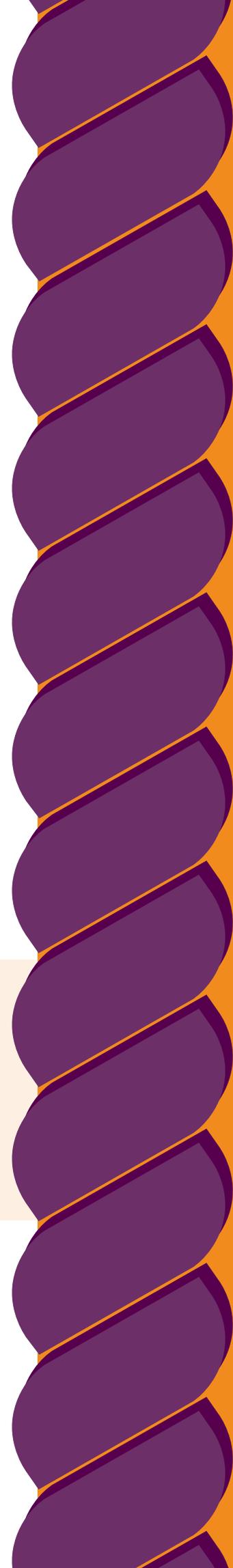


# Supporting seclusion reduction for Māori

“Taiheretia tātou  
kia puta te hua”

*Unite 'all' to achieve the result.*

*Come together as one and we  
can achieve anything.*



Recommended citation: Te Pou. (2014). Supporting seclusion reduction for Māori: “Taiheretia tātou kia puta te hua”. Auckland, New Zealand: Te Pou o te Whakaaro Nui.

Published in November 2014 by Te Pou o Te Whakaaro Nui  
PO Box 108-244, Symonds Street, Auckland, New Zealand.

ISBN 978-1-877537-14-1 (print)  
ISBN 978-1-877537-15-8 (online)

[www.tepou.co.nz](http://www.tepou.co.nz)  
[info@tepou.co.nz](mailto:info@tepou.co.nz)

## Contents

|  |    |
|--|----|
| <b>Executive summary</b> .....                                       | 4  |
| <b>Introduction</b> .....  | 4  |
| <b>Background: the study</b> .....                                   | 6  |
| <b>Method</b> .....  | 6  |
| Procedure.....   | 6  |
| Data collection .....  | 6  |
| Participants.....  | 7  |
| Data analysis.....   | 7  |
| <b>Findings</b> .....  | 8  |
| Contextual challenges of acute mental health units in Aotearoa ..... | 8  |
| Tāngata whai ora in acute mental health units.....                   | 9  |
| Use of medication.....   | 10 |
| The high use of seclusion on Māori .....                             | 10 |
| Impact of seclusion.....   | 11 |
| Drivers to reduce seclusion .....                                    | 11 |
| Whanaungatanga.....  | 12 |
| Kanohi kitea: a Māori visibility.....                                | 12 |
| Māori therapeutic relationship .....                                 | 13 |
| Focused engagement .....   | 14 |
| Relational-centred interventions.....                                | 15 |
| Acute mental health unit workforce development.....                  | 16 |
| <b>Discussion</b> .....  | 20 |
| Limitations .....  | 20 |
| <b>References</b> .....  | 21 |

## Executive summary

There is an unacceptable difference in the number of Māori who are treated with seclusion compared to non-Māori in acute mental health inpatient units in New Zealand (El-Badri & Mellso, 2002; Tapsell & Mellso, 2007). For Māori with mental health concerns, their quality of life and recovery can be shaped by their access to, and experiences with, health care services.

Emerging evidence about Māori access to and through acute mental health inpatient care is limited. The available information suggests attention to Māori cultural perspectives in mental health care can play an important role in providing holistic care and reduce the use of seclusion of Māori. This is in addition to Māori mental health professionals providing effective support to Māori and facilitating their access to health care which in turn enhances recovery and promotes whānau-centred care (Hutt Valley District Health Board, 2009; Tai Rawhiti District Health Board, 2013; Wharewera-Mika et al., 2013).

This report presents findings from a small study completed by Māori Caucus, Te Ao Māramatanga of Māori mental health nurses who have worked in acute mental health inpatient units in New Zealand, with a specific focus on reducing the use of seclusion on Māori. The study was premised on a belief that Māori mental health nurses provide a different model of practice to Māori than non-Māori mental health professionals. A purposive sampling approach was used to seek out Māori mental health nurses with acute mental health nursing experience.

The findings suggest there are factors which impact negatively on the interaction between Māori and acute mental health services such as the environmental context of the unit, the variable pathway of care in mental health services, and the use of medication and seclusion.

The major theme that emerged in this study highlighted 'whanaungatanga' as the Māori mental health nursing model of practice which includes intricate components of a method described as kanohi kitea; a Māori therapeutic relationship focused on engagement and relational-centred interventions. These findings are supported by stories and insights from Māori mental health nurses about their practices which provide deeper understanding about the way in which they work. The study concluded with observations and recommendations for the Māori and non-Māori mental health workforce.

## Introduction

The term tāngata whai ora that is used in this report refers to people who identify as Māori and are seeking wellness for a mental health concern.

Seclusion is widely used in acute mental health inpatient units in New Zealand, even though its efficacy has not been demonstrated. Numerous attempts have been made over the past decade to implement strategies to reduce the use of seclusion in a bid to find new ways to respond to challenging situations (Mental Health Commission, 2004; Barton, 2007). These strategies all require a multi-disciplinary and multi-level approach (NAMSHPD, 2006).

Of concern is the unacceptable difference in the episodes of seclusion of Māori while they are in acute mental health inpatient units in New Zealand. Evidence from a pilot study of nine district health boards estimated Māori were four times more likely to have been secluded than non-Māori, especially young Māori males (17-24 years) and older Māori females (55-64 years) (McLeod et al., 2013). In similar studies, the use of seclusion on Māori was double the rate of non-Māori (El-Badri & Mellso, 2002; Tyrer, Beckley, Goel, Dennis, & Martin 2012; Radio New Zealand, 2013).

In an aim to find ways to reduce the high rates of Māori seclusion, Wharewera-Mika et al. (2013) identified six best practice strategies which were formulated from hui with Māori mental health professionals. These strategies also drew upon New Zealand evidence to highlight the efficacy of Māori cultural interventions that could be helpful in preventing the seclusion of tāngata whai ora.

