Taiohi and Whānau Hīkoi from the Community into Acute Mental Health and Addictions: A Kaupapa Māori Study

Debra Lee Gerrard

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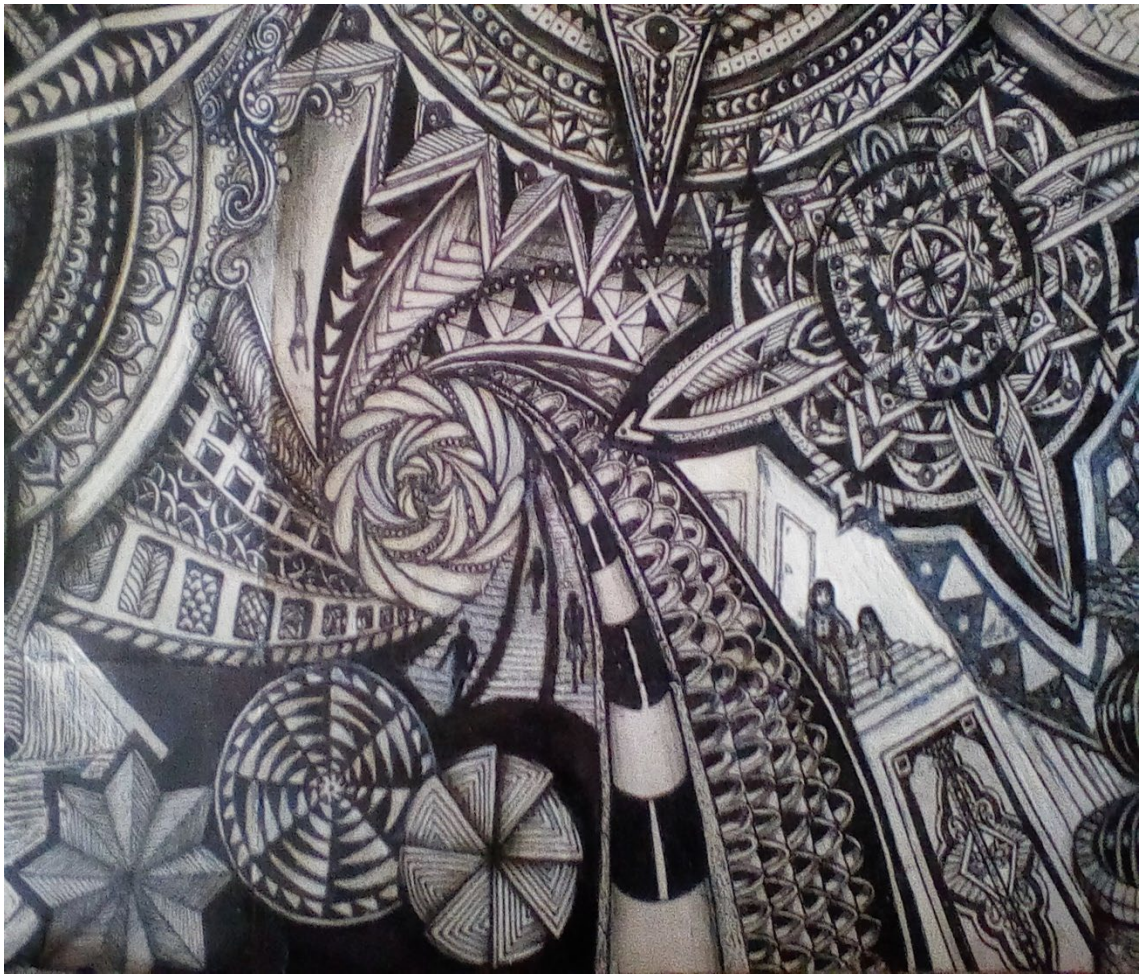

This picture represents the complexity of taiohi and whānau hīkoi from the community into acute mental health and addiction services.

My sister Sheryl Gerrard drew the picture freehand.

It has been reproduced here with her permission.

Abstract

Taiohi Māori, the Indigenous adolescents of Aotearoa, have inequitable mental health and addiction outcomes when compared to their Pākehā (New Zealand European/other European/"White") counterparts, with unacceptably high levels of suicide. Despite the high levels of concern for the mental well-being of taiohi, they are less likely to access to the care they need, and experience worse outcomes. Understanding taiohi and whānau experiences when accessing acute mental health and addiction services is critical for improving equitable mental health and substance misuse outcomes for taiohi and their whānau. This thesis explores an Indigenous empirical exploration of taiohi and their whānau as they hīkoi (journey) from the community into acute mental health and addiction services.

An Indigenous paradigm philosophically underpinned this research, based on Kaupapa Māori Theory that anchored a distinct epistemological and metaphysical positioning reflective of Māori worldviews and contemporary realities. A qualitative research design enabled 19 participants, taiohi (n=9), whānau (n=5) and keyworkers (n=5), to share their experiences through interviews. Inductive questioning in semi-structured interviews with. A thematic analysis utilising a te ao Māori lens and key themes and sub-themes were generated.

The findings provide insights into the uniqueness of taiohi identities and the importance of Māori cultural engagement and wider social determinants in the recovery care pathway. The first key theme, '*Surviving Socially'*, includes the sub-themes of *living with social pain* and *being heavy on drugs*. The second key theme, *Entering a Scary Place*, includes the sub-themes of *locking me in* and *clearing my thoughts*. The final theme, *Whānau Healing in the Community*, includes these sub-themes *providing hope*, *kotahitanga*, and *carrying on with life*.

This research provides insight into taiohi lived realities of engaging with mental and addiction services. Colonisation, intergenerational trauma, racism, culture, and wider environmental factors significantly impact taiohi healing journeys. These social and cultural determinants make it challenging to address mental health and substance use issues for taiohi effectively, without challenging current colonial systems. Understanding the determinants of wellbeing for taiohi offer valuable levers for action, including prevention strategies, health service delivery and policy.

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Attestation of Authorship

I hereby declare that this submission is my work. To the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements) nor material which, to a substantial extent, has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Date: 7/7/2023

Dedication

I dedicate this thesis to my mokos, my two daughters, and whānau in spirit who have travelled higher into the heavens with Atua; my beautiful daughter Vishayne; my father, Stanley Herbert Llyod Gerrard; my mother, Peata Hamahona Himiona; and my youngest sister, Christine Peata Gerrard.

Thank you, Dad, for the wisdom and strength you instilled in me to keep going. A gentle voice of reason always came with bundles of love; thank you, Dad.

Acknowledgements

Completing my thesis retains my mana in a colonial paradigm but has distanced me from whānau and friends. However, my journey has many people to acknowledge. Firstly to Atua, who helped *keep my wairua strong through the experiences, challenges, and rewards that shaped* this journey.

A special mihi to the participants who engaged in this thesis. Thank you for sharing your experiences that provided the knowledge necessary to complete this thesis. Without you, there would be nothing.

Thanks to all my friends and whānau who supported and encouraged me through this journey, including kaumātua Pita Pou, Peremi Porter, Whero Nāhi, and Tianiwa Tutara, who gave me insight into the wairua, tikanga, and te ao Māori. Also, thanks to Caroline McKinney (senior lecturer), who uplifted my mana as a young Māori nurse. I will never forget her advice when experiencing racism: "*It is not your problem, and it is theirs*". Thanks to the many other Indigenous and non-Indigenous academics, nurses, and professionals who believed in me.

I acknowledge the Health Research Council of Aotearoa (number 17/201) for recognising the importance of this study for young tangata whenua and providing me with a Māori PhD scholarship that helped me financially to achieve academic success and completion of this thesis.

Thanks to my supervisors—Professor Denise Wilson, Dr Helen Wihongi, and Dr Eleanor Holroyd—for supporting and believing in me. Also, thank you to those who helped recruit participants and make this journey possible.

Finally, thank you, Dad, for always being there with wisdom, compassion, perseverance, and understanding. The strength you gave me while growing up made me who I am today. You have shown me that anything is possible.

AUT Ethics Committee (AUTEC; number 072015) granted ethics approval and supported this kaupapa Māori research study.

Preface

Kia pono ki te uri Tupuna – tanga o te wairua

Kia pono ke te uri Tupuna – tanga

Tou whakapapa, tou wairua te Atua

Ko Marmarie te waka

Ko Whangape te moana

Ko wharerimu te maunga

Ko Makora te pa

Ko Taio te marae

Ko te Rarawa te Apouri te iwi

Ko Kaingamata te hapu

Ko Amukiti te tangata

Tōku rua aku tamariki ko Waiora me Vishayne, tōku aku mokopuna Azaira Joy.

My whakapapa privileges me as tangata whenua and enables a connection with taiohi and whānau to highlight their experiences as they hīkoi from the community to acute mental health and addiction services.

I am of Te Tai Tokerau descent, from the far north of Aotearoa. I was born in Devonport, Northshore, and went to Devonport primary school during the mid-1960s and 70s. My grandmother brought me up, and we moved to Australia when she passed. I went to high school in Sydney and went to school with Greeks, Italians, Lebanese, Australians, and many other ethnicities. At the time, I did not recognise my Māori culture and saw myself as a kiwi. Knowledge of my Māori culture came later when I returned to Aotearoa in the late 1980s. It is from this positionality and from being a Māori nurse that I write this dissertation.

Chapter One: Introduction

Taiohi Māori are the youth of tangata whenua living in Aotearoa New Zealand. Tangata whenua are the Indigenous people referred to as those connected to their ancestral lands before colonial intervention (Mohatt et al., 2014; Wilson & Richmond, 2009; World Health Organization, 2007). As tangata whenua, taiohi affinity with the land of Aotearoa affirms a vital component for developing a secure identity and sense of belonging (Durie, 2001). The signing of Te Tiriti o Waitangi in 1840 was a treaty between Māori and Pākehā, suggesting two cultures come together and each culture manages its people, with Māori never ceding sovereignty. As the Pākehā population rapidly grew, Māori knowledge and ways of life were diluted and overshadowed by colonial beliefs, values, and knowledge (Durie, 2001; Walker, 1989).

Colonialism in Aotearoa neglected Māori value systems and survival in a Euro-Western world brought significant changes to health and wellbeing of Māori. Overtime, Māori experienced high unemployment rates, low-income levels, and poor housing. Partnerships offered in Te Tiriti o Waitangi were ignored, leaving Māori powerless with systems that no longer served them (Waitangi Tribunal, 2019). For contemporary taiohi, this is reflected in poor social, justice, educational and health outcomes such as those related to poverty, income, housing, education, and other daily issues (Durie, 2021; Harris et al., 2018; J. Reid et al., 2014; Wirihana & Smith, 2019). According to Robson and Harris (2007), Māori youth have experienced multiple levels of trauma that began with colonialism and continued colonial hegemony (Brave Heart, 2000; Evans-Cambell, 2008; Pihama, 2014; Wirihana & Smith, 2019).

Taiohi (Māori youth) are a highly vulnerable population in Aotearoa, with a disproportionate amount entering acute mental health and addiction services with substance use, anxiety, and psychological distress (Abel et al., 2012; Baxter et al., 2006; Baxter, 2008; Clark, 2014; New Zealand Government, 2018; Oakley Browne et al., 2006; Ramage et al., 2005). According to Theodore et al. (2022), taiohi experience higher mental health distress rates and addiction issues than Pākehā (Cunningham et al., 2018). Taiohi are 56% are more likely to be admitted to hospital for self-harm, and they are more likely to be in contact with specialist services (Durie, 2021; Harris et al., 2018). Also, taiohi living in the most deprived areas are 49% more likely to experience substance use issues.

The primary support system for young taiohi Māori is their whānau. Whānau enhances taiohi identity and well-being (Gone, 2013; Marsden & Royal, 2003; Moeke-Pickering, 1996; Murphy & Gray, 2013; Peterson, 2014; L. T. Smith, 2012; Taylor & Oskay, 1995). Lark et al. (2018) affirmed that the whānau relationship is intrinsic to positive mental health outcomes for taiohi. Whānau are major support systems that work hard to keep taiohi out of trouble. However, alongside taiohi, whānau struggle with daily social issues.

Colonialism is regulated by colonial norms and philosophies deliberately established to displace Indigenous people from their land, culture, and people (Duran & Duran, 1995; Durie et al., 2009; Gone, 2010, 2013; Kirmayer et al., 2000; Waldram, 2009). According to Taylor-Moore and Varona (2014), the confiscation of land, economic stability, and resources have caused long-term effects on Māori health outcomes. Noted by Liu and Temara (1998), the disconnection from their lands has eroded traditional Māori identities and perpetuated the decline in Māori ways of being (Gifford-Smith, M, 2005; Pihama (2014) concurred that colonisation has interrupted and disrupted the intergenerational knowledge of te ao Māori, tikanga Māori, and mātauranga Māori.

Understanding taiohi and whānau exposure to past and present trauma provides insight into the realities of taiohi substance use, mental health issues, and whānau challenges (Abel et al., 2012; Baxter, 2008; Baxter et al., 2006; Clark, 2014; New Zealand Government, 2018; Oakley Browne et al., 2006; Ramage et al., 2005). This information is critical for transforming clinical pathways that treat and support taiohi mental health and addiction outcomes. Rethinking the clinical pathway of care for taiohi and whānau is critical for enhancing equitable outcomes that are culturally safe. This thesis examines taiohi substance use, mental health issues, and whānau challenges when supporting taiohi. Taiohi and whānau shared their experiences as they moved from the community looking for help to support taiohi recovery. The research aimed to answer the following question:

> *What are taiohi and whānau experiences as they hīkōi from the community to acute mental health services with substance use and mental health issues?*

Study Aims

This study sought to explore the following:

- Understand taiohi uniqueness and realities as they move from the community into acute mental health and addiction services with substance use and mental health issues.

- Understand whānau realities when providing manaakitanga for taiohi with substance use and mental health issues.
- Gain information regarding taiohi and whānau realities and experiences when entering mental health and addiction services to inform mental health addiction services, policymakers, funders, and other appropriate academic areas.

Academic research concludes that colonisation has positioned taiohi in a place of heightened risk and vulnerability for substance use and mental health issues (Clark et al., 2022; Theodore et al., 2020). Clark et al. (2022) used data from cross-sectional representative surveys of New Zealand secondary school students undertaken in 2001, 2007, 2012, and 2019. Health indicators between 2001 and 2019 and 2012 and 2019 presented a picture of Māori and Pākehā health and well-being. The data highlighted that poor health outcomes burden taiohi, despite 2-decades of prioritising Māori well-being.

Accessibility and utilisation of mental health and addiction services is a barrier for taiohi pushing them to the top of the priority list in Aotearoa (Abel et al., 2012; Baxter, 2008; Baxter et al., 2006; Clark et al., 2014; New Zealand Government, 2018; Oakley Browne et al., 2006; Ramage et al., 2005). According to Robson and Harris (2007), fewer than one in three taiohi are likely to contact mental health services for support when mentally unwell. Access barriers for taiohi include negative perceptions of the health system, the stigma attached to mental health, and not wanting to make a fuss (Clark et al., 2014; Jansen et al., 2009). Also, once they enter a Euro-Western health institution, racism and discrimination heighten (Bhugra & Jones, 2001; Fernado, 2014; Mcintosh et al., 2006).

The substance use and mental health surveys in Aotearoa conclude that while there have been some improvements, taiohi experience higher rates of mental unwellness than Pākehā youth, particularly for depression (Clark et al., 2022) and psychotic presentations (Tapsell & Mellsop, 2007). Fleming et al. (2022) found that 11% of students reported levels of substance use that put them at significant risk of harm, concluding that taiohi mental well-being requires urgent attention. Access to substances is easy, and various payment methods increase availability opportunities. Today underutilisation of and poor access to appropriate mental health and addiction treatment remain equity issues for Māori and taiohi (Abel et al., 2012; Baxter, 2008; Baxter et al., 2006; Clark et al., 2014; New Zealand Government, 2018; Oakley Browne et al., 2006; Ramage et al., 2005).

Some taiohi are still experiencing a disconnect from Māori knowledge systems and their connection with whakapapa (genealogy), whenua (land), and whānau oppressed and weakened Māori identity (Gertz, 2018). Also, their social positioning is on the margins of society, where Māori children and youth are three times more likely to live in poor households (Clark et al., 2018; Cram, 2019; Simpson et al., 2016). Others suggest that poverty affects the food eaten, housing, and educational achievement (Children's Commissioner, 2012; Wills & Bantum, 2012). Sinclair (1969) affirmed that the displacement of Indigenous peoples from their traditional knowledge contributes directly to disease, poverty, and disadvantage. Moreover, Paradies (2016) asserted that colonisation brutally exploits the colonised in several ways, including spiritual, cultural, educational, economic, health, and social aspects. Colonisation's impact on cultural genocide was devastating and traumatic for Indigenous (Priest et al., 2011). Many believe a relationship exists between memory, history, contemporary contexts, and individual and collective responses to these contexts (Brave Heart & DeBruyn, 1998; Crawford, 2013; Evans-Campbell, 2008).

Evans-Cambell (2008) concurred that there are links between recurrent historical trauma, oppression, and survival. Others affirmed that cultural groups with trauma histories also experience present-day marginalisation (Chandler & Lalonde, 2009; Crawford, 2013; Gone, 2013). According to C. Smith and Tinirau (2019), the accumulation of historical trauma has severely affected Māori well-being. Evidence suggests Māori children exhibit higher exposure rates to trauma, abuse, and poverty than non-Māori (Salvation Army Social Policy and Parliamentary Unit, 2014). Mohatt et al. (2014) affirmed that historical trauma is a source of present-day distress and resilience, suggesting trauma narratives and health issues influence one another. Paradies (2016) concluded health and overall well-being of Indigenous communities are severely affected by the traumatic experiences of colonisation.

In contrast, Denham (2008) and Mohatt et al. (2014) argued that historical trauma can also sustain resilience. Further racism is a historical and contemporary effect of colonialism that impacts Māori. According to Turner (2010), Captain Cook was among the first colonists to provoke historical racial stereotypes that continued into contemporary society. Additionally, penalising Māori for being Māori is seen in the enactment of the Tohunga Suppression Act (1907). A political strategy to outlaw traditional Māori healing, forcing healers to go underground, taking their knowledge with them (Durie, 2001). In contemporary society, the Ministry of Health (2012) found that

taiohi who identify as Māori are more likely to experience racism and discrimination. Pack et al. (2015, 2016) concurred that racism is a discourse of Pākehā ignorance of Māori. Ignorance leads to conscious and unconscious bias, such as power imbalances, stereotyping, and miscommunication (Martel et al., 2017). Clark et al. (2022) affirmed the need to quickly remove structural racism that maintains the status quo of colonial hegemony. Disruption to taiohi lifestyle and environmental losses has led to psychological and physical distress, impacting taiohi mental health and well-being (Bjerregaard, 2001; Bjerregaard & Larsen, 2015; L. Wexler, 2009). Crawford-Garrett (2018) asserted that the weakening of Māori identity and colonial discourse placed Māori in a place of oppression instead of self-determination.

Taiohi ability to self-determine their health and well-being is out of reach for many. Taiohi have unconsciously absorbed the effects of trauma through intergenerational colonialism. The effects of colonialism have weakened taiohi identity through the disconnection from their land and Māori knowledge systems. Also, colonialism has positioned taiohi on the margins of society, where they live in poverty at all levels. The multiple layers of historical and contemporary trauma have heightened taiohi risk of substance use and mental health issues. Taiohi are the future leaders of Māori and the nation. Therefore, uplifting their mana through the obligations of Te Tiriti o Waitangi is essential if they are to reach their full potential. Additionally, a balance that promotes holistic well-being requires a positive mental state that supports and strengthens their development, identity, and self-worth.

Taiohi is a unique term describing the youthful tangata whenua of Aotearoa, New Zealand. Tangata whenua refers to Māori, the Indigenous peoples of Aotearoa. Māori affinity with the land affirms their Māori identity as tanga whenua, confirming their mana and authority over Aotearoa, vital knowledge needed to develop a secure identity (Durie, 2001). Taiohi are the young tangata whenua of Aotearoa, but defined as rangatahi means ‘fishing net’. Evidence suggests the term rangatahi came from the work of Hoani Waititi after he wrote *Rangatahi 1* and *Rangatahi 2* for schools. Further reinforcing the term, TeApirana Ngata used rangatahi in his books, referencing the whakataukī—“Ka pū te ruha ka hao te rangatahi” (when the old net is worn out, the new net is put into place) (Ware, F., 2018)

Nevertheless, a Northland kaumātua suggested referring to rangatahi as the youth is incorrect and misleads Māori words. For instance, the Ministry of Youth Affairs

translation in te reo Māori is te tari taiohi, given to them by Te Taura Whiri I Te Reo Māori (The Māori Language Commission) an explanation that taiohi meant youthful or young, and the noun taiohinga means youth (Ware, F., 2018). Additionally, variance exists in taiohi age descriptions. For instance, the Ministry of Youth Development referred to taiohi age as 12-24 years, while Te Puni Kōrkiri considered the age to be 15-24 years. For this study, I refer to taiohi aged 16-25 years, as Herd (2018) used to refer to young Māori.

Taiohi have a unique cultural identity in te ao Māori and tikanga Māori handed down by their tūpuna. Also inclusive of their uniqueness is mātauranga Māori, a term traditionally unknown in Māori ontologies and epistemologies, having evolved with colonial intervention. Mātauranga Māori knowledge is grounded in te ao Māori and tikanga Māori. Although changing lifestyles and experiences have created new philosophies of knowledge that maintain the evolution of mātauranga Māori, the evolution of mātauranga Māori advances with the effects of colonial intervention and colonial hegemony. Pihama (2014) concurred that colonisation has interrupted and disrupted the intergenerational knowledge of te ao Māori and mātauranga Māori. Losing whakapapa (genealogy), whenua (land), and whānau oppressed and weakened Māori identity (Gertz, 2018).

This study focuses on understanding the historical and contemporary trauma that has displaced taiohi from their unique identity as tangata whenua. It considers their realities in contemporary society with whānau as they hīkoi from the community to acute mental health and addiction services in search of mental health and substance use recovery.

Overview of Chapters

Chapter One: Introduction

This chapter has introduced the thesis and offers a brief overview of the following chapters.

Chapter Two: Literature Review

Chapter Two sets the scene for understanding taiohi uniqueness. It provides a peripheral understanding of traditional links between te ao Māori and taiohi cultural identity formation and development. The chapter pays attention to traditional tools used by whānau, hapu, and iwi that support the strong development of taiohi identity and a sense

of belonging as the young tangata whenua of Aotearoa. Also reviewed is the arrival of the colonists. Understanding colonial intent to disarm and displace Māori from their cultural foundations of te ao Māori supports an understanding that addresses taiohi mental health and substance use issues.

Chapter Three: Methodology and Methods

This chapter initiates a discussion about Indigenous knowledge and decolonisation. It overviews a thematic analysis that invites an understanding of kaupapa Māori and tikanga as the decolonising methodology. Highlighted is the displacement and misinterpretation of Indigenous ontologies and epistemologies attuned to an empirical agenda in contemporary society.

Chapter Four: Findings

Chapter Four outlines critical elements of taiohi and whānau hīkoi from the community into acute mental health and addiction services. Analysing taiohi and whānau voices begins with understanding taiohi social positioning and how this vulnerability adds to their substance misuse. Taiohi and whānau discuss their substance misuse experiences, anger, and fear. As taiohi substance misuse worsens, whānau look for support. Eventually, all taiohi enter acute mental health and addiction services. Their hīkoi in the unit initially overwhelms both hindering and helping factors. As they enter the acute mental health unit, they enter a foreign culture with multiple racist practices and policies. Taiohi and whānau voice their experiences in the unit before returning to the community.

Chapter Five: Discussion

The discussion chapter brings together taiohi and whānau experiences and a discussion framed within a Māori model of health—Te Pae Māhutonga, represented by elements of health promotion and Māori culture. Symbolically Te Pae Māhutanga depicts the Southern Cross, a star formation only seen in the Southern Hemisphere. Traditionally, a navigational tool guided Māori ancestors on their hīkoi through the Pacific to Aotearoa, New Zealand. This model assists in portraying a comprehensive overview of taiohi and whānau hīkoi. It raises relevant issues related to taiohi substance misuse and whānau, awhi, and manaaki while bringing forth knowledge of spiritual, environmental, psychological, and cultural issues relevant to taiohi mental health and well-being.

Chapter Six: Conclusion and Recommendations

The final chapter concludes by revisiting the research question and the research aims, and critical findings. It draws on Chapter Five, providing a final examination of taiohi and whānau voices on their hīkoi from the community to acute mental health and addiction services. It highlights implications for understanding taiohi uniqueness that brings forth potential areas of inequities. Also emphasised is the effectiveness of a comprehensive approach to care coordination and treatment for taiohi with mental health and substance misuse issues. Lastly, three recommendations focus on supporting taiohi mental health and well-being into the future—allowing them to flourish as tangata whenua and future kaumātua of Aotearoa.

Chapter Two: Literature Review

Introduction

This literature review explores three key areas. The literature about te ao Māori knowledge and tikanga provides an understanding of the unique qualities of taiohi before colonial contact. Also explored are the effects of colonialism and its relevance to substance use and mental health issues for taiohi. Finally, the literature search investigated taiohi and whānau access to acute mental health and addiction services. The literature review asked four questions identified from the study topic and aims.

1. What are taiohi unique qualities before colonial contact?
2. After colonial contact, what are taiohi realities with substance use and mental health issues?
3. What are whānau realities when providing manaakitanga for taiohi?
4. How do mental health and addiction services support taiohi substance use and mental health issues?

Search Strategy

Information in the literature review included peer-reviewed and grey literature, including journals, national and international strategies, policies, reports, reviews, evaluations, magazines, newsletters, and reports. The collection features literature from Aotearoa and international and Indigenous literature from various academic fields, including history, psychology, philosophy, theology, law, languages, and literature. The databases searched include CINAHL, Medline, EBSCO, Ovid-Cochrane Library, Medline, and Scopus. Indigenous publications such as AlterNative - an interdisciplinary journal by and for Indigenous peoples - and Te Kaharoa - a Journal on Indigenous Pacific issues - were also accessed. Also accessed was *MAI Journal*, an open-access journal that addresses Indigenous and Pacific issues in the context of Aotearoa, Ngā Pae o te Māramatanga Māori Centre of Research Excellence and Te Aka, the online Māori dictionary. Literature accessed was in te reo and English, spanning the years 1940-2023. The search strategy contained keywords mentioned in Table 1. Other keywords included colonisation, marginalisation, oppression, racism, assimilation, socio-economic, inequality, inequity, socialisation, education, intergenerational trauma, and historical trauma, as well as rangatahi, taiohi, whānau, identity, homelessness, kohunga reo, literacy/literacy, medical distrust/mistrust, substance use/misuse, drugs, and alcohol. Further refined to include

youth and Māori youth in Aotearoa, New Zealand. A mix of words captured Māori youth in Aotearoa, substance use and mental health issues.

Table 1

Keywords Used in the Search Strategy

Taiohi	Whānau	Mental Health	Substances	Indigenous
Child	Whānau	Mental health service	Substance abuse	Māori
Adolescence	Māori family	Mental health service delivery	Alcohol	Māori identity
Youth	Māori family	Child and adolescent mental health	Alcohol abuse	Māori sense of belonging
Young adult	Māori families	Mental	Psychosis	New Zealand
Young person	Māori families	Mental disorder	Schizophrenia	Aotearoa
Rangatahi		Mental health illness	Marijuana Cannabis	
Māori youth	Māori	Mental health issues	Methamphetamine	Indigenous youth
Māori youth	New Zealand	Mental disorder	Drug abuse	Indigenous adolescence
Māori young people		Addiction	Drugs	
Rangatahi sense of belonging	Aotearoa	Historical trauma	Substance use Substance misuse	Aboriginal
Rangatahi identity			Substance dependence	American Indian
Spirituality and health				

Peer-Reviewed Journal Articles

Appropriate peer-reviewed literature was predominantly qualitative. Accessing relevant literature occurred by first reviewing the title, abstract, and discussion. The literature selection relied on the following inclusion and exclusion criteria.

Inclusion criteria

- Published in te reo and English
- Published between 1940 and 2023 (older articles provided background)
- Māori, taiohi, and whānau cultural identity before colonial contact
- Other Indigenous peoples' experiences before colonial contact
- Colonisation, colonialism, colonial hegemony
- Maori, taiohi, and Indigenous socio-cultural, socio-political, and socio-economic inequities
- Taiohi, Indigenous youth, and non-Indigenous youth substance use and addictions
- Taiohi, Indigenous youth, non-Indigenous youth and mental health
- Māori whānau role in supporting taiohi
- Taiohi and other Indigenous youth access to mental health services encompassing utilisation, retention, cultural safety and Māori mode of care

Exclusion criteria

Over time I began to exclude literature that was not primary to the research, including:

- Literature not related to Indigenous peoples, Indian Nations, Aboriginal, and Australian Aboriginal
- Literature that did not focus on taiohi and whānau

The literature needed to answer the research question and aims were broad, covering multiple concepts. These concepts covered traditional Māori knowledge and contemporary realities for taiohi and whānau, leading to substance use and mental health issues. The literature search occurred over seven years, between 2015 and 2022.

Grey Literature Document Review

Grey literature includes materials and literature outside traditional peer-reviewed and commercial journals (Bushnell et al., 2001). Grey literature provides a unique selection of literature from books, Google Scholar, and online websites with relevant information such as kaupapa Māori, rangatahi, and Indigenous youth. Websites included Te Puni Kokiri (Ministry of Health), Ministry of Youth Development, and YouTube (i.e., kaupapa

Māori information). University websites provided access to additional references, dissertations, and research related to taiohi/rangatahi, such as Youth 2001, 2007, 2012, and 2017 cohorts (Clark et al., 2018); and the University of Otago longitudinal studies conducted by Child and Youth Research Support Service (Craig et al., 2012; University of Otago, n.d.). The release of He Ara Oranga (New Zealand Government, 2018) set the scene for the development of more up-to-date literature highlighting the importance of Māori connection to te ao Māori and mātauranga Māori, as well as the impact of colonisation, the effects of historical and inter-generational trauma, and the impact on Māori identity and sense of belonging.

The review of documents in the grey literature provided an extensive range of relevant information. The criteria for accessing grey literature varied slightly from peer-reviewed literature, allowing for a broader overview. The review of documents in the grey literature provided extensive relevant information to Māori and rangatahi, as opposed to taiohi. Additionally, retrieved documents pertinent to whānau, mental health, addictions, mental health services, and mental health service delivery came from online sources such as the Beehive, New Zealand; Ministry of Health, New Zealand; Counties Manukau District Health Board Library; Te Puni Kōkiri – Kāinga; YouTube; Health and Disability Commission; Health Statistics New Zealand; Office of the Children's Commissioner, New Zealand; and the World Health Organization.

Further, several District Health Boards (DHBs) and Community Alcohol and Drug Services within the North Island of New Zealand contributed to the grey literature sourced. For instance, clinical and administration staff within DHBs provided information about policies and procedures, funding, eligibility criteria, affiliations with other pertinent staff, and services within the DHB and surrounding communities. Community Alcohol and Drug Services provided information about their policies and procedures, including admission and discharge criteria. Clinical and administrative staff shared their experiences with both taiohi mental health and substance misuse issues and their whānau. Additionally, they shared taiohi and whānau stories, changes they have noticed over the years, and thoughts about future directions. Most sources of papers were qualitative, using kaupapa Māori methodology, grounded theory, or participatory research. Quantitative sources included mixed methods and surveys with a population focus. Table 2 overviews the number of articles included in the study.

Table 2

Number of Articles Included in the Review

Articles identified	3,745	Articles removed	3,042
Articles screened	703	Articles excluded	257
Full-text articles	446	Articles excluded	0
Studies included	29	Studies excluded	0

Literature Selection

In the early days of reviewing the literature, there was limited information comparing Indigenous youth with youth-centred Euro-Western studies. The beginning search drew on early research, such as the Mental Health And General Practice Investigation (MaGPIe) (Bushnell et al., 2001), which outlined psychological problems in New Zealand primary health care. Another study of importance was the prevalence of mental disorders among Māori in Te Rau Hinengaro: The New Zealand Mental Health Survey (Baxter et al., 2006). Other documents released from the Ministry of Health (2007), Te Raukura Seclusion under the Mental Health (Compulsory Assessment & Treatment) Act 1992 (Ministry of Health, 2010a). Also valuable are acknowledgements to Professor Mason Durie and Professor Terryann Clark, who have continued producing information relevant to taiohi mental health and well-being. Identified were over 3,000 articles. Those removed included 3,042, considering 23 duplicate articles. To determine eligibility, I reviewed the titles and abstracts of the remaining articles based on the predetermined inclusion and exclusion criteria (Table 2).

Further screening occurred by reducing Indigenous information to include mainly Indian Nations, Aboriginal, and Australian Aboriginals. These Indigenous groups mirror the effects of colonialism on taiohi. After removing much literature, I screened 703 articles and excluded 25. Out of the 446 full-text articles reviewed, 29 articles were finally included in the literature review.

Literature Review Findings

The literature review aimed to understand taiohi and whānau unique identity and the realities of taiohi substance use and mental health issues as they move from the community into acute mental health services. The findings from the literature present

answers relevant to the four literature review questions. Question one describes taiohi uniqueness and includes concepts that relate to their Māori cultural philosophies and knowledge systems before colonial contact embracing te Ao Māori and Mātauranga Māori. Question two links taiohi realities to contemporary society's substance use and mental health issues. The concepts include historical trauma, social-political trauma, poverty, racism education, and justice. Question 3 relates to whānau realities when providing support and manaakitanga for taiohi. To capture the concept of manaakitanga, whānau roles and responsibilities before colonial contact have been discussed. The discussion discusses whānau realities and the challenges they face in contemporary society. Lastly, question four describes how mental health and addiction services support taiohi. It includes accessibility and utilisation, the medicalisation of mental health and addiction services and cultural safety.

The Unique Qualities of Taiohi Before Colonial Contact

Te ao Māori

Taiohi unique qualities focus on ontological assumptions and epistemological perspectives that underpin Māori ways of knowing and being. Ontology is a reality of existence that explains how humans learn and understand the world and the people within it (Beazley, 2013). From an Indigenous perspective, Chilisa (2012) explained that for Indigenous peoples, relational ontology is a social reality where humans connect with the living and the non-living. Taiohi ontological uniqueness stems from whakapapa related to Māori connections with the spiritual realm and the physical realm, including land and the people; it affords a sense of belonging (Benton, 2019; Gone, 2013; Liebenberg et al., 2019; Marsden & Royal, 2003; J. Reid et al., 2016; L. T. Smith, 2012). According to Ja and Jose (2017) and Rua et al. (2017), whakapapa connects Māori with their tūrangawaewae (place of standing) as the natural (Māori) people of Aotearoa New Zealand.

The philosophical underpinnings of te ao Māori suggest whakapapa begins in the cosmos and transcends through the spiritual agenda of Ātua (spiritual ancestors). The spiritual whakapapa gives birth to tangata whenua (Māori), born out of aroha (love) between Papatuanuku (Māori earth mother) and Ranginui (sky father). The spiritual separation of Papatuanuku and Ranginui gave birth to light, igniting the creation of the earth and the people (Royal, 2007; Tate, 2010; Tse et al., 2005); a story passed down from generation to generation (R. Walker, 1989; S. Walker et al., 2006). Walker, R. (1978) asserted that a spiritual connection embraces ‘mauri’ as a life force that expresses a relationship with

the natural environment and portrays people as born of the land and inhabiting it. Harmsworth and Awatere (2013) argued that relationships with spirituality, land, and people promote a Māori sense of belonging, cohesiveness, and connection. Durie (2001) affirmed that awareness of whakapapa and cultural connections strengthens taiohi identity.

Taiohi connection to te ao Māori and whakapapa enhance Māori ontological concepts that support positive identity formation. Te ao Māori embraces the whakapapa, connection, and interrelationship between the living and the spiritual world (Ja & Jose, 2017; Royal, 2007; Rua et al., 2017). Connection through whakapapa establishes what and whom one is, which develops personal traits, self-confidence, and awareness (Ja & Jose, 2017; Royal, 2007). Benton (2019) stated that engagement with te ao Māori develops Māori cultural identity and enhances a sense of belonging and self-worth, enhancing the mana of taiohi and their whānau. Stuart and Joss (2014) concurred that connection to te ao Māori builds on positive identity formation, a sense of belonging, and pride. Farruggia et al. (2011) suggested that the pooled connection can bring a positive sense of self and a loving and supportive environment reducing feelings of loneliness.

Land provides an ecosystem, a natural environment that sustains life where plants, animals, weather, landscapes, and other organisms work together to form a life bubble (National Geographics, 2022). Mika et al. (2022) claimed that people's health, well-being, and survival depend on a healthy local ecosystem. Regarding te ao Māori, the relationship with the ecosystem and the people is a spiritual gift from Papatūānuku (mother earth) that enriches the mauri. If the natural world's mauri weakens, the well-being of the people is affected (Durie, 2001). Therefore, it is essential to maintain the mana of the land.

Taiohi health and well-being occur when whānau, hapū, and iwi share resources from the land, a balance crucial to survival (Dell et al., 2022). Traditionally, Māori social structure was dynamic and evolving, organised into small, self-sufficient tribes (Best, 1934). Waa and Love (1997) affirmed that tribes existed in whānau, hapū, and iwi units, mostly connected through whakapapa bloodlines (genealogy). Hēnare et al. (2014) concurred that traditionally the natural world and wealth distribution cemented relationships among Māori by sharing food, food-gathering areas, and other natural resources. According to Rout et al. (2021), the connection between people and nature is an enriched life force seen

as an ancestral gift that provides biological entities to embrace life via a complex network of sustainable community activity.

Māori health and well-being depended on collective resource-sharing between the land and people. Consequently, Māori power and prestige did not arise from material wealth or accumulation; instead, it was the enactment of collective mana (Dell, 2022). Durie (2001) claimed that mana does not invest in individual deeds but in the community's collective well-being. Therefore, a person's mana decreases when the community's shared vision weakens. These origins shape how Māori engage within their world and cultural philosophies of knowing and sustainability. Maori cultural values are at odds with colonialism, which involves a country taking control of people or territories for strategic and individual gain. For instance, one of the first interventions enacted by the colonists was surveying Aotearoa into land blocks that were to be sold individually to the colonists (Walker, 1990). This approach leads to the displacement of Māori from their whakapapa, lands, and people.

Mātauranga Māori

The theoretical concepts of Māori ontologies are evident in te ao Māori and overlap the epistemological knowledge of mātauranga Māori. According to Van Meijl (2019), epistemology locates knowledge in space, time, and whakapapa. Affirmed by Tahau-Hodges (2021), Māori knowledge is an epistemology involving metaphysics which proclaims the expression of traditional Māori knowledge commonly referred to as mātauranga Māori. Chilisa (2012) asserted that epistemology questions the knowledge that constructs realities, and the reliability and truths people perceive. As proclaimed by Tahau-Hodges (2020), each generation's unique exposure to the natural environment embraces expansive and relational forms of values, experiences, attitudes, and worldviews weaved into evolving, unique knowledge systems.

Further, Smith (2015) asserted that colonial contact distinguishes Indigenous epistemology between traditional Māori knowledge systems and scientific knowledge models. Amiria Salmond (2013) and Van Meijl (2019) concurred those scientific accounts of knowledge conflict with culturally diverse realities and ways of knowing. Van Meijl claimed that traditional knowledge is intangible, not collectable, or observable, demonstrating a conflict with scientific metaphors. Penehira et al. (2014) argued that this position does not celebrate self-determination or support reclaiming cultural knowledge, identity, and belonging. Crawford-Garrett (2018) asserted that the weakening of Māori

identity and colonial contact has resulted in locating Māori in a place of oppression instead of self-determination.

