

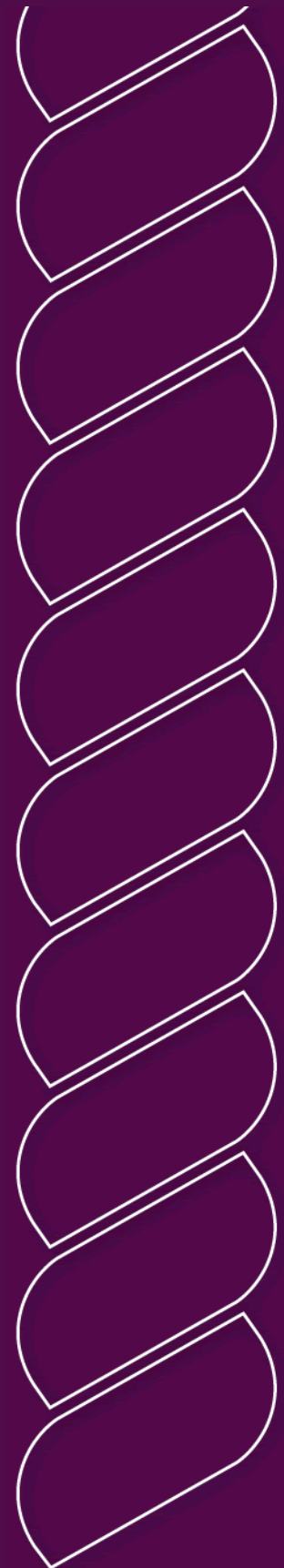
Strategies to reduce the use of seclusion and restraint with tāngata whai i te ora

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Email info@tepou.co.nz

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Naku noa, na

Dr Julie Wharewera-Mika (Ngāti Awa, Tūhoe, Te Whānau-a-Apanui), clinical psychologist, School of Psychology, The University of Auckland

Dr Erana Cooper (Ngā Puhi, Ngāti Hine), clinical psychologist, School of Psychology, The University of Auckland.

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Executive summary

This study explored Māori clinical, cultural and consumer perspectives on potential strategies and initiatives considered likely to facilitate reduction in the use of seclusion and restraint with tāngata whai i te ora in acute mental health inpatient services (see the Glossary for definitions of all Māori terms).

This report is based on qualitative analyses of a hui with 16 participants who collectively held a high level of clinical, cultural and consumer expertise. The specific aims of the study were to examine, from a Māori perspective, current strategies used to reduce the use of seclusion or restraint with tāngata whai i te ora; specific cultural strategies and initiatives that may assist with reducing the use of seclusion and restraint; and to make recommendations for practice to reduce seclusion and restraint of tāngata whai i te ora that could potentially be trialled and evaluated within acute inpatient services.

Existing evidence for best practice to reduce the use of seclusion and restraint has been framed within “six core strategies” (Huckshorn, 2006). The findings of this study align with these strategies. The recommendations represent a comprehensive approach to the reduction of the use of restraint and seclusion with tāngata whai i te ora, which is clearly based on a kaupapa Māori model of care and a vision for transformation of practice in mental health inpatient services.

Recommendations for clinicians in inpatient mental health services

- Prioritise the involvement of Māori staff in care and treatment with tāngata whai i te ora, including Māori staff with specialist cultural skills.
- Build early intervention by specialist Māori staff into the clinical pathway when working with tāngata whai i te ora, particularly at times of crisis and first admission. Implement and maintain admission processes for Māori that incorporate access to Māori culturally safe physical space (such as the marae and whare hui where possible) and culturally specific means of encounter and engagement (pōwhiri, whaikōrero, mihimihi and kai).
- Increase the use and availability of tikanga Māori approaches to working with tāngata whai i te ora on the ward environment, including (whaka)whānaungatanga, manaakitanga, a preference for ‘kanohi ki te kanohi’ interactions and access to Māori conflict resolution processes, such as hohourongo, which may specifically support the de-escalation of potential risk situations. This would include the development and understanding of the importance of wairuatanga to many Māori and a need for service providers’ commitment to holistic wellbeing among tāngata whai i te ora.
- Support easy access to cultural healing practices and activities which represent a Māori approach to sensory modulation such as karakia, mirimiri and kapa haka.

- Provide opportunities for tāngata whai i te ora to learn about or enhance their Māori cultural identity in the inpatient setting. This will enable the restoration of mana or mana-enhancing practices to improve tāngata whai i te ora wellbeing and preventing episodes of distress.
- Integrate ‘whānau-centered’ care to tāngata whai i te ora in your clinical treatment plans, where the inclusive involvement of whānau at all points of care is enabled and facilitated by the service.
- Foster and strengthen the ‘trauma informed care’ in the ward milieu to ensure interventions in inpatient services do not exacerbate any difficulties with regard to previous trauma among tāngata whai i te ora, and instead reduce the likelihood of re-traumatisation.

Recommendations for leaders and managers of inpatient mental health services

- Prioritise and strengthen effective Māori participation in leadership in all areas of service delivery, including in decision making and management of services, service development, workforce development, planning, funding, and provision of services to tāngata whai i te ora.
- Develop and maintain a strong and sustained commitment to reducing and eliminating the use of seclusion and restraint with Māori through facilitating concrete action and reporting on progress.
- Promote consistent documentation and use of this information to review effectiveness of interventions for tāngata whai i te ora. This will enhance opportunities for critical reflection on care practices by staff.
- Develop and assess staff cultural competency to work effectively with Maori. Ensure staff have access to programmes that develop cultural competency.
- Increase supervision and support for all staff to critically reflect on their cultural competency.

Introduction

Te Pou o Te Whakaaro Nui (Te Pou) is the Ministry of Health-funded organisation that supports and develops the mental health and addictions workforce to improve the experience of service users. One of its projects, Seclusion: Time for Change, is focused on supporting district health boards to reduce the practice of secluding or restraining service users in acute mental health inpatient services. This work supports the Ministry of Health's call for limiting the use of seclusion and restraint. Te Pou's own analysis of national statistics on the rates of seclusion and restraint indicates the over-representation of Māori in these statistics (McLeod et al., 2013).

Project aims

The aim of this scoping research was to gather Māori clinical, cultural and consumer perspectives on potential strategies and initiatives considered likely to facilitate reduction in the high rates of seclusion and restraint with tāngata whai i te ora in mental health inpatient services.

Objectives

1. To examine strategies currently employed within inpatient services that reduce the use of seclusion or restraint of tāngata whai i te ora.
2. To gain Māori perspectives on these approaches that reduce the use of seclusion or restraint.
3. To gain Māori perspectives on culturally-based strategies to reduce the use of restraint and seclusion with tāngata whai i te ora.
4. To make recommendations for practice to reduce restraint and seclusion of tāngata whai i te ora that can be trialled and evaluated within inpatient services.

To meet these objectives, this project initially undertook a comprehensive literature review of the national and international literature on strategies to assist in the reduction of the use of seclusion or restraint with indigenous people. The outcome of this review is reported in the next chapter.

The methodology chapter outlines the research design of this project based on data collected from a hui with 16 participants who collectively held a high level of clinical, cultural and consumer expertise. This data was subject to thematic analysis. The results chapter outlines these themes and associated sub-themes. The major themes are considered in relation to the six core strategies (Huckshorn, 2006), that have been collated from existing evidence as best practice for reducing the use of seclusion and restraint.

The discussion chapter combines the review of the literature and the analysis of the data, to make recommendations on the reduction of the use of restraint and seclusion for Maori, for clinicians and manager/leaders, in acute inpatient services.

Literature review

Restraint has been defined as the “use of any intervention by a service provider that intentionally removes the normal right to freedom” (Standards New Zealand, 2008, p. 28). Seclusion is a particular type of restraint where the service user is placed alone in a room or an area from which they cannot freely exit. Seclusion involves containment, isolation and reduction of sensory input (the room is bare apart from a bed and toilet facilities).

To ensure the safety of those in seclusion, the health and disability services standards (Standards New Zealand, 2008) recommend that providers should ideally observe service users continuously. Any breaks in observation should be no longer than 10 minutes and physical checks should also be made to further ensure service user safety.

A major focus of the Mental Health Commission has been on the reduction, and ultimately the eradication, of seclusion as an intervention (Mental Health Commission, 2004c; 2004d). The commission based its position on a general consensus that seclusion is counter-therapeutic and associated with many negative consequences for both staff and service users; human rights concerns; and recently, evidence that indicates that seclusion can be reduced and even eliminated without increasing the risk of harm.

Further to this, a significant research focus of Te Pou has been the Seclusion: Time for Change project (O’Hagan, Divis, & Long, 2008). Such work has focused on alternatives to the use of seclusion and restraint, including, for example, supporting district health boards to safely and effectively implement sensory modulation (Te Pou, 2009a). This programme of work is important in Aotearoa, where seclusion statistics portray a worrying picture. In particular, there are notable differences between district health boards in seclusion rates, and there is also variation in the time a service user spends in seclusion. Particularly concerning are statistics indicating that Māori are over-represented in both the seclusion rates and number of seclusion events (McLeod et al., 2013; Ministry of Health, 2007).

An exploration of the over-representation of Māori in seclusion rates necessitates a review of Māori mental health statistics, including inpatient service admission and readmission rates, length of stay, ward admitted to, involuntary admissions and diagnosis.

Māori mental health statistics

Despite some improvements in Māori mental health over the past four decades, disparities continue between Māori and non-Māori. *Te Rau Hinengaro: The New Zealand mental health survey* (Ministry of Health, 2006) identified the prevalence of mental disorders in Aotearoa. A total of 12,992 people participated in the survey, with 2,595 people (approximately 20 per cent of the total sample) self-identifying as Māori.

