He Maungarongo ki Ngā Iwi: Envisioning a Restorative Health System in Aotearoa New Zealand

National Collaborative for Restorative Initiatives in Health

The aims and purpose of this framework are supported by:

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Te Ngāpara Centre for Restorative Practice

Restorative Practices Aotearoa

"It has become routine to speak not only of restorative justice but also of restorative practices and restorative organisations, and to view them as different facets of the same diamond, as varied applications of the same values, principles and relational philosophy, as distinct manifestations of an eclectic, global social movement for a more inclusive, peaceful and participatory democracy… a project aimed at the creation of interpersonal relationships and societal institutions that foster human dignity, equality, freedom, mutual respect, democratic engagement and collaborative governance."

Emeritus Professor Chris Marshall [1]

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Restorative systems

The roots of restorative philosophy are rich and diverse and encompass ancient wisdom and Western science.

Figure 1 presents the image of two rākau (trees), the northern rātā and kauri. The two rākau represent the approaches of *restorative practice* and *hohou te rongo* within the Aotearoa NZ health and disability system context. The rākau symbolise the Tiriti-led relationship between these two approaches, one developed from Western science and ancient wisdom, the other specifically from the mātauranga (knowledge) of whānau, hapū and iwi communities.

In our setting, both approaches are grounded in our whenua (land), which is to say that the approaches are affected by our local context and environment. The two approaches also grow to provide shelter, support and sustenance to the health and disability system, the people who work within those systems, and the individuals and whānau who experience harm. The communities and systems that are affected are represented by a number of native birds. As is the case in the ngahere (the forests), the roots are intertwined together. Both rākau are distinct and have their own integrity and dignity, just as both restorative practice and hohou te rongo are distinct. In a healthy Tiriti relationship the roots act symbiotically, benefitting and contributing to each other, whilst enhancing the whole system.

Figure 1: The rākau (trees)

Introduction

Restorative initiatives are a nascent area of development in health systems globally. Restorative responses are increasingly being applied to healthcare harm, and there is tentative evidence for their use, with evaluations highlighting positive impacts on human wellbeing as well as financial benefits.[2-5] Aotearoa New Zealand (NZ) has been at the forefront of global innovation, with Manatū Hauora Ministry of Health commissioning an unprecedented restorative response to harm from surgical mesh in 2019.[3] An evaluation determined that healing after harm is possible when approached within a relational framework, and that a restorative approach should be embedded alongside existing regulatory structures, policies, and procedural responses in Aotearoa NZ.[6]

Our health and disability system is currently undergoing a period of major transformational change. The reforms provide opportunities to weave restorative principles into policy and practice and to contribute to achieving Pae Ora – healthy futures for all New Zealanders – by advancing equity and embedding the special relationship between the Crown and Māori under Te Tiriti o Waitangi. With these thoughts in mind, the National Collaborative for Restorative Initiatives in Health (the Collaborative) formed in 2020 to nurture and guide the development of restorative initiatives within the health and disability sector. It is comprised of Māori and non-Māori stakeholders, collaborates with experts in mātauranga Māori, kawa and tikanga, and has foundational roots at Te Ngāpara Centre for Restorative Practice and Manatū Hauora Ministry of Health. Members are listed in appendix 1.

The Collaborative developed this framework in partnership with a diverse range of health system stakeholders over an eighteen-month period. The proposed recommendations intend to enhance the overall health and wellbeing of consumers and providers of healthcare, whilst accounting for the unique features of the health system context. For example, the fact that healthcare harm is context specific, emergent, and is rarely intentional.[7-9] Within complex adaptive health systems there is no single way to improve safety, enhance wellbeing, or respond to harm because the behaviour of 'the system' reflects the interconnections and interdependencies between people, organisations, policy, and other elements.[10] Providers cannot become 'restorative' by simply altering individual components and/or behaviours. We must instead accept our collective responsibilities, share risks and opportunities and embrace collaboration, co-design and mahi tahi.

We acknowledge that some of the recommendations in this framework may require legislation, regulation, and policy to be enhanced and that co-designing how to operationalise the proposed changes will take time. It is imperative that restorative initiatives grow alongside unique features of our health and disability system that uphold the rights of the people of Aoteroa NZ and make positive contributions to system safety. The establishment of Te Whatu Ora (Health New Zealand) and Te Aka Whai Ora (Māori Health Authority), and the changes in Manatū Hauora Ministry of Health, provide the opportunity to also take some simple immediate steps and provide a national consistency of approach. This is not an operational toolkit and responsibility for taking the recommendations forward is a decision that must rest with all those who have a responsibility in designing, improving or delivering the systems that mitigate and respond to harm.

Hohou te rongo: Overarching principle

The deliberate inclusion of experts in mātauranga Māori, kawa and tikanga in the leadership of the Collaborative and the development of this framework recognises that te ao Māori is an important root of restorative mahi in Aotearoa NZ. The strategy also aspires to ensure the continued ownership of mātauranga and tikanga by Māori communities. The framework intends to harness existing knowledge relating to restorative practices in Aotearoa NZ, whilst also positioning the development of any approach to addressing harm for Māori within the health and disability sector, within the Mātauranga Māori Directorate of Te Aka Whai Ora, as guided by Iwi Māori Partnership Boards. The approach is important because Māori stakeholders have been critical of the development of restorative initiatives within other Crown structures. For example, justice developments are critiqued as enclosing *"Indigenous culture and Indigenous participants within a Eurocentric, formulaic and standardised process"*.[11]

As in all societies, within Māori communities there are many approaches to addressing harm which can differ by place, be dynamic (shift and change over time), and hold competing perspectives. This framework appreciates peace-making from te ao Māori within the kawa[i] of hohou te rongo. We understand that hohou te rongo is a kawa that existed before colonisation and one whose authority derives from the whakapapa and practices of iwi, hapū and whānau. There are other local terms including hohou rongo, hohou te rongopai, and hohou te rongo, and the local term should take precedence in any reference to this kawa. This kawa exists widely throughout the iwi and hapū of Aotearoa NZ and tikanga varies from iwi to iwi, hapū to hapū.

The principles articulated in this framework deliberately interact with te ao Māori concepts to ensure a point of connection should iwi, hapū and Māori communities choose to lead the development of hohou te rongo alongside the Crown as a Tiriti partner. Where hohou te rongo is included in the following recommendations, the overarching principle is that as an approach to addressing harm for Māori within the health and disability sector, hohou te rongo is developed within the Mātauranga Māori Directorate of Te Aka Whai Ora and is guided by Iwi Māori Partnership Boards.

i Kawa here are understood to be customs and protocols, many of which are shared across iwi and Māori communities, for example pōhiri, tangihanga and poroporoaki. Tikanga is understood as how these kawa are conducted, and as such vary among whānau, marae, hapū and iwi.

Recommendations

The National Collaborative recommends that health and disability sector leaders, in partnership with iwi and Māori communities and alongside consumers and whānau, those with lived experience and other experts, policy makers, providers, and practitioners prioritise the following actions:

Embed restorative principles across the policy, programme delivery, and practice standards that intend to mitigate and respond to healthcare harm.

- Policies and practices are human centred and recognise the needs of workers and consumers as whole persons. They will cultivate a culture of belonging and respect, strive for inclusive, dignity or tapu enhancing decision-making procedures, and promote distributed styles of leadership. They will develop culturally safe practices and partnerships, understanding that mātauranga Māori is an important root of restorative knowledge.
- Policies, programmes, and practices will listen and respond to the justice needs (substantive, procedural and psychological) of all parties whilst embedding the special relationship between the Crown and Māori under Te Tiriti o Waitangi. Responses to harm will promote the restoration of wellbeing, relationships, and trust alongside learning and improving. Policies, programmes and practices need to consider hauora Māori through Māori models of health such as the Meihana Model to ensure holistic consideration of whānau, wairua, tinana, hinengaro, taiao and iwi katoa.[12]
- Policies, programmes, and practice explicitly cite listening and understanding to all voices equally as the first step of any review or investigative process. The potential for healing, learning and improving is enhanced within a restorative just culture where people feel safe to raise concerns and talk openly about a harmful event or experience without a fear of being judged.
- There is investment in psychosocial peer, and cultural supports (formal and informal), as needed. Supports are provided for those affected by a harmful event or experience and those providing restorative services (consumers, workers, investigators and their whānau and communities).
- Such an approach would apply at the system level to include new national policies (e.g., professional standards, people and capability and health and safety policies), and upcoming policy reviews (e.g., The Code of Health and Disability Services Consumers' Rights 1996, the Health and Disability Commissioner Act 1994). An example is the recent review of the previous National Adverse Event Policy 2017. In effect as of 1 July 2023 – Healing, Learning and Improving from harm – Te whakaora, te ako me te whakapai ake i te kino (National Adverse Events Policy 2023) now includes restorative responses. The same approach would also apply to regional and locality policies and programmes to thus reduce the risk of compounded harm to all those who provide and receive care.

Provide a navigation service for all serious harms – Tatau pounamu – the green stone door, the safe space.

- A navigation service is provided in keeping with the Code of Expectations for Health Entities' Engagement with Consumers and Whānau,[13] and legislation that protects worker wellbeing. The sector invests in mahi tahi that brings together those with experience of investigations (coroners, investigators, Human Factors professionals, claims assessors, Te Tāhū Hauora Health Quality & Safety Commission specialists, clinicians, consumers, whānau and communities) to co-design a navigation service into a networked coordinated trauma-informed, culturally safe response to healthcare harm.
- Restorative practice and hohou te rongo are provided as a valuable addition to the suite of options people have available to them for resolving complaints and addressing harm, so that people can choose which resolution pathway will best meet their needs.
- Recognising that agencies and regulators such as Coroners and the Health and Disability Commissioner may hold competing or conflicting responsibilities, the Tatau pounamu process will mitigate the risk of compounded harm, identify and respond to the substantive, procedural, and psychological needs (justice needs) of those directly affected and embody restorative principles alongside safety science and legislative responsibilities.

