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'Special Treatment'

a 30-year case study exploring whether Pacific peoples as an ethnic minority are being privileged in public policy

Abstract

This article interrogates claims of 'special treatment' for ethnic minorities by examining the alignment between documented Pacific mental health need and 30 years of public mental health and Pacific health policy (alongside relevant estimates of appropriations). Using frequency analysis and close reading, it finds that despite longstanding and well-evidenced inequities, Pacific mental health is inconsistently addressed, rarely prioritised, and seldom supported through targeted investment. Analysis by governing party shows that both inclusion and prioritisation are generally lower under National-led governments. While Labour-led governments have adopted more inclusive rhetoric, this has not consistently translated into substantive policy action or resourcing. Overall, the study finds that claims of special treatment for Pacific peoples as an ethnic minority are supported by neither policy content nor investment.

Keywords public policy, mental health, Pacific peoples, equity, ethnic-specific policy, political discourse

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Introduction and background

Claims of 'special treatment' for minority groups recur regularly in political and electoral discourse in Aotearoa New Zealand, often mobilised by political actors to provoke controversy and shape public debate. 'Special treatment' – defined here as the explicit and measurable prioritisation of a minority group through differentiated policy attention, resource allocation, or strategic inclusion beyond that afforded to the general population – is most commonly invoked in relation to ethnic minorities and continues to feature centrally in contemporary debates about equity, identity and public investment. Such claims are not merely rhetorical; they shape public trust, influence electoral politics, and inform decisions about the allocation of limited public resources.

Under the current National–New Zealand First–ACT administration, rhetoric of 'special treatment' has once again re-emerged, evident in parliamentary debates over the Treaty Principles Bill and Regulatory Standards Bill, as well as in high-profile public commentary such as Kate Hawkesby's discussion of surgical waiting list prioritisation (Broadcasting Standards Authority, 2024). These arguments echo earlier political moments, including National Party leader Don Brash's 2004 Orewa speech (Brash, 2004). Yet despite the persistence and political salience of these claims, there is limited empirical analysis examining whether they are borne out in policy content or resourcing decisions.

What is well evidenced, however, are the enduring inequities experienced by ethnic minority communities – including Māori, Pacific and MELAA populations – across health, education, justice and social development, resulting in poorer outcomes and reduced opportunities (Ministry for Ethnic Communities – Te Tari Mātāwaka, 2024).

This article responds to the gap between rhetoric and evidence by examining the extent to which Pacific peoples – used here as a representative ethnic minority – have been prioritised within public mental health policy, as a representative policy domain. Drawing on a PhD study by the lead author (Tuesday, 2023), it presents a 30-year case study of public policy documents, including mental health strategies, Pacific health plans, and estimates of appropriations. Using document analysis, the article contributes an evidence-informed perspective to debates about equity and public policy.

Talavou o le Moana ... highlights the needs of Pacific youth, reflecting a higher rate of significant depression symptoms among Pacific youth (25.9%, compared with 19.6% for Pākehā), and increasing suicidal ideation and attempts.

A brief overview of Pacific peoples and their mental health needs

Pacific peoples in Aotearoa New Zealand are a young, rapidly growing and culturally diverse population, most of whom are New Zealand-born. The identities of this population group are shaped by strong cultural, linguistic and communal ties that span Moana-Nui-a-Kiwa/the Pacific region. Despite the many strengths and contributions of Pacific communities, they continue to face persistent inequities across key determinants of health and wellbeing, including a disproportionate burden of mental illness (Ministry for Pacific Peoples, 2018).

Te Rau Hinengaro, the 2006 New Zealand mental health survey, found that 25% of Pacific people had experienced a mental disorder in the past year and 46.5% across their lifetime, a significantly higher proportion than of the general population (20.7% and 39.5% respectively). The survey also found that only 25% of Pacific people with serious mental illness accessed any mental health service, compared with 58% of others, highlighting substantial unmet need (Foliaki et al., 2006). Although *Te Rau Hinengaro* is now two decades old, more recent findings from *Te Kaveinga* (Ataera-Minster & Trowland, 2018) suggest these disparities persist. Pacific peoples had higher Kessler-10 scores (14.6 vs 13.9) and were 1.2 times more likely to report moderate or high psychological distress. These disparities persisted across subgroups, including multi-ethnic and realm-nation Pacific populations. Alarmingly, 15% and 24% of Pacific people in this study did not know where to seek help for depression or anxiety respectively.

Talavou o le Moana (Veukiso-Ulugia et al., 2024) highlights the needs of Pacific youth, reflecting a higher rate of significant depression symptoms among Pacific youth (25.9%, compared with 19.6% for Pākehā), and increasing suicidal ideation and attempts. Findings from the Growing Up in New Zealand study also highlight that Pacific children experience more anxiety and depression symptoms and Pacific mothers experience higher rates of antenatal depression than their European counterparts (Morton et al., 2020; McDaid et al., 2019).

