MINISTRY OF HEALTH
MANATŪ HAUORA

Section 99 Inspection into Canterbury – Waitaha Adult Inpatient and Associated Mental Health Services

August 2025

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1. Executive summary

1.1. Introduction and process

The Director of Mental Health has powers under section 99 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 to inspect any hospital, or any ward, unit, or other part of a hospital, in which psychiatric treatment is given. This is a report of the section 99 inspection into Canterbury – Waitaha adult inpatient and associated mental health services.

The inspection arose from concerns the Director held as to whether there were systemic issues in these services. The Director needed assurance that the services were complying with legislation and related guidelines, and were able to deliver appropriate care and treatment for tāngata whaiora under their care. The inspection examined not only the operational and clinical governance and functioning of the adult inpatient and associated mental health services but also how that operational and clinical governance is overseen by wider organisational processes.

An inspection team assisted the Director during the inspection and report drafting. The inspection team spoke to range of people at the Canterbury – Waitaha service, from senior and executive leadership to front-line staff. The lived experience member of the team also spoke directly to people with lived experience, and the Māori team member specifically focused on how well the service incorporated te ao Māori. Interviewees were assured confidentiality, so this report presents only summarised information.

This final report presents the final views and recommendations of the Director.

Canterbury – Waitaha adult inpatient and associated mental health services provide a comprehensive range of services and operate in a whole service delivery system. They also provide regional services for the South Island.

The Canterbury – Waitaha region has been further exposed to a series of disruptive events, including earthquakes and terrorism events. These have affected service delivery, and the staff delivering the services. This inspection took place within a national context of specialist mental health services reporting significant demand and stretched resources. Services had been significantly impacted by COVID-19, which increased demand and exacerbated staffing issues.

Most of the interviews and information gathering took place between July and November 2022. Over this time, the inspection team reviewed a large volume of documentation and correlated it with the results of interviews.

Health New Zealand – Te Whatu Ora has not waited for this report to begin making improvements. This report reflects the situation during the inspection. Given the length of time since the inspection, it includes references to changes made after the inspection, and Appendix 2 describes the actions that Health New Zealand – Te Whatu Ora has taken since that time.

1.2. Findings

1. **Accumulating legacy impacts on service and staff resilience**

   The region had experienced the Canterbury earthquakes, the Kaikoura earthquake, the Christchurch terror event, the COVID-19 pandemic and substantial general and prison population increases.

   The prison population had increased by 35% in the last decade, and COVID-19 had heightened demand for services. The ongoing impacts on housing stemming from the earthquakes made it difficult for staff to secure suitable community placements for patients at discharge. This led to some patients experiencing long stays, preventing community reintegration and the admission of people with acute needs.

   While services nationwide are grappling with the residual impacts of COVID-19 and constrained resources, these impacts were experienced by the Canterbury – Waitaha mental health service as an overlay to an already sustained period of pressure.

   When the inspection occurred, new facilities for specialist areas were under construction (eg, for services relating to rehabilitation; child, youth and family; and mothers and babies). The specialised facilities have subsequently been opened. At the time of the inspection, the buildings that housed the core inpatient and forensic services were badly designed and in a poor state of repair. Plans were under way for a campus redevelopment. In the interim, the physical environment posed real challenges for both staff and patients.

2. **Critical staffing shortages**

   The most significant and prevailing issue was ensuring safe staffing in the clinical areas – especially in the adult inpatient, community and forensic services. In the inpatient areas, there were daily issues in ensuring minimum safe staffing levels. In mid- to late 2022, when the inspection took place, the residual impact of COVID-19 was a significant exacerbating factor.

   While the effects were different across the various disciplines, it was evident that all disciplines (nursing, allied health and medical) were affected. In addition, it was clear that not all disciplines felt heard and involved in clinical decisions. There were reports of impacts on clinical care.

   Forensic mental health services were particularly challenged. Not only were there issues in maintaining minimum safe staffing levels, there were issues associated with the experience and seniority of staff. Staff members expressed concern that understaffing, and an imbalance in the junior to senior staff ratio, could lead to safety issues. The issue affected all disciplines.

   Appendix 2 describes staffing updates since the inspection.

3. **Staffing vacancies affecting admissions and discharge processes**

   It was evident in reports from multiple sources that tāngata whaiora were affected by the staffing and service challenges the services experienced. The impacts included a reduction in the types of interventions offered, diminished effective multidisciplinary

care, pressure for early discharge (with consequent readmissions) and delayed admissions.

One response to the staffing challenges was bed closures. This had consequences across the continuum of care and placed pressure on services to achieve early discharges. The services put processes in place to address this and created a role of Transitions Coordinator in the acute area to support the movement of people back into the community. Despite this, some long-stay patients struggled to find suitable community accommodation.

4. Significant disruption to staff learning and development

The pressing need to focus on safe staffing had resulted in a reduction in training and staff development, including mandatory training. Some staff reported reduced clinical supervision. These factors added to significant morale issues and compromised the safety of staff and tāngata whaiora.

5. A siloed culture and care model

There also appeared to be a lack of cohesion between disciplines. The inspection team had concerns about the model of care. The Director was subsequently informed that the forensic psychiatric training scheme was in jeopardy because it did not employ a psychiatrist who was a full member of the Faculty of Forensic Psychiatry.

There appeared to be an issue in terms of the way the services incorporated te ao Māori into their model of care. This was of particular concern to the inspection team given the cultural needs of the people accessing the forensic mental health services at the time of the inspection.

The Māori member of the service team observed there were issues in the relationship between mana whenua and the Te Korowai Atawhai (kaupapa Māori) team. In addition, that team was not well integrated into the operational and clinical governance function of services. The relationships between kaimahi Māori and management in Te Korowai Atawhai were strained. It was not apparent that there was a model of care or pathway that allowed tāngata whaiora to incorporate their cultural needs.

The lived experience team also experienced staffing issues. Often, staff were not used to their full potential. For instance, staff spoke about a reduction of their involvement in seclusion reviews. In some service areas, this was compounded by a failure to use best-practice models. For this reason, practices had a more institutional feel. There also appeared to be a lack of awareness of the adjunct role of the chaplain service. At the time of the on-the-ground inspection, the role of Programme Director for Lived Experience was unfilled, which no doubt exacerbated the issues.

A new Director was appointed in January 2025.

6. Poor morale

Staff demonstrated a high degree of dedication during a prolonged environment of strain. They expressed frustration they could not deliver the standard of care they aspired to. Some staff expressed that they had experienced burnout and had concern for colleagues' wellbeing. They noted the compounding impact of long shifts and were concerned the service struggled to recruit due to its known issues.

Some staff reported that there was 'a culture of blame' in the services which exacerbated the morale problems. However, this was not a universal complaint: in some areas, staff reported being able to trust each other and depend on colleagues.

7. **Governance not working effectively**

   The inspection team was informed that clinical governance at a district level was not working effectively and that an emergency framework had been put in place. The Director only received a draft clinical governance structure at a level above the service in March 2024.

   At the service level, the operational and clinical governance structures, while clearly documented, appeared to have variable levels of implementation and effectiveness. Staff reported difficulties in the escalation and consultation processes and gave examples of issues that had not been effectively resolved.

   The services have a dedicated quality and safety unit with a broad brief of patient safety, quality, informatics and customer services. There were issues in terms of how this brief was integrated into the front-line services. For instance, while the services collected a wealth of good information, this was not well integrated at the team management level.

8. **An overall reactive mode of governance, with a focus on immediate issues at the expense of longer-term stewardship**

   Senior leadership was aware of the impact of staffing issues and had been putting reactive plans in place under urgency to address this (often daily). However, this very short-term focus compounded governance and communication issues.

9. **Delayed resourcing decisions at the regional governance level**

   To address some of the issues, the forensic leadership team had created business cases that the service leadership team submitted to Health New Zealand – Te Whatu Ora regional leadership for approval. However, at the time of the Director's inspection, these business cases had not received decisions. After the on-the-ground inspection, the services reported they had taken further steps to address both the lack of staff seniority and the staffing levels.

   Since the inspection there have been a number of changes to staffing, including additional resources. Appendix 2 describes these.

1.3. Recommendations

The Director's recommendations fall into three broad categories: governance, care model and resourcing.

The uniting thread across these recommendations is the need for better cooperation between leadership and service delivery to prioritise these services, enable staff to do their best, improve the models of care and plan for the future.

Governance

1. **Prioritise and focus on forensic mental health service performance**

   Given the findings of the inspection, and the outcome of the independent review into the serious incident, there should be a particular focus on forensic mental health

services, to address staffing/vacancy issues (including in forensic psychiatry), embed a multidisciplinary model of care and implement the recommendations of this report and the independent review.

2. **Ensure that service delivery complies with legislative requirements and guidelines**

   Minimum standards of care and human rights are enshrined in law, which means resources and facilities must be prioritised to ensure they are being met, including as minimum standards evolve over time.

3. **Implement clear pathways of decision-making and governance**

   This framework should articulate how the continuum of care is governed across the various pillars within the organisation, commissioning, service delivery, people and capability, and facilities.

4. **Strengthen the connection between service and regional leadership teams**

   There should be clear processes for how escalations, decisions and communications flow from the national and regional levels to the front-line service level, and proactive communication loops to and from service staff.

   Build a transformative leadership culture with a strong emphasis on the concept of 'servant leadership'[1] and a 'just culture'[2] involving a system of shared accountability and timely, open and honest reporting.

5. **Re-engage and involve the workforce at all levels and ensure the work of all disciplines is valued and that multidisciplinary teamwork is effective**

   The workforce needs to be included in providing solutions to the challenges faced by the service. Staff, Māori and people with lived experience need to be part of this process, and all front-line staff should be regularly updated on governance priorities and outcomes. The organisation should support all disciplines to take their place within leadership structures.

   Deliver a campaign aimed at fostering respect for individuals and professional groups. The service culture framework should be explicit about above- and below-the-line behaviours. It should make clear that bullying in all forms is unacceptable.

6. **Ensure Te Tiriti o Waitangi partnership is evident at all levels of the organisation**

   There should be a clear commitment to work with tāngata whenua in a spirit of partnership at all levels of the service, from service delivery to the governance team.

   Māori are overrepresented in mental health services, and it is essential that appropriate cultural services are available to tāngata whaiora. This is not an 'add-on'; it needs to be embedded in the service framework.

