Reducing Māori seclusion

A summary report with recommendations for managers and leaders of mental health services

Te Pou
o Te Whakaaro Nui

Acknowledgements

Te Pou would like to thank the following people without whom this work would not have been possible.

The DHB mental health services Te Pou has been privileged to work with in the area of reducing Māori seclusion.

Moe Milne, Te Moemoea, Independent contractor and Nicola MacDonald, REAL.

The authors of the *Strategies to reduce the use of seclusion and restraint with tangata whai i te ora* report:
- 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
- The Rangahau Whanau including Nick Wiki (Te Aupouri); Trudy Field (Ngā Puhi); Jason Haitana (Ngāti Tuwharetoa, Te Āti Haunui a Pāpārangi); Erika Edwards (Ngā Puhi); and Mike Toko (Ngāti Whatua), and also Associate Professor Brian McKenna

The authors of the report: *The use of seclusion for Māori in adult in-patient mental health services in New Zealand:*
- Dr Melissa McLeod, Dr Paula King, Dr James Stanley, Shirley Simmonds of Te Rōpū Rangahau Hauora a Eru Pōmare, University of Otago, Wellington
- Dr Cameron Lacey, of Māori/Indigenous Health Institute (MIHI), University of Otago, Christchurch
- Dr Ruth Cunningham, Social Psychiatry and Population Mental Health, University of Otago, Wellington

Contents

Executive summary

In New Zealand there have been recent moves towards limiting the use of restraint and seclusion, along with encouragement for use of preferred alternative interventions, in the mental health in-patient setting. Data on the use of seclusion has limitations. Available information suggests there are ethnic differences in the use of seclusion in New Zealand, with Māori more likely to be secluded than non-Māori (El-Badri and Mellsop, 2002; Mental Health Commission, 2004b; McLeod et. al, 2013).

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

Evidence shows that when a comprehensive seclusion reduction strategy comprising of multiple components is employed, services can successfully reduce their rates of seclusion (NAMSHPD, 2006). To assist the implementation of a comprehensive strategy to reduce seclusion and restraint use, the National Association of Mental Health Programme Directors (NAMSHPD, 2006) developed a set of six core strategies. These include:

- leadership towards organisational change
- use of data to inform practice
- workforce development
- use of seclusion and restraint prevention tools
- consumer roles in in-patient settings
- debriefing techniques.

This paper provides a brief summary of the work undertaken to address high rates of Māori seclusion to date. It then outlines practical strategies to reduce Māori seclusion that services can implement as part of their seclusion reduction work.

Using the Six Core Strategies developed by NAMSHPD, practical strategies and recommendations have been developed to address high rates of Māori seclusion. The target audience for this summary paper includes service managers and leaders, and clinical leaders who are keen to reduce high rates of Māori seclusion and restraint use.

Introduction

In New Zealand there have been recent moves towards limiting the use of restraint and seclusion, along with encouragement for use of preferred alternative interventions, in the mental health in-patient setting (Mental Health Commission, 2004b; O'Hagan, Divis and Long, 2008; Te Pou, 2009a; Te Pou, 2009b; Te Pou, 2010, Te Pou, 2011; Ministry of Health, 2010b). While data on the use of seclusion has limitations, available information suggests there are ethnic differences in the use of seclusion in New Zealand, with Māori more likely to be secluded than non-Māori (El-Badri and Mellsop, 2002; Mental Health Commission, 2004b; McLeod et. al, 2013). A targeted focus on reducing seclusion for Māori will contribute to significantly reducing this inequity. Te Pou continues to be concerned about the high rates of Māori seclusion and the length of time Māori spend in seclusion.