Approach

To develop this case study, the authors analysed a targeted set of public policy documents published between 1990 and 2022. The time frame captures developments since the Mason Inquiry into psychiatric hospital care (1987–89) and the first national mental health strategy (Mason, 1989; Ministry of Health, 1994), and the completion of data collection for the lead author's PhD in 2017.

The analysis focused on six key document types:

- public mental health strategies and action plans (mainstream and, where available, Pacific) (Crawley et al., 1995; Ministry of Health, 1994, 1997b, 2005b; Ministry of Health, 2006a, 2010, 2012, 2020a, 2021a, 2021b);

- Pacific health strategies and action plans (Ministry of Health, 2020b, 1997a, 2014; Te Whatu Ora | Health New Zealand, 2022; Ministry of Health & Ministry of Pacific Island Affairs, 2010; King, 2002);
- Vote Health appropriations (New Zealand Government, 2021a, 2022a; Te Kāwanatanga o Aotearoa, 2023a; Treasury, 1998a, 2001a, 2010a, 2019b, 2020a, 2019a);
- Vote Pacific Island Affairs/Pacific Peoples' appropriations (New Zealand Government, 2021b, 2022b; Te Kāwanatanga o Aotearoa, 2023b; Treasury, 1998b, 2001b, 2010b, 2019c, 2019a, 2020b).

These documents were selected to represent key avenues for Pacific mental health in public policy. While all strategies and action plans within the time frame were reviewed, only second-year estimates of appropriations were prioritised for each National- or Labour-led government term, allowing a manageable yet representative review.

A frequency analysis was conducted to assess the visibility of Pacific peoples and mental health: mentions of 'Pacific', 'Pasifika', 'Pasefika' and 'Pacifica' were counted in mainstream documents, while references to 'mental health', 'mental wellbeing', 'mental illness' and related terms were counted in Pacific-focused documents. Frequency counts – presented as average number of mentions per page – served as a proxy for attention, alongside close readings of content and tone.

This analysis was situated within a broader policy landscape, including relevant legislation, Māori health strategies, mental health workforce plans, consultation summaries, briefings to incoming ministers, budget speeches, and the Mental Health Commission's 'Blueprint' documents. For the purposes of this analysis, primary emphasis was placed on formal policy documents and estimates of appropriations, as together these provide the clearest line of sight between stated government priorities and how those priorities are operationalised through public spending. While briefings, speeches and other policy-adjacent texts inform context and intent, they do not carry the same directive or fiscal force.

Table 1: Number of mentions of 'Pacific' (and related terms) in mainstream, public mental health policy, 1990–2022

Name of Document	# of Mentions of " Pacific", "Pasitika", "Pasefika", or "Pacifica" AND # of Pages	Average # of Mentions of "pacific", "pasifika", "pasefika", or "Pacifica" per page
Looking Forward: Strategic Directions for Mental Health Services (1994)	Count: 2 Pages: 30	0.07
Moving Forward: The National Mental Health Plan for More and Better Services (1997)	Count: 65 Pages:74	0.87
Te Tāhuhu: lmproving Mental Health 2006-2015 (2005)	Count: 6 Pages: 21	0.29
Te Kōkiri: The Mental Health and Addiction Plan 2006-2015 (2006)	Count: 40 Pages: 82	0.49
Mental Health and Addiction Plan (2010)	Count: 0 Pages:7	0.00
Rising to the Challenge: Mental Health and Addiction Service Development Plan 2012-2017 (2012)	Count: 21 Pages:69	0.30
COVID-19: Kia Kaha, Kla Māia, Kia Ora Aotearoa: Psychosocial and Mental Wellbeing Recovery Plan as at 15 May 2020 (2020)	Count: 39 Pages:42	0.93
Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing (2021)	Count: 19 Pages: 76	0.25

Figure 1: Average number of mentions of 'Pacific' (and related terms) per page in mainstream public mental health policy, 1990–2022

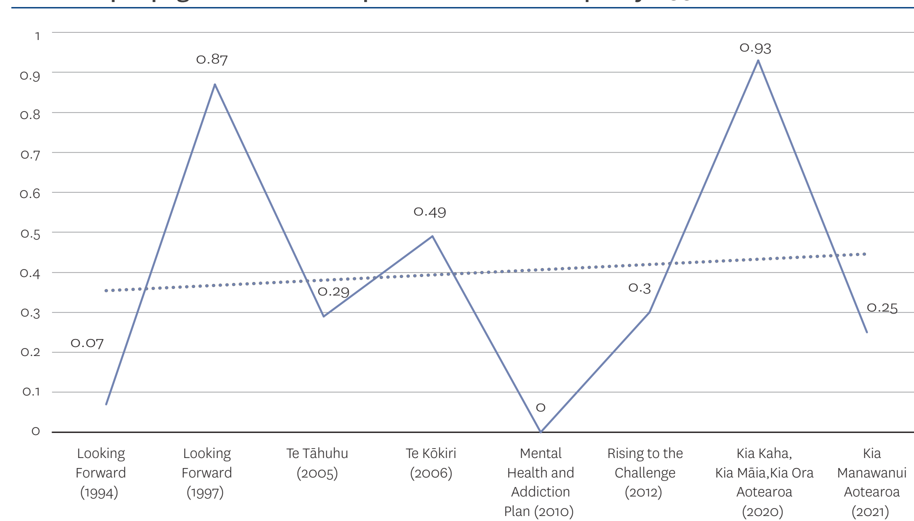


Figure 2: Average number of mentions of 'Pacific' (and related terms) per page in mainstream, public, National government-led mental health policy, 1990–2022

