AN EXPLORATION INTO THE REASONS WHY MĀORI MEN (TĀNE) ARE SECLUDED IN ACUTE MENTAL HEALTH SERVICES IN NEW ZEALAND MORE FREQUENTLY THAN MEN OF OTHER ETHNICITIES

A Thesis

presented in partial fulfilment

of the requirements for the degree of

Master of Health Science

at the

Eastern Institute of Technology

Hawke's Bay, New Zealand

Christopher Bruce (Chris) Drown

2017

Originality Statement

I declare that the work presented in this project report "An exploration into the reasons why Māori men (Tāne) are secluded in acute mental health services in New Zealand more frequently than men of other ethnicities" is, to the best of my knowledge and belief, original and my own work, except as acknowledged in the text and reference pages.

Signed: Date: 21st May, 2017.

Abstract

The aim of this thesis was to explore the reasons why Māori men (Tāne) are secluded in acute mental health services in New Zealand more frequently than men of other ethnicities. A literature review identified that over the last two decades Tāne were secluded up to five times as often as men of other ethnicities. There was found to be a dearth of qualitative literature nationally and internationally related to seclusion of indigenous men.

The qualitative research design for this thesis was based on the recollection of the researcher's professional experiences of being a mental health nurse working in acute mental health services. It utilised the method known as memory-work to generate narratives from the perspective of a mental health nurse caring for Tāne, These narratives were analysed as a way to explore the key issues surrounding the seclusion of Tāne, such as environmental issues and an inadequate acknowledgement of the cultural needs of these men. Discussion of these key issues have led to recommendations for nursing practice in acute mental health services in New Zealand.

Acknowledgements

Firstly, thank you to my two supervisors, Shona Thompson and Sue Scott-Chapman, whose advice, guidance, feedback, humour and giving of their time on a regular basis throughout the writing of this thesis has been invaluable to me – kia ora rawa atu. Special thanks to Shona for convincing me that the methodology used in this thesis is valid, I did have my doubts.

Thank you to my wife, Noreen, who has steadfastly supported me in every way possible to afford me the time and space to achieve this thesis.

Thank you to EIT's library staff Jadwiga Kozniak and Marcus Simkin, whose research and library skills have been of great help to me.

Thank you to Thomas Harding and more recently Jennifer Roberts who, as my immediate line-managers, have given great support and encouragement throughout.

Thank you to the members of the reference group who gave me excellent feedback and a sense of credibility in the content and analysis of my narratives.

Finally, I would like to acknowledge the many unnamed Tāne who I have referred to by fictionalising their stories to form the data set of this thesis. These experiences were stressful for them and those around them. This thesis is designed to reduce this stress in future.

Table of Contents

Glossary of Māori Terms and Words

Hīmene = Hymn

Hui = Meeting

Kai manaaki = Carer

Kanohi kitea = Recognition

Karakia = Prayer

Kia ora rawa atu = Thank you very much

Kōrero = Discussion

Mana = Prestige / authority

Pōwhiri = to welcome or invite

Pouwhirinaki = Māori support person

Tamariki = Children

Tāne = Māori male(s)

Tangihanga = weeping, funeral

Tangata whai i te ora = Māori person seeking health care

Tikanga Māori = the Māori way of doing things / cultural norms

Tino rangitiratanga = self determination

Tiriti o Waitangi = Treaty of Waitangi

Tohunga = Priest

Tūrangawaeawae = a place where one has the right to stand

Waiata = Song

Whakapapa = Genealogy

Whānau - Family

Whānaungatanga = kinship / family connections

CHAPTER 1 INTRODUCTION

"Since the Middle Ages seclusion and restraints have been used to control the behaviour of persons with mental disorders" (Fortinash & Holoday Worret, 2004, p. 53).

The purpose of this qualitative research is to explore the intervention of seclusion in acute mental health services in New Zealand. Specifically, to examine the disproportionate over representation in the seclusion of Māori men (Tāne) in these services. New Zealand's acute mental health services are based in the public sector and facilitated in a hospital setting by the 20 District Health Boards (DHBs) across New Zealand. Within these hospitals, there are specialised areas of health (mental health). Patient access to these services is usually via referral from emergency mental health services and other health providers including general practitioners. The New Zealand Police are also involved at times.

Within these acute mental health services, the practice of seclusion of patients in specialised seclusion rooms is common. Patients may be secluded when they are acutely mentally unwell to the point where they are deemed a significant danger to themselves and / or others. Seclusion within these services is defined under Section 71 of The Mental Health (Compulsory Assessment and Treatment) Act, 1992. When patients are deemed to require seclusion, this decision is usually made by the medical clinician who is directly responsible (known as the responsible clinician) for the patient's care and treatment. However, there may be emergencies such as an acute exacerbation of the patient's mental health condition during a time when the responsible clinician is not present. In these situations, the registered nurse who is directly responsible for the patient's care under their caseload allocation may initiate the intervention of seclusion. That nurse must then make contact with the responsible clinician as soon as possible to notify them of the action that has been taken.

Statistical information concerning seclusion of patients in acute mental health services has been gathered by the Office of the Commissioner of Mental Health Services since 2006. The latest statistics available from the Ministry of Health (MOH) (2016) reflect that "in 2015, Māori were almost five times more likely to be secluded than people from other ethnic groups" (p. 34), and that Māori men comprised approximately 17% of people secluded in adult inpatient services compared with non-Māori men who comprised approximately 10% of this group (MOH, 2016). Prior to 2006, statistical information appears to have been very difficult to obtain.

While these statistics indicate the trends in the seclusion of Tāne at higher levels than others, they do not begin to explain the reason why this is occurring, nor the experience of the individuals involved in this area of health care, including nurses. This paucity of information means that methods of reducing this disparity are yet to be explored fully.

Justification for this research is also related to The Tiriti o Waitangi. That is, Te Puni Kokiri (1993) states that Article two of the Tiriti O Waitangi "gives Māori the right to pursue tino rangitiratanga (self-determination) on matters affecting their well-being" (p. 8). Te Puni Kokiri (1993) also address Article Three which "accords Māori, as individuals, the same rights and privileges as other citizens" and therefore, that "Māori, as a minimum, have the right to enjoy at least the same level of mental health as non-Māori consistent with the Government's objective for Māori health" (p. 8).

There is also a dire need for this qualitative research, as there is a dearth of information in the current literature relating to the lived experience of seclusion for Tāne. The narrative approach used in this thesis has been chosen to raise awareness of the experience of seclusion, particularly for Tāne. It draws on the experiences of a mental health nurse caring for this group of people over a ten-year period at the turn of the 21st century. It appears that there are limitations in current practice to meet the needs of Tāne. This research is designed to elicit information regarding these needs and to identify ways of addressing them from a mental health nursing perspective.

1.1 Thesis overview

This thesis will endeavour to explore some of the reasons why Tāne are disproportionately over-represented in the quantitative statistics regarding seclusion in mental health services in New Zealand by utilising the following process.

Chapter 2: Literature review: This chapter will define the intervention known as seclusion in acute mental health services in New Zealand and the associated legal and ethical issues therein. It will outline the overseas experience of seclusion in indigenous groups and the statistical information available globally. This chapter will examine the literature (qualitative and quantitative) to review what is known about seclusion of Tāne and others.

Chapter 3: Methodology: This chapter explains the methodological approach taken in this research, including rationale for the process used and considerations when researching issues concerning vulnerable populations. It also addresses the issue of quality and validity of the research.

Chapter 4: Findings: This chapter presents the findings of the research in the form of four separate narratives based on experiences from nursing practice.

Chapter 5: Analysis: This chapter presents the analysis of the narratives utilising an interpretive analysis approach. Key findings are identified which are discussed in chapter 6.

Chapter 6: Discussion: This chapter examines the findings of the research in relation to the available literature.

Chapter 7: Conclusions: This chapter outlines a summary of the research, including its findings, and presents some recommendations for potential future directions for nursing in acute mental health practice, particularly for Māori men.

CHAPTER 2 LITERATURE REVIEW

2.1 Introduction

The aim of the literature review is to discover where, when and why seclusion is used in acute mental health services, both in New Zealand and internationally. Also, to explore which groups of people are secluded most frequently and why this is so. To enable this process, seclusion as an intervention will be defined and the legal and ethical issues that surround this process will be explored. Additionally, changes in the use and the impact of seclusion will be addressed. While the focus will be on the New Zealand experience, international literature will be sourced as a comparative exercise.

Databases searched: Scopus, CINAHL, ProQuest Central, ProQuest Dialog, Google Scholar, New Zealand National Union Catalogue, Index New Zealand, Informit Humanities & Social Sciences Collection. PubMed. Search engines used were: Google Scholar.

Search terms: (**restrain*** or restrict* or **seclu***) and (**mental** or **psychiatric**) and **Māori and (male or men or Tāne).** Date range: open,
and subsequently in an effort to locate literature related to seclusion of indigenous populations globally: (restraint OR seclusion OR isolation OR restrict*)
AND (mental OR psychiatric) AND (indigenous OR native OR aborig*) AND (men OR male).

2.2 Definition of Seclusion

In the field of acute mental health nursing patients are, at times, restrained and secluded to protect themselves and others. These powers of restraint and seclusion are provided for by Section 71 (s 71) of The Mental Health (Compulsory Assessment and Treatment) Act 1992 (The Act).

Seclusion in this field is a specialty intervention. The Mental Health Commission (2004) states that seclusion involves containment within a bare room (often only containing a bed and toilet), where the person is alone, and their exit from the room is decided upon and

controlled by the clinical staff. Initiating, maintaining and cessation of seclusion requires adherence to the law i.e. s 71(2) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (The Act), where:

> "(2) A patient may be placed in seclusion in accordance with the following provisions:
>
> - (a) seclusion shall be used only where, and for as long as, it is necessary for the care or treatment of the patient, or the protection of other patients:
> - (b) a patient shall be placed in seclusion only in a room or other area that is designated for the purposes by or with the approval of the Director of Area Mental Health Services:
> - (c) except as provided in paragraph (d), seclusion shall be used only with the authority of the responsible clinician:
> - (d) in an emergency, a nurse or other health professional having immediate responsibility for a patient may place the patient in seclusion, but shall forthwith bring the case to the attention of the responsible clinician:
> - (e) the duration and circumstances of each episode of seclusion shall be recorded in the register kept in accordance with section 129(1)(b)."
>
> (Mental Health (Compulsory Assessment and Treatment) Act 1992, p. 57).

2.3 Legal and Ethical Issues

The Act is designed to provide treatment and support of the person who is mentally unwell and to protect the general public from people with mental illness (Bell & Brookbanks, 1998). Nurses practising in mental health settings are guided by The Act, amongst other legislation amendments and policy guidelines. It would be fair to say that the

treatment of patients in mental health services in New Zealand prior to 1992 may now be considered archaic and inappropriate. For instance, Ball (2010) asserts that, while New Zealand started to have its own legislation from 1840 onwards, the legislation enacted in early New Zealand history was directly influenced by the thinking within England at the time. Brunton (2012) asserts that the period between 1840 and the early 1900's was when authorities in New Zealand tried to respond in a practical way to mentally ill people (who were referred to at that time as 'lunatics') who threatened public safety, could not look after themselves or who had no one to care for them. The intervention of seclusion was first introduced into New Zealand legislature in the Mental Health (Compulsory Assessment and Treatment) Act, 1992.

Nurses working in mental health care in New Zealand are sometimes required to restrain or seclude patients in their care. This intervention can be dangerous and also has the potential to impinge on the basic human rights of patients. Therefore, "ethical issues abound in mental health, and nurses practising in this area are confronted daily with the need for ethical decision making" (Elder, Evans & Nizette, 2009, p. 75). The decision to restrain another human being or placing them into seclusion is one that should not be made lightly and raises many questions including why this action is being taken and what are the alternatives to this action. Bigwood and Crowe (2008) assert that, in stressful clinical scenarios, nurses tend to choose correctional interventions for their patients rather than the relational ones. This appears to focus on control of the environment, rather than on a therapeutic relationship. Muir-Cochrane (1996) points out that nurses used the practice of seclusion as a supplementary intervention when they considered the patient to be out of control, and that a framework of power and control underpinned these nurses' perceptions, which were identified as being in stark contrast to the contemporary philosophies of nursing care in general.

The Mental Health (Compulsory Assessment and Treatment) Act, 1992 (The Act), specifically refers to restraint and seclusion under S.71 i.e. patients' right to company and seclusion. According to Bell and Brookbanks (2005), the practices of restraining and

secluding mentally unwell patients exemplifies the tensions and difficulties when considering the rights of the individual patient on one hand, and, the protection of the public on the other. While nurses act within the law in cases of restraint and seclusion (section 71 of The Act), ethical dilemmas persist where nurses need to weigh up the patient's autonomy and self-determination in situations where the patient may be viewed as a danger to themselves or others. The ethical challenge lies in the nurse's ability to maintain a therapeutic relationship with the patient, whilst engaging in a practice which infringes on the patient's basic human rights to freedom.

Bell and Brookbanks (2005) note that laws such as The Act, "which have the potential to infringe a right in the Bill of Rights, must be interpreted in a way that ensures that those rights are not infringed" (p. 334). Under the New Zealand Bill of Rights Act 1990, there are several areas that could be seen to be impacted upon by the practice of restraining and secluding patients. These include the right to freedom of movement (s 18); to be secure against unreasonable search and seizure (s 21); to be treated with humanity and with respect for the inherent dignity of the person (s 23(5)); and to justice (s 27). The Act also has the potential to intersect with the Health and Disability Commissioners Act (1994), i.e. right 1 (2) the right to respect of privacy, right 3 the right to dignity and independence, and right 7, the right to make an informed choice and to give informed consent.

Additionally, the New Zealand Nurses Organisation Nursing Code of Ethics (2010) address the underlying value of beneficence (doing good) in the context of the nurse-client relationship as, "creating a partnership, the outcome of which the client views as beneficial" and non-maleficence as "promoting the safety of clients by means of competent and safe nursing practice" (p. 15). These ethical standards are also reflected by the MOH (2001) who state that, "The Act endeavoured to balance the interests of the person with a mental disorder against society's greater interests, while providing sufficient 'checks and balances' to protect the person's civil liberties" (p. 2). The practice of seclusion is fraught with clinical issues and ethical dilemmas, which create challenges for nurses on many levels.

2.4 What is Happening Overseas?

It appears that indigenous groups are secluded more frequently than others in many parts of the world. For instance, in a study at Pennsylvania State Hospital on the use of seclusion and restraint, Smith et al. (2005) found that “patients from racial or ethnic minority groups had a higher rate and longer duration of seclusion than whites. i.e. 4.3 episodes per 1000 patient-days compared to 2.5 episodes per 1000 patient-days” (pp. 1115-1116).

There seem to be limitations in the accurate reporting of seclusion and restraint in terms of the differences experienced within countries and between countries. Janssen et al. (2008) assert that inaccurate data may belie the conclusion that Dutch rates of seclusion were higher than other countries. They continue by stating that differing methods of data collection and presentation are not congruent with accurate comparisons and these may impact upon communication between hospitals and countries about the use of seclusion (Janssen et al., 2008).

There also appears to be a dearth of international information related to the practice of seclusion. Janssen et al. (2008) found that, in an extensive search of seclusion rates of regions or countries in Europe, Australia, or the United States, only 11 articles were found referring to this matter. Additionally, Steinert et al. (2009) state that while there are moves to carry out research in several different countries, that information related to the use of seclusion and restraint is scarce. Brophy, Roper, Hamilton, Tellez, and McSherry (2016) note that, in Australia, there is a gap in the literature related to patients and patients’ supporters’ perspectives on the use of seclusion and restraint. Ypinazar, Margolis, Haswell-Elkins, and Tsey (2007) share that “an extensive search of medical and sociological databases found only four published empirical studies that explored indigenous people’s understandings of mental health” (p. 475). Martin, Bernhardsgrütter, Goebell & Steinert (2007), assert that “the use of coercive measures is an indicator of the quality of psychiatric inpatient treatment. To date, there is no data available to European comparisons on the incidence of such measures” (p. 1).