This paper sets out the issue, the evidence and provides recommendations for actions that services can implement to reduce high rates of Māori seclusion. This paper draws together key evidence and recommendations from the following sources:

- McLeod, M., King, P., Stanley, J., Lacey, C., Cunningham, R., and Simmonds, S. (2013). *The use of seclusion for Māori in adult in-patient mental health services in New Zealand*. Auckland. Te Pou. This paper was commissioned by Te Pou to investigate ethnic disparities in the use of seclusion in adult mental health in-patient units in New Zealand.
- Wharewera-Mika, J., Cooper, E., McKenna, B., Wiki, N., Field, T., Haitana, J., Toko, M., and Edwards, E. (2013). *Strategies to reduce the use of seclusion and restraint with tangata whai i te ora.* Auckland: Te Pou o Te Whakaaro Nui. This paper was commissioned by Te Pou to review the international and national evidence and gather Māori clinical, cultural and consumer perspectives on potential strategies and initiatives likely to facilitate the reduction in high rates of Māori seclusion.[1] Given the dearth of literature in the field, this study makes a useful contribution to the understanding of Māori perspectives on reducing seclusion and restraint with tāngata whai i te ora in mental health in-patient services.
- Te Whare Ahuru: Providing alternatives to seclusion and restraint (2009b). A story about Te Whare Ahuru initiative to reduce Māori seclusion.
- Te Pou's recent work with DHBs to reduce seclusion, with a specific focus on reducing high rates of Māori seclusion.

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

---

[1] The sample size and method of participant recruitment may limit generalisability, albeit that generalisability is not commonly a goal of qualitative research. It is not a representative sample. However, a range of thoughts, experiences and understandings were gathered in this research from Māori clinical, cultural and consumer experts in the field, and this reflected the fact that some diversity among participants existed.

This summary paper sets out the policy and legal context for seclusion and a summary of the evidence for high rates of Māori seclusion. It then describes the evidence for reducing seclusion rates and makes recommendations that leaders of mental health services can implement to reduce the high number of Māori seclusion events.

Use of seclusion in New Zealand

The Ministry of Health's Service Development Plan (SDP) (Ministry of Health, 2012) describes a range of health sector improvements and priorities which will be put into action over the next five years. One of the priority actions outlined under the goal "Cementing and building gains for people with high needs" in the SDP is to "support the in-patient workforce to reduce and eliminate the use of seclusion and restraint (including pharmacological restraint), based on national and international best-practice examples" (p25). The plan makes particular reference to reducing Māori rates of seclusion.

Seclusion is provided for in section 71 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 and can only be legally implemented subject to the conditions that are specified in that Act. The Health and Disability Services (General) Standard (Standards New Zealand, 2008a, p. 30) defines seclusion as "where a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit". The guidelines for the use of seclusion (Ministry of Health, 2010c, p. 1) state that a period of seclusion commences when the service user enters the conditions of seclusion. The seclusion period is deemed to have ended when the service user leaves the conditions of seclusion without the expectation of return, and in any case, if the service user has been out of seclusion for more than one hour.

The Health and Disability Services (Restraint Minimisation and Safe Practices) Standards (Standards New Zealand, 2008b) came into effect on 1 June 2009 and state that:

> Seclusion should be used for as short a time as possible and is best conceived as a safety mechanism rather than a therapeutic intervention or treatment. The decision to seclude should be an uncommon event, used as a final alternative and subject to strict review. The information in NZS8134.23 is provided with the expectation that although seclusion is legal, services will be proactive in reducing and minimising/avoiding its use (p6).

In February 2010 the Ministry of Health published revised guidelines for the use of seclusion in mental health services (Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992, Ministry of Health, 2010c). These guidelines identify best practice for the use of seclusion in mental health acute in-patient units. They also clearly state that, over time, the intent is that mental health services will limit the use of seclusion and restraint on service users.