[1] 'Servant leadership' is a leadership and management style focused on encouraging the growth and development of others; it takes care of the wellbeing of staff before organisational goals.

[2] 'Just culture' is the concept of designing, implementing and supporting a fair and just learning culture within an organisation. More information is available at the 'Just Culture' website: www.justculture.healthcare/introduction-to-just-culture/ (accessed 1 July 2025).

Ensure there is a senior Māori Health leader who has responsibility for growing and supporting the Māori mental health team, provides connections to the rest of the hospital and ensures there is a collective Māori voice at the leadership table.

Support mana whenua-led change to deliver mana motuhake and Māori self-determination in the design, delivery and monitoring of health care. Support Māori oversight and ownership of decision-making processes. Support the expression of hauora Māori models of care and mātauranga Māori.

Demonstrate critical consciousness, self-reflection and self-awareness in terms of the impact of individual bias on interactions and service delivery. Support the review or removal of policies, procedures and practices that cause inequity. Support the Māori-led responses necessary to achieve Māori health equity.

7. **Ensure clinical governance is present at all levels**

   Terms of reference for the various governance committees should be updated to include clinical leadership and align to the new regional governance frameworks.

8. **Incorporate lived-experience partnership at all levels of the organisation, including governance**

   The inspection team observed a lack of support for the inclusion of lived-experience practice at many levels in the organisation. The lived experience and family/whānau teams were not being used to their full potential, and the key role of Director of Lived Experience & Family/Whānau has been difficult to fill.

9. **Foster a learning and quality improvement culture at all levels, including revising the process for how serious incidents are reviewed**

   The inspection found issues with the services' ability to review and learn from incidents. This creates concern regarding the services' readiness to respond to serious events.

Care model

10. **Review the care model**

    The care model project should include clinical, allied health, lived experience and te ao Māori/cultural perspectives to produce a best-practice model in which the expertise of all staff is recognised and sought during delivery.

11. **Develop a multidisciplinary training programme with a focus on forensics**

    A multidisciplinary training programme should be developed in conjunction with the Nursing Director, Director Allied Health, Lived Experience Director and General Manager to ensure modules are appropriate to each discipline. Training and information on core requirements should be provided across the broader services – recognising that staff from other areas may transition into, or be required to provide short-term support to, the forensic service.

    There also needs to be a forensic psychiatry programme, to develop a talent pipeline.

12. **Involve Senior Medical Officers in service planning and quality improvement and give clinicians an effective forum in which to raise concerns regarding the quality of service provision**

    These roles balance leadership and operational responsibilities and are an excellent resource in developing and implementing new standards. Currently, the governance-enhancing value of this network is largely untapped.

    While senior doctors are only one cohort within a multidisciplinary workforce, they are an essential group providing leadership and expertise.

    A useful way of thinking about the various contributions that senior medical staff should make can be found in the CanMEDS framework for professional development.[3]

    There needs to be a safe culture in which people can hear and clarify concerns, develop strategies to address concerns or elevate concerns to someone with the delegated authority to deal with those concerns, and provide timely feedback to clinicians who have raised concerns.

13. **Better include lived experience and allied health skills and perspectives**

    The services should better include lived experience and allied health skills and perspectives, particularly at the point of patient admission, the development of the rehabilitative programme and at preparation for discharge.

14. **Develop a clear partnership with people who can offer lived experience understanding**

    Develop and deliver mandatory training for all new staff (in each unit) about the role of the lived experience team, the family/whānau advisory team and the chaplaincy team in the care model.

    Create a coordinating lived experience role to support the work of the newly appointed Director of Lived Experience.

Resourcing

Resource limitations are part of the current landscape of mental health service provision in Aotearoa New Zealand and will not be resolved in the short term.

15. **The organisation needs to focus maximum effort on staff recruitment, retention, supervision, training and mentoring**

    The services should concentrate on recruitment, retention, supervision, training and mentoring, particularly in the forensic mental health service and in the 'middle tier' of nursing across the services as whole.

16. **Rescope roles that are necessary for the provision of services, care and treatment, and consider using the broader workforce**

    Leverage a broader workforce, including support workers, cultural workers, peer support workers and other multidisciplinary roles.

[3] Royal College of Physicians and Surgeons of Canada. (nd). The CanMEDS Framework. URL: https://www.royalcollege.ca/en/standards-and-accreditation/canmeds.

The service needs to plan to make better use of resources and enable staff to work to the top of their scope of practice.[4]

17. Develop strategies for long-term management, budget, staffing and facilities

The services need to develop local and district strategies and processes that supplement wider Health New Zealand – Te Whatu Ora workforce strategies. Succession planning is essential. A four-year outlook for these resourcing topics should be developed, with decision-making supporting investment for a 24-month outlook.

Ensure clinicians understand and support this strategy. Working within resource constraints is stressful and can lead to a sense of 'moral injury'. Clarifying the way existing resources can be used for best effect, and what the longer-term outlooks are, will support a joined-up approach.

The services must plan with regional governance how service provision will be maintained during facilities upgrades.

Maximise the rights and needs of tāngata whaiora receiving care and support by enabling existing resources to work effectively across disciplines to deliver therapeutic and culturally responsive care.

18. Establish and invest in a Māori mental health service

It should be led and managed by Māori with both clinical and operational skillsets and operate in partnership with the community, connecting with mana whenua, kaupapa Māori providers, primary health organisations, non-governmental organisations (NGOs) and community-based services.

The Director considers that action on these recommendations will address concerns regarding service culture, and staff burden and burnout.

[4] Le Va. 2015. *Scope it right: Working to top of scope literature review*. Auckland: Le Va.

2. Introduction

2.1. Purpose of the inspection

The Director of Mental Health (the Director) had concerns regarding the functioning of Canterbury – Waitaha adult mental health services. These concerns arose from regular reporting from statutory officials, informal communications and a serious incident that led to the death of a member of the public in June 2022.

The Director sought assurance the services were complying with legislation and related guidelines and were able to deliver appropriate care and treatment for tāngata whaiora under their care. This necessitated consideration of the governance of the services, whether culturally appropriate care was being delivered and whether equity and Te Tiriti o Waitangi obligations were being met.

The Director gathered an inspection team to commence a detailed inspection under section 99 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act). The appendix to this document contains the terms of reference for this inspection.

2.2. Role of the Director of Mental Health

The Director of Mental Health is a statutory officer appointed under the Public Service Act 2020. The Director is 'responsible for the general administration of the Mental Health Act under the direction of the Minister and the Director-General of Health'.[5] The current Director, Dr John Crawshaw, took up the position in November 2011. He has extensive experience in clinical practice, clinical and operational leadership, change management and executive management.

The Director has powers (including the power of inspection) under his direction and oversight of regulatory practice under the Mental Health Act. In general, the Director's focus is on monitoring services and facilitating responses to issues as they arise. When this is not possible, intervention becomes necessary.

As set out in the terms of reference, on this occasion it became necessary for the Director to become directly involved in inspecting the service, to receive assurance on the care and quality of services Canterbury – Waitaha was delivering under the Mental Health Act.

2.3. Section 99 of the Mental Health Act

Section 99 of the Mental Health Act gives the Director all the powers of the Director-General of Health under section 148 of the Hospitals Act 1957, to allow for the inspection of any hospital, ward or unit. This means that the Director has access to all documentation that may be required for review and can talk to any employee of the services. The independence of a section 99 inspection is an essential factor, as it allows for greater trust and accountability.

[5] Section 91 of the Mental Health Act.

There has only been one other section 99 inspection since the initiation of the Mental Health Act. It took place in 2015 and involved the Waikato DHB mental health services.[6] The rarity of such inspections is an indication of the seriousness of this intervention.

2.4. Treatment and rights under the Mental Health Act

Most inpatients are, or have been, treated under the provisions of the Mental Health Act. They are often at their most vulnerable when they are in care due to the impact of their serious mental disorder and the restrictions on their liberties that come with compulsory treatment.[7] It is important that services actively protect the rights of these people.

The Mental Health Act provides mechanisms for oversight and monitoring of the care people receive. Provisions govern the responsibilities of certain statutory officers, including the Director, Directors of Area Mental Health Services (responsible for the local administration of the Mental Health Act) and District Inspectors. District Inspectors advise people on their rights under the Mental Health Act, conduct inspections, investigate complaints[8] and, if requested by the Director, undertake commissions of inquiry.[9]

The Mental Health Act explicitly sets out people's rights under the Mental Health Act. Service providers must also consider the provisions of the New Zealand Bill of Rights Act 1990 whenever they apply any of the provisions of the Mental Health Act. People subject to the Mental Health Act also continue to have rights under the Human Rights Act 1993 and under the Code of Health and Disability Services Consumers Rights, unless a provision in the Mental Health Act specifically overrides these.

Specific guidance has been provided in the Manatū Hauora – Ministry of Health documents *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* and *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*.[10] These guidelines were promulgated under section 130 of the Mental Health Act and are regarded as secondary legislation. The Ministry of Health expects everyone and every service operating under the Mental Health Act to comply with this guidance.

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[6] See Ministry of Health. 2016. *Section 99 Inspection of Waikato District Health Board Mental Health and Addiction Services*. Wellington: Ministry of Health.

[7] Section 59 of the Mental Health Act.

[8] Section 75 of the Mental Health Act.

[9] Section 95 of the Mental Health Act

[10] Ministry of Health. 2022. *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health. Ministry of Health. 2020. *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

3. Setting

3.1. Canterbury – Waitaha mental health services

At the time of the inspection in 2022, the then-Canterbury District Health Board (DHB) served a population of 589,240 people and covered the east coast of the South Island from Kaikōura to Ashburton. It was one of the largest DHBs in terms of population and catchment area. It provided mental health and addiction services for Waitaha – Canterbury and inpatient services for the whole of the South Island in specialist areas including maternal mental health, eating disorder, medical detox and child and adolescent services. It also provided inpatient forensic mental health services for the South Island, excluding the area covered by the then-Southern DHB.

