Practice guide for leaders

Whakakaha i te ara rangatira: embedding AOD knowledge to reduce restrictive practices

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Introduction

This practice guide is designed to help leaders and kaimahi strengthen safe, equitable, and least-restrictive responses when supporting tāngata whai ora who may be experiencing alcohol and other drug (AOD) related distress. Grounded in kaupapa Māori values, Te Tiriti commitments, and evidence-informed AOD knowledge, the guide turns everyday situations into practical learning moments that build confidence, enhance whanaungatanga, and reduce reliance on restrictive practices. The guide is intended to be used flexibly—in huddles, supervision, team meetings, and on shift—to support consistent, compassionate, and culturally safe practice across services.

Purpose

Equip service leaders, nurse managers, clinical leads, charge nurses, and kaimanaaki leads to implement the **AOD knowledge** suite in ways that:

- reduce seclusion, restraint, and other restrictive responses,
- strengthen cultural safety, whānau partnership, and lived experience leadership, and
- protect kaimahi wellbeing and confidence under pressure.

Leadership stance: the three pou

Pou 1 — Manaakitanga & whanaungatanga (relationships first)
Model relational safety daily: begin hui with karakia/quiet minute; prioritise connection before tasks; invite whānau, peers, and cultural supports early. Use “10-minute wellbeing check-ins” in supervision and huddles (see Weeks 1-2 on the 12-week implementation plan below).

Pou 2 — Tiriti-led equity
Embed Te Tiriti principles (Tino Rangatiratanga, partnership, active protection, options, equity) across decisions, dashboards, and review meetings. Ensure kaupapa Māori and Pasifika pathways are visible and resourced; track access and outcomes by group.

Pou 3 — Least restrictive, trauma-informed practice
Champion de-escalation, harm reduction, supported decision-making, and diagnostic overshadowing checks as default responses. Make restrictive measures a last resort with documented alternatives tried first.

Change framework: CLARC + ADKAR* in practice

Leaders operationalise change using CLARC (your role in change) and ADKAR (kaimahi journey).

Your CLARC roles (what to do this month)

Communicator — run a 20-minute initial kōrero in each team: "why this matters", local data on seclusion, and how the AOD modules will help. **Share the quick guidance cards**

Liaison — set up a fortnightly loop between ward, AOD service, peers, Māori and Pasifika advisors; resolve challenges together with leadership.

Advocate — spotlight kaimahi wins in reducing restrictive practices; nominate "AOD champions" on each shift.

Resistance manager — host short "ask me anything" sessions; validate concerns about time/skills; offer micro-skill practice (e.g., harm reduction phrases).

Coach — pair newer kaimahi with mentors; use **the practical strategies for the ward cards** for brief skill practice in safety huddles.

The ADKAR journey (how to take your team with you)

Awareness: share clear rationale (stigma → coercion risk; AOD literacy → safety).

Desire: ask "What would encourage kaimahi to engage?" Capture suggestions (e.g., protected training time, buddy cover).

Knowledge: schedule 45–60 min micro-sessions. **Course: Building alcohol and other drug (AOD) knowledge to reduce restrictive practices | Pūkoro** (You will need to sign into Pūkoro to access these E-learning modules.)

Ability: run on-shift run-throughs using **practical strategies for the ward cards** and **decision-support flowchart.**

Reinforcement: celebrate safe de-escalations; publish weekly "lessons learned"; link outcomes to professional development plans and team goals.

How to make a difference in the next 12 weeks: 12-week implementation plan

Weeks 1–2: Awareness building & baseline & baseline
Announce programme; share resources from the Te Pou suite, confirm champions per shift. **Capture baseline data;** seclusion/restraint episodes, PRN use for acute agitation, medical escalations, kaimahi confidence (1–10). **Start 10-minute wellbeing check-ins;** in supervision or at handover.
Weeks 3–4: Foundations (stigma, language, equity)
Micro-session; Module 1 (Addressing stigma and discrimination) + team agreement on non-judgemental documentation (You will need to sign into Pūkoro to access these E-learning modules.).
Weeks 5–6: Clinical safety (overshadowing, risk)
Micro-session; Module 2 (diagnostic overshadowing) Run through the **decision-support flowchart** during handover, 15-minute team huddle script (See the practical leader tools section below) (You will need to sign into Pūkoro to access these E-learning modules.).