Mātauranga is a term that developed after colonisation with the arrival of Pākehā in Aotearoa (Sadler, 2012). It was not a term traditionally used by Māori iwi, hapū, and whānau (Tahau-Hodges, 2021. Instead, it is a treasure of knowledge passed on from Māori tūpuna (ancestors), developed and shared over centuries (Mead, 2013; Royal, 2007). Mātauranga Māori is constantly evolving. Mead (2013) and Royal (2007) affirmed that the evolving scope of mātauranga Māori generates complex knowledge systems, values and attitudes from life experiences. Therefore, mātauranga is flexible and adapts to change, providing an understanding of the natural and developed worlds (Mead, 2013; Procter & Black, 2014; Royal, 2007). Latulippe (2015) and L. T. Smith (2012) claimed that mātauranga Māori has intrinsic complexities that make it hard to define. According to Marsden and Royal (2003), the unique knowledge systems of mātauranga Māori produce unique cultural markers that can form and shape a strong Māori identity. However, an inability to access Māori knowledge, the loss of land, and the absence of coordinated health and well-being from the collective weaken taiohi sense of belonging and their unique cultural identity.

Traditionally taiohi knowledge came from te ao Māori, a spiritual gift through the relational concept of whakapapa, land and people, an ancestral taonga of knowledge. Built on relationships that enrich and strengthen the development of a strong identity and sense of belonging (Farruggia et al., 2011). Multiple findings suggest that Indigenous youth who connect with their cultural identity are more likely to have positive psychosocial outcomes (Barton & Wilson, 2008; Boulton et al., 2004; Durie, 1995, 2011; Kidman, 2012; Reading et al., 2007; Ritchie & Reading, 2004; L. T. Smith, 2012; Wirihana & Smith, 2019). For taiohi to maintain a strong identity and a sense of purpose, they need the space and opportunity to embrace te ao Māori and engage in cultural practices (Carlson & Tongi, 2011; Fox Neha & Jose, 2018; Kingi et al., 2017; Wirihana & Smith, 2019). Also supported by many are those who affirm an awareness of cultural connections through the whakapapa of spirituality, land, and people strengthens taiohi identity (Durie, 2001; Farruggia et al., 2011; Wirihana & Smith, 2019). However, some taiohi have experienced a disconnect from their traditional knowledge, weakening their identity (Gertz, 2018). As affirmed by Crawford-Garrett (2018), the weakening of their identity and colonial discourse has suppressed taiohi, positioning them in a place of vulnerability and risk.

As taiohi identity evolves, the term mātauranga acknowledges identity flexibility and the ability to adapt to change offering a comprehensive understanding of both the natural and developed worlds (Mead, 2013; Procter & Black, 2014; Royal, 2007). According to Marsden and Royal (2003), despite the intrinsic complexities of mātauranga Māori, it works to define unique knowledge systems, which form and shape an evolving Māori identity. However, the inability to access Māori knowledge, the loss of land, and the absence of coordinated health and well-being from the collective significantly weaken the sense of belonging and unique cultural identity of taiohi. It is imperative to address these issues to preserve and strengthen the cultural identity of taiohi to improve their health and well-being.

Colonial Contact and Taiohi Realities with Substance Use and Mental Health Issues

The colonial strategy to suppress Māori knowledge has enforced multiple practices, including cultural displacement, forced removal of children from their parents, development of Euro-western residential schools, environmental destruction, assimilation and extermination of Indigenous knowledge, ways of knowing and living (Evans-Cambell, 2008; Paradies, 2016). Disputing Western worldviews, Māori have a resilient unique culture and body of knowledge that evolved from ancient values and traditions, adapted and manifested in various attitudes, behaviours, and beliefs (Hikuroa 2017; Maxwell et al. 2020). Rameka (2017) contended that the evolving cosmic movement in time intertwines with the past and present, shaping both the present and future identity as the mana of Māori ancestors moves from the spiritual realm to the physical realm.

Colonial hegemony reinforces the progression of colonialism and the subjugation of Māori. Paradies (2016) suggested that colonial hegemony exploits the colonised at multiple levels: spiritual, cultural, educational, economic, health, and social. A driving force of colonisation is cultural genocide, lethal devastation, and trauma towards Indigenous people (Priest et al., 2011). Sinclair (1969) confirmed that the displacement of Indigenous peoples from their traditional ways of knowing is linked directly to the burden of disease, poverty, and disadvantage. According to Paradies, colonisation caused long-lasting psychological trauma inherited by generations of Indigenous people, negatively affecting their overall health and well-being.

Historical trauma

Historical trauma influences psychological development and biological, neurological, and genetic pathology (Spear, 2009; Stevens et al., 2016). Māori experiences of colonial

trauma are unique (Clark et al., 2018; Mead, 1994; Pihama, 2001; Pihama et al., 2017; Pool, 2015; Stanley, 2002). Tattooed into the minds of taiohi and whānau is the unconscious effect of colonial genocide (Pihama et al., 2014). An unconscious effect is in neural pathways connecting neuronal and behavioural functions (Gröger et al., 2016; Wexler, 2006).

Historical trauma is associated with emotional wounding, evident in self-destructive behaviour, suicide, depression, anxiety, aggression, low self-esteem, substance use, and an inability to express emotions (Brave Heart, 2003; Gluckman & Hanson, 2007). Getz (2018) theorised that historical trauma has manifested in high rates of suicide through the loss of whakapapa, whenua, whānau, and identity. Coleman et al.(2016) proposed that intergenerational trauma theories suggest racial minorities are at greater risk of developing post-traumatic stress disorder (PTSD). Historical trauma is also associated with the development of schizophrenia. Taitimu et al. (2018) interviewed 57 Māori participants to understand how they understood schizophrenia as a psychotic phenomenon. They found spiritual and cultural explanations for psycho-social constructs, including interpersonal trauma and drug abuse.

Colonial constructs, historical, biomedical brain imbalances, and cultural alienation influence taiohi identity development. Crawford-Garrett (2018) asserted that the weakening of Māori identity and colonial discourse has suppressed Māori. Historical trauma disrupts a positive sense of belonging and internal feelings of self-worth (Egeland et al., 1993). For instance, Māori youth with a positive relationship between ethnic identity and self-esteem display a strong sense of ethnic pride and identity. However, Bronk (2011) argued that youth without a sense of purpose struggle with a secure identity. For instance, taiohi experiencing mental health issues often feel stigmatised, expressing feelings like ‘I do not fit in’ or ‘What is wrong with me?’ The driving forces behind such feelings align with identity formation and are associated with loneliness, alienation, and the hopelessness of living with mental illness (Hagerty et al., 1992). The unconscious effects of historical trauma linger in taiohi psyche, impacting their mental health and well-being.

Social-political trauma

Taiohi realities within a socio-political context affirm a colonial discourse of socialisation (Kirmayer, 2012; Pachucki & Breiger, 2010; Statistics New Zealand, Tatauranga Aotearoa, 2016). Colonial hegemony has successfully reorientated mātauranga Māori to

Euro-Western ideals through urbanisation, assimilation, poverty, and racism (Benton, 2019; Chilisa, 2012; Evans-Campbell, 2008; Glenn, 2015; Kirmayer, 2012; Paradies, 2016; E. P. Smith et al., 1999). Urbanisation moved Māori from their tribal lands to urban dwellings dislocating Māori from their cultural knowledge and aligning them with Euro-western global forces of capitalist and neoliberalist rule (Kirmayer, 2012). According to many authors, urbanisation stimulated assimilation by rearranging Indigenous economic stability and social, cultural, and spiritual practices to benefit the colonial discourse (Chilisa, 2012; Evans-Campbell, 2008; Glenn, 2015; Paradies, 2016; E. P. Smith et al., 1999).

Assimilation influenced the progression of colonial subjugation. Pachucki and Breiger (2010) confirmed that urbanisation reshaped Māori identity and belonging while reinforcing a colonial discourse. Benton (2019) suggested that establishing colonial institutes within politics, health education, and justice perpetuated the forces of Euro-western philosophies and dislocated many Māori from their cultural knowledge. In response, Penehira et al. (2014) suggested Māori position of subjugation fails to recognise the power of the state, which perpetuates oppression while also playing down the hardships of Māori survival (New Zealand Government, 2018). The political bias of the state asserted that Māori are to blame for their inequitable social position, poor health, and well-being (Penehira et al., 2014). Wirihana and Smith (2019) contended that urbanisation and assimilation have relentlessly exploited Māori children, youth, and whānau. The success of the colonial socio-political agenda positions taiohi and whānau in economic poverty, educational poverty, exposure to racism, and confinement in discriminative justice systems.

Poverty

Poverty is a lack of money to meet basic needs, including food, clothing, shelter, education, and health. Many Māori children and youth are three times more likely to live in poor households (Clark et al., 2018; Cram, 2019; Simpson et al., 2016). The Children's Commissioner (2012) and Wills, R. (2012) argued that poverty means Māori children and youth experience a cheaper diet with low nutritional value; they go to school hungry; and live in cold, damp households. They also experience lower educational achievement, poor health outcomes, and social exclusion. Poverty for taiohi includes "inadequate and overcrowded housing, inability to afford food that provides proper nutrition, inability to afford medical care, and inability to participate fully in society" (Haultain, 2012, p. 31).

According to Haultain (2012), poverty and its effects can be handed down across generations.

Gracey and King (2009) confirmed that Māori have a lower life expectancy and poorer health outcomes for psychological, emotional, physical, and financial well-being and education (Atkinson et al., 2014; Gracey & King, 2009). Poverty is strongly associated with physical health, mental health, and substance misuse (Lund et al., 2011). Te Ohonga Ake, a report prepared for the Ministry of Health, affirmed that taiohi (15-24 years) living in poverty have a higher risk of substance use and mental illness, including schizophrenia, delusional disorders, depression, bipolar disorder, affective disorder (Craig et al., 2012). Simpson et al. (2017) argued that substance misuse and mental illness are more likely when associated with poverty. Theodore et al. (2022) affirmed that social determinants such as poverty, unemployment, housing insecurity, and loss of communal spaces link to a lower life expectancy. A troubling claim by many is that poverty rates experienced by Māori are not slowing down (Blakely et al., 2006; Clark et al., 2018; Elgar et al., 2015; Poata-Smith, 2013).

Racism

Most traumatic in contemporary society are the experiences of racism and discrimination (Clark et al., 2018; Harris et al., 2006; Paradise et al., 2008). Many argue that negative experiences based on cultural and ethnic identities result in discriminative treatment (Bouhaddani et al., 2018; Cormack et al., 2013Schmitt et al., 2014; Veling et al., 2008). The Ministry of Health (2012) found that taiohi who identify as Māori are more likely to experience racism and discrimination. For instance, penalising Māori for being Māori is seen in the enactment of the Tohunga Suppression Act (1907) (The Ministry of Health, 2012), a political strategy to outlaw traditional Māori healing, forcing healers to go underground, taking their knowledge with them (Durie, 2001). According to Donald (2009), colonial hegemony dominates and imposes power to define what good health is for Māori

Māori understand good health is multidimensional and connects with whānau, physical, emotional, mental, and spiritual modes of care (King et al., 2009). However, scientific research argues that racism affects health outcomes (Paradies, 2016; Ricci et al., 2018; Williams et al., 2019). Harris et al. (2018) studied multiple cross-section national surveys in Aotearoa between 2002 and 2012. They found that racism against Māori and Pacifica youth links to poor mental and physical health outcomes and ethnic health inequities.

Additionally, Clark et al. (2011) asserted that racism increases the risk of developing PTSD and influences taiohi suicidal rates. Others found that between 2012 and 2019, racism and inequitable access to mental health services contributed to the deterioration of mental health and wellness for taiohi (Clark et al., 2022; Ellison-Loschmann & Pearce, 2006).

Pākehā struggle to reflect and understand how their values and beliefs determine what is best for Māori health and well-being (Martel et al., 2020). The failure to recognise their cultural beliefs in health leads to conscious and unconscious bias, such as power imbalances, stereotyping, and miscommunication (Martel M. et al., 2017). Addy (2008) and Daltom (2005) asserted that white people must learn from those who have experienced oppression to ensure they do not remain ignorant because remaining ignorant reinforces racism. McCreanor's (1993) paper 'mimiwhangata' argued that Pākehā deliberately and advantageously positions themselves as unaware of racism because it supports the discriminatory practice void of the harmful consequences of their actions.

Further, power imbalances promote inequities in treatment (Lacey et al., 2020; Lee et al., 2017). For instance, taiohi are more likely to be treated under the Mental Health (Assessment and Treatment) Act 1992, secluded, and readmitted after discharge (New Zealand Government, 2018). Also, taiohi are less likely than non-Māori youth to receive medications such as antidepressants. Theodore et al. (2022) noted significant under-reporting, treatment, and assessment of emotional issues compared to non-Māori. Additionally, taiohi reluctance to access mental health services due to racism compromises early detection of mental health and substance use issues at early stages of distress, causing the severity of symptoms (Bowden et al., 2015).

Racism disrupts a positive sense of belonging and internal feelings of self-worth (Egeland et al., 1993). Bronk (2011) argued that youth without a purpose struggle with a secure identity. For instance, taiohi experiencing mental health issues often feel stigmatised, expressing feelings like 'I do not fit in' or 'What is wrong with me?' The driving forces behind such feelings align with identity formation and are associated with loneliness, alienation, and the hopelessness of living with mental illness (Hagerty et al., 1992). Ramsden (2002) concurred that accepting racism triggers a negative self-perception of being Māori. Pere (1982) argued that Māori youth's right to be free and have choices is impossible within the colonial discourse. As confirmed by Crawford-Garrett (2018), the colonial discourse has placed Māori in a place of oppression.

Education

Racism, physical abuse, control, and domination began for Māori children in the 1900s when attending native schools (Jenkins & Mountain Harte, 2011). As a result, Māori children leave school as early as ten years of age (Wirihana & Smith, 2019). Today, racism in education continues, and poor academic outcomes for taiohi include declining attendance, high dropout rates, and mental health and substance use issues (Clark et al., 2018; Marie et al., 2008; Ministry of Education, 2013; Poa & Wright Monod, 2017). Taiohi are signalling that a cause for dropping out of school is the discomfort in the dominant cultural environment. A discomfort that also heightens the risk of suicide (Clark et al., 2011).

Additionally, Māori students experience higher suspension rates than non-Māori Ministry of Education, 2013). Further, hegemonic practices include low expectations of Māori student educational outcomes (Hynds et al., 2018). For example, both Māori university and high school students reported that Pākehā students or teachers disbelieved their success, criticising success as special treatment (Baleinakorodawa, 2009; Holmes et al., 2001; Mayeda et al., 2014; Turner, 2014). Taiohi argue that they feel like second-class students in their own country (Clark et al., 2018; Crengle et al., 2013; Poa & Wright Monod, 2017; Te Puni Kokiri, 2017). The New Zealand Government (2018) asserted that Māori youth are likelier to leave school without formal educational achievements.

To improve Māori educational success, the Government of the day supported the revitalisation of Māori culture through the kōhunga reo movement during the 1980s. Matua Rautia, the Report on Kōhunga Reo Claim (New Zealand Waitangi Tribunal, 2013), acknowledged the importance of tino rangatiratanga and the development of kōhunga reo childcare facilities. Kōhunga reo language nests included te reo Māori, tikanga Māori, and mātauranga Māori in their learning (Farrelly et al., 2006; L. T. Smith, 2012). According to Mitchell et al. (2006), kōhunga reo strengthened Māori children learning through Māori socialisation. Additionally, whānau developed a renewed sense of identity through connection with other Māori. Nevertheless, kōhunga reo remained under the governance of a colonial pedagogy and, over time, kōhunga reo nests declined nationally (New Zealand Waitangi Tribunal, 2013). Duckworth et al. (2021) affirmed that cultural knowledge acquired from whānau and other Maori systems contributes to solid identity formation, which is fundamental to the achievements and aspirations of Māori.

While outcomes for Māori are improving, nationally, educational outcomes remain poor (Ministry of Education, 2018; Office of Auditor General, 2016; Tertiary Education Commission, 2018). Mainstream education systems are failing Māori, and the negative perception of Māori ability to succeed places them in a deficit model, suggesting they are incapable (Bishop & Berryman, 2006; Macfarlane, 2004; Simmonds et al., 2014). However, during the 1830s and 1840s, many Māori taught themselves to read and write English (Elsmore, 1985 cited in Walker, 2016), suggesting that Māori capability to learn in their way and in their environment was possible and practical. Nevertheless, colonisation has effectively limited access to Māori knowledge in the education system, focusing on dominant Pākehā knowledge systems (Education Counts, 2019; Penetito, 2010; Walker, 2016). Promoting a thriving learning environment requires space for taiohi to draw on their cultural knowledge.

The justice system

Colonial hegemony reaches deep into the justice system. Theodore et al. (2022) argued that taiohi position in the justice system results from structural determinants of inequity, including colonisation, racism, and poverty, leading to higher rates of taiohi cannabis convictions than non-Māori youth. Others argue that poverty drives Māori criminal intent (Poata-Smith, 2013; L. T. Smith, 2012). According to Judge Bidois, long-term improvement requires reversing the poverty of spirituality, hope, opportunity, and cultural poverty. Workman (2019), a police youth aid officer and an employee in the Ombudsman's Office, recently participated in the Royal Commission of Inquiry about historical abuse in state care. His statement reflects on the systemic discrimination and ill-treatment of Māori youth. He described his experience from the 1970s, claiming that when he visited Kohitere (a state-run institution for young men), he saw that 90% of those locked up were young Māori males. A realisation that the State had absolved itself of any responsibility and treated them as offenders (Workman, 2019).

Further, by 2014, Māori youth apprehensions had risen to 60% (Workman, 2019). Norris and Lipsey (2019) argued that engagement in criminal activity increases when taiohi experience societal and political challenges of systemic discrimination. Cunneen et al. (2016) proposed the need to challenge disorderly and threatening deficit labels towards youth. According to Poa and Wright Monod (2017), taiohi are more likely to be prosecuted and sentenced in the justice system than other ethnicities. For instance, in 2012, taiohi represented 20% of the youth population, representing 53% of the youth apprehensions. In response, the Government developed a Youth Crime Action Plan

(2013-2023), recognising that youth needs and vulnerabilities require partnering with communities, minimising escalation, and supporting early exit (Ministry of Justice, 2012). Acknowledging and implementing positive steps that help shift negative perceptions Māori hold about the justice system is critical

The social status of taiohi has undergone significant changes due to colonial hegemony. Colonial hegemony has eroded Māori traditions and ways of knowing, as racist practices and policies perpetuated in crucial institutions such as government, education, health, and justice systems. As a result, taiohi and their families have been marginalised in society, struggling with poverty and limited access to income, employment, and education. These challenges have increased social stressors and negatively impacted their health and well-being. The disruptive effects of colonialism have also caused trauma and upheaval within Māori whānau units, forcing them to adapt to new family arrangements and individual survival. Despite these challenges, taiohi and whānau still possess varying Māori knowledge and continue supporting each other with awhi and mānaakitanga.

Whānau Realities of Providing Manaakitanga for Taiohi

The roles and responsibilities of whānau before colonialism

Colonisation has deconstructed whānau roles and responsibilities of Māori in contemporary society (Child Trends & World Family Map, 2014; Statistics New Zealand, 2015; Waldegrave et al., 2011, 2016). Before colonial contact, whānau shared a mutual connection of responsibilities and obligations that sustained the shaping of young Māori identities (Peterson, 2014; Taylor & Oskay, 1995) made possible through whānau knowledge of a Māori worldview (Peterson, 2014; Taylor & Oskay, 1995). Whānau connectedness is crucial for taiohi because it enhances cultural identity and a sense of belonging (Stuart & Jose, 2014; Wehipeihana & McKegg, 2018). The collective responsibility of the whānau upholds the mana of their hapu and iwi (Dell, 2022; Durie, 2001). Whānau Māori believed their full potential lay in the knowledge of te ao Māori, mātauranga, and their ability to participate in New Zealand society (Durie, 1999; New Zealand Government, 2018).

Acknowledgement of the flax bush is a guiding metaphor for whānau. According to Metge (2015), Māori flax bush symbolises whānau (te Pā harakeke) (see Figure 1). The flax bush has long sword-like leaves sprouting out like a fan. Roots intertwine at the bottom of the fan, and a sharp tool is required to separate the roots (Metge, J 1995). Growth occurs at the core of the fan, where new shoots (rito) blossom, and here they are

protected by the older roots to ensure the continuation of growth. According to Metge (2015), the rito (centre shoot) identifies a child in each fan (tamaiti) emerging and protected by its parents (mātua) on either side. Like fans in the flax bush, parent-child families in the whānau share common roots and derive strength and stability from forming part of a larger whole.

Figure 1

Harekeke - Flax Bush (personal photo)

Like rito, children are the hope of continuity into the future. Flax and whānau live through growth, death, and regeneration cycles—"New life grows from the old" (p. 19). The flax bush portrays the whānau unit as many generations whose roles and responsibilities reflect their birth position or the status and place achieved or earned within the whānau (Metge, J., 1995; Tate, 2010; R. Walker, 1990). As a collective, whānau have the potential to sustain a productive and healthy lifestyle for all members. Therefore, whānau are the core social unit of whakapapa and kaupapa Māori principles such as manaakitanga (N. Smith, 1948; L. T. Smith, 2012).

Whānau manaakitanga

Manaakitanga exercises mana and power for whānau, hapū, and iwi. Mana represents spiritual authority and power within the whānau (Marsden & Royal, 2003; Tate, 2010). Many believe spiritual authority provides a life force in the universe—energising, caring, and connecting pathways for positive Māori identity formation (Gone, 2013; Marsden & Royal, 2003; Moeke-Pickering, 1996; Murphy & Gray, 2013; L. T. Smith, 2012). Others believe positive identity formation is supported by sharing roles and responsibilities (Witherspoon et al., 2009; Woolley et al., 2009; Zimmer-Gembeck et al., 2006). According to Ware and Walsh-Tapiata (2010), manaakitanga represents relationships and collective connections nurturing relationships with kindness and respect (Murphy & Gray, 2013; Ware & Walsh-Tapiata, 2010). For instance, the grandparents' role and

responsibilities were nurturing the ideals of manaakitanga through sustained responsibility and influence; and providing leadership, guidance, and manaaki for the whole whānau (Edwards et al., 2007; Penniman, T 1986). They encouraged parents to maintain their responsibilities to support their extended whānau economically and physically and develop their children's economic and physical well-being (Bray & Hill, 1973; Buck, 1950; Pere, 1982).

Williams et al. (2010) shared insights about kaumātua when they were taiohi. Many tell stories of living with large whānau, with the freedom to move between houses, making themselves at home—part and parcel of that household. They also talked about living off the land and sea while embracing their role in kaitiakitanga, maintaining their role as guardians of the land and resources. Durie et al. (2010) agreed that whānau share a universal kinship as a collective that generates reciprocal ties and aspirations. Sharing engagement with tikanga Māori, whakapapa, and spirituality was reciprocal amongst whānau but discouraged by colonial hegemony (Jaram, 2009; Williams et al., 2010; Wikitera, 2019).

> E tā, taku kupu ki a koe, kia manaaki i te tangata rahi, i te tangata iti.
> My friend, let me say this to you, care for all great and small people. (Moorfield, 2011)

Whānau Realities After Colonial Contact

Disruption of the whānau unit

Colonial hegemony and economic priorities have influenced whānau constructs, with many adopting colonial concepts (Durie et al., 2010), suggesting colonial discourse has tampered with and reshaped Māori sense of belonging to whānau connectedness roles and responsibilities (Edwards et al., 2007). For instance, today, Māori define and decide their whānau, which may be kin or other (New Zealand Government, 2018). Kingi et al. (2018) interviewed rangatahi (taiohi), who engaged in self-harming behaviour. They referred to two types of whānau—kaupapa whānau and whakapapa whānau, as did Metge (2001). Whakapapa whanau connect through blood ties. Rangatahi engaging in self-harming behaviours felt supported by kaupapa whānau because they provided awhi and manaaki for each other and felt disconnected from their whakapapa whānau. Whereas kaupapa whānau self-identified with each other, including their peers and those they met at school. The disruption of whakapapa whānau dynamics means taiohi cannot always live with their loved ones or connect to develop and maintain a relationship of mutual benefit

(Edwards et al., 2007; Worrall, 2009). Tamihere's (2003) speech on the 'Myth of whānau' suggested that many Māori whānau struggle to nurture, teach, and guide as they did in traditional times. Tapsell et al. (2018) concurred that the social glue of connectedness, which traditionally provided Māori purpose and cohesion, is changing. According to Paul et al. (2017), disruption to family units has led to unhealthy coping mechanisms. Affecting the capability of whānau nurturing (Buu et al., 2009). Reid et al. (2014) suggested that limited connectedness with whānau can be associated with behavioural problems such as impulsivity, aggression, and substance misuse later in life. According to Hamely et al. (2023, despite the challenges, what is vital for taiohi is connecting with rich networks of intergenerational support, the environment, and practices that connect them to whānau. This connection to whānau highlights the importance of te ao Māori and recognising the fluidity of engaging in Māori cultural ways of knowing.

One-parent whānau

Deconstruction of the whānau unit has led to the reconstruction of one-parent families (Dhunna et al., 2018). Aotearoa has one of the highest rates of one-parent families within economically developed societies. Single parents are one in four, and Māori comprise many of these numbers (Child Trends & World Family Map, 2014; Statistics New Zealand, 2015). Many single-parent families cope well but are susceptible to social, educational, and financial poverty (Waldegrave et al., 2011). Waldegrave et al. (2016) conducted a qualitative study in Aotearoa to develop policies and interventions to support single-parent families. They interviewed 60 sole parents (20 Māori Pacific, 20 Māori, 20 Pākehā) and their children. The point of difference was the values, beliefs, cultural, and spiritual resources vital for single parents to develop a positive and resilient outlook on life. An excellent example of an initiative that empowers Māori whānau and communities while embracing Maori cultural values is driven by Whanau Ora. Affordable housing and access to quality education are crucial for promoting family resilience. Single parents often prefer to work but need flexible work hours that align with their lifestyle to work while caring for their children.

The conception of children at a young age

Another cultural difference for Māori whānau in a dominant Euro-western discourse is conceiving children at a young age. Wirihana and Smith (2019) mentioned that childrearing responsibilities strengthen the connection with the whānau, hapū, and iwi. However, in contemporary society, young Māori parents are stigmatised for having children at a young age (Breheny & Stephens, 2015). Ware et al. (2018b) examined how

young Māori parents navigate and negotiate the negative experiences of young parents. Using a snowballing strategy, they recruited young Māori parents from local parent services bringing to attention two key kaupapa. First, young Māori parents embrace te ao Māori as a safety net when resisting negative assumptions. Second, they resist racism and stigma by strategically adopting Euro-Western concepts. Adopting Western concepts of being a good parent lessens the stigma associated with being a young and Māori (Ware et al., 2018).

Mental Health Addiction Services and Taiohi and Whānau

Accessibility and utilisation

Accessibility and utilisation of mental health and addiction services is a barrier for taiohi, making them a priority in Aotearoa (Abel et al., 2012; Baxter, 2008; Baxter et al., 2006; Clark, 2014; New Zealand Government, 2018; Oakley Browne et al., 2006; Ramage et al., 2005). Gordon-Larsen, P. et al. (2004) argued that rangatahi Māori are less likely to connect with mental health and addiction services. As noted by Robson and Harris (2007), fewer than one in three taiohi are likely to contact mental health services for support when mentally unwell. Globally, child and adolescent mental health service delivery is underdeveloped (McClintock, 2012). Many believe adolescent ethnic minority populations continue to have unmet needs (Commander et al., 2003; Garland et al., 2005; Yeh et al., 2003; Yeh et al., 2005). Globally, the adolescent ethnic population experiences mirror child and adolescent mental health services in Aotearoa (Baxter, 2008; Baxter et al., 2006; McClintock et al., 2012; Ramage et al., 2005; Tapsell & Mellsop, 2007).

Poor accessibility to mental health services for youth long-term affects personal development, education, employment, and social engagement (Gibb et al., 2010). Clark et al. (2014) argued that delayed access to mental health services leads to mental distress, including major depression, anxiety, psychosis, and substance use. Likewise, American Indian and Alaskan Native youth also experience poor access to mental health and addiction services due to understaffing and underfunding (Trimble, 2012). Australian Aboriginal youth are also reluctant to access mental health and addiction services due to their distrust of monocultural mental health services. Additionally, social-political adversities impact access for taiohi and other Indigenous youth groups. These adversities include experiences of poverty, deprivation, racism, social isolation, and trauma (Cunningham et al., 2018; Harris et al., 2018; Petrović-van der Deen et al., 2020; Reid et al., 2014). Others suggest that socio-political adversities, including limited access to money and transport, affect mental health service utilisation (Clark et al., 2014; Mills et

al., 2012; Pagey et al., 2010). Extra pressures in lifestyle affect the motivation to engage in treatment (Pagey et al., 2010).

However, mental health and addiction services fail to connect with taiohi. As a result, their needs go unmet (Jansen et al., 2009; New Zealand Government, 2018), increasing mental health acuity on admission (Te Puni Kokiri, 2017) and preventing early intervention and treatment (Ministry of Health, 2018; New Zealand Government, 2018). Christie et al. (2018) believed the failure to connect with taiohi could provoke early treatment dropout and non-completion. Schroder et al. (2009) concurred that up to a quarter of young people in their study dropped out of treatment because of disciplinary issues. Underutilisation of health services continues in the community as young people resist access to general practitioners (Crengle et al., 2013). Inequitable care compromises retention and utilisation and can cause early discharge.

In response to child and youth mental health and addiction issues in Aotearoa, the 'Youth Mental Health Project' was launched to improve access and promote opportunities for young people with mental illness and addiction issues (Key, 2012). A review and evaluation of the project complemented the project's success after Malatest International (2016) found that the project increased access for youth in Aotearoa. However, Mills et al. (2012) argued that the evaluation failed to recognise the uniqueness and realities of taiohi among the majority, creating false positives about their access to mental health and addiction services. Kieling et al. (2011) argued that a continued lack of government policy, inadequate funding, and workforce development hinders access to services.

The medicalisation of mental health and addiction services

The ongoing effects of colonial hegemony, racism, and health inequities in mental health service delivery have failed taiohi, highlighting a breach of Te Tiriti o Waitangi (Came et al., 2020). Further, the absence of Māori modes of care removes the collective approach that incorporates Māori cultural identity and traditional knowledge. Māori epistemologies acknowledge the effects of colonialism and offer a framework that recognises intergenerational trauma and the importance of te ao Māori and tikanga Māori. An approach supported by various researchers and the Ministry of Health (Baker, 2010; Durie, 2003; Kenney et al., 2015; Ministry of Health, 2002; Moeke-Pickering, 1996;

The medicalisation of mental health and addiction services fails to connect with the consumer when seeking support for their mental and emotional distress (Beresford, 2005; Menzies et al., 2013; Watermeyer, 2013). Beresford (2005) suggested this is related to

two conflicting paradigms. One paradigm promotes a holistic mode with the consumer's best interests, while the other offers control, regulation, and surveillance pressures. Taiohi mental health and well-being depend on holistic and culturally safe care. Bennett and Liu (2018) added that the dichotomy between spirituality and science affects barriers to competent assessment and effective treatment. Additionally, the first line of treatment is typically chemical and compulsory hospital admissions aimed to keep consumers in check instead of supporting their mental distress. Others proposed that practitioners, health professionals, and scholars working in mental health may normalise and accept medicalised assumptions without advocating for other care options (Timander & Möller, 2016; Timander et al., 2015).

Confinement

A critical barrier to accessing mental health is the dominant approach to initiate the Mental Health (Compulsory Assessment and Treatment) Act (1992) process. Taiohi are more likely than non-Māori youth to enter mental health and addiction services via police escort for intervention and compulsory treatment (New Zealand Government, 2018). According to Lyons et al. (2001), confinement into acute mental health and addiction systems exacerbates mental health issues due to opposing environmental contexts. When taiohi resist access to mental health services, they are labelled as having antisocial behaviour, increasing their risk of entering justice or social welfare systems (Buchanan, 2006). Additionally, youth facing confinement are more likely to experience physical and mental health issues and higher mortality and morbidity outcomes (Barnert et al., 2017; Porter & DeMarco, 2019).

Diagnostic and treatment bias

Bias in diagnosis is another bone of contention in a medicalised mental health and addiction system (Durie, 2011). For instance, Māori are less likely to be diagnosed with depression or anxiety (Abel et al., 2012; Thomas et al., 2010). However, they are more likely to be misdiagnosed with schizophrenia. For instance, taiohi who admit to substance misuse for the second time are likelier to be diagnosed with a psychotic disorder or schizophrenia than an addiction issue (Bell et al., 2011). Read et al. (2006) contended that a mental disorder, such as schizophrenia, promotes negative discriminative attitudes that internalise stigma, causing low life satisfaction and self-esteem. Stigma can also activate substance abuse, depression, and suicidality (Birchwood et al., 1993; Pompili et al., 2003; Sayce, 2003). Bell et al. (2011) discussed bias in emergency departments for substance use patients. For instance, those with mental health issues are more likely to receive

follow-up treatment, and those with substance use are less likely to receive follow-up on discharge. Bhugra (2001), Fernando (2014), and Mcintosh (2006) concurred that discriminative Euro-Western psychology and psychiatry diagnostic paradigms affect youth self-esteem.

Workforce issues

Taiohi have unique mental health and substance use issues resulting from multiple complex problems, including poverty, weakened Māori identity, negative colonial, intergenerational historical trauma, and a lack of belonging. Oppression of their identity and belonging is impacted by experiences of racism and discrimination, contributing to power imbalances and unequal treatment (Lacey et al., 2020; Lee et al., 2017). According to Dowell et al. (2009), general practitioners struggle to keep up with the complexity of taiohi mental health needs. School counsellors are also overwhelmed by the number of emotionally distressed students (New Zealand Government, 2018). Several writers have suggested that the workforce lacks the confidence to manage, treat, and refer youth to appropriate services (Curtis, 2010; Jansen et al., 2009; Schroder et al., 2009). A lack of referrals to culturally focused programmes is a concern (Abel et al., 2012; Thomas et al., 2010). Disregarding cultural communication and social and environmental relationships in psychiatry impacts treatment options. Durie (2011) affirmed that this leads to cultural alienation, inadequate access, and inappropriate assessment.

The ability to engage in cultural knowledge and ways of being have a positive effect on youth well-being. Westerman (2010) reviewed the effectiveness of culturally appropriate care models for Aboriginal youth in a mental health setting, and findings demonstrated that adopting a cultural perspective provides positive outcomes for Indigenous youth. In support, Haswell et al. (2013) agreed that mental health outcomes are improved for Aboriginal youth when connected to and integrating a cultural perspective in health service delivery improves outcomes. Further, Schroder et al. (2009) asserted that more training and work development are needed to increase service utilisation. Colonial hegemony embraces a discriminative discourse that causes taiohi to distrust the Western system (Pack et al., 2016), and negative perception of mental health services creates barriers to early intervention and utilisation (Jansen et al., 2009).

Lack of trust

Taiohi have little trust in mental health and addiction services. Durie (2001) argued that Māori feel ignored and are reluctant to disclose their mental health beliefs for fear of

marginalisation. Martin and Mirraboopa (2003) concurred that Indigenous youth lack confidence in doctors and are reluctant to disclose mental health issues. Clark et al. (2018) claimed that taiohi fear a breach of confidentiality and believe they can manage their mental health and addiction issues. Denny et al. (2012) surveyed 13-19-year-old students to understand their mental health services experience. They found that students had difficulty accessing services for sensitive issues, often due to having little confidence in clinicians maintaining their confidentiality. In a study by Taitimu et al. (2018), one Māori patient explained why he remained silent when experiencing psychotic symptoms:

> If you fight against being psychiatric, you are going to go down, you're going to get locked up, and you are going to get hurt. I've done Lake Alice, which is a highly psychiatric prison, I've been to Lake Alice, and you've just got to face it, the truth is psychiatric, you're getting punished by God. (Taitimu et al., 2018, p. 17)

Cultural safety

The concept of cultural safety arose in nursing training in Aotearoa. According to Papps and Ramsden (1996), it was a response to the poor health status of Māori and recognition of the statutory obligations for Māori under Te Tiriti o Waitangi. According to Ratnam et al. (2022), cultural safety is an obligated right for taiohi in Aotearoa. Under Article 30 of the 'United Nations Convention on the Rights of the Child,' Aotearoa and Australia are expected to promote Indigenous cultural safety in their respective family laws. A specific obligation is due to the intergenerational trauma Indigenous young peoples have suffered due to colonisation. Curtis et al. (2019) signalled that cultural safety requires a balance of power between professionals, caregivers, and people receiving care.

Cultural safety requires an individual or family working with someone from another culture to reflect on their cultural identity to understand the impact this has on their care delivery. According to Hromek (2023), cultural safety creates a space for people who are often silenced or historically excluded from expressing their concerns to be heard. Focussing on power relationships and patient rights allows the individual or family to determine if they feel culturally safe (Hromek, 2023; Ramsden, 1995). In opposition, the New Zealand Nurses Organisation (1995) described cultural unsafety as a practice that demeans or disempowers cultural identity endangering individual or whānau well-being. Therefore, cultural safety must ensure that all cultural expressions are enabled, irrespective of personal values and opinions.

Cultural safety for Māori includes acknowledging a Māori worldview that embraces mātauranga Māori and tikanga Māori. Culturally safe interventions in mental health and addiction services demonstrate effective care pathways for taiohi and whānau. In Aotearoa, the absence of Māori cultural models in care pathways compromises equitable health outcomes for Māori (Waitangi Tribunal, 2019). Access to Indigenous knowledge and understanding of social adversities improve access and promote wellness (Atdjian & Vega, 2005; Gurung & Mehta, 2001). According to Clark et al. (2014), Māori led kaupapa Māori services for Māori create positive points of difference to support successful access and utilisation that improves health outcomes. Bicultural mental health services also offer concepts such as tikanga, awareness of social adversities, and psychological input (Martel et al., 2020).

Māori modes of healthcare

Understanding the unique and complex cultural needs of Māori is critical (McLachlan et al., 2021). According to McLachlan et al. (2021), the importance of Māori cultural worldviews has developed over 3-decades in recognition of inequitable health outcomes for Māori (Waitangi Tribunal, 2019). Māori healthcare models recognise the importance of a solid relational and cultural identity that offers collective approaches to healthcare and access to traditional lands and knowledge. Māori models of healthcare intend to empower and build on mātauranga Māori. Mātauranga embraces Māori ontological knowledge that expands into Māori epistemologies. Māori epistemologies acknowledge the influence of colonial contact on every facet of Māori livelihood (McNeil, 2009). They provide a cultural worldview that recognises intergenerational trauma as a result of colonisation and the impact of marginalisation, racism, and the role of te ao Māori and tikanga Māori (Baker, 2010; Durie, 2003; Ministry of Health, 2002; Moeke-Pickering, 1996; O'Hagan et al., 2012; Pitama, Robertson, et al. 2007).

Nonetheless, Māori modes of healthcare and well-being have remained in the background for too long, to the detriment of secure Māori cultural identity and health and well-being. Moreover, equitable health outcomes for Māori require culturally based Māori health and well-being modes to deliver essential cultural values, processes, and practices for improving Māori health outcomes (Wilson et al., 2021). Wilson (2021) suggested three key concepts conceptualising Māori modes of health, including whanaungatanga (connectedness), whakawhanaungatanga (building relationships), and the socio-political health context. Whakawhanaungatanga operationalises relational connections—whanaungatanga—underpinned by whakapapa, a source of identity and support (Pere,

1991), to enhance connectedness and growth of relationships. It embraces aroha (empathy and compassion) and manaakitanga (kindness, generosity, and support to look after others) to support the establishment of connection (Barton & Wilson, 2008; Robinson et al., 2020).

Whanaungatanga is vital for building trusting relationships (Love, 2004) and engaging with health services and practitioners (Wilson et al., 2021). It considers whānau kinship, social roles, and bonds with others outside the whānau. Other vital factors presented in Māori models of health include wairua (spiritual), whānau (extended family network), hinengaro (the mind), and tinana (physical) (Barton & Wilson, 2008; Durie, 1999; Love, 2004; Mark & Lyons, 2010; Murray, 2010; Pere, 1991; Pitama et al., 2007; Stevenson, 2018); all of which are fundamental to a person's holistic well-being.