The researchers found that mental disorder is common in Aotearoa with 46.6 per cent of participants meeting the criteria for a disorder at some time in their lives; and 20.7 per cent having a disorder in the past 12 months

(Ministry of Health, 2006). Mental disorders were more common amongst Māori and Pasifika people. The prevalence of mental disorders in Māori was only slightly higher than average, with 50.7 per cent of Māori experiencing a mental disorder over their lifetime; 29.5 per cent in the past 12 months, and 18.3 per cent in the previous month. The most common lifetime disorders among Māori were anxiety, substance use and mood disorders, with lifetime prevalence of any disorder highest in Māori aged 25 to 44, and lowest in those aged 65 and over. Of Māori with any mental disorder, 29.6 per cent had serious disorders, 42.6 per cent moderate disorders and 27.8 per cent mild disorders (Baxter, Kingi, Tapsell, & Durie, 2006).

Admissions: Since the significant increase in Māori first-time admissions to mental health services in the 1970s (Sachdev, 1989), Māori have continued to enter inpatient services at a rate that is disproportionately higher than other population groups (Abas, Vanderpyl, Le Prou, Kydd, & Foliaki, 2003; Fitzgerald, 2004; Edmonds, Williams, & Walsh, 2000; Ministry of Health, 2004; 2006), and at least twice that of non-Māori (Te Puni Kokiri, 1998; Wharewera-Mika, 2012). Service pathways for Māori are also of concern with Māori admissions being primarily via the legal system (Durie, 1998b; Edmonds et al., 2000). As such, rates of Māori admissions to secure or forensic mental health services are also high (Tapsell & Mellsop, 2007).

Readmissions: Despite the development of community services, and the shift of primary service care from inpatient mental health services to the community, inpatient readmission rates have been a significant challenge for mental health services (Appleby, Desai, Luchins, Gibbons & Hedeker, 1993; Gibson, 1999). Between 1980 and 1990, Māori were 40 per cent more likely to be readmitted to inpatient mental health services than pākehā, particularly Māori males. Between 1984 and 1993, the rate for Māori inpatient readmissions increased by 65 per cent. Over the same period, the readmission rate for pākehā dropped by 25 per cent (Bridgman & Dyal, 1993; 1996; Te Puni Kokiri, 1998).

In a more recent study of readmission rates in the Counties Manukau District Health Board catchment area (an area of higher numbers of Māori and Pasifika people), Fitzgerald (2004) analysed first-time admissions from 1997 to 2000. Similar to other studies, Māori were significantly over-represented in the proportion of first admissions, making up 32 per cent of the first admission in-service users. However, the readmission rate was not significantly different to that of non-Māori. There are a number of possible explanations for this finding regarding readmission rates in this region. One is that the more equal rates may have reflected the positive impact of the expansion and developments of kaupapa Māori (by Māori, for Māori) services, including a marae complex at the inpatient service; and of compulsory tikanga training for staff (learning about Māori customs and practices) contributing to their cultural competence (Fitzgerald, 2004; Wharewera-Mika, 2012).

Length of stay: New Zealand-based studies examining ethnic difference in the length of inpatient admissions have found variable results. Abas, Vanderpyl, Robinson, Le Prou and Crampton (2006) found Māori to have longer lengths of stay, by 7 days, and higher rates of involuntary admissions. Conversely, more recent reports stated that in comparison to other ethnic groups, Māori, on average, received less inpatient admission days per episode (16.3 days) compared with Pasifika (21.2 days) and Asian (22.5 days) people; and less inpatient days per service user: Māori (25.2 days), Pasifika (29.5 days) and Asian (27.3 days) (Ministry of Health, 2010a). Despite

this variation, comparisons between ethnic groups were found to be insignificant in other New Zealand studies (Kumar, Ng, Simpson, Fischer, & Robinson, 2008; Wharewera-Mika, 2012).

Diagnosis: Research has consistently found that Māori are diagnosed with schizophrenia and other psychotic disorders at higher rates than other ethnic groups: schizophrenia 3.5 times more often, and bipolar 2.4 times more often than non-Māori (Baxter, 2008). These statistics have been found in both inpatient (Wharewera-Mika, 2012; Wheeler, Robinson, & Robinson, 2005) and outpatient services (Wheeler, 2007). Similarly, international studies have found that indigenous people are also more likely to be diagnosed with schizophrenia (Fernando, 2003; Read, 2004a) and psychosis (Harrison, 2002; Nazroo & King 2002; United States Department of Health and Human Services, 2001).

This diagnostic pattern is associated with an increased use of medication at higher doses (Humberstone, Wheeler, & Lambert, 2003). Māori are given higher doses of anti-psychotic medication and are more likely to be given two or more medications at the same time (Wheeler, Humberstone, & Robinson, 2008). Furthermore, Māori are more likely to be injected, rather than prescribed oral medication (Wheeler et al., 2008). This finding has also been reported amongst African-Americans in the United States (Arnold et al., 2004).

Involuntary admissions: High rates of Māori involuntary admissions to inpatient services, involving compulsory treatment, have been identified and are associated with elevated levels of coercion and use of force compared with voluntary admissions (Abas et al., 2006; Durie, 1998b). Wheeler and colleagues (2005) examined the admission rates of tāngata whai i te ora in three inpatient services in the Auckland region in 2000. Māori were found to be involuntarily admitted more frequently under the Mental Health (Compulsory Assessment and Treatment) Act 1992. These elevated rates are consistent with international studies on the use of compulsory assessment and treatment with indigenous and ethnic minority groups, conducted in Australia, Belgium, the UK and the USA (Read, 2004b). For instance, in the UK, men from ethnic minorities were more likely than other groups to be detained under the Mental Health Act 1983 (Care Quality Commission, 2009).

Seclusion and restraint

Internationally, a search of the literature revealed that seclusion of mental health service users from indigenous and ethnic minorities is problematic. A comprehensive literature review of studies focusing on compulsory admission to inpatient mental health services in the US and the UK found that there was a general overestimation of the potential violence of ethnic minority service users when compared with “white” service users (Spector, 2001). Moreover, the authors noted that there was a higher tolerance level for “difficult” behaviour with white service users, concluding there was a possible “stereotyping effect” towards ethnic minority service users (Spector, 2001). This is consistent with other research, which indicated that service users involved in a violent episode were more likely to be secluded if they were from an ethnic minority (Gudjonsson, Rabe-Hesketh, & Szmukler, 2004).

One of very few studies from outside of these regions found that indigenous people of Australia, between the ages of 25 and 34, were more likely to experience seclusion than non-indigenous people (Happell & Koehn,

2010). Although these findings were non-significant when all age groups were taken into account, the disparity in seclusion rates for this age group is consistent with the other research discussed.

In New Zealand, excessive use of seclusion and restraint involving tāngata whai i te ora has been reported (McLeod et al., 2013; Mental Health Commission, 2004d; Wharewera-Mika, 2012), with 20 per cent of Māori admitted to inpatient services experiencing at least one period of seclusion during an admission, compared to only 11 per cent of Pākehā service users (El Badri & Mellsop, 2002).

A study investigating the use of seclusion for Māori in adult mental health inpatient services in New Zealand was recently conducted (McLeod et al., 2013). Of the total admissions ($n = 7,702$ during the period from 1 July 2008 to 30 June 2010), 25.2 per cent were Māori.

The findings of this study demonstrate that, in terms of absolute numbers, young Māori males are the most likely group to be seen in seclusion and are an important group to target seclusion reduction interventions at. In addition, Māori females between the ages of 55 and 64 years, although contributing to small numbers of overall admissions, were found to have the highest rate of seclusion of all the age groups admitted to the ward, and this finding may require further exploration and tailored interventions (McLeod et al., 2013).

Tāngata whai i te ora experiences of seclusion and restraint

Internationally the indigenous experiences of seclusion and restraint have been described as harmful and are considered to be counter-therapeutic (Finke, 2001; Haimowitz, Urff, & Huckshorn, 2006; Happell & Koehn, 2010; Kontio et al., 2012; Mayers, Keet, Winkler, & Flisher, 2010). Similarly, Māori experiences of seclusion have been described as negative and likened to a confined prison encounter (Wharewera-Mika, 2012). Restraint was viewed by a number of participants in the Wharewera-Mika study as a force of punishment, rather than a therapeutic intervention ensuring safety. Furthermore, many of the participants felt that restraint could be avoided if communication was improved, more specifically listening to the needs of tāngata whai i te ora.

The use of force and restraint was also extremely distressing for whānau participants who described a sense of hopelessness when their whānaunga were restrained (Wharewera-Mika, 2012).

Factors associated with seclusion and restraint

A number of key factors have been identified that relate to high seclusion rates. For example, men are more likely to be secluded than women (El Badri & Mellsop, 2002; Bowers, Allan, Simpson, Nijman, & Warren, 2007) and the age of those that are secluded is significantly lower than those that are not secluded (Mason, 1995; Harte & Burgess, 2003). Those that are secluded are more likely to be involuntarily admitted (Thompson, 1986; Harte & Burgess, 2003), and the diagnosis of those secluded is more likely to be schizophrenia, psychosis, bipolar affective disorder or borderline personality disorder (Swett, 1994; Harte & Burgess, 2003). Those that are in seclusion are more likely than those not in seclusion to have spent a longer time in inpatient services (Swett, 1994; Harte & Burgess, 2003), and are reported to be on higher doses of medication (Ibikunle & Kettl, 2000).

There is also some indication that forensic mental health services have a high frequency of seclusion, which has been argued to be the result of higher rates of violence (Heilbrun, Golloway, Shoukry, & Gustafson, 1995).