* You can find more about the ADKAR here: The Prosci ADKAR® Model | Prosci https://www.prosci.com/methodology/adkar

Weeks 7–8: Harm reduction & methamphetamine literacy
Micro-session; Module 4 (Harm reduction) + local referral map; invite peer worker kōrero (You will need to sign into Pūkoro to access these E-learning modules.). **Poster/quick view:** Drug Foundation substances overview.
Weeks 9–10: Screening & assessment flow
Micro-session; Module 5 (Screening and assessment) + when/where to use them safely in IPU. Establish warm handover protocol with local AOD services and whānau ora providers (You will need to sign into Pūkoro to access these E-learning modules.).
Weeks 11–12: Consolidate & review
Capture post-data; compare with baseline; identify 3 system tweaks (e.g., quiet space access, peer roster, documentation prompts). **Host a 30-min reflective hui;** What strengthened safety? What reduced restriction? What equity shifts are visible?

Practical leader tools

15-minute team huddle script (weekly)

Opening: karakia/one minute silence.

Wins & wisdom: one strength spotted in a colleague (strengths round).

Safety focus: one de-escalation cue or diagnostic overshadowing check for this week.

Workload balance: "What's tipping you over?" → one stop/start/continue as a team.

Close: acknowledge effort; confirm who's on duty for peer/whānau support today.

On-shift coaching micro-skills (5 minutes)

Language swap: replace "non-compliant/manipulative" with "working on strategies—what support helps?" (practice aloud).

Choice offer: "Would being somewhere quieter help, or would you prefer to stay here?" (demo).

Grounding cue: "Notice your feet; take a slow breath with me." (demo).

AOD champions: role & rhythm

Keep **practical strategies for the ward cards** stocked; orient new kaimahi; lead 10-min run-throughs; liaise with AOD service/peers; log weekly "what helped" notes for the learning loop.

Protected time menu (pick any one each week):

- 20-min module micro-session,
- 10-min scenario reflection, and
- 10-min wellbeing check-in.

Measures that matter (leader dashboard)

Track monthly and review in multi-disciplinary team; disaggregate by Māori, Pasifika, rainbow and older adults where possible.

Experience & equity

- % of admissions with whānau involvement (where consented).
- % of notes using agreed person-first language (audit sample).
- Kaimahi wellbeing pulse (1–10 energy scale; "What's one thing draining/energising?").

Safety & least restrictive practice

- Seclusion/restraint episodes per 100 admissions; median duration; alternatives attempted logged.
- Medical escalations for AOD-related presentations (vitals' red flags identified early).

Capability

Kaimahi self-rated confidence (1–10) in: de-escalation, harm-reduction communication, overshadowing checks, AOD screening.

Governance and continuous improvement

Monthly review hui (60 minutes)

Open with Whanaungatanga; share one kaimahi story of a least-restrictive success.

Review dashboard; identify 1–2 system shifts (e.g., access to low-stimulation spaces, peer roster availability, documentation prompts).

Confirm actions, owners, timelines; publish a 3-bullet "What we changed" summary to the team.

Incident learning loop.

Leader FAQs (quick answers you can use)

"We don't have time."

Protect 10–20 minutes per week: micro-sessions, run-throughs, or huddle prompts. Short, repeated practice builds ability faster than sporadic long training.

"Staff worry about safety if we don't use seclusion early."

The pathway emphasises rapid medical triage for red flags and one-to-one supportive containment while escalating clinically when necessary — seclusion is last resort, well-documented, and time-limited.

"How do we keep momentum?"

Celebrate de-escalations weekly; publish a 3-bullet "what changed"; keep **quick guidance cards** visible; rotate champions; keep ADKAR visible in team rooms (refer to the ADKAR information on page 2).

Acknowledging that at times restrictive practices are required

Below is a short case scenario which demonstrates how restrictive practice is sometimes unavoidable, but when this occurs it must always be the absolute last resort, for the shortest time possible and underpinned by mana-enhancing approaches.

Bruce, a 32-year-old tangata whai ora with significant AOD-related distress, has been admitted to the inpatient unit following several days of stimulant use, no sleep, and increasing paranoia. At the start of the shift, kaimahi notice he is pacing quickly, scanning the room, and expressing fear that others intend to harm him.

