Tōpūtanga Tapuhi Kaitiaki o Aotearoa
NEW ZEALAND NURSES ORGANISATION

NZNO Nursing Survey Report: Hillmorton Hospital Mental Health Services

May 2026

> *There have been countless shifts where unsafe staffing has meant essential care simply does not happen. It is not a one-off incident. It feels like every shift. We are constantly stretched between mandatory observations, crisis responses, and documentation, leaving no capacity for meaningful therapeutic work.*
>
> *The role becomes risk management rather than nursing. Patients receive the minimum required to maintain immediate safety, but they miss out on thorough assessment, emotional support, physical health care, and preventative interventions. Care becomes reactive and containment focused.*
>
> *Repeated exposure to this environment is exhausting and demoralising. It creates moral injury because we are consistently forced to work below acceptable standards, knowing our patients deserve far more than basic containment.*
>
> (Registered Nurse, Te Awakura West Inpatients, Hillmorton Hospital)

Hillmorton Hospital and associated mental health services provide a comprehensive range of services from emergency mental health, community mental health and adult inpatient services, including forensic mental health. A Section 99[1] inspection into Canterbury Waitaha Inpatient and Associated Mental Health Services was conducted through 2022 following concerns over systemic issues in the delivery of mental health services. The review was triggered in part by the death of a member of the public in June 2022. Concerns with the service related to compliance with legislation and related guidelines and the ability to deliver appropriate care and treatment for tāngata whai ora under their care.

The Ministry of Health's Director of Mental Health, Dr John Crawshaw, publicly released the Section 99 Inspection into Canterbury - Waitaha Adult Inpatient and Associated Mental Health Services in August 2025.[2] The report made 18 recommendations across governance, care, and resourcing functions to improve services, supported by a 12-month monitoring programme and quarterly visits by the Director of Mental Health to understand and

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[1]Section 99 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 gives the Director of Mental Health statutory powers to conduct an independent inspection of mental health services.
[2] Ministry of Health (2025) *Section 99 Inspection into Canterbury – Waitaha Adult Inpatient and Associated Mental Health Services*.

assess progress. In November 2025, Dr Crawshaw completed a visit to Hillmorton Hospital and reported that “visible progress has been made since the report was published.”[3] The same statement was repeated in the February 2026 monitoring update. In follow up reporting, the service was commended for addressing some of the most acute staffing shortages, the hard work of staff to deliver health services, improvements in partnerships with Māori and an increased Lived Experience workforce. However, barriers to recruitment were cited as a specific area for improvement.[4]

Monitoring visits in November 2025 and February 2026 did not include engagement with frontline nursing staff or draw on their accounts of any progress or decline in the ability to safely and sustainably deliver mental health services to the region. Frontline nursing staff have reported the staffing levels and conditions at Hillmorton Hospital are worse than when the Section 99 report was released in August 2025.

Recommendation 5 of the Section 99 report calls for re-engaging and involving the workforce at all levels. This inclusion of workforce in identifying and reporting challenges to the service and providing solutions needs to be extended to the follow-up monitoring process undertaken by the Ministry of Health.

This report provides the first-hand assessment of nursing staff working in Hillmorton Hospital and associated mental health services of the continuing chronic issues with unsafe staffing, inadequate resources and equipment, moral injury, culturally unsafe care and risks to vulnerable patient populations.

Key Findings:

- Four out of five (80%) nurses surveyed felt unsafe due to understaffing on shifts worked in the last month.
- Nine out of ten (89.2%) nurses reported being recently required to work with broken or faulty equipment.
- Staff described broken heaters, peeling wallpaper, graffiti, worn carpet with stains or soaked in urine, infestations of ants, rats and mice, building leaks, broken panels in lounge areas and patient room doors getting jammed. At a higher level of severity, staff described cameras not working, security doors that do not lock or close properly, malfunctioning duress alarms, delayed alarm responses and blind spots where patients climb up walls and fences.
- Just over half (51.9%) of the workers surveyed reported that they have felt unable to raise concerns without fear of blame or retaliation. A further third, (32.4%) reported sometimes feeling unable to safely raise concerns.
- Nearly 9 out of 10 nurses (86.5%) reported negative impacts on their wellbeing from working at Hillmorton Hospital. One third reported experiencing burnout, and a further third reported feeling constant stress and anxiety.