There appear to be some common themes related to the demographics of those who are involved in seclusion in mental health services. The act of seclusion may be seen as an imbalance of power between staff and patients generally. Findings by Sambrano and Cox (2013) suggest that "power imbalances that exist between nurses and clients in the mental health setting are especially problematic for indigenous people" (p. 524). This perception of power imbalance may also be due partly to communication differences from a cultural point of view. This is apparent to Eley, Hunter, Young, Baker, and Haqnnah (2006) who found that communication issues were a major finding which showed "discrepancies in the views and perceptions of our two study groups ((i) clinical and non-clinical staff and (ii) indigenous patients, their families and carers) regarding the mental health needs of Indigenous people" (p. 36). In addition, there is an indication that "this lack of communication is related to awareness of cultural practices and sensitivity to try to improve this situation" (Eley et al., 2006, p. 36). Participants in focus groups carried out by Brophy et al. (2016) recognised that there were specific challenges for culturally and linguistically diverse populations and that their findings indicate the need for further research into the practice of seclusion and restraint of minority and marginalised groups. Moreover, this idea is expanded by Sambrano and Cox (2013), who suggest that "future research could explore how sociocultural factors can be incorporated into the decision-making process nurses and psychiatrists undertake when considering secluding indigenous clients" (p. 529). The idea of including sociocultural factors is also reflected by Durie (2003), who argues that "good mental health depends on many factors, but among indigenous peoples the world over, cultural identity is considered to be a critical prerequisite" (p. 14). And so, there appears to be an over representation of indigenous people in seclusion intervention. This highlights a need for further research to be carried out in order to identify why this is occurring and to then explore methods of reducing this disparity.

2.5 What is the Impact of the use of Seclusion and What Changes Are Occurring in Practice?

Seclusion is a practice that has evolved over time, and is a continuation of a widely-used intervention which was practised more extensively prior to introduction of psychopharmacology in the 1950's, and continues to be utilised to a lesser extent since. It is used for therapy, environmental control and coercion (amongst other rationale) and is practised worldwide in a variety of ways. There are many reasons for the use of seclusion, and there is much controversy around its use. The Mental Health Commission (MHC) (2004) state that seclusion is often perceived as a punishment by service users and traumatising for all involved. O'Hagan (2008) supports this view, stating that there is wide agreement among users and survivors that the use of force can have overwhelming negative consequences that outweigh any possible benefits. Cannon (2006) adds to this by stating that the wider issues around the impact of restraint and seclusion are "that comments from service users are almost exclusively polarised towards the view that restraint is actually a form of assault and that seclusion is a breach of human rights" (p. 11). The MHC (2004) concurs with the view that compulsory treatment in New Zealand, whether in the community or as an inpatient, is used too often, and that the lived experience cited by many consumers suggests that seclusion for many people may have been anything but therapeutic. Furthermore, Huckshorn (2004) has the view that seclusion and restraint traumatises patients and staff, and impacts on the therapeutic and recovery process.

There is a national and international move to reduce the intervention of seclusion in acute mental health services. According to Huckshorn (2004), reduction of seclusion and restraint begins with clear leadership and a specific plan. This is supported by O'Hagan et al. (2008) who reflect that "active, committed, high profile leadership is essential in any process to reduce seclusion and restraint" (p. 6).

According to Huckshorn (2004), highly visible, consistent and effective organizational leadership appears to be the most significant and critical component in any successful seclusion and restraint reduction initiative. This suggestion is supported by

O'Hagan et al. (2008), who maintain that best practices that contribute to seclusion and restraint reduction include "a national direction that supports seclusion and restraint reduction and elimination efforts, active, committed and high profile organisational leadership and oversight, and an organisational culture that embodies recovery oriented approaches" (p.ii). Additionally, O'Hagan et al. (2008) maintain best practice methods that support reduction include service user development and participation through provision for feedback and employment in advisory, educator, peer support and advocate roles.

Further, according to Huckshorn (2004), organizations that wish to reduce the use of seclusion and restraint as a therapeutic practice need to embrace a prevention approach, follow the tenets of continuous quality improvement, and develop a reduction plan individualised for that facility. This idea is built upon by Fortinash and Holoday Worret, (2004), who maintain that "the use of seclusion and restraint has been dramatically reduced in recent years, partly because of the stringent new standards, but also because of a new commitment on behalf of mental health professionals to change seclusion and restraint practice" (p. 53). Staff involvement is also supported by O'Hagan et al. (2008), where workforce development is another crucial aspect of successful reduction efforts and includes recruitment, education, supervision, performance appraisal and staff involvement" (p. 8). Fortinash and Holoday Worret (2004) state that the key concepts implemented were "identifying the use of seclusion and restraints as a treatment failure, restriction of the use of seclusion and restraint to emergency situations only, having adequate numbers of staff, and providing staff training in crisis prevention and intervention" (p. 54). International guidelines are tending to impact on changes in New Zealand. O'Hagan et al. (2008), referring to practice in New Zealand, share that there are two training curricula developed in the United States that incorporate a range of the best practice methods. The two packages are:

- NASMHPD (National Association of State Mental Health Program Directors – Training Curriculum for the Reduction of Seclusion and Restraint)

- SAMHSA (Substance Abuse and Mental Health Services Administration)

O'Hagan et al. (2008) recommend that these curricula be adapted for use in New Zealand, which is happening. According to Te Pou (2008), six New Zealand DHBs are described as being well underway with initiatives specifically targeting the reduction of seclusion. There has not yet been a complete uptake of these curricula, however; "four DHBs had introduced whole or parts of the NASMHPD package along with other seclusion reduction best practices, while two DHBs were implementing initiatives that closely modelled parts of the NASMHPD package" (Te Pou, 2008, p. ii).

As well as the interventions already mentioned, there are specific one-to-one patient-healthcare worker interventions which, when put into practice, have the potential to reduce the use of seclusion and restraint. O'Hagan et al. (2008) suggest that milieu management and use of practical tools, like the provision of meaningful activities, create an atmosphere of listening and respect. Interventions such as crisis prevention planning, violence and trauma assessments, behavioural coaching, de-escalation and sensory modulation support reduction in use of seclusion and restraint. These ideas are supported by Champagne (2004), who discusses concepts such as alternative sensory-based approaches including wrapping in weighted blankets, a sensory diet, aromatherapy and therapeutic touch.

2.6 What is the Quantitative Literature Telling Us?

The Office of the Director of Mental Health has kept quantitative information since the utilisation of a new recording template in 2006 (MOH, 2006). These statistics reflect that rates of seclusion nationally are decreasing, however there is a marked disparity in the decrease of Māori service users compared to non-Māori. In the 2008 publication, Māori men were said to have been secluded as 28% of the proportion of inpatients secluded, while non-Māori men comprised 17% of this proportion (MOH, 2008). Over subsequent yearly publications, the latest being 2015, this rate has decreased to 15% for Māori men and 10% for non- Māori men (MOH, 2015). Further disparity is evident in the reduction of seclusion

rates over time. It is noted by the MOH (2011) that between 2007 and 2011 the number of people secluded decreased by 10 percent and, of those, Māori rates decreased by 4 percent and non- Māori by 14 percent. Also, according to the MOH (2012), between 2009 and 2012 the overall national seclusion rates fell by 22 percent. However, while the service users secluded that identified as non-Māori decreased by 24 percent, those who identified as Māori remained the same at 34 percent. Over time, more detailed analysis has been possible and, according to the MOH (2013), "in 2013, Māori were 3.7 times more likely to be secluded in adult services than people from other ethnic groups. Of the 768 people (aged 20 to 64 years) secluded in adult services during 2013, 36 percent were Māori" (p. 31). Additionally, "nationally between 2007 and 2014 the number of people secluded decreased by 40 percent. Consistent with the declining national rate, the number of people secluded who identify as Māori decreased by 32 percent over the same time" (MOH, 2015, p. 44). The statistics from the MOH (2016) are not specific regarding Māori men. However, they do state that males were more than twice as likely to have been secluded than females" (MOH, 2016, p. 29). Furthermore, "in 2015, Māori were almost five times more likely to be secluded in adult inpatient services than people from other ethnic groups" (MOH, 2015, p. 34).

During an 8 month period in 2000, information was gathered by El-Badri and Mellsop (2002) for all newly admitted patients requiring seclusion in the Waikato region of New Zealand. El-Badri and Mellsop (2002) found that,

> During this period 84 patients were secluded in 129 seclusion episodes. Males accounted for 80% of episodes of seclusion with 23% of admitted males but only 7% of females secluded at least once. Overall 20% of Māori patients, 22% of other non-European and only 11% of European patients were secluded. (p. 400)

These statistics are supported by McLeod, King, Stanley, Cunningham and Samuels (2013), who found in a pilot study of nine DHBs that Māori were estimated to be four times more

likely to be secluded than non-Māori, particularly Māori men aged 17-24 years and older Māori females aged 55-64 years.

2.7 What is the Qualitative Literature Telling Us?

There appears to be a dearth of literature based on qualitative research considering why are Māori, and Tāne in particular, secluded in acute mental health services more frequently than men of other ethnicities. Recently, however, there have been some attempts to address this lack of information. Wharewera-Mika et al. (2013) carried out a study which,

> explored Māori clinical, cultural, and consumer perspectives on potential strategies and initiatives considered likely to facilitate reduction in the use of seclusion and restraint with tangata whai i te ora (service users of Māori descent) in acute mental health inpatient services. (p. 5)

Their report was based on qualitative analyses of a hui of 16 participants with a high level of mental health clinical, cultural and consumer expertise. Data collection was facilitated by digitally recording all discussion at the hui and were analysed by thematic analysis. The three key themes related to the Māori world identified were:

- Ensuring a Māori presence and the availability of Māori healing environments at services.
- sustaining existing helpful cultural practices and processes during the inpatient stay.
- Providing whānau-centred care (Wharewera-Mika et al., 2013).

Te Pou (2014) carried out a study involving eight Māori mental health nurses with the aim of building on current literature with real clinical experience, to offer practical and cultural advice for mainstream staff, and to create a document which could be used across inpatient units in New Zealand. The concept of Whānaungatanga was identified by all nurses as being a point of difference in their practice as compared to their non-Māori colleagues.

This model of practice is supportive of the themes identified above by Wharewera-Mika et al. (2013) and developed from Māori tikanga, where Whānaungatanga 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.

Moreover, Wharewera-Mika et al. (2013) state that it is not straightforward to address the disproportionate levels of Māori under psychological distress resulting in admission to mental health inpatient services and potential for seclusion. They continue by saying that, given the scale of how frequently seclusion and restraint is used as an intervention for Māori, developing ways of improving care of this group of people should be a priority for all health workers concerned. El-Badri and Mellsop (2002) support these ideas by postulating that it is not easy to explain the disproportionate over- representation of Māori compared to non-Māori around seclusion, but that it may be related to stereotypical perceptions by staff that non-European patients are more dangerous and they therefore responded to these patients with defensive or pre-emptive methods. This idea is supported by Te Pou (2014) who argues that,

> 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 (p. 10).

There were noted limitations in the study by Wharewera et al. (2013), such as the small sample size, and while it was not representative of all views on this topic, findings gave a range of relevant points from Māori clinical, cultural, and consumer perspectives in this area of practice. Wharewera et al. (2013) noted the dearth of literature in this area and that their study was a starting point for understanding Māori points of view on the reduction

of restraint and seclusion of tangata whai i te ora. They stressed the need for further research in this area. This idea is similarly reinforced by Te Pou (2014) who asserts that,

> 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 (p. 20).

CHAPTER 3 METHODOLOGY

3.1 Introduction

To address the research question, why are Tāne in mental health services secluded more frequently than men of other ethnicities, a qualitative research methodological approach will be used. The research is based on narrative inquiry and the analysis of stories generated through 'memory work' to draw on my real-life experiences of seclusion while working as a mental health nurse in the field of intensive mental health nursing. These experiences occurred between 1993 and 2003 in two regional hospitals in New Zealand. The method chosen for this research will enable a close examination of contemporary literature alongside accounts of actual experiences with the aim of illuminating issues and implications concerning the practice of seclusion in mental health nursing. The research also takes into consideration the many ethical issues that arise when focusing on sensitive health issues and vulnerable populations.

The narratives for analysis are drawn from a process that entails recalling real life experiences, which are anonymised and written in the third person as stories. The anonymity of these stories means that real names and personal details of people are not identifiable. Clandinin & Connelly (1998) state that "anonymity and other ways of fictionalising research texts are important ethical concerns in personal experience methods" (p. 170). The narratives that comprise the research data will be subjected to critical analysis to address the research question and to gain insight into the lived experience of those who have been secluded as part of their mental health treatment.

3.2 Qualitative Research

The concept of research is complex, as there are many paths researchers could take to find answers to their questions. These paths will depend on the type of question(s) the researcher has in mind. The research process is described by Borbasi, Jackson, and Langford (2004) as "an orderly series of phases and steps that allow the researcher to move from asking a question to finding an answer" (p. 96). These phases are cyclical and help to:

1) “Conceive the study
2) Design the study
3) Conduct the study
4) Analyze the study
5) Use the study” (Borbasi et al., 2004, p. 97).

The relevance of research in the field of professional nursing practice is highlighted by Basford (2003), who states that the impact on research outcomes will inform nursing practice and education, and the relationship between these three disciplines will be the basis for the future nurse. This idea is supported by Hall (2013) who expressed the view that the association between nursing theory and research constructs the scientific arena of nursing. This arena is then applied to practice, and that the interrelationship of concepts within a theory often supports creation of research questions.

Schneider, Elliot, LoBiondo-Wood, and Haber (2003) state, of research, that “qualitative, or humanistic approaches provide emphasis on the personal and subjective nature of an enquiry with findings reported in a narrative form” (p. 250). By sharing real experiences from practice in a narrative form, this study will endeavour to throw light on the lived experiences of men who were secluded, particularly Tāne. Dempsey and Dempsey (2000) maintain that “generally, qualitative researchers aim to develop sensitising concepts and to create theory rather than testing theory” (p. 33). They highlight how qualitative research may elicit descriptions of multiple realities from the participant’s perspective as ascertained during the study, and then discover particular meaning in the given situation (Dempsey &Dempsey, 2000). Similarly, according to Borbasi et al. (2004), “qualitative researchers view reality as a subjective, multifaceted experience, rather than as a single, fixed, objective actuality” (p. 131). Qualitative research as discussed by Dempsey and Dempsey (2000) employs the process of inductive logic, a reasoning method that moves from the specific to the general.

Within this study, the aim is to induce these theories from experience by borrowing from the principles of ethnographic methods. That is, this research endeavours to explore situations involving Māori men in seclusion to explore details of their lived experiences. Polit and Beck (2008) define ethnography as “a type of qualitative inquiry that involves the

description and interpretation of cultural behaviour" (p. 224). Further, De Chesnay (2015) asserts that, "culture basically refers to beliefs, values, and attitudes that influence behaviour patterns of a specific group of people" (p. 96). The experience of seclusion in acute mental health services has the potential to impinge upon these cultural concepts of any individual in specific ways. Willis and Anderson (2010) describe focused or micro-ethnography as a process whereby research is concentrated "on a single problem in a particular setting" and, "rather than attempting to portray an entire cultural system, focused ethnography draws on the cultural ethos of a microcosm to study selected aspects of everyday life" (p. 95). The intervention of seclusion in acute mental health care is usually carried out in a private setting and therefore carries elements of mystery for those who are not involved. This may also lead to misunderstandings.