Services provided for adults included:

- adult inpatient services:
  - Te Awakura – an acute mental illness facility with 24-hour nursing care
  - Seager Clinic – an inpatient rehabilitation unit
  - Tupuna Villa – an inpatient extended care unit (closed in late January 2023)
- adult community services – four metropolitan teams, Ashburton, a rural team, Assertive Outreach, early intervention community team
- intellectual disability services:
  - Whaikaha Unit – forensic intellectual disability secure unit
  - psychiatric services for adults with an intellectual disability
- forensic services:
  - Te Whare Manaaki – medium secure inpatient admission unit
  - Te Whare Hohou Roko – medium secure inpatient rehabilitation unit
  - Te Whare Mauriora – minimum secure inpatient rehabilitation unit
  - Te Whare Rangihau – forensic mental health community team with a forensic prison team and court liaison
- specialist services:
  - eating disorders service
  - mothers and babies service
  - the Kennedy Detoxification Unit
  - the anxiety disorders service and clinical research unit
  - Christchurch Opioid Recovery Service
  - community alcohol and drug service
  - Te Korowai Atawhai – Māori Mental Health Team.

4. Methodology

4.1. Inspection team and approach

The inspection team had expertise in the following areas:

- lived experience
- te ao Māori and Te Tiriti o Waitangi
- mental health nursing
- psychiatry
- forensic mental health
- management
- regulation.

The inspection team sought to gain a range of perspectives. The team made a concerted effort to meet with all professional groups and held interviews with management and front-line staff. Specific effort was given to hearing from people with lived experience and a te ao Māori perspective. The inspection team also met with unions to ensure their views were received.

The inspection team then cross-referenced its observations with documentation and data the service supplied.

While the focus was largely on inpatient services, the inspection team also paid attention to the adult community teams providing services to tāngata whaiora prior to and following admission. Inspection team members visited the forensic mental health, acute mental health and intellectual disability facilities.

4.2. Information

The inspection team received support and documents from the divisional leadership team, which, at the time of inspection, consisted of the following people:

- General Manager
- Chief of Psychiatry
- Director of Nursing – Mental Health and Addictions
- Director of Allied Health
- Director of Quality & Operations
- Pou Whirinaki (Cultural Advisor)
- Director of Lived Experience & Family/Whānau (vacant at the start of the inspection but appointed during the course of the inspection).

The inspection team received differing information on whether the Pou Whirinaki and the Director of Lived Experience & Family/Whānau were included in the divisional leadership team. They were both listed in the terms of reference for service leadership team meetings, but the inspection team was told the roles did not attend in practice. In March 2025, the service leadership team advised the Director that these roles attend the divisional

leadership team but only attend the operational leadership team when they are required to or wish to. This distinction appears not to have been well understood by staff and indicates a lack of clarity at the service level around the role and composition of leadership groups.

The service leadership team provided the inspection team with an overview of Canterbury – Waitaha's services and gave several presentations showing how the service was organised and governed. These presentations also covered the strategic direction and challenges facing the service.

In addition, the inspection team received documents covering:

- an overview of the services
- strategic plans and priorities
- terms of reference for the various committees
- organisational and clinical governance structures
- cultural services
- education, training and orientation
- escalation processes
- facilities and infrastructure
- lived experience and family and whānau
- staff-related data
- samples of internal and external incident reports.

4.3. Interviews

Together or as sub-teams, the inspection team made a point of conducting interviews or meetings with people from all levels of the organisation. This ranged from the district executive management team[11] and service leadership team through to front-line staff. Some senior clinical staff made written submissions and some requested, and received, an opportunity to speak directly to inspection team members.

Staff were assured of confidentiality. For that reason, this report presents only summarised analysis of the themes and information gathered.

4.4. Timeframe for the inspection

Inspection team visits to the Canterbury – Waitaha service took place on:

- 6 and 7 July 2022
- 26 and 27 July 2022
- 8 August 2022
- 17 November 2022.

[11] At the time of the inspection, the district executive management team comprised the Chief Medical Officer, Executive Director of Nursing, Executive Director of Allied Health, Executive Director of Midwifery and Chief Executive Officer.

The drafting of this report took longer than anticipated due to the following issues:

1. **The extreme weather events in 2023** affected inspection team members' ability to prepare aspects of the report. Cyclone Gabrielle had a severe personal impact on one member.
2. **Delay in receiving key information**
    a. Information about how the mental health service fitted within the wider Health New Zealand – Te Whatu Ora operating and governance model was requested in 2022, so the inspection team could understand the full scope of the situation and form timely recommendations. A draft clinical governance framework was eventually supplied in March 2024. The Director was assured that, while the framework was in draft form, implementation of it was under way.
    b. Canterbury – Waitaha assured the Director that by the end of 2022 he would receive a copy of the report of the independent review into the serious adverse event that resulted in the death of a member of the public. A copy of the independent report was eventually supplied on 31 May 2024 and the Director was advised its release had been delayed by legal issues.

5. Findings

5.1. National context

The Director of Mental Health has made informal visits to mental health, addiction and intellectual disability services across Aotearoa New Zealand, including large metropolitan services. These visits provide the Director with assurance on the operation of the Mental Health Act, highlight innovative practices across the sector, address challenges, promote equity and provide opportunities to engage with iwi and whānau. The Director also receives statutory reporting on services from Directors of Area Mental Health Services and District Inspectors in each region.

Members of the inspection team came from other mental health services in Aotearoa New Zealand. This, combined with the experience of the Director, helped to provide a wide contextual lens through which Canterbury – Waitaha services could be compared to the national context.

In the national context, all mental health, addiction and intellectual disability services are under pressure, facing the following challenges:

- Māori are disproportionately high users of mental health services, especially in forensic mental health settings. Mental health services struggle to improve access and outcomes equity for Māori.
- The need for mental health, addiction and intellectual disability services is greater than the available resources. Some inpatient mental health units often run at 100% occupancy or higher.
- There is a shortage of suitably qualified mental health clinicians and a need for investment in facilities.
- All health services were affected by the COVID-19 pandemic and the measures necessary to address it. This affected demand for mental health services and exacerbated already existing staffing issues.
- At a population level, strong social drivers of poor mental health prevail. These include poverty, inequity, the downstream effects of colonisation and the harms arising from substance use (particularly methamphetamine).
- When things go wrong during the delivery of mental health services, service providers are subject to intense scrutiny and criticism. As a result, many mental health clinicians practice in a risk-averse manner. This also affects staff recruitment and retention.

5.2. Canterbury – Waitaha Context

The earthquakes of 2010/2011 and the subsequent rebuild took a significant toll on the population of Christchurch – including the staff of the Canterbury – Waitaha mental health services. This resulted in increased strain on specialist mental health services in Canterbury. The service summarised this for the inspection team in the following way:

> The population of Canterbury (from Kēkerengū in the north, south to Rangitata and west to Arthur's Pass) has been exposed to a series of natural and human-created

events that have impacted on the population's mental health. Our staff are part of this population and have been exposed to these stresses. The population have been exposed to an earthquake sequence of over 15,000 shakes as well as exposure to other significant events over an extended period including:

- 4 September 2010, Mag 7.1 earthquake
- 22 February 2011, Mag 6.3 earthquake
- 13 June 2011, Mag 6.4 earthquake
- 23 December 2011, Mag 6.0 earthquake
- 2013 and 2014, Several serious floods, continuing earthquakes
- 14 February 2016, Mag 5.7 earthquake
- 14 November 2016, Mag 7.8 Kaikōura earthquake
- 13 February 2017, Port Hills Fire
- 15 March 2019, Terrorist Attack
- From March 2020, Covid-19 pandemic

Since the earthquakes the Canterbury population has increased by approximately 95,000 (19%). As a result of these events demand has increased significantly among the population with changes in volume and acuity of people presenting to services. This aligns closely to reports in the literature; however, the ongoing nature of disasters may have led to a longer period of negative determinants compared with single event disasters.

A ceiling effect is evident in demand for inpatient services due to the static number of beds. The demand is manifest in growth in specialist community services and NGO services and increased acuity within services.

The inspection team heard that Canterbury – Waitaha was not well placed to meet the additional strain on services created by the COVID-19 pandemic given the ongoing effects of the other significant events in the area.

An important feature of Canterbury – Waitaha's district service system (the whole service delivery system) is the high level of integration it has with wider health care and other services' delivery systems. The divisional leadership team provided details of how the following were key partners or elements in the system:

- NGO partners
- Te Ao Mārama: a peer-led acute alternative service in Christchurch
- Mana Ake: a service providing mental health and wellbeing support for children in years 1–8 across Canterbury
- Manu Ka Rere: a mental health and addictions service for young people aged 13–24 across Canterbury
- Mental Health and Addiction System Design: a Ministry of Health – Manatū Hauora funded project to develop a system-wide collaborative design process

- Integrated Safety Response: a multiagency family violence response process
- police watchhouse interfaces[12]
- South Island Alliance: a collaboration between the five South Island district health services
- South Island Mental Health Leaders group
- Oranga Tamariki liaison role
- Alcohol or Other Drugs Central Co-ordination Service.

Historically, Canterbury – Waitaha's mental health services had strong leadership. Information provided to the inspection team during interviews gave the perception of a somewhat conservative culture with a 'top-down' leadership style. Some staff labelled this style as 'controlling' and 'punitive'. Top-down leadership works best in times of stability. It is less agile or adaptive in times of significant disruption.

5.3. Service organisation and leadership structures

Service structure

The inspection team saw documentation on the strategic purpose and plans of Canterbury – Waitaha's specialist mental health, addiction and intellectual disability service. Specific documents outlined the target culture and how it was to be achieved. The service is grouped into seven clusters:

1. adult community north and adult community west
2. adult community south and adult community east
3. adult inpatient group
4. forensic mental health
5. intellectual disability
6. child, adolescent and family
7. specialist:
    - alcohol and other drugs
    - eating disorders
    - mothers and babies
    - anxiety disorders.

The main focus of the inspection was the adult inpatient group and forensic mental health clusters.

[12] Police watchhouses (or custody suites) are temporary holding cells for individuals before they are released from police custody or transferred to another facility. An interface with a police watchhouse involves qualified nurses assisting police in monitoring people in their custody or managing risks they may present.