Whanaungatanga ensures a shared balance of power when engaging with taiohi (Barton & Wilson, 2008; Lacey et al., 2011; Pere, 1991; Pitama et al., 2007; Robinson et al., 2020; Stevenson, 2018). The concept of whanaungatanga includes recognising taiohi rights and upholding the principle of tino rangatiratanga (self-determination). It is necessary to empower taiohi and give them control over their own experiences, as Jones et al. (2010) highlighted. Whanaungatanga offers opportunities to understand socio-political concepts such as historical trauma, poverty, and education issues, leading to increased involvement in the justice system. Socio-political contexts can inform and encourage healthcare practitioners to explore the realities of taiohi and whānau experiences living in a racialised society (Wilson et al., 2021). It also promotes positive physiological and psychological outcomes (Reis & Gable, 2003). Adverse social positioning and political and environmental consequences increase the risk of mental health issues (Coid et al., 2020; O'Donoghue et al., 2016; T. R. Kake et al., 2016; Linscott et al., 2006). Māori care pathways provide a relational and reciprocal process necessary for clinicians to understand (Durie, 2001) to promote respectful engagement necessary for developing rapport and trust and supporting equitable health outcomes

Kaupapa Māori services

The impetus for kaupapa Māori health services began in the 1980s, embracing multiple Māori cultural strategies and influencing the development of Māori models of health (Durie, 2011; Ministry of Health, 2002). Kaupapa Māori approaches led to the indigenisation of health service delivery, believed to enhance identity by reconnecting with cultural knowledge and balancing relationships between whānau, hapū, and iwi

(Durie, 2011). Kaupapa Māori models of care are ideal because of the immersion into a Māori worldview that embraces te ao Māori and mātauranga. Additionally, responding to trauma experienced by Māori requires Māori modes of care and Indigenous approaches (Rosenberg, 2011).

Kaupapa Māori services mobilise principles of te ao Māori to inform and enrich Māori self-determination (rangatiratanga) and mātauranga (Marsden & Royal, 2003; Peterson, 2014; Tate, 2010; Taylor & Oskay, 1995. According to Tse et al. (2005), kaupapa Māori services embrace spirituality as a holistic approach to promoting and improving social skills, social support systems, self-esteem, and hope. These services enhance cultural safety and influence the cultural and clinical treatment that supports early intervention opportunities (A. Bell, 2016; Clark et al., 2013; Durie, 2011; Fleming et al., 2014).

Adapting and embracing kaupapa Māori models of care is vital for mental health and addiction services (Durie, 2011; Ministry of Health, 2002). Tse et al. (2005) described the development of 'Your Choice', a kaupapa Māori programme developed by doctors in West Auckland, focused on improved accessibility. The positive points of difference were cultural diversity, explicitly supporting taiohi exposure to social adversities (Atdjian & Vega, 2005; Clark et al., 2014; Gurung & Mehta, 2001). Abel et al. (2012) evaluated 'wairua tangata', a holistic Māori health programme run by a kaupapa Māori service. The programme addressed mild to moderate anxiety and depression for young Māori. The cultural emphasis increased engagement with the target population. A decrease in not attending appointments was a vital marker of success.

Bicultural services

To uphold the obligation to te Tiriti o Waitangi, the Government established a bicultural policy of equality and partnership (Bishop, 2005; Durie, 1997; L. T. Smith, 2012; Wirihana & Smith, 2019). According to Bennett and Liu (2018), biculturalism in Aotearoa is a symbolic attempt to mobilise Māori culture as a national identity. Bicultural healthcare delivery is a collaborative approach between Māori and Pākehā used to improve health outcomes for Māori. It is comparable to the HEEADSSS assessment tool (Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide/Depression, and Safety) that includes cultural models of care, including tikanga, understanding social adversities, and psychological issues (G. L. Smith & McGuinness, 2017). Martel et al.'s (2019) mixed-methodology study evaluated 'Youth CHAT', a bicultural electronic screening tool in the Taitokerau region of Northland, Aotearoa. The

findings showed that youth CHAT created collaborative relationships across government agencies with positive outcomes.

Another bicultural study by NiaNia et al. (2017) used a narrative approach with four participants, including a 16-year Māori female who had experienced depression and suicidal ideations, a Samoan lady, a Māori healer, and a non-Māori psychiatrist for adolescents. The collaborative partnership included cultural elements of the Māori healer, who focused on mana and wairua, and the psychiatrist, who offered Western knowledge and psychotropic medication. The bicultural partnership provided an opportunity for Māori youth to benefit from the healing expertise located in both Indigenous and Western traditions.

A collaboration approach empowers individuals and families while considering peers, school, and community elements (Curtis et al., 2004; Henggeler & Schaeffer, 2010; Ogden & Halliday-Boykins, 2004). Curtis et al. (2019) concurred that collaborative treatment provides the necessary skills to help youth reduce mental health, substance use, and antisocial behaviour. Collaboration has a strong community focus, providing collaboration and connectivity within the environment. Pagey et al. (2010) argued that unity-based programmes positively affected youth behaviour, self-confidence, self-esteem, and physical activity.

Conclusion

Taiohi and whānau unique qualities stem from a relational aspect that embraces whakapapa, spirituality, and connection to land and people. Their traditional cultural knowledge of te ao Māori and tikanga set the scene for the evolving knowledge of mātauranga Māori. However, colonialism has disrupted Māori ways of knowing, displacing them from their land, whānau, and cultural knowledge. The effect of multiple losses and exposure to traumatic experiences has increased taiohi risk of substance use and mental health issues. For some, Taiohi have become victims of historical trauma; cultural disconnection has weakened identity formation and a sense of belonging, significantly impacting their mental health and well-being.

Colonialism has positioned taiohi in a place of ongoing risk, and the proportion in this study have entered a pathway of substance use and mental health issues. Taiohi and whānau sought help from mental health and addiction services to support taiohi recovery.

However, delays in obtaining help occurred due to issues related to accessibility. Taiohi using mental health and addiction services, experience the trauma of racism; confinement; and culturally unsafe practices, policies, and procedures. Exposure to these practices compromises taiohi trust in the system and those who provide the care in acute mental health and addiction services. Optimising taiohi treatment and recovery is possible through Māori modes of healthcare that provide a holistic approach. An approach that is relational and inclusive of whānau to enhance and uplift taiohi mental health and well-being.

Chapter Three: Methodology and Methods

Introduction

This chapter describes the research methodology and theoretical underpinning using te ao Māori as a decolonising lens. Using a kaupapa Māori research methodology provides opportunities to use Māori concepts of te reo Māori, tikanga Māori, and mātauranga Māori. Additionally, it aims to uplift the mana of taiohi and whānau by enabling a decolonising theory by Māori for Māori and with Māori (Cram, 2018). A kaupapa Māori research methodology can highlight the displacement and misinterpretation of Indigenous ontologies and epistemologies created by an empirical agenda in contemporary society. A conflict exists between Indigenous knowledge, realities, uniqueness, and dominant Euro-Western ideologies discourse (Chilisa, 2012; L. T. Smith, 2012).

Research that uses Indigenous methodologies within the academy can enhance human rights and social justice and revitalise Indigenous ways of knowing (Bishop, 2008; Chilisa, 2012; Pidgeon, 2018; Pihama, 2015; L. T. Smith, 2012). Kaupapa Māori research methodology resists colonial heritage and the hegemony of Aotearoa's colonial past to enable Māori cultural expectations and accountabilities. It is a collective relational approach that uncovers Indigenous ontology and epistemology founded on te ao Māori and tikanga evolving into mātauranga (Chilisa, 2012; Henry & Pene, 2001). Kaupapa Māori research offers an ethical approach open to evaluation and questioning. It seeks to find the tika (the truth) of taiohi social positioning and their exposure to substance use and mental health issues. Further, it helps to discover the pono (the right way) of working with taiohi and whānau along their pathway in search for taiohi recovery and well-being.

Applying a kaupapa Māori research methodology assisted in understanding taiohi and whānau experiences when moving from the community to acute mental health services. The preference for using an Indigenous theory is that it enhances a culturally unique inquiry into taiohi substance use and mental health inequities. It moves the discourse of victim blaming to understanding taiohi and whānau realities when confronted with substance use issues that lead to mental health issues. Responding to taiohi mental health inequities and the moral obligation to inform mental health services, policymakers, funders, and academic arenas of taiohi and whānau truth when faced with substance use and mental health issues is possible through a kaupapa Māori research methodology.

Indigenous Knowledge

The global population of Indigenous peoples is extensive, and each region is diverse, with a local framework of knowledge threaded through their political, social, and economic systems, evident in their different languages, cultures, and beliefs. Indigenous people's historical experiences, diversity of thinking, and locality influence their knowledge base and living philosophies. Indigenous knowledge is shared and shaped by specific people through historically lived experiences and diversity of thinking within a local environment (Kincheloe & Steinberg, 2008; L. T. Smith, 2012). Indeed, local knowledge captures. Indigenous voices, values, and ways of knowing to produce their epistemologies, ontologies, and cosmologies played out in their local environment (Chilisa, 2012; McIlwaine, 2006; L. T. Smith, 2012). Indigenous knowledge embodies languages, legends, folktales, stories, and cultural experiences of the formerly colonised and oppressed; symbolised in cultural artefacts such as sculpture, weaving, and paintings; and embodied in music, dance rituals and ceremonies (Chilisa, 2012; Pihama, 2015; Wirihana & Smith, 2019).

Kincheloe and Steinberg (2008) acknowledged the interconnectedness of Indigenous knowledge, including physical, mental, emotional, and spiritual understanding. This unique knowledge formation is distinct to Indigenous people's existence and survival. A critical and common component of Indigenous epistemology is spirituality, which unites Indigenous peoples (Bhagwan & Chan, 2014; Coyle, 2017; Dyson et al., 1997; Marsden & Royal, 2003). Māori believe spirituality has distinct spheres that cross the human-divine and mythical aspects of the world (Lilley, 2015; Marsden & Royal, 2003). However, spirituality is not readily observable in scientific discourse, and, as a result, western epistemologies often transfer spirituality to a religious realm (d'Abbs & Chenhall, 2013). This viewpoint opposes the proper understanding of spirituality and interconnectedness from a Māori perspective intertwined in the world of te ao Māori.

The interconnectedness of Indigenous intellect extends to a relational perspective with spirituality, the earth, the stars, the world, and the universe (Chilisa, 2012; Marsden & Royal, 2003; L. T. Smith, 2012; Wirihana & Smith, 2019). This relational philosophy embraces respect, balance, and reciprocity for all, challenging individual economic wealth and material gain (Chilisa, 2012; Denzin et al., 2008; Pihama, 2018; L. T. Smith, 2012). This construct acknowledges the living and the non-living, bringing assumptions and predictions about Indigenous reality to the forefront. The relationship with the land

is also a significant foundation for kinship and connectivity processes (Ahukaramu & Royal, 2012; L. T. Smith, 2012; Wirihana & Smith, 2019).

Indigenous knowledge and interconnectedness are unique to Indigenous groups that challenge Euro-Western paradigms of commonality and individualism. Their difference is significant, and their ways of knowing have created an academic discourse called Indigenous knowledge. Indigenous knowledge engages people across community boundaries with disciplinary, institutional, philosophical, and intergenerational theories, informing knowledge constructs Indigenously (L. T. Smith et al., 2016). In Aotearoa, mātauranga Māori is the term Māori use to define their ontologies and epistemologies (Le Grice & Braun, 2016). Indigenous knowledge provides a philosophical framework that guides, organises, and promotes an Indigenous identity that makes sense of the world (Kincheloe & Steinberg, 2008; Lavallée, 2009). It acknowledges the uniqueness of an Indigenous perspective in the literature that challenges dominant pedagogies constructed and developed through the Euro-western lens of research and methodologies.

Indigenous pedagogies outline and preserve different ways of knowing. Indigenous ways represent generations of collective experiences, astute observations, and active and harmful experiments known to be dynamic and specific to local identity (Chilisa, 2012; Pihama, 2018; L. T. Smith et al., 2016). Indigenous intellect incorporates traditional communication, learning, and living forms, challenging Euro-western knowledge discourse. If Indigenous pedagogy is analysed and explored effectively, it can positively affect change (Biermann & Townsend-Cross, 2008). Nevertheless, power relationships continue, and legitimising Indigenous knowledge is challenging (Denzin et al., 2008). Biermann and Townsend-Cross (2008) affirmed the theoretical articulation of Indigenous pedagogy as a valid knowledge system. Indigenous knowledge validates Indigenous realities and traditions but reinforces the colonial hierarchical power position in the Euro-Western paradigm.

There has been a call for Indigenous peoples to stand together and voice the urgent need to reframe, reclaim, and rename the research endeavour (Chilisa, 2012; Denzin et al., 2008; L. T. Smith, 2012). Given (2008) concurred that traditional writers from the West are encouraged to produce critiques of power relations that enforced oppression, marginalisation, poverty, and powerlessness. Chilisa (2012) asserted that understanding Indigenous epistemological ways of thinking must include Indigenous axiology of moral and ethical philosophies made possible by implementing collective ways to reclaim and

restore Indigenous ways of knowing to enable more culturally relevant 'bottom-up' research processes to align with the needs and traditions of specific Indigenous communities (Denzin et al., 2008). Therefore, the uprising of Indigenous research is essential to ensure. Indigenous peoples continue to inform dominant philosophies and knowledge of their truths and uniqueness.

In Aotearoa, Indigenous research and kaupapa Māori methodology encourage a structural inquiry into Māori health disparities and marginalisation (Curtis, 2016). The methodology moves the discourse of victim-blaming and emotional deficits to understanding people's lives and health and wellness (Cram, 2018). A kaupapa Māori inquiry paradigm articulates how research can support a decolonisation agenda, enhancing the revitalisation of Indigenous knowledge by responding to Indigenous people's human rights and the need for social justice. For this study, the decolonisation of Euro-Western pedagogy is possible using a kaupapa Māori research methodology.

Kaupapa Māori Research

Kaupapa Māori describes different ways of doing things. According to Henry and Pene (2001), kaupapa means a Māori way of doing, being, and thinking, a traditional description encapsulated in a Māori worldview of cosmology. Chilisa (2012) argued that Kaupapa Māori research embraces different ideas and issues important to cultural safety and research. Kaupapa derives from two words, kau and papa. Kau means to appear for the first time, to consider the interpretation of Papa, in this instance, emphasises foundations (Marsden & Royal, 2003). It adopts Māori relationality expressed in whakapapa (family tree) (Kana & Tamatea, 2006; Paki & Peters, 2015). An understanding that whakapapa means to lay one thing upon another; for example, to lay one generation upon another (Moorfield, 2011). Hence kaupapa can be explained as ground rules or principles through a Māori worldview.

Further, Kauapapa Māori research addresses Western ideologies of superiority that privilege the colonists (Bishop, 2008). Others suggest Kaupapa Māori research decolonises Euro-Western perspectives by critiquing ways of knowing and bringing together Māori understandings, experiences, teachings, and insights into the traditional cultural values that have influenced contemporary Māori worldviews (Henry & Pene, 2001; L. T. Smith et al., 2016). Kaupapa Māori research upholds the mana of a Māori worldview. Glover (1997) suggested that kaupapa Māori embraces a desire to recover and

reinstate mātauranga Māori. A system that holds traditional philosophies before colonisation.

Bishop (2008) framed the discourse on Kaupapa Māori research in the context of Te Tiriti o Waitangi. Kaupapa Māori theory explains and understands a Māori worldview, Māori space connected to tangata (people) and their tūrangawaewae (land). The founding document of Aotearoa, Te Tiriti O Waitangi, aims to protect the principles of a Māori worldview. Kaupapa Māori validates Māori ways of knowing (Cram, 2018; Kerr, 2012; Mane, 2009; Pihama, et al., 2015). Kaupapa Māori research informs Māori ontology through tikanga and whakapapa (Henry & Pene, 2001; L. T. Smith et al., 2016). According to Smith, L (1999), kaupapa Māori research provides a local theoretical positioning through which historical, social and political contexts happen.

Kaupapa Māori research informs Māori ontology through tikanga and whakapapa (Henry & Pene, 2001; L. T. Smith et al., 2016). The ontological concepts of whakapapa and te ao enhance and restore Māori identity (Durie, 2001). The relational structure expressed through te ao Māori and whakapapa also connects to the land, people, and everything in life (Henry & Pene, 2001; L. T. Smith et al., 2016). Therefore, te ao Māori and tikanga portray intricate relationships of Māori identity implicit in cosmology, spirituality, and reciprocity (Barlow, 1991; Henry & Pene, 2001; Mead, 2016; L. T. Smith, 2012). This relational philosophy of whakapapa highlights an ontological perspective of unity, accountability, and mutual respect, emphasising collaboration, power-sharing, and cooperation. (Marsden & Royal, 2003; Paki, 2007; Paki & Peters, 2015).

“Everything has a whakapapa: birds, fish, animals, trees, and every other living thing; soil, rocks, and mountains also have a whakapapa” (Barlow, 1991, p. 173). When Māori formally introduce themselves, they summarise their whakapapa, highlighting a relational identity. For example, my pepeha stems from my whakapapa. Expressed as below:

> Ko Makorā te maunga (mountain), Ko Whangape tōku moana (ocean), Ko Māmari te waka (canoe that came from Hawaiki), Ko Taio te marae (house of hospitality), Ko Kaingamata te hapu (subtribe), Ko Te Apouri, Te Rarawa, nga iwi (tribe), Ko Debra Gerrard tōku ingoa (name).

Mātauranga Māori reflects te reo and tikanga (Māori philosophies); it has distinct ontological, epistemological, and metaphysical understandings that underpin a Māori worldview (Mercier, 2013; E. P. Smith et al., 1999). Māori ontologies also embrace the

principles of tikanga Māori. As affirmed by Tate (2010), the principles of tikanga include mana, pono (to do the right thing), tika (truth), and aroha (love and compassion). Practices of tikanga include protocols that are incorporated into concepts such as kanohi ki te kanohi (face-to-face), whakawhanaungatanga (developing relationships through shared experiences), manaakitanga (hospitality, kindness, generosity), koha (gift, offering), and aroha ki te tangata (compassion for the people) (Jones et al., 2006; Walsh-Tapiata & Ware, 2010).

Mātauranga Māori is an evolution of Māori knowledge shared and shaped by Euro-western pedagogy. Nonetheless, it has distinct epistemological and metaphysical understandings underpinning a Māori worldview (Mercier, 2013; E. P. Smith et al., 1999). Mātauranga Māori has evolved and refers to Māori knowledge that is relational to other ways of knowing and being. It resides in a space that embraces Indigenous knowledge, epistemological and ontological understandings and vocabularies (Hikuroa, 2017; Mercier, 2013; Royal, 2013; L. T. Smith, 2012). Mātauranga Māori is academic expertise and refers to natural or organic knowledge captured in the metaphysical by bringing together the spiritual and material world (Ahukaramu & Royal, 2012). Kaupapa Māori upholds the mana of a Māori worldview.

The epistemology of mātauranga Māori acknowledges traditional ontological concepts and positions Māori realities in contemporary society. Epistemologies create axiology—a set of morals, ethics, and values. According to Chilisa (2012), axiology refers to analysing values, thereby better-understanding meanings, characteristics, origins, purpose, and acceptance. Mātauranga Māori as axiology aligns with tikanga and kawa (custom, ceremony), which uphold relational axiology to embrace social accountability and interpersonal skills (Hikuroa, 2017; Mercier, 2013; Royal, 2013). Kaupapa Māori enhances the development of change and analyses all forms of oppression that disempower Māori (Kerr, 2012). It enhances and restores the mana of Māori knowledge in recognition of colonialism.

Indigenous knowledge provides a starting point for developing an awareness of Indigenous realities and relational values (Chilisa, 2012). It has grown over 30 years from an understanding of tūpuna (ancestors) passed down over centuries. Today, Māori researchers question the influence of Euro-western philosophies on the construction of Māori identity. Māori question the realities and perceived truths about their identity documented in Euro-Western literature (Chilisa, 2012; L. T. Smith, 2012; Wirihana &

Smith, 2019). Kaupapa Māori research aims to decolonise Euro-Western perspectives by critiquing ways of knowing and bringing together Māori understandings, experiences, teachings, and insights (Chilisa, 2012; L. T. Smith, 2012). However, hegemonic powers continue to construct policies of privilege that undermine a Māori worldview. Repairing this knowledge through a Kaupapa Māori lens will support decolonisation and mobilise a Māori pedagogy.

Decolonisation

The decolonisation of Euro-Western knowledge nurtures Māori gain, power, and mana. It locks into mātauranga Māori, asserting a uniqueness of Māori realities framed in tradition and justified in contemporary society, thus, embracing relational knowledge systems, including whānau, hapū, and iwi.

Kaupapa Māori research as a decolonisation methodology is suitable for this study because it examines the Indigenous people of Aotearoa and their experience in a Euro-Western world. It reclaims Indigenous knowledge held by the tangata whenua (Māori) and affirms the injustices of Euro-western philosophies and historical domination. It provides an Indigenous reasoning discourse and a critique of the Indigenous language, allowing for alternative knowledge. Nevertheless, decolonisation does not assume colonisation is over (L. T. Smith, 2012). It explores Māori ontologies, epistemologies, and axiologies and uncovers the discourse of colonialism.

Uncovering the traumatic effect of colonialism experienced by Māori provides a framework for transformation. Chilisa (2012) believed it was time to liberate the captive mind and restore Indigenous knowledge systems and cultural practices. An approach that provides unity and revitalisation of Indigenous ways of knowing and provokes thought about colonialism constructed with a Euro-Western discourse. Decolonisation examines the struggles and changes from colonialism and the traumatic effect on Indigenous peoples' livelihoods in contemporary society. Chilisa affirmed that decolonisation allows Indigenous people to begin demystifying and decolonising their ways of knowing.

However, a confrontational pedagogy of Indigenous knowledge is challenging and uncomfortable for the West (Yuha Jung, 2015). Confronting the Euro-Western pedagogy leads to a clash of forces, ideas, and denial, reinforcing Indigenous struggle. L. T. Smith (2012) challenged the concept of resistance and believed that struggle is a tool to overturn oppression and seek freedom and social justice. It provides opportunities to embrace and mobilise change. To action new ways of identifying strengths and weaknesses while

uncovering challenges. For instance, the term Indigenous emerged in the 1970s out of the struggles of the American Indian Movement (L. Smith, 1999). The struggle drove social change and helped interpret tensions between academic views and political stances within the academy's dominant structures and systems. According to Chilisa (2012), these struggles created a theoretical tool for decolonising Indigenous theory.

Further, decolonisation has a political agenda enmeshed in activism to challenge the silencing of Indigenous epistemologies. While the Indigenous theory within kaupapa Māori does not have defined guidelines, the agenda is fluid and strategically focuses on critical components, including self-determination, survival, spirituality, and psychological and physical well-being (L. T. Smith, 2012). Self-determination includes social justice expressed through various components, including social position, social relations, and economic and cultural issues. Decolonisation is a driving force of transformation, healing of struggles, and oppression. Denzin et al. (2008) argued that decolonisation is possible through the mobilisation to announce new processes, approaches, and methodologies—elements of a strategic Indigenous research agenda. A process that connects, informs, and clarifies local, regional, and global Indigenous tensions (Chilisa, 2012; L. T. Smith, 2012).

Decolonisation challenges the status quo and resists colonial thinking to create a decolonisation pedagogy that critically reflects underlying assumptions, motivations, and values that inform the dominant research academy. Kaupapa Māori embraces the pedagogy and discourse of Indigenous ways of knowing and being. Therefore it uplifts the mana of a Māori worldview and Māori identity and sense of belonging.

Research Design

The overarching design will incorporate the foundations of Kaupapa Māori research. The goal is to honour taiohi and whānau as Aotearoa tangata whenua and recognise their rights as participants. The focus is on fostering a relational experience where taiohi, whānau, and keyworker voices express their experiences of taiohi substance use, mental health issues, and mental health service delivery. Using a kaupapa Māori research methodology provides insight into taiohi and whānau cultural realities and livelihood before and after entering acute mental health services.

Whakawhanaungatanga is the basis for participant engagement. As a connection principle, it is a basis for engaging in power relations with te ao Māori (D. Jones, 2015; R. Jones et al., 2006; Pihama, 2018; Pihama et al., 2002). Whanaungatanga began with engaging acute mental health and addiction services and identifying keyworkers wanting to participate in the study. A whānau-based recruitment method was attained through snowballing and whanaungatanga. The process stimulated self-determination by giving eligible participants the choice of interview time, date, and location. The cultural approach influenced recruitment and data collection by engaging keyworkers who work with taiohi and whānau in acute and community mental health and addiction services. Whanaungatanga continued through written knowledge about the study outlined in flyers and information sheets. Following was the connection through phone calls and interviews. Whanaungatanga was a critical factor in the interview process. It provided an opportunity to share whakapapa that supported a connection principle.

Tikanga guided the study through the interview process and elevated the participants' voices. Tikanga was the methodological framework that informed the research study. It is a Māori worldview with distinctive Māori concepts, including language, culture, protocols, customs, values, practices, and worldviews. Tikanga also values the principles of tapu, mana, pono, tika, and aroha (Tate, 2010). Upholding these concepts enhances tikanga, which is concerned with the ordering of relationships with Ātua (God), tangata (people), and whenua (land); that is, the right to exercise mana, the right way to do things (Hudson et al., 2010). The foundations of tikanga allowed me to interpret the participants' experiences within their own social and cultural context.

A kaupapa Māori methodology helps recognise the challenges taiohi and whānau experience in an environment with competing philosophical views. Face-to-face interviews with all participants include concepts of te reo Māori, kotahitanga (unity, togetherness), whanaungatanga, and mātauranga Māori. In turn, this provided an opportunity to understand better the provision of mental health service delivery for taiohi and whānau who enter acute mental health services with substance use and mental health issues. Specific local tikanga practices were also relevant to Ngāti Whātua iwi to preserve iwi mana and relationships within the methodology (Hudson et al., 2004). In respect of Ngāti Whātua kawa, a kaumātua of Ngāti Whātua descent provided time, advice, and guidance throughout the study.

Methods

This qualitative study was exploratory with a general inductive design. A kaupapa Maori research approach informed the study design, participant selection, participant recruitment, and data collection procedures to promote appropriate cultural protocols when engaging with Maori and non-Māori participants. A kaupapa Maori approach offers a unique relational and empowering practice that locates power and control within the research process to benefit research participants. In addition, the cultural framework of the study aimed to enhance a Maori worldview, language, customs, and knowledge legitimate in its own right (R. Bishop, 2005).

The methods section begins with the research question that tries to give meaning to taiohi and whānau experiences of substance use and mental health issues as they move from the community into acute mental health and addiction services. I discuss the challenges experienced when consulting with mental health and addiction services and explore the inherent challenges in selecting and recruiting participants, which speaks to the realities of working in kaupapa Māori research. The methods section overviews the data collection process and shows the different approaches to listening to participant voices. The section ends with cultural, legal, and ethical issues, including disseminating results.

Research Question

This study asked the question, *What are taiohi and whānau experiences as they hīkōi from the community to acute mental health services with substance use and mental health issues?* The question underpins the assumption that cultural and socio-political circumstances affect taiohi mental health and substance use outcomes. The focus includes whānau manaakitanga and their collective journey from the community into acute mental health and addiction services. The aim of the study is to

1. Understand taiohi uniqueness and realities as they move from the community into acute mental health and addiction services with substance use and mental health issues.
2. Understand whānau realities when providing manaakitanga for taiohi with substance use and mental health issues.
3. Gain information regarding taiohi and whānau realities and experiences when entering mental health and addiction services to inform mental health addiction services, policymakers, funders, and other appropriate academic areas.

Success in achieving the aims provided insights into taiohi mental health and substance misuse issues when living on society's margins. It also affirmed the challenges experienced by whānau as they hīkōi with taiohi to seek help.

Consultation Process

Before commencing the study, I consulted with Māori researchers who shared their experience and knowledge. The consultation began with the Auckland University of Technology Ethics Committee (AUTEC), kaumātua engagement, and the Health and Disability Ethics Committee (HDEC). The consultation was also informed by specific cultural readings that contributed to identifying ethical issues (Chilisa, 2012; L. T. Smith, 2012). The readings included ethical frameworks such as Te Ara Tika: Guidelines for Māori Research Ethics and Guidelines for Researchers on Health Research Involving Māori (Hudson et al., 2010). These guidelines provided a framework that incorporated tikanga, whakapapa, whakawhanaungatanga, and manaakitanga. Guidelines for Maori Research Ethics: A Framework for Researchers and Ethics Committee Members (Hudson et al., et al., 2010) affirmed respect, reciprocity, and the incorporation of Te Tiriti o Waitangi.

This research received ethical approval from AUTEC (number 16/08) in February 2016 (Appendix A). Kaumātua support and guidance were essential (Appendix B) because they enhanced the use of te ao Māori and tikanga Māori, providing culturally specific and specialised knowledge practised daily and guided by kaumātua (L. T. Smith 2012). Marsden and Royal (2003) stated that the kaumātua role upholds the people's mana and mauri. Therefore, kaumātua involvement guided the process and upheld the mana of this research. The kaumātua involved in this research study provided a letter of support, and his fluency in te reo Māori enabled him to translate raw data, although this was not required. Only basic te reo Māori occurred in all of the interviews, and I was able to translate the meanings.

Taiohi, with substance use and mental health issues, may be considered vulnerable. Lamb et al. (2001) acknowledged that adolescents are considered vulnerable because of their youthfulness and immaturity to engage in research. According to Kertesz et al. (2018), personalised guidance is vital to help vulnerable youth make informed choices. Building a strong connection with a reliable adult is the best way to protect their rights while ensuring their safety. Perez et al. (2013) added that those vulnerable populations might also include individuals who feel stigmatised by identifying with the researched target

population. In Aotearoa, stringent government regulations aim to prevent harm, and the HDEC determines harm to vulnerable groups when participating in the study. Within HDEC criteria, taiohi come under vulnerable populations because they are young, have a pre-existing mental illness, and are consumers of mental health support services (New Zealand Government, 2021). However, the HDEC review (Appendix C) surmised that taiohi were outside the HDEC scope, suggesting that the probability and magnitude of possible harm were no more significant than what taiohi encountered in their everyday lives.

After consultation with professional bodies, consultation with more than 15 mental health and addiction services occurred and included DHBs and Non-Government Organisations (NGOs) that worked with the targeted population of taiohi. Initial contact with these agencies was via phone, email, or kanohi ki te kanohi (face-to-face). Establishing relationships and connections began with whānaungatanga with health providers, keyworkers, and the researcher. Whānaungatanga is a connection principle for engaging in power relations integral to Māori culture and well-being (Jones et al., 2006; Pihama et al., 2014). While there was much interest in the study, only two urban DHBs provided the opportunity to present the study to the service.

Keyworker engagement in the study was critical for recruitment. Ibrahim and Sidani (2014) argued that collaborative engagement with keyworkers provided flexible opportunities and helped develop participant rapport and trust. The study presentation aimed to target keyworkers to assist in recruitment. Explaining the study aims meant they were informed and understood the selection criteria. Keyworkers were ideal for supporting recruitment because they had established rapport with taiohi and could inform them of an opportunity to engage. However, some keyworker resistance to support recruitment demonstrated that, despite whānaungatanga, it was ineffective. The low response could also be due to multiple factors. For instance, structural issues include under-resourcing within the workplace, lack of capacity at the ground level, and limited capability within the clinical environment.

Other challenges included suspiciousness among Māori keyworkers about research. Keyworkers verbalised that Māori have been over-researched, something discussed by L. T. Smith (2012). This suspiciousness protected taiohi from participating in the research (Bishop, 2008; Pihama, 2018; L. T. Smith, 2012). Protection was evident when keyworkers took ownership of taiohi opportunities to participate, believing they needed

to protect taiohi from research initiatives. Hence they resisted sharing information about the study, which impacted recruitment. As the researcher, I had to accept their realities and the tika of their choice rather than undermine their decision. In response to keyworker resistance, I looked further to find keyworker support. Extending the catchment area to include other regions was prosperous, providing an opportunity to increase recruitment capacity. I focused on areas with a high Māori population which required an amendment to the ethics application and approval from AUTEC (Appendix D).

In all regions, engagement with keyworkers began with a whakatau (formal welcoming). The whakatau included a mihi (opening speech) and karakia (prayer) and ended with a waiata (song). A tikanga approach acknowledges the relationship of whakapapa (genealogy) and keeps the process culturally safe. As Tate (2010) affirmed, the spiritual essence of a whakatau embraces te tapu o te Ātua (God), te tapu o te tangata, and te tapu o te whenua. This formality is an essential part of tikanga because it enhances the mana of the relationship.

Selection of Participants

Recruitment and selection of participants began after receiving ethical approval from the DHBs (Appendix E). Sampling was purposive in that participants were selected based on specified criteria, allowing diversity in the sample (Morgan, 2012). Wright et al. (1992) said selective sampling works well when the researcher has extensive knowledge about the population's characteristics when discovering specific information about individuals in the target population. I have extensive work experience in acute and community mental health environments and lecturing in mental health nursing for under- and post-graduate studies. Also, being Māori provided cultural knowledge and skills to embrace tikanga principles promoting embracing cultural safety for all participants.

Diverse sample representativeness included three participant groups—taiohi, whānau, and keyworkers. Initially, the aim was to recruit 8-10 taiohi, 8-10 whānau, and six keyworkers from each DHB, considering over-subscription and choosing not to exceed six taiohi and 12 whānau from each DHB. Following are the sample representations and eligibility criteria.

Keyworker eligibility criteria

Key workers were either registered nurses or mental health support workers who must have worked with taiohi and whānau in their clinical workload capacity. They would have

witnessed taiohi and whānau experiences while working in acute mental health and addiction services where substance use and mental health issues existed. Ethnicity was not an inclusion criterion for keyworker participation.

Taiohi eligibility and exclusion criteria

Taiohi selection determined an age range of 16-25 years, including tāne (male) or wāhine (female), who self-identified as Māori. They must have had admission into an acute mental health and addiction service within the past 4-years, where substance misuse and mental health issues existed.

Exclusion occurred if taiohi presented acutely unwell or had been under researcher care in the psychiatric nursing capacity. A screening tool (Appendix F) was used in several instances before recruitment to ensure acute mental illness was absent and there were no signs or symptoms of a psychotic phenomenon. Using a screening tool supported the concepts of tikanga in that taiohi presenting with acute mental illness are in a state of tapu. Therefore, it would be disrespectful to interview taiohi with acute mental illness morally and spiritually because it would violate their tapu and undermine their mana (Tate, 2010). The screening tool supported spiritual protection, ensuring no tapu restrictions and taiohi remained in a state of noa (free of tapu restrictions) during the interview process. Hence, the exclusion criteria demonstrated respect and empowerment for taiohi and their spiritual relationships with Ātua (God), tangata (people), and whenua (land).

Whānau elgibility criteria

In more traditional terms, whānau make up hapū (subtribe) and iwi (prominent tribe) (Durie, 2001; Marsden, M., & Royal, T. A. C., 2003). Whānau participants identified as adult Māori tāne or wāhine who supported taiohi hīkoi from the community into acute mental health services where substance use and mental health issues were present. He Korowai Oranga, the Māori Health Strategy, suggests that whānau represent the parents, the extended family network, or a family group such as a church or a kohunga reo whānau group (Ministry of Health, 2013). However, in the current study, whānau also included friends or peers who were not blood-related (Moorfield, 2011).

Recruitment

Purposive and snowball sampling provided a relational and whanau-based recruitment approach. Snowball sampling was possible through keyworker clinical workloads and social networks (Wright et al., 1992). The snowballing approach grew from

whānaungatanga with keyworkers, taiohi, and word of mouth. There is an argument about the absence of scientific rigour in snowball sampling, although Wright et al. (1992) confirmed that the benefits of accessing youth through snowballing compensated for possible losses in their resistance to engage. Keyworkers informed eligible taiohi about the study and provided taiohi with a flyer to share with other taiohi and whānau (Appendix F). Participation required written information informing taiohi, whānau, and keyworkers about the study. Eligible participants who voiced their intent to engage in the study received an information sheet outlining the reason for the study, the process, and support mechanisms. Before the research interview, commencement eligibility for participants required signing a written confidentiality and consent form (taiohi, Appendix H; whānau, Appendix I; keyworkers, Appendix J).

Data Collection

Data collection occurred between 2016 and 2018 in Aotearoa's urban and rural regions. In the first instance, the data collection process aimed to provide a collective approach by having two hui. The first hui included whānaungatanga and an aesthetic approach using photo images to stimulate conversation. The following hui also provided a collective approach promoting discussion and change management using the technique of Planning Alternative Tomorrows with Hope (PATH). After considering the challenges outlined above, I determined that this method was complicated and did not align with the needs of taiohi and whānau. As a result, I opted not to pursue this strategy.

Initial data collection process – Hui

The proposed data collection method involved two hui (gatherings) that used a relational process of bringing taiohi and whānau together to share their experiences. The first hui included photovoice, providing a direct visual representation of their realities and allowing participants to express themselves using symbolic mediums to analyse their worldview (Wang & Burris, 1997). The second hui embraced the PATH workshop, which encouraged taiohi and whānau collectively to consider how an acute mental health and addiction service could become more culturally appropriate (Pipi, 2010). Both approaches were aesthetic and challenged conventional methods of data collection. The collective approach affirmed tikanga, whānaungatanga, and manaakitanga—important concepts within kaupapa Māori research (Fryer & Stambe, 2014; Stambe & Fryer, 2014).

The challenges that came to the forefront of the initial data collection technique led to rethinking the data-gathering process. While the collection process appeared effective on

paper, the reality for all taiohi, whānau, and keyworkers to meet at the same place on the same day for several hours was impractical. Also, combining several abstract processes appeared complicated for taiohi with substance use and mental health issues. Supporting this notion, I asked a keyworker to pre-test the photovoice instructions with taiohi. The keyworker feedback suggested that taiohi would struggle to follow very abstract photovoice instructions. Other feedback from keyworkers implied that the initial research design for photovoice and PATH would overwhelm taiohi. Further, the risk of taiohi selling the cameras was high.

Another consideration was the breach of confidentiality. Group members may gossip outside the group sharing information and communicating without repercussion (Scott, 2000). Another breach of privacy and confidentiality may occur in relationships through genealogy and previous mental health services participation, which was hard to control. Further concerns could arise if the group members' feelings were not reciprocal, leading to challenges that could create an atmosphere of tension (Randall & Wodarski, 1989). In talking with potential participants, no one wanted to meet strangers in a group environment.

Amended data collection method

The amended data collection using snowballing maintained a qualitative method using interviews kanohi ki te kanohi, providing a physical and spiritual connection that weakens if using a phone or Zoom. Interviews involved a semi-structured process. In-person interviews with taiohi and whānau relied on purposeful conversations between me and the participant (McIntosh & Morse, 2015; Oishi, 2003). Additionally, uplifting rangatiratanga (self-determination) meant all participants determined a place, time, and day of the interview process. The interviews aimed to gain information about taiohi and whānau experiences where taiohi engaged in substance use—an experience that led to taiohi mental health issues and a journey from the community into acute mental health and addiction services.

All interviews were digitally audio-recorded. I chose not to write during the interview to enhance the attentive body language of listening and engagement. Participant kōrero dedicated to the study was tapu (sacred) in its raw form. Participant kōrero was downloaded onto a portable hard drive and stored securely for six years. The primary and secondary supervisors accessed the raw data during the data collection analysis. The raw data were transcribed but underwent a de-identification process to ensure the privacy and

confidentiality of individuals and their families. The transcriptionist was a professional who understood the importance of confidentiality. Hudson et al. (2004) emphasised that protecting the voices of individuals and families safeguards their knowledge from misuse and exploitation and prevents misappropriation, misinterpretation, and misrepresentation of their stories.

Once the raw data were transcribed and combined with other kōrero and academic terms, that data became noa, referring to a state of balance (neutrality). Royal (2003) affirmed that noa occurs when the mauri is released, making it neutral or common. In this instance, the mauri is released from participant kōrero once the raw data is combined with other terms, preventing the violation of tapu (Jones, R et al., 2006). Respecting the tapu of the participants' voices upholds their mana and the mana of their kōrero. Transcriptions were also compared with the raw data to ensure consistency and misinterpretation, emphasising te reo Māori.