Partner with educational providers, restorative practitioners, and iwi and Māori communities to build capability and capacity in restorative practices and hohou te rongo.

- The sector invests in the capability and capacity of accredited restorative practitioners with specialist health system expertise and supports the development of communities of practice. Practice networks are developed, recognising that social capital is a powerful lever for systemic change.
- The sector invests in partnership with iwi and Māori communities and resources and supports iwi, hapū and Māori communities to address harm through the kawa and tikanga of hohou te rongo.
- The sector partners with professional bodies, restorative practitioners, education, and accreditation providers to develop practice and operational standards that consider and respond to the needs of the diverse range of stakeholders.
- Those involved in the pre and post graduate education of healthcare workers embed restorative philosophy and practices into existing programmes in order to proactively develop relational habits and meaningful human connection as a way to mitigate healthcare harm.

Partner with agencies, regulators, and other bodies to review the pursuit of restorative initiatives within current legislation to thus inform how legislation might be enhanced.

- Current legislation is enhanced to account for the human and relational dynamics of safety and wellbeing and to maximise opportunities for healing alongside learning and improvement.
- To achieve these aims, legislators should consider enhancements that focus on mitigating the risk of compounded harm and enhancing the relationship between the Crown and Māori under Te Tiriti o Waitangi.
- Proposed enhancements account for the considerable body of evidence that concludes that individuals are rarely culpable for adverse events and supports safe spaces where affected parties can provide an honest account and take responsibility for harm and repair.

Develop processes and practices that promote healing, learning, and improving.

- Following a harmful event or experience, providers address actual or perceived conflicts of interest early. When a conflict exists, the people involved should have the option to request a restorative or other review process led by an external facilitator.
- Providers co-design reparative and preventative actions with the people who are most directly affected by a harmful event or experience. Actions are realistic, account for systemic or relational complexity, and have the potential to affect meaningful improvement. Actions are documented in a co-developed agreement, that is transparently shared with all parties, and includes timeframes and the processes for ongoing communication and addressing future concerns.
- Providers and policy makers are transparent and honest about their ability to prevent harm in the face of complexity. Assurances that actions will prevent the same event from happening again in the future are avoided.
- Taking responsibility for healthcare harm requires those who possess organisational authority, or have a professional or moral obligation to those affected by events, to respond to a situation in a way that addresses the needs and rights of all those involved. Shared agreements identify the ongoing roles and responsibilities of all parties who must have the authority or means to enact them.

Evaluate restorative initiatives to develop evidence-based practice that appreciates what works, for whom, how and in what contexts will differ.

- There is investment in research to evaluate restorative programmes, develop the evidence base for policy and safe practice, and to ensure accountability for using a novel process in the complex health environment.
- Research design accounts for the complexity and unique features of the health system, upholds the articles of Te Tiriti o Waitangi, and considers what works for whom, how and in what contexts. Evaluations consider the human and financial impacts.
- There is investment in kaupapa Māori research and evaluation that is designed and led by Māori, for Māori.

Executive summary

- This framework provides an overview of the systems that mitigate and respond to healthcare harm in Aotearoa NZ. Healthcare harm can be a physical, psychological, social, spiritual injury or experience that occurs during the provision of care. In Aotearoa NZ, harms also occur and endure due to the impacts of imperialism, colonisation, and racism. In te ao Māori, harms are conceived as diminishing of the tapu and mana of people, their environments, and their spiritual connection.
- Compounded harm can result from well-intentioned responses characterised by rational, objective, or linear investigation or review.[14] Compounded harm emerges when responses disrupt normal human, relational or community adaptations; erode the dignity or tapu or the people involved; fail to provide a safe space where those directly affected can provide an honest account and take responsibility; or fail to respond to the justice needs – substantive, procedural or psychological – of all the people who are affected equitably. Within te ao Māori compounded harm is articulated as a state of continued violation through whakanoa.
- A human centred and relational approach is required to mitigate the risk of compounded harm and maximise opportunities for healing, learning and improvement. When our people experience harm, it is essential that they can easily access a suite of options, including restorative responses. The prioritisation of human and relational wellbeing and hauora may be best achieved by weaving restorative principles into regulation, policy, and practice. This framework presents the principles, practices, and terminology of restorative systems, explores the enablers and barriers to development, and makes recommendations to support the development of restorative potential within a Te Tiriti o Waitangi framework.
- Restorative systems are distinguished by an emphasis on relational principles, practices and goals that promote and restore human dignity and wellbeing. In Aotearoa NZ, restorative systems and organisations are underpinned by five principles:
  a. ***Whakawhanaungatanga*** – Systems are comprised of people and relationships
  b. ***Whakapapa*** – Human wellbeing and relationships are interdependent
  c. ***Tapu*** – Restorative systems maintain and enhance dignity through relationships
  d. ***Taiao*** – Contextual conditions affect people and their relationships
  e. ***Mahi Tahi*** – Relationships are enhanced by co-production and co-design.
- Restorative justice, restorative practices, and restorative organisations are all based on and apply the same relational values, principles, and philosophy. They aim to create interpersonal and societal institutions that foster human dignity, equality, freedom, mutual respect, democratic engagement, and collaborative governance. Restorative responses involve honest dialogue in a psychologically safe environment and are guided by a concern to address harms, meet needs, restore trust, mitigate repetition, and promote repair.
- Te ao Māori has its own restorative response of hohou te rongo (peace-making from a te ao Māori world view). Hohou te rongo is a kawa. Kawa is the collective and agreed values, principles and protocols that connect whānau, hapū, iwi and Māori communities. There are other local terms including hohou rongo, hohou te rongopai,and hohou te rongo. The local term should take precedence in any reference to this kawa. This kawa exists widely throughout Aotearoa NZ and tikanga varies from iwi to iwi, hapū to hapū.

- The kawa is understood here as a process for addressing harm by restoring the mana (power and authority) and tapu of people, the environment and spiritual connections, and the relationships between them. The special relationship between the Crown and Māori under Te Tiriti o Waitangi has relevance for hohou te rongo, as hohou te rongo is a form of knowledge that is a taonga under Article II and the Article III obligation for the Crown to ensure equitable outcomes for Māori in responses to harm. The Crown has an obligation to resource iwi and hapū to protect and develop this mātauranga under their mana motuhake.
- The National Collaborative for Restorative Initiatives in Health facilitated the development of the policy and practice recommendations in this document. A series of hui were held in 2021/22 to seek feedback from a range of health system stakeholders, including the people who provide and receive healthcare, kaumātua and kuia, and those who investigate healthcare harm. Aims included understanding the impacts and needs resulting from embedded strategies and the enablers and barriers to the development of restorative potential. Hui participants critiqued the status quo as costly, slow, and unduly confrontational, proposing that responses perpetuated inequity, colonisation, and injustice. Many people suggested responses could be traumatising, particularly when multiple protracted processes were involved.
- Stakeholders identified a number of barriers to the development of restorative potential; legislation, healthcare hierarchies, variations in quality, implementation standards, capability and sector support. Initially, six overarching recommendations were identified as having the potentional to assist in mitigating the risk of compounded harm, and support the development of restorative initiatives in the health and disability system. The recommendations were developed further in November 2022, when consideration was given to leveraging existing enablers and focussing on areas of most need within the context of the health system reforms. An overarching principle was added to ensure that hohou te rongo is protected and developed within Te Aka Whai Ora, guided by the newly established Iwi Parternship Boards.

Framework purpose

The framework assumes there is no single way to improve safety, enhance wellbeing, or respond to harm in our complex adaptive health system.

It explores the human impacts and needs that arise from current policy and practice, identifying how well-intentioned approaches contribute to compounded harm. It presents the principles, practices, and benefits of a restorative health system and identifies the enablers and barriers to growth. The framework concludes by making recommendations to guide the development of policy and practice in Aotearoa NZ that align with, and contribute to, the core legislative and strategic priorities presented in table 1.

Table 1: Legislative and strategic priorities and their intent

Legislation or strategy	Intent
Pae Ora (Healthy Futures) Act 2022	Aims to protect, promote, and improve the health of all New Zealanders, achieve equity, and build a healthy future for all.
Interim Government Policy Statement on Health 2022-24	Lays the foundation for an inclusive dynamic health sector with Te Tiriti at its core.
Whakamaua Māori Health Action Plan 2020-25	Supports iwi, whānau and Māori communities exercising their authority to improve their health and wellbeing, in a system that is fair, addresses racism and discrimination, protects mātauranga Māori and delivers more equitable outcomes for Māori.
Kia Manawanui 2021	Outlines a long-term pathway to mental wellbeing with people being supported to proactively manage their own hauora.
Code of Health and Disability Services Consumers' Rights 1996	Sets out the rights of consumers to: be treated with dignity and respect; have their needs, values and beliefs met; receive services of an appropriate standard; make an informed choice and give their informed consent; receive support; and complain.
The Health and Disability Commissioner (HDC) Act 1994	Details the process the HDC is required to follow to secure the fair, simple, speedy, and efficient resolution of complaints and also offers further explanation for the establishment and function of the Health and Disability Consumer Advocacy Service.
Health and Safety at Work Act 2015	Protects the health, safety, and wellbeing of workers.
Te Tāhū Hauora Health Quality & Safety Commission: Healing, Learning, and Improving from harm – Te whakaora, te ako me te whakapai ake i te kino (National Adverse Events Policy 2023 – In effect as of 1 July 2023)	Aims to improve consumer and healthcare worker safety by supporting organisations to heal, learn, and improve following harm that occurs in health and disability services.
Code of expectations for health entities' engagement with consumers and whānau 2022	Outlines health entities responsibilities in how they engage with consumers, whānau and communities in the planning, design, delivery, and evaluation of health services.

How was the framework developed?