Operational leadership

Operational matters were taken to the operational leadership team. This team had a functional relationship to the divisional leadership team and accountability to the General Manager and the Director of Quality and Operations. The inspection team saw terms of reference for the operational leadership team, whose membership consisted of:

- Service Manager: Child, Adolescent & Family Services
- Service Manager: Specialty Services
- Service Manager: Adult Community North/West
- Service Manager: Adult Community South/East
- Nursing Director: Forensic Mental Health and Intellectual Disability Services
- Nursing Director: Adult General Inpatient Services
- General Manager
- Director of Nursing: Mental Health and Addictions
- Director of Allied Health
- Director of Quality & Operations
- Quality Manager
- Facilities Lead Mental Health
- people and capability representation – Human Resources Business Partner, Senior Advisor, Health & Safety Advisor (the process through which these roles would attend and contribute was unconfirmed)
- cultural representation (who would attend and contribute was unconfirmed)
- consumer and family-whānau representation (who would attend and contribute was unconfirmed).

At the date of the operational leadership team's terms of reference, 18 November 2021, there were a number of uncertainties about the formal membership, as repeated notes of 'to be confirmed' indicate.

Clinical service leadership

In addition to the above leadership roles and teams, divisional leadership team business partners had important roles and responsibilities for the services. These were:

- Clinical Lead Mental Health Facilities
- Finance Business Partner
- Human Resources Business Partner
- Quality Manager
- Team Leader Mental Health & Addictions, Planning & Funding.

The seven service clusters listed above had regular formal service leadership meetings that, from their terms of reference, involved all the following:

- the cluster's service manager / nurse director (chair)
- the cluster's clinical director
- the cluster's nurse consultant
- the cluster's allied health consultant
- the General Manager
- the Chief of Psychiatry
- the Director of Nursing
- the Director of Allied Health
- the Director of Quality & Operations
- the Pou Whirinaki (Cultural Advisor)
- the Director of Lived Experience & Family/Whānau.

Governance

The inspection team was informed that the following governance forums were held every one to two months:

- clinical governance:
  - divisional group
  - local clusters – combined with quality forums
- health and safety:
  - divisional group
  - local clusters led by health and safety representatives
- Serious Event Review Team (SERT) and complaints:
  - weekly review of Severity Assessment Code (SAC) 1 and 2 events[13]
  - weekly review of complaints.

Perceived effectiveness of these structures

The inspection team was provided with the terms of reference and sample minutes for these committees. The documentation showed there was a formal set of processes for the operational and clinical governance of the services. However, the inspection team heard these were not always effective and there was uncertainty about which governance body made decisions.

The divisional leadership team acknowledged that staffing challenges, and other matters arising from responses to the COVID-19 pandemic, had resulted in a loss of momentum for

[13] The Health Quality & Safety Commission developed Severity Assessment Code (SAC) ratings for adverse events. A SAC 1 event involves death or permanent severe loss of function; a SAC 2 event relates to permanent major or temporary severe loss of function.

key recruitment processes. For example, there were delays to recruitment of key roles (Quality Manager, Director of Lived Experience, Cultural Educator and Pukenga Atawhai). The focus of attention on the COVID-19 pandemic response also affected Canterbury – Waitaha's quality improvement work.

The inspection team noted that the terms of reference for some committees were outdated. There appeared to be various working parties that had become disconnected. At times, the inspection team had difficulty understanding how the various governance, oversight and leadership teams linked with each other. This was particularly noticeable in relation to risk escalation and decision-making pathways.

6. Clinical governance

The inspection team received documentation setting out a well-considered clinical governance terms of reference and process. However, interviews indicated these were not reflected in actual practice.

The inspection team heard that, at the district level, the clinical governance process had become challenging. Despite efforts to tighten the process up, there was no overarching framework. The district executive management team instituted an emergency clinical governance framework in recognition of these challenges, which included clinical leaders' meetings to bring the clinical leaders together.

At the division level, there had been an ongoing review of clinical governance over the previous two years. This review drew from a Health Quality And Safety Commission framework: *Clinical Governance: Guidance for health and disability providers*.[14] The COVID-19 pandemic had resulted in this review being deferred, and a decision had been made to not extend the membership of the core divisional clinical governance members (the Chief of Psychiatry, Director of Nursing, Director of Allied Health, Quality and Patient Safety Manager, Pou Whirinaki and Consumer & Family representatives). The terms of reference noted that the chairs of service or cluster clinical governance, as well as other members of the divisional leadership team, would attend from time to time.

During the inspection, the clinical governance group noted there was confusion as to what each group was responsible for, and a refresh of the governance framework was required. For example, clarity was needed between the roles of the operational leadership team and clinical governance meetings. The clinical governance group described itself as an oversight group rather than an approval group.

This confusion around which group dealt with which matters and how escalation and decision-making pathways flowed was clear in the interviews conducted with the cross-section of leadership groups and staff.

This lack of clarity around escalation and clinical governance is problematic. It impedes the service, and staff within it, from delivering effective governance and quality oversight. These challenges were compounded by the lack of clear clinical governance structures at district, regional and national levels.

6.1. District-wide clinical governance

When the inspection commenced, district executive management informed the inspection team that the district-wide clinical governance process had become challenging and that an emergency clinical governance framework had been instituted. This challenge was evident to the inspection team and had an impact on how the service-level clinical governance processes would report into the district-level clinical governance framework.

As a result of these acknowledged challenges, the Director repeatedly sought to clarify what had changed in terms of district-wide clinical governance and how it was connected with governance at a regional and national level. It is somewhat telling that the Director did not receive a clinical governance framework until March 2024 and that, even then, it was a draft

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[14] Health Quality & Safety Commission. 2027. *Clinical Governance: Guidance for health and disability providers*. Wellington: Health Quality & Safety Commission.

framework. Even so, the Interim Group Director Operations assured the Director that the framework had been implemented within the district.

The framework supplied appeared to be well considered, and it was consistent with other clinical governance frameworks that the Director has seen and used. The Director does not yet know how well the framework is achieving better service integration and clinical governance.

6.2. Inpatient management

The inspection team noted that, in the adult inpatient services, the role of manager and nursing director had been combined. While this is perhaps understandable, in that nursing plays a significant role in an inpatient setting, there are disadvantages to this approach.

First, it has the appearance of privileging one discipline over other disciplines. In an attempt to mediate this, the service had a leadership structure that incorporated other disciplines (including the role of nurse consultant). This did not totally overcome the issue.

Second, the merging of manager and nursing director roles has the potential to result in an overly large sphere of responsibility and attention – one person is simultaneously responsible for nursing leadership as well as service leadership and management overall.

This was particularly the case in the forensic mental health services. The inspection team heard that the previous nursing director had stepped back, due to the size of the role, to become a nurse consultant. Further, the role spanned two service delivery clusters (forensic mental health and intellectual disability). People interviewed described these two areas as the most challenged in terms of staffing and the management of safety within the inpatient settings. The inspection team formed the view that the role was an onerous one, with a range of responsibilities that could not be easily achieved by one full-time employee.

The inspection team also heard concerns that combination of the manager and nursing roles could lead to a conflict of interest when clinical and administrative leadership have competing interests. Managers usually provide general leadership and ensure efficient and effective service delivery (including use of resources) at an operational level. Nursing directors provide professional leadership and direction for nursing practice, and oversee matters such as nursing competencies, professional standards and ethics. Health New Zealand – Te Whatu Ora has subsequently changed these arrangements[15] (see Appendix 2).

6.3. Specialist mental health services' quality and patient safety

At Canterbury – Waitaha, specialist mental health services' quality and patient safety is the responsibility of a dedicated team made up of:

- patient safety officers
- informatics
- quality coordinators
- accountability and document control
- a customer servicers officer.

[15] In early 2024, the Forensic Mental Health Nursing Director role became vacant and was returned to a Service Manager role; the Nurse Consultant role continued to be the professional lead for the nursing discipline.

This team appeared to have a wide brief that covered all aspects of quality assurance, risk management and mitigation; consumer safety; and continuous quality improvement and innovation. The inspection team heard that the team was in the process of developing infrastructure governing quality and patient safety. It was also developing a framework to ensure the division and services had a robust learning system and that findings from adverse events could be implemented across the division.

The inspection team received documents indicating that serious adverse events were reported and escalated to the serious event review team (a governance forum). There was evidence of a robust process of incident triage and review escalation pathways. The inspection team received full documentation of the process, which included guides to assist services and staff with the reporting procedure.

The Director of Mental Health has, as part of his role outside of this inspection, received several reports from the incident review process and considers them robust. As noted above, Canterbury – Waitaha were in the process of trialling how to share learning across the division. It was not clear to the inspection team how the service would decide whether an independent or external process was needed to review a major event to provide public assurance.

The lack of clarity as to the process for commissioning an external review of a serious incident became evident after the serious event that occurred leading up to the inspection. Ultimately, the Chief Executive of Health New Zealand – Te Whatu Ora made the decision to undertake an independent review after prompting by the Ministry of Health – Manatū Hauora.

6.4. Health informatics

The inspection team received a detailed overview of how the division used data. Canterbury – Waitaha appeared to have a data-rich environment and the ability to undertake various analyses of that data.

Specialist mental health services in Canterbury – Waitaha gather and analyse a range of data. The General Manager at the time of the inspection came from a health promotion background and had a particular strength in epidemiology. During the inspection, service representatives talked about using Microsoft's Power BI software[16] to generate reports. However, leadership groups and staff interviewed by the inspection team were unclear on how the services used this data to influence quality improvement. While there was some evidence of data being used, particularly for rostering and the movement of patients from admission to discharge, this use did not seem to be systematic.

It appeared that the staff in the health informatics and service quality improvement area were not well connected to other parts of the service. There was no strong evidence that service quality improvement was being driven from the staff delivering services. The sense was of a top-down pushing of data and analysis, as opposed to information flowing in both directions. It seemed the specialist mental health service executive team was able to provide data-rich descriptions of how their service was functioning but had no sense of how to use the data to optimise service delivery or to address crucial resource shortages.

[16] Microsoft's Power BI is interactive data visualisation software to assist with the analysis of data.

6.5. Escalation and consultation pathways

The inspection team received documentation setting out escalation pathways for issues, incidents and decisions. The division (and the district) had developed a daily process for addressing staff shortages and the impacts of COVID-19. Despite these pathways and that process, interviewees repeatedly said that decision-making processes and responses were unclear.

Clinicians reported that there were mechanisms to record concerns about some aspects of service delivery being suboptimal. However, they reported, these mechanisms were not always able to adequately address their concerns.