The following table summarises the six strategies.

|  |  |
|--|--|
| <p><b>Strategy 1:<br/>Leadership and rangatiratanga</b></p>  | <p><b>Strategy 2:<br/>Better use of data to inform best practice</b></p>   |
| <ul style="list-style-type: none"> <li>• Oversight exists over seclusion and restraint practices.</li> <li>• Māori leadership and participation exists across all service levels.</li> <li>• A commitment to Te Tiriti o Waitangi is evident.</li> <li>• Organisational culture focuses on recovery, tāngata whai ora and whānau-centred, holistic and trauma informed care.</li> <li>• A commitment to the Māori model of care and principles.</li> </ul> | <ul style="list-style-type: none"> <li>• Improved collection and use of relevant information.</li> <li>• Accurate recording of ethnicity.</li> <li>• In-depth analyses and examination of seclusion data (in relation to Māori).</li> <li>• Regular review and audit to encourage critical reflection on practice.</li> </ul>  |
| <p><b>Strategy 3:<br/>Workforce development</b></p>  | <p><b>Strategy 4:<br/>Seclusion and restraint prevention tools</b></p>   |
| <ul style="list-style-type: none"> <li>• A culturally competent workforce.</li> <li>• Increase Māori staff at all levels of intervention.</li> <li>• Trauma informed interventions, care and practitioners.</li> <li>• Improved supervision and support for Māori and non Māori.</li> <li>• Awareness of the impact of organisational regulations upon cultural differences.</li> </ul>  | <ul style="list-style-type: none"> <li>• Culturally informed processes for Māori across the care continuum.</li> <li>• Inclusion of cultural practices in care, including healing.</li> <li>• Increased use of te reo me ona tikanga.</li> <li>• Increased awareness about and promotion of wairuatanga.</li> <li>• Whānau-centred care.</li> <li>• Emphasis on Māori cultural identity for recovery.</li> <li>• Environments conducive to Māori.</li> </ul> |
| <p><b>Strategy 5:<br/>Tāngata whai ora roles</b></p>   | <p><b>Strategy 6:<br/>Debriefing techniques</b></p>  |
| <ul style="list-style-type: none"> <li>• Increased tāngata whai ora presence and advocacy roles in units.</li> <li>• Increased Māori peer support resource.</li> </ul>   | <ul style="list-style-type: none"> <li>• Debriefing techniques and opportunities in both Māori and mainstream.</li> <li>• Encouragement for critical reflection on practice and ongoing development.</li> <li>• Purposeful evaluation of practice in response to working with Māori.</li> <li>• Debriefing opportunities for tāngata whai ora and whānau.</li> </ul>   |

**Figure 1:** Six best practice strategies to reduce the use of seclusion of Māori. Adapted from Wharewera-Mika et al., (2013).

## Background: the study

The high use of seclusion on Māori is a concern for Māori mental health nurses who consciously focus on not using or promoting the use of seclusion as best they can.

*I don't want him locked up in there... because I know [what] they're gonna, you know [look] like the next time I [see them]... start dribbling.. they... mimi [wet] themselves... and all that. Especially, if they're um young men, and like between 16-20 [years of age]... just seeing that, it's like someone grabbing their wairua and pull[ing] it right out of them... and that's devastating... it's like being at their tangi"*

*(Māori mental health professional cited in Pere, 2006 p. 179).*

Māori mental health nurses have solutions for reducing the use of seclusion and restraint of tāngata whai ora. They use traditional approaches such as whanaungatanga to foster therapeutic relationships that negate the need for seclusion. This was revealed in a small study of the experiences and expertise of eight Māori mental health nurses who recently worked in acute mental health units.

The objectives of the study were to:

- build on the available literature by using practical clinical examples
- facilitate opportunities for experienced Māori mental health nurses to offer practical and cultural advice for mainstream staff
- provide a document that could be used by a range of clinical staff in acute inpatient units in New Zealand.

A member of Te Ao Māramatanga Māori Caucus named the study “Taiheretia tatou kia puta te hua” which impresses that if we all do not come together and strive to eliminate seclusion and restraint we cannot achieve the desired outcomes for tāngata whai ora.

## Method

The most conducive method for this study was to conduct it with a Kaupapa Māori approach in order to align with Māori culture and a way of knowing and being (Elliott-Hohepa, 2007). This also enabled an analytical approach for structuring how Māori mental health nurses thought about ideas and practice. By using this methodology, it was important to ensure the findings would in time help to benefit and address the important needs of Māori (Smith, 1999), thus guiding a more positive transformation in experiences of Māori using mental health services in New Zealand.

### Procedure

Access to study participants was facilitated by the Māori Caucus of Te Ao Māramatanga (College of Mental Health Nurses) who sought interest from Māori mental health nurses to participate. This involved email, phone and hui presentations.

A project leader within the Māori Caucus worked with a small steering group of Caucus members and provided the primary point of contact for all study participants. The project leader also gathered the research data and provided regular reports to the funder and Caucus to maintain consistency in the overall study.

### Data collection

Data collection consisted of eight in-depth interviews which were conducted by phone and face-to-face. Each interview was recorded and lasted between 40 to 100 minutes.

The semi-structured questionnaire was designed to elicit features about tāngata whai ora in acute mental health units, including the anticipation for and use of seclusion of Māori. Also included were prompts about what motivated Māori mental health nurses to reduce the use of seclusion, and what their successes and challenges were in doing so. We also asked the nurses for strategies to reduce the use of seclusion of tāngata whai ora and to make suggestions for how other mental health professionals in acute mental health units could also reduce the use of restraint and seclusion.

## Participants

Eight Māori mental health nurses participated in this study; all were female and ranged in nursing experience from two to 23 years. All nurses had experience in acute mental health care, and most continued to work in adult acute mental health settings; two had recently changed roles and moved into community mental health nursing within the previous year. Most participants held postgraduate diploma or certificate qualifications. Two held Master's nursing degrees with second class honours.

Native Māori plant names are used as pseudonyms for the Māori mental health nurses, and the tāngata whai ora they reflected on during this study to maintain confidentiality.

## Data analysis

Data analysis was completed concurrently with data collection. Interview transcripts and field notes were analysed for key words and ideas relating to the study objectives. Following this a Kaupapa Māori perspective was provided for the overall data analyses.

| Interview Number | Gender | Iwi  | Years of nursing practice | Highest Qualification | Current place of work    |
|------------------|--------|--|---------------------------|-----------------------|--------------------------|
| 1                | F      | Te Aupouri, Te Rarawa                              | 17.5                      | PGDipHealthSci        | Acute mental health unit |
| 2                | F      | Te Aitanga-a-Hauiti, Ngāti Porou                   | 2                         | Masters Nursing       | Community mental health  |
| 3                | F      | Ngāti Kaurukikawhio                                | 23                        | Masters Nursing       | Acute mental health unit |
| 4                | F      | Ngāpuhi  | 7                         | PGDipMHNursing        | Community mental health  |
| 5                | F      | Ngāti Hine   | 2                         | PGCertMHNursing       | Acute mental health unit |
| 6                | F      | Ngāpuhi, Ngāti Kahu                                | 11                        | PGDipMHNursing        | Acute mental health unit |
| 7                | F      | Te Aitanga-a-Māhaki, Ngāti Porou                   | 16                        | PGDipMHNursing        | Acute mental health unit |
| 8                | F      | Ngā Tai Manuhiri, Ngāti Mahunga, Ngāpuhi, Te Arawa | 18                        | PGCertMHNursing       | Acute mental health unit |

**Table 1:** Overview of Māori mental health nurse study participants.

## Findings

### Contextual challenges of acute mental health units in Aotearoa

The environment that is constructed and provided for adult acute mental health units in Aotearoa, New Zealand has an influence on the capability of staff to create and negotiate acute mental health care options for tāngata whai ora. Māori mental health nurses viewed acute mental health units as not being conducive to healing; they were clinically cold and poorly designed with cell like facilities with little space.