[3] Ministry of Health (2025) Canterbury – Waitaha Mental Health Services monitoring update, 16 December: https://www.health.govt.nz/news/canterbury-waitaha-mental-health-services-monitoring-update

[4] Ministry of Health (2026) Canterbury – Waitaha Mental Health Services: 2nd monitoring update, 10 April: https://www.health.govt.nz/news/canterbury-waitaha-mental-health-services-2nd-monitoring-update

NZNO Hillmorton Hospital Nursing Survey

The survey was open for a period of 3 weeks in March 2026 (2/3/26 – 24/3/2026) for nursing and care staff employed at Hillmorton Hospital and associated mental health services. There were 186 respondents from a range of nursing roles across mental health wards and services, a response rate of one third. The largest cohort was Registered Nurses (71.9%), followed by Enrolled Nurses (16.8%) and a range of Senior Nursing roles (8.6%). Questions addressed staffing levels, equipment and facilities, moral injury, cultural safety and the opportunity to reflect on their experiences working at Hillmorton Hospital

Role	Count	Percentage
Registered Nurse (RN)	133	71.9%
Enrolled Nurse (EN)	31	16.8%
Clinical Nurse Specialist (CNS)	6	3.2%
Charge Nurse Manager	4	2.2%
Healthcare Assistant (HCA)	4	2.2%
Duty Nurse Manager	2	1.2%
Associate Charge Nurse Manager	1	0.5%
Clinical Team Coordinator	1	0.5%
Crises Team Duly Authorised Officer	1	0.5%
Nurse Coordinator	1	0.5%
Nurse Practitioner	1	0.5%
Prefer not to say	1	0.5%
Total	**186**	

Ward/Service	Count	Percentage
Adult Rural Community Psychiatric Service	1	0.54%
Alcohol and Drug Service	4	2.15%
All Hospital Site	4	2.15%
Child, Adolescents and Family	8	4.30%
Christchurch Opioid Recovery Service (CORS)	4	2.15%
Adult Community Mental Health Services	13	6.99%
Emergency Mental Health Service (EmMHS)	10	5.38%
Forensic Mental health	4	2.15%
Kennedy Centre (detoxification unit)	6	3.23%
Permanent Pool	5	2.69%
Prefer not to say	7	4.30%
PSAID (Psychiatric Services for Adults with an Intellectual Disability)	5	2.69%
Te Awakura Adult Inpatient (all wards)	52	27.96%
Te Whare Hohou Roko (medium secure inpatient rehabilitation unit)	12	6.45%
Te Whare Manaaki (medium secure inpatient admission forensics unit)	10	5.38%
Te Whare Mauri Ora (minimum secure inpatient rehabilitation unit)	6	3.23%
Te Whare Rangihau (forensic mental health community team with forensic prison team and court liaison)	4	2.15%
Training Unit	1	0.54%
Wahi Oranga (adult inpatient unit based at Hillmorton)	11	5.91%
Watch House (24hour mental health team based in Central Christchurch police station)	1	0.54%
Whaikaha Unit (forensic intellectual disability secure unit)	7	3.76%
Whāngai Aroha (mothers and babies service)	10	5.38%
Total	**186**	

Unsafe Staffing

The 2025 Section 99 report described daily issues in meeting minimum safe staffing levels in inpatient services. Critical staffing shortages in clinical areas were reported to be the "most significant and prevailing issue." Six months on from the report's publication, acute and chronic staffing issues continue despite Te Whatu Ora Health New Zealand claims of changes to staffing and additional resources.

Four out of five (80%) nurses surveyed felt unsafe due to understaffing on shifts worked in the last month. Nursing and care staff reported unsustainable workloads that are exacerbated by unfilled vacancies and extended leave. This context of strain on the wards can lead to an increased likelihood of errors, delayed or missed care, and avoidable harm. Baseline rosters are not adequately resourced to meet the clinical and therapeutic needs of high-acuity patients. Redeployed staff and the use of pool or agency staff results in inappropriate skill mix to provide safe care, increases staff dissatisfaction where specialised nurses become generalist resource, and undermines the wellbeing of patients who require consistent relationships with the people providing them care.

Data from the Care and Capacity Demand Management (CCDM) system shows persistent shortages in nursing resource. CCDM is a staffing methodology that provides an FTE calculation that matches the care a patient requires with the corresponding nursing capacity to meet this demand 24/7. It records staff available hours and where staff spend their time during the shift and captures patient acuity and patient flow. This allows for accurate planning and provision of direct and in-direct patient care, and records when shifts are understaffed and cannot meet patient need.

Shift below target data for Hillmorton Hospital provides evidence of sustained levels of understaffing across mental health services and is detailed in Table 1. The ID Forensic Adult service, Whaikaha, is the most acutely understaffed. In 2025, Whaikaha ward reported a shift below target for almost every shift (91.3%). A further eight wards reported shifts below target above or close to almost half of all shifts in 2025. Compared with 2023 data, all wards where data was provided indicated higher levels of understaffing for nursing resource, increasing shifts below target between 2% and 40% across the service. The median increase in Hillmorton Hospital wards shifts below target reported in 2023 and 2025 was 10%.