In New Zealand higher rates of seclusion for Māori has been reported (McLeod et. al., 2013; Mental Health Commission, 2004b; Wharewera-Mika, 2012), with 20 per cent of Māori admitted to in-patient 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).[2]

The McLeod et. al. (2013) report investigating the use of seclusion of Māori in adult mental health in-patient services found that Māori had 4.0 times higher age-standardised population rates of seclusion events rates than non-Māori, non-Pacific, at 27.1 seclusion events per 10,000 resident population per year. Of concern is that the crude population rate for Māori of 258 seclusion events per 100,000 resident population/year is the highest population-based rate of seclusion events reported internationally (McLeod et. al., 2013). The findings of this study demonstrate that in terms of absolute numbers, young Māori males are the most likely group to be placed in seclusion and are an important group to target for seclusion reduction interventions. In addition, Māori females between the ages of 55–64 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).

It is important to remember that the McLeod (2013) study was exploratory in nature. It only included seclusion data from nine of all the District Health Boards (DHBs) for the 1 July 2008 to 30 June 2010 period and drew solely on routinely collected data. The report identified several potential reasons why Māori have a higher risk of experiencing seclusion than non-Māori. A key reason identified was the result of the differential distribution of age and legal status on admission. However other factors such as differences in severity of illness, staff and organisational factors as well as ward environment were unable to be included in the analysis. Restraint data was not available and therefore not included in the analysis.

Strategies to reduce Māori rates of seclusion

Researchers have identified best practice in reducing seclusion. Evidence shows that when a comprehensive seclusion reduction strategy comprising multiple components is employed, services can successfully reduce, if not eliminate, seclusion use (NASMHPD, 2006). These components comprise the following:
- A national direction that supports seclusion and restraint reduction and elimination efforts.
- Active, committed and high profile organisation leadership and oversight.
- Organisational culture that embodies recovery oriented approaches.
- Workforce development initiatives including those which address recruitment, orientation, education, supervision and staff involvement.
- Service user development and participation (for example through provision of feedback, employment of advisors, educators, peer support and advocate roles).
- Milieu management and use of practical tools, including the provision of meaningful activities, an atmosphere of listening and respect, crisis prevention planning, violence and trauma assessments, behavioural coaching, de-escalation and sensory modulation.

---

[2] One of very few Australian studies found that Indigenous people of Australia between the ages of 25-34 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.

- Effective debriefing procedures and collection and use of information to learn from seclusion and restraint events and to inform on-going service improvement.

The constitutive elements described above have been synthesised and referred to in the literature as the Six Core Strategies for reducing seclusion (NASMHPD, 2006). These six strategies include:

- leadership towards organisational change
- use of data to inform practice
- workforce development
- use of seclusion and restraint prevention tools
- consumer roles in in-patient settings
- de-briefing techniques.

The ability of services to determine appropriate services and workforce development will be supported if services understand what 'excellent' practice looks like and that they can easily assess their performance in relation to this. Te Pou draws on the NAMSHPD Six Core Strategies to assist services do this.[3] Hence, the recommendations in this report are framed in terms of the Six Core Strategies with a specific focus on strategies to support reduced rates of seclusion for Māori.

As highlighted in the review of the national literature and hui reported on by Wharewera-Mika, et. al. (2013), within the New Zealand context there is an evolving articulation of culturally specific interventions that may be helpful in preventing of 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 which is culturally meaningful, empowering and therapeutic.

Examples drawn together by Wharewera-Mika et. al. (2013) from the New Zealand literature includes the following:

- The importance of understanding a Māori framework of mental health; Māori healing; and cultural aspects within general mental health services (such as karakia and waiata) (Ihimaera, 2004) (Lapsley, et. al., 2002).
- 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 found significant in relation to both illness and recovery (Ihimaera, 2004) along with strengthening Māori identity (Durie, 1998b).
- 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), to provide alternative distress tolerance strategies. In addition, given the calming nature of the marae space, it is envisioned that this area could also be utilised in such a way (Durie, 1998a; Lapsley, Nikora & Black, 2002; Taitimu, 2008; Wharewera-Mika, 2012).

---

[3] Te Pou has developed a checklist to assist services to assess what they could do to embed a comprehensive strategy for reducing the use of seclusion. The checklist includes a specific focus on strategies to reduce Māori rates of seclusion.