*The mental health unit is not an environment conducive to healing, it's not an environment I like to see whānau go into, and it's awful! In the wards I worked, we were always busy, full and it was really poorly laid out, really bad organisation in terms of room structure. Over the years, the bed numbers were reduced and it's become really chaotic. You would have unwell little grannies with agitated depression mixed in with highly agitated manic or psychotic tāngata whai ora. So you were often needed to utilise all your skills to deescalate or minimise potential incidents.*

(Kowhai)

*If we had an environment that was more conducive to Māori, like having a marae. When I was working in X, you noticed the difference, and change in the person when they stepped in to the marae at the acute mental health unit. The wharenui with its carvings and tukutuku was calming, so Māori did not feel threatened even if they were being admitted to or treated in the unit.*

(Miro)

The culture of the acute mental health unit was an area that Māori mental health nurses were concerned about. They described environments influenced by negative staff prejudices and bias guided by individualistic values, beliefs and practices.

*I think there has always been a culture of locking someone up and I know that they're working hard to try and change that culture which had been perpetuated by people who have been employed in the mental health unit way too long. You know that sort of attitude that if tāngata whai ora don't do as they're told, then they are locked up. It's definitely a challenge to change this type of culture, but I know there's been some progress and work around this culture.*

(Rimu)

*It's important to be working in an environment where the general thinking amongst staff is 'let's use other stuff' before we think of any form of restraint or seclusion of tāngata whai ora. For me, when there are tāngata whai ora in the unit I try my best to get them on my case load for the shift, so that I can offer them awhi in the way Māori do things.*

(Kauri)

Equally, Māori mental health nurses were extremely concerned about the level of assaults on staff in the units and the serious impact of conditions that tāngata whai ora were bringing into the units, such as coming off drugs (especially methamphetamine), including the impact on staff trying to care for and support them in confined spaces.

*Safety in the acute mental health unit environment can be the thing that makes a difference between secluding people and not secluding people. If there is no space set aside for healing, or for time out for tāngata whai ora to be by themselves or to be with their minister or whānau, even a space for peace and quiet, then the physical environment can impede a person's recovery.*

(Totara)

*Seclusion is not ideal, but sometimes we have to use it to bring someone who's especially on P or weaning off to a place so they can come down, it's then that seclusion is a place to try, with two hourly reviews, and ten minute checks, so the person can sleep. If they are up, we will go in, see if they're ok and really try our best to get them right.*

*(Puriri)*

Concerns about staff safety were heightened during periods of high acuity in acute mental health units when there were additional demands and stress on staff, pressure on the availability of beds and the need for maintaining budgets. The availability of staff and the ability to negotiate staffing arrangements for care was crucial in most cases where alternative support to prevent tāngata whai ora from being secluded was also needed.

*When we know we're going to get this person we know who has had a history of assault or a history of being disorganised, if we have access to extra staff it makes for a safer environment, and if we are able we'll care for the person three to one down the back instead of using seclusion. But of course we can't pluck staff off trees and it doesn't happen straight away so that's when seclusion occurs.*

*(Puriri)*

With the high number of tāngata whai ora using mental health services (McLeod et al, 2013), acute mental health units need to be more welcoming and conducive to Māori and their whānau. The nurses felt the units needed to commit to a more holistic approach to health and wellbeing that is inclusive of Māori spirituality and cultural intervention.

*One of the major things that need to happen is the environment needs to look better and feel comfortable spiritually as well as physically for Māori. There needs to be more emphasis on whānau, particularly during the admission phase of the process.*

*(Kowhai)*

The acceptability of acute mental health services to Māori is critical in determining whether or not Māori are responsive to mental health services. The design of acute mental health care environments needs aesthetic enhancement to reduce stress and anxiety, improve Māori satisfaction, and promote healing and Māori health.

## **Tāngata whai ora in acute mental health units**

The pre-entry and admission process into the acute mental health unit is one of the most influential in terms of what tāngata whai ora may experience thereafter while they are in acute care. In regard to Māori, the use of force by police prior to admission seemed common, thus influencing the way tāngata whai ora were viewed by acute mental health unit staff.

*A patient will come through the roller door into the building, it's a really awful process and they'll just sit there and wait for the psychiatrist. If they're highly agitated they'll get locked up, especially if they're under the Act.*

*(Kowhai)*

*The majority of Māori will come through the door with police and handcuffed. If you look at our situation, non-Māori colleagues will go out on crisis, as soon as they hear its Māori, that's it, the police go out and they're brought into the unit angry, irritable and fighting.*

*(Miro)*

Māori mental health nurses often identified there was a loss of freedom and power felt by Māori when they were admitted into the acute mental health unit and, for most, this was emphasised by the enforced psychiatric treatment recommended to them by the acute mental health unit.

*People are being taken away from their homes and placed in an unfamiliar environment and forced to take medications that they might not want to take so they have no sense of power over themselves*

*(Puriri)*

*I get disheartened. You see our people put into seclusion, and they have lost their power. So I am continually saying to tāngata whai ora and to colleagues this is what is needed to give them their power back. A lot of tāngata whai ora are angry for being secluded, and I say to them use that anger differently so we can ensure you stay out of there.*

*(Miro)*

Furthermore, Māori seemed unaware of their rights as clients of the service upon admission, and in most cases were too unwell to appreciate fully what their rights might be. At times staff would take personal items and possessions away from tāngata whai ora which had personal and cultural significance such as taonga. This would heighten the sense of loss for the tāngata whai ora.

*I think that can be demeaning especially to Māori and their mana, as they don't have any choice whatsoever.*

*(Totara)*

## Use of medication

The way medication is used in acute mental health care was raised by most Māori mental health nurses as needing a focused approach that assertively addressed the presenting issues of tāngata whai ora in a way that was beneficial to them and their needs.

They considered that medication was beneficial for most when it was therapeutically used to immediately help tāngata whai ora to sleep, rest and rid alarming symptoms, especially due to psychotic episodes in the early period of admission. With such an approach it was considered that the use of seclusion of tāngata whai ora was likely to be used less.