Table 1: Shifts Below Target - Hillmorton Hospital, Canterbury 2025

Service	Ward	Shifts Below Target	% Shifts Below Target
MH ID Forensic Adult	HMH-Whaikaha	1000	91.3%
MH Acute Adult	HMH-Seclusion (Te Awakura)	660	60.3%
MH Acute Adult	HMH-South Inpatient	597	54.5%
MH Forensic Rehab	HMH-Te Whare Hohou Roko	573	52.3%
MH Forensic Acute	HMH-Te Whare Manaaki	533	48.7%
MH Forensic Rehab	HMH-Te Whare Mauriora	512	46.8%
MH Acute Child and Adolescent	HMH-Ward 14A Nga Kakano	510	46.6%
MH Acute Adult	HMH-East Inpatient	487	44.5%
MH Acute Adult	HMH-West Inpatient	477	43.6%
MH Rehab Adult	HMH-Ward 12 Wahi Oranga	349	31.9%
MH Acute Adult	HMH-North Inpatient	347	31.7%
MH Rehab Adult	HMH-Ward 8B Wahi Tautoko	315	28.8%
MH AOD Medical Detox	HMH-Kennedy	269	24.6%
MH Rehab Adult	HMH-Aroha Pai	232	21.2%
MH Eating Disorders & Maternal (HNZ)	HMH-Ward 14B Whangai Aroha	196	17.9%
MH - PSAID Inpatient	HMH-PSAID Inpatient (Psychiatric Services for Adults with Intellectual Disability)		

Source: Te Whatu Ora HNZ, CCDM data, OIA requests.
Blacked out areas indicate data for these wards has not been provided.

Workloads

Staff reported an overall decline in the base staffing levels over time. Emergency Mental Health Services (EmMHS), for example, previously had 12 staff on the floor in a day/afternoon shift but has now reduced to between 5 and 8 staff. Nurses in the EmMHS reported in the weeks and months preceding the survey, shifts regularly had less that 50% of the required FTE, accompanied by significant increase in demand on the service. One RN stated that despite expectations that the patient load should not exceed 100 patients, the service could carry high workload acuity of 140+ patients under the care of emergency mental health services, while already operating below minimum FTE. This inevitably creates lengthy wait times, which can escalate antisocial or aggressive behaviours towards staff and lead to dangerously unwell people abandoning ED without being seen or assessed. Understaffing of emergency mental health services is a fundamental barrier to meeting the Government's health target for 95% of mental health and addiction related emergency department presentations to be admitted, discharged, or transferred from an emergency department within 6 hours.

Staff across inpatient units described patient numbers increasing without a corresponding increase in available beds. This leads to frequent patient transfers and "sleepovers" between units, creating further strain and significant pressure to every shift. Increased patient numbers are not reflected in increases in staffing FTE and create unsustainable patient loads for nursing staff. One respondent described leading a shift working with one pool nurse and a new graduate in their first month of employment. They were responsible for 18 patients on the ward, two with

no bed. This included a seclusion patient and another patient requiring a 2:1 nurse to patient ratio who was located in another building.

Chronic understaffing was described in high acuity wards with high-risk patient conditions (such as violence or suicide). Staff are unable to maintain optimal clinical standards, complete thorough assessments and ensure consistent observation compliance in these conditions. Attempting to balance acuity, seclusion, observations and high care areas with staff entitlements often results in care rationing, missed breaks and unpaid overtime.

> *We are running at full capacity daily with high-risk, high-acuity patients while understaffed. RNs are expected to carry a full patient load (4-5 patients each), supervise students, and direct hospital aides simultaneously. At the same time, we are often required as first responders to incidents on other wards. This creates an unsafe environment due to workload pressure, staff burnout, and reduced ability to provide adequate observation and therapeutic engagement. Due to workload pressures, we rarely have adequate time to complete comprehensive assessments or meaningful therapeutic engagement. This increases clinical risk, particularly with high-acuity patients* (RN, Te Awakura – West Inpatients, Hillmorton Hospital).

Managers are also often required to go 'on numbers,' where they must provide direct care to patients to meet staffing minimums with no additional time or resource to complete core managerial duties. These duties are then completed in unpaid time after the shift with no compensation. A Senior Nurse in Emergency Mental Health Services described working 4 days in a row with no breaks and needing to leave 3-4 hours late each day to complete their work. One RN in Ngā Kakano (Child, Adolescents and Family Unit) described being a shift co-ordinator on a short-staffed shift with several patients in locked areas requiring 2:1 level care due to the high risk of violence:

> *It was near impossible to manage my own patient load, help with de-escalation and management of situations on the ward, organise and safely cover staff breaks (only 3 of the 8 required breaks were covered), support colleagues and deal with any afterhours coordination (admissions, discharging, liaising with Clinical Team Coordinator or Duty Nurse Manager etc).*

Nurses in senior management roles such as Associate Clinical Nurse Managers and Duty Nurse Managers described the stress of managing understaffed high acuity units, trying to balance the severity of unwell, vulnerable patients with the need to support and protect the physical and psychosocial safety of staff. They described being unable to fill the rostering gaps across all units in the service, staff raising safety concerns, forensic units where patients cannot be checked on because of the stretched staffing capacity and the pressure for staff to do extensions or double shifts to ensure that minimum staffing levels are met.