Importantly, there are many factors associated with seclusion that have been located in the environment, including those that relate to staff and the facilities where service users reside. For example, lower staffing levels have been associated with higher rates of seclusion (Mental Health Commission, 2004c; O'Malley, Frampton, Wijnveld, & Porter, 2007), as are shift times where staff have been preoccupied with ward work (O'Malley et al., 2007; Smith et al., 2005). Some studies indicate that the gender of staff can influence the frequency of seclusion, however, it is unclear whether there is a bias toward either gender (De Cangas, 1993; O'Malley et al., 2007). There is also some indication that the attitudes of staff influence the frequency of seclusion (Mental Health Commission, 2004c; Livingstone, 2007), and some suggestion that there may be racial stereotyping that leads to an over-use of restrictive practices (Spector, 2001). This has also been found to extend beyond individual staff to the ward, where the culture in a ward can influence staff reactions to patient behaviour and therefore the use of seclusion (Crichton, 1997; Walsh & Randell, 1995). Importantly, unit over-capacity is one the strongest predictors of seclusion (Mental Health Commission, 2004c).

Guidelines to reduce seclusion and restraint

A summary of the literature revealed a number of effective ways to reduce the incidence of seclusion and restraint (O'Hagan et al., 2008). An important point raised in the literature was that the use of alternative methods should not create an increase in injuries or the use of alternative restraints. On the contrary, the reduction should be associated with a decrease in injuries to both staff and service users (Currie, 2005; Haimowitz et al., 2006; Huckshorn, 2006; National Association of State Mental Health Program Directors, 2006; Smith et al., 2005).

Existing evidence for best practice has been collated into six core strategies to reduce the use of seclusion and restraint. These focus on leadership towards organizational change; use of data to inform practice; workforce development; use of seclusion and restraint prevention tools; service user roles in inpatient services; and debriefing techniques (Huckshorn, 2006; National Association of State Mental Health Program Directors, 2006). To date, there is a lack of Māori-specific literature with regard to these strategies.

Leadership towards organisational change: An important initial step to reducing seclusion and restraint is direction at a national-level. This level of direction has been found to be necessary in order to produce significant change. In the US, this has led to significant restructuring of policy and legislation that determines the characteristics of mental health services.

At the level of the organisation, there are a number of ways in which change can be implemented. Having a strong sense of leadership is important at all phases to carry the vision, develop policy and action plans, ensure data collection and training, and provide personal oversight of seclusion and restraint practices. Of equal importance is the style of leadership, which must champion reduction of such practices and make it a clear priority. There must also be a clear communication of these intents to key stakeholders via a constant dialogue.

The environment must also be conducive to change through the implementation of rewards and through language use that models recovery values (Fixsen, Naoom, Blasé, Friedman, & Waace, 2005).

Of equal relevance is ensuring that there is a culture within the organisation that is supportive of change. There needs to be a strong focus in the organisational culture on a recovery-based model of care (Mental Health Commission, 2004b), trauma-informed care (National Association of State Mental Health Program Directors, 2006; National Executive Training Institute, 2004) and international human rights (United Nations, 2006). In a Māori sense, the concept of rangatiratanga is pertinent to this strategy.

The use of data to inform practice: The collection and use of relevant information has also been identified as an essential aspect for seclusion reduction (McLeod et al., 2013). This includes, but is not limited to information on total seclusion events, total seclusion hours and the number of service users secluded. In collecting this type of data, it is important that it is not used in a punitive way (O'Hagan et al., 2008).

Dumais, Larue, Drapeau, Ménard and Allard (2011) analysed high incidence rates of seclusion and restraint, identifying correlated demographic characteristics and diagnoses. A total of 2721 admission were analysed: 23.2 per cent ($n = 632$) were secluded with or without restraint, and 17.5 per cent ($n = 476$) were secluded with restraint. Findings reported that service users diagnosed with bipolar and personality disorders are more likely than those with other psychiatric disorders to be secluded, with and without restraint, during their stay in this hospital. A recommended solution was that implementing a comprehensive record-keeping system that tracks patient risk factors, and seclusion and restraint episodes, would enhance the capacity of clinicians to identify complex cases that present risks. This would allow the development of strategies to engage proactively with this service user group, in a manner that avoided the use of restraint and seclusion.

Workforce development: There is also a strong evidence-based emphasis placed on the need to ensure there is sufficient workforce development within any organisation. This includes adequate recruitment and staffing, such that there is a high staff-to-service user ratio; mature and well trained staff; stable staffing; and ensuring that recruitment makes implicit the intent to reduce seclusion and restraint (O'Hagan et al., 2008).

In addition, staff education has been identified as a crucial element in workforce development. Education needs range from developing the personal attributes of staff, to ensuring risk assessment and management strategies are developed that negate the use of restraint and seclusion. The involvement of staff in the design, implementation and evaluation of seclusion and restraint initiatives is also of importance (American Psychiatric Association, 2003).

Given the aforementioned disparities experienced by Māori in inpatient services, an emphasis on cultural competency in work force development must be pursued. A broad indigenous health framework for clinicians has been devised to improve understandings, and promote more culturally appropriate ways to interact with, assess and treat indigenous people. The areas discussed include understanding indigenous notions of health and identity; mental health and addictions; urbanisation and environmental stresses; whole health and healing; and reconciliation (King, Smith, & Grace, 2009). The development of recent research regarding cultural competency

within New Zealand has produced various training initiatives, many within specific health professions, and has identified varying levels or stages of competent practice (Levy, 2007; Ministry of Health, 2005). Note that cultural competence will be discussed in more detail in a later section of the literature review.

Use of seclusion and restraint prevention tools: The literature suggests that developing service user coping skills is an effective means to reducing seclusion and restraint (Visalli, 2000). This can be promoted by staff supporting service users in their autonomy and personal choices, and working with them on behaviour management plans. For those with issues of anger or mood dysregulation, dialectical behaviour therapy skills (distress tolerance) have been implemented with some success (Fisher, 2003). Also, gaining insights from service users on the helpful and unhelpful aspects of services is a way to ensure that practices are meeting service users' needs (American Psychiatric Association, 2003; National Association of State Mental Health Program Directors, 2006; Substance Abuse and Mental Health Service Administration, 2007; Sullivan et al., 2005).

There are also a number of practical intervention methods cited in the literature, including milieu management of the physical environment; partaking in meaningful strategies, such as rewarding pro-social activities for those with anger issues; and developing an atmosphere of listening and respect (American Psychiatric Association, 2003; National Association of State Mental Health Program Directors, 2006; Substance Abuse and Mental Health Service Administration, 2007; Sullivan et al., 2005). In addition, the implementation of crisis plans, violence and trauma assessments and plans, behavioural coaching and therapy, de-escalation, sensory modulation and dispute resolution processes have also shown positive outcomes (National Association of State Mental Health Program Directors, 2006)

Practical prevention methods: Creating a therapeutic environment with central principles of wellness and recovery has been the focus of many inpatient services in New Zealand (Te Pou o te Whakaaro Nui, 2009a; 2010), and has contributed to the changing face of inpatient service therapeutic environments through increased awareness of cultural, familial, spiritual and social aspects of recovery. A focus on creating therapeutic inpatient environments, along with alternative strategies to support service users faced with extreme distress, are potential strategies to reduce the use of force, restraint and seclusion. Therapeutic environments providing low stimulus areas, where *tāngata whai i te ora* are able to self-soothe and tolerate distress, such as an adapted sensory modulation room (which could incorporate kaupapa Māori interventions), may provide alternative distress tolerance strategies. In addition, given the calming nature of the marae space, it is envisioned that this area could also be used in such a way (Durie, 1998b; Lapsley, Nikora, & Black, 2002; Taitimu, 2008; Wharewera-Mika, 2012).

As a local example, Te Whare Ahuru inpatient service (Northland District Health Board) has reportedly developed strategies to enhance the inpatient environment. Some of the key strategies implemented have included: a treatment focus shift towards a recovery-based, non-discriminatory and holistic approach; cultural safety and psychodynamic training for staff, with a reflective practice approach; a smoke-free environment; a flexible therapeutic programme to address boredom issues; increased staff levels to improve quality of care; the creation of low stimulus areas (such as relaxation rooms); and debriefing following critical incidents (such as assaults, restraint, and seclusion) (Te Pou o te Whakaaro Nui, 2009c).

Although formal evaluation is yet to be completed, feedback from Te Whare Ahuru inpatient service suggests that seclusion reduction has been beneficial in improving the culture of service delivery. The rate of use of both seclusion and restraint has reduced significantly, from 2,710 seclusion hours and 101 restraints in 2006, to 232 hours of seclusion and six recorded restraints in 2009 (Te Pou o te Whakaaro Nui, 2009c).

McClintock, Moeke-Maxwell, & Mellsop (2012) reiterated the capacity of indigenous groups, with a commitment to finding their own solutions, to address mental health concerns, such as the reduction of seclusion and restraint. Their literature review focused on the factors contributing to responsive child and adolescent mental health services for Māori rangatahi, and highlighted the need for improvement.

A specific cultural intervention premised in this study was based upon processes and principles associated with pōwhiri. This model aligns with the traditional processes of engagement and participation, particularly the components of karanga, mihimihi, whaikōrero and koha (McClintock, Mellsop, Moeke-Maxwell, & Merry, 2012). Participants in this study reported that within child and adolescent mental health services, the pōwhiri process valued respectful relationships, commitment and reciprocity. Furthermore, it was argued that the use of this model could enhance engagement with tāngata whai i te ora, supporting ongoing therapeutic interventions (McClintock, Moeke-Maxwell, & Mellsop, 2012). These types of developments may also be considered useful for Māori adult mental health services.

Sensory modulation: One evidence-based approach to reducing the use of seclusion and restraint is the use of sensory modulation. Based upon international literature (Champagne, 2003), the goal of sensory modulation is to provide practical means to reduce distress among service users.