However, because of the delay between the person's initial episode until when they were finally seen by mental health services, many tāngata whai ora would be seriously unwell by the time they were admitted to the acute mental health unit.

Concerns were raised by nurses when further delays occurred in accessing therapeutic care for Māori because of consequences of Mental Health Act processes and the varying treatment preferences of psychiatrists and treating mental health teams. In these situations, some Māori mental health nurses expressed frustrations in constantly battling over the needs of Māori with medical staff who often needed more education and coaching in how best to respond to Māori.

*Doctors nowadays don't treat in a way that our people need when they are the most unwell. They need to sleep, and to rest mentally and physically. It's not until tāngata whai ora act out; decisions are made for certain approaches.*

*(Rata)*

*There needs to be an acute recipe for some tāngata whai ora, to provide them with a quick response to the issues they bring with them, to help them to rest, to let their mind rest and not to draw out their time in the unit.*

*(Totara)*

## The high use of seclusion on Māori

There is concern among Māori mental health nurses about the high number of tāngata whai ora in secure, intensive care and acute mental health units, and their subsequent exposure to the use of restraint and seclusion by staff.

Various rationale suggested by their colleagues for the use of seclusion in the acute mental health units were: for a form of 'time out'; to reduce 'stimulation' within the unit's environment; and as a measure to maintain the safety of the tāngata whai ora or staff especially when tāngata whai ora were seriously unwell, aggressive or perceived to be a potential threat to others.

It is how the potential threat of harm to others was determined by mental health staff that concerned Māori mental health nurses most. In particular Māori men, and the assumptions made by staff that most Māori men entering acute mental health care would require seclusion.

*Often particularly young Māori men, there is an assumption that they're going to end up in seclusion, I feel like that some of my colleagues are quick to make that conclusion before they've actually assessed the situation.*

*(Kowhai)*

*I've seen it before, I think that they're scared of our people, especially our Māori boys; they might start playing up.*

*(Mamaku)*

In some cases seclusion would be used in a punitive way, as a form of punishment which seemed similar to sending a child to their bedroom for unacceptable behaviour. In other cases it was based on what the nurse's believed was a moral judgment made by a staff member about the behaviour of the tāngata whai ora being unacceptable even when they were seriously unwell.

*It's about encouraging the staff to understand that just because they're Māori, doesn't mean that they automatically need to go into seclusion for any petty reason, there are other ways of dealing with our people.*

(Rata)

### Impact of seclusion

The impact of seclusion on tāngata whai ora is traumatising. It has the potential to trigger issues from old traumas, resurfacing feelings and thoughts from past abuse which may not have been resolved. For some tāngata whai ora, the depth of trauma was felt spiritually, at a personal wairua level that needed cultural redress.

*There's a sort of trauma when tāngata whai ora are being secluded, it brings up memories and triggers things in the past for tāngata whai ora*

(Puriri)

*Many tāngata whai ora talk about their experiences of seclusion, they talk about the wairua side of things and how spiritually it has impacted on them and caused them to be traumatised, not just from the physical restraint of being locked in a room but it's the impact on their wairua that is never considered. Some of them talk about hallucinations they'd never experienced before the seclusion. Some of them refer to the seclusion as a traumatic experience and for those tāngata whai ora with histories of trauma it just adds to their issues.*

(Kowhai)

### Drivers to reduce seclusion

Māori mental health nurses do not want to see people locked up. The high proportion of tāngata whai ora that are secluded is prime motivation for Māori mental health nurses to try and reduce the use of seclusion.

#### Example of Māori mental health nursing practice

I'd been off shift and returned to find "Nikau" had been secluded for long periods of time on the unit. He didn't have a history of assaulting staff but staff had reacted to his verbal threats toward them. I was motivated for things to change for Nikau, so I said to my colleagues, "this guy is manageable, we don't need to lock him up, he's all talk and its illness driven. Sure he's saying I'm gonna beat you up, but he has never done it before in his whole history, he is high as a kite, and remember the last time he was here on the unit he was low, he wouldn't hurt anyone!"

I believe as a Māori mental health nurse working in acute mental health care you have to trust your professional and personal instinct, this guy could've been managed elsewhere, and his history both written in the notes and shared by his whānau did not in any way support the reason for his seclusion.

I realise that it can be a hard skill to learn, especially if you're a staff member with a history of abuse or you are someone who cannot tolerate swearing and being yelled out. Unfortunately this is a part of psychiatry when people are unwell they will say things that they wouldn't have otherwise! I'm not saying all tāngata whai ora swear and yell abuse, but this was no reason for seclusion. So at the risk meeting it was asked, does Nikau need to be secluded? I said, "no, no way! We can bring in extra staff if we need, but seclusion is not needed". Upon reflection, this highlighted some of the hidden challenges on the unit which may contribute to the decision to seclude tāngata whai ora such as mental health staff stress and burn out, the acuity on the unit and at times pressure on beds. But these are no real reasons to seclude anyone!

## Whanaungatanga

Whanaungatanga was commonly described by Māori mental health nurses as the method to their practice and how they worked with tāngata whai ora and their whānau in acute mental health units.

Rather than minimise the breadth and depth of whanaungatanga from a Māori perspective, in this small study whanaungatanga was identified as a customary Māori practice which Māori mental health nurses applied to enable and strengthen relationships and ties with tāngata whai ora and their whānau.

Māori mental health nurses had adapted the use of whanaungatanga when working with tāngata whai ora with whom they did not necessarily have direct whakapapa connections. This involved establishing a shared purpose of recognition, a Māori therapeutic relationship, focused engagement and relational-centred interventions. This approach influenced the care of tāngata whai ora, particularly in reducing the use of seclusion.

The following discussion presents the practice of whanaungatanga from a contemporary Māori mental health nursing perspective providing examples of its dynamics, relevance and influence on the use of seclusion as well as snapshots of Māori mental health nursing practice.

### Kanohi kitea: a Māori visibility

Kanohi kitea means to be 'seen'. Visibility is considered an important practice in Māori society. According to Mead (2003) visibility within iwi determined Māori acceptability as 'ahi kā' or of the local people of an area, often representative of the people at home keeping the home fires burning (Mead, 2003). It is this presentation, by Māori showing their face to another Māori face, which recognises the deep association among Māori and the automatic response that occurs between Māori.