> *Some shifts are so badly under resourced with staff that you are running/scrambling and experiencing high stress levels – how can staff working*

> *under that sort of pressure provide safe and effective nursing care to vulnerable, unwell people?* (Senior Nurse, Hillmorton Hospital).[5]

Skill mix

While overall vacancy rates may have improved since the publication of the Section 99 report, the issues with skill mix, reliance on redeployment and failure to support junior staff continue. Concerns over the imbalance between junior and senior staff and its impact on patient and staff safety have not been addressed. Recommendation 11 of the Section 99 report calls for training and information on core requirements to be provided across the broader service to support staff who may be redeployed into other services and wards to ensure safe practice, particularly for the forensic service. Base rosters are routinely supplemented with permanent pool staff or staff raided and redeployed from other wards or units. Workers reported that if wards are fully staffed at the beginning of a shift, nurses are almost always moved to other wards to cover other short-staffed areas. Redeploying rostered nursing resource then compromises the ability for wards to safely conduct activities within ratios policy or guidelines, such as safely restraining in forensic wards or operating High Care Areas and seclusion.

High turnover and issues with inadequate skill mix in the qualification and experience levels of rostered staff mean that more senior and experienced staff are pressured to come into work when they are sick to reduce the workload burden on their colleagues and mitigate the clinical risk to patients of a poorly staffed ward. One nurse reported coming to work sick because the rostered staff were two new graduate NESP (new entrant to specialist practice) nurses and a pool staff member who were not familiar working with acute patients. Newly qualified nurses are left to deal with unsafe working conditions and confronting behaviours with negligible guidance or support.

Junior nurses are not provided with a supportive environment that enables opportunities to train and develop specialised skills in mental health nursing. Despite newly established programmes for nurses to transition into mental health, staff described issues with the real-life implementation that did not provide depth of training, practical tools, mentorship or consistent clinical supervision needed to safely build competence in such a complex specialty. Mental health nursing requires hands-on guidance, protected learning time, and experienced support. Without that, nurses can feel underprepared and vulnerable in a high-risk environment.

The problem with using agency staff in highly specialised, high vigilance clinical environments is they are unable to receive appropriate training, induction and support to safely complete cares. This puts additional work on the supervising RNs or co-workers carrying their own patient load. Nurses described the difficulties of working with agency staff who have not received restraint training or account details to log-in to IT systems for documentation. This means permanent staff must supervise agency staff use of computers on their own accounts or take on the additional paperwork and documentation for the full patient-load themselves.

> *In my work on the mental health ward, I see a constant tension between offering a least restrictive environment for patients and the toll this takes on staff. We do have pool staff and care aides, for which I'm grateful, but many aren't equipped*

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[5] Quotes from nurses in management or designated senior roles have been generalised to protect their anonymity.

> *with the training or tools they need—they can't chart, administer meds, or de-escalate safely. This is frightening because, while we have extra hands, we don't always have the skills or structure to keep everyone safe* (RN, Te Awakura, Hillmorton Hospital)

Gender mix

Many respondents spoke of the male ratios on shifts. Often male staff working in non-patient facing roles are included in the shift male ratio when they are regularly unavailable for support. For example, a Nursing Services Manager who may be out for meetings, visiting patients in prison or working in physically separate parts of the building. Female nurses described being unable to safely care for patients or take protective measures for their own safety on wards with high proportions of male patients and limited male staff available or shared across multiples wards.

An RN in Te Whare Mauri Ora (forensic rehab unit) described a night shift when the ward had 12 patients and one "sleeping over" with a recent history of suicide, staffed with 2 RNs and 1 HCA. The Duty Nurse Manager called to redeploy the male RN to another unit, leaving a new hire RN and an HCA in the forensics unit overnight. Another RN based in a forensic unit described the issues with gender mix:

> *Gender mix is important as we have 2 male patients who are locked 24/7. One patient requires 3 staff for entries – one of whom must be a male, while the other requires 4 staff for entries – 3 of whom must be males. We have shifts where we have no males on the floor and are having to scramble to find males to assist just to provide basic needs let alone socialisation* (RN, Whaikaha Unit (forensic intellectual disability secure unit), Hillmorton Hospital).

Workplace culture

The Section 99 report described issues with a 'culture of blame' that contributed to poor morale and an inability for workers to escalate or express concerns with the delivery of services that put patients or staff at risk. Just over half (51.9%) of the workers surveyed reported that they have felt unable to raise concerns without fear of blame or retaliation. A further third (32.4%), reported sometimes feeling unable to safely raise concerns.