The interview schedules consisted of open-end questions that allowed for a range of participant responses. Open-ended questions provided the kōrero (speech) framework used in the interviews. Participants' kōrero expressed their tika (truth), which upholds the research validity. It was beneficial to prepare questions in advance to ensure the raw data aligned with the data needed for the study (Given, 2012; McIntosh & Morse, 2015). Interview questions covered topics based on the research question and aim.

Attention to the differing characteristics of the participant groups required separate questionnaires for taiohi (Appendix K), whānau (Appendix L), and key workers (Appendix M). Overall, I contemplated interviews taking between 30 and 45 minutes. Probes allowed a form of motivational interviewing. Rollnick et al. (2010) stated that probes work well as change mechanisms through phrases. Examples of phrases may include "Tell me more about...?", "What do you mean?" and "Can you give some examples?". Promoting phrases encourages participants to bring clarity, strengths, and aspirations (Rollnick et al., 2010). Probes explored concepts, allowing participants to expand their responses (Given, 2012; McIntosh & Morse, 2015).

Professionalism is essential when gathering data. According to L. T. Smith (2012), professionalism demonstrates competence and skill that supports rapport development. It helps prevent researcher anxiety and assists the interview flow from beginning to end. Maintaining professionalism required me to be well-prepared. Preparation required having a backpack containing everything needed for the interview, including the koha, a

voice recorder, extra batteries, a mobile phone as a second alternative if the recorder stopped working, and extra stationery. The primary researcher kept a folder for easy access containing all necessary documents, such as the information sheet, consent form, confidentiality agreement, and participation certificate (Appendix N) for every participant.

Within a kaupapa Māori framework, upholding and maintaining the principles of tikanga is critical for enhancing the mana of participants. Engagement with participants began with whānaungatanga. Entering someone's personal space and intimate environment entertains first impressions. I was respectful upon entering to prevent any impression of superiority. When visiting participants in their home environment, the practice of leaving shoes outside the door on the doorstep was a must. I still removed them even when taiohi or whānau said to leave the shoes on, preventing possible internal judgment or assumptions. The professional approach was acknowledged in participant feedback (Appendix O).

Whakawhanaungatanga

Kanohi ke te kanohi initiated impromptu whānaungatanga, providing a relational exchange for self and others. Whānaungatanga extended to sharing whakapapa that connected to their whānau and whenua (land), a connection with participants that embraces Māori identity through Māori tūrangawaewae, a place of standing and belonging through kinship (Moorfield, 2011; Tate, 2010). This process set the scene for further discussion. Whānaungatanga continued by verbally reviewing the information sheet and consent form with participants to ensure informed consent. Instead of providing time to read the information alone and assuming they understood, the participants received an explanation about the interview process and the expected time for the interview.

Whānaungatanga further communicated participant rights that actioned the principle of tino rangatiratanga (self-determination) by considering control and empowerment for the participants (Jones et al., 2010). Whanaungatanga also amplified my persona that expressed internal aroha. Explanations included their right not to answer questions if they felt uncomfortable or to withdraw from the interview and to ask questions so that all concerns about the study were answered (Tate, 2010).

The formal progression of the interview began by offering a karakia that set the scene for a two-way process of giving, receiving, sharing, and empowering by embracing te tapu o

te Ātua while upholding the interviewer and interviewee's mana (Tate, 2010). Karakia supports manaakitanga and acknowledges participant comfort and spiritual essence (Chilisa, 2012; Jones et al., 2006; L. Smith, 2012). However, personal experience told me that taiohi could be reluctant to disclose information for fear of a confidentiality breach or feeling of whakamā—a personal or collective shame or embarrassment (Moorfield, 2011; Sachdev, 1990; Stephens, 2020). Whakamā refers to an imbalance of the spiritual dimension, an unease. Therefore, attention to verbal and non-verbal cues provided information about participants' feelings (Given, 2012; McIntosh & Morse, 2015). The use of probes also benefited this situation.

Towards the end of the interview, participants had space to voice anything else they wanted to add, allowing them to reflect on the positives and negatives (Appendix O). Karakia was used to end the interview process formally. Karakia enhanced the spiritual recognition of the shared knowledge to be nurtured and treasured. Additionally, each participant received a koha (a gift, an offering) as recognition of the participants' koha by sharing their experiences. It also acknowledged their role in the study and shared information with others through the publication of this thesis. Participants could choose between a NZ$20 meat pack, NZ$20 food voucher, NZ$20 mobile top-up, or NZ$20 petrol voucher. Additionally, each participant received a certificate of participation (Appendix N), further reinforcing the gratitude for participant engagement in the study.

Data Analysis

A kaupapa Māori research methodology created opportunities to express themes in te reo Māori, te ao Māori, and mātauranga Māori, producing a Māori medium of data. The dominant research design is a qualitative approach that utilised Braun and Clarke's (2006) thematic analysis methodology. Thematic analysis differs from other types of analysis that seek to describe patterns, such as grounded theory and interpretative phenomenological analysis. The thematic analysis provides the opportunity to identify, analyse, and create themes from the raw data (Braun & Clark, 2006). Because the approach does not link to any particular theory, its flexibility and accessibility provide a unique opportunity to analyse the participants' voices (Braun & Clarke, 2006; Clarke & Braun, 2018; Terry et al., 2017). Antaki et al. (2003) argued that anything goes without a structured format.

Critical themes developed from data provide various findings from participant voices (Braun & Clarke, 2006; Clarke & Braun, 2018; Terry et al., 2017). According to Taylor

and Ussher (2011), discovering emerging themes hidden in interviews is exciting and a passive analysis process. James (2007) argued that the 'giving voice' approach allows one to carve out unacknowledged narrative pieces. Braun and Clarke (2006) affirmed that a flexible method can take an essentialist or realist approach that reports meaning and participant realities. Alternatively, it can be a constructionist approach examining experiences, meanings, and realities that affect various societal discourses. Therefore, thematic analysis reflected and unpacked the surface of reality.

An inductive approach identifies themes that adhere to data (Patton, 2014). It is a process of coding the data without fitting into preexisting conceptions. This approach steers away from the researcher's theoretical interest in the topic. The process involved organising and describing data sets in detail while also interpreting different aspects; collating data-generated codes to establish potential themes. Initially, I read and re-read, carefully noting initial ideas and then checking and comparing with the raw data over and over to ensure accuracy. The process of re-checking and coding was thorough, resulting in the development of significant themes. These themes were then compared to the plain text to ensure coherence, consistency, and distinctiveness.

Ongoing analysis refined the specifics and generated clear definitions. Allowing significant themes to develop and produce a summary consistent with the epistemological positioning of the research (Braun & Clarke, 2006; Clarke & Braun, 2018) helped to understand different viewpoints and experiences relating to the question and literature (Appendix P).

Ethical, Cultural, and Legal Issues

Māori ethics is about tikanga. As a guide, I have used Te Ara Tika Māori ethical framework (Hudson et al., 2010). The framework considers the research design and the cultural and social responsibility identified through four factors: Whakapapa – relationships, Tika – research design, Mana – justice and equity, and Manaakitanga – cultural and social responsibility.

Whakapapa

Whakapapa refers to the quality of relationships and the structure and process that establish these processes. Aroha is a protective factor relating to engagement risks and risks mitigated.

The participant information sheets, and consent forms (Appendices H, I, J) were reviewed and approved by the AUTEC (Appendix A). The information sheet invited voluntary engagement in the study. The information sheets clarified the study's purpose and explained how participants were identified for the study and what would happen to the research. Also outlined was the right to have complete control over what was said and not to answer a question or drop out of the study without repercussions. Also, they had an opportunity to review their transcripts if they wished.

An explanation to participants of the purpose of the digital recordings during the interview occurred, as well as protecting participants' identities throughout the study process and during presentations and publications. The information sheet also provided an understanding of consent and the need to sign the consent form. The option of verbal consent provided a different mode of consent for those who could not write. Individual information sheets accommodated each group of participants, taiohi (Appendix H), whānau (Appendix I), and keyworkers (Appendix J).

Local consultation with a kaumatua of Ngāti Whātua descent ensured that the mana of the local iwi was embraced (Appendix B). Local consultation also included working with my supervisors, two of whom are Māori. Engagement with the kaumatua and supervisors was ongoing throughout the study. Also, engagement with both Māori and non-Māori mental health and addiction providers occurred at the beginning stages of the study. Māori workers were few within these services, the majority being non-Māori. However, the principles of tikanga and whakawhanaungatanga guided the process of all engagement interactions. As the primary researcher of the research project, maintaining the role of the kaitiaki meant capturing whakapono (hope) through a kaupapa Māori methodology. The methodology provides an opportunity to use te reo Māori, te ao Māori, and tikanga Māori consistently and transparently throughout the study and across additional supporting documents.

Tika

Within the framework of te ara tika, tika refers to what is right and good in any situation. It enhances the validity of the study proposal. Enhancing tika through a kaupapa Māori research approach required a significant proportion of participants to be Māori. Māori participants influenced the shape of the research and contributed to the findings and results. I completed the analysis that ensured a Māori lens over the process. Potential

benefits of this research to the participants, the researcher, and the wider community include:

Participants

- Recording and reflecting on their experiences through photography
- Building on their knowledge by voicing their experiences and learning from other taiohi/whānau experiences
- Achieving tino rangatiratanga (self-determination) through their voice and experience

Researcher

- Supporting the development of Indigenous theory and kaupapa, Māori research methodology
- Informing policymakers, funders, and decision-makers by building on information and theory that will highlight the needs for taiohi and whānau when accessing mental health and addiction services
- Completing a doctoral study with a strong Māori flavour that would be published and shared with Māori and non-Māori

Wider community

- Producing Māori specific knowledge informs decision-makers and possibly influences policy change to support all taiohi and whānau who access mental health services where substance use and mental health issues are within Aotearoa, New Zealand.
- Providing DHBs and NGOs with knowledge and information which will support national and local strategies.

Manaakitanga

Traditionally manaakitanga upholds the mana of the people. This context includes cultural safety, social responsibility, and respect. A kaupapa Māori research methodology enabled a culturally safe environment allowing Māori to be Māori and to assert tino rangatiratanga (self-determination). Supporting this is manaakitanga (hospitality generosity), tika (correct, true), pono (genuine, truth), and aroha (compassion, concern). The study may invoke certain emotions, and should this have occurred, and if appropriate, the participants were encouraged to share their feelings with counselling services to provide awhi (embrace, sit with) and manaaki (support, take care of) (Appendix Q).

Social responsibility has specific academic rules and regulations essential in a Euro-Western system (Crown) that also listens to Māori at the grassroots, encouraging tino rangatiratanga. The research design encouraged partnerships between myself (Crown) and participants (Māori). The mutual goal was to strengthen an Indigenous approach in a biomedical system and other theoretical models of health (Hudson et al., 2010). The partnership in this project will produce findings for policymakers, funders, and other academic sources building on existing theory and information to improve accessibility and completion of treatment for taiohi. Also, taiohi and whānau participate in a safe environment grounded in the philosophies of te ao Māori. Cultural safety embraces the principles of tikanga, such as the whakatau, which includes mihi, karakia, and waiata. A process that protects the project's mana includes kaumātua knowledge about the mana of the kōrero. Throughout the study, utmost respect was given to Māori protocols. Privacy and confidentiality were thoroughly explained to the participants verbally and in writing on the information sheet. During interviews, taiohi and whānau asked about substance use and mental health issues. While the questions were not part of the interview schedule, responding with information demonstrated manaakitanga and supported health literacy. Also, manaakitanga was enhanced when allowing participants to choose the time, day, and place of the interviews. Participants felt safe and respected, and their feedback after the interviews confirmed this (Appendix O).

Mana

Within the context of Te Ara Tika, mana relates to equity and justice. Te Tiriti o Waitangi is the foundation that sets out the obligations for this study. The articles in Te Tiriti o Waitangi obligations embrace equity and justice and include ōritetanga, tino rangatiratanga, tikanga, and kāwangatanga. Ōritetanga ensures taiohi and their whānau have the right to equity and equality; therefore, access to culturally safe mental health services and treatment is essential. They have the right to be free from discrimination and marginalisation, and they have the right to experience the same mental health outcomes as Pākehā.

Tino rangatiratanga provided an opportunity for taiohi and their whānau to voice their experiences promoting self-determination and autonomy to support the development of health services by Māori for Māori and by Māori in a Euro-western system. Tikanga principles occurred through the kaupapa Māori research methodology used in this study. The ethical dimensions of tikanga are based on te ao Māori providing an interface for accessing repositories of cultural knowledge and experience that can inform service

provision in acute mental health and addictions (Hudson et al., 2010). Kāwangatanga can improve the capacity of key personnel to respond appropriately and respectfully to Māori issues within mental health and addiction services; and, in doing so, enhances Māori communities' confidence and trust in the decisions made by the government (Hudson et al., 2010).

Additionally, each participant received a koha to uphold and embrace their mana for openly and honestly sharing experiences throughout the interviews. The mana of participants' experiences in written form underwent a deidentification process to ensure confidentiality and a safe place for transcripts only accessible by myself and my supervisors occurred.

Dissemination of Results

Data interpretation and dissemination intertwine concepts of mātauranga (knowledge), tikanga (correct procedure, custom, habit, and lore), whakapapa (genealogy), and whānaungatanga (sharing experiences). Dissemination of the results will be in the form of presentations, posters, papers, and handouts. Additionally, a one-page report on the results will be available to participants. Presentations summarising the findings will occur at academic institutes, DHBs and NGOs in Aotearoa. On request, other external stakeholders, including Māori health providers, maraes, community organisations, funders, and planners, will receive a summary of the findings delivered verbally or in written form. I also aim to write journal articles that can reach a broader population.

Conclusion

This chapter has overviewed the research design using kaupapa Māori principles and uplifting taiohi and whānau uniqueness. This study aims to support taiohi aspirations contributing to positive mental health and substance use outcomes. The study design validated taiohi and whānau voices and experiences as they moved from the community to mental health services, searching for the support of taiohi recovery. The concepts of whānaungatanga, the principles of tikanga Māori, te ao Māori, and mātauranga Māori strengthened the study and enhanced the mana of myself and the participants. This connection was meaningful because it provided space for me and the participants to kōrero and share experiences of their hīkōi stories about leadership and well-being.

Kaupapa Māori provided a guideline for conducting semi-structured interviews with taiohi, whānau, and keyworkers. I have highlighted cultural and ethical considerations that impact research processes, researchers, and participants. The next chapter describes the themes developed during the data analysis phase of the study.

Chapter Four: Findings – Taiohi and Whānau Hīkoi

Introduction

The findings outline taiohi and whānau experiences as taiohi become mentally unwell in the community due to substance use. Taiohi and whānau shared their experience of their hīkoi from the community into mental health and addiction services and their return to the community. Keyworkers shared their insights from working with taiohi and whānau in acute mental health and addiction services. The challenges define their hīkoi and support taiohi and whānau encounter along their pathway to support taiohi recovery.

Kaupapa Māori offered a decolonising strategy to understand taiohi and whānau realities within a Māori worldview. Discussed in this chapter are the three major themes:

1. **Surviving Socially** – contextualises the social realities and adversities of taiohi and whānau struggling to survive within the community. This theme has two sub-themes, *Being heavy on drugs* and *Living with social pain.*
2. **Entering a Scary Place** – describes the acute mental health addiction services experiences and comprises the sub-themes, *Entering a scary place* and *Locking Me in*.
3. **Whānau Healing in the Community**. This theme has three sub-themes, *Providing hope*, *Kotahitanga*, and *Carrying on with life.*

Figure 2 depicts a circular process indicating the possibility of a revolving door. Ideally, the analogy of a hīkoi should end for taiohi in the community with whānau.

Figure 2

Thematic Overview: Taiohi and Whānau Hīkoi: Significant Themes and Sub-themes

Taiohi Participants

Nine taiohi participated in the study, seven tāne and two wāhine. Five taiohi lived in urban areas, and four lived in rural areas. Six lived with whānau, one in a residential boarding facility, and two were boarding in a house when they became unwell. One taiohi (wāhine) admitted to using marijuana but denied using other substances. The other wāhine taiohi overdosed on a prescribed psychotropic medication. The most commonly used substances were synthetic cannabis (four tāne) and methamphetamine (three tāne), although keyworker voices suggested others had used marijuana, alcohol, and tobacco. All taiohi were admitted to mental health and addiction services under The Mental Health (Compulsory Assessment & Treatment) Act (1992). Police escort into mental health services occurred for seven taiohi, and two entered with whānau awhi (support). Table 3 summarises the demographic data for taiohi

Table 3

Taiohi Participants

Participant Taiohi	Age (years)	Gender	Place	Mental Health Act	Place of residence	Substance misused	Entry into mental health services
1	20-25	Tāne	Rural	Yes	Boarding house	Meth*	Via police
2	16-19	Tāne	Urban	Yes	Lived with mother	Synthetic cannabis	Via police/ambulance
3	16-19	Wāhine	Urban	Yes	Lived with uncle	Psychotropic medication	Via police/ambulance
4	20-25	Tāne	Rural	Yes	Lived with mother	Synthetic cannabis	Via police
5	20-25	Tāne	Rural	Yes	Lived with brother	Meth	Via police
6	20-25	Tāne	Urban	Yes	Boarding house	Synthetic cannabis	Via police
7	16-19	Wāhine	Rural	Yes	Lived with boyfriend	Marijuana	Via whānau
8	20-25	Tāne	Urban	Yes	Boarding	Synthetic cannabis	Via police
9	20-25	Tāne	Urban	Yes	Lived with sister	Meth	Via sister

Note. Meth = methamphetamine

Whānau Participants

In total, five whānau members participated in the study. Four were young, single-parent mothers rearing their children on their own. All the mothers stated they were struggling emotionally and economically. Three were on income support. One mother receiving

income support also worked part-time to increase her income. The other mother previously worked full-time but had to leave her job when her son became unwell and was reliant on income support. The only male whānau member was on income support. This tāne and his wife decided to whāngai one of the wāhine taiohi as her mother had mental health issues and struggled to cope with childcare. To whāngai is to adopt, raise, and nurture (Moorfield, 2011). The uncle and his wife shared custody of their niece. However, his wife passed away, and he asked his sister (birth mother) and boyfriend (both had mental illness) to move into his house to provide female support. All three adults in the house were recipients of income support. See Table 4 for a summary of whānau participants.

Table 4

Whānau Participants

Whānau	Role	Place of residence
1	mother	Rural
2	mother	Rural
3	mother	Urban
4	mother	Urban
5	Uncle	Urban

Keyworker Participants

In total, five keyworkers participated in the study. Three keyworkers were Pākehā, and two were Māori. All keyworkers were from rural regions but had worked with taiohi in acute mental health and addiction services in urban and rural areas at some point in their careers. All keyworkers experienced escorting and supporting taiohi admission into the main acute mental health and addiction Child and Family Unit. The unit specialises in children aged 13 and 18 with acute mental health and addiction issues. Participants read the information sheet (Appendix J) and signed the consent and confidentiality forms. Table 5 summarises keyworker demographics.

Table 5

Keyworkers

Keyworkers	Role	Ethnicity	Workplace
1	Registered nurse	Māori	Rural
2	Registered nurse	Māori	Rural
3	Registered nurse	Pākehā	Urban
4	Registered nurse	Pākehā	Urban
5	Mental health support worker	Pākehā	Urban

Times and places of participant interviews varied. Three whānau were happy to meet during the day; one mother chose to meet after 1900 hours so she could put their tamariki (young children) to bed. After reading the information sheet, they consented to participate in the first meeting by signing the confidentiality and consent form (Appendix I). Four whānau interviews occurred with the presence of taiohi; one occurred without taiohi presence. The taiohi, not present, had been there earlier but decided to leave before I arrived. For most whānau, it was the first time they shared their struggles and experiences, expressed through emotions of crying and anger.

Setting the scene in each interview with karakia and whakawhanaungatanga assisted in developing trust that allowed participants to voice their experiences freely. It took several taiohi a little time (approximately 10 minutes) to share their experience. They opened up as time passed and, in several situations, when taiohi shared their experiences, whānau stated, "I did not know about this". Two younger taiohi became restless after 30-40 minutes; their restlessness and body language indicated they had had enough.

Surviving Socially

Theme one, Surviving **Socially**, contextualises taiohi and whānau realities of living with social adversities and their struggle to survive within the community. **Surviving Socially** comprises two sub-themes: *Being heavy on drugs* which describe taiohi use of drugs and other factors related to easy access to substances, socio-political determinants of well-being, and whānau and peer engagement. These factors lead to the use of substances by taiohi and their experiences of entering another reality, which was scary for taiohi and whānau as they tried to cope with the effects of substances. *Living with social pain* encompasses income, employment, housing, and education poverty which contributed to

the social pain taiohi and whānau lived with. They struggled with multiple social adversities within the community, causing daily suffering and hardships.

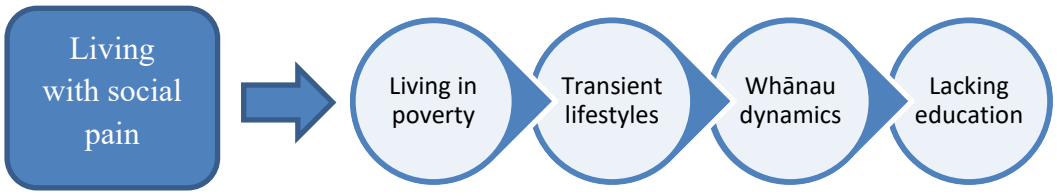
Surviving Socially explains the taiohi and whānau day-to-day struggles and juggling of social adversities. Living in poverty compromises taiohi and whānau livelihood, affecting their dignity and sense of security and creating unconscious social pain, as affirmed by an inability to afford necessities such as food and a space to sleep. Further, education poverty, resulting from taiohi exiting school without formal education and qualifications, limits their economic opportunities and influences their identity formation and sense of belonging.

Living with Social Pain

This sub-theme refers to an unpleasant emotional feeling experienced by daily social adversities associated with hardship (see Figure 4). The ongoing experiences of social challenges compromise taiohi identity and sense of belonging.

Figure 3

Indicators for Living with Social Pain



In addition to the indicators for living with social pain (Figure 3), the effects of colonialism are becoming more evident in today's Māori societies. Research highlights concepts such as social pain, intergenerational trauma, mental illness and much more. The participants shared their insights into social pain.

Living in poverty

The influences of taiohi and whānau living in poverty include low income and employment. For instance, most whānau received social welfare benefits, known to be below the poverty line. Only one whānau member worked. Financial disadvantages meant money for the whānau would run out before the next payday, and necessities were not always obtainable. Coping with unexpected financial commitments was a struggle.

I had nothing. Nothing to go to the hospital with, like no clothes or anything, so it was kind of tricky. (Participant 8 – taiohi)

It was hard for me because my cupboard didn't have much in it. (Participant 10 – whānau)

One mother could not visit her son. Mainly about the hardship of having the money to get up there and that sort of thing. (Participant 16 – keyworker [Māori])

Whānau and taiohi experiencing all the elements of poverty and not knowing when they are going to get their next feed. (Participant 19 – keyworker [non-Māori])

SNAPSHOT: Social Pain

Whāngai mātua travelled to Auckland to stay with his niece who was scared to be in the hospital alone. His niece had entered the acute unit after overdosing on anti-depressant medication at home. The overdose was related to the loss of her whāngai aunty who recently died from cancer. The uncle was anxious about going to the hospital to stay with his niece. He knew he needed to use his weekly food budget for travel, which meant he could not maintain his diabetic diet. Further he had to revisit the memory of losing his wife who passed away in the same hospital due to cancer. But he knew his niece was not coping and as the primary carer he needed to be with her.

> *I remember when looking after my wife in the hospital, they would always have a meal for her and a meal for me because I was her carer. However, I was unsure of changes in hospital policy and didn't want to push asking for anything. I thought well, we are all beneficiaries, you know. And what happened we were discharged on Tuesday, and because like our payday was on Wednesday, I knew we needed something to carry us over. Yeah, but this lady gave us a food parcel to take home, which I did not know they offered at the hospital. Yeah, so it was like I am still sort of like learning what support I can get.* (Participant 13 – whānau)

The snapshot above portrays an uncle's experience of *living with social pain.* Uncle knew that to provide his niece with manaakitanga and aroha, he had to sacrifice his diabetic diet to cover travel costs. He also had to confront past grievances after losing his wife to cancer

in the same hospital. His choice to prioritise his niece's needs enacted his collective obligation to uphold the mana of whānau responsibilities.

Transient lifestyles

Another example of *living with social pain* occurred for several taiohi living a transient lifestyle between the home and on the streets. Some taiohi moved from one whānau house to another or lived on the streets, never knowing if they had a bed to sleep in for the night.

> *Yeah, he went to stay with his father, but that didn't work out.* (Participant 12 – whānau)

> *He wasn't coming home, and I would drive around looking for him.* (Participant 14 – whānau)

> *Son was living on the streets with his brother, begging for money to get their drugs.* (Participant 10 – whānau)

Further, keyworkers witnessed the social pain experienced by taiohi and whānau. They often felt psychiatrists lacked insight into the effect experienced by taiohi living in poverty. Suggesting that psychiatrists' professional realities and social norms are distant from such adversities, making it impossible to understand the depth and breadth of *living with social pain*.

> *Our psychiatrists have got no idea, not forgetting they come from very well-off families, and they have never had a shit day in their lives, you know. They have not known what it is like to not eat at the end of the day. Why do you (taiohi) eat pies? Well, because it is available and it is cooked, and I do not have to cook it. I have no power at home to cook anything. They start thinking about healthy budgeting services, but it does not happen. Until you see it, I feel like dragging them down there and showing them what I see. I took a psychiatrist to a client's home, and he was sleeping on a mattress on the floor in the lounge room. Does the psychiatrist ask why he is sleeping on the lounge floor? That is where they fit! To them, it is a significant problem; it is wrong, you know, this should not be like that, and it becomes a lecture about everything they do not understand.* (Participant 19 – keyworker [non-Māori])

Whānau dynamics

All taiohi in this study grew up in single-parent whānau. *Living with social pain* was experienced by parents trying to cope independently with taiohi substance use and mental health issues. Taiohi relationships with their fathers were variable, with three fathers resisting accountability for their sons; while two fathers wanted to support their tamariki, their engagement and responsibility were brief. One father and mother had no contact after the taiohi parents had separated. One mother had passed away.

> *His father rang me because friends had seen him begging on the street, and I said what do you want me to do? I can't make him do anything. His father put him in a drug rehabilitation centre and trespassed him from his house.* (Participant 10 – whānau)

> *Son's father left us, and I got support from my whānau, but it was hard for them because they lived on an island and had to catch a boat and bus to get to us.* (Participant 14 – whānau)

> *I was working, so he would be alone. So I sent him to his father for five weeks, and then he put him into hospital.* (Participant 12 – whānau)

> *My wife and I took care of her because her mother was sick. When my wife passed, I asked her mother to stay with us to build a relationship with her daughter.* (Participant 13 – whānau)

> *I live with my boyfriend, but he doesn't like mental health. My dad and auntie help me.* (Participant 7 – taiohi)

I observed that taiohi did not talk about the parent who had left the whānau. The two taiohi who had absent mothers relied on their aunties for female support and leadership. At the same time, taiohi with absent fathers relied only on their mothers for help. Where possible, mothers reached out to their fathers. However, their brief engagement heightened social pain and anxiety. For instance, one mother contacted her ex-partner as she struggled to cope with her son's behaviour and substance misuse. She organised for her son to go and stay with his father.

> *Son never had a good relationship with his dad, and he hated him after he left us, but I know he loved his dad. So I felt being with his dad would be awesome. Son went to live with his father and step mum. However, she touched him physically*

and aggressively. Yeah, she hurt him and caused him to run away. Yeah, and then he attacked his dad. He started telling me, "I do not trust you anymore". His father and partner set a trespass order on him and admitted him to the hospital. They texted, saying they didn't want anything to do with him. They blamed me; they were like-god, it is your fault; your mother did this to you. But the only thing I did was love my son and give him all you know, I mean, I do have my growlings, but I am an easy mum, you know. It is not easy. (Participant 12 – whānau)

In another situation, a father contacted his son's mother because his friends had seen him begging on the street. He found his son on the streets and placed him in a drug and alcohol facility. After doing this, he provided no further support.

His father rang me and said, look, one of our friends said they saw that boy begging on the street. I said, 'Well, what do you want me to do? I can't; I can't, you know, go and get him; I can only tell him. The father says, ' We are not like that. Why is he doing that?'. I said, 'It was for drugs'. So his father put him in a drug and alcohol rehabilitation service. Son was in there for 26 days, and then he started behaviour problems and was transferred to mental health services. I did not see his father after he had admitted his son to the rehabilitation service. Yeah, he wasn't very accommodating. (Participant 10 – whānau)

Living with a mother and father enhanced the mana of the whānau by role-modelling both male and female responsibilities and obligations. However, mothers who parented independently voiced the need to maintain dual parental and father responsibilities. They talked about the difficulties they experienced with their son's behaviour and their need for a male role model.

I need him [son] in mental health because he is unsafe at home with me. I need help. I needed help. And that is the hardest thing for Māori women because we always try to do things independently. Because we know we are strong enough to have been brought up that way. Yeah, it was hard. He is in the right place now. Yeah, well, it got to the point why I put him in there because he hit me twice. (Participant 11 – whānau)

A te ao Māori worldview of parenting is a collaborative relationship that includes immediate whānau, extended whānau, hapū, and iwi. Trying to cope independently was traumatic for mothers. Despite the emotional and physical challenges, whānau continued

to awhi and manaaki taiohi throughout their hīkoi. Absent mothers and fathers is an example of whānau displacement from the collective orientation of te ao Māori principles, tikanga Māori and mātauranga Māori. Absent mothers and fathers have chosen an individual pathway for themselves instead of maintaining the mana of the collective needs of the whānau. Absent mothers and fathers have not always chosen their pathway. Often their way has been violated by many experiences, and to enhance mana, they work collectively.

Lacking education

Lacking education is an indicator of *living with social pain.* Most taiohi and whānau in this study exited school before completing formal training or education. The result was limited employment opportunities and compromised social integration, impacting their sense of worth and belonging. Lacking education compromises their ability to survive socially. Here, my interpretation describes the effect gathered through whakawhanaungatanga verbal and non-verbal language that is often intangible. One taiohi feared being ostracised and resisted admitting to limitations in their education. Instead, they avoided situations where they had to read or write. They created a protective barrier of resilience to lessen the impact of admitting illiteracy by laughing it off. One taiohi spoke of being given a piece of paper with the patient's rights written on it; however, he could not read it. During the interview, he laughed it off by saying,

> *No, I am not a reader, aye. They said we could make complaints if we got treated wrong.* (Participant 5 – taiohi)

Taiohi, who dropped out of school, developed a sense of belonging with peer groups in similar cultural and social situations. Hanging out with peer groups led one taiohi into crime. On one occasion, he was stealing cars, and the police had to place spikes on the road to catch him and his friends. One mother shared,

> *He stopped going to college over a year ago. He was doing many things with his friends. They were smoking weed and gaming. No girlfriends, which was excellent. Nevertheless, they were involved in stealing cars and going on police chases. Their vehicle was spiked twice, causing damage to other people's vehicles, and then they just started to smoke 'P' a lot more. While I was away at work, his mates would come over, and they would get careless and leave their shit* [utensils for smoking P and small empty plastic bags which contained P, empty food

wrappers, and evidence suggesting they had been playing games all day] *around.* (Participant 12 – whānau)

Several other taiohi had an opportunity to return to school. However, taiohi returning to school struggled, finding it hard to keep up and eventually dropping out. Surviving socially, living in deprivation, and working with ongoing social complexities and adversities is a recipe for substance use and mental health issues.

Daily, taiohi and whānau experience the hardships of living in poverty and, often, transient lifestyles are part of survival. Struggling through these hardships affects whānau relationships and impacts educational opportunities. The traumatic effects of persistent problems and struggles cause intergenerational *social pain*. *Living with social pain* is an effect of colonisation and is layered with multiple adversities. Sadly, *social pain* is often normalised, keeping taiohi and whānau on the margins of society. Taiohi and whānau expressed their social pain by describing their everyday challenges, such as not having food in the house, being unable to heat the home, or buying a pie because they had no power.

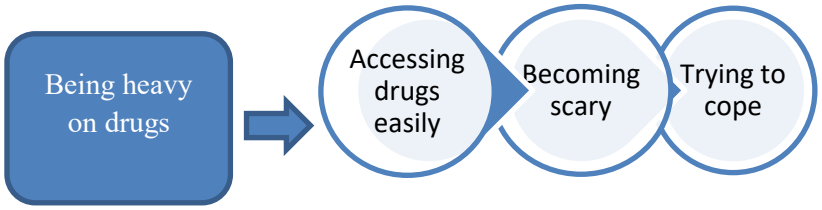
Being Heavy on Drugs

Consistent substance use leads to heavy dependence on drugs, and the effect is psychological and spiritual disarray. *Being heavy on drugs* provides an opportunity to distance ones self from the trauma of *living with social pain*. The combination of colonialism and social pain are manifested in taiohi *being heavy on drugs.* Substance use removed the pain temporarily, but the realities of social trauma remained. Taiohi access to substances was easy, and sharing among peers and whānau was common. Taiohi have access to various substances, including tobacco, alcohol, marijuana, synthetic cannabis, methamphetamine, ecstasy, and prescription medications. However, the most problematic implications are methamphetamine, synthetic cannabis, and marijuana.

Whānau noticed changes in taiohi as they became unpredictable, and their behaviour and mood swings worsened. They hid in their rooms or walked the streets day and night; psychologically, they moved into a psychotic reality. Most whānau struggled to understand the links between substance use and mental health issues until taiohi became unwell. Nonetheless, whānau continued to provide awhi and manaaki for taiohi until the coping mechanisms for taiohi and whānau failed. Figure 4 overviews the elements of *Being heavy on drugs.*

Figure 4

Sub-theme Overview – Being heavy on drugs



Accessing drugs easily

Taiohi were *accessing drugs easily***.** The supply came from a variety of places close to where taiohi lived. Suppliers included chemists, retail stores, friends, friends of friends, whānau members, neighbours, peers, gangs, and people living on the street. Moreover, taiohi had experienced illegal substances at a younger age. One taiohi disclosed that he started smoking marijuana at 12 years. Regarding obtaining illegal substances, taiohi voiced that marijuana had become hard to access and that synthetic cannabis and methamphetamine were always accessible.

> *He couldn't get hold of marijuana, so he started taking synthetics. It was cheaper to get the synthetic stuff, and it was legal.* (Participant 14 – whānau)

Accessing drugs quickly occurs among peers, including school friends and local friends. There was a sense of comradery among peer groups in that they shared their drugs when a friend had none. They also meet and hang out together, always looking for a place to connect and share their substances. One taiohi began to miss school, taking advantage of his mother going to work. He would invite his friends to his house while she was working. Within the peer group, they used many substances, which became their primary entertainment source while playing video games. The mother voiced her frustrations:

> *He was doing a few things with his friends, which led to him stopping school. I know he was smoking synthetics daily with his friends. I found out later that they were coming around to my house. And I also heard that they could have been snorting codeine.* [During the interview, her son nodded, confirming he had been groaning codeine]. (Participant 12 – whānau)

> *I just smoked marijuana. I smoked a tinny a day. I got it from my mates.* (Participant 4 – taiohi)

Son smoked marijuana and regularly used other drugs with his friends, then stopped attending school. Smoking weed, gaming, stealing cars and going on police chases. (Participant 12 – whānau)

Accessing drugs quickly was also evident with whānau comradery. A mother explained how her son had easy access to synthetic cannabis from a tinny house next door to his grandmother's house. He would pester her to stay at his grandmother's, knowing the drugs were available next door, or he would beg on the streets for money to buy substances.

He had a bad drug problem and was begging for money on the streets; when he had the money, he could buy his drugs anytime, day or night. He could also go to my mum's place, and next door was a drug dealer where he would go to get the drugs and substances. (Participant 10 – whānau)

I was smoking marijuana and meth with my uncle. Before you know, I was puffing it night and day for a couple of weeks, and I was up for a couple of weeks, and then I couldn't sleep. (Participant 5 – taiohi)

Gangs are also whānau, known to support easy access to substances. A keyworker described working with one taiohi who developed a mental illness due to substance use.

SNAPSHOT: Gangs, Whānau, and Exposure to Drugs

Quite an intelligent young man who speaks fluent Māori and studies at the local Kaupapa School. He had all sorts of strengths. Well-loved in the community. The only glitch was that this taiohi whanau was associated with gangs in the local area. Often people would turn up at the house in their gang patches. They were seeking highs around the house and everything like that. Talking with the brother, he said he (taiohi) went off with them(gang members), and they had to do a job. Also, on his 21st birthday, one of his friends was blatantly attacked by a group of mobsters. It was done with a mere (Māori weapon). The taiohi picked up the mere and threw it down the back of the garage. His mother found it, and he tried to grab it off her, but she threw it into the fire. Due to this taiohi knowledge of te ao Māori, he understood the mere had a cultural element and throwing the mere in the fire really affected him. (Participant 16 – keyworker [Māori])

Becoming scary

Becoming scary occurred when taiohi realised something was wrong; something negative happened to their thoughts and behaviour. They began to see and hear things. They felt ill and started smashing walls; it became scary because they did not understand what was happening. Taiohi experienced distorted perceptions of reality, and they struggled to find the truth. One taiohi heard voices, saw things, and thought he was psychic with spiritual abilities. Another taiohi became suspicious about his environment and the people within his surroundings. They were upsetting friends and whānau and wanted to fight with everyone.

> *I was ill, and I could not explain how depressed I was. I could not feel properly. I thought people were putting nasty stuff on me. When I approached them, I felt they couldn't do anything right. I think it was my illness. There was some negative thing going on.* (Participant 8 – taiohi)

Many taiohi voiced how scary their drug-induced reality had become. One taiohi believed people were after him; it felt so real that he armed himself with weapons to protect himself. In desperation, he broke into a building and rang the alarm for help.

> *I was just out of it on meth. I was running and jumping over fences thinking people were after me. It was scary. I thought people with guns were after me climbing up the building. I thought people were hanging from trees. I broke into the fire station and rang the fire alarm. The cops came, and I had lots of knives on me*. (Participant 5 – taiohi)

Becoming scary occurred when mothers became terrified for themselves and their other children as taiohi, heavy on drugs, displayed aggressive and scary behaviours. Whānau experience of taiohi substance use was overwhelming. They struggled to cope with taiohi. All mothers were emotional when disclosing their experiences and blamed themselves for struggling to cope.

One mother voiced how she noticed changes in her son's behaviour and mood. It became scary, and nothing made sense. As she talked, she began to cry and struggled to stop crying as she shared her experience. As her emotions surfaced, she reflected on her experience and asked questions. She and her extended whānau tried to make sense of her son's voices and evil thoughts, questioning if it was a mākutu. After exhausting their

Māori ways of knowing, she tried contacting people for help. However, she struggled to reach the right people for almost a year before connecting with the local psychiatric emergency (crisis) team. She felt relief with their help but soon regretted getting them involved. She believed their approach was horrible and upsetting. The crisis team arrived with the police, and, in that instant, everything got worse. Without any explanation, the police retrained her son, handcuffed him, and drove away. The whānau were crying, and his sister was screaming. They all drove away, providing no information, leaving the whānau devastated and shocked.

SNAPSHOT: Becoming Scary for Whānau

This interview is the first time I have talked about my experiences that began over 2-years prior. Son came back from Australia and was just a totally different person. He was talking and behaving abnormally. Saying he could hear voices and they weren't good voices, they were, oh, I have had a rush of emotion, telling him to kill himself or hurt others. He thought my parents' dog was possessed and was trying to hurt him; yet the dog was the most loving dog, and my parents had him for a couple of years. I tried to get him to go outside but he wouldn't. At that stage, I rang so many people asking for help that I rang the psych 0800 number. They told me to bring him. I betrayed him and said we were going to see a Māori doctor. He opened up, and the doctor said he had to be admitted immediately. I said I needed support from my whānau and they came. The doctor explained he would be committed, and they made it sound easy. We went home, and the next day all the whānau were there to support him. Two people arrived at the house and presented son with a letter. I said he probably wouldn't go, and then the police arrived. He got scared and took off. The two people said your family like blaming us and said he needed to go and have some medication to get better. It's like, what the fuck? Then they got him handcuffed and shoved him in the car. I didn't know I could go. I was scared, thinking he'll try to commit suicide. (Participant 14 – whānau)

Another mother described changes in her son's mood over a few weeks, but she thought it was a stage he was going through. In weeks to follow, she quickly realised something was not right. He started fighting with his sister and tried to assault her and his mother. Like the whānau above, this mother sought her knowledge in te ao Māori and the wairua, believing it might be a mākutu.