- A specific cultural intervention premised in a study by McClintock, Moeke-Maxwell & Mellsop (2012) was based upon processes and principles associated with a pōwhiri. This model aligns with the traditional processes of engagement and participation, particularly the components of karanga, mihimihi, whaikōrero and koha (McClintock et. al., 2012a). These types of developments may also be considered useful for Māori adult mental health services.

- Dyall and colleagues (1999), in their study of Māori expectations of mental health services, identified a common expectation across tāngata whai i te ora to receive 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 in-patient settings; and the need for "Māori faces for Māori cases at Māori places" (Dyall et. al., 1999; p. 17). With this development it was seen 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 to Māori as a Te Tiriti o Waitangi (Treaty of Waitangi) partner.

- 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).

- One emphasis for improving the service delivery for tāngata whai i te ora included improving the cultural competency of the mental health workforce (Ministry of Health, 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).

The above outline of potential strategies to reduce Māori seclusion rates highlights the need for a comprehensive, multi-faceted approach to reducing seclusion. It also reflects that mental health and addiction in-patient units can be intense, complex and challenging settings. Addressing the use of seclusion in this context requires multiple points of intervention, each supportive of the other and collectively providing a mutually reinforcing system response. However, responsiveness and adaptability are also required; the skills and experience to make practice decisions judged appropriate within context is critical. For example, there are many situations where existing rules are best fitted to adapt to the needs of individual experiencing extreme distress in order to reduce confrontation and likelihood of a more restrictive event. These take skill and experience to determine. Yet this is what can contribute to delivering client-centred, values-based care.

Reflecting the need for a comprehensive approach in the context of complexity, implementing actions to reduce seclusion involves an ongoing process of change. Each service will bring a unique set of enablers and barriers to the process and different stages of readiness, capacity and capability to change. Appropriate ways of working within this context are required. When barriers or resistance to change outweigh drivers, time and energy may first be required to address this imbalance, prior to more visible or tangible progress. Many of New Zealand's mental health in-patient services are already engaged in the processes of change towards reducing seclusion; some services are more advanced than others.

Recommendations

The following recommendations are drawn from a range of sources, in particular the work of Wharewera-Mika et. al. (2013). The Wharewera-Mika report provides a comprehensive outline of potential strategies that services, both mainstream and kaupapa Māori, could implement to reduce seclusion and restraint use.

Strategy one: leadership rangatiratanga

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 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.

Key recommendations to enhance Māori leadership include:
- a need for Māori participation in leadership in all areas of service delivery
- a need for recognition by existing leadership that the use of restrictive care practices such as seclusion and restraint is unacceptable, and is considered as a very last resort
- a need for recognition of the explicit connection between leadership direction and practice on the ground. When service leadership commits to a model of care that is firmly underpinned by Māori philosophies and principles, changes will be well supported to take place at the 'coal face'.

Strategy two: 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). The use of data to inform practice is an important tool to assist with reducing incidents of seclusion and restraint (Huckshorn, 2006; National Association of State Mental Health Program Directors, 2006; O'Hagan et. al., 2008)

Key recommendations to support better data use to inform Māori seclusion and restraint reduction initiatives include:
- audit to ensure ethnicity is recorded accurately by administrators and clinicians
- assist individual units to drill down into their seclusion data, and examine this in relation to Māori /non-Māori seclusion events, and in relation to time of event, shift, proximity to admission time, length of time and medications used
- in addition, Whare-Mika et. al. (2013) recommended consistent documentation and review of effectiveness of interventions for tāngata whai i te ora through existing data collection to enhance opportunities for critical reflection on care practices by staff.

Strategy three: workforce development

The Wharewera-Mika et. al. (2013) report indicated the need for staff to be culturally competent. A strong, robust Māori workforce at the forefront of service delivery was also seen as crucial. Workforce development focuses on recruitment, retention, orientation, education and staff involvement in seclusion reduction initiatives.