*It's the kanohi ki te kanohi, showing Māori there is another Māori face, tends to calm and settle them automatically.*

*(Miro)*

*When Māori see another brown face in the unit it makes a huge difference, and helps to establish rapport and connections.*

*(Kowhai)*

*Most of the time they will see these Māori faces, "Oh how's it bro? Oh you still here? No matter how paranoid, delusional, māuiui they might be, they will always remember seeing your face, and that you are there to help them. I'll always remember that if you treat someone really well from the start, it doesn't matter how unwell they are, they always remember you.*

*(Puriri)*

### Example of Māori mental health nursing practice

I was a junior staff nurse and I was asked to go down to seclusion by a senior staff nurse who said that five police were coming in, and security were also going to be present for a man being admitted with a history of bipolar disorder. Matai hadn't been in the ward for years, and I immediately thought something was unusual with this and some stressor must've upset him. I was walking down to the seclusion area, and the back door was open, the police came in holding him, he had handcuffs on, he was swearing and struggling, then I saw who he was, and he identified me. He called my name, and I greeted him in te reo, "Kia ora e hoa, what's happening?" He then responded in te reo, explaining that a lot had been occurring in his life.

I then asked the police to remove the handcuffs, as I knew him well from our haukāinga. I then invited Matai to sit down with me to have a kōrero. My colleagues seemed stunned with the response, but the psychiatrist was great, he affirmed the immediate response my approach had with Matai, and he suggested I take the lead in the admission process.

When I reflect back, what I was most concerned about was here was a Māori entering the service; I needed to show my face. Upon doing so, I discovered he was my whanaunga (relative), we had a whakapapa connection and we knew each other. So it was important to honour these connections, so by doing whakawhanaungatanga, these connections were recognised and embraced. The impact of this approach did calm the situation, where the police and security were not required; the psychiatrist was duly able to conduct his assessment with Matai without any issues.

## Māori therapeutic relationship

There is a premise that similarities in cultural heritage, history and a spiritual association do exist between Māori. These connections are translated into the therapeutic relationship by Māori mental health staff working closely with tāngata whai ora and whānau. The impact of this therapeutic connection between Māori is critical in reducing the use of restraint and seclusion of Māori in acute mental health units.

*I see a big difference when Māori staff are available. A tāngata whai ora came into admissions, he was agro as and agitated. He was brought in by two non-Māori male staff members. We were waiting for his arrival and the staff were all ready to seclude him. When he arrived I went over to him and said, “kia ora, where are you from bro?” and then made the connections with him. We were both from the same area in Northland. He calmed down and we were able to proceed with the kaupapa.*

*(Totara)*

*I see that often, not just with me but with other older Māori staff working on the floor, they come down and they will provide a different approach to tāngata whai ora, E tama, kaua e kōrero pēnā, or something like that and the tāngata whai ora responds to it immediately.*

*(Puriri)*

Māori mental health nurses expressed that it was of the utmost importance to create a pathway for Māori prior to being admitted to the acute mental health unit. As soon as the pending admission of a tāngata whai ora was known and communicated to the unit, the crisis or admitting team should involve a kaumātua or cultural worker to be a part of the admission.

*When a tāngata whai ora comes into the unit they need to feel that they're not alienated and by having the presence of Kaitakawaenga can eliminate that feeling and show them there are strong cultural supports in place.*

*(Kowhai)*

For one acute mental health unit this was an easy process as the cultural team was based at the unit. For another unit a wharehau and team of kaumātua and Māori cultural staff were also attached (to the unit), each making it easily accessible for such a response to occur.

Māori psychiatric aides made a considerable difference to the culture of acute mental health units in both urban and rural settings. They provided a sense of confidence among Māori mental health nursing staff that, when they were present, seclusion would not be used as the therapeutic approach with tāngata whai ora.

*I always found when our male Māori psychiatric aides were on shift, it was just so much more calm and organised. If we didn't have him on with us, you knew there would be some bullying type of behaviour.*

*(Rata)*

*I find especially with our Māori psychiatric aides, there is a sense of respect by tāngata whai ora, even when they are psychotic, they can still understand what is going on. Some of the older psychiatric aides have a long history with our tāngata whai ora, they remember they were treated respectfully by them and that's the only person that they will engage with.*

*(Totara)*

Additionally, when there were high numbers of Māori staff on a shift, Māori mental health nurses were assured that no challenges would occur and more time could be spent with tāngata whai ora attending to their needs and strengthening the connections.

*I know when I worked in IPC, if I had all Māori staff on, I knew we were going to have a good night, you'd guarantee that we'd have a cruisy shift because the clients were more settled.*

*(Kowhai)*

*I came away from the pm shift thinking this is the best shift I've had in ages as there were three of us Māori staff on together. I was able to have one-to-one time with a tāngata whai ora, and gauged the many challenges she had experienced prior to admission and I felt she had my attention without having to run off to other issues.*

*(Puriri)*

## Focused engagement

The engagement focus involved establishing and promoting a culturally safe environment for Māori; one that reflected an atmosphere and approach that was compatible with Māori by including the use of te reo me ōna tikanga and deliberate linking.

The use of te reo Māori, karakia and waiata were vital for engaging with tāngata whai ora, and supported the transmission of Māori knowledge and understanding in a way that no other language could convey such intricacies of their situation (Nepe, 1991).

*Often I had Māori clients on the ward and I found that being able to engage in te reo Māori was really useful, especially if they spoke te reo.*

*(Kowhai)*

*With Māori to Māori, I feel we can connect, we can talk about our iwi, we can use te reo and it just helps to de-escalate our people.*

*(Puriri)*

Taha wairua or the spirituality of Māori is important for the holistic wellbeing of tāngata whai ora. There is an interaction that occurs when Māori mental health nurses work with tāngata whai ora that is guided and supported by a spiritual presence. Through the use and practice of karakia there is an added element of calm, hope and inspiration in the care of tāngata whai ora that shows support of the person's wairua.

*My experience has been that even in a volatile situation karakia has been useful whilst working with Māori. It connects with Māori on a wairua level and generally calms the situation.*

*(Kowhai)*

Deliberate linking involves subjective and observable actions that carefully identify and generate ties, cohesion and cooperation among Māori. It can help in the process of mental health staff distinguishing key circumstances, concerns and preferences of the tāngata whai ora and their whānau.

*I make those links. My way of thinking is not to separate that person's tupuna, that includes everyone that walks beside them and are guiding them. You don't takahi on that mana! Our whenua is so small; sooner or later there is a link somewhere between you and them, as whanaunga.*

*(Totara)*

*Being able to find those connections is a skill, like within a name is a whakapapa, and within whakapapa are further links and names and connections.*

*(Miro)*

### Example of Māori mental health nursing practice

Karaka came into the ward other day, I had got on the ward early so I was preparing to start when the night nurse said Karaka was back in the ward, and she was happy I was on the morning shift. My colleague said Karaka had been high and when she had told her I was on in the morning she seemed to calm.