It was scary. He went into psychosis and was here, like there, right in front of you, but his mind was elsewhere. So, we were trying to figure out what was going on with him, and then he started self-harming. Punching himself up, hit me twice, lashing out. Yeah, he just got up and whacked me; I went aye? And then he whacked me again. I rang whānau to come, and my son is hurting himself; whom do I reach out to? And it was my niece's, her mum, rang mental health. That's how that came about; we put him in mental health. He was there for 3 or 4 days. I went to stay with him, but I would not say I liked it, nah I went home. I thought this was the wrong place for him. He was only 18. It was more adults for adults. (Participant 11 – whānau)

Whānau, who considered mākutu, understood the possibility of spiritual infliction of physical and psychological harm through spiritual powers. Therefore, they sought spiritual guidance from whānau elders and kaumātua as the first option for taiohi healing and recovery.

SNAPSHOT: The Fear of Mākutu

I mean to say that because the first two days it happened, we thought he had a mākutu on him. I got all my whānau in to help him like one of my cousins. He is a minister, a priest so he came to tautoko [support] me, and it didn't work. So, I grabbed my mum, and she came to see if it was a mākutu, but it wasn't. We were trying to figure out what was going on he was self harming, punching himself. It was all to do with him smoking synthetics. (Participant 11 – whānau)

Because we are into our Māori tanga I told son the voices weren't good because he was talking about his tupuna and they wouldn't be wanting to hurt him or others. I said you need to talk to a tohunga. (Participant 14 – whānau)

Becoming scary occurred for another mother. Her son was not sleeping, and he became very demanding. She felt hopeless and afraid. She loved her son, but he was freaking her out (scaring her).

He went withdrawn, and he would stay home. I struggled with him; he was demanding and didn't want to do anything. I don't think he gave his brain or his body enough sleep. Always awake, maybe sleeping a short time, and then awake again. When he is in his room, I don't see what's going on, but I hear crying, you know, through the walls and the house. Just, what's that kind of behaviour when you get angry and upset? Then he is just there next to me! He would follow me

around. Like I am by myself hanging out, washing, just enjoying my company, and then he is right there. I love him, but he scares me and freaks me out with his ways. (Participant 12 – whānau)

In another instance, *becoming scary* created feelings of hopelessness for a mother.

His conversations made no sense; he would talk to himself and act like a lunatic. Yeah, he was using synthetics. Yeah, a bad stage, smoking and begging for money to get these drugs, like starting fights, talking to himself. One of his bros said, 'Are you all right, my bro?'. And he started lashing out at him. He was talking to himself, yeah. He was pacing, pacing, pacing a lot, and thinking, disorientated thoughts that people were talking about him and, and trying to, you know, trying to harm him and stuff like that. He was that bad. He and my oldest son were on it badly. Like lunatics, they will be seizuring up, and they will be like drooling. It was not very good. (Participant 10 – whānau)

Trying to cope

Trying to cope was difficult for taiohi because they did not understand what was happening.

I told my whānau at least a year earlier that I was sick, but I didn't find out until I got older. I kept trying to tell my mother, but she didn't believe me then. I couldn't explain how depressed I felt. I was very ill, and I couldn't really feel properly. People did really bad stuff to me, and when I approached them, it felt like they didn't do anything right. I lost it all the time when I got ill, smashing walls. I didn't know what was happening, something bad. I started to get upset with people yelling and fighting. It was just my illness; it was a negative feeling. (Participant 8 – taiohi)

Trying to cope was difficult for whānau, and they struggled to get support.

I had rung so many people asking for the right help, where do I go? It was hard and took over a year. Till someone finally gave me the psych 0800 number. (Participant 14 – whānau)

Trying to cope was overwhelming for one mother with a history of mental illness. Her key worker recognised her distress and encouraged her to take time in a respite facility.

> ***SNAPSHOT: Coming Home to a Trashed House with no Support***
>
> *Both my sons were on synthetics the drug synthetics. They were on it bad. I went into respite for a week but it turned into 2 months and when I came back my house was trashed. I tried to kick my youngest son out but everytime my older son you know he was being really violent. Disrespectful. My youngest son just liked smoking synthetics. I said just get out of my house Ill chuck this stuff out. He grabed it back off me and said I need it mum. I can't think I need it to sleep. It was just awful the way they were smoking the drug. It was hard for me all my cupboards were full of buckie whatever utensils they use for it. All on my floors, my walls. He stopped coming home and was staying on the streets with homeless people being like a lunitic. They were siezuring and drooling it was awful. I called the police ten times for help but they just turned a blind eye*. (Participant 10 – whānau).

When taiohi became *heavy on drugs*, the pathway back to normality was impossible without professional help. Taiohi emotions, thoughts, and wairua were in disarray. They were scared because they did not understand what was wrong. Many whānau struggled to seek help because they did not know what they were looking for or where to get the help they needed. Two whānau had some understanding, and they knew where to seek help. Other whānau reached a crisis point before finding the support they needed. Eventually, taiohi and whānau accessed acute mental health and addiction services. Nevertheless, the scariness continued as they entered a psychiatry model care dominated by Western biomedical norms.

Entering a Scary Place

The second theme, **Entering a Scary Place,** describes the experiences of taiohi and whānau in acute mental health and addiction services. The two sub-themes emerging from **Entering a Scary Place** include: *Locking Me*, which reflects the overwhelming experience of entering acute mental health and addiction services for taiohi and whānau. While whānau and most taiohi felt relieved to connect with mental health, they experienced a culture shock. They did not know what to expect, lacked communication, and taiohi experienced confrontation with discriminatory police behaviours. It was a traumatic experience. Police intervention and a belief that they did not have a mental health issue led several taiohi to resist entering mental health and addiction services.

Clearing of thoughts happened as taiohi began recovering and whānau became familiar with the culture of mental health and addiction services.

Nonetheless, whānau experiences of poor communication were ongoing within the mental health and addictions services and the community. Factors enhancing taiohi recovery included their abstinence from substances, cultural support, and keeping busy on the ward. Treatment factors included medication therapy and a holistic dual diagnosis approach, including mental health, substance use, and social adversities. The combination of these factors supported whānau ability to cope and strengthen their relationship with taiohi. Factors hindering taiohi recovery included medication side effects, a lack of trust, and boredom with nothing to do with the unit.

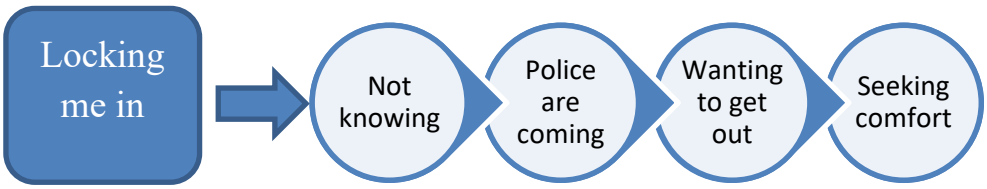
Taiohi and whānau hīkoi came to crossroads as they moved from the community into mental health services. **Entering a Scary Place** began with enacting the Mental Health (Compulsory Assessment & Treatment) Act of 1992. The Act's compulsory assessment and treatment provisions remained when taiohi accessed acute mental health and addiction services. The sub-theme *locking me in* has three indicators: *not knowing the police are coming*, *wanting to get out*, and *seeking comfort* (Figure 6). The second sub-theme, *clearing of thoughts,* has three indicators: *accepting treatment*, *having whānau around*, and *getting easier* (Figure 7). The following discussion begins with the sub-theme *locking me in*.

Locking Me In

Locking me in began for taiohi and whānau when they entered acute mental health and addiction services. All taiohi entered mental health services under the Mental Health (Compulsory Assessment & Treatment) Act 1992. Police escorted seven of the nine taiohi into acute mental health and addiction services. The Mental Health (Compulsory Assessment and Treatment) Act 1992 provided an entry point to mental health and addiction services for individuals experiencing an abnormal state of mind, suggesting taiohi were dangerous to themselves or others. Initiation of the Act led to a psychiatric assessment to determine whether or not the individual has a mental disorder (Ministry of Health, 2012). Post assessment, all taiohi were diagnosed with a mental health disorder and admitted for further assessment and treatment. Taiohi must accept treatment as prescribed by the psychiatrist. At this point, taiohi became a patient of the State removing many rights from the whānau and disestablishing tino rangatiratanga. Taiohi lost their autonomy and agency to decide or refuse assessment and treatment.

Figure 5

Sub-theme Overview – Locking Me In



Not knowing

Not knowing what would happen when admitted to mental health and addiction services created anxiety and fear for taiohi due to *being heavy on drugs*. Additionally, police involvement increased taiohi suspiciousness and distrust of the system. A keyworker explained,

> *A lot of the time, taiohi are frightened. It's scary because they are high on drugs and don't know what's happening.* (Participant 17 – keyworker- non-Māori)

Once initiation of the Act begins, taiohi must receive their patient rights both verbally and in written form. Legally this must occur with the presence of whānau. If whānau are absent, a Justice of the Peace must witness the process. *Not knowing* the Mental Health (Compulsory Assessment and Treatment) Act 1992 was evident in taiohi voices. Several knew they had access to a lawyer. Overall, taiohi understanding was superficial, and they believed it was not good when under the Act. One taiohi expressed his lack of *not knowing* and his feeling of being locked in.

> *I don't really understand the Mental Health Act; I felt locked in. Kind of like I just wanted to get out of there, but I had to go through it. I came off it, and then I went back on.* (Participant 5 – taiohi)

Another taiohi explained that *not knowing* about the Mental Health (Compulsory Assessment and Treatment) Act 1992 made him scared of saying the wrong thing.

> *I can't say nothing. I did understand a little bit. It meant that they looked after me, cared for me, and gave me medications on time. But things are not so good because I'm scared of what they will do*. (Participant 7 – taiohi)

Similarly, another taiohi reflected on his fear of *not knowing* about the Mental Health (Compulsory Assessment and Treatment) Act 1992 and having no say.

Yeah, they told me it was a protection of the mental state. This means you're being looked after and cared for. No, I didn't remember my rights. Others in the hospital didn't understand either; some say they did not have full freedom. I was on it, but I'm not on it anymore. It's not such a good thing. Because when you're unwell, you don't understand. It's like you have to say what will help you get out. Like you've got no say about what you want to do or how you feel, yeah, you've got no voice. (Participant 9 – taiohi)

Police are coming

Police are coming, explains the fear that taiohi experience with the presence of police. Once the Mental Health (Compulsory Assessment and Treatment) Act 1992 is activated, Section 41 allows police assistance meaning taiohi can be uplifted and taken to a place for assessment. However, many taiohi disliked the police and labelled them as 'Pigs'. In police presence, taiohi females were likelier to become emotional and anxious. However, male taiohi were likelier to run when they saw the police. They resisted getting caught and were likely to become abusive or assaultive towards police. In response, the police were more likely to discriminate against male taiohi due to their Māori ethnicity, behaviour, and robust build. Police rely on their combative role of physical, mechanical, and environmental restraint. Their lack of knowledge and de-escalating skills to work with taiohi *heavy on drugs* reinforced the label 'police are pigs'. All seven taiohi who experienced police escorts voiced that *police are coming* was a bad experience.

In one situation, *police are coming* occurred after receiving a phone call from peers about their friend overdosing on pills. She connected with her friends on Facebook about her feelings, plans, and execution. She had recently lost her whāngai aunty to cancer and wanted to join her. She had hoarded her prescribed antidepressants and then took them all at once when her whāngai uncle was out. When the police arrived, she was very drowsy; and when she saw them at the door, she was overwhelmed with anxiety, commenting:

The police came to the house. I got a shock, and then I just blanked out. (Participant 3 – taiohi)

A young mother voiced her experience of police coming. The crisis team rang and gave a date, and time they planned to see her son. Unbeknownst to her, the crisis team arrived with the police. When her son saw the police, he tried to run but was handcuffed and

placed in the police car. Both the police and crisis team drove off without any further explanation.

> *The crisis team turned up. I was upset then, and my son didn't want to go. Then the police turned up, and we didn't know that would happen. Son got scared, and he tried to run. But the police got him, handcuffed him, and shoved him in the back of the car. Everyone was upset, and his sister was screaming and crying. I didn't know where he was going and tried to ring mental health when they left. Didn't even know what the process was. I tried ringing the 0800 psych line. And then I finally got hold of a nurse who said they'd pass my message on. It wasn't until midnight that I got a call to say that he had been given some medication to help his brain stop being so busy. Then she told me it was best not to visit for a few days.* (Participant 14 – whānau)

A keyworker witnessed the police transfer of taiohi to the acute mental health unit in her role as a Duly Authorised Officer. She acknowledged the challenging behaviour police faced when dealing with taiohi *heavy-on drugs*. Nonetheless, she felt the police reacted to the behaviour instead of considering their mental illness.

SNAPSHOT: Police are Coming

Police officers' understanding of mental illness and taiohi behaviour can be quite challenging, and I think the police are overzealous you know, they've cuffed and hurt them. I understand that the police feel threatened, and they're fed up because they've been spat at and hit. But the police behaviour makes their behaviour worse. The kid doesn't know what's going on because they're psychotic. It's a vicious cycle because the kids are fed up with all the cops' energy getting aggressive and just, you know, boof. I don't think the police have an understanding of mental illness. They learn by default when you're sitting in the station with the kid and trying to explain to the police officer what's going on. Some might ask questions, but most put them in a cell and wait for us (nurses) to deal with them. They're not interested, they're not curious about what's going on. They're very much like the average layperson, ignorant of the urgency of what's going on for this young person. Police become aggressive, cuffing and shoving them in the back of a car or a cell. If they learned to de-escalate, they'd get a far better response and less trauma for these young people. Rather than every cop seeing them as drugged-up crazy, they must understand it's a mental illness. Even travelling in police cars with clients very rarely, you'll get a cop that will try and engage. The older ones who have been there for years will try and communicate. (Participant 19 – keyworker [Māori])

Wanting to get out

Wanting to get out is a feeling experienced by taiohi when they are locked in a room. A closed room is a form of restraint where taiohi are secluded and cannot exist freely. The experience of seclusion is frightening for taiohi. They felt *locked in* and alone in a strange place without whānau. They were often depressed or disorganised in thought because of *being heavy on drugs*. Several taiohi expressed their experience of seclusion and *wanting to get out*.

> *The hardest thing is that you feel locked into a place you can't escape. They would let us out for a little bit to have a smoke. Then back into the room, and then they lock the door. I was depressed and just wanted to get out into the other ward. I hate being boxed in little rooms. I didn't have full freedom.* (Participant 9 – taiohi)

> *I was in the hospital because I was unwell. They tackled me to the ground and put me in lock-up. You can leave the locked room, but there are only certain places you can go, but it was scary. Just surrounded me. I was scared, but after a while, my anger just left me.* (Participant 8 – taiohi)

Wanting to get out is also a response to the feeling of being 'freaked out' when admitted to acute mental health and addiction services. When someone feels freaked out, they experience sudden confusion or become upset about someone or something. They have mixed emotions of being scared or angry. One young lady who had overdosed said she did not want to be in the hospital.

> *The scariest part was when they put the stickers on me (an ECG machine). It reminded me of what I saw on TV shows; it was scary. I knew what had happened to me, and I was scared I would die. I didn't want to be in the hospital; I was scared. I tried to get out as fast as I could. Yeah, it wasn't really open with anything or anyone.* (Participant 3 – taiohi)

Keyworkers understood why taiohi *wanted to get out* of the unit. They witnessed the psychological trauma experienced by taiohi when they were high on substances and picked up by police. Keyworkers understood the challenges experienced by taiohi and how scary it must have been to be isolated, restrained and secluded in a foreign place without whānau or peers.

SNAPSHOT: Keyworkers' Experience of Taiohi Feeling Locked In

Keyworkers experienced taiohi feelings of being locked in and *wanting to get out*. They understood how this experience affected their willingness to engage in services and accept assessment and treatment.

> *They're going through a traumatic experience, they're hearing voices and they can't explain what's going on. They need whānau but often they don't have them.* (Participant 19 – keyworker – non-Māori)

> *I took one female taiohi to an acute unit and they locked her into a secure room. This young woman was shaking and terrified. A male nurse sat outside her room in the corridor like in jail. I had to go and talk to him and say she is really depressed and terrified in there on her own. This was a bad experience, and it wasn't what she expected.* (Participant 18 – keyworker – non-Māori)

> *Feeling locked in is really scary for taiohi and their family. One young lady had drug induced psychosis and she was freaking out. She was really scared, and she started banging her head and pulling her hair out. Then she curled up in a ball very, very scared. The family had brought her into the acute unit and they were scared very scared too.* (Participant 17 – keyworker- non-Maori)

Wanting to get out also occurred for taiohi when they interacted with unwell taiohi in the unit. Two taiohi talked about their experience with other co-clients.

> *It was kind of freaky. They bring in unwell people. Some were mean, and they made me feel unsafe. Other patients were angry. Some were pretty scary because they were coming down from crack. I would tell them to shut up, and we would argue. The staff would just put me in the lock-up room in the back.* (Participant 9 – taiohi)

> *One patient had mood swings, and she picked up a cup and tried to throw it at me because we told her to get off the computer. I just wanted to hit her. Staff were trying to calm her down.* (Participant 7 – taiohi)

Whānau, who stayed in the acute unit with taiohi, also felt scared. One mother voiced her experience of being on the ward and *wanting to get out*.

Very, very hard, very difficult. Scary, aye, because you could hear the rest of the patients like screaming, or you can hear them walking around, fuck are they going to come into my room? I didn't feel safe. I stayed there one night. I rang my whānau to come and get me. 'Where are you?' 'I'm in the mental health, come pick me up!'. 'What are you doing in there?' I said, 'Not me. My son is in here, come and get me. But nah, it was really scary, aye? No, he didn't like it. He did not like it. He said, 'Don't you put me in there again'. 'Well, if you play up, I will put you in there'. He didn't like it, not one bit. (Participant 11 – whānau)

Seeking comfort

As a coping mechanism, taiohi began seeking comfort in the scary place. *Seeking comfort* came from having whānau around. Taiohi understood how uncomfortable and difficult it was without whānau. They knew that having whānau around felt comfortable, safe, protected, and someone was listening to them.

When Mum came to the hospital, it helped me a little. Oh yeah. Like, I mean big time, she is my mum. I freaked out at her being there with me. Oh. Unbelievable. She stayed in the ward for 2 or 3 days. It helped heaps. (Participant 1 – taiohi)

My uncle, my mum, and my mum's partner came. I wouldn't have been comfortable going to the hospital without them. I would not feel comfortable around people I do not know, like the nurses. Yeah, my uncle stayed over—the best thing I had was whānau with me. (Participant 3 – taiohi)

Yeah, Mum came in. Yeah, it was good for me. Good to be back around family. I felt lonely on my own. She used to come in a lot during visiting hours. She used to bring my brothers and sisters sometimes, which helped me. (Participant 4 – taiohi)

Seeking comfort also came when taiohi felt someone cared. For instance, the experience of regular meals and a room with a bed. Comfort also came as rapport developed with nurses and doctors.

Yeah, yeah, it was pretty good. They looked after me and fed me and stuff. (Participant 1 – taiohi)

They were very nice; they would spoil us with food and activities. It was kind of good to stay there. The beds were comfy; I had my private space. It was good.

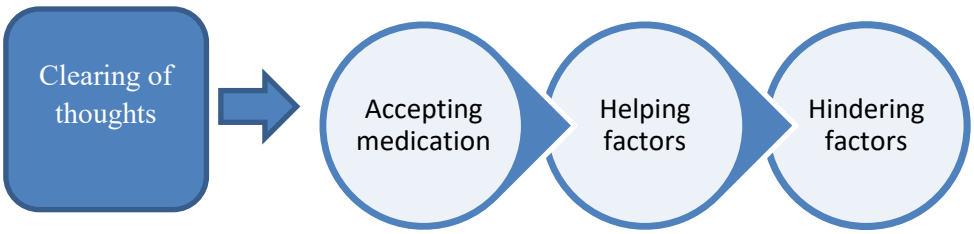
Very good in the hospital. Wouldn't mind living there! Yeah. A good place. (Participant 9 – taiohi)

Clearing of Thoughts

Taiohi and whānau hīkoi had multiple ups and downs, but things started getting easier. *Clearing of thoughts* began when taiohi accepted treatment. Taiohi and whānau quickly understood that receiving treatment meant they could go home. Taking treatment was easier when taiohi had a rapport with mental health clinicians. *Clearing of thoughts* was also supported by helping factors that included connecting with cultural support, dual diagnosis, keeping busy on the ward, and abstinence from substance use. Factors that hindered the *clearing of thoughts* included boredom, medication side effects, poor communication, and a lack of trust in the mental health system (see Figure 7).

Figure 6

Sub-theme Overview – Clearing of Thoughts



Accepting treatment

The legal obligation under the Mental Health (Compulsory Assessment and Treatment) Act 1992 was a key reason for accepting medication in the acute unit. Receiving treatment started with adherence to medication administration. Taiohi knew they had to take the drug to get out of the acute unit. Several taiohi enjoyed the over-sedation with medication because it kept them calm, blocking their negative thinking. Others felt it helped with sleep and could function better during the day. However, some taiohi struggled with compliance and the side effects.

Accepting treatment helped develop a therapeutic relationship with nurses and doctors. I asked taiohi if they found nurses and doctors helpful. Most saw nurses as helpful, kind, polite, and people who listened to them. They saw psychiatrists as someone to talk to, to take down the main points, and to explain mental illness.

SNAPSHOT: Nurses and Doctors are Kind and Helpful

Over time over half of the taiohi participants began to appreciate doctors and nurses. Taiohi voiced that nurses and doctors were kind and good listeners. They voiced nurses taught them heaps. They were always there to help them and always checking on them to make sure they were okay. Nurses made taiohi feel comfortable most of the time. Taiohi believed nurses explained things like taking medication on time. They would feed them and take them out for smokes. Taiohi felt both nurses and doctors were also good to talk too, and very helpful. Doctors listened and helped clarify things. Having a Māori nurse was seen as very helpful because they understood Māori concepts of whānaungatanga and tikanga. They were not in a rush and took time to listen and provide helpful advice.

Helping factors

Helping factors included cultural support offered by Māori cultural advisors. The comfort of receiving culturally competent care eased the anxieties and distress of taiohi and whānau. They felt understood and supported by Māori cultural input. Knowing Māori staff were accessible provided a sense of security and familiarity. It also meant they had access to cultural practices such as tikanga Māori (Māori philosophies) and mātauranga Māori (wisdom and understanding). Maori staff offered whakawhanaungatanga (establishing relationships), kotahitanga (collective action), and manaakitanga (support). They also provided wairuatanga (spirituality), karakia (prayer), and waiata (song) and often played the kitā (guitar). Several taiohi expressed their appreciation for Māori cultural input.

> *Māori culture thing. Yeah, yeah, that support, and yeah, that was pretty cool. Whaea came, yeah, to see me. She was so supportive and interested in what I had to say.* (Participant 7 – taiohi)

> *Kaumātua came. Yeah, it was good; we usually do karakia in the morning. Yeah, probably stayed half an hour or something.* (Participant 8 – taiohi)

> *A guy came along and helped us sing songs. That was good. Spiritually I am into my Māori stuff. I like the haka! But he only came one day. I like being with Māori having cups of tea and that.* (Participant 9 – taiohi)

One young mother expressed gratitude for cultural support for her and her son. In contrast, a younger man clashed with a Māori whaea who tried to offer him cultural support. While

his mother appreciated the connection, he became argumentative and resisted input. In another situation, one taiohi asked for Māori cultural support.

> *The staff kept bringing up the idea of a kaumātua visiting while I was there, but he wasn't available. The whaea was there, and she would do karakia for us before and after meetings, like big important things. It helped because I'm into prayer at the moment. Yeah, and I feel very safe and grounded when I hear karakia.* (Participant 12 – whānau)

Helping factors also included working with the principles of dual diagnosis. Dual diagnosis offers assessment and treatment of substance use and mental illness together. It is a holistic approach associated with hospitalisation, whānau issues, financial adversities, social isolation, homelessness, medical issues, and criminal activity. An essential part of treatment is education. A vital component of care to support taiohi understanding of the impact of substance use on their daily lives, relationships, engagement in school, and employment. According to keyworkers and whānau, there is a need for dual diagnosis residential care in the community close to home and with whānau.

However, in most situations, the dual diagnosis approach was absent. Nurses focused mainly on mental health issues; as vital substance misuse educators, their approach was very superficial. Overall, taiohi voiced little understanding of substance abuse and addiction. As a result, many continued to use some form of substance when discharged back to the community. Only one taiohi attended an addictions workshop while in acute care but had forgotten what he had learned.

> *Yeah, we were told to take care of ourselves. Take care when we are smoking. I know it is too much if I smoke for more than ten days. But three sessions a week is okay. When I smoke marijuana, it calms me down. It's a cool vibe.* (Participant 6 – taiohi)

SNAPSHOT: A Need for Residential Addiction Services in the Community

Keyworkers and whānau believed having a residential alcohol and addiction service in the community would be valuable. It could provide easy access to substance use information and support for taiohi and whānau. It would also provide services outside the 9 to 5 working hours. Also, it would be a place where taiohi substance use could be minimised, giving them enough time to realise and understand the effects of substance misuse. Additionally, whānau could be included in treatment and education. Whānau asked about drug and alcohol programmes when on the unit, but advice and options were limited.

A key *helping factor* whilst on the unit was abstinence from substances. The positive effect was that taiohi were glad to be free of methamphetamine and synthetic cannabis. No access to substances positively affected taiohi mental health and well-being, and it provided an opportunity to clear taiohi thoughts from a substance-induced reality.

> *It was getting off meth; that was the best thing. I couldn't handle it. I don't think anyone can handle it.* (Participant 5 – taiohi)

> *Synthetic cannabis is not good; I got well coming off drugs. It was pretty good. I started wellness as soon as I entered the mental health unit. I had a good recovery.* (Participant 8 – taiohi)

Other *helping factors* included participating in various activities on and off the acute unit. Taiohi enjoyed keeping busy. They enjoyed getting out of the unit and going for walks, playing sports, and weekly outings to the beach or lakes in the van. While on the unit, they enjoyed playing pool, cooking classes, and creative drawing. Several taiohi smoked tobacco; therefore, going out for smoke breaks was important. Other taiohi enjoyed talking to co-clients, voicing that listening to others' conversations was cool.

Hindering factors

Hindering factors included having nothing to do. Boredom is an outcome of a lack of interest in one's environment. Taiohi complained about boredom, a psychological or emotional state of mind with feelings of stress, emptiness, and frustration. When bored, taiohi would likely retreat to electronic devices rather than engage in a creative activity. The effect of boredom can also lead to anxiety, not being bothered to do anything, or feeling jittery and restless. Boredom varied. At times taiohi were kept busy; at other times, there was little or no stimulation.

Yeah, I was really bored. I just played with my iPad when I got out of seclusion and walked around the courtyard. They were letting us have cigarettes just to let us calm down. (Participant 5 – taiohi)

Didn't really do anything in there; it was boring. (Participant 6 – taiohi)

Other *hindering factors* included the side effects of medication. One young man talked about his weight gain when taking olanzapine, a typical outcome of this antipsychotic medication. Another young man felt fidgety all the time, a side effect of antipsychotic medication, especially in higher doses, which he received. All taiohi left the acute unit on psychotropic medication. Five male taiohi were on clozapine which has fatal side effects.

I couldn't keep still. I was fidgety all the time. I have started on a mean medication. I don't know what it is (according to the keyworker, it was clozapine). (Participant 4 – taiohi)

In the hospital, I was just on risperidone; it worked. Now I'm on clozapine. (Participant 9 – taiohi)

I was on olanzapine, but it wasn't really working, so they stuck me on clozapine. (Participant 8 – taiohi)

They were always chopping and changing the medication and didn't tell us. (Participant 14 – whānau)

One young man talked about feeling weak when taking quetiapine, an antipsychotic medication.

I took quetiapine, and I felt really weak. They (clinicians) *made me exercise for my weakness, which didn't help. I was more tired, and it made me stiff. I couldn't move; all I wanted to do was sleep. It made me feel suicidal.* Participant 9 – taiohi)

Did you tell anyone?

Nah, if you share it, you haven't got any mana. Only share with someone you trust. I just got over it and went to sleep. Without meds, I could get up in the morning, clean up, and do things. (Participant 9 – taiohi)

Whānau felt there was a lack of communication about the medication

I was just getting into a pattern of giving him morning medication. Then they changed it. I didn't receive any warning. I don't think that's fine if I know what to expect; it helps me. (Participant 12 – whānau)

Another *hindering factor* was a lack of trust in mental health and addiction services. Taiohi could see the positives of being in the acute unit, but most hid their suspicions of the system. Over half of taiohi did not want to take medication but knew they had to comply with treatment to get out. Several taiohi told their whānau not to put them there again.

To be honest, nothing went well because the doctors didn't understand. They think they do, but they need to walk in my shoes. (Participant 9 – taiohi)

They just said I was lying all the time and I was making it up. They just said mean things. Yeah, that made me angry. I would leave the room. (Participant 8 – taiohi)

Yeah, it was hard, to be honest. They said it was confidential, but I didn't know if they would tell someone. (Participant 3 – taiohi)

SNAPSHOT: Keyworkers' Observation of Taiohi Lack of Trust

Keyworkers noticed taiohi did not want to take the medication. It is like no thank you very much. They sit there nodding all the way through discussions, but they have really closed up. Taiohi are thinking "fuck off" basically. Keyworkers suggested many acute mental health clinicians do not understand taiohi and misinterpret them as dysfunctional. Taiohi pick up on this and they say what they think the clinicians want to hear. The silencing of how taiohi really feel impacts on their assessment and adherence to treatment especially when they return to the community. Where their medication compliance becomes ad hoc.

Another critical *hindering factor* was poor communication. Often whānau tried to call the acute unit, only to get an answerphone asking to leave a message. Sometimes whānau would receive a call-back, but most times, no reply, leaving whānau feeling anxious and worried. Whānau also experienced poor communication about taiohi when they were on the unit. For example, one mother rang the unit to talk to her son, but she was told he was not there, and she panicked. The acute team had moved him to another facility, but no one had informed her of his transfer.

> *I was like, why wasn't I contacted? I'm at work following up on my son, and my eyes bawled because I didn't know what was happening*. (Participant 12 – whānau)

A mother visited her son in the acute unit after being told not to see her son.

> *I went up the next day. I was just beside myself and needed to see him, and then he was just like sedated. He was just like sleeping, and to me, that made me worse. I didn't know what was happening, and I was going oh my god, I have sent him here to be drugged up. I talked to the psychiatrist, and he said he was given a low dose, and they wanted to see if there were any side effects. I kept thinking that he's a guinea pig. Why didn't they tell me the side effects from the start?* (Participant 14 – whānau)

Another mother rang the unit to talk to her son, who had been missing for over 4-hours. She felt sick, not knowing where he was and what he would do. She lived far from the acute unit and called whānau, who lived nearby, to look for him.

> *I had a go at the nurse because he went AWOL. I said anything could have happened to him. Their reason was that they didn't know his location and they couldn't send the police anywhere. I said they could have just put in a report to say he was missing, but they were laughing at me. I thought when I go to the next meeting, I'll fix them up, and they're going to get it from me* (Participant 10 – whānau)

Whānau also felt there was no communication about how they felt taiohi were doing or coping.

> *They (clinicians) ask taiohi questions, but they don't always comprehend, instead of asking the parents about taiohi who are in our care. As you know, we figure out what they are doing and what's going on and can relate to them.* (Participant 13 – whānau)

The *hindering factor* of *not knowing* occurred for a mother who stayed in the acute unit and attended all whānau meetings. However, she felt excluded during these meetings. At one meeting, she became frustrated when the staff confronted her son about taking the medication. She believed he would have been more accepting if she had explained it to him.

Well, at the whānau meeting, the psychiatrist said son's under the Mental Health Act, and legally they can force him to take the medication. And after that meeting, son ran away. And that was his thing of saying I don't want the medication. (Participant 1 – whānau)

Communication continued to break down in the community. For instance, the contact details of one taiohi did not get updated. As a result, messages went to the father, who had a protection order against his son. The father did not inform the acute unit or pass the messages to the mother. In another situation, a medication drop-off went to the wrong address because contact details were not updated. Poor communication between services was also an issue. For example, a social worker had gone to see one taiohi and had taken her out for a few hours. An hour later, the keyworker (nurse) arrived for a follow-up assessment. The whāngai uncle became angered by the lack of communication between the services as he knew the follow-up assessment was necessary.

SNAPSHOT: Whānau Frustration with Poor Communication

There were times that I didn't get contacted. He was in the hospital then they sent him to respite. I called respite to follow up, and they said no, your son is not here. I was like excuse me. Where is my son? Something happened, and then they sent him back to the hospital. I just bawled because I didn't know what was going on. I was like, why wasn't I contacted? Also, they were contacting his father, visiting his father's address and contacting the auntie. They hadn't updated the contact details. They shouldn't be contacting him he doesn't want to know about his son. Another time when my son was home, they stopped prescribing his morning pill, but no one told me. I was worried that this would affect his emotions and behaviour. (Participant 12 – whānau)

I don't remember them (clinicians) talking thoroughly about things. I just felt rushed. Like I was just another somebody, it didn't feel genuine. It just felt like many words just gobbled up. I had to take it all in because this was my first experience. I started looking for information about his label and his medication. (Participant 14 – whānau)

People in mental health don't talk to taiohi parents. They must realise that they are in our care, and we see what is going on so we can relate it back to them. Instead, they just talk to the patient. Another time one person came to visit, but we weren't home because no one told us. When we got home, there was someone else from another place, but my stepdaughter was recuperating and tired, but they kept talking to her. (Particpant 13 – whānau)

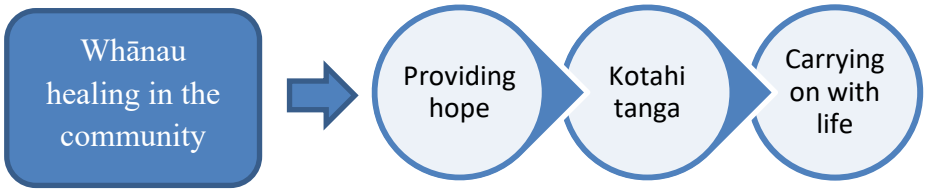
Clearing of thoughts for taiohi began when they stopped using substances, and the medication regime began to take effect. Other *helping factors* that supported medication treatment included having whānau around and interacting with Māori cultural supports. One taiohi also had the experience of a drug workshop providing a treatment regime of dual diagnosis. This approach would have benefited other taiohi but was absent in their treatment regime. Another *helping factor* was keeping busy with activities developed on and off the unit. However, a *hindering factor* was boredom. Another hindering factor for taiohi and whānau was medication side effects, which they struggled to accept. A critical *hindering factor* was ineffective communication. Communication about taiohi progress and concerns was ineffective. While whānau have been on a hīkio with taiohi substance use from the community into mental health and addiction services, there was a blatant disregard for their knowledge and insight.

Whanau Healing in the Community

The third theme, **Whānau Healing in the Community**, related to returning home to the community, which made coping with taiohi substance use and mental health issues easier for both taiohi and whānau. Home enhanced hope and promoted kotahitanga, uniting relationships with immediate whānau, extended whānau, and friends. Manaakitanga enriched caring and respect for each other. The sub-themes of **Whānau Healing in the Community** included *Providing hope*, *Kotahitanga*, and *Carrying on with life* (Figure 8).

Figure 7

Sub-theme Overview –Whānau Healing in the Community



Whānau healing began when taiohi left the acute unit. Back in the community provided hope and strengthened the whānau taiohi relationship for many. In the community, they had more freedom and could get on with their lives.

Providing Hope

Admission into mental health and addiction services was traumatic for over half of taiohi and whānau. Although, most taiohi and whānau were happy that they were substance-free after discharge. Being home in a familiar environment with whānau and peers provided hope.

> *Mental health really helped me. I got off the drugs, and those bad thoughts went away. I moved away from people who smoked (methamphetamine), and now I live with my brother.* (Participant 8 – taiohi)

> *In the unit, we were made to think it was a place where his needs would be met, but the experience was disastrous. I thought recovery meant he would go back to how he was before becoming unwell. But now I know he's not. Mum is still hoping he will come back to normal. He has changed since he came off the unit. He has more freedom and is social with us.* (Participant 14 – whānau)

> *Yeah, he didn't like being in mental health. Yeah, he was glad to be out.* (Participant 10 – whānau)

> *It was good when he came home. I felt good. The whole admission thing was confusing for him. He wanted to be home around his whānau and didn't want to be locked up.* (Participant 12 – whānau)

> *Yeah, on the unit, it wasn't really open with anyone or anything. Now that I'm home, I guess I am opening up more now. I feel better just being settled down at home.* (Participant 2 – taiohi)

> *Having him home means I can get my shit sorted. I needed to be here with my son, but my partner wasn't happy about having son home. Anyway, son and I are getting along, and things are so different. Year life is just getting better.* (Participant 12 – whānau)

> *I want to save up for a car because I have a learner.s* (Participant 7 – taiohi)

Kotahitanga

The principle of kotahitanga emphasises the importance of collaboration and knowledge within a cultural framework. It embodies the idea that everything is interconnected and supports unity through collective effort, as described by Henry and Foley (2018). Whānau kotahitanga had a highly positive impact on all individuals who utilised acute mental

health and addiction services. **Whānau healing in the community** improved after the experience of taiohi and whānau hīkoi from the community into mental health and addiction services. The taiohi and whānau relationship was enhanced when taiohi and whānau returned home. The interconnectedness of whānau in the community fostered a sense of mutual comfort and respect for each other. Taiohi showed gratitude for the awhi and manaaki whānau provided, and whānau developed an understanding of taiohi mental illness and substance misuse. Their affection for each other led to changes like less arguing and fighting and more remarkable patience with each other. Whānau had learned how to cope with taiohi behaviour and support them better towards their recovery.

> *Well, I think he's come to terms with being under the Act and having to take the medication. I think he's changed since he's come out of the unit and had that treatment. He's got more freedom at home and is still social with us. He is open with our conversations about life. He has come to terms with things like being under the Act and taking medication.* (Participant 14 – whānau)

> *She is opening up and knows that the whānau are paying attention... Being informed made me aware of keeping meds under lock and key... On discharge, a plan was put in place in the discharge summary, which helped me know what to expect.* (Participant 13 – whānau)

> *I would say you be wise, son. You have got to learn to cope at home. You can be well at home. We can have this at home. That's what I said to him because he didn't want to leave the hospital. He was scared of going back to using drugs. But he felt protected after being there for several months. However, it wasn't long before he went back to the streets with the homeless and back on the drug scene. But he slowly realises it's not all about the drugs. It's about coming home to the whānau and being respectful. Now he says things like you still keep the house clean, mum. Yeah, it was good to get him out.* (Participant 10 – whānau)

Carrying on With Life

Healing in the Community for taiohi and whānau meant trying to carry on with life. Taiohi being substance-free, supported whānau healing in the community.

> *I was happy to have him home, and I'm still trying to continue my life*. (Participant 14 – whānau)

> *Now son is home. I am working through things in my way. I take care of my whānau mainly on my own. I feel stressed, but I try to juggle everything and be there for my son. We go to a youth church group now, and he comes. Nothing much has changed in him. He still follows me around.* (Participant 12 – whānau)

> *Keeping up to date is important, and we did get our discharge summary, that was quite informative, so it didn't matter that they did tell us anything.* (Participant 10 – whānau)

For some taiohi, getting on with life meant they did not return home; instead, they found alternative accommodation.