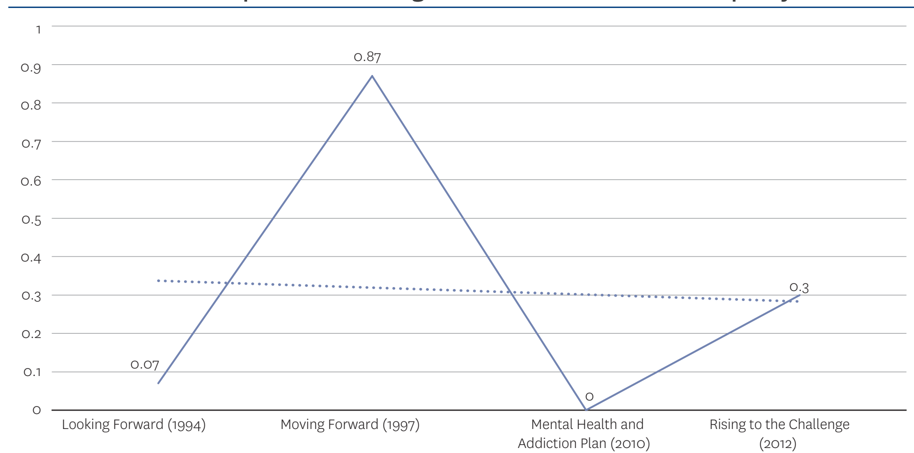


Figure 3: Average number of mentions of ‘Pacific’ (and related terms) per page in mainstream, public, Labour government-led mental health policy, 1990–2022

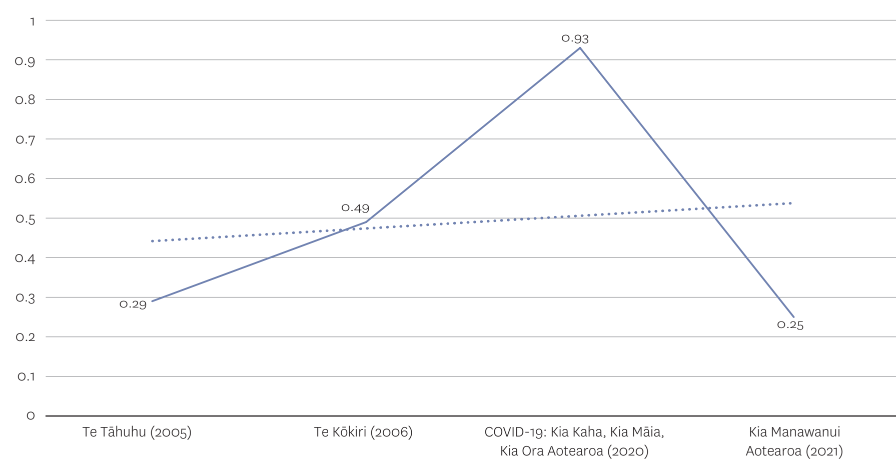
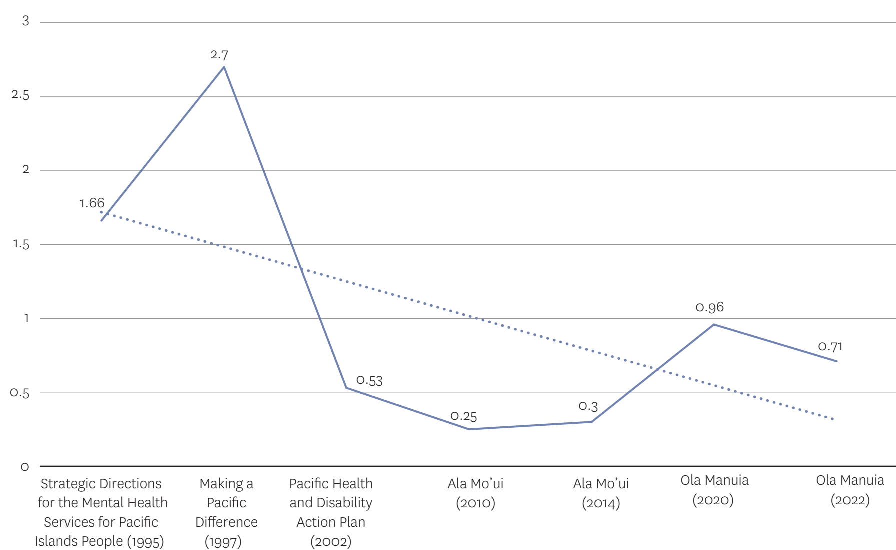