The inspection team heard of several examples of front-line or lower-level management teams raising particular matters with upper management. It became clear that while upper management heard the issues, there was no process to enable the staff who had made the suggestions to understand what decision had been taken and why.

Several clinicians said that managers occasionally made decisions about changes to service delivery without transparency or apparent consultation with those affected.

Staff raised a concern to the inspection team about a shortage of beds in the acute forensic mental health inpatient unit. It appeared the forensic mental health service clinicians had been asked to address this problem without being given the mandate or delegated authority to do so. Some felt that a decision on 'capped beds'[17] had been imposed on them, rather than being decided in collaboration.

Some clinicians felt that the whole specialist mental health service was under significant pressure, and that, in response to this pressure, individual teams had become rather insular and territorial, protecting their own area of work rather than seeing themselves as part of a whole system of care.

Some staff perceived that, historically, senior management roles in the specialist mental health services were something of a 'closed shop', with like-minded colleagues promoting each other.

There appeared to be a disconnect between clinicians working on the wards and their executive leaders. This created a situation in which some clinicians felt the need to take extraordinary measures to address concerns about service delivery.

6.6. Facilities

The inspection found that many of the inpatient mental health facilities were badly designed and in a poor state of repair. Aspects of the physical layout of the general adult inpatient facility created unsafe situations. For example, poor facility design compromised the safety of staff and tāngata whaiora when tāngata whaiora were escorted from open ward areas to low stimulus/de-escalation areas.

The adult inpatient and forensic facilities were the subject of a 2021 Ministry of Health – Manatū Hauora infrastructure fitness-for-purpose review that recognised that they needed

[17] 'Capped beds' is an informal term meaning a limit has been placed on the number of beds able to be occupied, usually lower than the physical number of beds available, for reasons such as safe staffing requirements.

to be replaced. The Canterbury – Waitaha district developed a site master plan for this purpose and has since commenced business cases for their replacement.

In the interim, it was clear that urgent remedial work to the buildings was necessary to support ongoing clinical service delivery. At the time of the inspection, the replacement buildings for the Seager Clinic, which offers long-term inpatient rehabilitation services, were well under construction.

6.7. Staffing

The most significant and prevailing issue discussed with the inspection team concerned staffing in the clinical areas – especially the adult inpatient, community and forensic services.

The divisional leadership team had significant concerns about the number of staff vacancies and the relatively junior nature of the clinical staff in some areas. Some of these issues pre-dated COVID-19, but the pandemic and measures to control it had a significant negative impact on overall staffing levels. It appeared to the inspection team that the need to minimise the impact of this staff shortage had become a significant focus for the divisional leadership team, to the cost of other areas requiring that team's attention. Further, the issue had resulted in a narrowing of focus onto short-term needs.

The magnitude of the issue is best illustrated by the following graphs, which were provided to the inspection team.

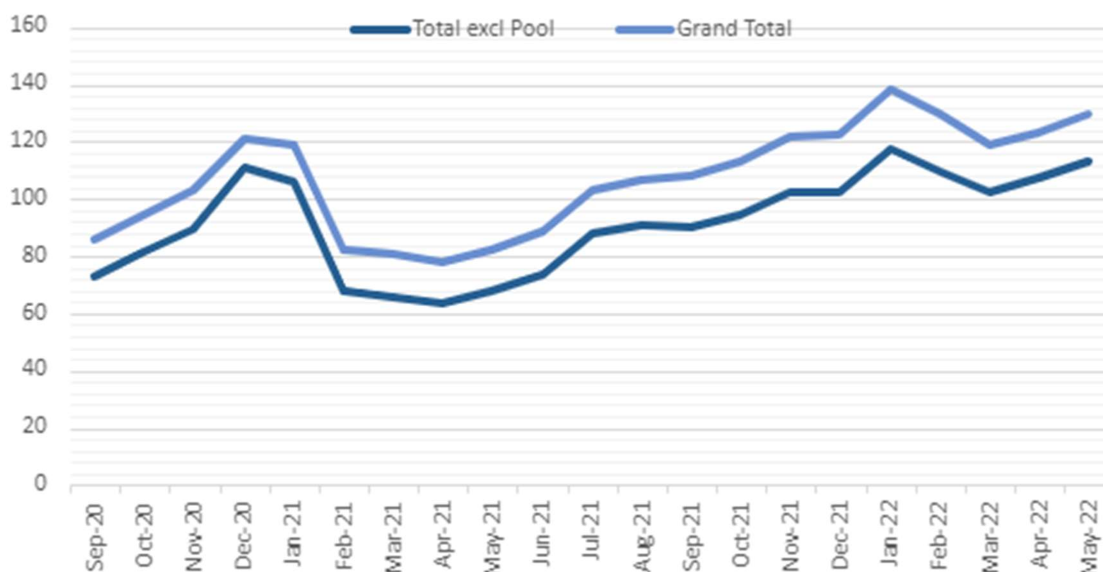


Figure 1: Indicative vacancy across staff groups, 2020–22

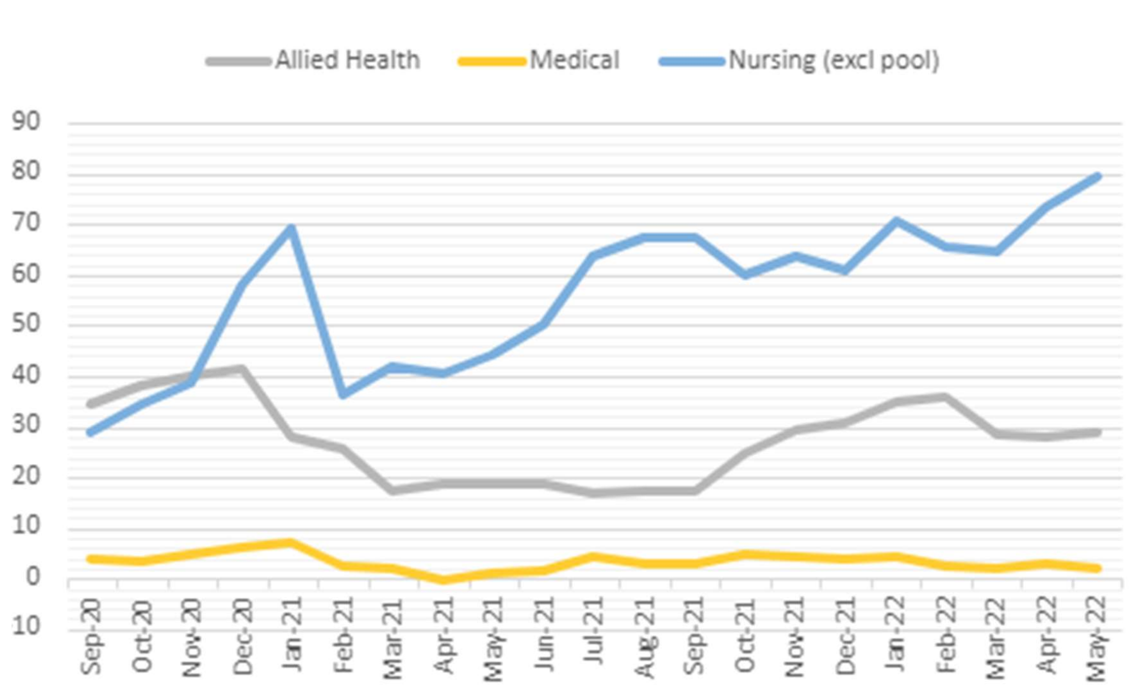


Figure 2: Indicative vacancy by major discipline, 2020–22

The divisional leadership team's concerns regarding vacancies were echoed at all levels in the organisation. Critical shortages of staff in many areas of the service existed, particularly in inpatient units. Clinicians frequently used the phrase 'on numbers', referring to being deployed to an inpatient unit to bring up the numbers of staff on a roster to a perceived safe capacity.

The inspection team heard concerns that people were working overtime and double shifts, to meet the 'on numbers' expectation. While the magnitude of the issue was unclear, it was raised repeatedly by staff in interviews. Some staff stated that they no longer wished to do overtime and double shifts due to the level of personal stress and strain it caused them.

The challenge of safe staffing in inpatient units was a clear focus and stressor for those in front-line management and responsible for ward staffing. In some interviews, a palpable level of distress was evident.

The focus on safe staffing levels appeared to have resulted in a reduction of training, including mandatory training, as staff were not able to be released for these activities. This appeared to be compounding morale issues and compromised safety among staff and tāngata whaiora. It meant staff could not complete up-to-date training like Safe Practice Effective Communication (SPEC).[18]

Some staff suggested to the inspection team that the issues of staffing pressure and lack of suitably qualified clinicians were the reason for recruitment challenges.

Staffing in forensic mental health services

Staffing shortages appeared to particularly affect forensic mental health services. This was due to the difficulty in maintaining safe staffing numbers and the relatively junior nature of the staff in this area. The inspection team heard that, at times, nurses who had come from

[18] This is a national training course provided by Te Pou to support least restrictive practice initiatives for staff in caring for tāngata whaiora.

other areas in the health system and/or who were new entry to specialist practice (NESP) nurses[19] were given shift lead responsibility for mental health services. These challenges appeared to be evident across all disciplines, not just nursing.

Dysfunctional relationships between staff groups appeared to compound the difficulties. The inspection team noted this culture appeared to be affecting the functioning of multidisciplinary teams.

The clinicians seemed tired. There was a sense that many of them were no longer putting in discretionary effort, due to fatigue and burnout. Many clinicians spoke of the ‘moral injury’ they experienced by being obliged to provide suboptimal care to tāngata whaiora. Moral injury can be described as a cognitive and emotional response following events that violate a person's moral or ethical code. This can have a significant impact on staff wellbeing and their daily functioning.[20]

In general, the various groups of staff appeared to have a perspective on services and practice that was drawn from local experience. It appeared the regional focus was prioritised over national standards. Unfortunately, this appeared to result in a limited application of practice models outside this perspective and produced a rather insular view of standards, quality improvement and practice.

Interviewees expressed the view that the staffing shortages were occurring in the context of inadequate resource planning. Several groups spoke about how there had been increasing demand on the services but no apparent increase in resources. This was not confined to any one discipline. Some felt that increased demand on the workforce contributed to existing challenges of recruitment and retention.