So I went to see her, and her whānau were with her, her partner and her daughter. We had a good kōrero together and I was able to encourage Karaka to consider a clear care plan for her time on the ward. We didn't consider the use of seclusion, and I arranged for another nurse to provide one-to-one care as I was the nurse in charge of the shift. I said to the nurse engage with Karaka this way... and then explained what she could do with her, I was confident and determined there would be no seclusion nor restrictions with her. I said "Karaka is extremely

tired, she hasn't slept for days"; I said the bed is made up, the room is warm and comfortable and that she could sleep as long as she wanted. I also ensured Karaka was to be provided hot milk drinks, kai and ongoing awhi through the shift.

It's about creating a supportive warm environment so she could rest. Her partner and daughter were able to go home happy, and to have a sleep. In the kōrero with the psychiatrist, who thought Karaka had relapsed in the previous three to four days, I shared with her that Māori whānau do have a high tolerance, and Karaka most likely had been unwell longer than the three to four days. I also said to the doctor that whānau will do their best for their whānau when it comes to their loved one being unwell. My view being that we have to respect and value whānau and to assure they do not feel guilty because they should've brought their loved one to services earlier, but to recognise them for their desire to help their loved one.

## Relational-centred interventions

Relational interventions centre tāngata whai ora within the context of their important and significant relationships. Māori mental health nurses argue that relationship-centred care offers a way of practice that is transferable and beneficial to tāngata whai ora, which is needed in acute mental health care.

*A lot of tāngata whai ora present unwell and psychotic, when you don't work in partnership with them it escalates them. So it's important our culture is respected and tāngata whai ora have choice in their pathway of treatment.*

*(Puriri)*

*In my very first placement I recall a tāngata whai ora who had been in the unit for seven months, he wasn't allowed to leave the unit, even on escorted leave and there had been a whole lot of things going on, but there was no interest in him or who he was. So I worked on establishing links with him, and creating a relationship with him, encouraging him to get out of bed, and to focus on something in his day. Over time he became motivated, he had something to look forward to each shift, even if he was still unable to leave the unit.*

*(Mamaku)*

Relational-centred interventions promote working closely with whānau of tāngata whai ora. Māori mental health nurses appreciated the significance of whakapapa, of connections to iwi and the importance of a strong sense of being Māori. For these nurses, acknowledging the links and dynamics within whānau, as well as the contributions whānau could make to the admission, treatment and support of tāngata whai ora while in the unit, was central to working with whānau.

*It's critical that we acknowledge who their kuia and koroua are and involve their whole whānau at that first point of contact.*

*(Puriri)*

*Whānau make a huge difference in the admission process. The mental health unit can be an intimidating place and many Māori are too scared, but if whānau are involved in the admission then the process for tāngata whai ora is easier.*

*(Kowhai)*

This included the ability to accommodate whānau, so they could be near by their loved one while they were in the unit receiving support.

*There have been situations when mostly female tāngata whai ora don't want to be here, and they plead to their parents they don't want to be there, please stay! I will always explore with the whānau if they can stay overnight or be nearby if it's going to be beneficial for the tāngata whai ora.*

*(Rata)*

*We had a whānau room attached to the unit where whānau would come and stay to be nearby the tāngata whai ora. You could guarantee that if whānau stayed, tāngata whai ora weren't secluded. They could have their own time-out space but the doors were always open.*

*(Rimu)*

What was particularly vital for whānau was to be involved alongside tāngata whai ora from the beginning of their journey with acute mental health services, especially in a first admission when they could get access to support, resources and information, and be involved in the recovery plan for the tāngata whai ora.

*Whānau are a huge contributing factor especially when they're brought into the unit for the first time. Whānau also play a huge part in tāngata whai ora treatment because when they're discharged, who do they go back too? Usually their whānau. If whānau aren't well informed, and the mental health staff do not provide them with the opportunity or space to talk and learn about their loved one, then the tāngata whai ora leaves the unit with no information or support plan and then the cycle of coming into the unit begins.*

*(Kauri)*

### Example of Māori mental health nursing practice

A young 17 year old girl Maire had been brought into the unit with first time psychosis, she came in with her whānau, she was really unwell and the whānau were anxious cause they'd put it off to bring her to hospital, they'd done everything possible to try and get her better through Māori means, using tohunga and going home to their marae, and going to their awa. They got to a stage where she was really frightened from the auditory hallucinations she was experiencing so when she came into the ward, her whānau were concerned and were present with her.

Maire was really scared, frightened and I could see she was starting to get really worked up and the whānau were getting anxious. Luckily it was in the evening where most of the clients had gone to bed so the ward wasn't busy. Although, it was near the end of my shift I knew that I needed to get Maire and her whānau into a room and to find a way to settle her and try to alleviate her anxiety without having to take her to the intensive care area.

So I immediately sat down with them, and did whakawhanaungatanga, I had a feeling I knew their whakapapa connections from their whānau name, although we were from differing marae, so I tried to

make the connections with them and my whakapapa connections.

Following this process, the father told me what had been going on, so I suggested we do a karakia as they'd never been in a mental health unit before, in which he was happy to provide. I observed an immediate calm in Maire, and less anxiety in the whānau. After the karakia, I contacted my Māori colleagues to come into the room to sit with us, whilst we awaited the arrival of the psychiatrist for an assessment.

I was concerned that the cold clinical environment of the mental health unit was not conducive to Maire or the whānau and that it would impact on sharing with me or others. So I continued to kōrero with them utilising the whanaungatanga process with Maire, as a means to distract her from her voices and to engage with her further. She responded well, and we even did a waiata together which seemed to further calm her and her whānau. As my Māori colleagues arrived, I handed her and the whānau over in readiness for the assessment process with the doctor.

The next day, when I returned to work, I was pleased to see that Maire had remained on the open ward, and she was not taken to the intensive care area to be secluded.

## Acute mental health unit workforce development

### Māori mental health workforce

All Māori mental health nurses identified the need for more well-trained and competent Māori staff to be employed across all shifts in acute mental health units, especially when the population and catchment of the unit was high in Māori numbers.

*For our people, they see Māori staff and it reassures them, they say, "oh choice! Such a such is on tonight." For tāngata whai ora they say, "great! You understand me, I can talk to you, you know where I am from, who I am," all those things and I think it's reassuring for tāngata whai ora.*

*(Rimu)*

In particular, access to Māori employed in cultural roles or teams attached to mental health services was identified as

a priority. Evidence of the effectiveness of Māori cultural support for tāngata whai ora included the alleviation of anxiety associated with the admission process and the ease of socialisation into the unit. In some cases, a dilemma arose for mental health units when admissions occurred after hours and Māori cultural workers were not as easily accessible due to human resource availability on the unit.

*The issue is that we did have Kaitakawaenga available after hours, but they stopped the service because no one was utilising it. So they have Kaitakawaenga through until 5pm, but we have so few, we may have six or seven across the whole of mental health services, but they're so busy. There definitely needs to be an increase in the number of cultural staff available to the service so that when Māori arrive, staff can ring to organise someone to be available and to do a karakia or whakatau.*

*(Kowhai)*

Focused professional, personal and cultural development is required for Māori mental health nurses who often are subject to being asked by colleagues in acute mental health services to bridge the challenges between tāngata whai ora, whānau and the service.