Table 2: Number of mentions of ‘mental health’ (and related terms) in public Pacific health policy, 1990–2022

Name of Document	#of Mentions of “ mental health”, “mental wellbeing”, “mental well-being”, “mental illness”, and “mental distress”	Average# of Mentions of “mental health”, “mental wellbeing”, “mental well-being”, “mental illness”, and “mental distress”
Strategic Directions for the Mental Health Services for Pacific Islands People (1995)	Count: 93 Pages: 56	1.66
Making a Pacific Difference: Strategy Initiatives for the health of Pacific People in New Zealand (1997)	Count: 54 Pages:20	2.70
Pacific Health and Disability Action Plan (2002)	Count: 17 Pages: 32	0.53
Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2010-2014 (2010)	Count: 8 Pages: 32	0.25
Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2014-2018 (2014)	Count: 12 Pages: 40	0.30
Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025 (2020)	Count: 46 Pages: 48	0.96
Ola Manuia Interim Pacific Health Plan July 2022-June 2024 (2022)	Count: 17 Pages:24	0.71

Figure 4: Average number of mentions of ‘mental health’ (and related terms) in public Pacific health policy, 1990–2022



Findings

Frequency

Mental health policy

Frequency analysis reveals a highly variable level of attention to Pacific peoples and their needs. This variability applies to both National- and Labour-led governments. Blue boxes reflect documents published under a National-led government, while pink boxes are those published under Labour.

This variability is not accompanied by a clear temporal trend. When analysed by leading party, a slight downward trajectory is observed in National government-led policies, while Labour government-led policies show a modest upward trend. This may be skewed by the increase in mentions of Pacific peoples in *Covid-19: Kia Kaha, Kia Māia, Kia Ora Aotearoa*, the Ministry of Health’s Covid mental health recovery plan, reflecting the disproportionate impacts of Covid-19 on Pacific communities (Ministry of Health, 2020a; Royal Commission of Inqury into Covid-19 Lessons Learned, 2024).

While the dataset is limited, and frequency analysis serves only as a proxy measure of attention, the analysis suggests that Pacific peoples have not received consistent or sustained attention in mainstream mental health policy over the past three decades.

Pacific health policy

Since 1997, a series of Pacific-specific health policies have been developed. While their existence may be interpreted as evidence of ‘special treatment’, this must be considered alongside the consistent development of health policies for other key population groups, including Māori, children, older adults and disabled people (Ministry of Health, 2023).

As with mainstream policy, frequency analysis of Pacific health policies shows a variable level of attention to mental health. Overall, attention to mental health in Pacific public health policy has declined over time. Analysis by leading party shows a sharp drop in average number of mentions in National government-led policies, reflecting the high baseline set by the two earliest documents. When these outliers are excluded, the downward trend flattens out. Labour government-led Pacific

health policy shows a moderate upward trend in attention to mental health; however, this is inconsistent.

Bearing the previously stated limitations in mind, this data underscores a lack of consistent attention to Pacific mental health.

Estimates of appropriations

Where policy statements articulate strategic intent, estimates of appropriations indicate whether – and to what extent – that intent is translated into funded action. Examining the two in tandem allows assessment not only of rhetorical prioritisation, but also of whether such prioritisation is substantively supported.

To avoid inflated counts, analysis of estimates of appropriations focused on mentions of Pacific peoples in Vote Health documents and on mentions of mental health in Vote Pacific Peoples documents. This approach reflects the expectation that each vote would naturally prioritise its respective domain.

No lines of appropriations related to mental health were identified in Vote Pacific Peoples documents. While Vote Health documents included some references to Pacific peoples, only one instance – in the 2019 budget – provided a direct line of sight to investment in Pacific mental health, via funding allocated to *Ola Manuia*, the government's Pacific health

Figure 5: Average number of mentions of 'mental health' (and related terms) in Pacific, National government-led public health policy, 1990–2022