Nursing staff

The nursing workforce is tiered, comprising nurse practitioners, registered nurses and enrolled nurses. Health care assistants support the nurses. The organisation identified that it has a ‘missing middle’ in its nursing staff workforce, referring to nurses who are competent and experienced but still have a long career in front of them. A similar challenge exists in other services nationally.

At the time of the inspection, there was a cohort of staff nearing retirement. They were experienced but appeared fatigued and were possibly experiencing burnout.

There was also a group of new graduates who were keen to acquire new skills and gain experience. These graduates spoke of having been placed in unsafe situations, in which they were expected to practise at an advanced level of autonomy and responsibility under what they perceived as inadequate supervision. For example, a newly graduated registered nurse spoke of arriving for a shift at the forensic mental health inpatient unit and being told that they would be the shift leader, a task they felt wholly unprepared for.

Some clinicians spoke of nursing staff being afraid to come to work. Several clinicians spoke about the unacceptably high rate of assaults on nursing staff by tāngata whaiora.

Some clinicians also expressed the view that the current shortage of registered nurses working in specialist mental health services in Canterbury – Waitaha had been predicted at

[19] These nurses are typically new nursing graduates or new to working in mental health and addiction.
[20] V Williamson, D Murphy, A Phelps, et al. 2021. Moral injury: the effect on mental health and implications for treatment. *The Lancet Psychiatry* 8(6): 453–5.

least five years ago, and that proactive strategies had not put in place at that point to circumvent this shortage.

Staff reports of experiencing the clinical environment as unsafe were particularly prevalent in forensic services. There, staff described how a number of senior staff had recently left, particularly from the acute medium secure unit. This had left both a gap in staff numbers and a gap in expertise. Some staff appeared to be distressed by and angry at the situation; particularly those working in the acute medium secure forensic ward.

Charge nurse managers and clinical nurse specialists spoke of having to work on the wards because of roster gaps, at the expense of their managerial and clinical leadership responsibilities. The focus on safe staffing numbers was occurring, in their view, at the detriment of clinical practice and the service's ability to meet the needs of tāngata whaiora.

Allied health staff

Several allied health staff spoke of feeling disenfranchised. Some stated they felt 'bullied' by medical and nursing staff. It was their opinion that medical and nursing opinions were dominant within Canterbury – Waitaha mental health services, and that the organisation had not adequately embraced a recovery model of care.

Allied health workers felt their specific skills were not always valued. This was compounded by the need for them to be 'on numbers' in the inpatient settings, where they were focused on ensuring safe environments, meaning they felt they did not have space to use their professional therapeutic skills.

Allied health staff reported that the organisation did not value their leadership skills. They pointed to the comparative lack, in their perception, of allied health leadership positions. They also spoke about not being able to use their specific skills due to the need to engage in generic case management.

These concerns were not universal. Some allied health staff described well-functioning multidisciplinary teams.

Senior medical staff

The primary mechanism by which senior medical staff were involved in clinical governance appeared to be via appointment to formally defined clinical leadership roles. There was a 'chain of command' from senior medical officers through clinical leaders to the Medical Director and, ultimately, to the Chief Medical Officer.

There did not seem to be a strong investment in the notion that all senior medical staff had an important role to play in clinical governance.

Mention was made of a small number of senior medical leaders who had left Canterbury – Waitaha's specialist mental health services in recent years. There was a sense that these departures had left something of a leadership vacuum.

Some senior medical officers expressed concern about the adequacy of the process for medical staff development, from the recruitment and training of registrars to the mentoring of junior psychiatrists, and the meaningful involvement of senior medical staff in clinical governance. Senior medical staff were almost unanimous in concerns about high workloads and the lack of non-clinical time for professional development and supervision.

Some interviewees raised concerns regarding the recruitment and retention of senior medical officers in the specialist forensic mental health service. Documents demonstrated this concern had been ongoing since approximately 2018. There was a view that senior medical officers' opinions were not heard or listened to, despite the expectation they would carry responsibility for tāngata whaiora, particularly in terms of risks.

Staff training and development

The inspection team heard from staff at multiple levels that there had been a reduction in the training and development of staff, including cancellations of training, especially since the COVID-19 pandemic. Other health districts report similarly. This appeared to have two causes: first, there were fewer training opportunities (including for essential and mandatory training) and second, due to staffing pressures it was difficult to release staff to attend training. This appeared to have a negative impact on morale.

Staff also spoke about the lack of, or a reduction in, clinical supervision. Again, this appeared to be in response to the intense focus on ensuring minimum staffing levels and an inability to make time to release staff for this.

6.8. Acute and forensic inpatients

The service has routinely capped inpatient beds numbers to ensure minimum staffing levels. The service has 193 beds, but the number of beds in use or available at the time of the inspection was 178.

Table 1: Number of beds per inpatient service in 2022

Inpatient service	Funded beds	Capped beds
Adult acute	64	62
Extended care	39	33
Forensic mental health	37	34
Forensic intellectual disability	4	4
Psychiatric services for adults with an intellectual disability	14	10
Medical detox	6	6
C Ward – Mothers and babies	13	13
Child, adolescent and family	16	16
Total	**193**	**178**

This response is understandable in view of the need to maintain minimum safe staffing levels, but it has brought challenges. The inspection team heard there were occasions when tāngata whaiora needed to be managed overnight in a unit or service different to the ward they were initially admitted to. This placed further strain on already reduced staffing numbers.

Staff also reported there was general pressure for early discharge or delayed admission. Community staff raised concerns regarding the perceived risks they were holding and

managing as a result. Some expressed concern that this was resulting in suboptimal care for tāngata whaiora.

As in many other services across the country, there were tāngata whaiora in the acute inpatient wards who no longer had acute needs, but no other suitable placements were available for them. The services were working on solutions to this, including the appointment of a Transitions Coordinator whose focus was on enabling appropriate discharge pathways. The inspection team heard about some early successes in this area.

Again, similarly to other services around the country, a recurrent theme was a challenge in managing patient flow. For example, an inability to find appropriate housing for tāngata whaiora leads to pressure on beds. The service noted the overall lack of housing in Christchurch, a downstream effect of the Canterbury earthquakes. This contributed to a lack of suitable accommodation for tāngata whaiora, which in turn resulted in a significant number of long-stay[21] tāngata whaiora who could not be discharged from hospital because suitable accommodation could not be found for them.

The forensic service drew attention to two additional issues arising from the bed number caps, as follows:

1. The limited number of beds resulted in delays in admitting people from prison who needed urgent care. Clinicians felt they had to make admission decisions based on the availability of beds, rather than offering access to treatment based on need. Further, prisoners were often significantly unwell, or their mental state had further deteriorated due to the wait for admission.
2. It was sometimes the case that people with serious mental illness who had not entered treatment through the justice system fell out of care or were unable to be admitted. This appeared to be related to the lack of stable accommodation, follow-up difficulties due to a mixture of avoidance and service issues and the practice of early discharges to make space for tāngata whaiora with more urgent needs.

These issues were not unique to Canterbury – Waitaha but placed an additional stress on clinicians.

6.9. Forensic mental health services

The greatest challenges applied to the forensic mental health services. Staff raised the point that safe staffing was essential, particularly in terms of relational security[22] management in the inpatient environment. As previously outlined, low staff numbers were of concern for all groups of staff. In addition, there was concern that the staff lacked experience, and this contributed to concerns about safety.

Front-line staff expressed significant concern about their safety and their ability to provide a service. In one meeting, staff expressed anger about the risks they felt they were exposed to.

[21] The term 'long-stay' describes tāngata whaiora who, due to a lack of appropriate community placements, have stayed in the inpatient service longer than clinically necessary.

[22] The term 'relational security' represents a way of thinking about resources and quality of care, including staff-to-patient ratios, the quality of therapeutic relationships and the availability of treatment programmes. See H Kennedy. 2002. Therapeutic uses of security: Mapping forensic mental health services by stratifying risk. *Advances in Psychiatric Treatment* 8(6): 433–43.

The inspection team heard there was a particular difficulty in the acute medium-secure unit. Apparently, a significant number of senior staff had retired or left that unit, affecting both staff numbers and experience levels. There was a reliance on relatively junior staff: 50% of the staff in the unit had less than three years' experience working in health services. There were significant difficulties in recruiting, and the majority of recruits were new entry to specialist practice (NESP) mental health and addiction nurses.

The extended care and unlocked rehabilitation unit appeared to have more stable staffing.

The service had taken steps to address the concerns, including through the use of security staff, increasing the number of health care assistants and bringing more front-line clinical leadership to support the more junior staff.

Forensic mental health business cases

On numerous occasions, the forensic mental health clinical governance team had raised concerns to senior management about shortages of staff in the forensic mental health service and the poor state of the forensic inpatient units.

The forensic mental health clinical governance team pointed out that nursing staff rosters for the forensic mental health inpatient units were based on older models of care, when forensic mental health nursing practice was based on a relatively restrictive model of care. Newer models of nursing care have recommended higher staff-to-patient ratios in these services.

In addition, the service reports that its local prison population has increased by approximately 35% in the last decade. This has created an increased need for forensic mental health service intervention, including a larger number of secure inpatient beds.

The forensic mental health clinical governance team had, on several occasions, escalated their concerns regarding the number of mentally unwell prisoners within their district who were waitlisted for inpatient assessment and treatment.

Actions undertaken in the forensic mental health service during the inspection

The forensic mental health service reviewed its staffing and service provision and took actions including the following:

- ensuring that full on-the-ground clinical leadership consists of the charge nurse, clinical nurse specialist and three associate charge nurses covering morning and afternoon shifts. One of the functions of the clinical nurse specialists and associate charge nurses is to support and develop junior staff
- ensuring that one of the functions of the clinical nurse specialists and associate charge nurses is to support and develop junior staff, including newly graduated NESP registered nurses
- supporting general nursing staff and allied staff to move into the service
- appointing a nurse educator
- seeking to diversify the workforce by increasing enrolled nurses and peer support roles
- reviewing existing leadership positions for Māori

- ensuring lessons from service delivery are discussed broadly across the service
- engaging an external senior forensic psychiatrist to provide the acting Clinical Director with supervision and support.

Despite these steps, challenges continue. In February 2023, the only accredited member of the Faculty of Forensic Psychiatry resigned. This challenges maintenance of the forensic psychiatry training programme.

In March 2025, the Director received further updates regarding improvements made in and ahead for the forensic mental health service. These are set out in Appendix 2.