> *I stay down the road in a boarding house. It's good recovery, and it is nice and peaceful.* (Participant 8 – taiohi)

Another mother did not want her son to return home. She felt he needed to be independent. After discharge from the acute unit, he stayed at a respite facility, waiting for permanent residence.

Getting on with life for others meant returning to substance use. Several continued to use tobacco, drink alcohol, and smoke marijuana. One returned to methamphetamine again.

> *Yeah, I was taking marijuana. I still take marijuana. It relaxes me. It's like lorazepam, that's why I like lorazepam.* (Participant 5 – taiohi)

Summary

Colonisation has positioned taiohi and whānau in a place of social oppression that has strained whānau dynamics. *Surviving socially* meant taiohi and whānau lived with *social pain*—an effect of poverty with daily adverse exposure to the poverty of income, housing and education. The consistency and regularity of these adversities become traumatic, affecting taiohi and whānau ability to effectively engage in society, as well as their psychological health and well-being. It also affects whānau dynamics due to the displacement of traditional Māori values that undermined the mana of the whānau collective through a conflict between Euro-Western values of individualism and monetary gain. The impact on taiohi is a poor sense of belonging and a weakened identity leaving them in a psychological crisis.

The impact of social pain created a space for taiohi to engage in substance use and misuse. An area that temporarily removes them from the trauma of ongoing social adversities and hardships. Within this space, they *become heavy on drugs*. *Easy access* to substances prolongs their use until they slip into a drug-induced reality. The emotional, behavioural, and psychological changes they experience become scary for themselves and their whānau. Eventually, they both reach a point where they are *struggling to cope*. They look for healing within a Māori worldview, but it is a Pākehā substance that has put them in a psychological crisis, and they need Pākehā treatment for recovery.

Seeking Pākehā treatment came easy for those who understood mental health issues. However, most struggled to find help delaying taiohi treatment and promotion to recovery. Eventually, all taiohi entered acute mental health and addiction services. Appreciative of help, taiohi and whānau entry into mental health services felt like they were *entering a scary place*. They immediately felt *locked in* and *wanted to get out.* What was also frightening was *not knowing* or understanding the culture of a psychiatric institution. A culture where taiohi lose their freedom to leave and whānau lose their privilege to parent as taiohi become the state's responsibility under the Mental Health (Assessment and Treatment) Act 1992.

Over some weeks or months, taiohi and whānau learned the culture of mental health service policies and procedures. Despite their many struggles, they learned that accepting treatment is a favourable option for getting out of the institution. Treatment included psychotropic medication, seclusion, poor communication, and police involvement. From a positive perspective, whānau received support from mental health and addiction services, including Māori cultural support. Being locked up kept taiohi free from substance use, and the medication helped with their drug-induced presentation.

Nonetheless, the healing happened when they returned home to the community. Returning home felt safe because it provided a collective space with whānau and friends. It provided an environment where they could enjoy the freedom of space, fresh air, engagement with friends and extended whānau. Taiohi and whānau relationships improved as they found increased respect for each other after their traumatic hīkoi from the community into acute mental health and addiction services.

Final Comments at the End of the Interview

At the end of the interview, I asked all participants how the interview went.

SNAPSHOT: Taiohi and Whānau Experience of the Interview Process

Taiohi felt it was alright. Some said it was awesome and they liked it. They felt it was positive getting to talk about their experience and felt there were no negatives. Most were not scared to share their experiences. They were generally grateful and felt the questions needed to be asked to understand them as Māori.

> *It takes a lot of effort, and how you are going about it is a way of acknowledging us.* (Participant 9 – taiohi)

Whānau were also appreciative of the experience. They expressed that it was the first time they had shared their experience, and it was an opportunity to offload and get it all out. They also wanted to share their experiences so other whānau could understand what they had to go through. They felt that sharing their experience would help others in the future.

> *It was good to get it out so you can help people in the future. You can get something from my koreroa to help others.* (Participant 10 – whanau)

> *This has helped. I really feel pai, it's like, oh yeah, finally, I can offload. Because it is distressing for everybody, including me, my kids.* (Participant – 11 whānau)

> *Because of the kid's safety, it's been a struggle tough. If we share our information with you to help another, I am happy to do that because I was crying almost every day.* (Participant – 12 whānau)

Chapter Five: Discussion – Taiohi and Whānau Hīkoi into Acute Mental Health and Addiction Services

This chapter discusses the essential findings and locates them within the existing literature. The question asked in this research was:

What are taiohi and whānau experiences as they hīkoi from the community to acute mental health services with substance use and mental health issues?

The development of the study question came after retrospective reflections regarding the increase in taiohi entering acute mental and addiction services with critical substance use and mental health issues. Growth in taiohi presenting with perceptual disturbances, aggression, anxiety, and fearfulness became common. Synthetic cannabis was one substance that became fatal for taiohi. Signs and symptoms included uncontrolled drooling, seizures, and fatality. Synthetic cannabis was called the 'zombie drug', manufactured from chemicals 75-100 times stronger than THC (New Zealand Drug Foundation, n.d.). The criminalisation of synthetic cannabis appeared to lead to the uprising of methamphetamine use. Methamphetamine dealing and trafficking increased from 2010 to 2018, and possession rose from 2011 to 2020. In 2016 there were 95 deaths, an increase from 46 in 2013. The impact of these drugs has a devastating effect on taiohi, whānau, and communities. Psychologically, the use of these substances positioned taiohi in a psychotic reality.

A secure cultural identity responds to taiohi unique whakapapa. According to Marsden, M., & Royal, T. A. C. (2003). whakapapa is a complex series of rhythmical patterns of energy needed to enhance, sustain, and replenish life in the spiritual realm and the natural world. Taiohi whakapapa identifies them as tangata whenua, the Indigenous youth of Aotearoa. Therefore, Aotearoa is their tūrangawaewae, their place of standing, reinforcing their identity and sense of belonging. Strengthening taiohi identity means access to concepts of Māori knowledge, including te ao Māori, tikanga Māori, and mātauranga Māori. Traditionally, such knowledge was an inheritance given to whānau, hapū, and iwi over many generations. However, taiohi identity and cultural realities in contemporary society have weakened through colonialism. The effect of colonialism has created exposure to multiple levels of trauma influencing taiohi substance use and mental health issues. McLachlan et al. (2021) affirmed that Māori cultural concepts and a secure identity are notable core factors for health and well-being.

Using a kaupapa Māori research approach, the following discussion recontextualises participant voices within Te Pae Māhutonga, a Māori health promotion model. I have chosen this model because it affirms the effect of socio-political factors such as poverty, racism, and dropping out of school on substance use. The holistic health promotion model uses Māori concepts to describe multiple factors that support psychological health and well-being for all people. Te Pae Māhutonga is transferable across acute and community mental and additions services.

Te Pae Māhutonga (Southern Cross)

Te Pae Māhutonga is a navigational tool for health and well-being. According to Ryks et al. (2018), Te Pae Māhutonga offers an exploratory framework for mental health and health promotion through the imagery of the Southern Cross. It has a substantial Māori cultural influence that promotes Māori health and brings together significant components of health promotion (McNeil, 2009). The elements embrace sociocultural aspects such as deprivation, environmental violations (Durie, 1999), and sociopolitical environments dominated by colonial hegemony (McNeil, 2009). Te Pae Māhutonga provides an opportunity to situate taiohi and whānau voices across multiple domains of health that brings together a holistic understanding of psychological health and well-being for the collective

The beginnings of Te Pae Māhutonga developed with Pomare's understanding of five health points: recognising community leadership in health promotion and knowledge that health links to socioeconomic diversity and Māori cultural realities. Political commitment is critical for transformation and improving psychological equities experienced by taiohi. Recognising the conflict between Māori aspirations and colonial hegemony provides an understanding of the effect of dual cultural and medical conditions (Durie, 1999). Te Pae Māhutonga, further developed by Durie (1999), reflects healthy goals represented in the imagery of the six stars of the Southern Cross. The Southern Cross is seen in the universe's southern skies and appears as a constellation of six stars. It sits in a cluster of stars known as Matariki, bringing a national familiarity that marks the start of the Māori new year. The Southern Cross provided a navigational tool that guided Māori ancestors on their hīkoi through the Pacific to Aotearoa, New Zealand.

> *Nā Māhutonga i tohutohu mai ō koutou tūpuna, me te nui hoki o tō rātou māia, kia whakawhiti ora mai rātou i Te Moana-nui-a-Kiwa, ki tēnei whenua.*

> The Southern Cross guided our ancestors, and with their bravery, they safely crossed the Pacific Ocean to Aotearoa. (Moorfield, 2011)

Te Pae Māhutonga frames the discussion that acknowledges the experiences of taiohi and whānau participants in this study. It omits other taiohi and whānau outside of this study, although experiences are often transferable to other taiohi and whānau who share similar substance use pathways and mental health issues.

The three key themes from the findings, **Surviving Socially**, **Entering a Scary Place**, and **Whānau Healing in the Community**, are intertwined within the imagery of stars that overlay the whakapapa of taiohi and whānau hīkoi from the community to acute mental health and addiction services. The imagery of Te Pae Māhutonga represents six stars. The first four stars include *mauriora*, *waiora*, *toiora*, and *te oranga*. Each star represents a different domain of health necessary for overall well-being. The two pointer stars are *ngā manukura* which represents leadership, and *te mana whakahaere,* which means autonomy in health. I have not included *mana whakahaere* for this study because it is a further step that needs more research. The discussion begins with mauriora.

Mauriora

Mātauranga Māori introduces new images of Māori knowledge and new environmental connections that respond to a Maori worldview and a Euro-western culture, language, and new technologies. According to Durie (2001), mauri is a life force, a spiritual essence that cultivates a secure identity that links to good health. However, the well-being of 'taiohi mauri' has been severely impacted both in the past and present. Colonisation has resulted in the loss of essential aspects of Māori culture, such as language, traditional knowledge, land, family connections, and environmental resources. Furthermore, this group faces significant challenges in accessing economic resources, social privileges, and the ability to participate in social settings.

Mauriora involves a fluid process that reaches into whakapapa, social and environmental interactions, and engagement (Durie, 1999). However, the assimilation of Māori cultural identity into a Pākehā frame of Euro-Western heritage and philosophies conflicts with taiohi identity (Durie, 1999). A Euro-Western philosophical aspiration embraces values of scientific methodology, individualism, capitalism, and neoliberalism and conflicts with a secure Māori identity.

Taiohi identity traditionally grew from intergenerational relationships with spirituality, land, and people, a collective identity development that embraces positive well-being. Well-being also relates to rangatiratanga, a place of self-determination (Carr et al., 2022). However, colonialism has reframed taiohi identity. Of concern, a deculturation process is aggressively robbing the identity of generational and relational connections to Māori knowledge (Jackson, 2019; Mutu, 2019; Ngata, 2017).

Enhancement of mauriora for taiohi and whānau involves access to multiple Māori knowledge systems, including:

- language and knowledge
- cultural institutions (e.g., marae)
- Māori economic resources such as land, forest, and fisheries
- social resources such as whānau, Māori services, networks
- societal domains where Māori can be Māori. (Durie, 1999)

Access to Māori language and knowledge.

Traditionally the evolution of Māori cultural identity and sense of belonging came from intergenerational knowledge from tūpuna. A Māori worldview developed from understandings of te ao Māori and tikanga Māori. Te ao Māori positions taiohi as spiritual beings—a taonga, precious and full of potential (Cameron et al., 2013). Taiohi identity and belonging connect to their tūrangawaewae (place of standing), Aotearoa. Symbolically represented in the rito of the flax bush, the central shoot in its formation (Pihama et al., 2010). The connection is evidenced through Māori whakapapa (Benton, 2019; Gone, 2013; Hamley & Le Grice, 2021; Liebenberg et al., 2019; Marsden & Royal, 2003; Reid et al., 2016; L. T. Smith, 2012).

Before colonial contact, Māori spiritual teachings and knowledge came from tohunga (Māori professors) in whare wānanga (university level) (Marsden & Royal, 2003). From these teachings, taiohi developed spiritual insight and experience of knowledge that was acquired into wisdom (Marsden & Royal, 2003). The role of the hapū and iwi was relational, and their collective response was to sustain whānau, hapū, and iwi well-being (Brougham & Haar, 2013; Wirihana & Smith, 2019). For instance, some parent roles were hunting and gathering, providing food and shelter for the whānau, hapū, and iwi (Walsh-Tapiata, 2002; Wirihana & Smith, 2019). Grandparents shared their knowledge of te ao Māori and tikanga with the whānau and nurtured younger whānau members. As affirmed

by Poananga (2011), Māori knowledge and exposure to a Māori worldview are crucial for self-development.

Māori knowledge of mātauranga Māori has brought forth fresh perspectives on environmental connections, with images catering to Euro-western culture and new technologies. Colonialism has set adrift taiohi and whānau origins of traditional knowledge, repositioning taiohi identity and sense of belonging. The colonial intervention compromised taiohi mauriora, an assault on their mana, affecting their self-esteem, self-worth, health, and well-being. An act of genocide, it has weakened taiohi and whānau cultural identity. A deculturalisation process through displacement from their lands and cultural norms disadvantages Māori (Orange, 2004), an effect referred to as intergenerational trauma.

Historical and intergenerational trauma is the unconscious accumulation of emotional and psychological wounding over the lifespan and generations. Whānau talked about their parents and extended whānau struggles with not having much money. Many whānau had accepted their social positioning as their norm. However, they also understood that some people received more benefits, known to be colonial laws and privileges that displace and disconnect Indigenous peoples from their land, people, and cultural knowledge (Brave Heart, 2003; Brockie, 2012; Bryers-Brown, 2015; Cooper et al., 2019; Crawford, 2014; Evans-Campbell, 2008; Fast & Collin-Vézina, 2019; Getz, 2018; Gone, 2013; Paradies, 2016; Snider et al., 2018; Turanovic & Pratt, 2017). Colonial pervasiveness blames Māori for their poor health outcomes (McCreanor & Nairn, 2002)

Nonetheless, Māori carry psychological wounds due to the impact of historical trauma. Increased stress, grief, and displacement of whānau connections (Anderson, 2006; Prior, 2007; Sherwood, 2009, 2013). Unresolved grief leads to low self-esteem, anxiety, self-destructive behaviour, suicidal thoughts, and anger to express emotions (Brave Heart, 2003). Taiohi have encountered both of these ideas during their relatively brief existence. Historical and intergenerational trauma manifests in *living with social pain* and *becoming heavy on drugs*. As Hagerty et al. (1992) affirmed, a discourse that disrupts taiohi social world is associated with identity crises, loneliness, alienation, and hopelessness of living with mental illness.

A space to be Māori in contemporary society supports taiohi well-being. Providing space for taiohi and whānau to embrace a Māori worldview reinforces a strong identity and sense of belonging and asserts the advantage of engaging in Māori cultural practices

(Carlson & Tongi, 2011; Fox et al., 2018; Kingi et al., 2018; Wirihana & Smith, 2019). Others argue that Indigenous youth who connect with their cultural identity are more likely to have positive psychosocial outcomes (Barton & Wilson, 2008; Carr et al., 2022; Durie, 1995, 2011; Kidman, 2012; Reading et al., 2007; Ritchie & Reading, 2004; Wirihana & Smith, 2019).

Durie (1999) referred to the forced abandonment of Māori customs, culture, and language as deculturalisation. During the interviews, deculturalisation was evident in most taiohi and whānau responses to questions such as ko wai koe (who are you?) and no hea koe (where do you come from?). Most taiohi and whānau demonstrated some knowledge of their whakapapa during the interview, such as identifying their iwi and place of origin in Aotearoa. However, they could not express this further, including their waka, marae, maunga, and hapū. Overall, proficiency in English was dominant in taiohi and whānau voices. Although there was a limitation in whakapapa knowledge, the connection to land and iwi set the scene for open conversation; the interviews promoted trust, self-confidence, and awareness (Farruggia et al., 2011).

Two taiohi demonstrated socialisation of te reo Māori and te ao Māori during the interview. Both taiohi provided a karakia at the beginning and end, showing depth in their knowledge of pepeha. Enhanced cultural well-being for one taiohi was attendance at kohanga reo and kura kaupapa, and the other a course in te reo Māori. A robust cultural identity connects with cultural pride and self-worth (L. T. Smith, 2012) and informs tikanga (Marsden & Royal, 2003). However, it is hard to maintain cultural pride when *surviving socially*, *living in poverty*, engaging in *transient lifestyles*, and working with *challenging whānau dynamics*.

Tiny gems of te ao Māori knowledge had two whānau consider mākutu as a cause for taiohi substance use and mental health issues. Mākutu is a Māori concept of sickness inflicted by psychological or physical harm through spiritual powers (Moorfield, 2011). A mākatu encompasses spiritual connections with ancestors and seeing visions of the future (Bennet, 2009; Fusar-Poli et al., 2017). Cultural language and knowledge may be limited in some instances but remains part of Māori identity and sense of belonging. Determining if mākatu was present, whānau accessed extended whānau for advice. In both instances, after a Māori assessment, mākutu was not present. Another whānau member was burning sage, an American Indian tradition to clear negative energies and promote healing.

Access to Māori cultural interventions

Access to cultural interventions relied on whānau knowledge and engagement with te ao Māori. Most whānau had gems of a Māori worldview handed down from whānau. Some whānau accessed kaupapa Māori education and Māori cultural agencies such as marae in their community. Cultural interventions in acute mental health and addiction came mainly from whānau. Connection with Māori health services supported taiohi *clearing of thoughts* and provided access to kaumātua and Māori cultural activities such as karakia and waiata. However, the referral to these services was often uncoordinated and happened by chance. As voiced by taiohi and whānau, access to cultural interventions helped relieve the fear and anxiety of *entering a scary place*. Māori health offered care pathways based on te ao Māori, tikanga, whakawhanaungatanga, manaakitanga, and aroha.

Further, taiohi who accessed cultural services appreciated the familiarity of Māori to Māori. They felt relaxed and supported and having kaumātua around provided security. Listening to karakia helped strengthen their wairua and kept them grounded. They enjoyed singing and listening to the guitar. However, referrals to Māori cultural interventions by clinicians were inconsistent. One taiohi, fluent in te reo and knowledgeable of tikanga, repeatedly asked for Māori cultural support but never saw anyone. Whānau also requested cultural permission for taiohi to no avail. Additionally, taiohi would have preferred a Māori doctor.

Access to Māori economic resources

Traditionally taiohi were economically stable within whānau, hapū, and iwi. Māori had their knowledge base and were trading in international waters. Access to Māori economic resources was not in the interview schedule. However, information from the New Zealand Foreign Affairs and Trade (2021) suggests that traditionally Māori financial resources came from a history of international trade. Māori were financially fiscal as entrepreneurial traders nationally and internationally (King, 2003). Globally, Māori trading occurred through the political authority of He Whakaputanga o Te Rangatira o Nu Tireni (The Declaration of Independence), signed in Hokianga 1835, confirming Māori rights of fair trade on international waters (King, 2003). He Whakaputanga o Te Rangatira o Nu Tireni recognised Aotearoa as an independent state, articulating and asserting the mana and rangatiratanga of Māori in international trade (O'Malley, V., 2017; Manning, R., 2018).

However, this position has reversed for taiohi and whānau. In contemporary society, economic determinants such as income, employment, occupation, housing, and education

are variable for whānau depending on their priorities. For instance, some mothers had part-time work but left their job when taiohi became unwell. All whānau participants had left school early in their lives, and all but one taiohi had left after substance misuse began affecting them.

All taiohi and whānau were surviving on the social welfare benefit. Some taiohi had lived on the streets when *heavy on drugs.* Survival on minimal wage was not uncommon for taiohi and whānau. **Surviving Socially** is reflected in the findings and includes *living with social pain* and *being heavy on drugs*. Theodore et al. (2022) affirmed that mental distress disorder is a severe issue for young people in Aotearoa. They also recognised environmental problems such as poverty, social isolation, and discrimination. These are the economic realities experienced by taiohi and whānau daily.

Access to social resources

Social belonging requires acceptance as a group member in interpersonal and sociostructural constructs (Leary, M. R., & Baumeister, R. F. (1995). However, taiohi and whānau experienced restricted feelings of acceptance and weakening of social belonging on their hīkoi for help. Colonisation has distanced Māori from their rights as tangata whenua on their tūrangawaewae in Aotearoa. Without this knowledge, taiohi and whānau accept social belonging in poverty as the norm, 'just the way it is'. They take **Surviving Socially** and *living with social pain* as highlighted by one whānau member who voiced being only "a beneficiary of the state" (Participant 13 - whānau).

Social resources are tangible and intangible objects of exchange used among people to enhance well-being. According to Rettig, K. D., & Bubolz, M. M. (1983), social resources are constructs necessary to improve and maintain health and access resources that affect equitable health outcomes (Webel et al., 2016). Many believe optimising social resources requires an individual and collective approach (Cohen et al., 2000; Rettig, K. D., & Bubolz, M. M., 1983; Kawachi & Berkman, 2001), social belonging/friendship (Hawthorne, 2006; Holt-Lunstad et al., 2010), social capital (Murayama et al., 2012), and social networks (L. Berkman, 1977; Kawachi, I., Berkman, L.F., 2000).

Building social capital requires confidence in community participation, including connecting with neighbours, work, whānau, feelings of trust and safety, and value of life (Webler et al., 2015). Social capital from a Māori cultural perspective can include access to Māori churches and kaupapa Māori agencies and maraes that assist and support taiohi

and whānau. On discharge, one whānau chose to access church services for her and her son. Some whānau had access to the marae for physical health issues. Social capital can also develop through employment. However, most whānau participants and all taiohi were unemployed, reducing opportunities for social capital gains.

Reduced access to social capital impairs access to mental health and addiction services. Two whānau quickly accessed mental health and addiction services because they had prior knowledge of the mental health system. Two other whānau struggled to access mental health support. They called over 6 to 8 months before connecting with acute mental health. Health literacy and cultural, environmental, and social complexities were holistic issues experienced by whānau and taiohi. Further, mothers had to provide dual roles of mother and father due to absent fathers reluctant to share responsibility for their sons.

Absent fathers challenge the spiritual authority that enhances the mana of the whānau and positive identity formation and development (Gone, 2013; Marsden & Royal, 2003; Moeke-Pickering, 1996; Murphy & Gray, 2013). One male whānau member (uncle) relied on his sister to share roles and responsibilities (Peterson, N., 2014; Witherspoon et al., 2009; Woolley et al., 2009; Zimmer-Gembeck et al., 2006). One female taiohi accessed acute mental health and addiction services quicker because her whangai father was literate about mental health issues and left earlier. Access to mental health and addiction services took longer for taiohi with absent fathers.

Taiohi and whānau hīkoi had multiple challenges. However, they continued to provide a social structure of connectedness and engagement (Stuart & Jose, 2014) reinforced with awhi and manaakitanga, affirming feelings of trust and safety. According to Ware and Walsh-Tapiata (2010), manaakitanga is essential for relationships and connections that bring spiritual and emotional healing, faith, and aroha. Taiohi continuity of care with whānau was relational and connected, providing consistency, trust, flexibility, and commitment (Reid, 2002). Effective connections embrace sharing and nurturing relationships with kindness and respect (Murphy & Gray, 2013; Ware & Walsh- Tapiata, 2010). Despite whānau challenges with taiohi behaviour, aggression, and psychological instability, they remained connected and supportive throughout the hīkoi.

Taiohi social belonging and social capital also came from peers. Social relationships and peer interactions support a secure identity (A. Best, 2011; Goffman, 1961). A social connection with peers replicates a kaupapa whānau relationship and excludes those

different from themselves (Waiti & Te Kani Kingi, 2014). Taiohi felt comfortable with peers who experienced the same social situation. They voiced hanging out with peers who had also dropped out of school. They developed interpersonal relationships with peers with similar interests and a common purpose. For example, their peer groups lived close together, and they had stopped going to school and were all using substances. With peers, they found places to play video games while engaging in substance use, away from adult supervision. Hanging out with peers appeared to provide a sense of belonging. Social existence experienced by taiohi was fraught with challenges at multiple levels limiting their social capacity to engage with others outside the whānau.

Increasing access to substances locally and close to home further impacted the situation. In one instance, whakapapa whānau connections became a precursor for taiohi substance use. One taiohi preferred to stay with his nana because the neighbour next door was dealing with illegal substances. Another taiohi was smoking methamphetamine with his uncle; before he knew it, two weeks had passed, and he became very psychotic. Several taiohi are associated with gang members from whakapapa and kaupapa whānau. As with the relationship with peers, when normalising the behaviour of substance use among people, one mixes with influences and normalises substance use. Substance use is detrimental to a person's mauri and their whānau. The longer the substance use, the longer the psychological, social, and physical abuse. The attack on mauriora stunts taiohi identity and prevents engagement with Māori knowledge and community connection.

Waiora

Waiora embraces the external world, which links to a spiritual element and connects human wellness and the environment. The promotion of health and well-being is reliant on protecting the environment so that:

- water is free of pollutants.
- air must be free from inhaling irritants or toxins.
- earth is abundant in vegetation.
- noise levels are compatible with human frequencies and harmonies.
- opportunities for people to experience the natural world are created. (Durie, 1999)

Waiora represents external well-being with connections to the spiritual and physical environment. A healthy waiora enhances a secure identity and the relationship between people and the environment (Durie, 1999). The relationship between people and the environment is vital to enhancing Māori mana, whakapapa, and identity (Severinsen & Rewiti, 2021; Tate, 2010). Whakawhanaunga was critical for improving the waiora. The

use of tikanga uplifted the mana waiora and the connection. For instance, telling the truth, doing the right thing, and showing compassion when we met kanohi kete kanohi. Whakawhanaungatanga included sharing, iwi links and whakapapa. I connected with all whānau in their homes. The time varied from early in the morning to late at night but was often dependent on other siblings. Through whakawhanaungatanga, we identify ourselves, which, in this instance, was a good thing because it created an environment of trust. Although intangible, the physical and spiritual worlds are in tune, uplifting the mana of waiora.

Durie (1999) mentioned that strengthening the waiora requires non-pollutant air, earth, and noise. All whānau and taiohi lived in households dependent on power and council water. On reflection, no whānau had big televisions, which is optimistic regarding noise pollution. However, many taiohi had electronic devices. Taiohi use of electronic devices is a violation of the waiora. According to Durie (2001), with exhaustive exposure to television, computers, and social media, the fatigued environment weakens the waiora and exhausts the balance between health and well-being. Taiohi were gaming and listening to music—some mums reported not always good music. Sitting around all day limits physical activity and turns off the tune or connection with the waiora.

Exposure to pollutants in individuals, families, and communities for extended periods increases health risks. Returning to their homeland provided access to fresh air and water for some whānau, but they returned for other whānau members. Many expressed that they had not returned home in quite some time. This picture suggests that a bicultural model of care is needed to ensure both partners—Māori and Pākehā—are responsible. A bicultural approach requires a partnership with a bio-medical way of care with a Māori model of care. The process could bring a method that strengthens Te Tiriti obligations and add mana to the collaboration and the waiora.

Taiohi and whānau voiced returning to their homeland and needing to be in the fresh air, a form of environmental protection. Concepts of te ao Māori and tikanga Māori recognise that an environment free from contamination is good for health and well-being (Durie, 1999). Traditionally Māori demonstrated immense respect for the environment, knowing that upholding the mana of the land maintains the people's mana (Tate, 2010). For instance, when cutting down a tree or taking clippings from a plant, a karakia to Atua (spiritual realm) was performed, acknowledging the spiritual violation of the land and environment.

Additionally, the practice of rāhui separates people from the tapu (the attack) of the environment, a temporary prohibition to protect the environment (Durie, 2021; Moorefield, 2011). A breach of tapu may include the death of someone in the waterways, polluted waterways, or the depletion of natural resources, acknowledging a time for restoration and replenishment. Polluted waterways often require a rāhui to recognise the breach to tapu with the environment and the need for conservative measures.

The land has become tapu in many regions of Aotearoa, a position of risk and conflict with the spiritual code for life (Durie, 2021). At the same time, improvements are occurring. However, land destruction is for economic gain, challenging Indigenous connection to the land and kinship (Woolombi, W, 2018). For example, dairy farming, a valuable commodity that pollutes waterways, is offensive to the land's mana. Increasing air and water pollution breaches the mana of the land and the people. Chemical use in agriculture or the town water supply is another breach of tapu. Environmental contamination is affecting taiohi health and well-being.

Simon Upton, a former Parliamentary Commissioner for the environment, suggested that monitoring waterways and integrating a Māori perspective into New Zealand's Zero Carbon Act to respond to environmental disasters is a positive step forward. While the Act promotes practical measures to reduce climate pollution, the environment's continuous damage weakens its ability to sustain health and well-being, compromising its mana. This imbalance disrupts the harmony of spirituality, mind and emotions, family, and physical body.

During taiohi and whānau stay in the acute unit, they sought opportunities to experience the natural environment. According to Sultanoff (2002), there is a connection between exposure to natural light and mental health in the physical environment. Taiohi wanted to be outside to connect with nature, breathe fresh air, and walk in the park or beach. Being outside helped alleviate their distress and provided comfort and freedom. They also enjoyed beach and park trips, strengthening their wairua, hinengaro, and tinana (Durie, 1999). Taiohi and whānau expressed their desire to return home and be surrounded by their natural environment, representing freedom and space. There are multiple environmental contaminants in both communities and home environments.

A different environmental contaminant affecting taiohi is entertainment on social media, gaming, and other devices. The World Health Organization (2015) affirmed that the excessive use of smartphones, computers, the internet, and similar electronic devices is a

public health concern that negatively affects a person's physical, mental, and social well-being. The waste from these products also involves the land's mana and the people. The World Health Organization claimed that excessive use of electronic devices highlights concerns about developing and sustaining a harmonious environment. Lunderberg (1998) asserted that physicians must reflect on their medical prejudices to consider environmental well-being and mental health. Environmental contamination is intangible and unapparent but critically affects the waiora, health, and well-being.

Toiora

Toiora promotes healthy lifestyles that prevent the capacity to distort the human experience. According to Durie (1999), healthy lifestyles require,

- harm minimisation
- targeted interventions
- risk management
- cultural relevance
- positive development

Te Pae Māhutonga implies that toiora is freedom from injury, promoting survival and protection from evil influences to ensure health and well-being (Moorfield, 2011). It requires a lifestyle risk-free of preventable consequences such as risks from poor nutritional intake, substance misuse, sedentary habits, risky-taking adventures, and discriminating social-political factors such as poverty and racism (Durie, 1999).

Concerning is taiohi entrapment in risk-laden lifestyles, never fully able to realise their potential. Enhancing and enriching toiora requires a risk-laden lifestyle. According to Durie (1999), strengthening personal behaviour is associated with movement in the community, how one moves around and connects with others, their lifestyle, and what one does in everyday life. Taiohi exposure to substance use was daily, and access was the primary focus for the day. Preventing engagement in targeted interventions that promote toiora.

Harm minimisation

Harm minimisation begins with the identification of factors that cause harm. Taiohi experiences poverty and heavy dependence on substances. According to the Children's Commissioner (2012) and the Expert Advisory Group on Solutions to Child Poverty (2012), healthy lifestyles for youth requires access to many items, including education, housing, nutritional food, and healthcare. The challenge for taiohi is access to a healthy

lifestyle daily. Understanding taiohi and whānau realities, and going without essential items, is a critical problem that highlights an emergency due to the high risk of harm. Taiohi and whānau struggle to access the necessities regularly.

Living in poverty can also lead to social pain, as families miss out on opportunities that might have helped them thrive. This pain can manifest in many ways, including substance use, mental health issues, and criminal activity. Taiohi and their whānau face significant economic and social challenges that leave them struggling to make ends meet. Whānau household income falls below the poverty line (Houkamau, 2010; Houkamau et al., 2017; New Zealand Government, 2018; C. Sibley et al., 2011). All whānau rely on welfare benefits leaving tough choices between food and power. Wickham et al. (2016) asserted that children's long-term social, behavioural, developmental, and psychological outcomes are related to poverty. Lund et al. (2011) concurred that mental health and poverty are a cycle related to low income. Many taiohi and whānau struggled alone in the community without the right help—some for weeks, others for months.

Furthermore, substance use is associated with poverty and is often used to escape the harsh realities of daily life (Morgan & Freeman, 2009). Substance use adversely affected taiohi and their whānau, including abusive behaviour, criminal activity, and homelessness. It can also lead to mental health issues, such as psychosis, which can be incredibly challenging for young people (Kake et al., 2008; Linscott et al., 2006). Psychotic presentations align with poverty, deprivation, trauma, and racism. Taiohi, in particular, are at risk of experiencing mental health issues due to their social position and substance use. Some may even be diagnosed with schizophrenia, although this can be difficult to diagnose accurately (Harris et al., 2018; Morgan et al., 2019; Reid et al., 2014).

Other areas of trauma concerning taiohi include transient lifestyles, leaving school before receiving formal qualifications, racism, and health literacy. Taiohi transient lifestyles links to colonialism and Māori displacement from tribal lands (Durie, 2013; J. Kake, 2016; Peters & Christensen, 2016) as a result of alienation from their lands (Jenkins & Mountain Harte, 2011). Māori personal space and place-based identities have changed, and the impact has occurred across generations. Further, risk-laden behaviour among taiohi hinders their ability to establish a positive sense of self and belonging. Māori children are affected by racism in education, leading to poor academic outcomes, high dropout rates, and declining attendance (T. Clarke et al., 2022; Wirihana & Smith, 2019). When taiohi are not at school, they are more likely to engage in criminal activity.

The Youth Justice System reported that Māori youth offending rates are higher than non-Māori, and court appearances are twice that of non-Māori (Reil, J., Lambie, I., Horwood, J., & Becroft, A., 2021; Lambie, I., 2018). A criminal conviction is likely (Heerde & Hemphill, 2015; Hoeve et al., 2015). The issue of health illiteracy, particularly regarding taiohi and whānau limited understanding of the Mental Health Act, needs to be addressed. Several taiohi were engaging in criminal activity daily, and whānau had no idea until the police caught taiohi.

Additionally, entry into acute mental health and addiction services was traumatic. When professionals discriminate against taiohi and treat them as criminals, they misinterpret taiohi real feelings of being scared, locked in, and wanting to run away. As evidenced by taiohi logic, police are pigs; when confronted by police, they retaliate or run. Holley et al. (2016) affirmed that a discriminative police approach invokes a risk-averse culture and prevents a positive risk approach to recovery. Taiohi and whānau were overwhelmed, scared, and locked in when they stepped into acute mental health services for the first time. While there is no easy solution to these issues, nurturing taiohi the future development is essential for Māori and the nation.

Te Oranga

Health and well-being embrace the formation of a solid cultural identity, connection to an unharmed environment and avoidance of risks. Most importantly, te oranga welcomes positive social participation and confidence to access health services. Durie (1999) stated that te oranga relies on positive social engagement and trust to access choice services. It is about confidently accessing goods and services, such as good health services or the school of their choice. Also important is a sense of ownership and autonomy in decision-making. Health promotion enhances te oranga by optimising Māori participation in the following areas of society:

- economy
- education
- employment
- knowledge society
- Involvement in decision-making. (Durie, 1999)

Participation in the economy, education, employment, and knowledge of the society

Taiohi participation in society falls short of expected engagement in a fair community. Māori experience disparities that confirm gaps in most social indicators (Durie, 1999).

Colonisation is the bearer of these disparities (Came et al., 2020; Clark et al., 2002; Hamley & Grice, 2021; McCreanor & Nairn, 2002; R. Walker, 1990), promoting and weakening a secure cultural identity (Barton & Wilson, 2008; L. T. Smith, 2012; Wirihana & Smith, 2019). Disregarding the effect of an unhealthy environment (Durie, 1999; World Health Organization, 2020) or blaming taiohi and whānau for their social position without understanding racism and inequitable care does not support equitable care. Colonialism places Indigenous peoples at risk of trauma (Brave Heart, 2003; Wirihana & Smith, 2019), suggesting it is customary to live with trauma and hardship.

Access to societal knowledge

Access to societal knowledge is possible when society shares knowledge with all members. Support of Western knowledge should include personal, economic, scientific, political, and social expertise. Whānau, without prior knowledge of mental health and substance use, struggled to access the appropriate services needed to support taiohi. Their varied cultural knowledge embraces te ao Māori, tikanga Māori, and mātauranga Māori and is shared collectively with each other. Taiohi and whānau reached out to both learning paradigms based on positive engagement in society and the confidence to access the services of their choice. Te oranga embraces positive social participation and spiritual trust to access health services (L. Smith, 1999). Social participation for taiohi came from peers in similar situations and whānau with multiple stressors. They were not offered the correct information or knowledge of health illiteracy within their peer group.

Access to information in society on mental health and addictions was hard for whānau and taiohi. Information provided to whānau and taiohi throughout the hīkoi was inconsistent. Enforcement of the Act meant taiohi separation from their whānau. Whānau were overwhelmed by the processes and procedures of acute mental health services. Whānau remained close to taiohi; some stayed in the unit and others visited regularly. Whānau were also distressed by the lack of decision-making capability when supporting taiohi in the unit. They wanted to engage in the care pathway and participate in collective decision-making in treatment; however, they felt left out. Taiohi and whanau experiences suggest a failed health system that ignores taiohi and whānau health literacy.

Participation in the knowledge of mental health and addiction services

Most whānau struggled to engage in mental health service processes. Whānau felt the clinical staff did not engage with them. They felt left out of taiohi care pathways. While they were present at whānau meetings, they were often not included. Taiohi and whānau

engagement in health literacy brings forth a series of demands on health knowledge. According to several authors, mental health literacy is understanding mental health conditions to help recognise prevention and treatment options (Furnham & Swami, 2020; Tay et al., 2018). Health illiteracy is linked to poverty, income, education, and employment, preventing early access to mental health and addiction services. Whānau were eager to learn and participate in taiohi care but felt excluded. In one instance, a whānau member was laughed at by clinical staff saying something.

Whānau talked about struggling to cope without information and struggling to prioritise other issues. Struggling to understand can lead to the underutilisation of mental health services (Clark et al., 2014; Mills et al., 2012) and increase the vulnerability of taiohi who are mentally unwell (Pagey et al., 2010). According to the Ministry of Health (2010b), whānau who have access to information seek help promptly. Nevertheless, this was not the case for most whānau. Many whānau did not receive the correct information. Two whānau knew of mental health services and their taiohi and entered and left quicker than the other taiohi. Taiohi discharge was more prolonged when they did not know how to access the right service.

Without health literacy, whānau go without the necessary information to seek help (Ministry of Health, 2010b). According to the New Zealand Government (2018), whānau struggle to navigate and access mental health resources. Prior mental health knowledge is an advantage for easy access. Delay in access to mental health knowledge demonstrated extended time in the acute unit. Furnham and Swami (2020) suggested that an inability to recognise mental health issues can lead to self-help options over Euro-western medical treatments. Several reached out to extended whānau and Māori healers for support and guidance.

Stigma prevents access to mental health and addiction knowledge.

Stigma influences mental health and addiction knowledge. Taiohi occupy a unique space in Aotearoa. However, institutional racism has compromised their abilities to access care pathways to assist taiohi and whānau wellbeing and enhance their rangatiratanga (Latimer, 2021). Satorius (2002) affirmed that stigma is an obstacle to accessing mental health care. Angermeyer and Dietrich (2006) claimed a need to reduce misconceptions and improve attitudes toward mental health issues to improve access. Taiohi are aware of the stigma attached to mental health; they tend not to make a fuss about how unwell they feel (Clark et al., 2014). As one taiohi mentioned, “I am not mental health. I am not like

that" (Participant 2). These thoughts hold views of prejudice presumed through observations of people with mental health issues (Angermeyer & Dietrich, 2006). Jorm (2000) affirmed that improving mental health literacy can help reduce stigma. As evidenced by Ojanen (1992), New Zealand launched a national media campaign to counter the stigma and discrimination associated with mental illness. As a result, there was an increase in acceptance of people with mental health issues, although the attitude towards people with schizophrenia did not change.