The challenge of this research is to expose the experiences of a group of people in a real way. This entails a fully comprehensive and all-inclusive study with focussed attention to the detail of individual experiences (Knoblauch, 2005; Polit & Beck, 2008). The process of focussed ethnography is particularly felicitous in healthcare research, as it lends itself toward a practical and efficient method of gathering information. This, in turn, focusses on an area of healthcare that is of particular consequence to healthcare professionals and which can be considered to improve interventions in practice (Higginbottom, Pillay, & Boadu, 2013). Therefore, drawing on these research methods is appropriate for the focus being undertaken and for the purpose of this research, which is to identify the reasons why Māori men are disproportionately secluded and to consider ways to reduce this disproportionality. By using a descriptive qualitative study method, I will carry out a "content analysis of themes and patterns that emerge from the narrative content" (Polit & Beck, 2008, p. 237).

As a registered nurse with many years of practice in mental health nursing, including intensive psychiatric care unit nursing, I have a wealth of experience with the seclusion of patients in my care. This experience is essential for the chosen method of research, as Knoblauch (2005) asserts, that while focused ethnography is able to focus on specialised

areas of unique organisations, it also assumes an expert knowledge of the areas to be researched.

In my experience, Tāne are involved in episodes of seclusion far more often than other groups of patients. This anecdotal experience is supported by statistical evidence cited elsewhere (El-Badri & Mellsop, 2002; McLeod et al., 2013; MOH, 2006, 2008, 2011, 2012, 2013, 2015, 2016). As stated previously, this research draws on anonymised narratives based on my own experiences of practices of seclusion in acute mental health, which will become the data for analysis. By utilising a descriptive qualitative study method, I will analyse the data to identify major issues that arise in the narratives. Polit and Beck (2008) relate that "narrative analysis focuses on the *story* as the object of enquiry, to determine how individuals make sense of events in their lives" (p. 236). They go on to say that people gain understanding of their world and can then relate this understanding to others by building and relating stories (Polit & Beck, 2008). This idea is also reflected by Riessman (2008), who maintains that narratives aim to convince the audience of accuracy, but that these claims may be questioned by a sceptical audience.

Given that the process of auto-ethnography immerses the researcher and the narrator, this is reflexivity in practice. Altheide and Johnson (1998) define reflexivity in research as being when "the scientific observer is part and parcel of the setting, context, and culture he or she is trying to understand and represent" (p. 285). This means that the researcher takes on two distinctive roles; relating the story and then describing the meaning of that story. Clandinin and Connelly (1998) put it this way, "people by nature lead storied lives and tell stories of those lives, whereas narrative researchers describe such lives, collect and tell stories of them, and write narratives of experience" (p. 155).

3.3 Methodological Considerations when Researching Issues Concerning Vulnerable Populations

When considering which research method to use, there were concerns that interacting directly with tangata whai i te ora would be challenging in many ways. The question that I asked myself was, how could I, as a Pakeha man, meet the cultural and research needs of these Māori mental health patients using either an interview or survey method? I did not think that I would be beneficent or that I could guarantee to be non-maleficent in this situation, even with the best of intentions. Cannon (2006) notes the importance "for any work on risk of harm to others to be seen within the context of broader aspects of the risks that face service users who are negotiating their way through mental health services and recovery" (p. 3). Difficulties arose when I considered the mental status of the individual Māori men I could foreseeably involve in my research, such as, were they psychotic at that time? Were they elevated as part of their diagnosis of bi-polar affective disorder? Were they clinically depressed? What do they remember (of being secluded)? What have they forgotten? Was the situation so traumatic that they cannot talk about it? Other researchers have also highlighted some of these dangers. For instance Cannon (2006) maintains that "it is important to acknowledge that sharing personal stories and experiences about issues of risk, safety and violence can be difficult, even traumatic, for service users" (p. 4). Therefore, directly engaging with consumers of mental health services would have raised ethical issues which could have negative connotations on the participants and the research outcomes.

Given the potential for harm or trauma, it appeared to be inappropriate and potentially harmful to directly engage with tangata whai i te ora on the issue of seclusion in mental health care, either by way of focus group discussions, personal interviews or survey. Therefore, the research design focuses on the researcher's autobiographical experience. By utilising memory work to write focused narratives based on the experiences of a mental health nurse caring for secluded Tāne, the research sought to generate the information

required to attempt to answer the research question without having a detrimental effect on tangata whai i te ora.

3.4 Memory Work

The narratives for analysis were generated using the process defined as 'memory work'. The origins of memory work stem from Frigga Haug and others who developed this method in 1987 as a study of female sexualisation (Koutroulis, 1993). Etheridge (2003) states that the process of memory work is "designed to collect, analyse and construct ideas about life that affect the meaning we give to life" (p. 59). Memory-work was developed in response to perceived shortcomings in traditional scientific methods and to censure the theorisation and misunderstanding of women's experiences in a patriarchal scientific world (Friend & Thompson, 2000). The same concept could be applied to the experience of other marginalised groups, such as those who are secluded in acute mental health services, whose experiences may be similarly under-theorised and/or misunderstood.

Considering possible concerns about using memory to develop a data set, the concept of accuracy or truth needs to be considered. Mollon (2002) proposes that memory can only record the individual's personal experience and that this will naturally be shaped by the person's perceptual biases and selectivity of attention. Therefore, one may question to what extent is the memory an accurate account of the original experience. Holloway and Freshwater (2007) concur with this concern and state that memory is selective, and different features may be at odds with each other. Moreover, Haug and Others (2008) add, "memory itself should be conceived of as contested; it contains hope and giving up; above all, memory is constantly written anew and always runs the risk of reflecting dominant perspectives" (p. 538). These dominant perspectives are likely to have importance however, as according to Crawford et al. (1992), "what is remembered is remembered because it is, in some way, problematic or unfamiliar, in need of review. The actions and episodes are remembered because they were significant then and remain significant now" (p. 38).

3.5 Method

The method undertaken, of using memory-work to generate narratives from the perspective of a mental health nurse caring for Māori men who were secluded in mental health care facilities in New Zealand, followed the process steps outlined below.

Step one: Using a 'brainstorming' method, I reflected on all of the situations in which I had been involved in relation to seclusion of tangata whai I te ora. My role in these situations was as a registered nurse practicing in mental health care between 1993 and 2003, in wards in two separate regional hospitals in New Zealand. I have also read widely around this subject in previous academic work and research. The issues that emerged from this brainstorming exercise were collated into a 'mind-map', a copy of which is included in Appendix B.

Step two: I selected several of the more pertinent of the concepts from my mind map, and drew on these to develop 'triggers' for the memories about which I wrote as exemplars of my experiences from nursing practice. Four memory triggers were determined which were:

- I think that guy is going to nut off
- This ward is jumping today
- This is not my tūrangawaewae
- That is the policy

Step three: Each of the four triggers was used to invoke the writing of narratives based on my recalled experiences of seclusion of Tāne in acute mental health services. These narratives were written according to the 'rules' of memory work method (Friend & Thompson, 2000). These rules are to write:

1. "about a particular episode related to a selected 'trigger' topic.
2. in the third person.

3. in as much detail as possible, including circumstantial and trivial detail; and
4. without interpretation, explanation, biography or autobiography" (Friend & Thompson, 2000, p. 99).

While one of the rules is to include as much detail as can be recalled, in these cases some details were withheld or obscured to protect the anonymity of the participants. In memory-work, Koutroulis (1993) recommends that an important rule is to write in the third person, much like a stranger observing another person's actions and then describing them, as this allows for a degree of detachment and provides opportunities to pay attention to minute detail. Etheridge (2003) supports these ideas where "the distance and perspective achieved by writing in the third person facilitates a freedom of expression" (p. 59).

Step four: Analysis of the narratives as exemplars of my experience.

By utilising an interpretive analysis approach, I examined the memory-work narratives and interpreted the major issues that emerged. The initial analysis was done singularly by me, as are the requirements of the Master's research project. This deviates somewhat from the collective approach to memory-work research as previously done by others (Crawford et al. 1992; Friend & Thompson, 2000; Haug and Others, 2008).

Step five: Checking analysis with a reference group.

To mitigate for bias, broaden the perspective of the analysis and add to its robustness, my initial analysis was shared with and discussed with a 'reference group' of four informed others. This group comprised my two thesis supervisors, a mental health nurse / educator, and a pouwhirinaki staff member based in a local district health board Māori Health Service.

3.6 Ensuring Quality of the Research

Discussion with the reference group helped provide an element of reliability to the research. Dempsey and Dempsey (2000) outline two areas of concern related to reliability. The first concern is the accuracy of the information gathered. The second is related to the data gathering instrument, which in this research is myself. My experience in the area of acute mental health nursing and the deep understanding that I have of this nursing practice lends me a certain credibility / mana in this area. Validity in qualitative research is closely linked to credibility (Borbasi et al., 2004). Given the statistic reported earlier concerning the higher rates of seclusion of Māori men in New Zealand mental health services, I feel that there is work to be done in exploring why these disproportionate rates of seclusion occur. I am sincere in my intentions. I care about this issue and I will say what needs to be said from the point of view of a health practitioner and maintain a sense of reality in this research.

CHAPTER 4 FINDINGS

4.1 Introduction

This chapter presents narratives that have been written using the methods outlined in the previous chapter. These stories were originally developed from a mind-mapping reflection on the concept of seclusion of Tāne in acute mental health services (Appendix B). From this, triggers were identified for the writing of four memory stories based on the experiences of the researcher (Jordon). These narratives, evoked by each trigger, are presented below as the 'data' of this research.

4.2 Memory Narrative One: I think that guy is going to nut off

Jordan is a 40-year-old male registered nurse with 3 years' experience in acute mental health nursing services. He is now currently employed elsewhere part- time as a registered nurse, and continues employment as a casual pool nurse in mental health services. Today Jordan is scheduled to work a Saturday afternoon shift in the local acute psychiatric unit (APU).

On arrival at work, Jordan is told by Geraldine (morning shift manager) that, as John (senior RN) has called in sick at the last minute, Geraldine would like Jordan to manage the afternoon shift in the APU, and he would be working with Jenny (24 years of age with one year's experience in APU) and two care associates. Geraldine has been trying to secure an extra registered nurse staff member for the PM shift to no avail, and hands over this task to Jordan. Jordan expresses his concerns that, as he is not currently updated in 'calming and restraint' and neither is Jenny that this could cause problems during the shift if restraint was necessary. Jordan is told that "this is the situation we are in and we need to make the best of it – it is the weekend and the ward is settled (5 patients currently admitted) and you should have no problems in this regard". While Jordan is not satisfied, he accepts this from his senior staff member.

The unit is normally staffed by three registered nurses and two care associates. Additionally, at least two of the three registered nurses should be skilled and have current

qualifications in the interventions related to calming and restraint of patients. It is against hospital policy for staff who are not currently qualified to take part in a restraint situation. That is for the safety of the staff member and the patient, and others in the environment.

The APU is designed to accommodate eight patients and there is one seclusion room adjoining the unit. It is a high security unit, which patients and visitors may only leave or enter on staff assessment. Exterior doors are locked (keys are held by registered nurses) as are some interior doors e.g. bathroom, drug room, etc. The nurses' office is locked and has a large window through which most of the ward is visible. Immediately outside this office is a nurse's station with a large counter that separates nurses from patients to some extent. The seclusion room is directly adjacent to this nurse's station and office.

So Jordan's priority is to secure an extra registered nurse but after 45 minutes he has exhausted all possibilities without success. The shift progresses uneventfully until at 1700 hours…..

The phone rings – it is Horiana (female registered nurse) who is coordinating the community assessment team (CAT). Horiana advises that she will be bringing an admission to the unit. She describes Alby as a 38-year-old Māori male with short history (6 months) of diagnosis of paranoid schizophrenia. Alby had been arrested by the police in a suburban house, where he had been verbally threatening and abusing his neighbours. He had smashed windows and furniture in the house, however had not assaulted anyone. The police were called by a concerned neighbour and, upon their arrival, Alby assaulted one of the police officers. He was arrested, handcuffed and taken to the police station where the CAT were called to assess him. It appears that Alby has stopped taking his anti-psychotic medications and is experiencing an exacerbation of his paranoid schizophrenia. He is assessed as such and the plan is to admit him to the local unit for ongoing assessment and treatment under the Mental Health (Compulsory Assessment and Treatment) Act, 1992.

Jordan is concerned about the level of staff (and their expertise) and shares this with Horiana. Horiana assures Jordan that she will be with the police and that her associate, Brian (registered nurse with 25 years' experience) would also be there. Horiana states that Alby is

psychotic and elevated to the point of heightened irritability. It would be prudent to be prepared to seclude Alby if deemed necessary on admission. Jordan attempts to locate the on-call psychiatrist who is “not available at this time”. Jordan also attempts to contact Geraldine to ask for support without success.

The bell rings – it is the new admission. Jordan opens the door and is faced with two police officers who are physically restraining Alby who is handcuffed. Alby is 38 years old and is of Māori ethnicity. He is 195cm tall and weighs 110 kilograms. He appears physically fit and carries very little adipose tissue on his body. His head is shaved of all hair. He has several teeth missing and is heavily tattooed – predominantly with insignia of the local gang and Māori designs and patterns. His tattoo’s cover all parts of his body. He is dressed in gang regalia including leather trousers and jacket adorned with insignia also. He appears extremely agitated and is struggling with the police officers who are backed up by a third police officer (dog handler) and police dog. Behind them are Horiana and Brian. Jordan assesses this situation and makes the decision that Alby should be immediately secluded on admission and thinks “I think that guy is going to nut off – let’s seclude him “.

Jordan has prepared the unit for this event. All other patients had been taken to the day room at the end of the unit and are being cared for by Ana and Sheena, the two care associates on duty. Jordan has also prepared the seclusion room for this contingency. He has on hand, prepared liquid anti-psychotic / sedative medication and intra-muscular preparation of the same medication for injection if required.

Alby is escorted into the seclusion room by the three police officers followed by Jordan, Horiana and Brian. Jordan offers Alby liquid anti-psychotic medication, which is knocked to the floor by Alby. This is repeated twice more. After refusing oral medication three times, Alby is restrained by the three police officers while Jordan administers IM injection of anti-psychotic – sedative medication – difficult with a moving target and requires two attempts to successfully administer. Alby is sat down in the furthest corner from the door as Horiana, Brian, Jordan leave the room (in that order singularly). Jordan waits at the doorway as the police officers remove the handcuffs from Alby’s wrists. One of

the police officers instruct Alby to remain seated as the police officers also leave the seclusion room singularly and, as the last officer leaves, Alby struggles to his feet and attempts to follow the last officer as Jordan closes the door and locks it. This is at 1800 hours. During a short de-brief with the staff involved and the police officers, plans are made for Jordan to contact the police for support when the next, and subsequent, room entry is to be made i.e. 2 hourly. Police support is due to the lack of staff in the unit who are qualified to do this.

During the next 1.5 hours Alby is assessed every 10 minutes as per policy. During this time Alby appears to calm down and at times appears to be sleeping on his bed. At the pre-arranged time Jordan contacts the police and is told that they are too busy to be of assistance. Jordan is forced then to make the decision not to make the two hourly room entry at 2000 hours and then again at 2200 hours. This situation is most unusual and is against the legal protocol for seclusion. Jordan's rationale is that it would be dangerous for staff and patient given the potential for violence.

At 2300 hours, the night staff arrive who can facilitate a room entry on arrival and within safety parameters i.e. there are three registered nurses who are currently qualified in calming and restraint practice. A room entry is made without the requirement to restrain Alby. Alby asks if the police are present and is told no. Alby appears relieved by this "those fucking pigs just wouldn't fucking listen, pricks fucking pricks". Alby complies with all instructions from staff. He is given food and a hot drink. He is offered oral medication and takes this of his own volition. While still presenting as agitated, Alby presents no threat to staff.