The National Collaborative for Restorative Initiatives in Health (the Collaborative) facilitated the development of recommendations which were co-designed by members of the health and disability community. The Collaborative was formed in February 2020, by representatives from Te Ngāpara Centre for Restorative Practice and Manatū Hauora Ministry of Health in the aftermath of a national restorative response to surgical mesh harm. Membership includes stakeholders from across the health and disability system, such as senior representatives from national agencies; Te Tāhu Hauora Health Quality & Safety Commission, Accident Compensation Corporation (ACC), Office of the Health and Disability Commissioner (HDC), the General Managers of People and Capability and Mahi Haumaru (WorkSafe). Kaumātua and kuia, and those providing perspectives from the sharp end of care provision (such as consumers and clinicians), are also represented.

The purpose of the Collaborative is to build a restorative community in the health and disability system that is grounded in whanaungatanga and manaakitanga. In addition, members have invested in their own programmes of restorative work, which have included socialising restorative principles, capability building, and even developing policy and practice with varying degrees of success. Educational workshops, seminars, and presentations have been well received, engaging with over five hundred healthcare stakeholders working in roles that include clinicians, advocates, investigators, system safety and quality improvement practitioners, people and capability practitioners and the unions. The Collaborative's work to date is summarised in appendix 2.

At the beginning of 2020, the Collaborative was concerned with how to mitigate the risk of compounded harm and grow restorative potential. Feedback from across the health sector and consumer advocacy groups indicated that current mitigation and response strategies to harm (conflict, complaints, and adverse events) were not always meeting the needs of the people of Aotearoa NZ. Most desired a coordinated systemic response that offered a suite of options and supported wellbeing in the aftermath of harm. With this in mind, the Collaborative held a series of virtual hui during the 2021/22 COVID-19 pandemic, with the agreed outcome being the development of a shared framework.

The hui explored the following questions

- **What impacts and needs have you observed in yourself or others in the aftermath of harm?**
- **Given this, what reparative and preventative actions are required to support restorative responses to develop in your context?**
- **Who do you imagine is responsible for the identified actions?**
- **What successes or challenges are you experiencing and/or what do you imagine are the enablers and barriers around readiness to engage with this work?**

Attendees at the first two hui (n=42) represented the organisations, professions, and communities that were directly affected by current policy, practice and/or any proposed adaptations (appendix 3). The views they expressed are consistent with the perspectives of healthcare stakeholders who had participated in Te Ngāpara Centre for Restorative Practice workshops and formal educational offerings during 2020-2022 (n=>150); and research and other work that has examined the impacts of healthcare harm mitigation and response strategies in both Aotearoa NZ [3,15-18] and other countries.[2,4,19]

In November 2022, draft recommendations were shared with members of the Collaborative and other interested stakeholders. Stakeholders included the Chief Executive Officers and other senior leaders from Te Whatu Ora and Te Aka Whai Ora or their designated representative, senior leaders from Manatū Hauora Ministry of Health, Te Tāhu Hauora Health Quality & Safety Commission, HDC and ACC as well as consumers, clinicians and other healthcare workers. Participants were invited to a final national hui where recommendations were refined and endorsed by distinct Māori and non-Māori caucuses comprised of stakeholders from across the health and disability system. Appendix 4 details the hui attendees and their roles within the health sector.

At the final hui attendees endorsed the draft framework and the collective leadership of the Collaborative, suggesting some minor changes. They also proposed that senior representatives from Manatū Hauora Ministry of Health, Te Whatu Ora and Te Aka Whai Ora should participate in the Collaborative to ensure recommendations were responded to swiftly. An updated draft was shared with the Collaborative in December 2022. Members were invited to socialise the document within their organisations, provide any final comments, and seek formal support from their executive team ahead of publication in May 2023.

Current approaches to healthcare harm and their impacts

> *"Until we shift from the idea that complex health services cannot be operated from a top-down policy approach, but need to be driven by relationships, then we will not see change."* Clinician

Healthcare is provided within a complex system characterised by uncertainty and unpredictability.[20] In this context, it is perhaps unsurprising that the global incidence of harm remains stubbornly persistent.[21] Harm has numerous causes, and the wide-ranging ripple effects and negative impacts on human wellbeing and relationships have been documented in Aotearoa NZ and beyond.[14,15,17,18,22] Harm emerges from interdependent factors, dynamic networks, and interactions within and between the people who provide and receive care. In te ao Māori, harms are conceived as diminishing of the tapu and mana of people, their environments, and their spiritual connection.[23]

The framework uses the following definition, whilst recognising that harm is best defined by those who are experiencing it:

> **Healthcare harm is a physical, psychological, social, spiritual injury or experience that occurs as a result of providing or receiving healthcare.**

Reporting and responding

In Aotearoa NZ, responsibility for an adverse event, such as an unexpected death or injury to a consumer or healthcare worker, could fall into the jurisdiction of a number of Crown processes. Consistent with the international approach, healthcare harm is usually categorised and recorded as an interpersonal conflict, hazard, complaint, or adverse event.[14] Several parallel legal, professional and provider responses follow, which are usually characterised by objective oversight, retrospective analysis of written documents, directed testimony, and expert opinion[8,24] (see appendix 5).

Safety scientists propose that these isolated, transactional, and linear procedures can limit opportunities to involve the people directly affected by harm, or promote the restoration of wellbeing, relationships, and trust.[8,14,17,24] Many of the stakeholders who contributed to the framework development shared this view and proposed that current harm responses are inconsistent with the goals of healthcare work. Quotes that illustrate this viewpoint are depicted in table 2.

Table 2: Quotes that illustrate the dominant stakeholder perspective of current responses

Role	Quote
Clinician	"We have a system that sorts us into categories because of time constraints. However, people are complex and don't fit necessarily into these boxes. We need to spend time to understand what whānau want, what outcomes they are keen to work on, what you as the health practitioner can do, and what they can do themselves."
Investigator	"There are usually a range of processes involved in an adverse event e.g., an adverse event investigation, responding to a complaint, referral to external agencies such as the HDC and the Coroner. In our quest to follow these processes and achieve learnings for the future, we often fail to ask the question and/or listen to what the person at the centre of the event, their whānau, and those involved in the person's care want or need to redress the harm which has occurred, which is often quite different to what these processes are seeking to achieve. This leads to outcomes which have taken a long time, and are meaningless, or worse still, more harmful, for those involved."
Harmed consumer	"I am a person. I know my body best. I may not fit into your 'tick box', it is a guideline. I am an individual... We are all individuals with individual needs, but our present system doesn't support this type of care... You didn't listen, you didn't look and I am now gone. My whānau is lost, they are trying to understand what happened, to deal with their grief and to find their way through a system unknown to them. Who will help them understand, who will help them through this? Please listen to them now. What do they want? What do they need? When tragedy happens you need to provide support that is also individualised to the needs of their whānau and they need a contact person ASAP so that they have some control of a very traumatic time, someone to call when 'they' are ready."
Government agency representative	"There are a multitude of processes [families] may need to be involved in, inquiries by different bodies, with the resulting potential re-traumatisation for both the family and the healthcare providers."

Compounded harm

Embedded processes pursue laudable goals that are important for system learning and improvement. For example; understanding what happened and why, resolving conflict, improving safety, and mitigating the risk of recurrence. Yet the impact of investigations on health system improvement globally remains challenging and is under researched.[25] Further, the negative impacts of adversarial systems are increasingly highlighted, and include preventing the dialogue necessary for healing,[14] blaming or shaming all those involved,[2,3,8] and perpetuating epistemic injustice [ii] or inequity.[6,17] Clearly, all those involved provide credible information that is crucial to capture and learn from,[26] but the current focus can privilege the act of learning, or the investigator perspective, over the experience of harm.[14,27]

Many hui attendees described current processes as "*re-traumatising*", with stakeholders suggesting the context in which the harm occurred, and the "*human impacts*" and needs that emerged were inadequately considered. Clinicians and consumers suggested that *"we often respond in terms of who is to blame"* and that when blame is unjustly assigned to a healthcare worker, or a lived experience is invalidated, it can result in prolonged distress, trauma, and loss of identity. A large body of scientific evidence clearly articulates that healthcare harm is rarely the result of an individual or intentional act.[9,28-30] Several national and organisational policies endorse this perspective and commit to organisational justice and balancing learning and accountability. However, many stakeholders suggested that in reality responses often blame or shame individuals (consumers and healthcare workers), expressing a deep frustration and dread of current processes. This perspective is consistent with recent reviews and research that has examined the experience of healthcare harm in Aotearoa NZ.[3,17,18,31,32]

Clinicians desired a process that would *"enable clinicians to be able to express, in a supported way, that their intent was not to cause the event that has caused the trauma for the family"*. Consumer advocates also desired a relational response that validated their lived experience and gave their perspective equal weight to the 'expert' voice, proposing that *"it's not about one person being seen as the expert in the relationship, it's about both people... it's about all people being valued... you're both experts on what happened because that's your experience"*. Consumers also highlighted that treatment injury processes could be a source of ongoing harm. Consistent with the experiences described by mesh harmed consumers,[3] treatment injury processes were described as insensitive and burdensome at a time when support and compassion was desperately needed:

> *"There's an inability to see that a lifelong injury needs to be treated on an ongoing basis, with support accordingly, so a resistance – the silencing of the voices of those affected – leads to a loss of trust in health professionals and the system itself, a system we've been socialised to believe would be there for us."* Consumer

Current policies and procedural responses to harm often do not see engagement from Māori, or lead to outcomes that are acceptable to Māori, and can serve to perpetuate colonisation by disregarding the Māori world view.[17,31] The same caution and trauma that Māori experience in adverse events and complaint processes can be experienced by Pacific peoples and other marginalised groups.[33] Whānau Māori stakeholders shared that current processes are culturally insensitive and colonising, perceiving them to serve a system that is not designed to invest in the welfare of whānau and iwi. Whānau Māori told us that they relied on wise navigators in their own whānau, hapū and iwi, including kaumātua, rangatira, tōhunga, and other cultural experts who provide tailored cultural support for the expression of grief, loss, and anger.

ii Epistemic injustice refers to a wrong done to someone as a knower or transmitter of knowledge due to unjustified prejudice, and includes exclusion, silencing, systematic distortion or misrepresentation of a person's meanings or contributions; undervaluing of their status in communicative practices; unfair distinctions in authority; and unwarranted distrust, so someone is unfairly judged to not have the knowledge or reasonable beliefs that they actually have.