Further, distrust prevents the acceptance of knowledge in mental health service provision. Weakened trust can lead to disengagement of expertise. Māori distrust dominant systems that practice colonial hegemony and racism (Pack et al., 2015, 2016). People's distrust can occur when they do not feel prioritised (Pearson & Raeke, 2000). Taiohi were unsure if their information is kept confidential, and they have a distrust toward professionals. As a result, they say what they believe needs to be said, which might not be how they feel.

Most taiohi resisted entry into mental health and addictions for fear of stigma and racism. This trauma experienced in day-to-day life experiences in the community reinforces this fear. They hide their signs and symptoms of perceptual disturbances from whānau, a mechanism for preventing concern. According to Robson and Harris (2007), fewer than one in three youth are likely to contact mental health for help. Cultural mistrust influences negative attitudes and perceptions (Bruwer et al., 2011); for instance, taiohi demonstrates fear by telling whānau, "Never put me back in that place again" (Participant 1).

Police involvement under the Mental Health (Assessment & Treatment) Act 1992 caused grief for the whānau. Taiohi dislike police, often referring to them as 'Pigs', and whānau are wary due to past experiences. Keyworkers believe police fail to acknowledge that taiohi have a mental illness and treat them as criminals. They also failed to engage and communicate with whānau. The approach by police is to restrain taiohi behaviour (Leoni, 2007; Willaims et al., 2018). Some taiohi tried to run away, and others became verbally aggressive and assaultive. Physical restraint and containment were the treatment options.

Māori are more likely to experience discrimination and racist practices (Ministry of Health, 2012; New Zealand Government, 2018; Wirihana & Smith, 2014). Discrimination based on culture or ethnic identity is common (Bouhaddani et al., 2018; Cormack et al., 2013; Schmitt et al., 2014). Entering into the mental health system seemed optimistic for taiohi and whānau. Nevertheless, enactment of the Act meant loss of trust and confidence in mental health services due to discriminative practices. Locking up of taiohi also

traumatised whānau. They feared for taiohi and, for several whānau, their past experiences exacerbated their fear. Whānau experience of powerlessness and hopelessness was voiced by not knowing. They felt guilty and scared knowing taiohi were alone. Taiohi were disconnected from whānau and had to deal with the situation independently.

The lack of clarity about the function and parameters of clinical services caused anxiety, confusion, and frustration for all involved (Cranwell et al., 2017). There was disrespect for whānau rights under Section 5 of the Mental Health (Compulsory Assessment and Treatment) Act 1992. The Act pertains to true cultural identity, personal beliefs, and the significance of respecting whānau. In conflict, taiohi become state citizens, dismantling whānau duty of care. The disrespect for taiohi and whānau increased their distrust of mental health and addiction services.

Further, the use of restrictive actions by police decreased trust. Accordingly, restrictive interventions are coercive, producing negative emotions (Bigwood & Crowe, 2008; Steinert et al., 2016. Restrictive interventions can cause physical harm and harm the professional relationship (McKenna, Furniss, et al., 2014; McKenna, McEverdy, et al., 2017). Male taiohi were more likely to experience physical damage, increasing the risk of recapitulating previous experiences of harm (McKenna, Furniss, et al., 2014; McKenna, McEverdy, et al., 2017) and distrust. Detainment in police cells occurred for several taiohi before entering acute mental health. Male taiohi were locked in at every entry point once they entered the police car and entered acute mental health.

During admission, all taiohi felt locked in; many expressed it was not good. Several authors believe the outcome of detainment is distressing due to unfair treatment based on personal experiences of racism (Armstrong et al., 2013; Corker et al., 2013). Alang (2020) argued that police brutality is a social determinant that impacts the mental health of minority populations and shapes health outcomes due to mistrust or fear of authoritative people due to experienced racism. Participation in societal knowledge is out of reach when there is distrust towards the dominant society.

The presence of trust provides confidence, reliability, and a belief that someone has their best interests in hand. Trust is a mutual, complex, multidimensional, and dynamic interrelationship of many factors including age, ethnicity, culture, and experiences as a service user that vary over time (Gaebel et al., 2014). Taiohi and whānau engagement in mental health services were initially one of trust, believing that taiohi best interests were

at the forefront; suggesting their trust was an act of positive risk-taking interlinking with approachability, disclosure/assessment, and treatment planning (Brown et al., 2016). However, the traumatic experience during taiohi admission into acute mental health and addictions led to distrust. According to Brown et al. (2016), if trust is defeated, it becomes an obstacle to meeting treatment needs and services or believing the service is trustworthy. It also affects therapeutic alliance (Gaebel et al., 2014) such as dropping out of treatment and compromising retention and utilisation (Schroder et al., 2009). Christie et al. (2018) believed the system fails youth when they drop out of treatment early without completing it. Taiohi and whānau just wanted to return home to the community and get on with life.

Participation in decision-making in mental health and addiction services

Both trust and distrust occurred when interacting with clinical staff in acute mental health and addiction services. Taiohi and whānau confidence towards clinicians varied. Some perceived doctors as knowing best, smiling, listening, and were seen as trustworthy (Brown et al., 2016). In line with Brown et al. (2016), a couple of taiohi felt they were being looked after and cared for, but most lacked trust in clinical staff. Trust requires confidence in staff rapport; without trust, open disclosure is not likely (Brown et al., 2016). Taiohi found it easier to say what the clinicians needed to hear to prevent lockup and help get them out of the acute mental health unit.

Participation in decision-making about medication did not happen. Taiohi and whānau had to accept whatever the psychiatrists suggested. Taiohi acceptance of taking medication varied; some saw the positive effects, while others experienced adverse side effects creating mistrust and resistance to accepting the prescribed medicines. Many taiohi initially refused medication but eventually got it, knowing they had to take it under the Mental Health (Compulsory Assessment & Treatment) Act 1992.

Several whānau were worried about the side effects experienced by taiohi, such as being fidgety all the time or becoming impotent or sterile, reducing the likelihood of mokopuna. Taiohi and whānau felt medication regimes were inconsistent; chopping and changing from one drug to another was common practice. The experiences of not having a voice in medication issues lead to dissatisfaction with treatment and care (L. Cooper et al., 2003; Doescher, 2000). Taiohi and whānau gave up trying to participate in medication interventions because no one listened.

Effective communication supports participation in decision-making and relational collaboration. Achieving a shared vision is essential for recovery, and good relationships with whānau are required. Newman et al. (2015) argued that a shared vision and good relationship with appropriate communication are necessary for continuity of care. Slade (2009, 2011) suggested that clinicians who reflect on their communication approaches can change the paradigm from the expert to the coach. Training is required to reflect on dominant values and beliefs that have risen from the biomedical model of psychiatry and the effect on clinical staff attitudes and communication styles (Cranwell et al., 2016). The lack of collaborative insight and judgment stalls taiohi recovery.

Poor communication prevents taiohi and whānau from participating in the care pathway. It removes whānau opportunity to work with clinical staff. Taiohi and whānau often felt excluded from care coordination. Overall, whānau felt a lack of shared information. They felt decisions occurred in isolation without effective whānau engagement in care coordination. One mother experienced racist remarks and slurs when she raised concerns about her son's care pathway while attending a whānau meeting. Her son also witnessed the insults about his mother.

Challenging experiences of racism require a review of informal policies and rules necessary to institutionalise discriminative actions such as labelling and to enable psychological disadvantage (Durie, 2021; R. Harris et al., 2006; Houkamau et al., 2017). Indirect racism can manifest in body language, such as racist jokes and slurs (Nelson & Walton, 2014). Racism is an enabler of poor mental health outcomes for taiohi and a predatory factor for undermining Māori health and well-being (Exeter et al., 2017; R. Harris et al., 2006; Paradies, 2016). Racism and bias supported excluding whānau participation in decision-making and involvement in the taiohi care pathway.

Ngā Manukura – Leadership

Leadership in health promotion depends on professional qualifications and the ability to sustain relational approaches that connect with people's realities. According to Durie (1999) leadership requires leadership at multiple levels

- community
- health
- tribal
- communication
- alliance between leaders and groups.

A lack of communication from mental health clinicians encourages whānau resilience to seek help for taiohi mental health by self-teaching. Moorfield (2003) referred to ngā manukura as leadership held by someone with high self-esteem. Ngā manukura represents leadership that combines skills and influences supporting health promotion and growth. Whānau did not receive the skills necessary to survive in acute mental health services. However, the combination of relational care and holistic approaches is shifting the culture of health service delivery. In Aotearoa, holistic approaches to mental healthcare embrace the bio-medical model and different cultural and regional options (New Zealand Government, 2018) and support health and tribal leadership.

A national leadership supporting taiohi and whānau comes from social and political systems (New Zealand Government, 2018). Stakeholders include psychiatrists, mental health clinicians, pharmacies, alcohol and drug services, schools, school counselling services, marae, Māori-led health, other counselling services, NGOs, and many others. The release of the Pae Ora (Health Futures) Act 2023 demonstrates the Government's commitment to change. The Act embraces mauri ora (healthy individuals), whānau ora (healthy families), and wai ora (healthy environments). Under the Act, the Minister of Health must issue a policy statement at least every 3 years. This transformative approach lays the foundations for different ways of thinking that protect and promote equitable health care for all New Zealanders (Department of the Prime Minister and Cabinet, 2021).

Effective communication between individuals, whānau, and services is essential to promote change and support leadership. Durie (1999) suggested that leadership requires various skills, not just a professional qualification. Understanding the whakapapa of each situation requires a collective approach using the principles of tikanga. More research is needed to evaluate the effectiveness of health promotion and equitable health gain that empowers patients and whānau to participate in their choice of mental health and addiction services. Providing choice means uplifting the mana of tino rangatiratanga. Taiohi and whānau depend on the system for support, but they need the power to rely more on their instincts. This promotes tino rangatiratanga. However, they need the understanding to support mental wellness.

Te Mana Whakahaere

Te mana whakahaere supports collaboration and embraces the importance of autonomy. Maintaining mana whakahaere requires collaborative participation in decision-making along the care pathway. Engagement with taiohi, whānau, and other service providers

supports mental health and substance use recovery. Additionally, appreciating cultural relationships and responses helps effective interventions for minority populations in health utilisation. Meeting the challenge requires cultural sensitivity and responsiveness toward diverse population values and needs (Brooks & Hopkins, 2017). According to Durie (1999), the promotion of te mana whakahaere requires the confidence of autonomy, including:

- control
- recognition of aspirations
- relevant processes
- sensible measures
- self-governance.

Taiohi and whānau mana whakahaere suffered when engaging in structural processes and engaging with clinical staff attitudes and communication styles. They lost control of the ability to engage in the taiohi care pathway. Clinicians failed to keep whānau up to date with changes along the care pathway. Whānau felt talked over and left out of the conversations knowing they were the primary carers. Effective clinical responsiveness and awareness were absent. Practical communication skills, caring attitudes, and culturally effective interventions necessary for improving engagement (Brooks & Hopkins, 2017) were often missing.

In a few cases, taiohi felt cared for because the nurses provided space to go outside, were polite, and explained how to take medication. One taiohi felt his doctor held no judgments. However, the risk is that negative experiences will override the positive experiences, such as staff bullying taiohi and whānau. Jaiswal and Halkitis (2019) proposed the need for a shift in thinking to address the problem of poor communication and inequitable outcomes. Education is needed to offer culturally safe modes of communication.

The primary source of relational care for taiohi was whānau. The blood connection provides consistency, trust, flexibility, and commitment (Reid, 2002). This study demonstrated that taiohi were more likely to accept treatment when their whānau talked to them about it. Therefore, effective whānau participation in decision-making supports taiohi recovery (Boulton et al., 2013; Durie, 2021; Kidd et al., 2010; Wirihana & Smith, 2019). Whānau provided a cultural reality of awhi and manaaki, bringing spiritual and emotional healing and trust. Gaebel et al. (2014) affirmed that improving confidence can help reduce stigma against those with mental illness and develop a therapeutic alliance

between multiple services. The trust held taiohi and whānau relationship together despite the challenges they experienced along the hīkoi.

Whānau play a crucial role in supporting youth mental illness; they help strengthen their resilience through tolerance, understanding, assistance, and encouragement (Boulton et al., 2013; Howard et al., 2020). Taiohi relied on whānau for mana whakahaere support. Taiohi said they felt safe knowing whānau were with them. They felt that if whānau were present, they were listened to and people could not hurt them. Whānau understood taiohi feelings of fear, being alone, and increased anxiety in a strange environment around strange people. Whānau awhi and manaaki enhance taiohi mana and influence acceptance of treatment. However, their experiences of communication were ineffective.

Whānau self-taught and learnt relevant mental health and addiction policies and processes. They began to understand mental health illness and the need for medication under the Act. Both taiohi and whānau knew that once back in the community, they would have a greater capacity to self-govern, trust, and respect each other. They also had the space to be Māori and be around the collective whānau. Challenging will be re-engagement with peers and whānau who use substances.

Conclusion

Taiohi and whānau hīkoi moved from the community into acute mental health and addiction services and back out into the community. Te Pae Māhutonga, a Maori model of care, symbolises multiple factors necessary for health and well-being, including *mauri ora*, *waiora*, *toiora*, *and he oranga.* The effects of colonialism are changing taiohi whakapapa as they move into adulthood. Their psychological, social, and environmental well-being is moving. Their Māori identity is moving. They need a connection to the knowledge of te ao Māori, tikanga Māori, and mātauranga Māori necessary to strengthen identity and sense of belonging; as well as an understanding of their social positioning and how to advance within the system. Sustaining the *waiora* requires caring for the environment and enhancing and restoring the mana of the environment and the people.

Taiohi and whānau have normalised daily trauma and risk impacting physical and psychological health and whānau dynamics. These factors influence access to mental health and addiction services. Engagement with services leads to immediate state control. Taiohi are separated from whānau and placed in a foreign environment. The environment

is culturally unsafe and discriminative, increasing the risk of distrust and poor mental health and substance use outcomes. Whānau, the most effective support system, has limited opportunities to make decisions along taiohi care pathways.

When engaging in equitable mental health and substance use pathways of care for taiohi, the assessment must be holistic, culturally safe, and inclusive of the whānau. The interventions must mirror the holistic review. The documentation should include a standing order for cultural input and whānau engagement. A cultural, social, and environmental assessment enhances a holistic treatment plan that promotes health and well-being within the framework of Te Pae Māhutonga.

Chapter 6: Conclusion and Recommendations

This chapter summarises the findings of taiohi and whānau experiences as they move from the community into acute mental health and addiction services. The results provide a unique understanding of taiohi and whānau experiences when taiohi use substances. Taiohi substance use and mental health issues are more prevalent than non-Māori youth. Nevertheless, mental health and addiction services are underutilised. Barriers to taiohi accessing services include not wanting to make a fuss, being aware of mental health stigma, not wanting to take medication or get involved with the police, and lacking trust in the clinicians and the system.

Taiohi substance use is harmful; it is a precipitator of drug-induced psychosis. When taiohi are heavy on drugs, they know something is wrong but cannot describe it. Whānau observe taiohi changes in behaviour, mood, and motivation. They notice increased verbal and physical aggression. Substance use issues exist in the community alongside social pain resulting from poverty, transient lifestyles, whānau dynamics, and lacking education. Additionally, exposure to cultural, physical, and psychological harm is a reality for taiohi.

Whānau have locked away their Māori knowledge creating space for the assimilation of Euro-Western knowledge systems. However, small gems of Māori knowledge still exist that can develop into large amounts of wisdom. Adolescence is a developmental stage when young people are more likely to take risks and more likely to be influenced by peers and other whānau. The combination of adolescence, substance use, social issues, and spiritual factors weaken taiohi identity and increase the risk of further substance use.

Te Ara Tika Guidelines have supported ethical, cultural, and legal factors to keep the study safe. The framework embraces whakapapa, tika, manaakitanga, and enhancement of mana. Tate (2010) affirmed that tikanga provides an understanding of Māori knowledge and relevance to health and well-being. Tikanga enhances the mana of the spiritual realm, the land, and the people.

Entering a Scary Place

Taiohi and whānau, in this study, accessed acute mental health and addiction services at different times. Taiohi and whānau described it as a scary place. The Mental Health (Assessment & Treatment) Act 1992 started for all taiohi. Those who accessed treatment early spent less time in acute mental health and addiction services. The longer it took to

access the services, the longer they stayed in acute mental health services. Whānau were grateful for the help to support taiohi wellness, although, they felt locked in and did not know what was happening. The police escorted most taiohi into acute mental health services, separating them from whānau and a familiar environment in the community. Taiohi and whānau struggled to regain confidence in clinicians after engagement with the police. They wanted to get out of acute mental health and addiction services.

In the acute unit, taiohi comfort came from whānau. Whānau were the primary carers. When whānau were not there, Māori cultural services helped. Also, taiohi enjoyed the fun things on the ward, like going to the beach or trips out. However, they hated the boredom. The main form of treatment was psychotropic medication. Only one taiohi had substance use education follow-up. Whānau received no education about substance use even though they had asked. Taiohi and whānau worked together to get out of acute mental health services. Returning to the community gave taiohi and whānau hope by working together and getting on with life. Taiohi also appreciated the clearing of their thoughts due to substance abstinence.

Cultural Modes of Care

The inequities affecting taiohi substance use and mental health issues are related to current Euro-Western models of care that clash with Indigenous models of care. Using Te Pae Māhutonga as a framework in healthcare supports the unique realities experienced by taiohi and whānau. It provides a holistic view that embraces taiohi and whānau spiritual, emotional, social, political, and environmental realities. The holistic view addresses harm, risk, and modes of care that seek to restore mauri ora, waiora, toiora, and te oranga, vital for health and well-being.

Holistic Māori modes of care are needed to provide options that strengthen taiohi identity and build their sense of belonging as tangata whenua. A shift to a holistic model of care inclusive of the whānau is critical. A holistic model identifies social issues such as housing, finances, whānau, and school. It reflects on cultural, spiritual and political issues. Māori modes of care restore mauri ora, waiora, toiora, and te oranga, which are vital for health and well-being (Durie, 1999). A holistic model can also reflect bi-culturalism. However, a safe bicultural pathway requires the lead Māori researcher to advocate for participant rights and uphold Te Tiriti o Waitangi principles in balance with Euro-Western processes. Biculturalism is not without its concerns according to Hamley et al.

(2022) the capability of the Euro-Western discourse to assimilate Euro-Western ideals into a Māori worldview is high. Māori models of care must be led by Māori to enhance mana and promote rangatiratanga. A bicultural effect developed within this study through the partnership of tikanga Māori and Western approaches that enabled a culturally safe process throughout recruitment and data collection.

Entry into acute mental health and addiction services means engaging in a Euro-Western model of care that lacks holistic, relational factors such as assessing the environment, social situation, and engaging with whānau. Unconscious bias is evident when all taiohi were under the Mental Health (Assessment & Treatment) Act 1992, and all male taiohi were secluded. Taiohi were separated from whānau and escorted by the police into acute services. Whānau experienced racism and discrimination in mental health and addiction services. Lack of information and communication was a primary problem. Holding back information caused distrust. Without health information, whānau struggle to support taiohi recovery. Overall, entry into acute mental health and addiction services was culturally unsafe. Taiohi and whānau experienced discrimination and feelings of being locked in, and whānau did not feel clinicians were listening to them.

Conclusion

Taiohi substance and mental health concerns are caused by a range of factors including living in unhealthy environments, influenced by colonialism, exclusion and poverty. In an unhealthy environment, other people are using substances or have dropped out of school, and people live with multiple social issues, including whānau dynamics, deprivation, and other stressors. A healthy environment includes exposure to traditional knowledge in te ao Māori, tikanga Māori, and mātauranga Māori and a range of high-level social determinants to address equitable access to whenua, housing, food, education and healthcare. Māori require self-determined solutions that build on traditional beliefs, values, and knowledge systems allow Māori to be Māori, and to determine their care pathway to support equitable care and outcomes.

Māori want to receive healthcare care close to home in their space of safety, they want care that feels safe, comfortable and meet their unique developmental needs. Resources and skilled workforce are needed to support and develop the community's kaupapa Māori and bicultural health services that offers a Māori worldview about their pathway of care

and service delivery. The fiscal envelope must be sustainable as often restructuring of health services means reducing Māori health services, seen time and time again.

Recommendations

1. Mental health curricula for health practitioner education must include the culturally safe care taiohi and whānau Māori living with complex mental health and substance misuse within various contexts. Curricula must include the ongoing impacts of historical and intergenerational trauma, contemporary colonisation and racism that impacts taiohi and their whānau health and wellbeing.

2. Mental health staff be required to undertake kanohi ki te kanohi orientation that is centred on the delivery of culturally safe multidisciplinary care coordination that is inclusive of both taiohi and whānau and cognisant of the multiple and complex needs that influence taiohi recovery.

3. Community-based (close to home) kaupapa Māori initiatives that focus on working with taiohi and whānau to address Māori youth's cultural, psychological, and substance misuse issues.

4. Development of kaupapa Māori primary care and residential facilities in partnership with taiohi and whānau with lived experience that focuses on uplifting their cultural identity and mana, and supporting taiohi and whānau when they need recovery from mental health and addictions challenges.

The challenge in writing this thesis was to reconcile conflicting realities that affect taiohi and whānau mental health and wellbeing daily. In doing so, it is useful to draw on tupuna wisdom enclosed in the following whakataukī.

Mai Papatū

Ki Papatū u nuku

Atu ki Papatū roa

Ko tēnei taku whakapapa

(Standing strong to the whakapapa of our spirituality and life-force: he ātua, he tangata, he whenua - mauriora)

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Glossary of Māori Terms

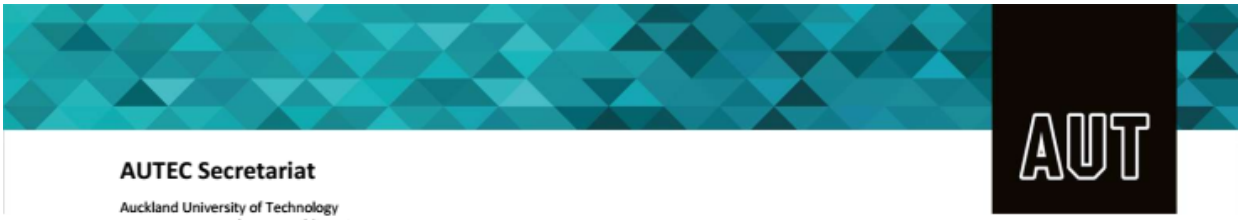
Ahi Kā	burning fires of occupation, home fires
Aotearoa	New Zealand
Aroha	loving care, compassion
Ātua	ancestors with continuing influence, god, demon, supernatural being
He Whakaputanga o Te Rangatira o Nu Tireni	The Declaration of Independence
Hīhoi	to walk, stride, step, march
Hōhā	be boring, tiresome, fed up with, annoying
Hui	to gather, congregate, assemble, meet
Kaumātua	to grow old. Adult, elder man or woman
Kaupapa	topic, matter for discussion, plan, purpose, proposal
Kore, Te	realm of potential being
Kohunga reo	a kindergarten where lessons are conducted in Māori
Kura kaupapa	primary school operating under Māori custom and using Māori as the medium of instruction
Mākutu	to inflict physical and psychological harm and even death through spiritual powers
Mamae	be painful, sore, hurt
Mana	prestige, authority, power, influence
Manaaki	embrace, caring
Mana tāngata	people with prestige
Māori tanga	includes te reo, whakapapa, and iwi tanga
Mara	garden cultivation
Marae	courtyard – the open area in front of the wharenui, where formal greetings and discussions take place
Mārama	to be clear, light (not dark)
Māramatanga	enlightenment, insight, understanding
Mātua	parents

Mauri	life principal, life force, vital essence, a material symbol of a life principle. A source of emotions – a quality of being or entity
Mauri Ora	called to claim the right to speak
Mimiwhangata	Mimiwhangata Coastal Park on Northland's east coast. Aotearoa.
Ngāpuhi	tribal group within Northland
Pākehā	English, foreign, European those from other countries
Rāhui	to put in place a temporary ritual prohibition, closed season, ban
Rangatiratanga	chieftainship, right to exercise authority, chiefly autonomy
Ranginui	Atua of the sky and husband of Papatuanuku from which originates all living things
Rito	centre shoot of the flax bush
Rongoā	to treat, apply medicines
Tamaiti	child
Tane	husband, male, man
Tāne-te-waiora	know as Tane-matua and Tāne-matua. Tāne-nui-a-Rangi and Tāne-matua helped separate Rangi-nui and Papa-tū-ā-nuku so the sun would shine on their children
Taitamariki	to be young, youth, teenagers, adolescent, young person
Tangata	human being, individual, womb
Tangata whenua	to be natural, at home, local people, Indigenous people born of the whenua
Tangata whaiora	Māori patients
Tauira	student
Tautoku	to support, prop up, verify, advocate, accept, agree
Te Ao Māori	Māori worldview
Te ao Mārama	a Māori concept relating to wisdom and understanding, and the natural world of life and light

Te Pā harakeke	flax bush
Te Pae Mahutonga	Southern Cross
Te Po	darkness, night
Te Reo Māori	Māori language
Tikanga	Māori customs
Toi-ngā-rangi	the most sacred
Tūpuna	ancestors, grandparents
Tūrangawaewae	place of standing
Wahine	female, women
Wahine toa	warrior women
Waiora	health
Wairua	the soul. Spirit of a person which exists beyond death. Non-physical. Spirit distinct from the mauri and the body
Whaea	mother, aunt, aunty
Whāngai	to feed, nourish, bring up, foster, adopt, nurture
Whakapapa	genealogy
Whare kura	school – traditionally the place where esoteric lore was taught. In modern Māori it is written as one word
Whare tangata	womb
Whenua	land

Appendices

Appendix A – AUTEC Approval



AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

18 February 2016

Denise Wilson
Faculty of Health and Environmental Sciences

Dear Denise

Ethics Application: **16/08 The experiences of taiohe and their whanau when taiohe enter acute mental health services under the influence of alcohol and/or drugs.**

Thank you for submitting your application for ethical review. I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 15 February 2016, subject to the following conditions:

1. Amendment of the Information Sheets where access to the counselling drop-in sessions are mentioned, noting that contact details for the counselling service should be provided in the document, so that participants may make an appointment;
2. Reflection of the ethical issues accompanying family based (group) consent to participate in research;
3. Clarification of whether participant facing documents might be presented in Maori language;
4. Review of all participant facing documents for appropriateness correct spelling, grammar and typographical errors (note "accept"/ should be "access" on the last bullet of the confidentiality agreement, "Photovice" on the Photvoice Protocol, "unsuccessful" on the letter for participants not chosen to participate, and potentially overstated use of the word" ground-breaking").

Please provide me with a response to the points raised in these conditions, indicating either how you have satisfied these points or proposing an alternative approach. AUTEC also requires copies of any altered documents, such as Information Sheets, surveys etc. You are not required to resubmit the application form again. Any changes to responses in the form required by the committee in their conditions may be included in a supporting memorandum.

Please note that the Committee is always willing to discuss with applicants the points that have been made. There may be information that has not been made available to the Committee, or aspects of the research may not have been fully understood.

Once your response is received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application. Full approval is not effective until all the conditions have been met. Data collection may not commence until full approval has been confirmed. If these conditions are not met within six months, your application may be closed and a new application will be required if you wish to continue with this research.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

I look forward to hearing from you,

Yours sincerely

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Debra Gerrad

Appendix B – Kaumātua Letter of Support

HE KORERO TAUTOKO
ia
DEBRA GERARD.

Anei te whakatauaki: Ko te manu i kai ai te miro,
nona te ngahere.
Ko te tangata i kai ai te matauranga,
nona te AO.

Teheiwa mauri ora, e te hunga ka whakapa mai ki tenei purongo korero kua hora-hia nei ki mua ia koutou, nga mihi Rangatira, nga mihi Tangi hoki ki a ratou kua ngaro ki te po, haere nga mate o te motu, ratou ki a ratou. Kia hoki mai ki a tatou te hunga ora, tena koutou, tena koutou, a tena tatou katoa.

Ko Tehemara Pita Pou taku ingoa, ko hau te tahi o nga "kai whangai i a Debra ki te ao-maori" mo nga taonga e pa ana ki wana mahi, no reira e whakapono ana kei aia te matauranga mo tenei turanga, a tauiwi/tohu hoki.
I am Debra's Kaumatua and Cultural Support for the past 20years, since her nursing career with Waitemata District Health Board and her continuation to better herself in ALL her career pathways, for herself and as a single parent mother for her children and mokopuna. Any mountain is NOT high enough for her to conquer and any career pathway is never to far for her to reach those goals.

Kia ora Tehemara Pita Pou, Kaumatua o Ngati Whatua, Ngapuhi. Kaimahi o Waitemata District Health Board.

1

Appendix C – HDEC Response

Health and Disability Ethics Committees

Health and Disability Ethics Committees
20 Aitken Street
Freyberg Building
PO Box 5013
Wellington

0800 4 ETHICS
hdecs@moh.govt.nz

Friday, 5 February 2016

Miss Debra Lee Gerrard
North Campus
90 Akoranga Drive
Northcote

Dear Miss Gerrard,

Study title:	Hui with Taiohe about Mental Health and Addiction Services

Thank you for emailing HDEC a completed application form on 26 January 2016. The Secretariat has assessed the information provided in your form and supporting documents against the Standard Operating Procedures.

Your study will not require submission to HDEC, as on the basis of the information you have submitted, it does not appear to be within the scope of HDEC review. This scope is described in section three of the Standard Operating Procedures for Health and Disability Ethics Committees.

This study involves gathering information from hui with Taiohe about their experiences using mental health services with drug and/or alcohol issues. This information will be used to inform policy makers, funders, and other academic arenas about what works best in for this group.

An observational study requires HDEC review only if the study involves more than minimal risk (that is, potential participants could reasonably be expected to regard the probability and magnitude of possible harms resulting from their participation in the study to be greater than those encountered in those aspects of their everyday life that relate to the study).

For the avoidance of doubt, an observational study always involves more than minimal risk if it involves one or more of the following:

- one or more participants who will not have given informed consent to participate, or
- one or more participants who are vulnerable (that is, who have restricted capability to make independent decisions about their participation in the study), or
- standard treatment being withheld from one or more participants, or
- the storage, preservation or use of human tissue without consent, or
- the disclosure of health information without authorisation.

If you consider that our advice on your project being out of scope is in incorrect please contact us as soon as possible giving reasons for this.

This letter does not constitute ethical approval or endorsement for the activity described in your application, but may be used as evidence that HDEC review is not required for it.

Please note, your locality may have additional ethical review policies, please check with your locality. If your study involves a DHB, you must contact the DHB's research office before you begin. If your study involves a university or polytechnic, you must contact its institutional ethics committee before you begin.

Please don't hesitate to contact us for further information.

Yours sincerely,

Fox Swindells
Advisor
Health and Disability Ethics Committees
hdecs@moh.govt.nz

Appendix D – EA2 Amendment

Please do not staple your application

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

AUCKLAND UNIVERSITY OF TECHNOLOGY ETHICS COMMITTEE (AUTEC)

EA2

For AUTEC Secretariat Use only

16/08

RESEARCH PROGRESS REPORT OR APPLICATION FOR AMENDMENT

Once this form has been completed and signed, please read the notes at the end of the form for information about its submission to AUTEC.

NOTES ABOUT COMPLETION

- Responses should use clear everyday language with appropriate definitions being provided should the use of technical or academic jargon be necessary.
- The AUTEC Secretariat and your AUTEC Faculty Representative are able to provide you with assistance and guidance with the completion of this report or application.
- Comprehensive information about ethics approval and what may be required is available online at http://aut.ac.nz/researchethics
- The information provided in this form will be used for the purposes of granting and monitoring ethics approval. It may also be provided to the University Postgraduate Centre, the University Research Office, or the University's insurers for purposes relating to AUT's interests.

To respond to a question, please place your cursor in the space following the question and its notes and begin typing.

A. *Project Information*

A.1. AUTEC Application Number

16/08

A.1.1. Current Expiry date

June 2019

A.2. Are you making an annual progress report? ☒ Yes ☐ No

If you have responded "Yes" to this question, please complete part B of this form

A.3. Are you making an application for amendments? ☒ Yes ☐ No

If you have responded "Yes" to this question, please complete part C of this form

A.4. What is the approved title of the research?

If you will be using a different title in documents to that being used as your working title, please provide both, clearly indicating which title will be used for what purpose.

The experiences of taiohe and their whānau when taiohe enter acute mental health services under the influence of alcohol and/or drugs.

A.4.1. Has the title altered since ethics approval was given? ☒ Yes ☐ No

If the answer is 'Yes', please answer the following question, otherwise please answer section A.5 and continue from there.

A.4.1.1 What is the proposed new title for the research?

The experience of taiohe and their whānau entering acute mental health services with drug and alcohol issues: A kaupapa Māori study

A.5. Who is the applicant?

When the research is part of the requirements for a qualification at AUT, then the applicant is always the primary supervisor. Otherwise, the applicant is the researcher primarily responsible for the research, to whom all enquiries and correspondence relating to this application will be addressed.

Professor Denise Wilson

A.5.1. Has the applicant altered since ethics approval was given? ☐ Yes ☒ No

If the answer is 'Yes', please answer the following, otherwise please answer section A.6 and continue from there.

A.5.2. Who is the new applicant?

When the research is part of the requirements for a qualification at AUT, then the applicant is always the primary supervisor. Otherwise, the applicant is the researcher primarily responsible for the research, to whom all enquiries and correspondence relating to this application will be addressed.

A.5.2.1 In which faculty, directorate, or research centre is the applicant located?

A.5.2.2 What are the applicant's qualifications?

A.5.2.3 What is the applicant's email address?

An email address at which the applicant can be contacted is essential.

A.5.2.4 At which telephone numbers can the applicant be contacted during the day?

B. ***Progress Report***

Please complete this section if you answered 'Yes" to section A.2

B.1. Has the recruitment of participants commenced? ☒ Yes ☐ No

B.2. Has the recruitment of participants been completed? ☐ Yes ☒ No

B.3. Has the collection of data commenced? ☐ Yes ☒ No

B.4. Has the collection of data been completed? ☐ Yes ☒ No

B.5. Has data analysis commenced? ☐ Yes ☒ No

B.6. Has data analysis been completed? ☐ Yes ☒ No

B.7. Has the writing up of the findings commenced? ☐ Yes ☒ No

B.8. Has the writing up of the findings been completed? ☐ Yes ☒ No

B.9. Has any publication of findings occurred? ☐ Yes ☒ No

B.10. If the research is for a qualification, is it on schedule to finish before its expiry date? ☒ Yes ☐ No

If the answer is 'No', please explain why and indicate when the research is likely to be completed. Otherwise, please answer section C.1 and continue from there.

B.11. Ethical issues that have arisen

B.11.1. Were there any previously unforeseen risks and if so, how have they been managed?

No

B.11.2. Were there any conflicts that may have arisen and if so, how have they been managed?

No

B.11.3. Were there any complaints and if so, how have they been managed?

No

B.11.4. Were there any problems with the approved research protocols and if so, how have they been managed?

Yes. Debra Gerard has realised that the approved protocols for participant recruitment have been unachievable and problematic despite DHB approval at both organisational and site level. For instance key workers are supportive of the research but their work demands over ride their ability to engage with the research and this creates a barrier to sampling opportunities. Mangers and clinicians with opposing views towards research restrict access to participants for example individuals believe Māori have been over researched. Also, noticeable were paternalistic behaviours where clinicians restrict access to potential participants by rejecting a shared approach with the primary researcher and the recipient and decide in isolation whether there is risk for taiohe participation.

The reality of recruiting taiohe and whanau with the prerequisite criteria has been challenging as they are recognised as a hard to reach group. Many taiohe and whānau left school prior to any formal qualifications compromising their literacy skills and asking them to write down information about the photos is a deterrent. Additionally, taiohe with mental illness are often disorganised in their thinking and many tend to be concrete thinkers. Therefore asking abstract questions like "How does this photo relate to your experience?" or "Was this a problem or a strength" is too difficult.

As a result, Debra has changed the research design. She now intends to use social networking and snowball sampling for the recruitment strategy. The theoretical framework remains the same for instance indigenous research using a kaupapa Māori research methodology.

C. ***Application for Amendments***

Please complete this section if you answered 'Yes" to section A.3

Please ensure all applicable revised documentation such as Advertisement, Participant Information Sheets or Consent Forms are attached to this application.

C.1. What amendments to the recruitment protocols are needed?

Sample Criteria

Sampling is initially purposive in that participants are selected on the basis of specific criteria which allows their diversity to be built into the sample (Morgan, 2012). For this study there are three groups of participants including taiohe aged 16 to 24 years old, tāne (male) or wāhine (female), who self-identify as Māori and have been admitted to an acute mental health service where drugs and/or alcohol was within the past four years. Whānau participants will identify as Māori who have supported taiohe when admitted to acute mental health services where drug and/or alcohol was involved. Informants can identify as Māori or Pākehā who have worked with taiohe and whānau in their clinical capacity and exposed to the experiences of taiohe and whānau who have entered mental health services where drugs and/or alcohol has been an issue. I aim to sample eight to ten taiohe, eight to ten whānau and six informants.

Sampling Strategy

Participants who meet the eligibility criteria are sourced through snowball sampling which is a type of purposive sampling. Snowball sampling identifies sets of individuals who represent the study population and uses their referrals to collect data through their social networks (Wright, Decker, Redfern, & Smith, 1992). Also, the participant group I am trying to reach is recognised as a vulnerable group. They are vulnerable because of the stigma surrounding mental illness, being young, Māori and facing social issues such as poverty in education, housing and economic status. This aligns with Perez, Nie, Ardern, Radhu, & Ritvo, (2013) who suggest vulnerable populations may include individuals who feel stigmatised by identifying themselves with the population being researched. Additionally, I received feedback from

mental health clinical staff suggesting the initial research design was overwhelming for taiohe and this resulted in a low response rate amplifying the need to look at an alternative data collection process.

Purposive sampling and snowball sampling provides a valuable alternative approach to reach those that are unlikely to be reached. Snowball sampling proposes improved participation by using social networks to gain referrals from participant's representative of the study group. However, snow ball sampling may be criticized for the absence of scientific rigor but according to (Wright, et al., 1992) this is not the case. Wright et al., (1992) argues the benefits of reaching hard to reach groups compensates for possible losses in generalizability. He also believes selective sampling works well when the researcher has extensive knowledge about the population's characteristics when seeking to discover specific information about individuals in the target population. As the researcher I have been working with this population group for over ten years and have extensive knowledge about their characteristics and clinical experiences.

Following is an outline of the process

1. (a)I will approach one informant from key locations as mentioned above and request they get in touch with others who meet the eligibility criteria (b) I will leave flyers, information sheets and my business card with informants to give to potential participants who may be interested in participating in the study.
2. Informants will engage with potential participants, provide the information I have left and potential participants will contact me expressing an interest in the study. I will set up a meeting and offer recruitment.
3. Advertise in strategic locations. I will make additional flyers with eligibility criteria and my contact information and place in strategic locations as per informant recommendations.
4. Ask participants whether they know anyone else who may meet the eligibility criteria and would be willing to talk about their experiences. Once eligible participants have been identified and the interview has been completed I will ask them to refer others and to recommend key areas to put flyers. (Note: For confidentiality, reasons I will not ask participants to give me the names or contact details for individuals). If participants know individuals who may be eligible for the study, they will provide a business card and a flyer to potential participants who can choose whether to contact me. This also provides an opportunity for the interviewed participant to vouch for the legitimacy of the study.

I will no longer recruit co-researchers to support with hui administration duties.

I have broadened the area in which to recruit participants including Auckland region, Northland and Waikato District.

C.2. What amendments to the data collection protocols are needed?

Data collection will remain qualitative using semi structured interviews. I will ask participants a series of predetermined open-end questions leaving the range of response open to ensure the participant feels listened to. The interview guide will be developed in advance and will consist of a list of topics based on the question. The interview process will move back and forth through the topic list depending on the participant's responses. When appropriate I will use probes to elicit further information and I will pay particular attention to verbal and non-verbal information (Ayres, 2008).

Permission will be sought to record the interviews and be stored in NVivo for analysis.