Jordan shares with staff his mixed feelings related to not having made room entries where he should have done. Jordan is reassured by his colleagues that he did the right thing. Subsequently room entry is made 2 hourly overnight without any untoward behaviour on Alby's part. On assessment by a psychiatrist at midday the next day, Alby is removed from seclusion and interacts appropriately in the ward environment. He is discharged to the community two days later.

4.3 Memory Narrative Two: This Ward is Jumping Today

Hemi was admitted to the acute psychiatric unit (APU) with drug-induced psychosis. This happened after a party where Hemi was introduced to “P” (pure methamphetamine). At the time Hemi, a Māori male, was 22 years old and of no fixed abode. He had left the family home 2 years before. Hemi was known to mental health services as he was diagnosed with schizo-affective disorder at the age of 18 years and had been admitted to APU several times since he was diagnosed.

At the party, under the influence of “P”, marijuana and alcohol, Hemi became increasingly violent and abusive towards people and property. He assaulted several people with a beer bottle and smashed tables and chairs and windows. The police were called and Hemi was non-cooperative to the point where several police with dogs had to resort to tasering Hemi to then be able to handcuff and arrest him. He was taken to the police station where community mental health services were called and Hemi was admitted to the APU. Here he was immediately placed in seclusion where he spent the following 4 days in various stages of psychosis. While Hemi has been admitted to the ward on previous occasions, this is his first experience in seclusion. He experienced visual and auditory hallucinations and appeared to be paranoid on assessment by staff. Hemi was also physically violent. During the first two days in seclusion he repeatedly threw himself at the door of the seclusion room with such force that he moved the hinges of the seclusion room door by approximately 5 centimetres and sustained a fractured scapula which was discovered days later, after he came out of seclusion. It is one day after Hemi was transferred from seclusion into the main ward environment. The APU is an 8-bed unit with two seclusion rooms adjoining it. This facility was built in 2002 and considered ‘modern’ in its layout.

The ward is full at this time. The patients:

Hemi is a 22-year-old male with drug induced psychosis and a diagnosis of schizo-affective disorder. He has a potential for violence.

Ella is a 38-year-old female diagnosed of bipolar affective disorder (BPAD). She has the potential for self-harm (sharp utensils).

Makere is a 78-year-old female. She has been diagnosed with major depressive disorder. Makere tends to isolate herself in the ward environment and does not communicate with any other person including staff unless responding to instructions.

Alison is a 29-year-old female. Alison has a diagnosis of BPAD and is currently elevated and displaying sexual disinhibition. She is seductive to men (patients and staff). Alison is dressed in a short denim mini skirt and revealing halter top. Her language (including her body language) is highly provocative and suggestive.

Tama is a 38-year-old male who is diagnosed with BPAD. Tama is elevated, grandiose and is displaying predatory behaviour, especially with Alison. Tama has a history of and a potential for violence and AWOL.

Helena is a 67-year-old female with a diagnosis of dementia and paranoid schizophrenia. Helena has a history of stroke and has difficulty communicating with others. Helena is a demanding woman with a potential for violence if her needs are not met.

Joanne is a 44-year-old female with a diagnosis of panic disorder / anxiety. Joanne has a history of and a potential for self-harm (razor blades – lit cigarettes, etc).

Alexia is a 22-year-old woman, diagnosis of narcissistic personality disorder. She has a history of constant demands and badgering behaviour.

There are three registered nurses on duty. Xanthia is the senior nurse. She is Pakeha and has 25 years of experience in this field of nursing. Jake is second in charge. Jake is Pakeha and has 10 years' experience. Jordan is the third registered nurse. Jordan is also Pakeha and has 6 months' experience in this field. There are also two care associates on duty. They are Alan and Tracy who are both Māori. Their responsibilities are to take care of the ward environment and to take instructions from the registered nurses when required.

This is a typical afternoon shift. That is, the maintenance of a low stimulus environment is the overall goal which is being achieved until….

At 2030 hours a message comes from the community mental health team concerning a pending admission. This is Zeb, a 30-year-old Pakeha male diagnosed with obsessive compulsive disorder. Fifteen minutes later, at 2045 hours, a further message comes from the

non-acute ward which adjoins the APU regarding a patient being transferred to APU. It is John, a 56-year-old Pakeha male with a diagnosis of paranoid schizophrenia and the potential for violence. John has assaulted a staff member and is to be secluded.

As the APU is already full the decision is made to open the other seclusion room which is to be used as a non-seclusion space with the door remaining open.

Since Hemi was the last person in the ward to be in seclusion, he is transferred back into that open seclusion room.

After admission of the two new patients, there is a "situation" in the main ward area involving the new admission, Zeb, who is elevated in mood and is threatening those around him. He is transferring his anger at the reasons surrounding his admission onto those in the current environment, particularly Ella with whom he has a long running relationship (his ex-partner who broke off with him 2 years before). Xanthia is working one to one with Zeb in attempts to de-escalate his anger. Zeb's elevation in mood leads to an unstable ward environment.

Joanne and Alexia are both vying for the attention of Jake. Joanne wants to access the property room to get her hair drier and Alexia is demanding that Jake help her to contact her lawyer. Both patients are irritable and impatient. Jake is trying to cope as best he can. However, he is dismissive of Alexia (body language – bats his eyelids and turns away from her) and she responds by slapping him on the face "don't ignore me you bastard". Joanne grabs Alexia to prevent further harm but ends up in a struggle and is also assaulted by Alexia. Jake intervenes physically and verbally and is struggling to quell this situation. Helena is watching this and encourages the fight verbally screaming "get into the bitch -she fuckin' deserves that – smack her one for me while you're at it!!!!!"

Alison is talking to Hemi, making conversation such as asking "Do you think I am sexy?" "You are a rugged looking man". Alison exposes her breasts to Hemi and jumps onto him on the settee in the lounge area. Hemi is not interested and pushes her away. Tama witnesses this and he attacks Alison from behind and pulls her into his bedroom. Here he

sexually assaults her. Alison is screaming “fuck off you cunt! – Get off me – get off me”. Hemi has followed them both into the bedroom and he physically attacks Tama, “get off her you dirty bastard”. A one to one fight breaks out between Tama and Hemi.

Makere is sitting in the corner of the lounge on a chair. She appears afraid and is cowering with her head in her hands and she starts a high-pitched wail for her long dead husband. “AAeeee Tamati save me - save me……”

Helena is close to Makere and is shouting at her, demanding repeatedly that she “shut the fuck up you bitch!!!!!”

Jordan, who is extremely agitated at the sudden turn of events and who has been trying to protect Makere and Helena from others, with support from Alan and Tracy, under instruction from Xanthia rings the emergency siren. At this point, extra staff from the non-acute unit arrive and over the next 45 minutes all staff manage to restore some semblance of order.

Alison who is “pissed off” at being rejected by Hemi, accuses him of sexual assault and reports this to staff. Tama supports Alison’s story (states that he witnessed the assault) and Hemi becomes angry at this accusation and is escorted by John into his room to give him time and space to calm down.

These events and the transfer to the seclusion room (albeit open) have a negative impact on Hemi, where he is exposed to recent memories and events. He experiences “flash-backs” to his drug induced psychosis and becomes irritable – inconsolable and violent to property and people. Hemi is re-secluded.

4.4 Memory Narrative Three: This is not my Tūrangawaewae

Kahu is a Māori male aged 64 years. Kahu was diagnosed with Bi Polar Affective Disorder (BPAD) at the age of 48 years. He was always thought to be a "bit different" i.e. a bit of a "hard case" by his whānau and friends but never thought to be dangerous by them. In fact, he was thought to have some spiritual prowess by some members of his whānau. Kahu had spent a lot of time with his grandparents as a child growing up and had learnt to speak te reo Māori and his whānau's whakapapa (genealogy) from them. He is the elder kaumatua when there is a call for representation of the whānau i.e.at whānau gatherings, pōwhiri, tangihanga, weddings, etc. Kahu is single and lives in a small house on the local marae. He is much loved and respected by his whānau and is cared for by all members and other residents on the marae who bring him kai and make sure that he is looking after himself generally. His primary care person is his older sister, Georgina, who lives with her husband in the house next door to Kahu. Kahu loves spending time with tamariki and sharing his knowledge of tikanga Māori with them, as well as all members of his whānau who want to listen. He has identified Hemi, who is his nephew, as his successor in carrying on the traditional role of kaumatua after Kahu "goes".

Kahu is under section 30 of the Mental Health (Compulsory Assessment and Treatment) Act, 1992, which means that he is supported in his home by a community mental health nurse who is called Alex. This section of the act means that Kahu must accept assessment and treatment as prescribed by his psychiatrist. Kahu's relationship with his mental health team is seen as an agreeable partnership, where Kahu understands why he is cared for in these ways including prescription of mood stabilising medications and regular visits by Alex.

During the last 6 months, Kahu has been acting increasingly out of character according to Georgina. While he has always had periods of depression and elation (his BPAD) these have become more frequent and more extreme. He has started to shout at whānau members and to verbally abuse some of them too. He is out in his garden at two in

the morning and is sleeping during the day, which he has never done before. He lashed out with his hand at Georgina recently when she was visiting him. It was when they were discussing an upcoming whānau anniversary. He is sometimes inappropriate in his speech, i.e. he makes sexual remarks about the women in his life. He is also sometimes found in various stages of undress, both at home and in the community. Kahu has estranged himself from his whānau and "does not want to see any of them". He was brought home by the police the previous week. They found him in the city centre in his underwear and singlet – he had been shouting at the sky and preaching to passers-by. It was at this time that a complaint to the police was made by the mother of a young woman (18 years old) who Kahu had made suggestive and sexual approaches toward.

Kahu was assessed in his own home by Alex. At this assessment Kahu presented in a bizarre fashion. He spoke rapidly and referred to himself as "the almighty". He exhibited delusions of grandeur and religiosity. He was assessed as sexually disinhibited. After consultation with Kahu's psychiatrist the decision was made that Kahu would be admitted to the local mental health inpatient unit for further assessment and treatment for his and others' safety.

Kahu was admitted to the acute mental health unit for assessment and treatment under the Mental Health (Compulsory Assessment and Treatment) Act, 1992. This unit (built in early 21st century) is designed especially for patients who present as acutely unwell. It is a 10-bed unit with two separate seclusion rooms. The unit is locked and patients are not able to leave or enter without assessment of unit staff. Other rooms, i.e. bathroom, nurse's station, drug / clinical assessment room, are also locked for reasons of safety. The unit is clean with white walls. There is little or no stimulation in this unit.

Kahu's mental state continues to deteriorate over the next two days. His behaviour is increasingly bizarre. He is increasingly sexually disinhibited which is evidenced by his repeated sexualised comments e.g. "those luscious student nurses – they love me!! They want me, don't they?" and advances to female staff and patients of a sexual nature. He has

been found on several occasions in various stages of undress and naked twice. He becomes more and more aggressive towards all people, lashing out at others without warning. His speech reflects continued delusions of grandeur and religiosity.

The unit is usually staffed by three registered nurses and two care associates, and this is the case on the day of Kahu's seclusion. John (senior registered nurse) is 45 years old and Pakeha – John has 20 years' experience in mental health nursing. Emma (registered nurse) is 55 years old and is Pakeha – Emma has 10 years' experience in mental health nursing. Jordan (registered nurse) is 38 years old and is Pakeha – Jordan has 6 months' experience in mental health nursing.

Given Kahu's deteriorating mental state, John and Emma make the decision to seclude Kahu at 2000 hours for the safety of others related to his aggressive behaviour and his physical lashing out at them, and to protect his dignity (sexual disinhibition). Staff in other parts of the unit are informed of this decision and are on stand-by should Kahu need to be restrained. Kahu is informed of this decision and appears nonplussed "Do what you want I don't care – you have no effect on me – I am the almighty God and you are insignificant to me". Kahu is led quietly into the seclusion room.

The seclusion room measures 6 metres X 6 metres. The walls are painted white. There is one door which is heavily metal clad and is lockable by staff from the outside. The door has a window to allow for constant (if required) observation of the patient. From the inside this window affords the patient a view of an unoccupied foyer which is also painted white. In the seclusion room there is a partially obscured en-suite toilet and basin, both constructed of rounded stainless steel. While a direct view of the patient is not possible in this area, a reflective stainless steel panel allows detection of movement. There is a bed in one corner which consists of a wooden base which is fastened to the floor, a mattress and a pillow. The blankets are specially woven so that they cannot be unravelled and used for self-harm. There is no other stimulus in this room. There are microphones in the room, which allow for detection of small movements and the sound of breathing.

While Kahu was initially compliant with being secluded, he becomes increasingly distressed (at 2200 hours) at this situation and pleads to be let out. He is wailing "AAAEEEEEE let me out of here, I can't breathe – help help help aaaeeee. Noooooo – let me out" and speaking in te reo Māori, saying karakia and singing patches of waiata and hīmene (hymns). "Where is my tohunga? This is not my turangawaeawae (my place to stand confidently) -somebody please help me." There is no cultural support available to Kahu and he is left on his own. He starts to hit his head on the walls and on a corner of the wooden bed base – drawing blood.

A room entry is effected by a team of five registered nurses. Kahu is offered liquid medication (sedative) and he refuses stating "you are trying to poison me". Several offers are made to him and each is refused. Finally, Kahu is restrained by the team and is administered with a sedative medication via intra-muscular injection which has good effect and Kahu calms down eventually and is again left alone in the seclusion room.

During a debriefing discussion amongst the RN's. Jordan asks, what sort of support are we able to provide for Kahu from a cultural perspective. John responds – "there is little we can offer him. We have no kaimanaaki (he resigned two months ago and no replacement has been found) and I certainly do not know how to help him in this way". His family are not interested given his recent behaviour towards them. Georgina is not happy with Kahu being admitted to the unit – she won't visit however as she says that the unit "frightens her". She is also expressing feelings of resentment toward Kahu, given his recent changes in behaviour. So we must just continue to care for him as per seclusion policy.

During the next 48 hours Kahu's mental state fluctuates and he remains in seclusion. He continues to call for his tohunga and becomes extremely agitated at times which requires further restraint and administration of sedation. Contact is made with Georgina but she is reluctant to enter the unit so does not visit her brother. No other whānau are willing to visit either.

Jordan attends morning handover on day three of Kahu's admission and is informed…

Kahu, 64 year old male. Diagnosis of bi-polar affective disorder. Has been in seclusion for the last three days. At 0100 hours Kahu appears to have experienced a myocardial infarction and despite all efforts to resuscitate him, he died this morning. One of the nurses on duty makes the comment that "it seems that he died of a broken heart".

4.5 Memory Narrative Four: That is the Policy

It is 1993. The setting is a mental health inpatient unit, acute ward, which is laid out in an 'L' shape. The vertical part of the 'L' is a corridor with 5 bedrooms on each side and a bathroom and toilet facility (one on each side). The bedrooms contain a single bed and bedside table. The bedroom doors are wooden and each have a small window to allow for patient observation as required. The base of the 'L' is a common area with TV, kitchen and dining area. There is a nurse's office in this area also. This is an old and poorly maintained building with thin carpets and paper and paint peeling in places. The area smells heavily of tobacco smoke as, while the smokers room / lounge is a room directly at the top of the 'L', smoke has permeated the whole facility over the twenty years since the ward was built.

The staff on duty at this this time include Elly, who is the charge nurse. Elly is 30 years old and is from Coventry, England. She has lived in New Zealand for 3 years and has been employed at this unit for the last 12 months. Elly's second in charge is John. John is 55 years old and is originally from Edinburgh, Scotland. He has been living in New Zealand for the last 10 years and has been employed at this unit for the past 8 years. The other staff nurse on duty is Kare, who is 23 years old and is Māori of Ngati Kahuhgunu descent. Kare has been employed at this unit for the past 6 months. She is the preceptor (assigned nurse) for Jordan who is a male student nurse aged 35 years. Jordan is New Zealand Pakeha and has links with Ngati Kahungunu. This is Jordan's second week of student practicum at this unit.