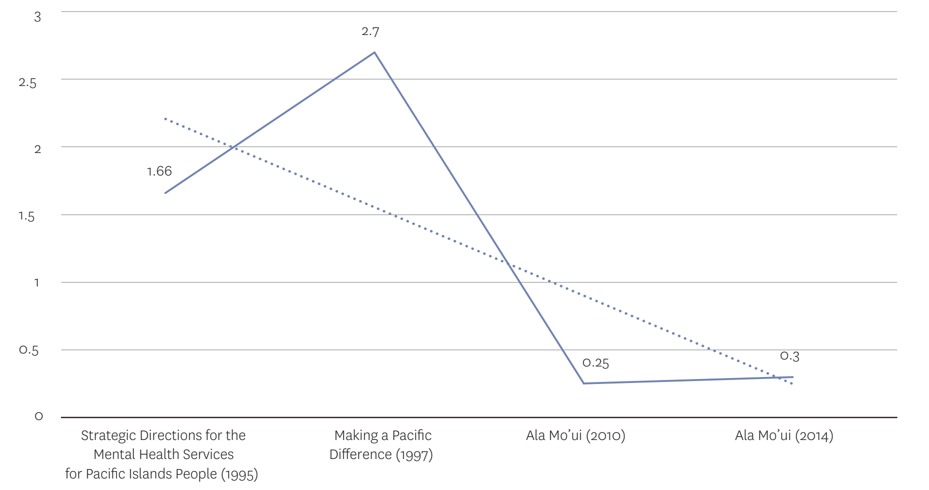


Figure 6: Average number of mentions of 'mental health' (and related terms) in Pacific, Labour government-led public health policy, 1990–2022

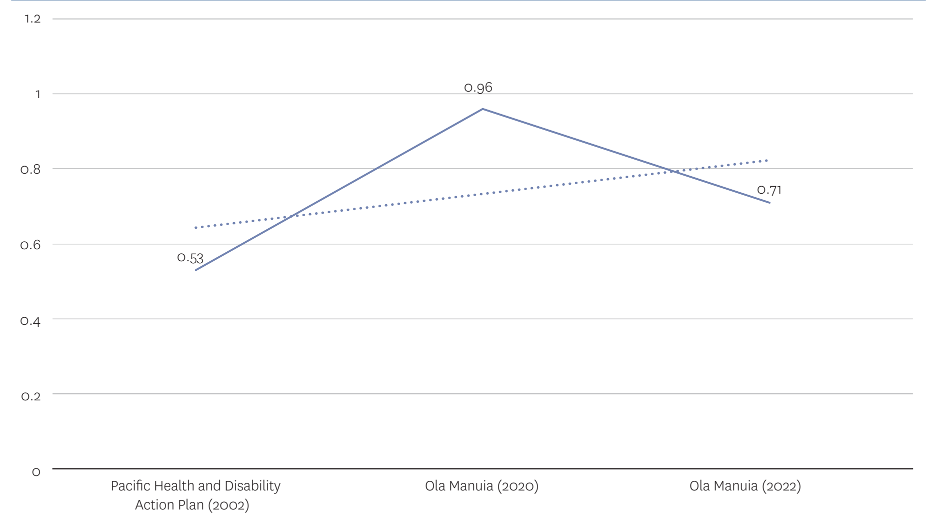
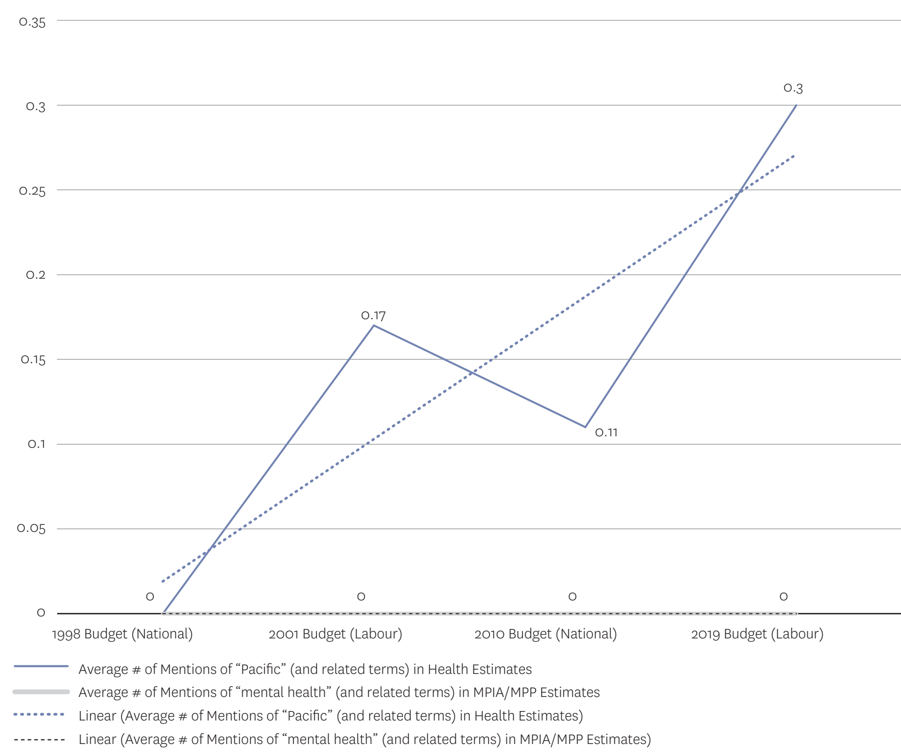


Table 3: Number of mentions of 'Pacific' and 'mental health' (and related terms) in second-year estimates of appropriations for Health and MPIA/MPP, 1990–2022