Key recommendations to upskill the workforce to reduce the use of Māori seclusion include the following:

- Training and assessment to have skilled staff capable of working effectively with Māori in the delivery of mental health care. This highlights the need for staff development of both cultural and clinical capabilities (dual competency).This is particularly relevant in light of the fact that most tāngata whai i te ora receive their care from mainstream (as opposed to stand alone kaupapa Māori) services.
- A positive recruitment policy to increase Māori staff in in-patient services at all levels of intervention, from prior to admission until discharge, including access to Māori staff with specialist skills in both cultural and clinical aspects to in-patient care, and kaumātua working with the crisis team.
- Development of a workforce that can foster trauma informed care to ensure that interventions in in-patient 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.
- Improved supervision and support for Māori clinicians when dealing with tensions related to balancing the cultural and biomedical models within secondary mental health care, and the potential difficulties they may be having with this in relation to their own practice and meeting the needs of tāngata whai i te ora.
- Improved supervision and support for non-Māori clinicians when working with tāngata whai i te ora to support effective engagement with Māori clients.
- A consideration of how rules, regulations and ward environments impact on how tangata whaiora respond, in particular due to cultural differences, e.g. inclusion of whānau wherever possible.
- The ability to 'bend' rules to reduce the need for direct confrontation with people who may be struggling with significant mental health issues has shown to be influential in reducing the need for restraint and seclusion.

Strategy four: use of seclusion and restraint prevention tools

Effective seclusion and restraint prevention incorporates the development of processes and practices that give staff alternatives and earlier interventions. The following processes, tools and tikanga Māori have been identified as strategies that would support reduced rates of Māori seclusion.

- Admission processes for Māori that include access to the marae and whare hui wherever possible.
- Inclusion of cultural practices in the design, implementation and management of care for tāngata whai i te ora by all personnel and management staff involved in in-patient services will enhance seclusion reduction initiatives. Increased use and availability of tikanga Māori approaches to working with tangata whaiora, where Māori lore is operationalised, for example:
    - introductions to the ward that include (whaka)whanaungatanga
    - manaakitanga which is about care and support
    - a preference for engagement that includes kanohi ki te kanohi (face to face) interactions

- increased access to cultural healing practices and activities such as karakia, mirimiri and kapa haka
- increased inclusion of and access to Māori conflict resolution processes which may specifically support the de-escalation of potential risk situations, such as hohourongo (rules of engagement)
- an understanding of the importance of wairuatanga to many Māori and a need for service providers to commit to meeting responsibilities towards supporting holistic wellbeing among tāngata whai i te ora.
- The provision of whānau-centred care to tāngata whai i te ora, where the inclusive involvement of whānau at all points of care is enabled and facilitated by the service.
- Environments that take into account factors such as light, access to outdoors and appropriate décor are integral to tāngata whai i te ora recovery, as this reduces distress.
- Māori cultural identity is essential to recovery for tāngata whai i te ora, therefore emphasis needs to be placed on the restoration of mana or mana-enhancing practices.

Strategy five: tāngata whai i te ora service user roles in in-patient services

Service user roles and participation within all levels of service delivery can impact positively on seclusion and restraint reduction. Key recommendations to increase tāngata whai i te ora participation include:
- increasing the role of tāngata whai i te ora and whānau in relation to consumer advisory and advocate roles in in-patient setting.
- increasing the support available to tāngata whai i te ora through the provision of Māori peer support staff within in-patient services.

These recommendations link with a positive recruitment workforce development strategy for Māori.

Strategy six: debriefing techniques

Effective debriefing procedures and the collection and use of that information are strongly influential in reducing seclusion. Wharewera-Mika et. al. (2013) study reported that hohourongo was 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.

