving it, but it will take time for the practice and culture changes necessary to achieve it**.

We therefore consider there should be phased approach to eliminating seclusion by five years from the date the Bill comes into force. After five years, the use of seclusion would be prohibited.

We consider a regulatory change is required. If non-regulatory options to eliminate seclusion – which is and has been the status quo – were effective, they would have succeeded by now. Some facilities have achieved zero seclusion for periods at a time, but, as we've found, seclusion is not only still being used generally, but more often and for longer periods on Māori. We consider that a legislative prohibition on seclusion will require those facilities who are still using seclusion at high rates to find alternatives – which our findings show are already being used in the form of kaupapa Māori approaches to great success.

We accept, however, that these alternatives cannot be embedded overnight. The phased approach would provide a balance between the need to reduce harm and inequity urgently by eliminating seclusion, and to not place undue strain on services that are already under-resourced and over-capacity. Many services are already using models like Zero Seclusion: Safety and Dignity for All and utilising highly effective kaupapa Māori approaches. We

[23] *Repealing and Replacing the Mental Health Act: Analysis of Public Consultation Submissions*, Dr Michael Roguski and Fleur Chauvel, Kaitiaki Research and Evaluation, prepared for Manatū Hauora, 2022.

consider five years is a reasonable timeframe for services to strengthen and embed these practices as a means of eliminating seclusion.

Our analysis shows that eliminating seclusion may have unintended consequences, such as an increase in safety risk to kaimahi. Some told us that this increased risk will result in higher rates of personal and environmental restraint as a means of managing that risk. But our findings also show that alternative approaches to seclusion, such as kaupapa Māori approaches, are also effective at reducing the need for restraint. This suggests that, by eliminating seclusion, the risk to kaimahi safety might actually improve. In the absence of restraint data, however, we cannot confidently verify this. We accept that personal and environmental restraint may still be needed as a last resort in the interests of kaimahi safety.

To ensure accountability for the proposed prohibition on seclusion, Phase 3 would involve additional reporting requirements for any facilities that have not eliminated seclusion by the five year deadline.

In making this finding we have considered the risk of failure. Any risk of non-compliance with a legislative prohibition must be weighed against the risk of ongoing harm that will be caused, especially to Māori, if seclusion is permitted to continue. Actual, ongoing human harm should not be outweighed by a speculative future risk to systems.

That said, there is significant precedent for legal prohibition of harmful practices that drive social and cultural changes. Examples include anti-smacking legislation, smoke-free environments reform, and regulations for the welfare of bobby calves, all of which resulted in significant decreases in the relevant harm.

To achieve this proposal, we consider the Bill should include provisions that:

- seclusion will be prohibited from the date that is no more than five years after the date the Act comes into force
- management of facilities that have not eliminated seclusion by this date will be required to report to the Director of Mental Health about the use of seclusion within their facility and their development of an action plan to ensure the facility can uphold the provisions of the new law.

Immediate prohibition of mechanical and chemical restraint

Mechanical and chemical restraint are both especially restrictive forms of restraint that are generally considered unacceptable and particularly affronting to tāngata whaiora. We see no reason why these specific types of restraint should continue and propose that they be immediately prohibited.

We consider the Bill should include provisions that:

- mechanical restraint is prohibited
- chemical restraint is prohibited
- management of facilities that have not eliminated these forms of restraint will be required to report to the Director of Mental Health about the use of mechanical and/or chemical restraint within their facility and their development of an action plan to ensure the facility can uphold the provisions of the new law.

For the purposes of these findings, restraint is a practice used to control or compel behaviour rather than for any safety or therapeutic benefit to tāngata whaiora. Chemical restraint would 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.

Ngā Kaupapa Tautoko | Supporting initiatives

"I fully support a zero-seclusion approach; however this will require significant resourcing to grow and turn around a burnt-out and understaffed work force." (Person who works in mental health services).

"There are significant needs to ensure physical and environmental safety for all involved, but our current inpatient units do not meet these. They are not conducive to the healing process or the need for whānau to rest and recover in their own time." (Clinical kaupapa Māori body).[24]

Our findings identified two significant barriers to kaupapa Māori approaches in inpatient and forensic facilities, which impacts their effectiveness at minimising restrictive practices: a low Māori workforce, and the physical environment of facilities.