Whānau Māori proposed that tikanga and kawa provide clear guidance and offer a better response because care is provided to whānau in a way that provides for cultural, spiritual, physical, emotional needs, and that what matters most to the whānau is the starting point of a response:

> *"We have the opportunity to make Māori norms our system-norms, to provide a framework that ensures whānau comes first. First and foremost, it's about engagement, relational care, aroha, and support... a process that provides whānau guidance regarding whare tapa whā – cultural, spiritual, whānau, physical needs – with what matters the most to the whānau being the starting point."* Māori leader

A kuia suggested that approaches intended to mitigate or respond to harm must also consider cultural complexity:

> *"Cross-cultural dynamics regarding Māori / Pākehā marriages, or those with Pākehā relatives in their whakapapa as well, mean different aspects of their cultural being would be expressed if they were given the opportunity to express it."*

To summarise, well-intentioned responses to healthcare harm can make things worse, and result in compounded harm.[14] Table 3 depicts how compounded harm manifests and the contributing factors cited by hui participants. Attendees overwhelmingly desired an approach that is consistent with the aims of health systems – one that promotes healing and alleviates suffering. It is therefore essential that harm mitigation and response strategies consider human and relational dynamics and provide opportunities for healing alongside learning and improvement.[14] Responses that do not appreciate that people are hurt, and relationships affected, can result in negative impacts on:

- The relationship between the Crown and Māori under Te Tiriti o Waitangi.
- Equitable outcomes for underserved communities.
- The safety of consumers, whānau, and healthcare workers.
- The wellbeing of the people and communities involved.
- Therapeutic relationships and public trust.
- Employer-employee relationships.
- Learning and improvement.
- Meeting the needs of all the people and communities involved.

Table 3: How current responses contribute to compounded harm

How responses compound harm	Common examples of contributory factors
Disrupting normal human, relational, or community adaptations to a harmful event or experience.	• Use of multiple processes, that require people to retell their story on multiple occasions, in order to meet the needs of different organisations or regulators. • Use of terms (e.g., victim, perpetrator) or processes (e.g., just culture algorithms or 'bullying investigations') that result in entrenched positions and prevent opportunities to bring people together. • Protracted processes that interfere with normal human adaptive responses (e.g., grieving, or adapting to change).
Eroding the dignity or tapu of the people involved. **Dignity: The mutual recognition of *"the desire to be seen, heard, listened to, and treated fairly; to be recognized, understood, and to feel safe in the world"*.[34]** **Tapu: Restricted or controlled access; intrinsic wellbeing, worth and dignity; mediated in relationships that enhance, sustain, restore, and empower.[23]**	• Limiting human agency or eroding mana enhancing decisions such as *how* the harm should be addressed and *who* is responsible for action. • People are ascribed a label or role that is not consistent with how they describe themselves (e.g., bully and employee; or an emotional consumer). • Lived experience is not believed. • Those closest to the incident lose their voice when: (a) their role is limited to a passive source of evidence, with 'testimony' focused on a specific event or (b) assigned 'advocates' such as lawyers, managers, or investigators, adopt the role of storyteller, and a narrative is scripted and shaped within frameworks concerned with litigation, reputation, or learning.
Failing to provide a safe space where those directly involved can provide an honest account of their actions, express remorse, and take responsibility for harm and repair.	• Organisational processes and legislation are experienced as unjust, for example when they: (a) actually blame or are perceived to blame individuals for systemic failures; (b) reinforce harmful behaviours or hierarchies; (c) focus on reputational risk; (d) are inequitable or discriminatory. • There is an actual or perceived conflict of interest. For example, when a provider investigates a complaint or adverse event in their own setting or team.
Not responding to the justice needs (substantive, procedural and psychological needs) of the people most directly affected.	• Processes fail to learn and improve, make false promises relating to prevention, or do not transparently share information. • The needs of the system (learning and improving) are prioritised over the needs of the people involved (healing, learning and improving). • The people who are directly affected are not supported to co-design and participate in a meaningful process (e.g., having a voice in who is involved, where meetings will occur, the questions asked by a review, and the reparative or preventative actions required).
Within te ao Māori compounded harm is also articulated as a state of continued violation through whakanoa.	• Response practices and procedures reinforce the impacts of colonisation or intergenerational trauma, or deep societal inequities.

What is a restorative system?

Above all else, restorative systems value people and relationships. They are distinguished by an emphasis on relational principles and practices that aim to promote and restore human dignity and wellbeing. Restorative organisations work to develop policies and practices that recognise the needs of people and cultivate a culture of belonging and respect.[35] In te ao Māori, restorative communities can enhance tapu, and support people to make mana enhancing decisions. In a restorative system, the people who deliver and use health services will feel safe to raise concerns, and talk openly about their experiences, without a fear of being judged. Positive relationships are integral to developing a safety climate in a healthcare setting and are essential for:

- Supportive Tiriti-led partnerships between Crown organisations and iwi and Māori communities.
- Effective leadership, communications, and teamwork.
- Provision of care and compassion to consumers and colleagues.
- Constructive resolution of interpersonal conflicts and workplace disputes.
- Healing, learning, and improving after harm.
- Constructive disciplinary procedures and professional learning.

The northern rātā flower in figure 2 represents the restorative system, which is underpinned by six restorative principles. The flower is a mass of dark scarlet stamens borne in sprays on the tips of branches. Each element can be seen clearly and distinctly, but it is the overall mass that provides the full impact of the delicate beauty of this flower. Similarly, each restorative principle is clear and distinct, but bringing the principles together as a restorative system has its full impact.

Figure 2: The northern rātā flower

Restorative system principles

1. *Whakawhanaungatanga – Systems are comprised of people and relationships*

Restorative systems prioritise, nurture and express relational values and principles in policy, practice, and human relationships. In the Māori world view, this is understood as the practice of whakawhanaungatanga, building familial and mana enhancing relationships. The same relational values and principles are embodied in restorative responses to healthcare harm.

2. *Whakapapa – Human wellbeing and relationships are interdependent*

Restorative philosophy appreciates that human relationships are at the core of our experience of the world, are fundamental to human wellbeing, and are implicated in how we heal and learn. The approach has similarities to the concept of whakapapa in the Māori world view, which touches on the interconnectedness between people for the benefit of future generations. The connection between human relationships and wellbeing is best expressed in Indigenous health models such as the Meihana Model.[12]

3. *Tapu – Restorative systems maintain and enhance dignity through relationships*

Restorative systems consider the needs of all the people affected by system function equally, regardless of their role or status. Restorative systems are not utopic. Conflict and disagreement are understood to be a normal component of everyday life, necessary for the safety and wellbeing of all. Safe, respectful dialogue is used to explore different perspectives of an issue, recognising that people experience and conceptualise things differently. In a restorative system people are accountable to each other and take responsibility for clarifying obligations and responding to people's needs. Restorative principles are relational principles that are concerned with upholding human dignity – or tapu – within human relationships – or whanaungatanga. They are concerned with the enhancement and diminishment of dignity or tapu within all relationships between people, the environments we live in and our spiritual relationships. Harm is the result of the diminishment of tapu or dignity.

Restorative relationships maintain and enhance dignity, and people feel seen and heard as though they matter both when all is well and in the aftermath of a harmful experience. For Māori it is the intrinsic worth of all people that is the foundation of their wellbeing, their tapu. The enhancement and diminishment of tapu occurs within relationships. Table 4 illustrates the relational principles that underpin dignifying relationships.

Table 4: The relational principles that underpin dignifying relationships

Māori	Non-Māori
Pono: Integrity, honesty, and truth	Voluntariness, informed choice, and truthfulness
Tika: Correct, right, worthy, fitting, and appropriate	Equity, safety, transparency, and responsibility
Aroha: Love, compassion, empathy, joy, and kindness	Respect, compassion, empathy, validation
Mana: Enhancing decisions	Dignity enhancing decisions

4. *Taiao – Contextual conditions affect people and their relationships*

Dynamic and uncertain systemic, institutional, relational, and individual contexts influence safety and the ability of the people working within the system to respond and recover from harm. This is the taiao, the environment that we all exist in.

5. *Mahi tahi – Relationships are enhanced by co-production and co-design*

Safety is created from our human capacity for learning, growth, and development though connection and collaboration. Humans are more likely to make positive behaviour changes when those in formal positions of authority work with them, rather than doing things to them. Therefore, restorative systems embrace co-production – a relationship in which authority figures, such as policy makers or organisational leaders, consumers and workers share power, risk, and the opportunity to co-design and deliver change. Conflict and disputes are expected within co-design processes and are surfaced and safely discussed. In the Māori world this is understood as mahi tahi, which is a *"culturally responsive method of co-design that builds approaches by utilising the worldview of the people that the health system most needs to impact upon."* [36]

Restorative responses

Restorative responses (restorative practice and hohou te rongo) are most effective when they are part of a larger commitment to becoming a restorative workplace or organisation rather than being a one-off intervention following a harmful episode.[35]

Restorative practice

Restorative practices can be proactive – promoting dignity enhancing relationships where people are seen and heard as though they matter – or reactive, where the goal is to restore wellbeing and relationships in the aftermath of harm. Restorative responses belong to a family of collaborative, non-adversarial 'Alternative Dispute Resolution' (ADR) pathways that are well established in international health settings, e.g., mediation, negotiation, or communication and resolution programmes.[37] Whilst ADR approaches to early resolution share some common features with a restorative response, each pathway is distinguished by the practices, underpinning principles and values, and outcomes sought.[6,38]

In contrast to approaches that promote disclosure, communication, and resolution, restorative responses are fundamentally relational in nature. They appreciate that human relationships are at the core of the human experience of the world, are fundamental to human wellbeing and are implicated in our healing.[38] Whether an act is intentional or not, a restorative response involves working together to repair the harm and to ensure that responsibility is taken for the impacts of the actions or behaviour of individuals, teams or 'the system' more broadly. The focus moves away from understanding what is 'wrong' with an individual, and instead appreciates the human impacts and needs of all the people, whānau, or communities involved.