The culture of bullying and blame makes staff fearful to participate in difficult situations or events such as restraints or seclusion room entries because of the risk that unsafe staffing will lead to procedural lapses, errors or negative outcomes. The focus of blame for these outcomes is put on the individual workers and not their conditions of strain in an understaffed ward. Several nursing staff described pressure to manipulate Trendcare data to inaccurately reflect staffing and VIS levels, creating lows levels of workforce trust in the integrity of staffing data and procedures. Some staff felt that if their VIS rating was green, indicating an appropriately staffed ward, management would consider this overstaffed and nursing resource is then redeployed to another ward.

Safety First forms are intended for reporting issues with patient behaviour, maintenance, facility or building issues, and staff health and safety. However, staff reported feeling pressured to identify themselves and the forms are onerous, requiring completion of at least 28 points of

inquiry in order to submit. This acts as a barrier and deterrent to reporting. Additionally, nurses reported frustration with senior leadership failing to act on concerns escalated through official pathways on multiple occasions. They reported that despite attempts to formally raise issues, there has been no observable improvement in staffing levels, workload allocation or environmental safety. Instead of feeling supported through raising official complaints or concerns, nurses described feeling exposed, pressured and increasingly isolated.

Infrastructure, Maintenance and Faulty Equipment

The Section 99 report described buildings as "badly designed and in a poor state of repair," posing challenges to staff and patients.[6] Nine out of ten (89.2%) nurses reported experiencing broken or fault equipment recently. Nurses described facilities and equipment in a severe state of degradation or malfunction. Examples ranged from maintenance and upkeep to fundamental risks to the safety of staff and patients. Staff described broken heaters, wallpaper peeling off the walls, graffiti, worn carpet with stains or soaked in urine, infestations of ants, rats and mice, building leaks, broken panels in lounge areas and patient room doors getting jammed. At a higher level of severity, staff described cameras not working, doors that do not lock or close properly, malfunctioning duress alarms, delayed alarm responses and blind spots where patients climb up walls and fences. While plans are underway for campus redevelopment, staff working in new facilities also reported issues with maintenance and building functionality that impacted on the wellbeing of patients and staff.

Basic equipment is often non-functional or in short supply which leads to sharing resources and machinery across wards, sometimes located in different buildings. This was reported to be the case with broken observations machines, and restricted numbers of bladder scanners and ECG machines. This creates potential safety risks, particularly in an emergency where delays in obtaining essential observations could compromise patient care.

Safety

Staff are frequently exposed to verbal abuse, threats and physical assaults from patients while also managing aggressive or distressed family members without adequate staffing support. It is essential that any risk to their own and patient safety is mitigated through health and safety policy that is supported by appropriate and functional facilities and equipment.

Staff regularly cited concerns with doors that cannot be locked and the risks with supporting potentially violent patients. Broken doors or short-staffing often means the High Care Areas are unable to be locked, including overnight, thereby increasing the risk of patients absconding. Nurses described inappropriate room layouts to protect them from the potential risks of dysregulated or potentially violent patients. For example, nurses working in the Canterbury Opioid Recovery Service described working in rooms with only one door, leaving no safe exit point for staff.

Staff in the Child, Adolescents and Family unit described staff being unable to leave locked areas if patients become aggressive. Assaults have occurred due to locked podding and limited

[6] Ministry of Health (2025) p.4.

support to facilitate de-escalation or debrief. Despite being housed in a new building, nurses in the Child, Adolescents and Family unit also described issues with faulty duress alarms that go off with false alerts, fire doors not closing, staff managing public access in and out of the building in the absence of dedicated security teams and heating issues that impact babies overheating or being too cold.

Physical environment

Issues with maintenance impact on the wellbeing of staff and patients. Nurses described the indignity for patients in unsanitary or damaged rooms, and the impact of repeatedly seeing the destruction left behind from a traumatic moment for patients left unrepaired. Maintenance issues with leaks, lighting and noise can contribute to patient dysregulation and disrupt use of staff areas such as kitchens and staffrooms. Below are a series of examples of the impact of physical spaces and maintenance issues.

> *I've worked shifts where there are panels missing from walls on the unit, ripped vinyl peeling off the walls due to patient damage, buckets on the floor to collect the water that is leaking from the ceiling. Flickering lights due to electrical issues. Doors not closing properly and having to be slammed shut to secure them. Windows not fixed and constantly remaining open causing temperature issues. Water taps not working in patient rooms. This is our ward constantly. I wouldn't wish it on anyone to be admitted to our ward. The physical environment is anything but healing* (RN, Te Whare Manaaki, Hillmorton Hospital).

> *We have had a vile stench of dead rotting rat carcasses trapped in the ceiling above our office space for over a year now. We have been told by our DLT H & S committee that there is nothing that can be done about it because there is asbestos in the ceiling which is why they cannot drill through to remove said vermin remains* (Senior Nurse, Emergency Mental Health Service, Hillmorton Hospital).