Hand over from night duty staff to morning staff on the day of the incident;
Matty is 24 years old and is Māori of Ngati Kahungunu descent. Matty is under the Mental Health (Compulsory Assessment and Treatment) Act, 1992 on a compulsory treatment order in the community. He was diagnosed with paranoid schizophrenia at the age of 19 years. Matty is thought to have been non-compliant with his anti-psychotic medication in the community and this is thought to be the reason for the exacerbation of his schizophrenia. He was found by his mother (Karina) at 0100 hours three days ago, after he attempted suicide by hanging in his parent's garage. Karina was the person who cut him down from the rafters. Matty lives on a local marae with his whānau. He is an arts student at a local polytechnic.

Matty was admitted to the unit via ED where he was assessed, and it is thought that he may have been deprived of oxygen for some time. Matty has sustained haematoma (bruising) to his neck. He is neurologically stable however. His vital signs are within normal range. There is also evidence of self-harming with scarring to his wrists and ankles and breast tissue which appear to have been caused by cutting. Matty has had relationship problems with his partner, Carl, who has recently left Matty and is now with a new partner.

Matty is currently admitted to the acute mental health ward environment and is under 10-minute nursing observation. This requires the registered nurse to locate and observe the patient at least every 10 minutes to ensure their safety. On admission to unit, Matty appeared dishevelled and unkempt. He remains bizarre in his behaviour i.e. stilted gross body movement – responding to unseen stimuli (auditory and visual). He presents with a flattened affect and remains intent on suicide i.e. suicidal ideation "I just want to die", "who the fuck does she think she is cutting me down" (referring to his mother), "Would serve that bastard right if I died – it's his fault" (referring to his ex-partner).

The incident involving Matty occurred at the end of the morning shift. This is a difficult time as staff are involved in shift change. Throughout the morning shift Matty had been vocalising a need to be discharged from the unit. Matty was agitated and verbose at times. Many one-to-one interventions were utilised to dissuade him from this with good effect. However, at 1500 hours Matty broke a coffee mug and threatened to self-harm with one of the shards if his needs were not met i.e. to be discharged immediately so that he "can see his ex". The emergency ward alarm was activated and staff qualified in calming and restraint respond in seconds. All other patients were moved away from this incident by a care associate for their safety. Elly, the charge nurse, instructs him to put the cup down and Matty refuses – instead reiterates his demands to leave and see his ex-partner. After 15 minutes of negotiation with Elly, Matty agrees and puts the coffee cup shard on a table, bursts into tears and crumples into a heap on the floor.

Kare, who has formed a therapeutic alliance with Matty as she has Iwi connections with him, offers to intervene by having a one-to-one kōrero (talk) with him in an attempt to

further de-escalate the situation. Elly responds by stating that “this situation is beyond that (i.e. talking) and this man needs to be secluded for his own safety and that of the other patients and staff”. The ‘team’ move in – four staff restrain a limb each on the floor with Elly taking lead role and responsibility for Matty’s head. Elly also retains responsibility as the person who is verbally communicating with Matty. Elly attempts to calm Matty, reminding him of who she is and encouraging him to cooperate and move freely into the seclusion room. As restraint takes place, Matty begins to struggle violently and scream at the staff. A sixth staff member then administers an intra-muscular anti-psychotic / sedative injection. The staff on each arm utilise a “thumb-lock” which is designed to cause pain to the patient and therefore gain control of the patient’s actions. Matty (still struggling and screaming) is then lifted and taken to a seclusion room.

Matty is sat on the bed by the restraining team who one by one leave the room. Elly is the last staff member to do this and locks the door behind her. Matty, who appears to have relented, puts a blanket over his head and body and remains seated on the bed visibly shaking.

Shortly afterward, with Matty in seclusion, there is a debrief meeting among the staff involved. This is to allow individuals to discuss their feelings around this event. This is also an opportunity for staff to reflect on the effectiveness (or not) of their efforts and to suggest future methods.

During the debrief, Kare is very upset and voices her concerns that she was not given the opportunity to korero with Matty. That is, he had appeared to calm down and was compliant with instructions when he was “taken down”. Kare questions why Matty was secluded given his cooperation. Elly’s response was that “he should be treated like anybody else. I don’t care about your tribal relationship with him; it hasn’t helped so far has it? As far as I am concerned, you have been spending far too much time with him. What about your other patients?” John is supportive of Elly and iterates Elly’s statements.

Jordan is also distraught at the events that he has just witnessed and while he does not feel confident to speak at the debriefing, at the end of the shift he talks with Kare and

expresses his concerns with her and asks “Why would they restrain, medicate and seclude someone who appears to be cooperative?” Kare can only agree with Jordan but does say that “It is sometimes better to seclude a person rather than risk harm to themselves or others.” Jordan detects a hint of acquiescence in Kare’s voice. This event becomes one of the driving forces in Jordan’s aspiration to become a mental health nurse in his future.

4.6 Summary

These narratives have created realistic scenarios based on recollections and interweaving of several situations as remembered by a registered nurse in practice. The detailed accounts of these events have attempted to evoke a picture which may be analysed to establish the underlying reasons why the seclusion events occurred and then to consider how, in future, these events may be reduced or avoided completely.

CHAPTER 5 ANALYSIS

5.1 Introduction

In this chapter, each of the narratives will be analysed in turn. By utilising an interpretive analysis approach, the memory-work narratives will be examined and issues that emerge will be identified.

5.2 Memory Narrative One: I Think That Guy is Going to Nut Off

The writing of this narrative was triggered by the phrase, "I think that guy is going to nut off". This analysis examines the memory narrative about Alby, a Māori male aged 38 years. He was diagnosed with paranoid schizophrenia and had been arrested by the police in the community after assaulting one of them. Alby had been verbally abusive in his neighbourhood and had destroyed some property prior to his arrest. He was assessed by the Community Assessment Team (CAT) and admitted to the local Acute Psychiatric Unit (APU) where he was secluded on admission.

On analysis of Alby's story, it appears that one of the key issues surrounding Alby's seclusion event in the APU was the perception of the staff of that unit that Alby was potentially dangerous and a physical threat to them and others in the APU environment, including other patients. It also appears that Alby's relationship with the police, and his behaviour in their presence, exacerbated this perception and lead to the behaviour which precipitated his seclusion. These conclusions are drawn from several parts of the narrative.

On Alby's admission, Jordan is described as faced with the arrival into the unit of a tall muscular man who looked physically fit and strong. Alby is a powerful man who has demonstrated that he is capable of destruction to property and physical and verbal assault. His outward appearance and dress is viewed as confrontational and frightening to some people. His gang affiliations as evidenced by his body tattoos and his gang insignia adorning his leather clothing, potentially evoking perceptions of aggression. When Alby arrives at the APU he is described as being extremely agitated and resisting police intervention. This is

what causes Jordan to make the assessment, “I think that guy is going to nut off – let’s seclude him”. Consequently, Jordan makes the decision to seclude Alby.

Earlier that day, Alby was damaging property and verbally abusing individuals, described in the narrative as smashing windows and furniture and verbally threatening and abusing his neighbours. It is important to note that he was not being physically abusive to anyone at the residence until the police arrived, after which he assaults one of the police officers. It is also noted that Alby had ceased taking his medication. This has caused him to experience changes in his perception of the world around him and to behave in reaction to these altered perceptions. Alby may have been responding to unseen stimuli, which may affect any of the senses, although most often the auditory and visual pathways in paranoid schizophrenia. These are typical signs and symptoms of paranoid schizophrenia and may have caused his aggressive behaviour. One of the many challenges faced by mental health nurses is to accurately assess a person’s alteration in mental health as opposed to their behaviour related to their personality.

Perceptions of dangerousness by the staff are further heightened as Alby is being restrained by two police officers, with a third officer and police dog in support. The fact that Alby is handcuffed also indicates a potentially dangerous individual. Also, that the decision has been to give Alby a sedative / anti-psychotic drug to be able to manage the situation reflects his ‘dangerousness’ as well. This assessment of dangerousness is further exacerbated by the vulnerability of staff. That is, they are low in number and, according to the local hospital policy, the staff on duty at this time are not able to physically restrain a patient and this leaves few options to them. Police presence, while helpful initially to the nursing staff (but, apparently not to Alby), is not an expected part of intervention in the APU and is not to be relied upon. In the narrative, the suggestion by Horiana, (a Registered Nurse working with the Mental Health Community Assessment Team) that seclusion might be necessary, may also have impacted upon the decision made by Jordan to seclude Alby, providing him with support for that decision. The unavailability of support from other staff members may also have been an essential part of the reason for secluding Alby. The on-call psychiatrist is

unable to be called to add a medical opinion and legal support in the seclusion decision made by Jordan, and no senior nursing staff are contactable for advice and support.

After staff leave the seclusion room, the door is locked and Alby is left on his own. It is noteworthy that he remains relatively calm over the next 90 minutes while staff do regular assessments. While the police had initially offered to return at two hourly intervals to support the unit staff, this did not occur. Without this back-up, and given Alby's demonstrated potential for verbal and physical assault, Jordan makes the unusual decision not to make two hourly room entries, even though this regime is required nursing practice for patient safety under the Mental Health (Compulsory Assessment and Treatment) Act, 1992 (The Act). This causes consternation in Jordan who appears to be in a dilemma, weighing up his concerns for staff and patient safety against Alby's rights to proper care under The Act.

At the beginning of the night duty, with more experienced staff having come on duty in the unit and now available to assist, an entry is made to Alby's seclusion room with no restraint of Alby being required and a relatively calm environment is maintained. Alby's comments when he hears that the police are not present, "those fucking pigs just wouldn't fucking listen, pricks fucking pricks", seem to indicate an historical animosity in his relationship with them which could account for his earlier aggressive behaviour in their presence. At the time of this entry into his seclusion room, Alby presents to mental health staff as being unwell mentally, but does not present any threat to staff.

Summary.

In the analysis of Alby's story, it transpires that some assumptions were made regarding Alby's potential for violence. While he appeared to be a dangerous individual to the staff of the mental health unit, the changes in his demeanour when the police were present seem to indicate historical animosity towards them, which may account for his violent behaviour at that time. Moreover, changes in his mental state, described as an exacerbation of his paranoid schizophrenia, may well have been managed safely (and without the need for seclusion) had the police not been involved. However, the staff

resources in the unit at the time of Alby's admission, such as the low staff numbers, their relative inexperience and the lack of support, were also contributory factors which impacted upon the decision to seclude Alby and the decision not to make two hourly room entries. Jordan saw no option, faced with a patient he assessed as violent and dangerous, but to make the decision to leave Alby in seclusion for several hours until the arrival of the registered nurses at 2300 hours for the night duty.

5.3 Memory Narrative Two: The Ward is Jumping Today

The writing of Narrative two was triggered by the phrase, "the ward is jumping today". This analysis examines the memory narrative about Hemi, a Māori male aged 22 years who was of no fixed abode. Hemi had been diagnosed with schizoaffective disorder four years prior to the incident described, and he had been well known to the local mental health services since that time. The narrative relates to events that unfolded after Hemi experienced a drug induced psychosis and his subsequent admission into an acute psychiatric unit (APU) and being put into seclusion in that unit.

On analysis of the narrative describing Hemi's experiences, the issues surrounding his admission to the APU and his two seclusion experiences are reflected to be multi-faceted. These conclusions are drawn from several parts of the narrative. Hemi's first seclusion experience was related to his psychosis and his violent and abusive behaviour in the community when under the influence of pure methamphetamine (P), where he "assaulted several people and smashed tables, chairs and windows". This aggressive behaviour continued upon his arrest by police, requiring "several police officers (with dogs) who had to resort to tasering Hemi in order to then be able to handcuff and arrest him". Hemi's psychosis continued for several days after this. He was "immediately placed in seclusion" on admission to the APU and continued to exhibit violent behaviour whilst in this environment, that is, "repeatedly throwing himself at the seclusion room door", which moved the heavily clad door five centimetres on its hinges and caused Hemi to sustain a fractured scapula (shoulder blade). It is fair to say that these events may well have given staff cause to be wary of Hemi.

The issues surrounding Hemi's second seclusion experience appears to be more complex than his first experience but related to it. The narrative reveals that on this day the APU was at full capacity, that is, all beds (apart from the two seclusion rooms) were occupied. As this is an acute unit, the patients are mentally unwell, with a wide range of serious mental disorders / diagnoses, many of which have the potential to lead to such behaviours as violence, self-harm, sexual disinhibition, and constant demanding and badgering.

This type of environment is always potentially volatile and dangerous. The core nursing objective in the APU is to maintain a low stimulus environment. On this day, it appeared the objective was being met until two separate events impacted negatively upon an otherwise calm environment. These events are the admission of two new patients to the APU, Zeb, a 30-year-old Pakeha male diagnosed with obsessive compulsive disorder and John, a 56-year-old Pakeha male diagnosed with paranoid schizophrenia. John has assaulted a staff member in the non-acute unit and is to be secluded.

These two admissions require the moving of patients already in the unit and, while one seclusion room is occupied by John, Hemi is moved into this room with the door left open, on a 'last out – first back in' basis. This move seems to be one of the reasons for Hemi's seclusion soon after.

The other admission, Zeb, is "elevated in mood and threatening those around him". This requires acute one to one intervention by Xanthia in an attempt to "de-escalate his anger". This one to one interaction has the effect of reducing the availability of staff numbers to care for other patients, which is evidenced by several outcomes. First, two patients (Joanne and Alexia) are demanding Jake's attention, and, when he is dismissive of Alexia when he bats his eyelids and turns away from her, she assaults him physically and slaps him on the face. Joanne attempts to restrain Alexia and is also assaulted by her. This is further escalated by Helena who verbally incites more fighting.

The situation means two staff members are dealing with four of the nine patients who are not in seclusion. This leaves Jordan, who is working with Alan and Tracy, with the

responsibility of keeping the other patients safe in this highly volatile and capricious environment. This creates opportunities for some patients to take advantage of the situation, such as Alison making sexual advances toward Hemi who is not interested and pushes her away. Tama, who has been unsuccessfully preying on Alison, takes the opportunity (where all staff are distracted in one way or another) to sexually assault her in her bedroom. Hemi is protective of Alison as he physically attacks Tama, telling him to "get off her you dirty bastard". This leads to a physical fight between Tama and Hemi. These events frighten Makere and she wails for her deceased husband. Helena verbally abuses Makere, saying "shut the fuck up you bitch". To call this situation volatile would be a huge understatement and it has a negative impact on a junior staff member, Jordan, who struggles to cope. Jordan activates the emergency procedure, which mobilises staff from elsewhere in the psychiatric unit and it takes three quarters of an hour to settle the unit.

This myriad of highly stressful situations appears to be the reason that Hemi is secluded a second time. He is wrongly accused of sexual assault and is escorted by Jake into his room to give him time and space to calm down. However, this has the opposite effect on Hemi, where he is exposed to recent memories and events. He regresses to his psychotic state and becomes irritable, inconsolable and violent to property and people, leading to his re-seclusion.

Summary.