*A lot of the time the Māori mental health nurse is called in to a situation to respond to our whānau in the too hard basket. Nine times out of ten, it's the Māori mental health nurses who notice the behaviours and provide the point of difference for tāngata whai ora in comparison to the non-Māori colleagues in the unit.*

*(Miro)*

### **Mental health workforce**

Māori mental health nurses identified a priority for non-Māori mental health professionals to receive specific training and coaching to improve their appreciation of the Māori worldview. The training would also need to teach them how to apply this knowledge into practice with tāngata whai ora and their whānau in acute mental health care.

*I get the feeling from our international colleagues that they think we are just brown Pākehā, they don't understand that Māori have a different worldview, and this includes a whole different world going on outside of mainstream society. I think that's the real challenge to try and educate staff in a genuine way that shows them an understanding of this Māori worldview.*

*(Kowhai)*

The type of workforce development needed for non-Māori mental health professionals requires a shift from the solely clinical model to one that brings the Treaty of Waitangi into perspective and establishes a strong foundation of best practice principles when working with Māori, not as individuals but as members connected to a holistic worldview.

*If you try to articulate the cultural aspects of practice that work for Māori, some non-Māori clinicians don't get it, because they think and work from a clinical model. You can't even bring the Treaty of Waitangi into the discussion, because non-Māori clinicians can't connect to it. They're still finding it difficult to connect the treaty to practice. I've found it easier to explain it differently to non-Māori clinicians so they are not wound up in behavioural patterns they don't understand. So it's about pointing out to them the connections Māori have, also of a Māori worldview and some of their realities.*

*(Kauri)*

Concern among Māori mental health nurses is that when non-Māori mental health professionals do not understand how best to work with tāngata whai ora, there is an unintentional mismatch of diagnoses and treatment applied to Māori.

*I worry about Māori, as often they're being misjudged. Often non-Māori do not understand our culture, and I do get frustrated that I have to explain tāngata whai ora behaviour especially when they are coming into the unit. Straight away they get diagnosed, without sitting down and talking to them, giving them a safe environment to open up and talk. Then you find out they've had a loss in the whānau or something but the diagnoses has been made and so has the medication been started.*

*(Miro)*

*It's real hard sometimes especially when we have consultants who have been consultants in other countries that come to Aotearoa and do not understand our people. The hardest battle as a Māori mental health nurse is educating our peers and justifying our culture.*

*(Rata)*

The suggested workforce development for non-Māori mental health professionals working in acute mental health care requires workplace-based training and coaching. The coaching would include developing communication strategies for working with Māori and be delivered by Māori mental health professionals so that all staff are capable and confident in making decisions and in their practice approaches when working with Māori.

*Sometimes our Pākehā colleagues don't pick up the cues or sometimes they don't understand what our people are saying, particularly if they're from overseas, and that's what contributes to their frustrations.*

*(Rata)*

*I think the biggest challenge is non-Māori do not listen to what is being said, they think they know what was said but, the majority of the time, they have made an interpretation of the person or situation before the person has had a chance to kōrero. What they have to do is open their ears and their eyes to what is happening to the person and listen!*

*(Kauri)*

*I think sometimes what instigates challenging incidents in the unit is the way staff speak to tāngata whai ora. I think if they learnt a bit about our culture and the importance of a person's whakapapa, also their status within their whānau, they would appreciate the perspective of tāngata whai ora. You know the person could be the kaumātua in their whānau or may speak Māori when they are unwell; all those things count.*

*(Totara)*

Professional guidance was recommended for mental health professionals working in acute mental health care to ensure clinical decisions were not shaped by bias, and thus predetermining the use of seclusion, particularly in regard to Māori men. There was a real desire among the

nurses to support all mental health staff so that if there were personal and professional challenges, aid would be provided through appropriate debriefing, supervision and, if necessary, counselling.

*I think they're scared of our people, especially our Māori boys. Sometimes they will behave in a certain way that gets interpreted as something else. To me, they are our boys, our whānau; we can work with them in a way that calms them a lot quicker.*

*(Puriri)*

*A lot of the time the story about a tāngata whai ora before admission can be over exaggerated, so there's a picture painted about how this person's going to present and it's not until you actually see them to do you understand. Usually I think, hmm, no I don't think that seclusion is really necessary, it won't work for that person.*

*(Miro)*

*There's some work needed for mental health staff, maybe having a peer to talk honestly to, especially if there is a tāngata whai ora that freaks them out! They have to unpack that, why does that guy freak you out? Why is that when I work with a big Pākehā tāngata? I don't feel the same way? What's happening with your prejudices? We can't let racism grow in acute mental health care; we have to attend to it head on!*

*(Mamaku)*

Māori mental health nurses acknowledge and appreciate their non-Māori colleagues who are confident and effective when working with tāngata whai ora and whānau. They believe this group of mental health professionals indeed brings a different skill set to the way they therapeutically engage and work with Māori. Attributes were identified as a willingness to learn, and a respect for and acceptance of the Māori worldview.

*Tauwiwi who choose to work with our people come with a different bag of tools, they come with a different set of eyes and a different understanding, and they are generally open and willing to learn. In my team, there is respect and acceptance that flows between them and the tāngata whai ora, honestly you could come in and not know who is wearing what hat because of the openness and approach with tāngata whai ora.*

*(Puriri)*

*There are staff who are receptive to being given advice, and accepting such around how to work with Māori.*

*(Rimu)*

*I have colleagues who have the right tools to work with Māori, they have the right attitude and I like seeing them work with our people. What they have done is acknowledge who they are as a people, and been prepared to work alongside Māori to learn.*

*(Kauri)*

There was further recognition of non-Māori mental health staff when they sought Māori mental health staff to attend to and support tāngata whai ora when the need arose. By doing so, they recognised the value of Māori mental health staff working directly with tāngata whai ora and their whānau.

*They know that's what we do, they embrace it, they're used to us (Māori mental health staff) attending to our Māori whānau. They encourage it! They might say, go and get such n such to come down. I've never seen any of our staff be resentful of Māori (mental health staff) doing their thing with Māori, especially if it means they're not going to get hurt or the tāngata whai ora – so they're quite supportive!*

*(Puriri)*

In addition, there was an understanding that Māori mental health nurses would engage with Māori deliberately in a way that honoured the practice of whanaungatanga.