> *Extensive leaking of water into the ward in multiple areas. Extensive leaking of water into light fixtures in staff room, leading to power needing to be turned off in the staff room, a manager's office and the medication room - this resulted in no power overnight, meaning medication administration was completed in the dark, as were all staff breaks. Newly instated "ascom" alarm system has been faulty on multiple occasions, most recently sending out a duress alarm to all "first responder" ascoms FIVE minutes after the initial alarm was triggered* (RN, Te Awakura, Hillmorton Hospital).

Moral Injury and Burnout

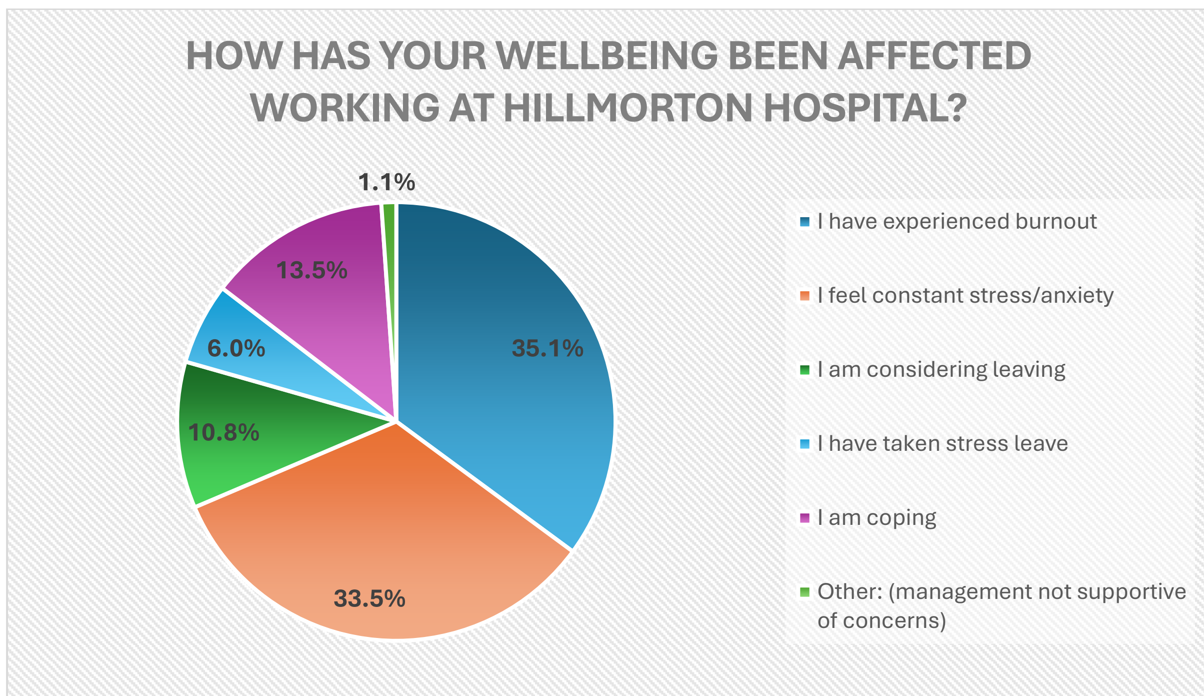
Understaffing, workload, and working in a high-stress, high-pressure environment means that nurses cannot work to best practice and patients do not get the care they deserve. The Section 99 report found poor morale was a product of working in a prolonged environment of strain, where workers could not provide a decent standard of care and contributed to burnout. In recent surveying, nearly 9 out of 10 nurses (86.6%) reported negative impacts on their wellbeing

from working at Hillmorton Hospital. One third reported experiencing burnout, and a further third reported feeling constant stress and anxiety. Only 13.4% reported that they were coping. High burnout rates contribute to absenteeism and staff turnover, reduced productivity and workplace engagement, which puts further pressure across entire care teams.

When nurses are stretched beyond sustainable limits, they are unable to provide person-centred care. Staff described the toll of being unable to provide the level of care they expect of their own practice and that their patients deserve. The impact on staff wellbeing was acute, where the constant pressure and demands of the work in an understaffed environment leads to fatigue, stress, anxiety and burnout. Nurse burnout directly impacts the quality and safety of patient care. Emotional exhaustion, compassion fatigue and chronic stress reduce focus, attention to detail and emotional availability.

> *Working at Hillmorton has an impact on my personal health. I am a more anxious and tearful person than I was before I started. I experienced burnout within months of working there. I went into mental health nursing because I care about people, but the level of care we are able to provide feels substandard. I constantly feel moral and ethical conflict, knowing that the treatment our tangata whai ora receive is often harmful and traumatising* (RN, Acute Inpatients, Hillmorton).