The opportunity to debrief, where in-depth analysis and critical reflection can take place, following any event of seclusion or restraint is essential to future reduction of the use of seclusion and restraint with tāngata whai i te ora. Particular recommendations included:
- the process of critical reflection which enables staff to develop their professional (clinical and cultural) competency in working with tāngata whai i te ora is essential
- debriefing which enables staff to evaluate their personal responses to challenging situations with Māori, and to undertake to critical reflection with regard to this
- rigorous debriefing which prequel events from a system perspective will provide the opportunity for planning changes in an acute in-patient setting (careful review of prequel events can shine light on what systems and practice changes can reduce the likelihood for the future)

- debriefing needs to guide and improve service delivery - not to find blame
- debriefing should include discussing with whānau/family their perceptions of the event and their thoughts about how this may be averted in future episodes of care should this occur.

Appendix one: 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
Hui	Meeting, gathering
Hohourongo	Rules of engagement between people
Kapa haka	Traditional cultural dance
Kai	Food
Kanohi kitea	The seen face
Kanohi ki te kanohi	Face to face
Kapa haka	Traditional cultural dance
Karakia	Spiritual stimulation, prayer
Kaumātua	Elder (male or female)
Kaupapa Māori	Māori principle, philosophy
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
Mirimiri	Massage
Mihimihi	Greet, pay tribute, introductory speeches which take place at the beginning of a gathering
Pākehā	Non- Māori New Zealander descended from settlers
Pōwhiri	rituals of encounter, welcome ceremony on a marae
Rangatiratanga	Self-determination; authority
Tāngata whai i te ora	Person seeking wellness; services users of Māori descent
Te Tiriti o Waitangi	The Treaty of Waitangi
Tikanga	Māori practices
Tino rangatiratanga	Self-determination
Waiata	Song
Wairuatanga	Soul; spirit
Whaikōrero	Make a speech, oration
Whānau	Genealogy; descent
Whānaungatanga	Relationships; social cohesion
Whare hui	Tribal meeting house

References

Drury, N., & Munro, T. A. (2008). Crisis engagement in mental health: a New Zealand Māori contribution. *International Journal of Mental Health Nursing 17*, 317-325.

Durie, M. (1998a). *Whaiora: Māori Health Development.* Melbourne: Oxford University Press.

Durie, M. (1998b). *Te Mana Te Kawantanga: the politics of Māori self-determination.* Auckland: Oxford University Press.

Dyall, L., Bridgman, W., Bidois, A., Gurney, H., Hawira, J., Tangitu, P., & Huata, W. (1999). Māori outcomes: Expectations of mental health services. *Social Policy Journal of New Zealand 12,* 71-90.

El Badri, A., & Mellsop, G. (2002). A study of the use of seclusion in an acute psychiatric service. *Australian and New Zealand Journal of Psychiatry 36*, 399-403.

Happell, B. & Koehn, S. (2010). From numbers to understanding: the impact of demographic factors on seclusion rates. *International Journal of Mental Health Nursing, 19*, 169–176.

Hurkshorn, K. A. (2006). Creating violence free and coercion free mental health treatment environments for the reduction of seclusion and retraint: Six core strategies to reduce the use of seclusion and restraint. National Executive Training Institute, Training Curriculum for the reduction of seclusion and restraint. Alexandria, VA: National Technical Assistance Centre, National Association of State Mental Health Program Directors (NASMHPD).

Ihimaera, L.V. (2004). *He Ara Ki te Ao Mārama: a pathway to understanding the facilitation of taha wairua in mental health services.* Unpublished Masters Thesis. Palmerston North: Massey University.

Lapsley, H., Nikora, L.W., & Black, R. (2002). *Kia Mauri Tau. Narratives of recovery from disabling mental health problems.* Wellington: Mental Health Commission.

McClintock, K., Mellsop, G., Moeke-Maxwell, T., & Merry, S. (2012a). Powhiri process in mental health research. *International Journal of Social Psychiatry, 58*(1), 96–97.

McLeod, M., King, P., Stanley, J., Lacey, C., Cunningham, R., and Simmonds, S. (2013). *The use of seclusion for Māori in adult in-patient mental health services in New Zealand.* Auckland. Te Pou.