Restorative practices begin by listening to understand what people, whānau, or communities need substantively, procedurally, and psychologically to maintain or restore wellbeing, relationships, and trust. The information is then used to co-design and prepare everyone to participate in a meaningful response. Accordingly, the dialogue is guided by a concern to address harms, meet needs, restore trust and promote repair for all involved.[38] Empathetic, respectful dialogue is achieved by ideally bringing people together in a safe environment, with the help of skilled facilitators, in face-to-face dialogue, to answer the five questions of a restorative inquiry[14] (Table 5). Restorative practice is principles based, and a procedural response can still be effective even when the people directly affected by an event choose not to engage in a facilitated meeting with each other. The key principles of restorative practice are summarised in appendix 6.

Table 5: Questions asked in restorative responses and embedded responses

Embedded Response	Restorative Practice	Hohou Te Rongo
What happened?	What happened?	What is the reality? (Pono)
How and why did it happen?	Who has been hurt and what are their needs?	What is right? (Tika)
May ask who is culpable and/or what was the intent of the individuals involved.	Who is responsible and what are their obligations?	What is compassionate? (Aroha)
What can be done to reduce the likelihood of recurrence and make healthcare delivery safer?	How can harms be repaired and relationships be made right again?	How can we restore diminished mana and tapu? (Utu)
What was learned? May ask who is to blame and/or how they should be punished or deterred from re-offending.	How can we mitigate the risk of harm in the future?	What will it look and feel like to be free of this harm from now on? (Whakawātea)

Hohou te rongo

In Aotearoa NZ, restorative responses must also be cognisant of the obligation to embed the special relationship between the Crown and Māori under Te Tiriti o Waitangi. Under Article III, all restorative responses that are integrated into the health and disability sector must be equitable and provide options to iwi and Māori communities, and Crown agencies have a responsibility to protect and support iwi and Māori communities in integrating hohou te rongo, as a taonga under Article II. The Crown has an obligation to resource iwi and hapū to protect and develop this mātauranga under their mana motuhake.

In Aotearoa NZ, the Indigenous root of a restorative system is the kawa of hohou te rongo and its tikanga. In this framework, hohou te rongo is understood as kawa, a practice that existed before colonisation and one whose authority derives from the whakapapa and practices of iwi, hapū and whānau. There are other local terms, including hohou rongo, hohou te rongopai, and hohou te rongo, and the local term should take precedence in any reference to this kawa. This kawa exists widely throughout the iwi and hapū of Aotearoa NZ and tikanga varies from iwi to iwi, hapū to hapū. Our framework is informed by the writings on hohou te rongo by Pā Henare Tate[39] and the practical application of hohou te rongopai in addressing harm experienced by Māori in the Bay of Plenty District Health Board. The short explanation here is based on those writings and learnings.

In te ao Māori, our wellbeing rests upon the enhancement of mana and tapu. Tapu has many meanings but can be regarded here as our individual and collective dignity and wellbeing. Our tapu is influenced by our relationships with people, with the environment and with the spiritual. Tapu cannot be extinguished but it can be diminished. Tapu is diminished by negative interactions and relationships. Mana is our power and authority, our tapu in action. The greater our sense of wellbeing, the greater our capacity to make decisions and act. Mana, like tapu, is derived from our relationships and our communities. Just as with tapu, mana is diminished by negative interactions and relationships. These diminishments are acts of whakanoa, unplanned and unconsented harm and trauma that can be regarded as violations. These violations break trust and relationships and in doing so diminish mana and therefore diminish tapu.

Hohou te rongo exists as a kawa because in te ao Māori there is an acknowledgement that life is full of whakanoa violations, and this protocol supports restoration of broken trust and relationships and enables people to process the impacts of harm and move forward. Rongo is an abbreviation of the full name of the atua Rongomatāne. This atua is the personification of peace and of peace making. Hou is to bind or new. Hohou then is to renew, to rebind, to restore. Therefore, hohou te rongo is to restore peace. The intention of hohou te rongo is that those who have experienced harm can alongside their community integrate the harm into their life story and be free of the violation. The primary focus is restoration of relationships. Where hohou te rongo is used, the tikanga, the process of conducting the protocol, varies from iwi to iwi, hapū to hapū. Appendix 6 provides a summary of the key principles of hohou te rongo.

Accountability and responsibility

Current responses to harm tend to focus on establishing individual or systemic failure and typically seek improvement by means of educational processes, procedural adjustments or at times disciplinary actions. By contrast, restorative responses aim to balance accountability and responsibility with learning and healing. It is useful to define *accountability* and *responsibility* from a restorative understanding:

Accountability includes the duty to disclose. When something goes wrong, health and care organisations and/or the individual practitioners involved have a professional obligation to provide an honest account of what has happened and their part in the story.

Responsibility involves the duty on the part of those who possess organisational authority, or have a professional or moral obligation to those affected by events, to respond to a situation in a way that addresses the needs and rights of all those involved. In a complex adaptive system, taking responsibility is usually a communal act.

Hohou te rongo also balances accountability and responsibility. However these are seen as primarily collective concepts. This returns to the centrality of restoration of relationships to healing from harm. The impacts of harm in te ao Māori are communal, so the accountability and responsibility are also communal.

The organisational and system benefits of employing a restorative framework

Dynamic and uncertain systemic, institutional, relational, and individual contexts influence people's safety and wellbeing, and their ability to respond to and recover from harm. By use of *proactive* and *reactive* practices, restorative systems can enhance system resilience capacity in the following ways:

- If we anticipate that harm will occur, we can mitigate it by promoting wellbeing though fortifying relationships. There is evidence that using co-production or co-design processes and restorative practices can provide 'relational slack' that can function as a buffer when things go wrong.[6,40]
- A restorative approach supports adaptive capacity.[6] The continuous assessment of people's needs allows a team, organisation, or program to adapt to contextual conditions both when all is well (proactively) and when harm inevitably occurs (reactively).
- We can learn about safety, harm, and justice by socially connecting in the emotion of compassionate dialogue.[38] This connection allows for the expression of remorse and is more likely to lead to behaviour change than processes that are experienced as shaming.[41]
- Even in the aftermath of severe harm and human suffering, the potential for adaption, learning and growth can, and indeed must, emerge from relational connection and co-production. For example, emergent social networks of harmed consumers or health professionals can scaffold the health system with essential resources during a period of isolation and trauma.[3]

Marshall suggests that adopting restorative values, principles and practices contributes to the formation of a wider climate of justice and respect in organisations.[35] The use of restorative processes:

- Entails the affirmation of shared values and interests in the organisation and reinforces the legitimacy of the collective rules and commitments.
- Strengthens the skills of collaborative problem-solving and consensus-based decision making in the workforce.
- Contributes to the improved capability of the workforce in being Tiriti led, pro-equity, anti-racist and culturally safe.
- Encourages the active participation of all those affected by the harmful episode in resolving the situation.
- Allows for multiple voices and multiple accounts of the problem to be heard.
- Helps to rebuild trust between colleagues and service users by making space for storytelling, confession, remorse, apology, and forgiveness to occur.
- Helps dissipate feelings of anger, alienation, and impotence in the affected parties by acknowledging each person's experience and empowering them to devise appropriate solutions.
- Enables systemic and structural factors contributing to the harm to come to the surface and allows mitigation strategies to be co-designed.

Developing restorative potential: Enablers and barriers

This framework provides a guide, rather than a prescription, as to how policy makers, providers and practitioners might operationalise restorative initiatives in their everyday context. The recommendations in this paper attempt to leverage the enablers and address the barriers identified from the literature, expertise and lived experience. To support development, stakeholders were asked to consider the enablers and barriers to restorative potential within our current system. Their responses are summarised in Table 6. The dominant view of stakeholders that the health reforms provide a significant opportunity but were characterised by uncertainty is well represented by the following quotes:

> *"While the health system reforms provide a number of opportunities, there are challenges currently in knowing who to go to or influence while the new structures and accountabilities are bedding in."* Government agency representative

> *"Building and maintaining meaningful relationships is foundational to achieving the objectives of the health reforms. Restorative practices must be built into the reforms to assist in resolving conflict, repairing harm, and restoring the balance of tapu and mana."* People and culture representative