The impact that inpatient psychiatry has on service users in their journey towards recovery cannot be overstated. It is therefore vitally important to use positive interventions which give our service users an opportunity to learn and experience alternative ways to help themselves in a caring supportive environment.

(Nancy King, clinical nurse manager, Northland District Health Board, cited in Te Pou o te Whakaaro Nui, 2009a, p. 1.

The function of sensory modulation is to support service users to relax, self-regulate and self-soothe, with the overall outcome of coping with distress and regaining self-control (Champagne, 2003). Sensory modulation provides a variety of strategies to achieve these ends. For instance, “A recliner rocker, a massage chair, weighted blankets, ambient lighting, neutral heating, aromatherapy, stress balls and soft toys, music and relaxation CDs, a range of hand creams and a foot spa.” (Te Pou o te Whakaaro Nui, 2009a, p.3).

Using the strategies involves service users having an individual safety plan identifying early warning signs and triggers of distress; a personalised sensory plan detailing how they choose to make the most of the choice of strategies; and a risk assessment (assessing “the likelihood of an event happening with potentially harmful or beneficial outcomes for self or others”) (Morgan, 2000). The strategies are used collaboratively, with staff supporting the process as required. Positive results to this therapeutic intervention have been reported in

reducing the use of seclusion and restraint (Te Pou o te Whakaaro Nui, 2009c) and also assisting in relationship building between service users and staff (Te Pou o te Whakaaro Nui, 2010).

Service user roles in inpatient services: A growing body of knowledge focused on mental health treatment interventions supporting recovery has also resulted in a number of innovative inpatient service delivery improvements. One such support-based initiative is peer support, referred to as: "...more than a change of mental health personnel. It is a rich philosophy of practice...which brings the abstract concept of 'recovery' to life" (Scott, Doughty, & Kahi, 2011, p. 128).

Peer support specialists (similar to mentors) can role model recovery practices by sharing personal stories, personal tools and skills supporting recovery, hence displaying that recovery is achievable (Davidson, O'Connell, Tondora, Styron, & Kangas, 2006). The establishment of peer support within New Zealand is well underway, with every district health board nationwide currently offering some form of peer support (Scott et al., 2011).

Te Mana mental health service is a tāngata whai i te ora-led kaupapa Māori service that provides peer support for community and inpatient tāngata whai i te ora living within the Lakes District Health Board catchment area. Informal feedback about the service has been positive, indicating that tāngata whai i te ora using the peer support service feel very supported to set and achieve personal recovery goals (Te Pou o te Whakaaro Nui, 2009a).

Although initial findings of peer support specialists are promising, further exploration into this innovative support service is required to reveal its full potential. For example, it is possible that improving the amount and availability of support to tāngata whai i te ora, through the provision of peer support staff within services, may potentially contribute to the prevention of seclusion and restraint (Scott et al., 2011).

Debriefing: Following a seclusion or restraint incident, taking time to debrief with relevant parties can assist with the prevention of further seclusion and restraint episodes. Debriefing can occur immediately following an incident, so that feelings and perceptions can be shared, and any plans (treatment or crisis-related) can be reviewed accordingly. Debriefing can also take the form of a critical incident review to consider the incident from a systemic point of view, in order to determine whether improvements or changes are needed across the whole service (American Psychiatric Association, 2003; Huckshorn, 2006; National Association of State Mental Health Program Directors, 2006).

Recovery-orientated services

Research focused on the service user journey of recovery also provides insights into how seclusion can be reduced. Lapsley and colleagues (2002) conducted a study highlighting factors supporting recovery for tāngata whai i te ora, with specific influences for recovery identified relating to whānau care; a Māori framework of mental health; Māori healing; cultural aspects within general mental health services (such as karakia and waiata) (Ihimaera, 2004); and Māori mental health services. In addition, some tāngata whai i te ora found an appropriate cultural setting beneficial, and some were helped by just seeing a Māori face (Dyall et al., 1999). The dimension

of spirituality was also found significant in relation to both illness and recovery (Ihimaera, 2004), along with strengthening Māori identity (Durie, 1998a).

Dyall and colleagues (1999), in their study of Māori expectations of mental health services, identified a common expectation across tāngata whai i te ora of receiving services in a Māori environment from Māori people. This included the importance of having control over their lives to support tino rangatiratanga for Māori, at both an individual and a collective level; the need for Māori mental health services within inpatient settings; and for “Māori faces for Māori cases at Māori places” (Dyall et al., 1999, p. 17). This study highlighted expectations for kaupapa Maori services which would ensure that kaumātua would be involved; tāngata whai i te ora and whānau members would be less isolated from the Māori community; and there would be greater respect afforded to Māori as a Te Tiriti o Waitangi partner.

Cultural assessment and cultural competency

The importance of cultural assessment in facilitating the identification of the cultural needs of tāngata whai i te ora and guiding therapy has been documented (Mental Health Commission, 2004a; Milne, 2005) and is widely accepted as a key element of mainstream mental health service delivery and responsiveness to Māori (BPAC New Zealand, 2008).

The practice of cultural assessment has been defined as “the process through which the relevance of culture to mental health is ascertained” (Durie et al., 1995, cited in Mental Health Commission, 2004a). Cultural assessors have been described as experts in te ao Māori, hosting a range of skills and knowledge including te reo me ona tikanga; knowledge of the Te Tiriti o Waitangi; kaupapa Māori mental health; mate Māori; oranga; hinengaro and oranga wairua (Milne, 2003). (See the Glossary for English translations of all te reo Māori terms.)

One imperative for improving the service delivery for tāngata whai i te ora is the need to ensure the cultural competency of the mental health workforce (Ministry of Health, 2005). Cultural competency can be defined as:

A set of academic, experiential and interpersonal skills that allow individuals and systems to increase their understanding and appreciation of cultural differences and similarities within, among and between groups. (Jansen & Sorrensen, 2002, p. 306).

There is a relationship between cultural competency and the concept of cultural safety. The latter was developed by Māori nurses in response to the health disparities of Māori; and the demands for service delivery improvements (Papps & Ramsden, 1996). Cultural safety has been described as interactions that recognise, respect and nurture the unique cultural identity of each person to safely meet their needs, expectations and rights, and involves showing respect and sensitivity to people, and taking into account their spiritual, emotional, social and physical needs. (Ramsden, 1991)

The basic foundation of such practice when working with Māori includes an understanding of Māori identity and Māoritanga (Milne, 2005). This practice requires health professionals to have undertaken a process of contemplation of their own cultural identity, and to adapt their practice in a way that affirms the culture of

tāngata whai i te ora (Papps & Ramsden, 1996). Furthermore, mental health staff engagement that fosters manaaki tāngata (to take care of, support and protect) and encourages whānaungatanga is an important aspect of cultural competency (Drury & Munro, 2008).

Summary

This literature review depicts a disturbing picture of the over-representation of tāngata whai i te ora in seclusion and restraint statistics in New Zealand. International restraint and seclusion reduction guidelines, such as the six core strategies (Huckshorn, 2006; National Association of State Mental Health Program Directors, 2006), are highly relevant to the current mental health environment, where a commitment to improving circumstances for Māori forms part of the vision for how mental health service delivery may develop in New Zealand.

Within the national literature, there is an evolving articulation of culturally specific interventions that may be helpful in preventing the use of restraint and seclusion. These include the use of a culturally appropriate physical space; the use of traditional processes of engagement and participation, particularly pōwhiri, karakia, mihimihi, and kai; the presence of Māori staff; appropriate cultural assessment; and the fostering of tino rangatiratanga or self-determination for tāngata whai i te ora and their whānau. In addition, staff need to attain cultural competency to engage with tāngata whai i te ora in a manner that is culturally meaningful, empowering and therapeutic.

Methodology

Research design

Perspectives on strategies to reduce the use of seclusion and restraint with *tāngata whai i te ora* were investigated through the use of qualitative methods, situated within a framework of kaupapa Māori research. Kaupapa Māori research “stems from a Māori worldview” (Moewaka Barnes, 2000, p. 9), giving full recognition to Māori cultural values and systems, and being carried out according to Māori cultural ethics (Cram, 2001; Smith, 1999).

A rangahau whānau (research advisory group) was established, comprising kaumātua, Māori mental health service experts and researchers, with a number of members of the group in more than one of those roles. The rangahau whānau was consulted throughout the project, with involvement in the design of the study and the analysis and interpretation of findings.

A two-day hui was designed to gather Māori perspectives and specific strategies on how to reduce the use of seclusion and restraint in inpatient services. The hui was facilitated by members of the rangahau whānau, some of whom also contributed as participants.

Ethical approval was sought from, and granted by, the University of Auckland Human Participants Ethics Committee (reference 8642).

Participants

Participants consisted of clinical, cultural and *tāngata whai i te ora* experts, who were identified by the rangahau whānau in consultation with regional leaders in the field. A number of participants held expertise in more than one of these areas. An information sheet was sent to 20 potential participants, who were all interested, with 16 available to participate on the days. Written consent was obtained from all participants and their service managers (employers). All received a koha to assist in expenses to attend the hui.

Participants consisted of four Kaumātua, five cultural advisors, five Māori nurse leaders and two Māori consumer advisors (*tāngata whai i te ora* experts). The participants represented the four district health boards in the greater Auckland and Northland regions – Auckland, Waitematā, Counties Manukau and Northland.

Procedure

The hui followed Māori tikanga and kawa of the host marae, Tāne Whakapiripiri, which is located at the mental health service of some members of the rangahau whānau. The hui was held in November 2012.

The first day of the hui began with a pōwhiri and included the opportunity for whakawhānaungatanga among participants. Following this, a presentation on the findings of the literature review for this study was delivered, which included a summary of the recent report by Te Pou on the use of seclusion and restraint in New Zealand (McLeod et al., 2013). Participants from each district health board also presented information about their particular services, and shared information from their broader areas of expertise relevant to the topic (e.g.,

Māori mental health workforce issues). In addition, research on Māori workforce issues was presented by one of the participants.