Government	# of Mentions of "Pacific", "Pasifika", "Pasefika", or "Pacifica"	Average # of Mentions of "Paciflc", "Pasifika", "Pasefika", or "Pacifica"	# of Mentions of " mental health", "mental wellbeing", "mental well-being", "mental illness", and "mental distress"	Average # of Mentions of " mental health", "mental wellbeing", "mental well-being", "mental illness", and "mental distress"
National 1990-1993 National 1993-1996	Budget records not available online			
National 1996-1999 *1998 Budget*	Health Count: 0 Pages: 49	0.00	PIA/PP Count 0 Pages 22	0.00
Labour 1999-2002 *2001 Budget* Labour 2002-2005 Labour 2005-2008	Health Count: 11 Pages: 65	0.17	PIA/PP Count 0 Pages 15	0.00
National 2008-2011 *2010 Budget* National 2011-2014 National 2014-2017	Health Count: 1 Pages: 9	0.11	PIA/PP Count 0 Pages 4	0.00
Labour 2017-2020 *2019 Budget* Labour 2020-	Health Count: 36 Pages: 122	0.30	PIA/PP Count 0 Pages 18	0.00

Figure 7: Average number of mentions of 'Pacific' and 'mental health' (and related terms) in estimates of appropriations for Health and MPIA/MPP, 1990–2022



and wellbeing action plan, which includes mental health actions. Analysis by leading party was not undertaken for this dataset due to its limited size (Treasury, 2019b; Ministry of Health, 2020b).

Attention has increased in some budgets but remains inconsistent. Moreover, increased visibility has not translated into targeted investment in Pacific mental health, despite the evidenced need. This highlights a landscape where we are more likely to be seeing 'special mentions' than 'special treatment'.

Analysis of content and tone

Policy

During the mid–late 1990s both mental health and the specific health needs of Pacific peoples started to emerge as distinct areas of policy concern (in 1994 and 1997 respectively). This was evident in the establishment of public policy (as documented here), but also in the creation of Pacific-specific roles and portfolios within the Ministry of Health (Wakefield, 2018; Aumua, 2003). Despite this coincidence of focus, mainstream mental health policy has historically positioned Pacific peoples as peripheral. New Zealand's inaugural public mental health strategy (Ministry of Health, 1994) acknowledged deficiencies in mental health services and prioritised Māori, youth and those with severe psychiatric disabilities. Pacific peoples were grouped under 'other priority groups' alongside refugees and older adults, with no specific actions or research directives.

Strategic Directions for the Mental Health Services for Pacific Islands People (Crawley et al., 1995) was released the following year and presented findings from extensive community consultation. It articulated culturally grounded recommendations, including the establishment of a Pacific mental health council, culturally safe services and family support mechanisms. However, only a subset of these recommendations – those most compatible with existing institutional structures – were adopted in the next mainstream public mental health policy (Ministry of Health, 1997b). This selective uptake reflects a broader pattern of acknowledging Pacific perspectives but subordinating them to dominant policy logics.

Subsequent mainstream policies continued these trends. Pacific peoples, while referenced in most documents, have never been afforded a dedicated section in mainstream public mental health policy. Targeted points for Pacific peoples have not been consistently integrated across service domains, and Pacific inclusion has either been minimal or framed in ways that – as per their inclusion in the 1994 strategy – conflated Pacific needs with those of other minority groups, obscuring the distinct cultural and service needs of Pacific communities and Pacific diversity. This absence of direct inclusion is accompanied by limited evidence of consultation or engagement, and limited (if any) citation of Pacific-authored research (which might have served as an indicator of engagement). Even when Pacific priorities, approaches or values have been acknowledged, they have usually been positioned as potential sources of difficulty rather than as complementary frameworks or sources of insight. This contributes to an overall tone of cautious accommodation rather than genuine partnership, respect or care.

Rising to the Challenge: the mental health and addiction service development plan 2012–2017 (Ministry of Health, 2012) was the final mainstream public mental health policy released prior to the 2018 Pacific mental health inquiry (Ataera-Minster & Trowland, 2018) and then the onset of Covid-19. It exemplifies the discursive exclusion of Pacific mental health. Pacific peoples are grouped with refugees and disabled populations and there are no specific actions directed towards Pacific people's mental health needs, making it the least engaged mainstream mental health policy in terms of Pacific inclusion since 1994 and indicating no meaningful shift in 30 years. Wider features of the document, such as the policy's emphasis on efficiency – through key performance indicators, brief interventions and e-therapies – stand in contrast to the research available at the time about culturally appropriate care, wherein time, relationship and cultural congruence need to be prioritised.