> *I am tired. Actually, beyond any form of exhaustion that I can put into words. I feel an overwhelming sense of dread coming onto shift every day. Not knowing what I'm going to be facing that day, nor how short staffed the shift will be. I'm frequently on the brink of tears and have frequent sleepless nights thinking about the crisis we are in currently. I feel I cannot provide the most basic of care to my patients most days. I go home distressed, too overstimulated and jaded to interact with my family or even cook a basic meal most days* (EN, Hillmorton Hospital)



Missed care

When wards are routinely short-staffed or specialised and experienced staff are substituted with junior nursing staff or hospital aides, critical care is rationed, missed, delayed or compromised. This can lead to gaps in mental state exams, appropriate medication administration, therapeutic communication, or essential documentation. Staff cited concerns for Māori and Pasifika patients in particular who do not receive culturally appropriate care and support. Staff described the pressure to rush and discharge patients quickly alongside their internal conflict over the pressure to prioritise one patient over another. Pressure to discharge before patients are clinically ready leads to increased admissions through acute or crisis teams.

> *Moral injury, for me, shows up when I know what good care looks like but don't have the resources to provide it. There have been shifts where patients were clearly distressed and needed time, therapeutic engagement, and consistent boundaries, but staffing and skill mix meant my focus had to be on safety and containment rather than care. Instead of time, presence, and de-escalation, medication becomes the default intervention.*
>
> *Instead of being able to sit with a patient, de-escalate early, or provide meaningful therapeutic support, I was pulled away to manage incidents, property damage, or competing demands. Knowing that a patient needed more than I could give — and that this may contribute to them returning in crisis — is deeply uncomfortable and stays with me after the shift ends* (RN, Te Awakura, Hillmorton Hospital).

There is not adequate staffing to ensure that patients classified as 1-to-1 level of care receive this level of attention and direct care. The section 99 report highlighted changes to newer models of care in forensic mental health that recommend higher staff-to-patient ratios than those used to determine current rosters, which are based on a relatively restrictive model of care. Staff said that spending meaningful time with patients is the first thing to be dropped when understaffed.

> *When you have such limited time, it is the patients that end up being neglected and missing out. Being able to provide good care to the children I look after is really important to me. Shifts like these I often apologise to my patients for not having enough time for them and spend my shift in a state of chaos and intense guilt. Children shouldn't miss out on quality mental health care because the adults in political power don't care about nurses, patients, and safe staffing* (RN, Ngā Kakano, Hillmorton Hospital).

Cancelled activities

Beyond the immediate clinical care, patients miss out on the opportunity to get out of the ward for a walk or other activities. In direct response to staff shortages, patients often become agitated or restless because staff are unavailable to provide adequate time, care, scheduled activities or supervised leave. Cancellation of planned activities and leave undermine patient wellbeing and rehabilitative outcomes which relies on predictable scheduling, structured

activities and staff continuity. This is slowing treatment and negatively impacts patient outcomes.

One nurse from Te Whare Mauri Ora forensic rehab unit described the impact of “the frequent cannibalisation” of their unit to staff other wards in undermining the provision of care for whai ora where planned outings and family meetups are cancelled. When rehabilitative practices are diminished because of poor staffing it shifts the model of care to a focus on behaviour management rather than reintegration and recovery. This creates mistrust towards staff and disrupts established rapport leading to the breakdown of therapeutic relationships, sometimes leading to hostility or aggression. Cancellation of family outings can also disrupt family dynamics and slow rebuilding of familial relationships that will act as a support network for whai ora upon discharge. They wrote “we feel so powerless, especially in the face of a system that preaches about recovery and reintegration but continually undermines that process.” Another nurse in the same unit framed the shift from recovery to containment as follows: “Ultimately, our patients are not getting the right care on our unit. We are not rehab any longer, we are a holding unit while they wait for accommodation in the community.”

Without the time, resource or staffing levels to provide holistic care to patients, the care moves from therapeutic to custodial. Staff feel strongly that patients deserve more than containment. They deserve care that promotes recovery, dignity and meaningful outcomes. Nurses described witnessing burnt out colleagues who wanted to provide better care but no longer have the emotional capacity nor time to give to their patients. Nurses also described instances of patients remaining unnecessarily long periods in seclusion because there was not sufficient nursing staff or room capacity for them to be moved to a High Care Area.

Cultural Safety

Nurses described the impacts on providing culturally safe care when the environment is not culturally safe. When care is culturally unsafe, patients do not engage in the service which leads to poorer health outcomes. While mana-enhancing and kaupapa Māori models of care may be adopted on an individual practice level, this is not embedded in the service framework and training is not widely promoted or accessible for staff.