The analysis of Hemi's story reveals several contributing factors to his seclusion events. His first seclusion event was on admission to the APU and the reason he was secluded was that he was in a drug-induced psychosis related to his first experience with pure methamphetamine. On this occasion, he presented as physically violent to himself, others and property and was secluded for his and others' safety. The reasons for his second seclusion event seem to be far more difficult to understand. The nursing staff appear all too ready to seclude him on this occasion. The process of 'last out – first back in' to the open seclusion room does not appear to consider Hemi's mental health needs. Rather, it seems that management of the unit, done in an expedient way, has a detrimental effect on Hemi's

mental status where he regresses to a psychotic state. It seems that Hemi was wrongly accused of sexual assault and no opportunity was taken to further investigate this event. Hemi showed his compassionate nature in supporting and protecting Alison, which was not considered. It is noteworthy that Zeb's admission to the APU had an explosive effect on the environment and, had Zeb been secluded at that time, then the events that occurred secondary to his elevation in mood, including Hemi's seclusion, may well have been avoided.

Given that Zeb was the initiator of the "jumping ward" situation it would be fair to ask why he was not secluded at that time, that is, he was "elevated in mood and threatening to those around him", which would have been reason enough to seclude him. The one to one intervention used by Xanthia instead, had the unintentional effect of creating an opportunistic environment which Tama took advantage of, and which Hemi paid the price for. It could be concluded that, as Hemi was displaying the same behaviour as Zeb, that something more subtle was at play when Hemi was secluded. On reflection of this narrative, recalled 14 years after the event, it could just be possible that there are elements of racial bias on the part of the nursing staff. Zeb, as a Pakeha male, was overlooked as being deserving of seclusion, while Hemi, a Māori male was not overlooked.

Given the separate and somewhat insular environment that exists in the APU, patient behaviour and nursing staff practice may differ somewhat from the norm in other hospital wards. The acute mental health environment is not open to the public eye nor, in fact, to the eyes of other health professionals including nurses from other specialities. This means that practices that occur in this separate environment, if they were under greater scrutiny, may not occur in the ways as have been described in these narratives.

5.4 Memory Narrative Three: This is not my Tūrangawaewae

Memory narrative two was written from the trigger ‘This is not my tūrangawaewae’. It is the story of Kahu, a Māori male aged 64 years who was diagnosed with Bi Polar Affective Disorder (BPAD) at the age of 48 years. The story tells of Kahu’s decreasing mental stability and his involvement with mental health services, ending with his seclusion in a mental health inpatient unit and his death subsequent to a myocardial infarction while there.

From an analysis of Kahu’s story it appears that the key issue surrounding his experience of being secluded in the mental health inpatient unit was the staff’s lack of consideration for tikanga Māori, the customs and traditions of Māori in which Kahu was well immersed and esteemed. This led to him feeling alienated within the unit, which exacerbated his mental distress and arguably contributed to the deterioration of his health status.

The lack of consideration for tikanga Māori is evident in several key areas in the memory narrative. For one, it portrays the mental health inpatient unit as being an unfriendly place for Māori people. This is exemplified by there being no mention of a kai manaaki staff member in the unit. The kai manaaki is a person who specialises in caring for and supporting Māori (and other non-Māori ethnicities) in a hospital setting. Also, none of the staff on duty at the time of Kahu’s admission and seclusion were identified as Māori and therefore were not able to adequately provide the type of cultural support Kahu needed. It was also evident that, despite Kahu having a close relationship with his sister Georgina, she does not visit him and is described as being “frightened” in the mental health inpatient unit. The impact of this is that Kahu is further isolated from the kind of support he most needs at this time. It is also apparent that, despite Kahu’s position of respect in his community, no other member of his whānau visits him, implying that they feel the same way about the mental health inpatient unit as Georgina, that it is unfriendly, unwelcoming and scary. Similarly, Kahu may well be left wondering why his whānau are not visiting him.

Adding to Kahu's alienation is the unit's sterile environment. The aim of nursing in the mental health inpatient unit is to create and maintain a low stimulus environment. This intervention is designed to have a calming effect on patients. In some ways this may be counter-productive for Kahu, as there is little for him to identify with. The mental health inpatient unit is described as a stark environment with "clean white walls and little or no stimulation", meaning there is nothing visual or auditory that reflects Kahu's culture, therefore nothing symbolic for him to identify with in terms of colours, patterns or images to make him feel 'at home'. The seclusion room, which is where Kahu is placed, is described as even less stimulating than the ward.

From the description of Kahu's behaviour, he needs spiritual interaction and support. He is calling (wailing) for his "Tohunga" i.e. his priest. His calls go unheeded and this appears to make him feel insecure, dislocated and unsafe. He protests, saying "this is not my tūrangawaewae", meaning this is not a place where he feels he belongs or is a comfortable and safe place to stand. Kahu is seeking the kind of support he is familiar with and that he almost certainly would have given to others in a culturally supportive way if it were required. Not only do the nursing staff in the mental health inpatient unit appear to not understand what Kahu is asking for, they also seem not to recognise the significance of providing this support in terms of caring for Kahu's peace of mind and his mental health. This contributes further to Kahu's isolation, spiritual as well as physical, adding another layer of isolation that has further ramifications.

Kahu is steeped in his tikanga Māori. He is thought to have spiritual prowess by his whānau. He is the patriarch of his community. He is the link between older and younger members of his whānau in terms of the passing on of important Māori traditions and genealogy. This position is one of high esteem in his community. This esteem could be greatly diminished by him being isolated in the mental health inpatient unit. He undergoes a transition from a man with mana, who is held in high esteem, to a man removed from the environment in which he is esteemed and robbed of his mana. This causes him a great deal

of anguish and he is described as self-harming. Kahu is in a locked room with no chance of egress and no support forthcoming. He is in despair, and this state continues for three days.

During this time, the response from the mental health inpatient unit staff, in terms of providing culturally sensitive support, is inadequate. Kahu experiences sporadic contact with staff, i.e. room entry by them every two hours to supply food, water and to assess his physical and mental status. At times he is physically restrained by up to five people to administer medication via intra-muscular injection which, in his psychotic state, could well have given him the impression he is being poisoned. The inability of staff to provide cultural support is rationalised by "adherence to policy" which appears to be a way of avoiding what is seen as being necessary. The statement by staff "we must continue to care for him as per seclusion policy" appears to close down any possible conversation amongst the staff about an alternative way to care for Kahu. No one can say for sure what brought on Kahu's cardiac arrest after three days in seclusion, but in the memory narrative, one of the registered nurses states "it seems that he died of a broken heart".

Summary.

It is argued that a lack of consideration of tikanga Māori in Kahu's care in the mental health inpatient unit had a detrimental and catastrophic effect on Kahu. His physical, mental and spiritual health, while in seclusion and isolated from his whānau, were not being cared for in a culturally sensitive manner.

The environment of the unit was alienating to Kahu's whānau and community, which further isolated him. Kahu's statement that "this is not my turangawaeawae" points towards his feelings of alienation and isolation.

5.5 Memory Narrative Four: That is the Policy

The writing of this narrative was triggered by the statement, "that is the policy". This analysis examines the memory narrative about Matty, a Māori male, aged 24 years of age. Matty lives with the diagnosis of paranoid schizophrenia and had attempted suicide by trying to hang himself in the garage at his family home. This action was thought to have been motivated by the emotional impact of a relationship break up with his partner and /or

the cessation of his anti-psychotic medications. Matty was assessed by the mental health team while he was in the emergency department of the hospital and was subsequently admitted to the mental health inpatient unit for further assessment and treatment under the Mental Health (Assessment and Treatment) Act, 1992 (The Act).

The analysis of the narrative about Matty reveals that Matty was not treated as an individual patient, nor was his ethnicity taken into account. This narrative describes a complex nursing situation. Matty is an individual with his own personal history, personal needs and cultural identity. The narrative about Matty highlights what could be seen as a conflict in health care, between the provision of patient centred care, attending to the needs of individual patients, and policy driven care, where the policy appears to enable a staff centred approach to providing care to patients. This conflict impacts in a particular way on the needs of Matty as a patient who identifies as Māori. This approach to care appears to be one of the driving forces leading to Matty being secluded in acute mental health services. These concepts are illustrated in a closer analysis of the narrative as follows.

There appears to be two disparate groups within the staff on the ward during the shift at the time described. That is, Elly and John, who are both recently from the United Kingdom, and Kare and Jordan, both from New Zealand and both with links to local Māori. It seems that neither Elly nor John appear to understand tikanga Māori (Māori customs and protocols), and therefore the potential support and mental health benefits that could be provided to Matty through greater consideration of his tribal links in communication with him. This lack of understanding is apparent when Elly says to Kare, “I don’t care about your tribal relationship with him; it hasn’t helped so far has it?” Kare is intent on speaking with Matty to further resolve the situation but is over-ridden by her senior. When Elly says “he should be treated like anybody else”, this does not acknowledge Matty as an individual patient nor recognise his need for tikanga Māori support. Elly’s comments to Kare related to time spent with Matty, “As far as I am concerned, you have been spending far too much time with him. What about your other patients? This seem to not only be a criticism of Kare’s

nursing practice, but also indicates Elly's belief that all patients have the same needs. John's support of Elly is also disempowering for Kare.

The seniority of Elly and John is the deciding factor in the treatment of Matty in this environment and, instead of allowing Kare to communicate with Matty one to one, the decision is made as per hospital policy to seclude Matty. Matty appeared to have followed instructions (putting coffee cup shard on the table) and desisted in his aggravating behaviour, albeit still emotionally upset. Yet the act of secluding him has the effect of causing pain and anguish for him where, "as restraint takes place, Matty begins to struggle violently and scream at the staff" and "the staff on each arm utilise a 'thumb-lock' which is designed to cause pain to the patient and therefore gain control of the patient's actions. Matty (still struggling and screaming) is then lifted and taken to a seclusion room".

Jordan and Kare's discussion after the debrief meeting reflects an understanding of the needs that Matty had as an individual and as a Māori person. As a concerned and inquisitive student, Jordan is unsure of the rationale for secluding Matty when he asks "why would they restrain, medicate and seclude someone who appears to be cooperative?" Kare appears to be in two minds about the answer to this question. On one hand, she has insight into the needs of her Māori patient and wishes to speak with him and support him and is upset that this did not happen. On the other hand, she is a junior staff member and does not have the power to affect the decision made by her superiors. Her statement "it is sometimes better to seclude a person rather than risk harm to themselves or others" appears to be disingenuous, given the acquiescence noted by Jordan. It seems that had Kare been the senior staff nurse on this duty that things may well have gone differently for Matty, i.e. seclusion may have been prevented. The same could be said for Jordan's lack of seniority.

Summary.

The analysis of this narrative has identified several potential contributing factors in the seclusion of Matty. It appears that, in this case, senior staff could make autocratic decisions. This reflects a hierarchy of power within nursing teams, which disempowers some and empowers others based on seniority. This is not always conducive to positive outcomes

for the patient or the nursing team. It also appears that the senior staff in this case were unaware of the cultural needs of Māori patients, and instead adhered to the hospital policy when other options were open to them. It is possible also, that the hospital policy did not address the different cultural needs of patients. There were opportunities within the scenario described in this narrative where different decisions could have been made, which may well have meant that Matty would not have been secluded.

5.6 Analysis Summary

In concluding the analysis chapter, the summaries for each of the four narratives are reviewed and the main findings highlighted. They are discussed separately in the order in which they were presented and the overall issues are extracted.

The analysis of Matty's story revealed a hierarchy of power within the nursing team, where autocratic decision-making by senior nursing staff was not therapeutic for patients. Senior staff and hospital policy did not address the cultural needs of Matty. These issues culminated in the avoidance of potential alternatives to seclusion.

In Kahu's story, lack of cultural support and a lack of understanding of this concept in practice affected Kahu directly. This lack of consideration also affected his whānau and community, which had indirect consequences for Kahu.

In Hemi's story, his presentation to mental health services as being violent toward people and property led to his initial seclusion event. His second seclusion was related to events and decisions that were not directly attributable to him, the lack of appropriate ward space / bedrooms and a volatile ward environment which required expedient decision making to manage. Also of note is the possible racial bias of the nursing staff.

In Alby's story, there were assumptions made regarding his potential for violence. Marked differences in his presentation with and without the presence of police indicate that these assumptions may have been wrong. The lack of adequate staff resources and experience was also a contributing factor to his seclusion and substandard level of care whilst in seclusion.

5.7 Chapter Summary

In this section, key issues surrounding the seclusion of Tāne are drawn out of the analyses of the four narratives. The following bullet points are a considered analysis of the possible reasons why Tāne may be secluded and why they may be secluded more frequently than other groups of people. By taking an interpretive approach these reasons have been amalgamated into a list of key findings which will be addressed in the discussion chapter of this thesis. These bullet points highlight the major issues which have been extracted from the narratives.

The major issues are:

- Lack of consideration of cultural support by staff
- Lack of understanding of the importance of considering cultural support
- Lack of consideration of cultural support in hospital policy or adherence to this by staff if policy does consider this.
- Racial bias amongst staff in mental health inpatient units
- Stereotypically perceived dangerousness of Tāne
- Inappropriate decision making made for the expediency of ward management
- Lack of resources and the impact of under resourced environments
- Impact of insular and volatile ward environment on outcomes for patients and staff.

CHAPTER 6 DISCUSSION

6.1 Introduction

The interpretive process used in the analysis of the narratives in this thesis has highlighted some important issues that exist in acute mental health nursing. These issues, if discussed and addressed, may have a positive impact on reducing the seclusion rates for Tāne in acute mental health nursing services in New Zealand. Discussion of these issues will be carried out alongside the current literature in an attempt to address the original aim of the research, which was to explore reasons why Māori men (Tāne) are secluded in acute mental health services in New Zealand more frequently than men of other ethnicities. The issues will be discussed under the headings, seclusion as a therapeutic practice, cultural support and resources.

6.2 Seclusion as a Therapeutic Practice

Seclusion (and restraints) are interventions that have been used since the middle ages to control people with mental disorders (Fortinash & Holoday Worret, 2004). The use of seclusion has been less frequent since the introduction of psychopharmacological products in the 1950s. The statistics kept by the NZ MOH (2012) reflect a steady decline in the use of seclusion in NZ since statistics were first kept in 2006. While the statistics reflect a decline in the use of seclusion as an intervention in acute mental health services, they also show that this decline has been slower for Māori than non- Māori men in particular. The 2008 MOH report states that Tāne men comprised 28% of the proportion of inpatients secluded, while other men comprised 17% of this proportion.

Currently, in acute mental health services in New Zealand, people are placed in seclusion for their care or treatment, or for the protection of themselves and others. Legal guidelines state that seclusion should be used only with the authority of the responsible clinician or, in what constitutes as an emergency, the practice may be authorised by the nurse who has direct responsibility for the patient. In these cases, that nurse must notify the responsible clinician as soon as possible of the seclusion intervention. These powers of

restraint and seclusion of acute mental health patients are provided for under Section 71 of the Mental Health (compulsory assessment and treatment) Act, 1992. They are, however, fraught with ethical dilemmas. As Bell and Brookbanks (2005) state, the practices of restraining and secluding mentally unwell patients exemplifies the tensions and difficulties associated with considerations for the rights of the individual patient on one hand and the protection of the public on the other. Seclusion is a controversial intervention, which has often been perceived as a form of punishment, where some patients who have been secluded consider that the use of seclusion is counterproductive to therapy. Other patients view seclusion as a form of assault, which is in breach of human rights. Some health care professionals view seclusion as a necessary and legitimate therapeutic intervention. However, there is a growing body of evidence that is not supportive of this view, for example, Huckshorn (2004) has the view that seclusion and restraint traumatises patients and staff, impacts on the therapeutic and recovery process. This is also reflected by the Mental Health Commission (2004) where they share that the lived experience cited by many consumers suggests that seclusion for many may have been anything but therapeutic.