The post-mental health inquiry and pandemic period saw the release of two mainstream mental health policies: *Kia Kaha, Kia Māia, Kia Ora Aotearoa* (Ministry of Health, 2020a) in 2020 and *Kia Manawanui Aotearoa* (Ministry of Health, 2021b) in 2021. The former was developed in direct response to the Covid-19 pandemic and adopted a broad equity lens that acknowledged the disproportionate risks

faced by Pacific communities. However, despite repeated references to Pacific peoples and a stated commitment to holistic wellbeing, the document did not include any actions specific to Pacific mental health. In contrast, *Kia Manawanui Aotearoa* marked a notable shift in both tone and intent. Drawing on the concept of 'pae ora' (healthy futures) and *Whakamaua*, the 2020 Māori health action plan (Ministry of Health, 2020c), it offered the most detailed articulation of Pacific health beliefs in any mainstream mental health policy to date. Pacific wellbeing was described as encompassing mental, physical, spiritual, family, environmental, cultural and ancestral dimensions, with values such as respect, reciprocity and collectivism explicitly acknowledged. While the policy remained aspirational and lacked clear implementation pathways, it did signal a more inclusive and culturally resonant discourse around mental health.

Public Pacific health policies – as opposed to public mainstream mental health policies – have offered more direct engagement, though not without limitations. *Making a Pacific Difference* (Ministry of Health, 1997a) both incorporated community consultation and acknowledged Pacific health beliefs, but privileged Western medicine over Pacific world views. Mental health was addressed briefly, with a focus on promotion, and recommendations from earlier consultations (e.g., Crawley et al., 1995) were largely omitted.

Despite increased attention to both Pacific peoples and mental health in other policy and policy-adjacent documents of this era, the focus on mental health in the *Pacific Health and Disability Action Plan* (King, 2002) was dampened by systemic and structural change. While the document acknowledged a range of health issues, mental health was not explicitly identified as a priority for Pacific peoples, and only two action points under the six priorities addressed it. This likely reflects that the 2001 health system reforms positioned Pacific health under the Clinical Services Directorate, while mental health was its own directorate, largely disconnected from Pacific health (Ministry of Health, 2005a; New Zealand Parliament, 2009). The document provided minimal engagement with Pacific cultural perspectives, incorporated no Pacific scholarship, and missed an opportunity to align with the Pacific-inclusive strengths of the Blueprint reports (Mental Health Commission, 1998, 2001) which had immediately preceded it (despite the recent, community-informed evidence in which these were grounded). Again, this likely reflects overarching government perspectives and values, rather than a lack of advocacy or insight from Pacific communities and policy actors.

Later policies, including the two *'Ala Mo'ui* documents (Ministry of Health & Ministry of Pacific Island Affairs, 2010; Ministry of Health, 2014), introduced more nuanced engagement with Pacific values, such as holism and the centrality of family. However, mental health remained a relatively peripheral concern, often addressed only in relation to broader mainstream strategies. The increasing emphasis on expert-led consultation also reduced visibility of community-driven priorities. The latter document focused more on equity but largely lacked specific actions for Pacific mental health; the only action provided is that 'DHBs will implement the Pacific specific actions in the Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017' (Ministry of Health, 2014, p. 14). As mentioned earlier in this section, no Pacific-specific actions are included in *Rising to the Challenge*.

> The 2020–25 plan represented a high point in Pacific-led policy development, with clear evidence of community consultation, explicit prioritisation of Pacific mental health, and a dedicated section outlining culturally grounded actions.

The two Pacific health strategies that appeared latest in the review period – *Ola Manuia: Pacific health and wellbeing action plan 2020–2025* (Ministry of Health, 2020b) and its 2022 interim successor (Te Whatu Ora | Health New Zealand, 2022) – offered contrasting approaches to mental health. The 2020–25 plan represented a high point in Pacific-led policy development, with clear evidence of community consultation, explicit prioritisation of Pacific mental health, and a dedicated section outlining culturally grounded actions. It embedded mental health within a holistic, family-centred model of wellbeing, and acknowledged the importance of cultural values. The 2022 interim plan, however, marked a regression. While mental health remained listed as a priority, the scope of action narrowed significantly, with a focus limited to maternal mental health and research into Pacific models of care. Notably, issues such as youth mental health and access to services – highlighted in the plan's own statistical appendices and clearly identified as priorities for Pacific peoples in mental health research – were not addressed as action points. This shift, occurring in the context of health system restructuring, highlights the fragility of progress and risk of deprioritisation in times of institutional change.

Estimates of appropriations

The estimates of appropriations provide a detailed view of funding decisions, yet Pacific mental health remains largely invisible. The only identifiable reference to Pacific mental health investment appears in the second-year budgets in the 2019 Vote Health estimates (Treasury, 2019b), where funding for *Ola Manuia* – which includes mental health actions – is noted. Even here, the connection is indirect, and no specific

appropriation is identified. This is the only instance across the review period where a budget line provides a clear line of sight to Pacific mental health investment. Vote Pacific Peoples documents contain no references to mental health, highlighting that attention to this domain is not being provided through ethnic-specific channels either. Despite rhetorical progress, targeted investment remains lacking.