Culturally safe care is compromised when staffing levels are not adequate. Nurses described the heightened anxiety for patients from high turnover and constant redeployment between wards resulting in a changing and inconsistent care team and routine. In response to unfamiliar faces, patients will often seek out staff they are familiar with, which creates a workload imbalance. However, staff will accept the additional patient responsibility because they do not want people to become dysregulated. Consistent rostering that supports whanaungatanga and meaningful therapeutic relationships between patients and staff is fundamental to culturally safe care and better patient outcomes.

Staff reported that Māori related work is shifted almost exclusively to Pūkenga Atawhai, however, this team is underresourced and there are not enough of them to fulfil all of the needs and preferences of patients. This means they are stretched across many units and have not been available to some units at all. Senior nurses did not report seeing an improvement or support in growing and supporting the Māori mental health team, Te Korowai Atawhai. Staff also reported that some had been replaced with Lived Experience kaimahi, which while an important

aspect of care and support should not replace the cultural needs that patients are seeking out through Te Korowai Atawhai.

Concerns over Integration of Psychiatric Services for Adults with an Intellectual Disability (PSAID) Service

The Section 99 report described issues with escalation and consultation pathways where clinicians described problems with "decisions about changes to service delivery without transparency or apparent consultation with those affected."[7] A recent example of this failure to consult with staff and affected patients about a specialty ward for intellectual disability being integrated into general adult inpatients by end of 2027 in the new facility currently under construction. Concerns over the safety and well-being of the vulnerable patients have been raised and there is no current plan for what the service will look like. Combining intellectually disabled patients with a general in-patient population is a proven failing model of care that puts vulnerable patients at risk. Nurses reported concerns that there has been no clear commitment to retaining a specialist nursing team in place to support these patients or if they will be spread over the new service as a generalist nursing resource.

The decision to integrate PSAID patients with the general in-patient population is also counter to recommendations made by the Ombudsman in a December 2025 report from a follow-up inspection of Te Whare Manaaki Unit at Hillmorton Hospital. The Ombudsman recommended Te Whatu Ora "ensure tāngata whaikaha are accommodated in facilities dedicated to meeting their needs."[8] While the Ombudsman's investigation is limited to the forensic unit under the OPCAT (Optional Protocol to the Convention Against Torture), the principles that underpin specialist facilities and clinicians apply to all tāngata whaikaha accommodated on the Hillmorton campus. The Ombudsman report states the Director of Mental Health will be informed of "any mixing of mental health patients and intellectual disability care patients in a unit and how their unique care needs will be provided for."[9] Frontline staff supporting patients with intellectual disabilities have not been consulted on proposed facility changes or advised of how they will be able to safely provide specialist care to their patients in the new facility. We recommend that PSAID patients are separately accommodated in the new facility and retain specialist care.

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[7] Ministry of Health (2025), p.26.

[8] Office of the Ombudsman (2025) *OPCAT Report: Report on an announced follow up inspection of Te Whare Manaaki Unit, Hillmorton Hospital under the Crimes of Torture Act 1989,* December: Wellington, New Zealand.

[9] Ibid, p.9.

What's Needed Now?

> *I've been a registered nurse for two years now, and I'm burnt out. I want to make a career of this but I'm at a loss of how to do that in a broken system… There's a couple wards I can think of where they have high staff turnover and it's simply because staff are feeling super overwhelmed, unsupported and they value their safety more than this job. Some of my friends have moved to different hospitals or even moved to Australia for better working conditions and I don't blame them. But I want to stick it out here because I strongly feel both staff and patients deserve better. How many more section 99 reports and Coroners Court investigations following murders and suicides need to happen in order for the Ministry of Health to wake up and listen to us on the frontline?* (RN, Te Awakura – North Inpatients, Hillmorton Hospital).

NZNO Recommendations:

1. Resource baseline rosters to ensure safe clinical and cultural care. Staffing levels must account for appropriate skill mix, induction and training requirements and gender ratios to recognise the specialised nature of the work. This is especially urgent in the forensic mental health services where short staffing has replaced therapeutic care with containment.
2. End reliance on redeployment to fill baseline rosters rather than exceptional roster gaps (such as unplanned leave).
3. Workforce planning and support for early career nurses in mental health as part of addressing staff recruitment, retention, supervision, training and mentoring.
4. Ensure PSAID is a separately accommodated service in the new facility for safety of patients and staff and address issues with failure to consult affected staff and patients on clinical changes to the service.
5. Immediately identify and rectify maintenance and equipment issues and establish a risk register and plan to mitigate risks to ensure safe delivery of care for patients and staff.
6. Establish an anonymous reporting system for staff to lodge issues to address culture of fear and blame in the service and to enable Te Whatu Ora to immediately address issues. This should be more streamlined and accessible than current Safety First forms which are onerous and act as a barrier and deterrent to reporting.
7. Pūkenga Atawhai are supported and resourced to regularly spend time and work with whai ora to ensure culturally appropriate services are embedded in the service framework.
8. Staff interviews are included in the quarterly visits under the section 99 monitoring programme in May and August 2026.