6.10. Organisational culture

The inspection team heard there was a tendency in the services to blame individuals. Interviewees used the term 'a culture of blame' and described situations where bullying had occurred and staff had been prevented from escalating issues due to a fear of repercussions.

However, in some areas staff talked about being able to trust each other and being able to depend on their colleagues.

6.11. Tāngata whaiora and tāngata whenua

The kaimahi who provided a tāngata whenua cultural perspective on mental health care seemed to sit to the side of the specialist mental health services, rather than working in a true partnership with those services. It seemed that services were not consistently and adequately addressing the cultural needs of tāngata whaiora who are tāngata whenua. This was of particular concern in forensic mental health settings, in which many tāngata whaiora are tāngata whenua.

Substance use by tāngata whaiora

Many clinicians noted that the wide availability of methamphetamine over the past decade had increased the severity of psychotic presentations to mental health services. This had resulted in significantly increased levels of violence by tāngata whaiora against staff.

Impact on tāngata whaiora using the service

The staff appeared dedicated to providing the best care they were able to, given staffing and other resourcing constraints. However, multiple sources told the inspection team that care was compromised in multiple ways:

- Due to staffing limitations, not all interventions were available to tāngata whaiora. For example, some missed out on psychological interventions that otherwise would have been part of their recovery plan.
- Effective multidisciplinary care was limited, which often led to a nursing and medically focused intervention.
- There was increased pressure for early discharge of tāngata whaiora due to the need to admit other people with high need. This appeared to compromise care on discharge and caused challenges in post-discharge follow-up.
- In some cases, people required readmission following discharge, or, where they were not readmitted, their mental state and care deteriorated in the community.

- Sometimes, staffing and bed capacity issues meant admission was delayed for people who required care.

These observations are similar to those the Director has heard from other services around the country. However, staff in Canterbury – Waitaha were particularly stressed.

6.12. Lived experience[23]

There were some lived experience and family/whānau advisors working in the service at the time of the inspection, but there were also several vacancies. The most significant vacancy was that of the Director of Lived Experience & Family/Whānau; which had not been filled at the time of the on-the-ground inspection.

Inpatient services were under pressure prior to the COVID-19 pandemic due to factors including the earthquakes and the terrorist attack of 15 March 2019. The pandemic greatly exacerbated those pressures, resulting in a system-oriented set of responses that were at odds with a model of care focused on tāngata whaiora and whānau.

The inspection team observed a lack of support for the inclusion of lived experience practice in many levels in the organisation. The lived experience and family/whānau teams were not being used to their full potential. Their representation on working groups was lacking due to unfilled vacancies or lack of prioritisation of their membership. The long delay in appointing the Director of Lived Experience did not help. In March 2025, the Director was informed this delay was due to an inability to gain funding approval for the role.

Lived experience staff spoke of having previously been involved in post-event seclusion and restraint reviews and said that their participation in these meetings had ceased. They spoke of an inability to access quality and safety processes.

The inspection team did not find evidence of effective engagement with lived experience teams in the context of service changes and options to address service pressures.

If lived experience perspectives had been more appropriately engaged, prioritisation of an approach centring tāngata whaiora and whānau could have occurred. This would have driven organisational responses to the pressures that the system was experiencing.

The chaplaincy team's pastoral support provided an adjunct support service to lived experience expertise. There appeared to be a lack of awareness and recognition in the service of how the chaplaincy team could support tāngata whaiora; for example, when the lived experience team is under-resourced.

The inspection team was concerned that care, treatment and support was compromised because of the lack of a dedicated commitment to the use of lived experience teams at all levels. The service was limiting the ability of these roles to deliver service and governance benefits.

6.13. Te ao Māori perspective

The inspection included a process to identify systemic or service issues from a Māori perspective, particularly in relation to the operation, clinical governance and functioning of

[23] Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 defines 'lived experience' as 'expertise, skills, and knowledge gained through direct, first-hand receipt of care or support services'.

Māori mental health services at Canterbury – Waitaha. The Māori member of the inspection team led this process.

The starting point for this process was a document supplied by the service titled *Purpose and Strategy of Specialist Mental Health Services in Waitaha*. This document included the following graphic.

Figure 3: Strategic pillars for specialist mental health services at Canterbury – Waitaha

6.14. Te Tiriti o Waitangi

The team used Te Tiriti o Waitangi as a benchmark to guide its observations. The Māori inspection team member provided the following interpretation of the preamble and articles of Te Tiriti o Waitangi and how these might be expressed in the context of mental health services.

1. **Whakawhanaungatanga (relationships):** We intentionally build rapport, make connections by sharing aspects of our own background and culture, and spend time getting to know tāngata whai i te ora and whānau, Māori providers, hapū and iwi, so our relationships are respectful, long-lasting and of mutual benefit. Our energy is focused on building trusting relationships with whānau of all tāngata whai i te ora in our service.
2. **Kāwanatanga (governance):** We prioritise the realisation of Māori (including Māori with lived experience) as partners in all decision-making across the directorate, to drive the work needed to eliminate Māori health inequities. Our energy is focused on ensuring our decisions and actions honour the worldviews of both partners.

3. **Tino rangatiratanga (self-determination):** We encourage and support meaningful Māori representation and participation at all levels of the directorate, so that our services are shaped by Māori philosophies, values and practices, including tikanga Māori. Our energy is focused on affirming the collective strength of kaimahi Māori to enable Māori voices to be heard more clearly.
4. **Ōritetanga (equity):** We recognise the irrefutable evidence of Māori health inequity and acknowledge the ongoing impacts of colonisation, racism and social determinants of health are major contributing factors to inequitable health outcomes for Māori. Our energy is focused on resourcing mana-enhancing or strength-based approaches to address institutional racism and biases that obstruct Māori health equity.
5. **Wairuatanga (spirituality):** We acknowledge that Māori identity and wellbeing are strengthened by connections with the past, present and future; especially connections to tupuna and the natural environment. Our energy is focused on providing cultural clinical models of care in environments that are spiritually welcoming, affirming and safe.

6.15. Observations from the inspection

Four key facts were apparent from the wide-ranging correspondence and interview material the inspection team gathered:

1. Te Korowai Atawhai Māori Mental Health Services is situated on the ancestral lands of Ngāi Tūāhuriri, yet Canterbury – Waitaha did very little to acknowledge mana whenua or the relationship between mana whenua and Te Korowai Atawhai in the delivery of their services. Developing and maintaining respectful and long-lasting relationships with mana whenua and tāngata whenua is an essential component of honouring Te Tiriti o Waitangi.
2. The philosophy of Te Korowai Atawhai is whanaungatanga: 'a concept which not only acknowledges that their work is not done in isolation but as a member of a whānau. Whanaungatanga also acknowledges the importance of tāngata whaiora being members of a whānau.'[24] While Te Korowai Atawhai practised whanaungatanga within its service, it was evident that the service operated in isolation from the whānau of Canterbury – Waitaha. Te Korowai Atawhai was not part of the organisational structure of mental health services, and there were no mechanisms in place to support the operation, clinical governance and functioning of the service.
3. Interviewees told the inspection team that the service, clinicians, allied health roles and nursing roles were all under-resourced and undermined, and that management underutilised and undervalued their skills. The relationships between kaimahi Māori and management in Te Korowai Atawhai were strained. Kaimahi described the environment in which they worked as culturally unsafe and in breach of Te Tiriti o Waitangi. They said there was no access to the community that would have allowed kaimahi to whanaunga and feel valued in their roles while working in a very unsafe place.

[24] Te Whatu Ora Waitaha Canterbury. (nd). Specialist Mental Health Services. URL: www.cdhbcareers.co.nz/Clinical/Our-Specialist-Services/Specialist-Mental-Health-Services (accessed 18 March 2025).

4. In the conversations the inspection team had with staff across services, there were no explicit care pathways for Māori.

6.16. Operational and clinical governance within Health New Zealand – Te Whatu Ora

The inspection team had significant concerns regarding the functioning of operational and clinical governance within the service. There was also little clarity as to how regional governance connected effectively to service governance. These challenges appeared to have been evident in the previous DHB structure. This was concerning in two ways:

- issues in governance culture had been carried forth, creating a pattern of disconnect affecting service quality across a lengthy period.
- governance processes are essential to the oversight of services and to ensuring quality of care for vulnerable people. Higher-level governance should respond to resourcing and other issues that are unable to be resolved at the individual service level.

The Director acknowledges that the setting up of Health New Zealand – Te Whatu Ora, a large and complex new organisational entity, brought with it a level of uncertainty about governance structures. However, there were long delays in providing information on the district-wide clinical governance framework that had an impact well after the structure of Te Whatu Ora had been finalised. This emphasised to the Director that the issue with governance structures was an ongoing and systemic problem.

When organisations transition from one structure to another, it is important they undertake due diligence to map existing governance structures to proposed structures so all necessary processes are maintained or new ones introduced. This is particularly important under interim governance arrangements that may become permanent.

The Director relies heavily on robust governance structures for assurance that services are functioning effectively and can deliver care that is safe and culturally appropriate and that meets the needs of the people receiving it. This care must uphold people's human rights to the maximum extent. This is especially the case where the care is imposed on people via the Mental Health Act.

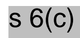
The Director expects that services will rapidly review and learn from any incident that might occur, and that critical matters will be monitored and escalated up to district governance. The Director expects district governance to provide timely and well-communicated response to risks and issues escalated. This may include executive management intervention to improve resources (people, physical and operational policies) to address service culture issues and/or to lead change management processes.

At the service level, the lack of a clearly articulated clinical governance framework resulted in uncertainty on the Director's part as to whether the service was taking the right actions and supporting and enabling staff to do their job.

The lack of a clear, well-articulated and functioning governance framework above the service level until March 2024 is concerning. It indicates obstacles to putting one in place and, hence, barriers to effective implementation. An outline of proposed regional-level governance reform was provided to the Director in March 2025. While it contains promising aspiration, it is at the early stage. Its implementation will require strengthened oversight

across governance tiers to ensure information and decisions flow in a clear and timely way to improve service outcomes. The combination of these factors is likely to result in the Director adopting a more intensive regulatory intervention regimen.