The notion of 'special treatment' is not supported by any of the data explored, and furthermore, where equity-focused rhetoric is present it has not been matched by resourcing.

Discussion

This article set out to examine whether Pacific peoples, as a representative ethnic minority, have received 'special treatment' in public mental health policy – as a representative domain – over a period of 30 years.

The introduction and background highlighted the persistent and well-documented mental health inequities experienced by Pacific communities in Aotearoa New Zealand, including higher prevalence of mental disorders, lower access to services, and limited awareness of support options. There is clear evidence of need among this population to justify an ethnically targeted approach – or 'special treatment'. However, the findings show that, even when such evidence is present for an ethnic minority, such approaches are not.

Policy documents signal what governments claim to value, but estimates of appropriations reveal what governments ultimately choose to resource. In this sense, funding decisions act as a critical test of whether stated commitments – including to equity – are rhetorical or operational. As such, the findings challenge the notion of 'special treatment'. Across mainstream mental health policy, Pacific peoples have been inconsistently referenced, rarely prioritised, and almost never afforded dedicated actions. Even in Pacific-specific health policies, mental health has often been marginalised or addressed only in general terms. The absence of sustained, targeted investment – particularly in budget appropriations – further undermines claims of preferential treatment. Instead, the data points to symbolic inclusion without substantive prioritisation.

Government leadership does appear to influence the tone and frequency of Pacific references, with Labour-led governments generally offering more inclusive language and higher mention counts. However, this increased visibility has not reliably translated into action or funding that is clearly tagged for Pacific mental health. This pattern of vacillation – where attention fluctuates across administrations, and even within policy cycles – creates a fragile policy environment. Gains made under one government are not guaranteed to persist under the next, and promising initiatives may be diluted or abandoned during transitions or restructuring.

This fragility is particularly evident in the contrast between *Ola Manuia*, the 2020–25 action plan, and its 2022 interim successor. The former demonstrated strong community engagement and a clear commitment to Pacific mental health, while the latter narrowed its scope significantly, omitting key areas such as youth mental health and access to services. Such shifts reflect the vulnerability of ethnic-specific priorities in times of institutional change, and the ongoing risk of Pacific mental health – a well-evidenced area of need – being deprioritised despite evidence of need.

It is important to acknowledge the limitations of this study. It focuses on one ethnic group within one policy domain, and while the findings are robust within this scope, they cannot be generalised across all ethnic minorities or policy areas. Further research is needed to explore whether similar patterns exist for other groups – such as Māori, disabled people or rural communities – whereby rhetorical gestures may indicate emphasis and attention, but resourcing does not. Additionally, while frequency analysis offers a useful proxy for attention, it cannot fully capture the depth or quality of engagement. The study's strength lies in its mixed-methods approach, combining quantitative trends with qualitative analysis of tone, content and context. This enables a more nuanced understanding of how Pacific mental health has been positioned, and how policy discourse has evolved over time.

Ultimately, the study highlights a very real and evidenced disconnect between need, rhetorical response and resource allocation. Despite persistent evidence of disproportionate mental health challenges among Pacific peoples, public policy has not consistently or adequately addressed these. The notion of 'special treatment' is not supported by any of the data explored, and furthermore, where equity-focused rhetoric is present it has not been matched by resourcing. Instead, Pacific mental health has been subject to passive inclusion, selective uptake and systemic avoidance. This raises critical questions about how equity is understood and operationalised in Aotearoa's public policy landscape, how the public perceives this, and how such perceptions can be weaponised in political discourse: when policy agendas are selectively framed, as in the case of discussion relating to 'special treatment', they risk fostering public narratives that may be categorised as disinformation – or even malinformation – particularly when they distort evidence to justify continued inaction or the reallocation of resources away from need.

In this context, what is the duty of care owed by members of Parliament and other policy actors? Where is the duty of care in ensuring that such communications do not cause harm, mislead the public, or perpetuate inequity? The analysis presented in this article underscores the importance

of accountability measures that ensure policy discourse remains aligned with evidence and responsive to the communities most affected. Ensuring that public communications accurately represent need is essential for maintaining trust and supporting evidence-informed investment. Accountability in policy discourse must include the integrity and accuracy of political communication.

Conclusion

In sum, this 30-year case study finds no evidence to support claims that Pacific peoples have received 'special treatment' in public mental health policy. Where attention has been given, it has often been rhetorical rather than substantive and rarely accompanied by targeted investment. What emerges instead is a landscape of 'special mentions', where Pacific peoples are acknowledged but not prioritised, and where equity remains more aspirational than operational. Addressing this gap requires not only better policy design, but a sustained commitment to accountability, and to being genuinely and comprehensively evidence-informed.

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Juliet Boon, of Samoan heritage, is currently a senior lecturer and PhD supervisor at the Auckland University of Technology, and has held diverse roles across education, health and justice, where her focus has been on supporting equitable outcomes for Pasifika students and families.