When the Mental Health Commission (2004) describes seclusion as containment of a person alone within a bare room (often only containing a bed and toilet), and where their exit from the room is decided by clinical staff, then the therapeutic value of this environment should be questioned. Maintaining a low stimulus environment is a therapeutic goal in mental health nursing. This environment may be achieved with the use of sensory modulation which is defined by Sutton and Nicholson (2011) as “a clinical intervention that focuses on the use of environments, equipment and activities to regulate individuals’ sensory experience and optimise physiological and emotional well-being” (p. 8). However, when the goal of providing low stimulus is taken to extremes, it may be counterproductive to the care of the mental health of patients. In other words, there is a fine line between low stimulus and no stimulus and the comparative therapeutic value of these environments.

6.3 Dangerousness

There are situations where nursing staff may perceive that the patients under their care are dangerous (to either themselves, others, or both). In addition, this dangerousness or perception of dangerousness may be the trigger for the seclusion of Tāne. While nurses act within the law in cases where they put patients under restraint or in seclusion (Section 71 of The Act), ethical dilemmas persist. Nurses need to weigh up the relative merits of a patient's autonomy and self-determination in situations where the patient may be viewed as a danger to themselves or others. The ethical challenge lies in the nurse's ability to maintain a therapeutic relationship with the patient, whilst engaging in a practice that infringes on the patient's basic human rights to freedom. In the narrative about Alby's experience, the nursing staff perceived Alby to be potentially dangerous and a physical threat to them and others in the APU environment, which was described as being the reason why he was secluded. It was also noted that Alby had ceased taking his medication. This may have caused him to experience changes to his perception of the world around him and to behave in ways that were a reaction to those altered perceptions. Alby may also have been responding to unseen stimuli, which may affect any of the senses, although most often the auditory and visual pathways are affected in paranoid schizophrenia. These are typical signs and symptoms of paranoid schizophrenia and have the potential to cause aggressive behaviour. However, the nursing staff made the decision to seclude Alby on admission to the unit, having immediately assessed him as dangerous even though his aggressive behaviour was later considered to be more to do with his historical relationship with the police and their presence. If nursing staff had been able to take the time, on his admission, for a comprehensive nursing assessment of Alby, then his seclusion may possibly have been avoided. The ready assessment of perceived dangerousness is an issue highlighted by Te Pou (2014), which states,

> It is how the potential threat of harm to others was determined by mental health staff that concerned Māori nurses most. In particular Māori Men, and the assumptions made by staff that most Māori men entering acute mental health care would require seclusion. (p. 10)

It is suggested that the propensity to assess Maori men as dangerous contributes to their higher rates of seclusion than men of other ethnicities.

6.4 Cultural Support

Culture is defined by Fortinash and Holoday Worret (2004) as a "collective process of acquiring shared beliefs, dominant patterns of behaviour, values, and attitudes learnt through socialisation" (p. 68). Cultural support within healthcare, therefore, is the acknowledgement and meeting of a patient's individual needs in terms of their unique cultural identity. For those within health care facilities who identify as Māori, this means being able to recognise that care policies and practices acknowledge their specific cultural needs, and that this aspect of an individual patient's need should be considered as part of a comprehensive nursing assessment.

The nursing assessment process requires knowledge and skills on the part of the nurse, incorporating cultural understanding and awareness of cultural safety parameters. It also requires time and space to allow nurses to carefully consider these concepts when caring for a patient. These resources are not always available to staff or patients in acute mental health care. Several of the narratives detailing Jordon's experiences as a mental health care nurse highlight instances where nursing care appears to be compromised by a lack of consideration for the specific cultural needs and appropriate support of Tāne. Additionally, the act of putting a patient into seclusion may be construed as an imbalance of power between staff and patients generally. Furthermore, Sambrano and Cox (2013) suggest that power imbalances in mental health settings are particularly challenging for indigenous people. This perception of power imbalance may be due partly to miscommunication between groups with different cultural points of view. This is apparent to Eley et al. (2006), who undertook a needs analysis to determine the quality and effectiveness of mental health services for the indigenous population of South Queensland, found that "discrepancies in the views and perceptions of our two study groups ((i) clinical and non-clinical staff and (ii) indigenous patients, their families and carers) regarding the mental health needs of indigenous people" (Eley et al., 2006, p. 36).

The lack of consideration of a Maori patient's cultural needs was evident in the narrative describing Kahu's experience. For example, Kahu's requests for his Tohunga were not met, which was distressing for him. The staff's lack of consideration for tikanga Māori further alienated Kahu, exacerbating his mental distress and arguably contributed to the deterioration of his health status. In addition, his whānau felt alienated and unwelcome in the environment, which meant they were not providing Kahu with support while in the ACU, potentially further negatively impacting on his mental health status. Kahu's experience of seclusion is one of deteriorating mental and physical health. It appears that, where consideration of cultural support for Maori is not one of the major priorities of the nursing staff, and when an individual Māori person's culture is not fully considered in their plan of nursing care, other interventions may not be as therapeutic as they could be and the overall level of care may be compromised.

While the memory narratives included in this research deliberately focus of Maori men as mental health patients, a common thread across the narratives relates to the demographics concerning the staff involved in the cases describing seclusion events. There are very few staff who identified as Māori, and those few who did were not in positions where they were able to make significant decisions that would have potentially had a beneficial impact upon the types of care and its outcome for their Māori patients. El-Badri and Mellsop (2002) postulate that it is not easy to explain the disproportionate over representation of Māori compared to non-Māori who are secluded, but that it may be related to stereotypical perceptions by staff that non-European patients are more dangerous and they therefore responded to these patients with defensive or pre-emptive methods. Such stereotypical perceptions imply a lack of cultural understanding. There appears to be, within the narratives, a lack of understanding of the importance of considering cultural support for Tāne generally. This could be construed as a racial bias by predominantly non-Maori staff, resulting in situations where Tāne were more likely to be secluded and men of other ethnicities not secluded in similar situations or when exhibiting similar behaviours.

6.5 Mental Health Care Policies

It is difficult to assess the extent to which hospital policies and practices in mental health care consider and adhere to understandings of the need for cultural support for Maori. Hospital polices are likely to vary amongst the 20 DHBs throughout NZ. However, Wharewera-Mika et al. (2013) allude to the potential here by stating that while it is not easy to address the disproportionate levels of seclusion and restraint for Māori, it should be a priority for all health workers concerned to develop ways of improving the level of care for this group of people. This could be effected by the development of hospital policies / kaupapa which are inclusive of Tikanga Māori values and principles and reflect the themes as identified by Te Pou (2014) and Wharewera-Mika et al. (2013). These should be developed in consultation with local Māori in each DHB to ensure that appropriate Tikanga is put in place.

This potential Tikanga is embedded in Mason Durie's (1998) Māori health model, Te Whare Tapa Wha. This model compares health to the four walls of a wharenui (meeting house) where all four walls are necessary to ensure strength and symmetry, by each wall representing a different dimension of the person (Durie, 1998). These dimensions are:

> Taha Wairua – a spiritual focus which addresses the capacity for faith and wider communion – health is related to unseen and unspoken energies.
> Taha Hinengaro – a mental focus which addresses the capacity to communicate, think and feel – where mind and body are inseparable.
> Taha Tinana – a physical focus which addresses the capacity for physical growth and development - where good physical health is necessary for optimal development.
> Taha Whānau -a focus on extended family which addresses the capacity to belong, to care, and to share – where individuals are part of wider social systems.
>
> (Durie, 1998, p. 68)

Consideration of these dimensions would potentially benefit all Maori in mental health care, patients as well as staff. It is argued that a firmly embedded Maori health model in mental health ACUs in NZ DHBs would go a long way towards addressing any lack of cultural support that may contribute to the higher rates of seclusion of Tāne.

6.6 Decision Making

One of the many challenges faced by mental health nurses is to accurately assess a person's alteration in mental health as opposed to their behaviour related to their personality and to make clinical decisions based on this assessment as part of the nursing process. For example, in the narrative describing Matty's experience, Matty appears to have reached the end of the patience with the staff in control of the nursing environment in which he finds himself. He had apparently calmed down but was secluded despite this. There was no consideration given to the suggested intervention by a junior staff member who related to Matty through shared cultural identity and the decision by a more senior, non-Maori, staff member was made to seclude Matty. Bigwood and Crowe (2008) assert that, in stressful clinical scenarios, nurses tend to choose correctional interventions for their patients, rather than more relational ones. This choice appears to prioritise control of the environment, rather than the more patient-centred therapeutic relationship. Muir-Cochrane (1996) points out that nurses may use the practice of seclusion as a supplementary intervention when they considered the patient to be out of control, and that a framework of power and control underpinned these nurses' perceptions which are in stark contrast to the contemporary philosophies of nursing care. In the narrative describing Matty's experience, the contemporary philosophy of cultural safety and relationship therapy was offered by junior nursing staff but this was discounted by a senior staff member who chose the correctional intervention.

6.7 Resources

In any health care environment, adequate resources are essential for the provision of quality services. Resources such as appropriate levels of staff numbers and staff ethnic mix, staff expertise, and adequate environmental setting and space are all important considerations in the provision of appropriate acute mental health care. It was evident in the analysis of the narratives in this thesis that lack of resources in terms of physical space and adequate staffing, including appropriate levels of expertise and cultural awareness, may well have contributed to most, if not all, of the seclusion events described. The implications of

there being under-resourced acute mental health care environments is that patients may not be given the time and care required by nursing staff to deliver optimal care. This includes care that is culturally appropriate, but also that involves accurate, comprehensive, mental status assessments, the careful consideration of de-escalation interventions when required, and the maintenance of a low stimulus environment. These all require skilled and focused nursing care. Resourcing pressures, particularly concerning nursing staff, persist in contemporary mental health nursing in New Zealand. Manchester, O'Connor, Stodart and Longmore (2017) have highlighted the realities for registered nurses currently working in a pressured healthcare system. They reported one anonymous registered nurse practicing in a DHB environment as saying,

> My acute mental health workplace is short 10 FTE RN's. Although these jobs are advertised periodically, the rewards for this very challenging job are not enough to attract the skilled workers we badly need. This in turn, means staff often feel pressured into doing 80-hour-plus weeks to keep our ward at a minimum 'safe' staffing level. Obviously the care provided by staff doing this many hours is, at times, not safe at all, and the stress impacts negatively on client care, staff health and workplace morale. (Manchester, O'Connor, Stodart, & Longmore, 2017, p. 11)

Although the narratives written for this research were recollections of seclusion events that occurred between 14 to 24 years ago, the resource and staffing pressures they sometimes described seem to remain current and may even be more critical today. A lack of adequate resourcing has an ongoing impact on the level of quality care able to be provided within ACUs and contributes to potentially dangerous ward environments. Nursing staff must make decisions about the care needs of Tāne within these stressful environments and, given the factors previously discussed, it appears that the often expedient decision is to seclude them.

6.8 Conclusion

Given the potentially volatile and capricious nature of the ward environment in acute mental health services in New Zealand, and the under-resourcing in terms of physical space, staff numbers and staff expertise, it is perhaps not surprising that the environment impacts negatively on the ability of nursing staff to provide patient-centred and culturally safe care

for all patients. Patients who are acutely unwell have the potential for behaviour that is challenging in many ways, including ways that pose danger to themselves and others. Decisions to seclude patients are often made acutely, and without the time and perhaps the knowledge to accurately assess and intervene with patients in ways that may prevent seclusion events. Additional factors suggest that, within these pressured ACU environments, the decisions that lead to the seclusion of Tāne at rates higher than those of men of other ethnicities may stem from the greater likelihood that Tāne are perceived by non-Maori as dangerous. This is alongside a profound lack of Maori cultural awareness that could be brought to the provision of care in acute mental health care units.

CHAPTER 7 CONCLUSIONS

This chapter outlines a summary of the research, including its findings, and presents some recommendations for potential future directions for nursing in acute mental health practice. The aim of this research was to explore some possible reasons why Tāne have been secluded in acute mental health facilities at disproportionate rates. By using a qualitative research methodology based on memory-work, which produced data written in narrative form, a picture has been painted of the experiences of nursing Tāne in seclusion interventions within acute mental health services. This has allowed discussion of some key issues that arose out of these narratives.

7.1 Summary of Findings

It appears that the acute mental health environment may be limited in its ability to meet the cultural needs of Tāne when they are admitted for therapeutic care, and that this lack contributes to their seclusion, which in some cases is not used as a therapeutic intervention. Seclusion is an outdated and archaic intervention which is slowly being removed from practice in acute mental health services in New Zealand. However, the rates of removal over time are slower for Tāne than men of other ethnicities. The isolation caused by seclusion is particularly troublesome for Tāne as it separates them from their support networks including their whānau. This isolation also has a negative impact on other important cultural concepts for Tāne, including their spirituality, physical and mental well-being.

The ethnic mix of nursing staff in mental health care would appear to have an effect on the frequency of seclusion of Tāne. A predominantly non-Māori nursing staff, with little understanding of tikanga Māori, may be unable to provide the patient-centred care that is of therapeutic value for Tāne. This lack of understanding may also contribute to a racial bias and a stereotypical view that Tāne are more dangerous than non-Māori men. This, at times, results in pre-emptive seclusion of Tāne for the safety of themselves and others.

Staffing pressures, including shortages in numbers and expertise, also affects the ability of staff to carry out comprehensive assessments of individual patients due to pressures of time and staff: patient ratios. This has a negative effect on delivery of optimal nursing care and perpetuates potentially dangerous ward environments.

These findings need to be put into the legal context with reference to Te Tiriti o Waitangi, where Te Puni Kokiri (1993) states that Article Two of the Tiriti o Waitangi "gives Māori the right to pursue tino rangitiratanga (self-determination) on matters affecting their well-being" (p. 8). Additionally, Te Puni Kokiri (1993) also address Article Three which "accords Māori, as individuals, the same rights and privileges as other citizens" and therefore, that "Māori, as a minimum, have the right to enjoy at least the same level of mental health as non-Māori consistent with the Government's objective for Māori health" (p. 8). These rights and privileges are not being accorded to Tāne in the current mental health environment.

7.2 Limitations

The narratives that are the data for this research are based on the recalled experiences of one registered nurse, and are written about experiences that occurred between 14 and 24 years ago. Therefore, they may be perceived as representing a narrow view of the environment studied. However, these experiences were important to that registered nurse at the time and remain important now.

A further limitation of the research is that it does not include the voices of the Tāne who were secluded. This limitation is addressed in Chapter 3. That is, there is the potential for harm for Tāne recollecting these stressful experiences. There is also a potential for misinformation, given the mental health status of Tāne at the time of seclusion. Future research may facilitate involvement of Tāne with support from senior members of the Māori community. There has been very little research carried out in this area and the dearth of current qualitative literature has limited the literature review and discussion chapters of this thesis. However, this research aims to address the lack of information available in this area and to start academic conversations about this subject.

7.3 Recommendations for Nursing Practice

The following recommendations for nursing practice in mental health care are suggested:

- Address staff shortages in Mental Health. An overall shortage of nursing staff means that optimal nursing care cannot be delivered to patients.
- Recruit more Māori staff to create an effective and appropriate mix of ethnicities. Encouraging the involvement of Māori staff in supporting Tāne will allow for cultural considerations of Tāne to be considered in their plan of care.
- Educate all staff in Tikanga Māori. This includes knowledge of waiata (song) and karakia (prayer). In addition, staff should be able to pronounce Māori words and patients' names correctly. An awareness of the more commonly practiced models of Māori heath, e.g. Te Whare Tapa Wha, should also be a part of staff development.
- Consider concept of Marae environment in mental health inpatient units. This would include changing a sparsely decorated environment by introducing Māori artwork and motifs.
- Encourage whānau to be part of recovery plans for Tāne. Mental health units appear to be foreign and frightening environments for Māori. Changing the environment as above and including tikanga Māori should go some way towards demystifying these units to Tāne and their whānau.

References

Altheide, D.L., & Johnson, J.M. (1998). Criteria for assessing interpretive validity in qualitative research. In N.K. Denzin, & Y.S. Lincoln (Eds.), *Collecting and interpreting qualitative materials* (p.283-312). Thousand Oaks, CA: Sage Publications.