On the second day of the hui, presentations about services continued, followed by information about current seclusion and restraint tools used in the field. This information included presentations on the six core strategies to reduce seclusion, and sensory modulation.

The purpose of the presentations was to facilitate discussion among participants about their own clinical or personal experiences of seclusion and restraint, as well as their perspectives on culturally appropriate strategies to limit the use of seclusion and restraint with *tāngata whai i te ora*. Participants were also asked to critically review the tools presented for use with *tāngata whai i te ora*.

Data collection

All discussions at the hui were digitally recorded with the consent of participants, and transcribed under confidentiality agreements by external transcribers. Transcribing and translation of *te reo Māori* was undertaken by specialist services.

Data analysis

Thematic analysis of the data was carried out following guidelines recommended by Braun and Clarke (2006). The guidelines identify six phases of conducting thematic analysis: becoming familiar with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing the report.

Initially, an independent Māori researcher generated codes from the hui transcripts by recording key points and comments discussed at the hui. During this process, the researcher identified the concepts and quotes that best illustrated each code and entered these into a spreadsheet. All codes had notations about how strongly the code appeared in the transcripts, how the codes might have been connected to other codes or topics discussed, and direct quotes that best illustrated the concepts that were discussed.

Following this, the raw data and codes were reviewed by three members of the project team, with a view to identifying any common patterns or variations in the data (searching for themes). A number of themes were identified, and further review revealed that these could be grouped under three main working categories. These themes and categories, along with a summary of the results, were then given to the *rangahau whānau*, hui participants and non-participating external experts to review. During this stage, the analysis was verified and themes were given their final names. The final report, including recommendations, was also externally reviewed.

Findings

This section presents the study findings, namely the three thematic categories derived from analyses of hui transcripts, these being:

- te ao Māori: access to a Māori worldview
- te ao hurihuri (whakaumutia): transforming practice
- rangatiratanga: leadership, power, and control.

Each category consists of a number of themes and includes relevant quotes. See the Glossary for translations of te reo Māori terms.

Te ao Māori: access to a Māori worldview

Opportunities for tāngata whai i te ora to access practices and processes based upon a Māori worldview during their journey of whakaoranga were considered vital by participants. Three key themes were identified as salient to the category of te ao Māori. These were:

- ensuring a Māori presence and the availability of Māori healing environments at services
- sustaining existing helpful cultural practices and processes during the inpatient stay
- providing whānau-centered care.

Ensuring a Māori presence and the availability of Māori healing environments at services

Participants were united in their belief that Māori involvement with tāngata whai i te ora, from the start of their care (including prior to admission) up until discharge from the inpatient service, was of paramount importance. In particular, the management of processes related to coming into a service was considered vital, in terms of establishing a safe, comfortable, and supportive environment for tāngata whai i te ora and whānau. With regard to the first point of contact, participants commented that:

“The answer is early intervention by Māori, by a specialist Māori team.”

“When the police come and they're getting out of their car at the unit, [the Māori staff] will just support them. They'll come to the door and say ‘kia ora bro’, that helps... You see people become calmer, there is a Māori face...”

“...if you have Māori that know Māori, they can introduce that first link to bring that person into the institution and not traumatise.”

In addition to the presence of Māori at all points of contact, participants considered access to Māori culturally safe environments, such as marae or whare hui, to be therapeutic and healing for tāngata whai i te ora.

“The whānau and tāngata whai i te ora are traumatised through the whole process [of involvement with the inpatient service], but coming into the whare...they feel safe.”

“...they feel safe with their tupuna (ancestors)...they are coming into a whare with kaumātua and kuia to welcome them...So I like to think that this is all helps to calm them.”

“For me that was a safe place when they came to take me off the ward, they took me down to a whare where I felt calm and quiet.”

Familiar cultural environments were not only considered to have the potential to be healing, but were also perceived by participants to assist with empowering tāngata whai i te ora and whānau.

“By bringing the clinical team into here, the whānau are empowered to ask difficult questions of the clinicians, as opposed to a clinical room that is intimidating.”

Overall, Māori presence and the availability of Māori healing environments at services was considered to be central, as this would enable and facilitate the use of helpful cultural practices and processes for Māori during the inpatient stay.

Sustaining existing helpful Māori cultural practices and processes during the inpatient stay

Participants identified the use of tikanga Māori as imperative to the care of tāngata whai i te ora, and expressed strong support for these practices and processes to be sustained within services where they already existed.

“Tikanga is about true, correct, and appropriate ways, and we have wānanga sessions here throughout the week so that they [tāngata whai i te ora and staff] can learn these principles.”

Such processes included use of the marae, processes of whānaungatanga and manaakitanga, and cultural healing practices such as karakia and mirimiri, and activities such as kapa haka. Participants noted many examples of the use of these types of tools in responding to the needs of tāngata whai i te ora. For example, Māori approaches to engagement were considered to be effective, particularly the use of kanohi kitea (being the ‘seen face’) during first, and ongoing encounters with tāngata whai i te ora.

“It’s simply ‘kanohi ki te kanohi’, and simple acts of graciousness, a simple act of humility. You get in there on the first instance, yeah, that first hongī, your whakawhānaungatanga, yeah that first instance, that’s at our core of what it is to communicate.”

“It basically comes down to the approach...treating people right, the way you’d like to be treated...Kanohi ki te kanohi, not six or seven [staff] standing around any individual, what it does is it freaks them out, it just raises their anxiety.”

“It is kanohi ki te kanohi to help to de-escalate these situations.”

The restoration of mana and the use of mana-enhancing practices in working towards, and supporting tāngata whai i te ora wellbeing was also highlighted by participants as integral.

“[It’s] supposed to be mana enhancing, it is about re-introducing [mana], it is about giving that other mana back.”

“...work with them on their restoration of their self-worth in terms of their mana.”

Participants identified that an important part of the work related to restoration or enhancement of mana sometimes included the need to assist tāngata whai i te ora to learn about or enhance their Māori cultural identity. A secure cultural identity was considered to be a valuable part of wellbeing for tāngata whai i te ora by all participants.

“So it’s all about identity, knowing where you come from, why you are here. It’s all about knowing who you are, where you’re from, where you relate...knowing your whakapapa.”

Accordingly, the relevance of cultural practices, such as whakawhānaungatanga, for creating connections and engaging with tāngata whai i te ora through whakapapa or ‘whānau of common purpose’ was felt deeply by participants. Many participants referred to the importance of attending to:

“...whānaungatanga, whakapapa, and looking after those relationships.”

The value and purpose of many of these cultural practices were interlinked, with comments from participants such as:

“Whakawhānaungatanga provides the platform for more than involvement however, as it also serves to restore our mana for our whānau.”

“Whānaungatanga, [is] about whakapapa, about looking after those relationships and the importance of those processes...working with whānau. Looking at Māori, working with Māori, placing yourself with Māori and that they just calm on your presence...connecting is a deliberate action...of linking, of Māori linking with Māori, or Māori linking with people, Māori linking with whenua, linking with whakapapa, linking with wairua. That’s what we do. We deliberately conduct it to uphold and enhance the mana of our people, and our culture, and who we are as Māori. We meet, we greet, we have riches of encounter, we engage, we share, we speak, we reciprocate, we use the same language, we explore, this is what we do...these actions are integral to our relationship with Māori.”

Within the many examples described, the centrality of wairuatanga and service providers’ responsibilities towards supporting holistic wellbeing among tāngata whai i te ora (including their spirituality) was affirmed by participants.

“...they [Māori staff] needed to ensure that the wairua of the whānau is safe. They needed to ensure that wairua was maintained for healing, wellbeing and for strength.”

“[We recognise] the importance of wairuatanga for all whānau and all kaimahi. So every morning there is karakia.”

Alongside the important day-to-day utility of cultural practices and processes, such as attending to wairuatanga through karakia, participants noted particular examples of the use of these tools in responding to tāngata whai i te ora who were distressed and traumatised.

“There is no doubt about it, with Māori intervention we seem to be able to calm them down, especially with the use of karakia...”

Other cultural practices were also identified by participants as useful for supporting the de-escalation of potential risk situations. Some participants described one specific process known to be currently in use at one service, that being hohourongo. This cultural practice establishes rules of engagement between people (e.g., between tāngata whai i te ora and/or between staff), thereby facilitating a process of restorative obligation.

“If you really want to know why we don't use seclusion and restraint it's because of this. What is it? We've said from day one sort it out in the whare nui. It's a social responsibility, it's the responsibility of looking after each other.”

“...so we are inclusive, not exclusive, [in] reducing seclusion, [by] having rules of engagement; if anybody's got something that's troubling them they can choose to bring it into the whare and we can agree or disagree, or agree to disagree, and then have a cup of tea.”

“If there is a rarururu out there, [we] bring it in here [to the whare hui]...”

The practice of hohourongo was further described by participants as also involving debriefing and reflective processes.

“We debrief...but we debrief in the whare.”

However, this was not the only practice of review to take place in the whare. A further example was provided:

“Clinical reviews are always in the whare nui, [tāngata] whai i te ora [are] always part of it, they open it, they close it [the proceedings].”

Alongside the helpful cultural processes and practices described in relation to working with individual tāngata whai i te ora, many references were made to the importance of working effectively and genuinely with whānau.

Providing whānau-centred care

The importance of whānau involvement in every aspect of tāngata whai i te ora inpatient service care was stressed by the majority of participants. In particular, close liaison between inpatient staff and whānau was seen as essential for promoting whakaoranga. Participants described how this process can be supported by keeping whānau informed about admission, ensuring collaborative involvement in treatment planning, and providing updates about ongoing progress and any other relevant matters. Participants also reported that close liaison and communication with whānau could significantly reduce potential challenges during the admission phase, and could also increase therapeutic engagement and adherence to treatment during the inpatient stay.