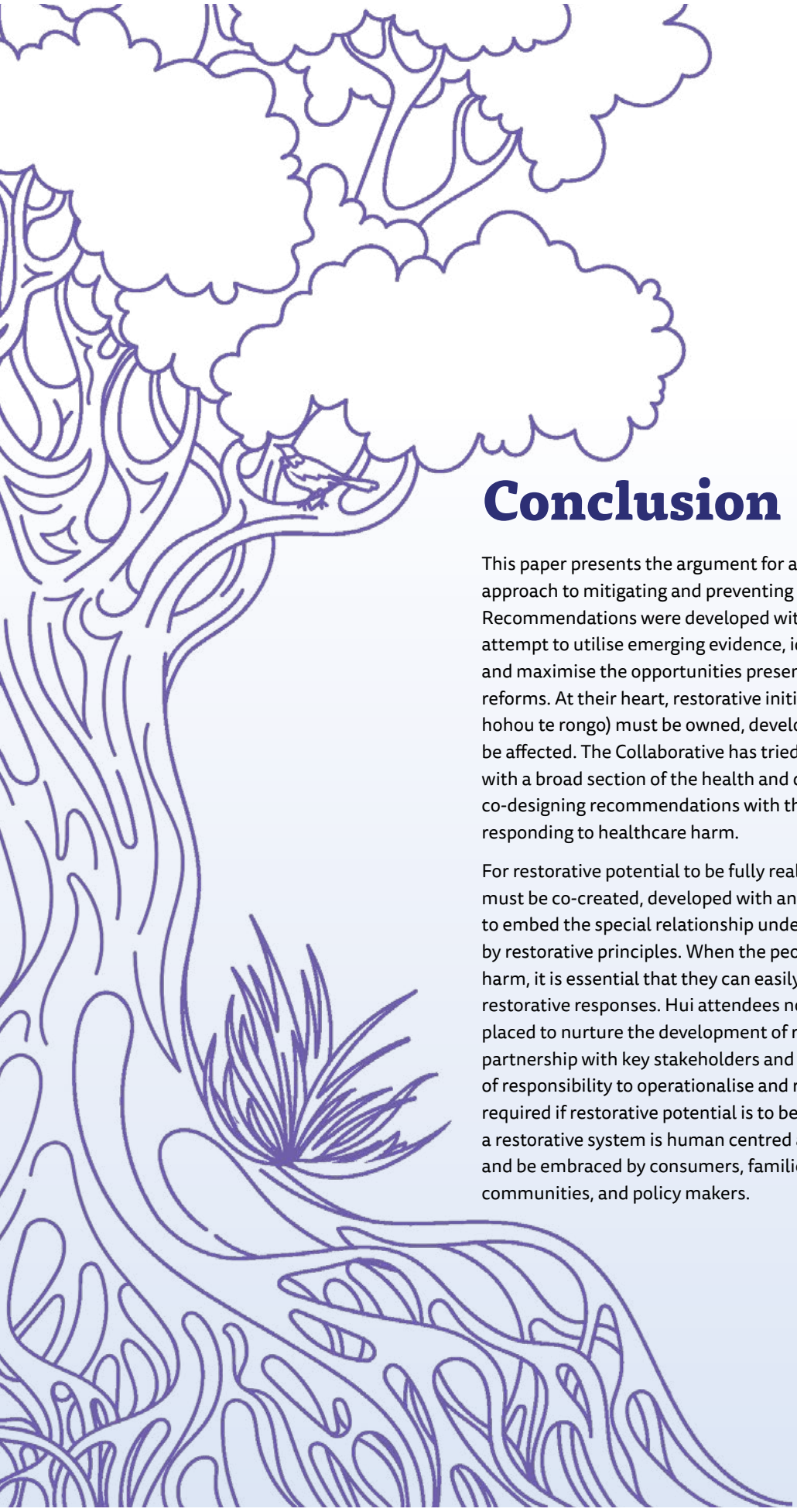
Table 6: The barriers and enablers to restorative potential identified by stakeholders

Barriers	Enablers
Health and legal systems have embedded hierarchies that favour linear, objective approaches (determining cause and effect, objectivity and rationality, and traditional expertise), whereas restorative systems encourage power sharing and validation of multiple perspectives and lived experience.	Health systems function best when they apply the same principles as restorative systems (informed consent, equity, upholding dignity, care, compassion and psychological safety). Restorative and health system goals are aligned (promotion and restoration of health and wellbeing within dignifying relationships). Restorative systems and health work both require us to value and respect the expertise that all parties bring to the table, including the consumer and their whānau. The health reforms were driven by a 'person centred' approach that aligns with a restorative approach. By a focus on setting the right foundation, and valuing relationships that promote dignity and tapu from first health encounters, the reforms support the introduction of restorative initiatives.
The approach within legislation, or policy, does not account for interdependencies or conflicting responsibilities (e.g., between coroners, the HDC and ACC). Legislative change is complex and takes a long time.	A restorative response may mitigate the risk of compounded harm from multiple protracted investigations and be more efficient. There is wide support for restorative systems within the agencies and communities who have a role to play in policy change. Restorative principles can be woven into the new health system policies of Te Whatu Ora and Te Aka Whai Ora, professional standards and upcoming policy and legislation reviews.

Table 6 continued on following page

Table 6 continued

Barriers	Enablers
Restorative responses are already being implemented but practice variations (such as facilitator or process quality) could negatively impact cultural safety, equity, or credibility and further compound harm.	National standards relating to capability, education and operational frameworks are evidence based and endorsed. Practices and processes of hohou te rongo are owned and led by Māori and respect the rights, needs and tikanga of iwi, hapū and whānau. Pathways, job descriptions and governance pathways exist that can be evaluated and implemented (e.g., Te Whatu Ora – Nelson Marlborough and Hauora a Toi).
As restorative systems require a shift towards people and relationships and sharing power, there is variability in (a) uptake/ support from different professional groups; (b) organisational readiness. The high level of interest is not matched by capability in restorative practice and hohou te rongo.	The relational focus of Māori and tikanga are fundamental to our identity as a nation. Te Tiriti o Waitangi outlines the Crown's obligations to Māori within their distinct and special status as the tangata whenua of Aotearoa. The system and organisational benefits of restorative initiatives are promoted. The capability and capacity of restorative resources (e.g., practitioners) is enabled. Clear leadership and resourcing is identified for each recommendation. Research to evaluate the human and economic impacts, efficacy, and quality of restorative initiatives is commissioned. A choice of options is provided, as some people may desire other investigative approaches as well as/instead of restorative options.
A lack of understanding of the restorative continuum. There is a focus on reactive restorative responses, rather than embracing the principles that underpin restorative systems in everyday interactions and practices with consumers and colleagues.	Restorative principles, language, conversations, and practices are introduced as foundational practice skills in pre-registration curricula and healthcare worker inductions. Everyday dignifying relational processes are identified and used as as illustrative examples of restorative practices.



Conclusion

This paper presents the argument for a community led, restorative systems approach to mitigating and preventing healthcare harm in Aotearoa NZ. Recommendations were developed within a collaborative framework and attempt to utilise emerging evidence, identify existing enablers and barriers, and maximise the opportunities presented by the health and disability reforms. At their heart, restorative initiatives (restorative practice and hohou te rongo) must be owned, developed, and led by the people who will be affected. The Collaborative has tried to uphold this principle by consulting with a broad section of the health and disability community and by co-designing recommendations with those responsible for mitigating and responding to healthcare harm.

For restorative potential to be fully realised, restorative policy and practice must be co-created, developed with an intention to meet our obligations to embed the special relationship under Te Tiriti o Waitangi, and be guided by restorative principles. When the people of Aotearoa NZ experience harm, it is essential that they can easily access a suite of options, including restorative responses. Hui attendees noted that the Collaborative is ideally placed to nurture the development of restorative initiatives to develop in partnership with key stakeholders and communities. Establishing clear lines of responsibility to operationalise and resource the recommendations is required if restorative potential is to be realised on a larger scale. Ultimately, a restorative system is human centred and this mahi will likely unite and be embraced by consumers, families, whānau, health professionals, communities, and policy makers.

Appendix 1: The National Collaborative for Restorative Initiatives in Health: Members

Current members (December 2022)

Jo Wailling. Non-Māori Co-chair

Graham Cameron. Māori Co-chair

Rose Wall. Deputy Commissioner Disability. Te Toihau Hauora, Hauātanga | Office of the Health and Disability Commissioner

Tayyaba Khan. Director of Advocacy. Te Toihau Hauora, Hauātanga | Office of the Health and Disability Commissioner

Ikimoke Tamaki-Takarei. Kaitohu Matamua Māori/Director Māori. Te Toihau Hauora, Hauātanga | Office of the Health and Disability Commissioner

Clare Possenniskie. Transitional Manager, Office of the Deputy Director-General. Public Health Agency | Te Pou Hauora Tūmatanui

Dr Arran Culver. Acting Deputy Director-General for Mental Health and Addictions. Manatū Hauora | Ministry of Health

Hannah Whittaker-Komatsu. Principal Advisor Lived Experience. Manatū Hauora | Ministry of Health

Heather Gunter. Independent consumer representative

Ria Earp. Chair of Te Rōpū Māori. Te Tāhū Hauora Health Quality & Safety Commission

Stephanie Turner. Executive Director Māori. Te Tāhū Hauora Health Quality & Safety Commission

Dr Leona Dann. Specialist, system safety | Mātanga – haumaru tūroro. Te Tāhū Hauora Health Quality & Safety Commission

Caroline Tilah. Senior manager, system safety & capability | Kaiwhakahaere matua – haumaru tūroro. Te Tāhū Hauora Health Quality & Safety Commission

Jacqueline Ryan. Quality improvement advisor | Kaitohutohu – whakapai kounga, Mental health and addiction quality improvement programme. Te Tāhū Hauora Health Quality & Safety Commission

Nick Maslin. Customer Response Lead. Accident Compensation Corporation

Dr Dilky Rasiah. Manager Strategic Clinical Advice & Governance. Accident Compensation Corporation

Dr Elizabeth Wood. Chair Clinical Governance Group. Te Whatu Ora Nelson Marlborough

Brenda Hall. Workforce Specialist. Te Whatu Ora Health New Zealand

Vanessa Cooper. Mentally Healthy Work Specialist. WorkSafe | Mahi Haumaru Aotearoa

Mike Hinton. General Manager. Restorative Practices Aotearoa

Appendix 2: The National Collaborative for Restorative Initiatives in Health: Actions to date

- In July to December 2019 the Manatū Hauora Ministry of Health commissioned a major and internationally unprecedented project that employed a restorative approach to address the harm caused by surgical mesh use in Aotearoa NZ.
- A process and impact evaluation concluded that healing after harm is possible within a relational framework which should be offered alongside existing regulatory structures, policies, and procedural responses. It identified that future work in the restorative and health sphere must be Tiriti led, and that additional research is required to identify the mechanisms that enable success.
- In February 2020, the Office of the Chief Clinical Officers Manatū Hauora Ministry of Health, Te Ngāpara Centre for Restorative Practice , ACC, and Te Tāhū Hauora Health Quality & Safety Commission committed to work together to support the development of restorative initiatives in the health sector. Essential partners were identified and invited to participate in a national collaborative.
- At this time, the agreed aims included:

  (a) Co-production of a film to socialise principles, values and goals and to explore people's experiences;

  (b) Partnership with mātauranga Māori experts;

  (c) Te Tāhū Hauora Health Quality & Safety Commission providing seed funding for a workshop in two District Health Board sites and a national hui;

  (d) Te Ngāpara Centre for Restorative Practice funding coaching resources and support for the two pilot sites; and

  (e) A program of work lead by Te Tāhū Hauora Health Quality & Safety Commission Mental Health and Addictions Quality Improvement Program (supported by Te Ngāpara Centre for Restorative Practice).
- In March 2020, ACC Manatū Hauora Ministry of Health and Te Tāhū Hauora Health Quality & Safety Commission were joined by representatives from the HDC. Attendees agreed that a collaborative national approach was required to explore how restorative practices might contribute to health sector resilience. As restorative work requires a Tiriti and interdisciplinary approach, the Centre invited experts in mātauranga Māori. A representative from Technical Advisory Services and the national General Managers of people and capability and health and safety were also invited to attend. In addition, there has been attendance from WorkSafe Mahi Haumaru Aotearoa.
- Collaborative members have been exposed to mātauranga Māori, pilot site feedback, the lived consumer experience, and formal research findings regarding Aotearoa New Zealanders' experiences of healthcare harm. In July 2020, the key area identified for further exploration was how restorative practices might be operationalised in everyday clinical work, policy, legal and investigation frameworks. Participants noted that investment in resources and working partnerships would be required and committed to exploring opportunities within their organisations, aiming to regroup and identify concrete actions.
- Te Whatu Ora Nelson Marlborough are developing a 'restorative practice program', led by the Executive Lead for clinical governance and patient safety. They supported five workshops to socialise the principles and values of a restorative approach and co-design a restorative response to harm with diverse representation and executive support. They have recruited two 'event review facilitators' and trained a small number of senior clinicians to support restorative responses. The principles identified in the workshops will guide responses to harm. Meanwhile restorative responses continue to be used to assist in resolving issues that arise between staff.

- Te Whatu Ora Hauora ō Toi Bay of Plenty Health Quality and Safety Service are developing a 'hohou te rongo' approach. The Pou Tikanga and Quality Safety team consulted with local kuia and kaumātua, who endorsed the use of hohou te rongopai, led by Māori, for Māori, for District Health Board (DHB) complaint and incident responses and staff complaints. Graham Cameron has endorsement from Te Rūnanga Hauora Māori o Te Moana a Toi and the provider Board to progress local development and funding. Next steps include finalising Board endorsement of the approach, a business case to support the training of hohou te rongo facilitators and embed the policy and process alongside iwi in the DHB, and an internal review for the Rūnanga on the pilot.
- Collaborative members agreed to support a Health Research Council project grant proposal to evaluate restorative initiatives underway in Aotearoa NZ (policy, practice, and community). Membership agencies and harmed consumers provided letters and informal emails of support. The grant was not successful, but the intention to seek funding remains.
- Te Tāhū Hauora Health Quality & Safety Commission launched its formal support of restorative responses to harm (restorative practice and hohou te rongo) at the release of the co-funded film 'Pou hihiri, Pou o te aroha | Healing and learning from harm' in June 2021. Due to COVID-19, a national 'Restorative Responses' hui was postponed during 2020 and 2021 and was replaced with supporting vignettes and eventually occurred on 28 March 2023. Restorative principles underpin the revised Healing, learning, and improving from harm: National adverse events policy 2023 | Te whakaora, te ako me te whakapai ake i te kino: Te kaupapa here ā-motu mō ngā mahi tūkino 2023 which comes into effect 1 July 2023. Te Tāhū Hauora Health Quality & Safety Commission supported two District Health Board pilots and the co-design and development of micro-credentials in restorative foundations and responses. Sixty health and disability system workers were sponsored or co-sponsored to attain the qualifications in 2022. Of these, 20 were further sponsored to attend an additional 2 day skills workshop. Te Tāhū Hauora Health Quality & Safety Commission is sponsoring a further 80 people from the mental health and addictions sector in 2023. A community of practice comprised of students who attained the qualifications is supporting the development of restorative mahi. Te Tāhū Hauora is working across the health and disability sector to support the development of an accreditation pathway for restorative responses to events of healthcare harm.
- The health system team at Te Ngāpara Centre for Restorative Practice have provided formal training, coaching and expertise to support the co-design, development and operationalisation of restorative initiatives across Aotearoa NZ. From 2022, formal training has been offered through two university endorsed micro credentials: Restorative Foundations and Restorative Responses (Health and Disability Sector). The courses were endorsed by Te Tāhū Hauora and the Health and Disability Commissioner (HDC). Participants have since formed a restorative practice network and are developing restorative initiatives within their own sphere of work. In early 2023, Te Ngāpara Centre for Restorative Practice limited its role to providing education and training.

Appendix 3: Stakeholders who contributed to the development of this document in two national hui in 2021/2022

Participant Role	Characteristics	Attendees (n=42)
Consumer advocate	Consumer advocate or those with lived experience in a formal role.	4
Kaumātua, kuia or Māori advisor	People whose primary focus is to represent the rights and aspirations of Māori communities.	5
Clinician	Registered health practitioners who may also have a sector or professional leadership role.	9
Investigator	People with a legal responsibility: Coroners, Health and Disability Commissioner, lawyers.	4
People and culture	People with responsibilities for the health, safety and wellbeing of healthcare workers and human resource policies and processes.	7
Quality improvement and patient safety	People with responsibilities for quality improvement or system safety.	3
Government advisor/agency representative	People working for agencies including ACC, the Health Transition Unit, Te Whatu Ora or Te Aka Whai Ora, Manatū Hauora Ministry of Health, WorkSafe.	5
Restorative parties	People who work in restorative practice or research.	5

Appendix 4: Stakeholders who further refined and endorsed the recommendations in November 2022

Māori Caucus

Riana Manuel. Chief Executive. Te Aka Whai Ora

Mike Hinton. General Manager. Restorative Practices Aotearoa

Ria Earp. Chair of Te Rōpū Māori. Te Tāhū Hauora Health Quality & Safety Commission

Ikimoke Tamaki-Takarei. Kaitohu Matamua. Māori/Director Māori. Te Toihau Hauora, Hauātanga | Office of the Health and Disability Commissioner

Matthew Tukaki. Director Office of Suicide Prevention. Manatū Hauora | Ministry of Health

Stephanie Turner. Executive Director Māori. Te Tāhū Hauora Health Quality & Safety Commission

Vanessa Duthie. Senior Service Development Advisor Consumer and Whānau Voice Team. Te Whatu Ora

Kirsty Rance. Team Leader Community Oral Health Service. Te Whatu Ora Nelson Marlborough

Graham Cameron. Co-chair National Collaborative for Restorative Initiatives in Health

Non-Māori Caucus

Denise Anstill. Consumer Advocate, Founder, Trustee and Executive Officer. Foetal Anti-Convulsant Syndrome NZ

Rose Wall. Deputy Commissioner Disability. Te Toihau Hauora, Hauātanga | Office of the Health and Disability Commissioner

Brenda Hall. Workforce Specialist. Te Whatu Ora Health New Zealand

Nick Maslin. Customer Response Lead. Accident Compensation Corporation

Elizabeth Wood. Chair Clinical Governance Group. Te Whatu Ora Nelson Marlborough

Vanessa Cooper. Mentally Healthy Work Specialist. WorkSafe

Clare Possenniskie. Transitional Manager, Office of the Deputy Director-General. Public Health Agency

Dilky Rasiah. Manager Strategic Clinical Advice & Governance. Accident Compensation Corporation

Dianne Marshall. Senior Service Development Advisor Consumer and Whānau Voice Team. Te Whatu Ora

Sue Bree. Director of Midwifery and Service Manager, Maternity Services. Te Tai Tokerau Northern Region

Dave Mann. Acting Executive Director of People and Culture. Te Matau-a-Māui Hawke's Bay

Roisin McGarr. Quality Manager Women's and Children's Division. Waitaha Canterbury

Hannah Whittaker-Komatsu. Principal Advisor Lived experience. Manatū Hauora | Ministry of Health

Alice Evatt. Rangitahi facilitator & Family adviser MHAIDS services. Te Whatu Ora Nelson Marlborough

Dr Leona Dann. Specialist, system safety | Mātanga – haumaru tūroro. Te Tāhū Hauora Health Quality & Safety Commission

Caroline Tilah. Senior manager, system safety & capability | Kaiwhakahaere matua – haumaru tūroro.

Te Tāhū Hauora Health Quality & Safety Commission

Jacqueline Ryan. Quality improvement advisor | Kaitohutohu – whakapai kounga, Mental health and addiction quality improvement programme. Te Tāhū Hauora Health Quality & Safety Commission

Professor Chris Marshall. Emeritus Professor of Restorative Justice. School of Government, Victoria University of Wellington

Jo Wailling. Co-chair National Collaborative for Restorative Initiatives in Health

Dr Iwona Stolarek. Senior Research Fellow. School of Government, Victoria University of Wellington

Dr Lesley Middleton. Senior Research Fellow. Faculty of Health, Victoria University of Wellington

Appendix 5: Aotearoa NZ organisations that respond to healthcare harm and their responsibilities

Different entities and regulators investigate harmful events. Whilst these investigations aim to learn and improve systems, they also have specific responsibilities within a legal or policy framework, particularly when harmful events result in death or disability.