The assigned nurse and kaimanaaki approach calmly, using grounding cues and offering choices about where he would feel safest. They invite whānau to attend by phone, offer access to a quieter space, and bring in a peer worker to support engagement. For several minutes Bruce appears settled and is able to kōrero.

Alternatives attempted (early de-escalation):

- The assigned nurse and kaimanaaki approach calmly.
- They use grounding cues and reassurance.
- Bruce is offered choices about where he would feel safest.
- Kaimahi invite whānau to attend by phone.
- He is offered access to a quieter, low-stimulation space.
- A peer worker joins to support engagement and trust.

However, his distress escalates rapidly. He begins shouting, hitting walls, and attempting to flee the unit. Kaimahi implement the agreed de-escalation pathway: one person leads communication; others stay quiet and present, and checks are completed quickly to rule out acute medical risk. They offer water, pacing support, a sensory kit, and a supported brief time in a low-stimulation area. Despite this, Bruce becomes increasingly disorganised and attempts to strike another person in the unit.

Further least-restrictive strategies attempted:

- The team implements the agreed de-escalation pathway.
- One person leads communication to avoid overwhelming him.
- Other kaimahi remain quiet, calm, and present.
- A rapid safety check is completed to rule out acute medical risk.
- Bruce is offered water and support to pace safely.
- Kaimahi provide a sensory kit.
- A brief supported time in a low-stimulation area is offered.

At this point, all least-restrictive alternatives have been attempted. The team pauses for a rapid clinical decision: Is restrictive practice now required to prevent imminent harm? The answer is yes. Safety, for Bruce, for others, and for kaimahi must take priority.

Decision question:

Is restrictive practice required to prevent imminent harm to Bruce or others?
Clinical decision: Yes.
Safety — for Bruce, for others, and for kaimahi — must now take priority.

The shift coordinator leads the interaction. The team moves with purpose, clarity, and respect: one communicator explains exactly what is happening and why; another monitors Bruce's breathing, comfort, and medical status; cultural support is present where possible; and kaimahi maintain calm, steady tone throughout. Physical restraint is applied carefully and only for as long as necessary to administer medication and ensure immediate safety. There is no raised voice, no unnecessary force, and no judgement—only professionalism and compassion.

Actions supporting mana and dignity:

- One person clearly explains what is happening and why.
- Communication remains calm, respectful, and transparent.
- Another person monitors breathing, comfort, and medical status.
- Cultural support is present where possible.
- Kaimahi maintain a steady tone and minimise sensory stimulation.

Shortest-time principle:

- Physical restraint is applied carefully and only for as long as necessary to administer medication and prevent immediate harm.
- No raised voices, no unnecessary force, and no judgement are used.
- The focus remains safety, dignity, and compassion.

Once Bruce is safe, the restraint ends immediately. Kaimahi remain with him, offering reassurance, warmth, and explanations. A debrief is completed with Bruce when he is ready, and a whānau update is provided. The team also completes their own debrief, reflecting on what worked, what didn't, and what could be done differently next time to avoid restraint. Documentation includes all alternatives attempted, who was involved, and how cultural and trauma-informed principles were upheld.

Debrief and learning to prevent future restraint

Bruce's debrief:

When Bruce is ready:

- Kaimahi kōrero with him about what led to the escalation.
- They ask what helps him feel safe during distress.
- Together they consider strategies that could work earlier next time.

Team debrief:

Kaimahi reflect together on:

- What early signs of escalation were observed.
- Which de-escalation strategies helped or didn't help.
- Whether anything could be tried earlier next time.
- How whānau, peer, or cultural supports could be strengthened.

Future prevention actions:

- Update Bruce's care and safety plan.
- Note preferred calming strategies.
- Record early warning signs of stimulant-related distress.
- Identify alternatives to try sooner in future situations.

Documentation requirements:

Following the event, documentation clearly records:

Alternatives attempted before restraint:

- Grounding and reassurance.
- Choice of safe spaces.
- Whānau involvement.
- Peer support.
- Sensory tools.
- Low-stimulation environment.
- Structured de-escalation approach.

Details of the restrictive intervention:

- Reason for use (imminent risk of harm).
- Who authorised and led the intervention.
- Who was present.
- Duration of the restraint.
- Monitoring of Bruce's physical and emotional wellbeing.
- Cultural supports offered or present.

Trauma-informed and cultural practice:

- Respectful communication.
- Maintenance of dignity.
- Support offered to Bruce and whānau afterwards.

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