*I can remember giving someone a kihi and a mihi, then thought that my preceptor was nearby watching me. I wondered how he'd feel about it so I spoke to him. He said it was fine, and that I would be the judge to what is appropriate in terms of boundaries and knowing whether it was appropriate for that tāngata whai ora. I knew right then that I had upmost support from my non-Māori preceptor.*

*(Mamaku)*

#### **Example of collaborative practice**

Whau came into the unit the other night when I was last on; we had this consultant on shift who Whau refused to talk too. So I went into his room and said, “kia ora what's going on? Why don't you want to talk to the doctor?” Whau said, “I don't feel comfortable talking to him”. I said, “are you comfortable talking to me?” Whau said, “yep, I'll talk to you but I won't talk to that white guy.” So I spent some time with Whau and gathered some background information and then went to see the consultant. My colleague was comfortable for me to complete the assessment and provided me with a range of queries he was wanting further information on.

The consultant quietly sat outside the door of the room where Whau and I were sitting and he listened intently to the kōrero as it unfolded. He offered me pieces of paper with additional questions as the interview progressed, and together we completed the formal interview.

## Discussion

Eight Māori mental health nurses with experience working in acute mental health units identified the contextual and cultural challenges of providing acute care in poorly designed facilities with destructive cultures. Their concerns for the high number of tāngata whai ora accessing acute mental health units and the use of seclusion on them, especially Māori men, are drivers to reduce the use of seclusion and, therefore, the trauma experienced by tāngata whai ora when seclusion is used.

Whanaungatanga was identified by all Māori mental health nurses as the point of difference in their practice from non-Māori colleagues. Adapted from Māori customary principles, this model of practice involves four elements.

1. Recognition (kanohi kitea).
2. Māori therapeutic relationship.
3. Focused engagement (using te reo Māori, karakia, waiata and deliberate linking).
4. Relational-centred interventions which include working closely with whānau.

Areas for improvements in acute mental health units included increasing the number of Māori mental health staff, especially in cultural roles, and professional support for Māori mental health nurses. In addition, implementing a non-Māori workforce development programme provided by Māori mental health professionals that would involve elements such as:

- understanding Māori worldviews
- a paradigm shift from a clinical model of practice to a holistic health model
- communication strategies for working with Māori
- challenging the bias and stereotyping regarding the use of seclusion of Māori men
- acceptance of the Māori mental health professional's model of practice and working relationships with tāngata whai ora and whānau.

These findings corroborate the best practice strategies identified by Wharewera-Mika et al. (2013) to reduce Māori seclusion rates in acute mental health inpatient units. Together, the studies provide an evidence base brought together by Māori in an attempt to respond in a culturally-appropriate way to the difficulties in mainstream acute mental health inpatient care.

## Limitations

While this small study will add to the knowledge base about Māori mental health nursing practices with tāngata whai ora in acute mental health settings, the limitation is that the study does not provide a lived experience of tāngata whai ora, specifically the perspectives of those that have been restrained or secluded. There is a need for the voices of tāngata whai ora to be heard if we are to explore and gain greater knowledge and understanding about how acute mental health services can best support them during their recovery and eliminate the use of restraint and seclusion.

## References

- Barton C. (2007, 6 November). An unpalatable reality in the age of improving care. *The New Zealand Herald*. Retrieved from <http://www.ect.org/?cat=1>.
- El-Badri, S. M., & Mellsop, G. (2002). A study of the use of seclusion in an acute psychiatric service. *Australasian Psychiatry*, 36(3), 399-403.
- Elliott-Hohepa, A. (2007). *Kaupapa evaluation methodologies: OTS Consulting for evaluation and planning workshop*. Retrieved from [http://www.ssw.org.nz/site/socialservices/files/Microsoft%20Word%20-%20Kaupapa%20Māori%20Evaluation%20Methodologies\\_1.pdf](http://www.ssw.org.nz/site/socialservices/files/Microsoft%20Word%20-%20Kaupapa%20Māori%20Evaluation%20Methodologies_1.pdf)
- Hutt Valley District Health Board. (2009). *Te whare ahuru*. Wellington, New Zealand: Hutt Valley District Health Board. Retrieved 3 September, 2014 from <http://www.tepou.co.nz/story/2009/06/27/te-whare-ahuru>.
- McLeod, M., King, P., Stanley, J., Lacey, C., Cunningham, R., & Simmonds, S. (2013). *The use of seclusion for Māori in adult inpatient mental health services in New Zealand*. Te Pou o Te Whakaaro nui. Auckland, New Zealand.
- Mead, H. M. (2003). *Tikanga Māori: Living by Māori values*. Wellington, New Zealand: Huia.
- Mental Health Commission. (2004). *Seclusion in New Zealand mental health services*. Wellington, New Zealand: Mental Health Commission.
- NASMHPD - National Association of State Mental Health Program Directors. (2006). *Training curriculum for the reduction of seclusion and restraint*. Alexandria, United States: National Association of State Mental Health Program Directors.
- Nepe, T. (1991). *E hao nei e tēnei reanga Te Toi Huarewa Tipuna Kaupapa Māori: An educational intervention system*. (Unpublished Master's thesis, University of Auckland, Auckland, New Zealand).
- Ministry of Health. (2009). *Office of the director of mental health annual report 2008*. Wellington, New Zealand: Ministry of Health.
- Pere, L. M. (2006). *Oho mauri: cultural identity, wellbeing and tāngata whai ora/motuhake*. (Unpublished Doctor of Philosophy thesis, Massey University, Palmerston North, New Zealand).
- Radio New Zealand. (2013). *Fear of driving seclusion rates - health provider*. Updated at 11:14 am, 12 November, 2013. Retrieved from <http://www.radionz.co.nz/news/te-manu-korihi/227435/fear-of-driving-seclusion-rates-health-provider>.
- Smith, L. T. (1999). *Decolonizing methodologies: Research and indigenous peoples*. London: Zed Books.
- Tai Rawhiti District Health Board (2013). *Finding solutions to reduce seclusion and restraint at Te Whare Awhiora*. Gisborne, New Zealand: Tai Rawiti District Health Board. Retrieved 3 September, 2014 from <http://www.tepou.co.nz/story/2013/09/17/finding-solutions-to-reduce-seclusion-and-restraint-at-te-whare-awhiora>.
- Tapsell, R., & Mellsop, G. (2007). The contributions of culture and ethnicity to New Zealand mental health research findings. *International Journal of Social Psychiatry*, 53(4), 317-324.
- Tyrer, S., Beckley, J., Goel, D., Dennis, B., & Martin, B. (2012). Factors affecting the practice of seclusion in an acute mental health service in Southland, New Zealand. *The Psychiatrist*, 36(6), 214-218.
- Wharewera-Mika, J., Cooper, E., McKenna, B., Wiki, N., Field, T., Haitana, J., Toko, M., & Edwards, E. (2013). *Strategies to reduce the use of seclusion and restraint with tāngata whai ora*. Auckland, New Zealand: Te Pou o te Whakaaro Nui.