“Yeah it’s during those admission phases [there is] the importance to greet people at the door and you tautoko (support, endorse) them. You have to reassure the whānau that their tāngata whai i te ora is going to be okay.”

“...that difference in having my whānau involved, being the ones that I trust and I know...being part of that admission process...the whole whānau ora approach.”

Respectful and inclusive involvement of whānau was described as particularly important during the admission phase, given the impact that imposed restrictive care practices can have on both tāngata whai i te ora and whānau.

“...the trauma that not only the tāngata whai i te ora, but also the whānau, that they go through that admission process.”

Participants discussed the sense of responsibility some whānau feel when tāngata whai i te ora are subject to restrictive care practices such as seclusion and restraint. A commonly held view by participants was that whānau will often develop a sense of failure about their lack of ability to protect their whānaunga, particularly in circumstances such as that described below:

“...when tāngata whai i te ora comes out and says [to their whānau], ‘why did you stand back?’, ‘why did you allow that [restraint] to happen?’”

The emphasis on whānaungatanga, connecting and meaningfully engaging with whānau of tāngata whai i te ora was seen as critical to ensuring whānau were supported throughout the inpatient stay.

“Being Māori; enduring constant challenge; we [staff] practice differently; [we are the] kaitiaki (guardian) of wairua; connecting; it’s about whānau.”

In addition to the importance of whānau-centered practice with known whānau of tāngata whai i te ora, some participants also highlighted the importance of specific Māori cultural teams being able to create a sense of whānau support for tāngata whai i te ora in cases where this previously didn't exist.

“For many of our [tāngata] whai i te ora, it's the first time that they have experienced 'whānau'. It's [the staff is] a surrogate whānau and we're really clear that we're on a journey to get you out of here.”

Also considered highly valuable was the input and involvement of tāngata whai i te ora in consumer advisory and advocate roles, as these extend the support available to tāngata whai i te ora and their whānau, as well as to the staff team.

Te ao hurihuri (whakaumutia): transforming practice

The significant distress and trauma that is associated with the use of seclusion and restraint with tāngata whai i te ora was strongly acknowledged by participants of the hui, and personal experiences were shared that re-emphasised how traumatising it is. All agreed that a transformation of clinical practice was needed to eliminate forceful restrictive care practices.

The category, te ao hurihuri (whakaumutia) highlights the key areas where participants considered transformation of practice to be possible and desirable. In some cases, changes to existing practices were described and emphasis was placed on the need for these to be sustained. Also described within this category were the challenges of bringing about and sustaining transformation of practice.

Three key themes were identified as salient to this category:

- acknowledging past trauma and history
- creating and sustaining changes in practice
- addressing challenges to implementing change.

Acknowledging past trauma and history

Staff awareness of past trauma (trauma histories) among tāngata whai i te ora was seen as essential. A lack of such awareness was perceived by participants as creating the potential for re-traumatisation of tāngata whai i te ora, which would be detrimental to their journey of whakaoranga.

“Some of our whānau and hapū have a history of trauma, and then we put our hands on them and contain them. And we can just re-traumatise them, we just don't realise.”

“...getting people to be a little bit more 'trauma informed' so that they understand what's happening for that person in their whānau and what's the best approach for them.”

In order to avoid re-traumatisation, participants recommended the need for comprehensive assessment of tāngata whai i te ora and whānau, which would include the opportunity to gather information about past

trauma. Following this, clear communication about the particular needs of the tāngata whai i te ora to all staff involved was considered a critical element to providing better trauma-informed care.

Creating and sustaining changes in practice

Having better informed staff, through improved admission and assessment processes, was not the only ingredient considered by participants to be necessary for services to be effective for tāngata whai i te ora. A recovery focused, tāngata whai i te ora-centered approach was seen as crucial for promoting a therapeutic environment within inpatient services. Belief in the value of whakaoranga was considered essential, along with the presence of tūmanako or hope, and the expression of these to tāngata whai i te ora and whānau.

“Tūmanako, faith, and hope in the future...it’s about giving them hope for the future, [with] their wellness in the whānau included in that process, because they are the most relevant to that person.”

Participants also identified factors that would support staff to be able to adopt a recovery focused, tāngata whai i te ora-centered approach. These included having a clear mission statement, staff cohesiveness and a shared team vision and values, and the presence of strong support. Maintaining the wellbeing of the treating team was also considered a particularly important factor.

“...when I walk through the door it’s probably my busiest at that time because I’m not only assessing the [tāngata] whai i te ora, I want to make sure they [the staff] are healthy on the floor so they can do their mahi. Cause that’s the important thing, you’ve got to have a team.”

Having skilled staff who were capable of working effectively with Māori was also identified as important (as previously noted in relation to the earlier category of te ao Māori: access to a Māori worldview). However, what was highlighted here was the importance of valuing cultural knowledge within staff teams, where Māori cultural advisors or experts could work in clear partnerships with clinicians; so that the contribution of both forms of knowledge would be valued as much as each other. For example:

“Responding to how Māori might actually respond to Māori whānau, coming through the service in a Māori way...[would be valued].”

“...offering the practical step of including standard clinical practice within a Māori process...”

With regard to working with tāngata whai i te ora, participants felt that focusing on expectations outlined in core competencies, and subsequent staff training and professional development, was often necessary to support a culture of service change.

“When we’re looking at this transformation, we’re looking at core competencies.”

“There needs to be some education...”

Accordingly, exposure of all staff to unified Māori and clinical approaches was considered useful by participants, especially where uncertainty about these processes might exist among teams.

“It’s really important that everybody from all of those units has exposure to the whare, so [as] to break down some of this misunderstanding...if people change their mindsets and their attitudes, it can be done [better care for tāngata whai i te ora].”

Participants also discussed some specific practices they considered to be currently effective (or have the potential to be) for tāngata whai i te ora. The use of sensory modulation and Māori-specific forms of this was highlighted.

“First-hand, I do believe the sensory modulation has positive effects for tāngata whai i te ora.”

“Māori have been modulating for years, it’s not a new concept, we have our own ways of modulating... Māori modulation.”

Kapa haka as a modulating intervention was described as a form of sensory modulation:

“...used to awaken senses, ground, alert, and calm.”

“Kapa haka as a tool to foster Māori identity and help tāngata whai i te ora to find themselves...”

This was clearly described further in one of the participant’s presentation:

“[There exists] the dynamic relationship between the concrete sensory experience [of kapa haka], the subsequent arousal and affective state, and the socio-cultural and personal meaning...contributed to Māori in gaining a sense of social connection and identity, experiencing shared embodiment, and embodying memory and identity...gaining a sense of physicality, embodying mana and movement...and, gaining a sense of embodied emotion.”

With regard to Māori-specific forms of intervention, participants noted the importance of documenting effective approaches. Some considered that this could be done through the use of existing tools.

“What we do is we create an environment [of consistent documentation processes]...we’re using HCC [HealthCare Community software] to capture the good interventions.”

Other participants considered the importance of using validated outcome measures appropriate to Māori, in order to accurately evaluate which treatment interventions are effective and therapeutic for Māori.

“[Having] our own outcome measures so we can measure what we’re doing, because we do practise differently.”

Promoting practices of keeping consistent documentation and reviewing the effectiveness and outcomes of interventions for tāngata whai i te ora would also foster opportunities for staff to reflect critically on their practices. This would involve reflection on the many factors at play when restrictive care practices were used. This was considered by participants to be essential for identifying alternative strategies, to reduce the use of restrictive care practices. Examples of undertaking critical reflection were as follows:

“So it’s about staff being able to look a little bit closer at why are we keeping on using this drug which is probably making people feel quite angry and agitated? And therefore we’re having more incidences of restraint and seclusion. So it’s about being able to drill down right through those things, the environment and the effect on other patients, their acuity levels, the staff dynamic. How many senior staff we’ve got as opposed to new staff, you know all those sorts of things that have an influence through there. And of course the timing, the time of day, how long after the last medication? All sorts of things factor into that. So we can get together all this data, and information from talking to the patients themselves.”

“It’s teaching staff to recognise their own fear, they’re too busy observing instead of thinking ‘well I’m scared, and how do I need to deal with this situation before I actually deal with them [the tāngata whai i te ora]?’”

Also considered vital to effective and therapeutic care of tāngata whai i te ora was the use of debriefing with the tāngata whai i te ora themselves after the use of restrictive care practices.

“...talking to patients after incidents of restraint and seclusion...[helps to] lessen some of the trauma, so that you can say ‘how are you doing after all this?’”

However, whilst highlighting the potential for positive transformation of practices, participants also acknowledged potential difficulties associated with creating, implementing, and sustaining change within services.

Addressing challenges to implementing change

A number of significant challenges for the implementation of change, or transformation of practices, were noted by participants. Of particular concern to participants was the issue of limited people resources, namely the lack of availability of Māori staff.

“We need Māori staff.”

Participants discussed the potential for poorer outcomes for Māori when cultural support and expertise was not present, highlighting the value that could be added to tāngata whai i te ora care if examples such as the following were possible:

“[Getting] cultural advisors out with the crisis team.”

“Getting more Māori into these sorts of places [inpatient services] looking after our people.”

Not only was there a recognised challenge relating to lack of Māori staff, but also a challenge with accessing a range of differently skilled Māori staff. For example, all participants recognised the special needs of tāngata whai i te ora who are living in the community, but who can no longer cope there, and the challenge of accessing the type of Māori expertise that may be needed to assist in these cases.