Mental Health Commission. (2004a). *Delivery of Cultural Assessment for Māori.* Wellington: Mental Health Commission.

Mental Health Commission (2004b). *Seclusion in New Zealand Mental Health Services.* Wellington: Mental Health Commission.

Milne, M. (2005). *Māori Perspectives on Kaupapa Māori and Psychology: a discussion document. A report for the New Zealand Psychologists Board.* Te Tai Tokerau: Te Moemoea.

Ministry of Health. (2005). *Te Tahuhu: Improving mental health 2005-2015: The second New Zealand mental health and addiction plan.* Wellington: Ministry of Health.

Ministry of Health. (2010a). *Mental health service use in New Zealand 2007/08.* Wellington: Ministry of Health.

Ministry of Health (2010b). *Office of the Director of Mental Health: Annual Report 2010.* Wellington: Ministry of Health.

Ministry of Health (2010c) *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992.* Wellington: Ministry of Health.

Ministry of Health (2012). *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017.* Wellington: Ministry of Health.

National Association of State Mental Health Program Directors (NASMHPD). (2006). *Training curriculum for the reduction of seclusion and restraint.* Alexandria: NASMHPD.

O'Hagan, M., Divis, M., & Long, J. (2008). *Best Practice in the Reduction and Elimination of Seclusion and Restraint. Seclusion: time for change.* Auckland: Te Pou Te Whakaaro Nui.

Papps, E., & Ransden, I. (1996). Cultural Safety in Nursing: The New Zealand experience. *International Journal for Quality in Health Care 8*(5), 491-497.

Standards New Zealand (2008a). *Health and Disability Services (General) Standard NZS 8134.0.2008.* Wellington: Ministry of Health.

Standards New Zealand (2008b). *Health and Disability* Services (Restraint Minimisation and Safe Practices) *Standard NZS 8134.0.2008.* Wellington: Ministry of Health.

Taitimu, M. (2008). *Nga Whakawhitinga: Standing at the crossroads: Māori ways of understanding extra-ordinary experiences and schizophrenia.* Unpublished PhD Thesis. Auckland: University of Auckland.

Te Pou o te Whakaaro Nui. (2009a). *Sensory Modulation: One approach to reducing the use of seclusion and restraint at Northland DHB.* Retrieved from http://www.tepou.co.nz/knowledge-exchange/stories-of-change/view/listing/45/ (Accessed 14.06.2011).

Te Pou o te Whakaaro Nui. (2009b). *Te Whare Ahuru: Providing alternatives to seclusion and restraint* Retrieved from http://www.tepou.co.nz/knowledge-exchange/stories-of-change/view/listing/22/ (Accessed 14.06.2011)

Te Pou o te Whakaaro Nui. (2010). *Impact of Sensory Modulation in Mental Health Acute Wards on Reducing the Use of Seclusion.* Te Pou o te Whakaaro Nui, Auckland.

Te Pou o te Whakaaro Nui. (2011). *Stories of Change: Acute home based service.* Retrieved from http://www.tepou.co.nz/knowledge-exchange/stories-of-change/view/listing/21/(Accessed 14.06.2011).

Wharewera-Mika, J. M. (2012). *Ahakoa te momo mate, whakanuia tāngata. Mental heath in-patient services: Understanding the needs of Māori when extremely distressed.* Unpublished Doctoral Thesis. Auckand: University of Auckland.

Wharewera-Mika, J., Cooper, E., McKenna, B., Wiki, N., Field, T., Haitana, J., Toko, M., and Edwards, E. (2013). *Strategies to reduce the use of seclusion and restraint with tangata whaiora.* Auckland: Te Pou o Te Whakaaro Nui.

The NATIONAL CENTRE *of* MENTAL HEALTH RESEARCH, INFORMATION *and* WORKFORCE DEVELOPMENT

www.tepou.co.nz

Te Pou

o Te Whakaaro Nui