Ball, C. (2010). *Mental health legislation in New Zealand from 1846 to date: A discourse analysis.* (Master's Thesis). Eastern Institute of Technology, Taradale, New Zealand

Basford, L. (2003). Nursing in an age of change. In L. Basford & O. Slevin (Eds.), *Theory and practice of nursing: An integrated approach to caring practice* (2nd ed., pp. 795-806). Cheltenham, United Kingdom: Campion Press.

Bell, S., & Brookbanks, W. (1998). *Mental health law in New Zealand*. Wellington, New Zealand: Brookers.

Bell, S., & Brookbanks, W. (2005). *Mental health law in New Zealand* (2nd ed). Wellington, New Zealand: Brookers.

Bill of Rights Act 1990. Retrieved May 14, 2017, from http://www.legislation.govt.nz/act/public/1990/0109/latest/DLM225517.html

Bigwood, S., & Crowe, M. (2008). It's part of the job, but it spoils the job': A phenomenological study of patient restraint. *International Journal of Mental Health Nursing, 17.* 215-222.

Borbasi, S., Jackson, D., & Langford, R.W. (2004). *Navigating the maze of nursing research: An interactive learning adventure.* Marickville, NSW. Elsevier.

Brophy, L.M., Roper, C.E., Hamilton, B.E., Tellez, J.J., & McSherry, B.M. (2016). Consumers and Carer perspectives on poor practice and the use of seclusion and restraint in mental health settings: Results from Australian focus groups. *International Journal of Mental Health Systems.* 10*:6.* DOI 10.1186/s13033-016-0038-x

Brunton, W. (2012). 'Mental health services - Mental health and mental illness', Te Ara - the Encyclopedia of New Zealand, updated 13-Jul-12
URL: http://www.TeAra.govt.nz/en/mental-health-services/page-1

Cannon, T. (2006). Creating safety within mental health environments: A review of some of the factors that impact on safety and risk within mental health services, as described by service users / tangata whai ora. Auckland, New Zealand: Mental Health Programmes.

Champagne, T. (2004). Sensory Approaches in Inpatient Psychiatric Settings: Innovative Alternatives to Seclusion and Restraint. *Journal of Psychosocial Nursing. 42*(9): 35-44.

Clandinin, D.J., & Connelly (1998). Personal experience methods. In N.K. Denzin, & Y.S. Lincoln (Eds.), *Collecting and interpreting qualitative materials* (p.150-178). Thousand Oaks, CA: Sage Publications.

Crawford, J., Kippax, S., Onyx, J., Gault, U., & Benton, P. (1992). *Emotion and gender: Constructing meaning from memory.* London, England: Sage.

De Chesnay, M. (2015). *Nursing research using ethnography: Qualitative designs and methods in nursing*. New York, NY: Springer Publishing Company.

Dempsy, P. A., & Dempsey, A.D. (2000). *Using nursing research: Process, critical evaluation and utilisation* (5th ed.). Baltimore, MD: Lippincott, Williams & Wilkins.

Durie, M. (1998). *Whaiora – Māori health development* (2nd ed.). Auckland, New Zealand. Oxford University Press.

Durie, M. H. (2003). *Ngā Kāhui Pou: Launching Māori futures*. Wellington, New Zealand: Huia Publishers.

El Badri, S., & 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.

Elder, R., Evans, K., & Nizette, D. (2009). *Psychiatric and mental health nursing* (2nd ed.). Chatswood, Australia: Elsevier.

Eley, D., Hunter, K., Young, L., Baker, P., & Haqnnah, D. (2006). Tools and methodologies for investigating the mental health needs of Indigenous patients: It's about communication. *Australian Psychiatry, 14*(1), 33-37

Etheridge, L. (2003). Using memory-work to facilitate exploration, analysis and expression of emotion in personal narrative. *English in Australia* (138). 56-61.

Fortinash, K.M., & Holoday Worret, P.A. (2004). *Psychiatric Mental Health Nursing (*3rd ed*).* St Louis, MO: Mosby, Inc.

Friend, L, A., & Thompson, S, T. (2000). Using memory-work to give a feminist voice to marketing research. In M. Catterall, P. MacLaren, & L. Stevens (Eds.), *Marketing and feminism.* London, England: Routledge.

Hall, A. M.(2013). Theoretical foundations of nursing practice. In P.A. Potter, A.G. Perry, P.A. Stockhert, A.M. Hall (eds.), *Fundamentals of nursing* (8th ed., pp. 40-49). St Louis, MS: Mosby.

Haug, F. & Others (2008). Memory Work. *Australian feminist studies, 23*(58), 537-541. doi:10.1080/08164640802433498

Health and Disability Commissioner Act 1994. Retrieved May 14, 2017, from http://legislation.govt.nz/act/public/1994/0088/latest/DLM333584.html

Higginbottom, G. M. A., Pillay, J. J., & Boadu, N. Y. (2013). Guidance on performing focused ethnographies with an emphasis on healthcare research. *The Qualitative Report, 18*(Art. 17), 1-16. Retrieved from http://www.nova.edu/ssss/QR/QR18/higginbottom17.pdf

Holloway, I., & Freshwater, D. (2007). Narrative research in nursing. Oxford, United Kingdom: Blackwell Publishing.

Huckshorn, K.A. (2004). Reducing seclusion restraint in mental health use settings: Core strategies for prevention. *Journal of Psychosocial Nursing and Mental Health Services 42*(9), 22-33.

Janssen, W.A., Noorthoorn, E.O., de Vries, W.J., Hutschemeakers, G.M.J., Lendemeijer, H.H.G.M. & Widdershoven, G.A.M. (2008). The use of seclusion in the Netherlands compared to countries in and outside of Europe. *International Journal of Law and Psychiatry, 31*(2008) 463–470.

Knoblauch, H. (2005). Focused Ethnography [30 paragraphs]. Forum Qualitative Sozialforschung / Forum: *Qualitative Social Research, 6*(3), Art. 44, http://nbnresolving.de/urn:nbn:de:0114-fqs0503440.

Koutroulis, G. (1993) Memory-work: a critique. In: B. Turner, L. Eckermann et al. (eds) Annual Review of Health Sciences (Geelong, Deakin University), pp. 76–96

Manchester, A., O'Connor, T., Stodart, K., and Longmore, M. (2017). Under pressure – Nursing in a stressed, underfunded health service. *Kai Tiaki Nursing New Zealand 23*(3), 10-12.

Martin, V., Bernhardsgrütter, R.G., Goebel1, R., & Steinert, T. (2007). The use of mechanical restraint and seclusion in patients with schizophrenia: A comparison of the practice in Germany and Switzerland. *Clinical Practice and Epidemiology in Mental Health 3*(1).

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

Mental Health (Compulsory Assessment and Treatment) Act, 1992. Retrieved May 14, 2017 from http://www.legislation.govt.nz/act/public/1992/0046/latest/DLM262176.html

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

Ministry of Health. (2001). *Competencies for the role and function of responsible clinicians under the mental health (compulsory assessment and treatment) act 1992.* Wellington, New Zealand: Author.

Ministry of Health. (2006). *Office of the director of mental health: Annual Report 2005.*Wellington, New Zealand: Author.

Ministry of Health. (2008). *Office of the director of mental health: Annual Report 2007*.Wellington, New Zealand: Author.

Ministry of Health. (2011). *Office of the director of mental health: Annual Report 2010*.Wellington, New Zealand: Author.

Ministry of Health. (2012). *Office of the director of mental health: Annual Report 2011*.Wellington, New Zealand: Author.

Ministry of Health. (2013). *Office of the director of mental health: Annual Report 2012*.Wellington, New Zealand: Author.

Ministry of Health. (2015). *Office of the director of mental health: Annual Report 2014*.Wellington, New Zealand: Author.

Ministry of Health. (2016). *Office of the director of mental health: Annual Report 2015*.Wellington, New Zealand: Author.

Mollon, P. (2002). *Remembering trauma: A psychotherapist's guide to memory and illusion* (2nd ed.). London, England: Whurr Publishers.

Muir-Cochrane, E. (1996). An investigation into nurse's perceptions of secluding patients on closed psychiatric wards. *Journal of Advanced Nursing, 23*(3). 555-563.

New Zealand Nurses Organisation (2010). *Code of ethics.* Author. Retrieved from *http://www.nzno.org.nz/LinkClick.aspx?fileticket=t6vd5nIYak4%3D*

O'Hagan, M., Divis, M., & Long, J. (2008*). Best practice in the reduction and elimination of seclusion and restraint; Seclusion: time for change*. Auckland, New Zealand: Te Pou Te Whakaaro Nui: The National Centre of Mental Health Research, Information and Workforce Development.

Polit, D.F., & Beck, C.T. (2008). Nursing research: Generating and assessing evidence for nursing practice. (8th ed.). Philadelphia, PA: Lippincott, Williams & Wilkins.

Riessman, C.K. (2008). *Narrative methods for the human sciences.* Thousand Oaks, CA: Sage Publications.

Sambrano, R., & Cox. L. (2013). 'I sang *Amazing Grace* for about 3 hours that day' Understanding Indigenous Australians' experience of seclusion. *International Journal of Mental Health Nursing 22,* 522–531. doi:10.1111/inm.12015.

Schneider, Z., Elliot, D., LoBiondo-Wood, G., & Haber, J. (2003). *Nursing research: Methods, critical appraisal and utilisation* (2nd ed.). Sydney, Australia. Mosby.

Smith, G.M., Davis, R.H., Bixler, E.O., Lin, H., Altenor, A., Altenor, R.J., Hardenstine, B.D., & Kopchick, G.A. (2005). Pennsylvania state hospital system's seclusion and restraint reduction program. *Psychiatric Services, 56.* Retrieved from http://ps.psychiatryonline.org.1115-1122

Steinert, T., Lepping, P., Bernhardsgrutter, R., Conca, A., Hatling, T., Janssen, W., Keski-Valkama, A., Mayoral, F., & Whittington, R. (2009). Incidence of seclusion and

restraint in psychiatric hospitals: A literature review and survey of international trends. *Society of Psychiatric Epidemiology 45*,889–897. doi:10.1007/s00127-009-0132-3

Te Pou. (2008). Survey of seclusion and restraint reduction initiatives in New Zealand acute mental health services. Auckland: Te Pou, the National Centre of Mental Health Research, Information and Workforce Development.

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

Te Puni Kokihi. (1993). *Ngai a o te orange hinengaro Māori-Trends in Māori mental health: A discussion document*. Wellington, New Zealand: Author.

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 tangata whai i te ora.* Auckland, New Zealand: Te Pou o Te Whakaaro Nui.

Willis, J., & Anderson, K. (2010). Ethnography as Health Research. In P. Liamputtong (Ed.), Research methods in health: Foundations for evidence-based practice (pp. 91-105). South Melbourne, Australia: Oxford University Press.

Ypinazar, V.A., Margolis, S.A., Haswell-Elkins, M., & Tsey, K. (2007). Indigenous Australians' understandings regarding mental health and disorders. *Australian and New Zealand Journal of Psychiatry 2007; 41*,467-478

Appendix A

Our Ref: 16/49

28 October 2016

Chris Drown
C/- School of Nursing
EIT

cdown@eit.ac.nz

Dear Chris

Thank you for the additional supporting information for your research project *"An exploration into the reasons why Māori men are secluded in acute mental services more frequently than men from other ethnicities."*

I am pleased to inform you that your research project was approved by the Research and Ethics Committee, following their meeting held on 28 October 2016.

You are reminded that should the proposal change in any significant way, you must inform the Committee. Please quote the above reference number on all correspondence to the Committee. Please send all correspondence to REACapprovals@eit.ac.nz.

The Committee wishes you well for the project.

Yours sincerely

Jeanette Fifield
Secretary - Research Ethics & Approvals Committee

cc: Shona Thompson, Sue Scott-Chapman – School of Nursing

Appendix B

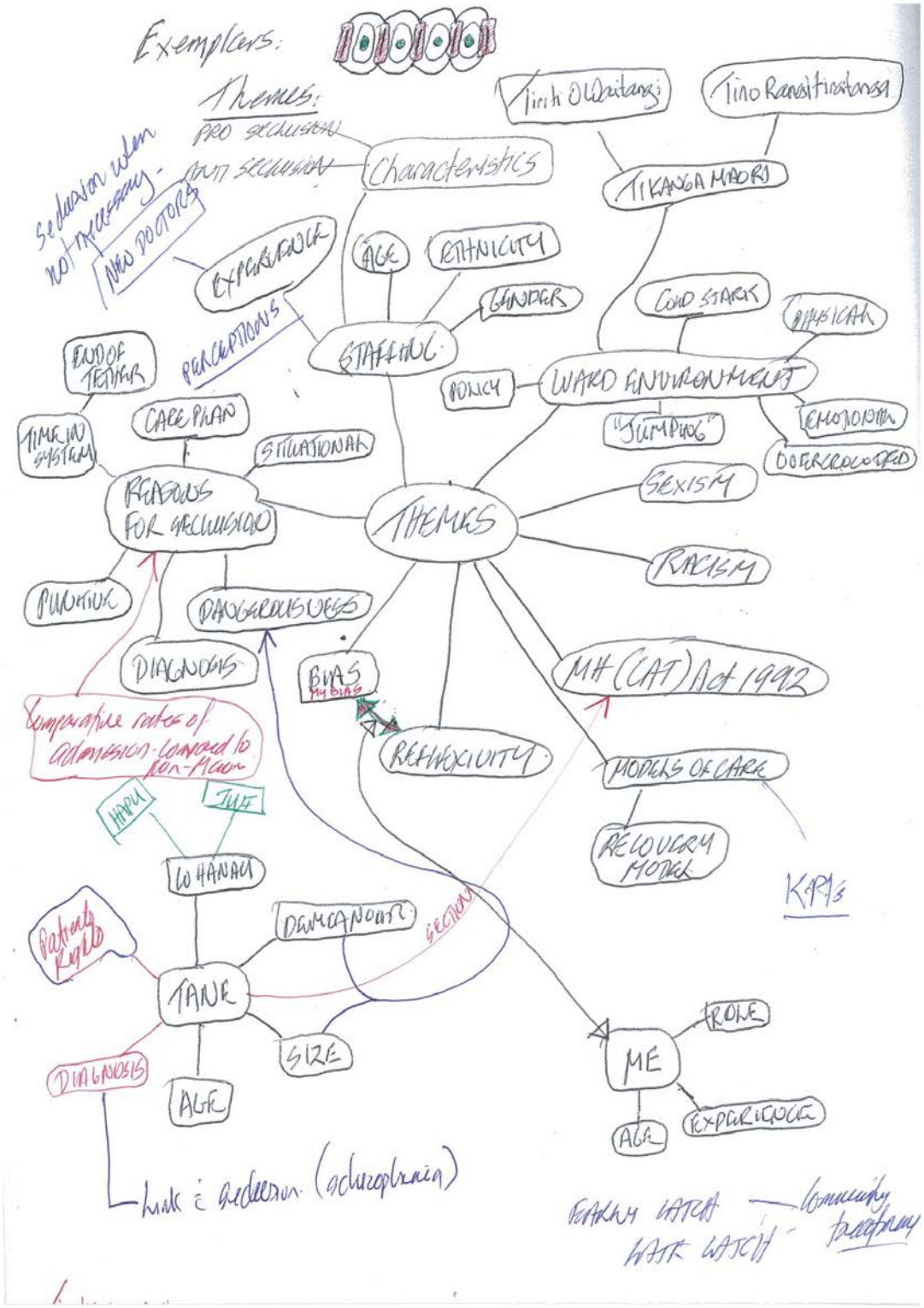

Figure 1. Original mind map