“Sometimes when people are wairangi it is very difficult, no matter how many Māori can intervene...that is the time when you need specialised Māori.”

With regard to this, the participants highlighted the need for specialist Māori teams, for example the development of specialist cultural services involved in crisis care intervention teams, as a first point of contact with tāngata whai i te ora and whānau.

“I think we just need to be there 24/7. That is my whakaaro, and I really think that the crisis team needs to get on board with this kaupapa.”

However, participants noted that there were also challenges present for Māori staff who work in inpatient settings with tāngata whai i te ora, particularly in terms of managing the sometimes competing obligations and demands of both cultural and clinical care. Suggestions were made that Māori staff would benefit from training and support to help them manage tensions arising from the need to bridge the dominant institutional world and te ao Māori in the workplace. Some participants considered this to be extremely difficult and potentially dangerous for Māori staff.

“...a Māori kaimahi, or Māori worker, coming into this business is walking into an area full of landmines...”

“Kaimahi Māori working in the care services and working in mental health services...they're grappling with two worlds. And their whakaaro was that the two worlds that they deal with is that which represents us in terms of being Māori...whakapapa, identity, tūrangawaewae, all those sorts of elements; and then the Pākehā world...so there's this whakaaro of this tension, stretching, pulling, conflict, difference, difficulty, challenge...the tension of these two spaces with the two worlds...”

Closely linked to challenges related to a lack of Māori staff and potential difficulties that existing Māori staff may experience, were challenges associated with negative attitudes and stereotypes about tāngata whai i te ora held by non-Māori staff. Racism, for example, was considered a strong existing barrier to the effective care of tāngata whai i te ora.

“...the process [of admission and treatment] is racist, that Māori are brought into a place and automatically bang, it’s medication, bang. It’s racist; it’s based on an inability to deal with Māori.”

The issue of racism was threaded throughout the kōrero in all of the themes, although it was rarely named explicitly as such. Instead, it was framed as attitudes, behaviours and environments that reflect a strong disconnect between the world of the mental health inpatient service and the world of Māori, including those tāngata whai i te ora who receive care, their whānau, and the Māori staff within the service. One participant highlighted this disconnection with this question:

“Are the institutions so non-Māori that it’s the Māori face that neutralises the unfriendliness of the institution?”

In addition to these complex staff-related challenges, was the challenge of limited time for evidence gathering, and limited physical resources in some service settings, to implement practices that appeared to be effective for tāngata whai i te ora. For example:

“I don’t think the sensory modulation is being picked up as good as it should be, that’s because we haven’t really provided any evidence so that our clinicians can see how this works, how they can work with it.”

“...[It’s a] good idea...[but our inpatient service] hasn’t got the resources...sensory modulation is great, but it was inevitable that it was never going to be fully implemented.”

Patient-related challenges were also identified by participants as a further factor that inhibited the effective implementation of helpful practices (such as Māori-focused admission or sensory modulation processes), in particular barriers created by late presentation of tāngata whai i te ora to services.

“...by the time they get to us...they’re wairangi, that they are so wairangi, that we cannot undertake the [admission] process in the whare.”

Many participants spoke strongly about the challenge of imbedded culture and the time required to change such culture in inpatient services. All participants considered that transformation of practice could potentially be a very long process and required a lot of effort in order to be sustained.

“...[It’s a] long process of culture change within organisations, they take a long time...no change happens in isolation...if it’s taking place in isolation then it’s not sustained.”

“...seclusion and restraint, it’s been an imbedded practice within our services for I don’t know how long...it was seen as a treatment...it was seen as something that was good for people...now we stand here today as a group and we’re actually saying no, it’s not alright.”

Rangatiratanga: leadership, power, and control

All participants felt that the essential component of care for Māori is Māori involvement in all aspects of mental health service delivery (as noted already in various examples in the first two categories of these findings). However, the kōrero from participants went beyond simply wanting more Māori faces added to existing services. Two themes in particular were identified as salient to the category of rangatiratanga, namely:

- participation of Māori at all levels
- leadership commitment to transforming practice.

Participation of Māori at all levels

Participants strongly reiterated the need for participation of Māori at all levels of care. In addition to the need to increase Māori staffing levels at the frontline of inpatient services, participants highlighted a need for Māori involvement in all areas of decision-making with regard to management of services, service development, workforce development, planning and funding.

“Māori to continue to demonstrate leadership...to organise things more in ways for Māori, which suit Māori.”

While recognising that capacity-building of the Māori workforce is ongoing and necessary in terms of enabling participation at all levels, many participants noted that there were increasing numbers of Māori currently involved in services, and also that there were existing examples within some services where models of shared power facilitated the ability of Māori staff to retain autonomy and control over how care is delivered to tāngata whai i te ora. One participant gave the following example:

“We [kaupapa Māori service] are supported one hundred per cent by our clinical director and our service manager. We are incorporated in every meeting that happens in here including programmes, and clinical governance meetings. We are supported to a degree by our own autonomy, [and] by what happens in our [Māori] programme.”

However, there was also discontent expressed. A number of participants expressed frustration in relation to the repetitive nature of solution-seeking from Māori by those charged with service delivery development and responses to inequity at a higher level. Some participants felt that this was tiresome, and reflected an inability of those in power to act on information already at hand.

“We have to re-emphasise that it’s about Māori in the places, Māori working with Māori. Again, in 2012 [the date of this research hui] when we’ve been saying this for the last 20 or 30 years, we’ve been saying Māori workforce development, kaupapa Māori services [etc]...and it seems to fall on deaf ears.”

Participants held the view that strong and sustained commitment from those in leadership positions was critical if there was to be any hope for transforming practice in the sector. They also held a strong desire that their involvement in the research hui would facilitate concrete action and progress in this area.

Leadership commitment to transforming practice

Transformation of practice was perceived by participants to involve, not only leadership commitment that was strong and could be sustained across time, but also leadership based on a foundation of commitment to genuine, meaningful engagement at a Treaty of Waitangi partnership level. Participants considered that genuine partnership between Māori and service managers would effectively enable transformation of practice, not only in services, but across the sector in all related areas.

“Consistent sustainable implementation...[and] leadership towards organisational changes...[requires] effective leadership.”

Participants felt that there was currently strong support for the development of such leadership aimed at reducing the use of restrictive care practices for Māori. However, they cautioned that any leadership would need to take heed of the preference of Māori to completely eliminate the use of seclusion and restraint with *tāngata whai i te ora*.

Summary

The major themes outlined in this section can be viewed in relation to the six core strategies (Huckshorn, 2006). These strategies have been collated from the evidence as best practice for reducing the use of seclusion and restraint.

Leadership towards organisational change: Having a strong sense of leadership is important at all phases to provide oversight of seclusion and restraint practices. Given the over-representation of Māori as the recipients of such practices, it is vital that leadership involves Māori, with a genuine commitment to partnership as reflected in the Treaty of Waitangi. This partnership should be directed toward ensuring that there is a culture within the organisation that is supportive of change. The themes of this study reflect the need for a strong focus in the institutional culture on a recovery focused, *tāngata whai i te ora*-centered model of care; *whānau*-centred care; holistic care; and trauma-informed care .

The use of data to inform practice: The collection and use of relevant information has been identified as an essential aspect for seclusion reduction (McLeod et al., 2013). A theme from this study recognised the need for the use of validated outcome measures appropriate to Māori, in order to accurately evaluate interventions put in place to eliminate seclusion and restraint.

Workforce development: There is a strong evidence-based emphasis placed on the need to ensure there is sufficient workforce development within any organisation in order to prevent the use of seclusion and restraint. The themes highlighted from this study indicate the need for all staff to be culturally competent. A strong, robust Māori workforce at the forefront of service delivery was also seen as crucial. It is believed that this workforce needs to extend into the crisis teams who approach Māori at the time they are most vulnerable. Furthermore, for the existing Māori workforce, both clinical and cultural supervision is required in order for

this workforce to balance what at times might be perceived as the competing interests of clinical and cultural care.

Use of seclusion and restraint prevention tools: There were a number of practical interventions cited in this study to prevent the use of seclusion and restraint.

Practical interventions: Therapeutic, culturally appropriate, physical space, where tāngata whai i te ora are able to self-soothe and tolerate distress, was suggested. There was also the suggestion of the use of culturally appropriate rituals of engagement using such practices as pōwhiri, whaikōrero, mihimihi and kai. Time spent connecting with the tāngata whai i te ora through an exploration of personal identity (whakawhānaungatanga) was also seen as an affirming process in engaging with tāngata whai i te ora. Cultural assessment was viewed as an avenue by which culturally specific needs could be identified and subsequently addressed.

Sensory modulation: One evidence-based approach to reducing the use of seclusion and restraint is the use of sensory modulation (Champagne, 2003). This study supported the use of culturally appropriate sensory modulation strategies. These included the use of karakia, waiata, mirimiri and kapa haka, for example.

Service user roles in inpatient services: The establishment of peer support within New Zealand is well underway, with every district health board nationwide currently offering some form of peer support (Scott et al., 2011). The findings of this study saw value in the development of Māori peer support initiatives for the prevention of seclusion and restraint.

Debriefing: In this study, a Māori-specific cultural practice was seen as relevant in preventing seclusion and restraint. Hohourongo establishes rules of engagement between people (e.g. between tāngata whai i te ora and staff) based on openness, social responsibility and mutual respect, thereby facilitating a process of restorative obligation. Concerns are taken into a culturally specific environment, and two-way discussion occurs until the parties can reach a point of mutual agreement about a way forward. Although it is a debriefing strategy, it can also be used as a preventative strategy as concerns arise. Debriefing among staff also enables critical reflection, which facilitates the development and enhancement of cultural competence.