Organisation	Role
Health and Disability Commissioner (HDC)	To promote and protect consumers' rights as set out in the Code of Health and Disability Consumers' Rights 1996, including through the resolution of complaints about infringement of those rights. HDC can investigate complaints where it appears that the provider has breached the Code. HDC also funds a Nationwide Advocacy Service which supports people to resolve their concerns directly with the provider. The Health and Disability Commissioner Act 1994 details the process HDC is required to follow to secure the fair, simple, speedy and efficient resolution of complaints and also offers further explanation for the establishment and function of the Health and Disability Services Consumer Advocacy Service.
The Coronial Service	To investigate when, where, how and why a death occurred under the Coroners Act 2006.
Mental Health District Inspectors	To investigate complaints and conduct inquiries within mental health settings under the Mental Health (Compulsory Assessment and Treatment) Act 1992 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.
WorkSafe	To investigate reported breaches of the Health and Safety at Work Act 2015.
Professional Councils (e.g., Medical, Nursing and Midwifery Councils)	To investigate complaints that assert that a registered health practitioner is in breach of a code of conduct or ethics.
Health Practitioners Disciplinary Tribunal	To hear and determine proceedings brought against health practitioners under the Health Practitioners Competence Assurance Act 2003.
The Accident Compensation Corporation (ACC)	In this context, to determine if a treatment or worker injury has occurred under the Accident Compensation Act 2001 and provide entitlements such as treatment, rehabilitation and compensation under the Act.
Employers	To determine if an employee has breached the conditions of their employment or legislation governing safety and refer accordingly, e.g., to a professional council.

Organisation	Role
Te Tāhū Hauora Health Quality & Safety Commission	To support healing, learning, and improving from harm within the national adverse events policy 2023 | Te whakaora, te ako me te whakapai ake i te kino: Te kaupapa here ā-motu mō ngā mahi tūkino comes into effect 1 July 2023. The policy provides a national framework for health and disability providers to continually improve the quality and safety of services for consumers, whānau and healthcare workers. It provides a consistent way to understand and improve through reporting, reviewing, and learning from healthcare harm. The policy guides the process for reporting to Te Tāhū Hauora and for using the information gathered from learning reviews, along with quality improvement approaches, to strengthen system safety.

Appendix 6: Restorative Responses: Summary of Key Principles and Practices

The following tables lists key restorative principles and what they mean in practice for restorative practice and hohou te rongo. It is not exhaustive or intended for use as a checklist.

Restorative principle	Implications
Process is voluntary	• Participants are fully informed about the potential risks and benefits of participating. • Participants are prepared for meetings with other parties. • Consent to proceed is agreed by all parties (including the facilitator). • Confidentiality parameters are agreed. • Independent facilitators are used if requested.
Active participation	• Substantive, procedural, and psychological needs of all parties are clarified during preparation meetings and other interactions, e.g., who needs to be involved? How would people like to tell their story and to whom?
Respectful dialogue	• Ground rules are established during preparation and start of meeting. • Facilitators minimise interruption and ensure conversational turn taking. • Facilitators uphold the ground rules by interjecting when required to reframe, redirect, or remind participants of their commitments. • If required, facilitators support private conversations to clarify and repair any perceived hurtful comments.
Safe environment	• Confidentiality rules agreed at the outset, e.g., what will be shared and with whom. • Access to emotional, peer or other identified support is available during the process, and particularly before, during and after any facilitated meetings. • Practical / comfort needs are attended to. • Physical safety needs are addressed. • Organisational policies support a just response that does not blame an individual for systemic failures. • Independent facilitators are used in cases of severe harm or intractable conflict, or where there is an actual or perceived conflict of interest.
Skilled facilitation	Experienced practitioners facilitate the co-design of the restorative process, prepare all the parties, and support debriefing.
Responsibility taking	Responsible parties directly hear about the harm experience to identify individual and shared responsibilities.

Restorative principle	Implications
Collaborative problem solving	• Restorative practices (conversations, facilitated meetings and Circles) have a democratic structure that is psychologically safe and supports shared decision making. • Responsible parties are asked to listen and reflect key themes.
Collaborative decision making	• Potential actions are collectively agreed.
Outcomes documented and shared	• The actions for repair and prevention are documented in a shared agreement.
Ongoing relational response	• Ongoing communication, roles and responsibilities are agreed.

Hohou te rongo principle	Implications
Hohou te rongo belongs to whānau Māori, hapū and iwi	• Hohou te rongo can only be led and delivered by whānau Māori, marae, hapū and iwi. • Hohou te rongo must be conducted in Māori cultural settings e.g., marae, kāinga of whānau, whare wānanga.
Hohou te rongo is a kawa that must be grounded in tikanga	• Hohou te rongo must retain its procedural integrity; it cannot be divided into elements that can be used independently. • Tikanga will vary from iwi to iwi, hapū to hapū, and that local context must be the foundation for this process.
Restored relationships is the primary focus	• Hohou te rongo is primarily a process of restoring relationships as restored, positive relationships enhance tapu and mana. • Alongside a desire for forgiveness or accountability, participants in hohou te rongo should be desirous of a relationship.
Cross-cultural hohou te rongo has specific risks	• Māori cultural harm risks being treated as inconsequential in cross-cultural interactions and is often ignored in the restorative process. • In a cross-cultural process, there is often an endorsement of symbolic bicultural outcomes (e.g. cultural safety training) but rarely resource-specific biculturalism. • The willingness to offer utu or compensation is key in hohou te rongo. Utu is a reciprocal response that rebalances a relationship. It is not primarily understood as revenge. Utu, whilst explained here as compensation, is not necessarily financial or material. The key element of utu is that it is seen to restore the tapu and mana of those who have been harmed.

Glossary

Consumer	A consumer is any person who accesses a healthcare service. In Aotearoa NZ the term consumer is used rather than patient or family member because consumer rights are enshrined in the Code of Health and Disability Services Consumers' Rights 1996.
Dignity	Dignity is *"the mutual recognition of the desire to be seen, heard, listened to, and treated fairly; to be recognized, understood, and to feel safe in the world."*[34]
Healthcare harm	Healthcare harm is a physical, psychological, social, or spiritual injury or experience that occurs as a result of providing or receiving healthcare.
Healing	Healing is defined as the restoration of wellbeing, relationships, and trust in so far as this is reasonably possible after a conflict, complaint, or adverse event.
Hohou te rongo	Hohou te rongo is a kawa. There are other local iterations of the name including hohou rongo, hohou te rongopai, and hohou te rongo. The local iteration should take precedence in any reference to this kawa, which exists throughout Aotearoa NZ, and tikanga can vary from iwi to iwi, hapū to hapū.
Justice needs	Justice needs encompass the substantive, procedural and psychological needs of the individuals, whānau and communities affected by a harmful event. Justice needs must be responded to in order to result in meaningful action and a meaningful apology.
Learning	Learning is an active process that involves the application of specific methods to investigate a harmful event, e.g., Human Factors Science. The goal of learning is to make system improvements and mitigate the risk of reoccurrence.
Mahi tahi	Mahi tahi involves collaborating with collective responsibility, accountability and commitment and sharing risk and opportunity.
Mātauranga Māori	Mātauranga Māori is the body of knowledge originating from Māori ancestors, including the Māori world view and perspectives, Māori creativity and cultural practices.
Organisational accountability	Organisational accountability can be a legal or moral duty or standard which sets out how organisations should tell those affected that an unintended or unexpected incident appears to have caused harm. They are required to apologise, to meaningfully involve all those who are affected by the incident in a review of what happened and to enable a response that is experienced as safe and supportive by all involved (consumers and healthcare workers).

Professional accountability	Accountability refers to the duty to give an account of what happened and one's part in the story, rather than thinking of it purely in terms of fault and blame. Every health professional must be open and honest with patients and people in their care when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that health and care professionals must: • Tell the person (or, where appropriate, their advocate, carer, or family) when something has gone wrong. • Apologise to the person (or, where appropriate, their advocate, carer or family). • Offer an appropriate remedy or support to put matters right (if possible). • Explain fully to the person (or, where appropriate, their advocate, carer or family) the short- and long-term effects of what has happened.
Responsibility	Responsibility relates to the duty to respond to a situation in which one possesses a level of organisational authority or a professional or moral obligation toward others.
Restorative just culture	Restorative just culture is a term associated with the seminal work of Professor Sidney Dekker. In a restorative just culture the people who use and deliver healthcare services will feel safe to raise concerns, and talk openly about adverse events or experiences, without a fear of being judged.
Restorative organisation	Restorative organisations prioritise people and relationships. They appreciate that wellbeing and relationships are interdependent and can be influenced by organisational conditions and look for ways to enhance relationships, such as distributing leadership and co-designing and delivering change. The ultimate goal of a restorative organisation is to ensure that all people – those providing and receiving care – feel seen and heard as though they matter.
Restorative practice	Restorative practices encompass relational philosophy, principles and processes that can be applied to prevent, mitigate, and respond to harm.
Restorative response	Restorative responses encompass relational philosophy, principles, and processes that aim to restore wellbeing, relationships and trust following a harmful event.
Safety climate	Safety climate is the perceived value placed on safety in an organisation at a particular point in time. Therefore, we can think of safety climate as the 'mood' of an organisation, based on what workers experience at a specific time.
Taiao	Taiao is the natural environment.

Tapu	Tapu refers to restricted or controlled access; intrinsic worth and dignity; mediated in relationships that enhance, sustain, restore, and empower. [23]
Tikanga Māori	Tikanga Māori is a term that encompasses the customary system of Māori values and practices that have developed over time and are deeply embedded in the social context.
Utu	Utu is a reciprocal response that rebalances a relationship. It is not primarily understood as revenge. Utu, whilst explained here as compensation, is not necessarily financial or material. The key element of utu is that it is seen to restore the tapu and mana of those who have been harmed.
Whakapapa	Whakapapa is a term that describes familial relationships, grounded in trust, in which people are invested in each other's wellbeing.
Whanaungatanga	Whanaungatanga is a term than encompasses relationship, kinship, and a sense of connection. A relationship developed through shared experiences and working together that provides a sense of belonging. It develops as a result of kinship rights and obligations that serve to strengthen all members of the group.
Whānau	Whānau is often translated as extended family, but its meaning is more complex. It includes physical, emotional, and spiritual dimensions and is based on whakapapa.

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