We anticipate that our findings above may be met with resistance on the basis of these barriers. It is likely that some people, particularly kaimahi in the sector, will consider that there are not enough kaimahi Māori to strengthen the use of kaupapa Māori approaches as a means of eliminating restrictive practices, and that facilities are not equipped for it.

Below, we set out two initiatives already underway that will help to address these barriers. We consider that they would greatly support our findings that seclusion could be eliminated within five years and mechanical and chemical restraint could be eliminated immediately.

Health Workforce Plan 2023/24

This is the greatest barrier to the provision of kaupapa Māori care under the Act. As our findings show, there is a disproportionately high number of whaiora Māori under the Act, and not enough kaimahi Māori to deliver the kaupapa Māori care they need.

On 4 July, the Health Workforce Plan 2023/24 was released. It sets out six action areas for focus over the next year to improve the sustainability of the health workforce.

One of these action areas is "Growing pathways for Māori in health". Within this action area are 3 headline actions:

- **Streamline pathways for tauira Māori into health careers**, including investing in Māori retention, and growing programmes that already support tauira Māori in to health
- **Strengthen hauora Māori workforce pathways from whānau, hapū and iwi**, including by scaling earn-while-you-learn pathways for Māori into health roles
- **Support for kaimahi Māori to thrive in the workplace**, including by expanding cultural and clinical support and coaching for our Māori workforce.

These actions are guiding both Te Aka Whai Ora and Te Whatu Ora in growing the Māori workforce across a range of initiatives.

One such initiative is Te Pitomata – The Power of Potential. This is an annual grants programme that supports the growth and upskilling of the Māori health workforce by supporting tauira Māori who wish to study in Midwifery, Allied Health, Nursing, Medical, or Corporate categories.

Another key focus of the Health Workforce Plan is on kaiāwhina and support roles. These are particularly important roles for tāngata whaiora Māori and a major source of kaupapa Māori care. This reflects the strong representation of Māori within this workforce, with 17.9% made up by Māori. Initiatives like Te Pitomata will support more kaiāwhina into other health professions while they learn on the job.

A further Workforce Plan is expected to be released in 2024 alongside the first full New Zealand Health Plan, which will set out actions to deliver on workforce objectives from 2024-2027.

[24] *Repealing and Replacing the Mental Health Act: Analysis of Public Consultation Submissions*, Dr Michael Roguski and Fleur Chauvel, Kaitiaki Research and Evaluation, prepared for Manatū Hauora, 2022

Mental Health Infrastructure Programme (MHIP)

The MHIP is a series of projects refurbishing, rebuilding, or upgrading mental health units led by Te Whatu Ora. It has ring-fenced total funding of $722.5m, of which $235m was funded in the Budget 2019 package. The remainder was funded through the 2020 New Zealand Upgrade Programme, the 2015 and 2018 Budgets, and baselines funding previously held by the DHBs. As at 2022, two of the 16 projects have been completed[25].

Rebuilds and refurbishment of inpatient facilities will significantly contribute to the strengthening of kaupapa Māori approaches and the elimination of restrictive practices. All projects are expected to comply with the Australasian Health Facility Guidelines (**AusHFG**), which are intended to support the delivery of optimal patient care through provision of an appropriate physical environment. These include references to the eliminating seclusion, promoting self-management through the availability of therapeutic spaces such as quiet, activity, exercise areas, sensory modulation rooms and de-escalation areas.

The AusHFG is supplemented by the "New Zealand Health Facility Design Guidance Note" (**the NZ Note**), which provides guidance specific to Aotearoa New Zealand. It includes design guidance for adult acute mental health inpatient units that incorporates relevant legislation and associated guidelines relating to mental health, substance addiction, human rights. and seclusion.

The NZ Note also recommends the engagement of Māori design practitioners and kaupapa Māori specialists, and includes a section specifically on kaupapa Māori considerations. This sets out guidance on kaupapa Māori concepts and spaces such as waharoa (an entry gateway), whānau rooms (for accommodating whānau to stay), and waerenga (internal courtyards for access to the natural environment). It also provides guidance on providing for certain tikanga, such as mihi whakatau and the handling of tūpāpaku (deceased).

We consider that the delivery of inpatient facility rebuilds and refurbishment under MHIP, guided by best-practice design principles and specific kaupapa Māori provisions in the NZ Note of the AusHFG, will contribute significantly to the strengthening of kaupapa Māori care and the elimination of restrictive practices.

[25] *Mental Health Infrastructure Programme Review*, Te Waihanga | New Zealand Infrastructure Commission, 2022.