Discussion

This study sought to examine strategies currently employed within inpatient services that reduce the use of seclusion and restraint of tāngata whai i te ora, and to gather Māori perspectives on these strategies. Māori perspectives on culturally-based strategies or approaches that may reduce the use of restraint and seclusion with tāngata whai i te ora were also sought. Based on the findings of this study, the following discussion and recommendations are provided.

The overall strategies and initiatives identified in this study represent a comprehensive approach to the reduction of the use of restraint and seclusion with tāngata whai i te ora; an approach that is clearly based on a kaupapa Māori model of care and a vision for transformation of practice in mental health inpatient services.

Addressing the over-representation of Māori suffering psychological distress, and their consequent admissions to inpatient services and exposure to restrictive care practices, specifically seclusion and restraint, is no simple task. Based on a review of the literature and analyses of data gathered, this study demonstrates a need for significant transformation of mental health inpatient services in New Zealand if restrictive care practices for tāngata whai i te ora are to be reduced.

The implications of this study, and recommendations arising from it, are highlighted for clinicians in acute mental health services; sector leaders and managers of such services; and policy-makers.

Implications for clinicians in inpatient mental health services

The scale of the use of seclusion and restraint on tāngata whai i te ora suggests that developing strategies for improvement in service delivery should be a priority for all clinicians. Although the literature to date is rudimentary in providing evidence for what works, the value of pragmatic suggestions made in the literature is strengthened by the findings of this study. These suggestions are worthy of introduction within a cycle of service improvement.

Recommendations for clinicians in inpatient mental health services

- Prioritise the involvement of Māori staff in care and treatment with tāngata whai i te ora, including Māori staff with specialist cultural skills.
- Build early intervention by specialist Māori staff into the clinical pathway when working with tāngata whai te ora, particularly at times of crisis and first admission. Implement and maintain admission processes for Māori that incorporate access to Māori culturally safe physical space (such as the marae and whare hui where possible) and culturally specific means of encounter and engagement (pōwhiri, whaikōrero, mihimihi and kai).

- Increase the use and availability of tikanga Māori approaches to working with tāngata whai i te ora on the ward environment, including (whaka)whānaungatanga, manaakitanga, a preference for ‘kanohi ki te kanohi’ interactions and access to Māori conflict resolution processes, such as hohourongo, which may specifically support the de-escalation of potential risk situations. This would include the development and understanding of the importance of wairuatanga to many Māori and a need for service providers’ commitment to supporting holistic wellbeing among tāngata whai i te ora.
- Support easy access to cultural healing practices and activities which represent a Māori approach to sensory modulation such as karakia, mirimiri and kapa haka.
- Provide opportunities for tāngata whai i te ora to learn about or enhance their Māori cultural identity in the inpatient setting. This will enable the restoration of mana or mana-enhancing practices to improve tāngata whai i te ora wellbeing and preventing episodes of distress.
- Integrate ‘whānau-centered’ care to tāngata whai i te ora in your clinical treatment plans, where the inclusive involvement of whānau at all points of care is enabled and facilitated by the service.
- Foster and strengthen the ‘trauma informed care’ in the ward milieu to ensure interventions in inpatient services do not exacerbate any difficulties with regard to previous trauma among tāngata whai i te ora, and instead reduce the likelihood of re-traumatisation.

Implications for sector leaders and managers of inpatient mental health services

Broad transformation of service delivery, as indicated in this study, can be aligned to the six core strategies for reducing seclusion and restraint (Huckshorn, 2006; National Association of State Mental Health Program Directors, 2006) and to the “practices that reduce and eliminate seclusion and restraint” outlined in Te Pou’s *Best Practice in the Reduction and Elimination of Seclusion and Restraint: Seclusion: Time for change* report (O’Hagan et al., 2008). These should be read in conjunction with the recommendations outlined below, which are based on the specific Māori perspectives gathered in this study.

Recommendations for sector leaders and managers of inpatient mental health services

- Prioritise and strengthen effective Māori participation in leadership in all areas of service delivery, including in decision making and management of services, service development, workforce development, planning, funding, and provision of services to tāngata whai i te ora.
- Develop and maintain a strong and sustained commitment to reducing and eliminating the use of seclusion and restraint with Māori through facilitating concrete action and reporting on progress.
- Promote consistent documentation and use of this information to review effectiveness of interventions for tāngata whai i te ora. This will enhance opportunities for critical reflection on care practices by staff.

- Develop and assess staff cultural competency to work effectively with Maori . Ensure staff have access to programmes that develop cultural competency.
- Increase supervision and support for all staff to critically reflect on their cultural competency.

Limitations

The sample size of this study was small. While not claiming to be representative of all views on this topic within the Māori population, the findings provide a range of salient points, gathered from the thoughts, experiences and understandings of Māori clinical, cultural and consumer experts in this field. Given the dearth of literature in the field, this study makes a useful contribution to beginning to understand Māori perspectives on reducing seclusion and restraint with tāngata whai i te ora in mental health inpatient services, and highlights the need for further research in this area.

Conclusion

The Te Pou *Best Practice in the Reduction and Elimination of Seclusion and Restraint: Seclusion: Time for change* report (O'Hagan et al., 2008) highlighted the important contribution that national leadership and direction can make towards promoting the reduction (and ultimately the elimination) of seclusion and restraint in adult mental health inpatient services in New Zealand. The findings of this study suggest that strong leadership and direction will be essential if the goal of improving the experiences of tāngata whai i te ora in these services is to come to fruition.

The recently commissioned Te Pou report on the use of seclusion for Māori in adult inpatient mental health services (McLeod et al., 2013), and this current piece of research on strategies to reduce the use of seclusion and restraint with tāngata whai i te ora, both contribute to developing the direction in which leadership needs to head in this area in New Zealand.

While the McLeod et. al., (2013) report paints a grim picture of the high rates of restrictive care practices with Māori in New Zealand, this current study highlights some of the positive, culturally appropriate, whānau-centered and recovery-focused practices that may reduce, and ultimately eliminate, the experience of seclusion and restraint for Māori.

In particular, this study reiterates the notion that the overall model of care, and how it is enacted, is what seems to count. It must be based on fundamental principles that are meaningful to tāngata whai i te ora and reflect their values. The model of care must provide guidance for the ways in which distress, agitation and conflict are managed, which is therapeutic and inclusive and values reciprocity, rather than one that further alienates and marginalises tāngata whai i te ora. This study has shown that Māori models of care provide such principles and guidance.

Glossary

The term tāngata whai i te ora (as opposed to tāngata whaiora) has been used when discussing service user (client) perspectives as advised by Naida Glavish (Ngāti Whatua, Ngāti Hine). Whaea Naida indicated this use to incorporate a more inclusive context.

| Māori | English |
|--|--|
| Aotearoa | Long white cloud; New Zealand |
| Hinengaro | Mind; thought; consciousness |
| Hohourongo | Rules of engagement |
| Hui | Meeting; gathering |
| Kai | Food |
| Kaimahi | Worker |
| Kaitiaki | Guardian; carer |
| Kanohi kitea | The seen face |
| Kapa haka | Traditional cultural dance |
| Karakia | Spiritual stimulation; prayer |
| Kaumātua | Elder (male or female) |
| Kaupapa Māori | Māori principle or philosophy |
| Kaupapa Māori services | Services based on Māori principles and philosophies |
| Koha | Gift of appreciation |
| Mana | Prestige; authority; dignity |
| Manaaki | To take care of; support; protect; look out for |
| Manaakitanga | Hospitality; kindness |
| Marae | Courtyard; meeting place; complex of buildings |
| Mate Māori | Māori illness |
| Mirimiri | Massage |
| Ora, oranga | Be alive; well; healthy |
| Pākehā | Non-Māori New Zealander descended from settlers |
| Poroporoaki | Formal farewell |
| Rangahau whānau | Research advisory group |
| Rangatahi | Youth; adolescent |
| Rangatiratanga | Self-determination; authority |
| Reo | Language |
| Tāngata whaiora; tāngata whai i te ora | Person seeking wellness; services users of Māori descent |
| Tautoko | Support; endorse |
| Te ao Māori | Māori worldview |
| Te reo Māori | The Māori language |
| Te reo me ona tikanga | Language and its customs |

| | |
|----------------------|--|
| Te Tiriti o Waitangi | The Treaty of Waitangi |
| Tikanga | Māori practices |
| Tino rangatiratanga | Self-determination |
| Tohunga | Māori spiritual healer |
| Tupuna | Ancestor |
| Turangawaewae | Place of standing; safe place |
| Waiata | Song |
| Wairua | Spirit; spirituality |
| Wairuatanga | Soul; spirit |
| Whakaoranga | Recovery |
| Whakapapa | Geneology; descent |
| Whakawhānaungatanga | The acts of establishing relationships; connecting |
| Whānau | Family; extended family |
| Whānaunga | Relative; relation |
| Whānaungatanga | Relationships; social cohesion |
| Whānau ora | Family wellbeing |
| Whare nui; whare hui | Tribal meeting house |

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AUCKLAND

Level 2, 8 Nugent Street (B), Grafton
PO Box 108-244, Symonds Street
Auckland 1150, NEW ZEALAND
T +64 (9) 373 2125 F +64 (9) 373 2127

HAMILTON

293 Grey Street, Hamilton East
PO Box 219, Waikato Mail Centre
Hamilton 3240, NEW ZEALAND
T +64 (7) 857 1202 F +64 (7) 857 1297

WELLINGTON

Level 3, 147 Tory Street
PO Box 6169, Marion Square
Wellington 6141, NEW ZEALAND
T +64 (4) 381 6475 F +64 (4) 238 2016

CHRISTCHURCH

21 Birmingham Drive, Middleton
PO Box 22105, High Street,
Christchurch 8142, NEW ZEALAND
T +64 (3) 339 3782 F +64 (3) 339 3783

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