6.17. Independent review report [subject to non-publication order – redact from public version until Coroner lifts the order]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Appendix 1: Terms of Reference

Purpose

The purpose of this review is for the Director of Mental Health (the Director) to inspect the adult inpatient and associated mental health services provided by Te Whatu Ora – Health New Zealand Waitaha Canterbury (Waitaha Canterbury), pursuant to section 99 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act), to examine how these services are functioning.

This will enable the Director to determine whether there are any systemic or service issues, and if there are none, to assure the public on how the services are being run. If issues are found, then recommendations will be made on how to address those issues. This inspection is not about identifying any individual staff issues – it is about scrutinising the functioning and resilience of this forensic mental health service.

Background

A serious incident occurred on Saturday 25 June 2022 in Christchurch where a patient subject to the Mental Health (Compulsory Assessment and Treatment) Act 1992, referred to hereafter as the Act, while on leave from forensic inpatient services at Hillmorton Hospital, allegedly[25] fatally stabbed a woman not known to him. This incident occurred in the context of concerns being raised around the safety and care being offered by these services.

Review

Reviewer and scope

The Director will be conducting the inspection in accordance with section 99 of the Act, with the help of a small team to ensure there is a comprehensive examination of not only the operational and clinical governance and functioning of the adult inpatient and associated mental health services but also how that operational and clinical governance is overseen by wider organisational processes.

Process

The review will involve data analysis, interviews with relevant people and a clinical file review. All care will be taken to minimise the effects of this review on the clinical staff involved; however, it will be important to meet with clinical staff as part of this review.

It should be noted that the care of the patient involved in the critical incident on 25 June 2022 is now the subject of a full and independent review. The review is being led by Te Whatu Ora (Health NZ) officials who are independent of the service. Thus, while there will be some overlap, this inspection is not a review into that individual's care.

Timing

A preliminary scoping inspection of these forensic mental health service will be held on 6 and 7 July 2022. This will determine the nature and scope of the full inspection.

[25] After these terms of reference were issued in July 2022, the alleged perpetrator pled guilty to murder. The word 'allegedly' remains here, as it was accurate at the time of release of the terms of reference.

Report

A report of the full inspection will be published on the Ministry of Health's website at the completion of this work. In the interests of supporting open disclosure of information, no details of individual interviews or information identifying individuals will be published. Participants can be assured that what they say will be in confidence, but the issues will be summarised in the final report.

Appendix 2: Summary of post-inspection improvements

The Director of Mental Health provided the Canterbury – Waitaha mental health service, and regional Deputy Chief Executive of Health New Zealand – Te Whatu Ora with an opportunity to review this report prior to publication. This provided a natural justice opportunity for the service to comment on service changes made following the inspection. In March 2025, the service advised the Director of Mental Health of the following improvements.

Improvements post-inspection	
Category	*Description*
Staffing	In direct response to inspection concerns regarding staffing levels and experience in the forensic mental health service, additional front-line clinical leadership, coaching and education was put into place. This included ensuring an Associate Charge Nurse Manager role was rostered seven days a week to both morning and afternoon shifts. Nurse Coach and then Nurse Educator roles were put into place in the forensic mental health service to ensure in-situ guidance, learning and leadership are available within this specialist area. Practice transition pathways have been put into place, enabling internationally qualified nurses and general nurses to transition into mental health nursing. Eight internationally qualified nurses have been supported through this pathway. A tuakana-teina model has been introduced by Ngā Toka o Te Aratika (the local Māori Nursing and Allied Health Rōpu). This model connects Māori nursing students to experienced Māori nurses to proactively improvement their training experience in the service. The Rōpu has an active programme to support and develop the Māori workforce, with the programme being directly linked to the Nursing and Allied Health Directorates. The allied health workforce has benefitted from the skills of a Pharmacy Prescriber, responding to requests for medication review and providing support to GPs. An Expert Occupational Therapist has been appointed into the intellectual disability service and the service has trialled a Speech and Language Therapist. With additional funding the service has recruited the first Peer Support Worker in the eating disorder service, and Canterbury – Waitaha is part of the first cohort of services to trial the implementation of the government-led Peers in Eating Disorders initiative. Canterbury – Waitaha continues to partner with NGO providers to embed Peer Support Workers in the forensic mental health service and the adult community service.
Staff training and orientation	The service acknowledged risk assessment and knowledge within the forensic mental health service had been impacted, with only a small number of experienced/trained clinicians within the service. Following the inspection, training in dynamic appraisal of situation aggression and relational security management recommenced. The forensic senior leadership team also supported a Clinical Psychologist to complete Historical Clinical Risk Management-20 (violence risk assessment) training, enabling the service to run this training in-house. This training is now provided to all staff. Orientation training for staff has been strengthened to include relational security, mandatory templates and case management expectations.
Relational security management	In addition to the increased training outlined above, the template for relational security management was reviewed immediately following the serious incident that led to the death of a member of the public. This review was led jointly by the clinical leadership team and members of the service leadership team. The review found the original template had been diluted over time. The template has been strengthened and now

Improvements post-inspection	
Category	*Description*
	operates electronically through the patient medical record system to prevent it from being altered.
Case manager roles and responsibilities	The forensic mental health service has developed a summary for Case Manager roles and responsibilities, to strengthen expectations. Audits are completed three to six monthly with results reported to Case Managers and followed up by the Clinical Nurse Specialist.
Clinical reviews in the forensic mental health service	Clinical Management Guidelines were updated in September 2022 with specific recommendations in relation to leave. Team-based clinical reviews are carried out so attendees can jointly discuss documents and relational security management plans.
Leave processes in the forensic mental health service	Prior to the adverse event that led to the death of a member of the public, the forensic mental health service had two leave processes for consumers: one for people with the legal status of special patient, and one for all other consumers. These processes have been consolidated into one protocol, recognising that all consumers taking leave are residing in the medium secure unit. All leave documents are filed in a central folder to ensure 'one source of truth' and sign-out and pre- and post-leave review processes have been strengthened.
Separation of Service Manager and Nursing Director roles	Each discipline within the service retains a professional lead to ensure all professions are represented on the service leadership team. In early 2024, the forensic mental health service Nursing Director role became vacant and was returned to a Service Manager role; the Nurse Consultant role continued to be the professional lead for the nursing discipline.
Capacity and bed closures	The service has increased bed availability and adjusted models of care to strengthen service capacity. Some bed-capping issues have been resolved through work to address staffing shortages, and some will be resolved through the planned facility upgrades outlined in the table below.
Te ao Māori perspective	The service has made efforts to recognise mana whenua and has developed a cultural narrative in partnership with Ngai Tahu.
Service culture	The service has accessed the following district-level training modules to encourage a learning-focused service environment: Active Bystander and Building High Performance Teams. Almost all areas have now hosted the Active Bystander workshops addressing above- and below-line behaviours. Most teams have then developed charters to prescribe how they work together. These are role-modelled by the leadership team and the nursing and allied health directorates. Teams have also started engaging with the High Performing Teams workshops. As part of overall strategy work that commenced in 2021, a service kaupapa has been developed outlining the values and beliefs, and types of collaboration, that underpin the expected standard of service. While the strategy has been well socialised, further work is needed to fully embed it.

Improvements planned	
Category	*Description*
Governance	The Service Leadership Team believes structures do exist to support local operational and clinical governance, escalation and consultation. However, the service acknowledges these are unclear or not supporting feedback and information closure loops. The service leadership team commits to ensuring these structures are fit for purpose and well socialised to staff.
Staffing	Challenges persist with Senior Medical Officer vacancies in the adult service and forensic mental health service. In the adult service, three senior registrars have recently completed their training and are joining on permanent contracts, and a number who were on locum contracts are looking to return to the service on permanent contracts. The international recruitment pipeline is growing, and fixed-term and permanent overseas-trained psychiatrists have been appointed. The service has also recruited a forensic-trained psychiatrist, which will enable the service to explore registrar runs and an advanced trainee programme. The service is committed to developing alternative workforce and advanced practitioner pathways. The adult service has a highly experienced locum Nurse Practitioner. The forensic mental health service has the first Nurse Practitioner in this specialist space and another Nurse Practitioner has completed training within the child and youth service. The nursing directorate is actively working to support further nurses through this pathway, with potential for further routes into non-medical Responsible Clinician roles.
Te ao Māori integration	The service acknowledges the gap in cultural leadership at the district and divisional level in the governance of the function or ‘cloak’ that is Te Korowai Atawhai. The gap exists following the move of the Executive Director Māori and Pacific Health out of the role at the district level and the retirement of the Pou Whirinaki and Kaiārahi Whaea. Te Korowai Atawhai is a function that culturally guides the service’s Pūkenga Atawhai (team of Māori Mental Health Workers). Pūkenga Atawhai are situated in each service area to ensure cultural safety. However, a direction forward is under development for a reset of cultural leadership at the divisional level and for renewed cultural education. The service and regional leadership also remain committed to building a leadership pathway for Pūkenga Atawhai.
Lived experience integration	The service acknowledges the impact ongoing vacancies have had on the Lived Experience and Family-Whānau Advisor Team, including at the Director level. A new Director was appointed in January 2025 and plans to fill the advisory vacancies within the team. The Director and team will actively discuss with the wider service where the lived experience voice is not being utilised and/or needs to be strengthened. Within the next 12 months, the Director intends to transition the service environment to one in which the lived experience team is a non-negotiable input in every area of the care continuum. To support this, there will be mandatory training for staff, comprehensive induction for new staff and role-modelling of cross-disciplinary practice by senior service staff. The Director of Lived Experience foresees different roles developing within the lived experience team, including advisors and peer support educators to help mitigate recurring themes and embed best practice.

Improvements planned	
Category	*Description*
Facility challenges	Facility development remains challenging, impacted by New Zealand's broader fiscal environment. Work is progressing with the completion and opening of fit-for-purpose facilities for adult inpatient, and also outpatient and inpatient child and youth, maternal mental health and eating disorder services. This programme of work also includes a refresh and reopening of the adult inpatient and medical detox area and Building 3b to provide temporary support to the psychiatric services for adults with an intellectual disability inpatient unit. Demolition of Buildings 5 and 6 is pending and will enable the build of the new adult acute facility. In-principle funding has been approved for a new high care area within the forensic mental health unit – Te Whare Mannaaki. This work is now being commissioned within a national programme of works. Forensic mental health inpatient units have been identified for improvement, with works dependent upon the outcome of the National Investment and Infrastructure Review.