I will no longer use photovoice and planning alternative tomorrows with hope (PATH) as will it looks achievable on paper it is practically impossible due to issues mentioned above.

C.3. What amendments to the research aims are needed?

C.4. What amendments to the research methodology are needed?

The theoretical framework remains the same for instance indigenous research using a kaupapa Māori research methodology. The methodology has been changed to person to person semi-structured interviews.

C.5. What changes are there to the proposed research outputs?

No changes

C.6. What other amendments to the research are required?

D. ***References***

Please include any references relating to your responses in this report or application in the standard format used in your discipline.

Ayres, L. (2008). Semi-structured Interview. In L. Given, *The Sage Encyclopaedia of Qualitative Research Methods*. (p 811)

California, United States of America. SAGE Publications, Incorporated

Morgan, D. (2008). Snowball Sampling. In L. Given, *The Sage Encyclopaedia of Qualitative Research Methods.* (p 816) California, United States of America. SAGE Publications, Incorporated

Perez, D., Nie, J., Radhu, N., and Ritvio, P. (2013). Impact of participant incentives and direct and snowball sampling on survey response rate in an ethnically diverse community: Results from a pilot study of physical activity and the built environment. *Journal of Immigrant & Minority Health, 15,* 1. 207-214. Doi: 10.1007/s10903-011-9525-y

Wright, R., Decker, S., Redfern, A., and Smith, D. (1992). A snowball's chance in hell: Doing fieldwork with active residential Burglars. *Journal of Research in Crime and Delinquency, 29,* 2. 148-161. Doi: 10.1177/0022427892029002003

E. *Checklist*

Please ensure all applicable sections of this form have been completed and all appropriate documentation is attached as an incomplete form will not be considered by AUTEC.

Have you discussed this form with your AUTEC Faculty Representative, or a member of the AUTEC Secretariat? ☒ *Yes* ☐ *No*

Is this form related to another ethics application? If yes, please provide the application number of the other application. ☒ *Yes* ☐ *No*

Are you seeking ethics approval from another ethics committee for this research? If yes, please identify the other committee. ☒ *Yes* ☐ *No*

I may need to apply for ethics approval from Auckland District Health Board, Northland District Health Board and Lakes District Health Board

Section A	***Project information provided***	X
Section B	***Progress Report information provided***	
Section C	***Amendment details provided***	X
Section D	***References provided***	X
Section E	***Checklist completed***	X
Section F.1 and 2	***Applicant and student declarations signed and dated***	X
Section F.3	***Authorising signature provided***	

Spelling and Grammar Check (please note that a high standard of spelling and grammar is required in documents that are issued with AUTEC approval)

Attached Documents (where applicable)

Participant Information Sheet(s)	X
Consent Form(s)	X
Questionnaire(s)?	n/a
Indicative Questions for Interviews or Focus Groups	X
Observation Protocols you mention noting non-verbal ques?	n/a
Recording Protocols for Tests	n/a
Advertisement(s)	X
Researcher Safety Protocol	X
Hazardous Substance Management Plan	n/a
Any Confidentiality Agreement(s)	X
Any translations that are needed	X
Other Documentation	X

F. *Declarations*

F.1. Declaration by Applicant

Please tick the boxes below.

X The information in this report or application is complete and accurate to the best of my knowledge and belief. I take full responsibility for it.

X In conducting this study, I agree to abide by all applicable laws and regulations, and established ethical standards contained in AUTEC's Applying for Ethics Approval: Guidelines and Procedures and internationally recognised codes of ethics.

X I will continue to comply with AUTEC's Applying for Ethics Approval: Guidelines and Procedures, including its requirements for the submission of annual progress reports, amendments to the research protocols before they are used, and completion reports.

X I understand that brief details of this report or application may be made publicly available and may also be provided to the University Postgraduate Centre, the University Research Office, or the University's insurers for purposes relating to AUT's interests.

20/9/2016

Signature Date

F.2. Declaration by Student Researcher

Please tick the boxes below.

☐ The information in this report or application is complete and accurate to the best of my knowledge and belief.

☐ In conducting this study, I agree to abide by all applicable laws and regulations, and established ethical standards contained in AUTEC's Applying for Ethics Approval: Guidelines and Procedures and internationally recognised codes of ethics.

☐ I will continue to comply with AUTEC's Applying for Ethics Approval: Guidelines and Procedures, including its requirements for the submission of annual progress reports, amendments to the research protocols before they are used, and completion reports.

☐ I understand that brief details of this report or application may be made publicly available and may also be provided to the University Postgraduate Centre, the University Research Office, or the University's insurers for purposes relating to AUT's interests.

Signature Date

F.3. Authorisation by Head of Faculty/School/Programme/Centre

Please tick the boxes below.

☐ The information in this report or application is complete and accurate to the best of my knowledge and belief.

☐ In authorising the continuation of this study, I declare that the applicant is adequately qualified to undertake or supervise this research and that to the best of my knowledge and belief adequate resources are available for this research and all appropriate local research governance issues have been addressed.

☐ I understand that brief details of this report or application may be made publicly available and may also be provided to the University Postgraduate Centre, the University Research Office, or the University's insurers for purposes relating to AUT's interests.

Signature Date

Notes for submitting the completed report or amendment for review by AUTEC

Please ensure that you are using the current version of this form before submitting your form.

Please ensure that all questions on the form have been answered and that none have been deleted.

Please provide ***one*** printed, single sided, A4, and signed copy of the form and all related documents.

Please deliver or post to the AUTEC Secretariat, room WU406, fourth floor, WU Building, City Campus or email to ethics@aut.ac.nz. The internal mail code is D-88. The courier address is 46 Wakefield Street, Auckland 1010.

Appendix E – Ethical Approval Three DHBs

CMH Research Office
Counties Manukau Health
Clinical Support Building
Room 124, Level 1
Middlemore Hospital

11 May 2016

Dear Debra,

Thank you for the information you supplied to the CMH Research Office regarding your research proposal:

Research Registration Number: **2318**

Ethics Reference Number: **16/08**

Research Project Title: **The experiences of taiohe and their whanau when taiohe enter acute mental health services under the influence of alcohol and/or drugs. (Taiohe are young Maori between the ages 16y to 24y)**

I am pleased to inform you that the CMH Research Committee and Director of Hospital Services have approved this research with you as the CMH Co-ordinating Investigator.

Your study is approved until **9 March 2019** as specified on your HDEC ethics application.

Amendments:

- All amendments to your study must be submitted to the Research Office for review.
- Any substantial amendment (as defined in the *Standard Operating Procedures for HDECs*, May 2012) must also be submitted to the Ethics Committee for approval.

All external reporting requirements must be adhered to.

Please note that failure to submit amendments and external reports may result in the withdrawal of Ethical and CMH Organisational approval.

We wish you well in your project. Please inform the Research Office when you have completed your study (including when a study is terminated early) and provide us with a brief final report (1-2 pages) which we will disseminate locally.

Yours sincerely

S. Karatela

Dr Shamshad Karatela
Research Advisor
Counties Manukau Health
Under delegated authority from CMH Research Committee and Director of Hospital Services

From: Charles Joe (WDHB)
To: Helen Wihongi (WDHB)
Cc: Debra Gerrard
Subject: RE: Debra Gerrard
Date: Rahina, 14 Poutu-te-rangi, 2016 9:55:41 a.m.
Attachments: image001.png
image002.png

Kia ora Helen,

Thank you – every day is a blessing.

I thought that I had sent an email to Debra endorsing the research. Some of our staff have been invited to participate. I am encouraging that. I recall asking Debra if there was a form or she required a formal letter – I think the answer was "no".

Yes, happy to support her research and I think I agreed to provide cultural 'support' to any participants if required.

Charles

From: Helen Wihongi (WDHB)
Sent: Friday, 11 March 2016 10:46 a.m.
To: Charles Joe (WDHB)
Cc: Debra Gerrard
Subject: Debra Gerrard

Tena koe Charles,

Hope you and your whanau are well. Debra Gerrard is about to start the data gathering part of her PhD thesis (I am one of her supervisors). She initially had permission to proceed at Waitemata from Timoti George (matua Pita was her mentor). As things have changed at Waitemata Awhina Research and Knowledge Centre have asked her to get sign off from the current Maori manager – I think that is you ☺

She has previously sent you information about her thesis so I will not attach it. If you are ok with her proceeding could you respond by return email. If you have any questions please get back to me, Debra or Denise Wilson at AUT

Nga mihi mahana

Dr Helen Wihongi I **Research Advisor – Maori**
He Kamaka Waiora I **Waitemata and Auckland DHB**
Level 2, 15 Shea Terrace, Auckland 0740, New Zealand
Private Bag: 93-503
p: +64 9 486 8920 ext. 3204 m: 02102031167
http://staffnet/mhsresearch/
www.waitematadhb.govt.nz
www.aucklanddhb.govt.nz/

Legal Disclaimer

Appendix F – Screening Tool

Screening Tool

Project title: The experiences of taiohe and their whānau when taiohe enter acute mental health services under the influence of alcohol and/or drugs.

Project Supervisor: Denise Wilson

Primary Researcher: Debra Gerrard

Have you experienced in the past 2 weeks any of the following?

- ○ Changes to medication.
- ○ Mental health crisis intervention.
- ○ Admissions to a mental health respite facility.
- ○ Admissions to hospital
- ○ Severe loses that may affect your mental health i.e. loss of a close family member, relationship break up, etc.

If you have ticked any boxes above please provide an explanation below.

Participants signature: .....

Participants Name: .....

Date:

Primary Researcher s Contact Details :

Debra Gerrard

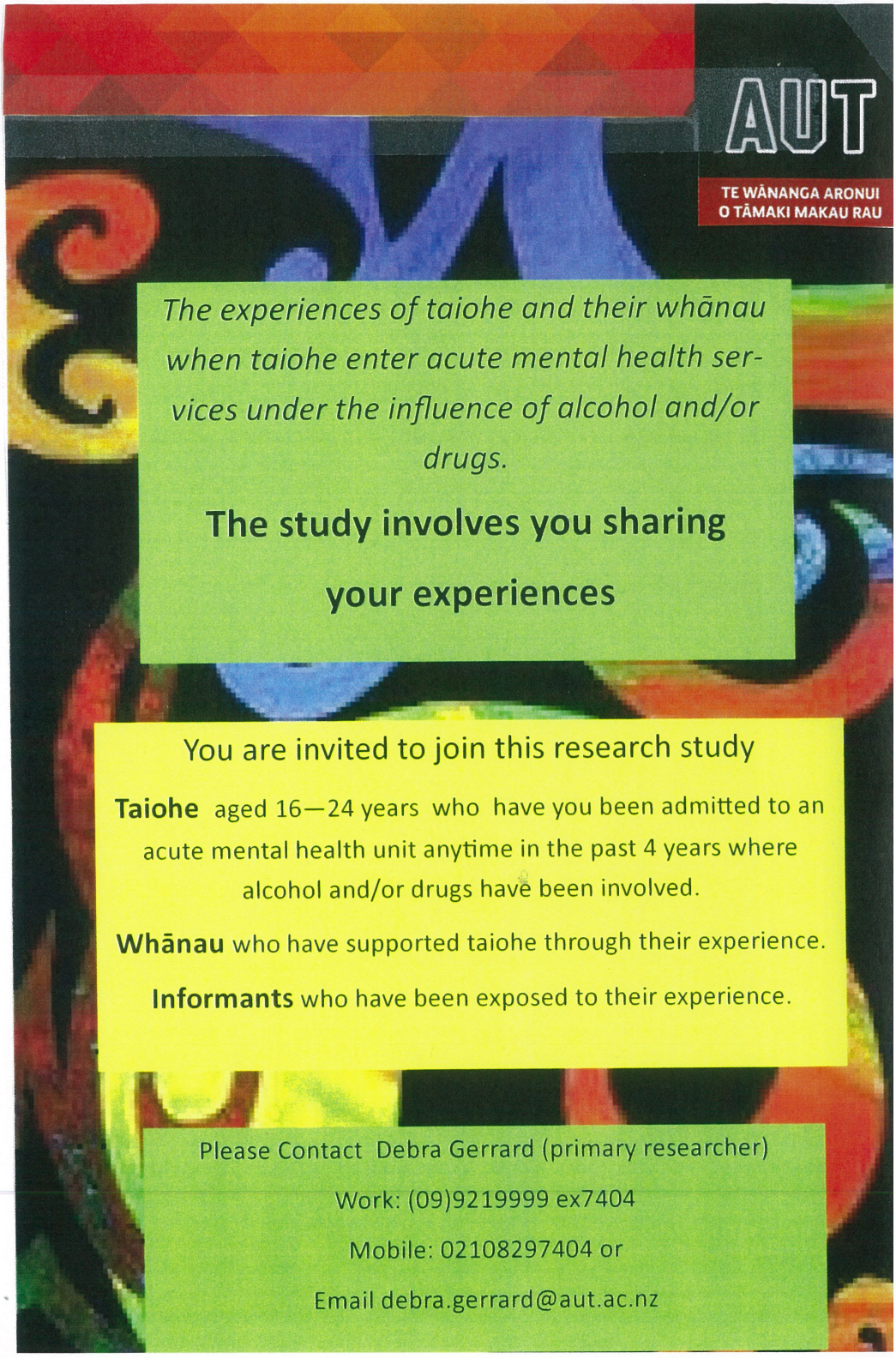
Email: debra.gerrard@aut.ac.nz phone: 021642244

Note: The participant should retain a copy of this form.

Approval yet to be granted by the Auckland University of Technology Ethics Committee. AUTEC Reference number reference number.

Appendix 10

Appendix G – Flyer



Appendix H – Taiohi Information Sheet and Consent Form

Participant Information Sheet

Date Information Sheet Produced:

26th September, 2016

Project Title

The experiences of taiohe and their whānau when taiohe enter acute mental health services under the influence of alcohol and/or drugs.

An Invitation

Tena koe, ko Te Rarawa, Te Apouri te iwi, ko Debra Gerrard tōku ingoa. I am a Māori mental health nurse inviting you to participate in this study. The study involves you sharing your experiences about the clinical journey for taiohe and/or whānau when admitted into acute mental health services where alcohol and/or drugs are involved.

Entry into the project is voluntary and you may withdraw at any time without any consequences.

What is the purpose of this research?

The purpose is to provide an environment for you to share your experiences to better understand what acute mental health services offers taiohe and/or whānau when they enter acute mental health services with drug and/or alcohol issues.

Based on your experiences I will develop theory and strategies that will produce a thesis and other academic publications or presentations to inform best practice.

How was I identified and why am I being invited to participate in this research?

Key informants identified you as someone who has experienced the journey of taiohe and/or whānau admission into acute mental health services with drug and/or alcohol issues.

I left my business card and a flyer with the informant who has passed this information to you inviting you to contact me.

You have been invited to participate because you are the EXPERT

What will happen in this research?

Once you have contacted me, we will organise a time and place to meet and I will explain the study in depth. If you agree to participate you will sign a consent form and an interview will take place at a time and place of your choice. The interview will be audio taped and I will take notes throughout the interview. You may choose to be interviewed at the first meeting or you may choose another time.

What are the discomforts and risks?

I am not expecting any discomfort or risk as you have complete control over what you say. You do not have to talk about things that are distressing or upsetting and you can leave the study at any time. The study includes digital recordings from the interview. These recordings and other information are available only to the research team. All identifiable details will be held secure and no information identifying you as a participant will be included in any academic publications or presentations. You may choose to listen to the recording and ask for information to be removed which is your right.

Appendix 11

How will these discomforts and risks be alleviated?

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Other options especially for those out of the Auckland region include 24 hour seven day a week services e.g. youth line (0800 376633), alcohol and drug help line (0800 787797), crisis team in the South Auckland (09)2613700 or North Auckland (09)4868900. Details are verbalised during whānaungatanga.

What are the benefits?

Voicing your experiences makes you an agent of change that represents the experience of youth and whānau when entering acute mental health services where alcohol and/or drugs are an issue. Sharing this information is rewarding for yourself and it will help others understand taiohe and whānau experiences.

What compensation is available for injury or negligence?

In the unlikely event of a physical injury as a result of your participation in this study, rehabilitation and compensation for injury by accident may be available from the Accident Compensation Corporation, providing the incident details satisfy the requirements of the law and the Corporation's regulations.

How will my privacy be protected?

Identifiable information will be held in a secure place at Auckland University of Technology for up to six years. The interviews will be digitally recorded and any other information will be available to the research team only. All details that identify you will be held in a safe place and no information identifying you as a participant will be included in any academic publications or presentations. You can choose to view the recordings on request and remove anything you wish by letting me know.

What are the costs of participating in this research?

The cost for you is approximately 2 hours of your time to share your experiences during an interview. You may choose to receive either a $20 petrol voucher, $20 food voucher or $20.00 phone top up to cover the costs of travel to the interview. A disposable camera will also be gifted to you.

What opportunity do I have to consider this invitation?

Once we meet I will explain the study in depth and answer any questions. You have two weeks to consider whether you want to participate.
You may choose to do the interview immediatley after the explanation and this can be confirmed by signing the consent form.

How do I agree to participate in this research?

As above I will provide an explanation of the study and signing the consent form confirms participation into the study.

Will I receive feedback on the results of this research?

You will receive an overview of the findings. Once these are available, you can choose to have them sent to you at an address you provide, or attend an information meeting given by the primary researcher. You will be provided with details of these options once the study has been completed approximately 18 months after the interview.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Denise Wilson, by email dlwilson@aut.ac.nz; phone (09) 921 9999 ext. 7392.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext. 6038.

Whom do I contact for further information about this research?

Researcher Contact Details:

Debra Lee Gerrard (primary researcher)

Work: (09)9219999 ex7404

Mobile: 02108297404 or

Email debra.gerrard@aut.ac.nz

Project Supervisor Contact Details:

Professor Denise Wilson, contact details

Phone (09) 921 9999 ext. 7392.

Email: dlwilson@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC 1608_09032016.

Participant Consent and Confidenitaility Agreement

Project title:

The experiences of taiohe and their whānau when taiohe enter acute mental health services under the influence of alcohol and/or drugs.

Project Supervisor: ***Denise Wilson***

Researcher: ***Debra Gerrard***

- O I have read and understood the information provided about this research project in the Information sheet dated 19thth September, 2016.
- O I have had an opportunity to ask questions and to have them answered.

Interview

- O I understand that discussions in the interview are confidential and I agree not to share this information with others.
- O I understand that discussions in the interview can only be shared with the researcher.
- O I understand that notes will be taken during the interview and that it will audio-taped and transcribed.
- O I will not keep any copies of any information from this project nor allow third parties to access them.
- O I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- O If I withdraw, I understand that while it may not be possible to destroy all records of the interview of which I was part, the relevant information about myself including tapes and transcripts, or parts thereof, will not be used.
- O I understand I will receive an overview copy of the findings from this project.

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* ***AUTEC Reference number*** *type the AUTEC reference number*

Note: The Participant should retain a copy of this form.

Appendix I – Whānau Information Sheet, Consent Confidentiality Forms

Participant Information Sheet

Date Information Sheet Produced:

26th September, 2016

Project Title

The experiences of taiohe and their whānau when taiohe enter acute mental health services under the influence of alcohol and/or drugs.

An Invitation

Tena koe, ko Te Rarawa, Te Apouri te iwi, ko Debra Gerrard tōku ingoa. I am a Māori mental health nurse inviting you to participate in this study. The study involves you sharing your experiences about the clinical journey for taiohe and/or whānau when admitted into acute mental health services where alcohol and/or drugs are involved.

Entry into the project is voluntary and you may withdraw at any time without any consequences.

What is the purpose of this research?

The purpose is to provide an environment for you to share your experiences to better understand what acute mental health services offers taiohe and/or whānau when they enter acute mental health services with drug and/or alcohol issues.

Based on your experiences I will develop theory and strategies that will produce a thesis and other academic publications or presentations to inform best practice.

How was I identified and why am I being invited to participate in this research?

Key informants identified you as someone who has experienced the journey of taiohe and/or whānau admission into acute mental health services with drug and/or alcohol issues.

I left my business card and a flyer with the informant who has passed this information to you inviting you to contact me.

You have been invited to participate because you are the EXPERT

What will happen in this research?

Once you have contacted me, we will organise a time and place to meet and I will explain the study in depth. If you agree to participate you will sign a consent form and an interview will take place at a time and place of your choice. The interview will be audio taped and I will take notes throughout the interview. You may choose to be interviewed at the first meeting or you may choose another time.

What are the discomforts and risks?

I am not expecting any discomfort or risk as you have complete control over what you say. You do not have to talk about things that are distressing or upsetting and you can leave the study at any time. The study includes digital recordings from the interview. These recordings and other information are available only to the research team. All identifiable details will be held secure and no information identifying you as a participant will be included in any academic publications or presentations. You may choose to listen to the recording and ask for information to be removed which is your right.

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How will these discomforts and risks be alleviated?

Should this project cause emotional upset free counselling is available at AUT drop in counselling services open Monday to Friday 9am – 4pm. City campus Wellesley St, Auckland, buildings WB219 or phone (09) 9219992; North Campus Akoranga Drive, Northcote, building AS104 or phone (09)9219998.

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What are the benefits?

Voicing your experiences makes you an agent of change that represents the experience of youth and whānau when entering acute mental health services where alcohol and/or drugs are an issue. Sharing this information is rewarding for yourself and it will help others understand taiohe and whānau experiences.

What compensation is available for injury or negligence?

In the unlikely event of a physical injury as a result of your participation in this study, rehabilitation and compensation for injury by accident may be available from the Accident Compensation Corporation, providing the incident details satisfy the requirements of the law and the Corporation's regulations.

How will my privacy be protected?

Identifiable information will be held in a secure place at Auckland University of Technology for up to six years. The interviews will be digitally recorded and any other information will be available to the research team only. All details that identify you will be held in a safe place and no information identifying you as a participant will be included in any academic publications or presentations. You can choose to view the recordings on request and remove anything you wish by letting me know.

What are the costs of participating in this research?

The cost for you is approximately 2 hours of your time to share your experiences during an interview. You may choose to receive either a $20 petrol voucher, $20 food voucher or $20.00 phone top up to cover the costs of travel to the interview. A disposable camera will also be gifted to you.

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Once we meet I will explain the study in depth and answer any questions. You have two weeks to consider whether you want to participate.
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How do I agree to participate in this research?

As above I will provide an explanation of the study and signing the consent form confirms participation into the study.

Will I receive feedback on the results of this research?

You will receive an overview of the findings. Once these are available, you can choose to have them sent to you at an address you provide, or attend an information meeting given by the primary researcher. You will be provided with details of these options once the study has been completed approximately 18 months after the interview.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Denise Wilson, by email dlwilson@aut.ac.nz; phone (09) 921 9999 ext. 7392.

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Participant Consent and Confidenitaility Agreement

Project title:

The experiences of taiohe and their whānau when taiohe enter acute mental health services under the influence of alcohol and/or drugs.

Project Supervisor: ***Denise Wilson***

Researcher: ***Debra Gerrard***

- O I have read and understood the information provided about this research project in the Information sheet dated 19thth September, 2016.
- O I have had an opportunity to ask questions and to have them answered.

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- O If I withdraw, I understand that while it may not be possible to destroy all records of the interview of which I was part, the relevant information about myself including tapes and transcripts, or parts thereof, will not be used.
- O I understand I will receive an overview copy of the findings from this project.

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

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.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* ***AUTEC Reference number*** *type the AUTEC reference number*

Note: The Participant should retain a copy of this form.

Parent/Guardian Consent Form

Project title:

The experiences of taiohe and their whānau when taiohe enter acute mental health services under the influence of alcohol and/or drugs.

Project Supervisor: ***Denise Wilson***

Researcher: ***Debra Gerrard***

- O I have read and understood the information provided about this research project in the Information Sheet dated 18th January, 2016.
- O I have had an opportunity to ask questions and to have them answered.
- O I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- O I understand that I may withdraw my child/children and/or myself or any information that we have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- O If my child/children and/or I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- O I agree to my child/children taking part in this research.
- O I wish to receive a copy of the report from the research (please tick one): YesO NoO

Child name: .....

.....

Parent/Gardians signature: .....

Parent/Gardians name: .....

Parent/Gardians Contact Details (if appropriate):

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.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* ***AUTEC Reference number*** *type the AUTEC reference number*

Appendix 16

Appendix J – Keyworker Information Sheet, Consent and Confidentiality Forms

Participant Information Sheet

Date Information Sheet Produced:

26th September, 2016

Project Title

The experiences of taiohe and their whānau when taiohe enter acute mental health services under the influence of alcohol and/or drugs.

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Participant Consent and Confidenitaility Agreement

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- O I understand I will receive an overview copy of the findings from this project.

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

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Date:

Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* ***AUTEC Reference number*** *type the AUTEC reference number*

Note: The Participant should retain a copy of this form.

Appendix K – Taiohi Questionnaires

The experience of taiohe and their whānau entering acute mental health services with drug and/or alcohol issues: A kaupapa Māori study

Taiohe Interview Guide

1. Tell me about what happened when you went into the mental health services. Prompts: were taiohe bought in by police escort, explain how you were involved in the process, how did you feel about coming into the mental health service, and why?

2. Tell me what you remember about the **Mental Health Act**. Prompts: how were your rights explained? Did you understand the process and give examples. Was legal support offered?

3. Tell me about the **questions** the psychiatrist and nurse asked you. Prompts: did you feel safe/unsafe and why? What were the positives and negatives?

4. How were your **drug and/or alcohol issues** addressed? What were the positives and the negatives?

5. Explain what **medication(s)** you usually take. Did the psychiatrist make any changes? What were they? Did you find the changes helpful and why?

6. Can you give me some examples of the **care provided** by staff? Did you feel staff listened to your requests and give me some examples? Was their approach compassionate and give some examples. Did you feel staff were being honest and open when talking to you?

7. Can you give me some examples of how your **cultural needs** were met e.g. whānau support, referrals to Māori health services, karakia, etc.?

8. Overall how do you think your "**recovery**" was supported and why?

9. Can you give me some examples of the positives and negatives about this interview?

10. Is there anything else you would like to talk about?

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number 16/08

Appendix L – Whānau Questionnaires

Whānau Interview Guide

1. Describe what happened on **admission**? Prompts: were taiohe bought in by police escort, explain how you were involved in the process, were you happy for taiohe to be admitted and why?

2. Tell me what you remember about the **Mental Health Act**. Prompts: how were taiohe rights explained to him/her? Did you understand the process and give examples, was legal support offered?

3. Tell me about the **mental health assessment** process with the psychiatrist and nurse. Prompts: did you feel safe/unsafe and why? Was communication therapeutic and give some examples.

4. Describe how your **drug and/or alcohol issues** were addressed.

5. Explain what **medication** you usually take. Were there any changes made whilst in the unit and what were they?

6. Give me some examples of the **care provided** by staff. Did you feel staff listened to your requests and give me some examples? Was communication therapeutic and give some examples.

7. Give me some examples of how your **cultural needs** were met e.g. family support, referrals to Māori health services, karakia, etc

8. How do you think your "**recovery**" was supported overall?

9. Is there anything we have not talked about?

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number

Appendix M – Keyworker Questionnaires

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Informant Interview Guide

1. Describe the usual **admission process** for taiohe. Prompts: What helps or hinders the process

2. When taiohe are placed under the **Mental Health Act** do you think this hinders or helps recovery and why? From your experience do you think whānau understand the process and provide some examples.

3. Give some examples of a **mental health assessment** that went well and some examples of an assessment that hasn't gone so well. What are your suggestions for improvement?

4. How are taiohe **drug and/or alcohol issues** addressed? Explain how whānau are supported to work with taiohe alcohol and/or drugs issues.

5. Give examples of the **medication** regime for taiohe whilst in the unit with drug and/or alcohol issues. Prompt: are psychotropic prescriptions chartered within the normal range? Give examples of therapeutic or non-therapeutic use of medication e.g. over/under sedated.

6. Give me some examples of the **care provided** for taiohe by staff. Do you feel staff listen to taiohe and whānau requests and give me some examples? How are whānau supported to engage in taiohe care.

7. Provide some examples of **culturally safe** practice and culturally unsafe practice offered to taiohe and whānau. Do you think this could be improved and how?

8. Give some examples of how taiohe "**recovery**" is supported/or not overall?

9. Is there anything we have not talked about?

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number

Appendix 16

Appendix N – Certificate of Participation

Appendix O – Participant Feedback

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Certificate of Participation

Thank you for your participation in the research project:

The experience of taiohe and their whānau entering acute mental health services with drug and/or alcohol issues:

A kaupapa Māori study.

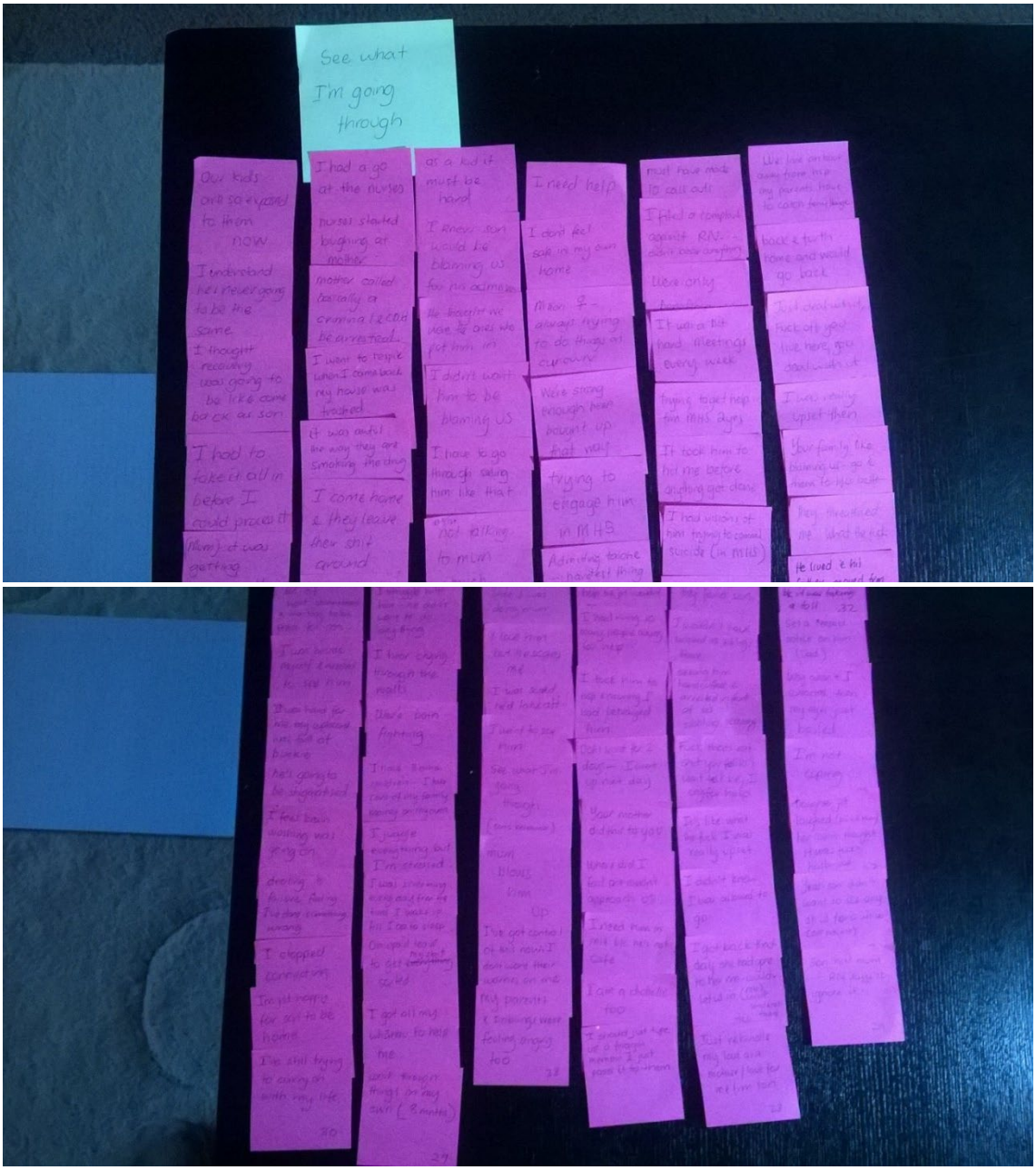
PRESENTED BY:

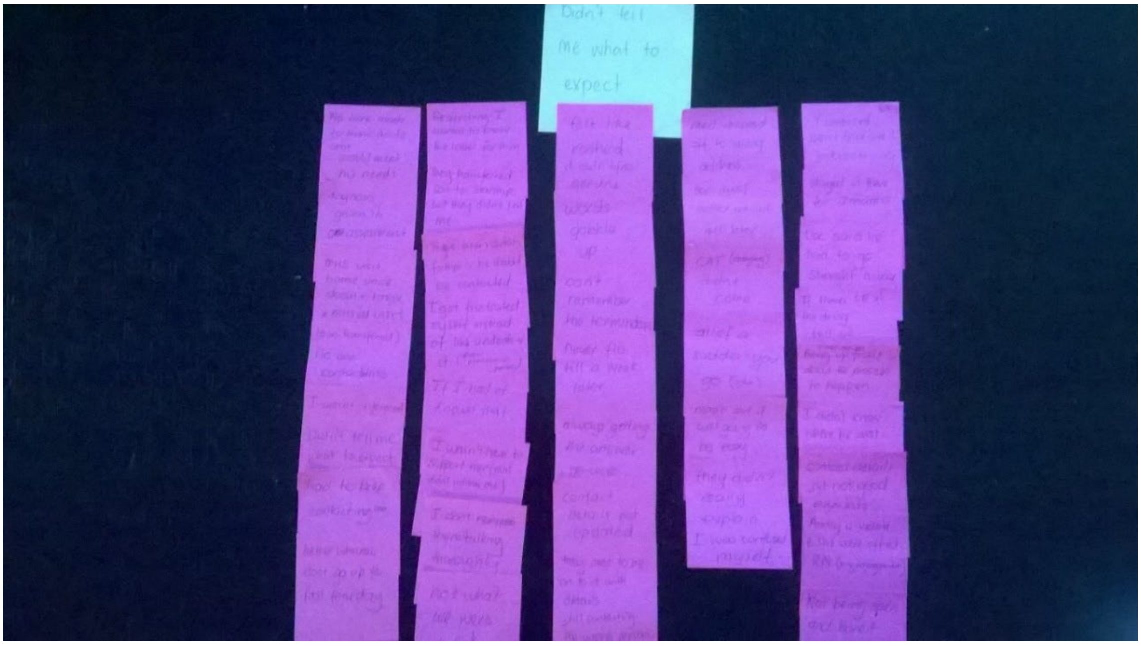
ON THIS DAY:

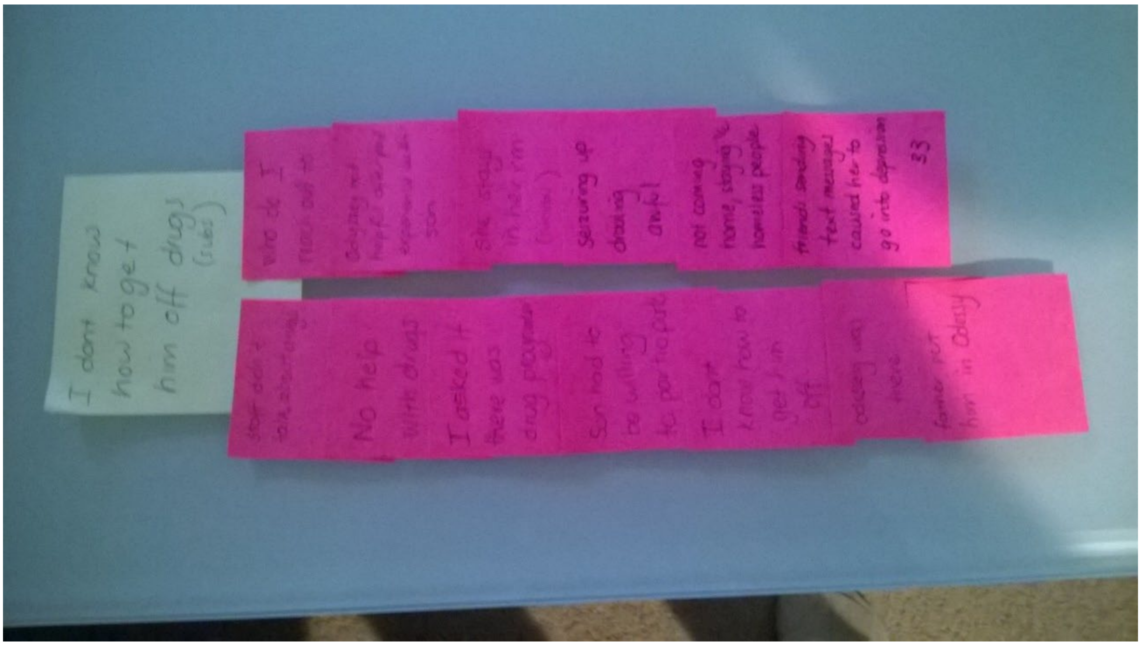
Participant Feedback re the Interview Process

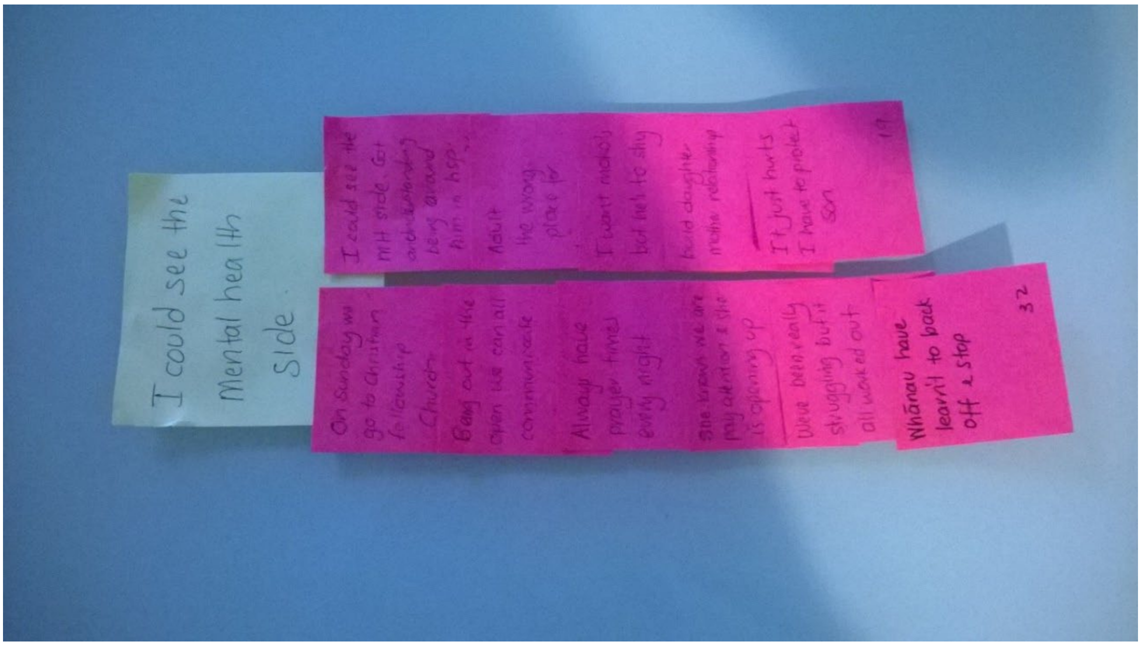
Taiohi
Loved being able to give my whakapapa at the beginning. It's happy days for me. Yes, good seeing someone and talking about everything I thought I forgot.
Yeah, it's been really awesome. I really loved it. The positive I get to talk to you. There's no negative. Thank you.
You asked the questions that need to be asked for Māori. It takes a lot of effort. The way your going is a way of acknowledging us.
Interview OK. Yeah
It's good. Thank you too. Thanks for everything.
Oh, this interview has gone alright. I'll just tell you and I am not scared to tell you anything.
Whānau
It's been supportive … I haven't been able to share this with anyone. For parents who go through what I am going through. Hang in there. I feel really pai. Finally, I can offload. Thank you for coming. Thank you so much because what I went through was a real trial. We can share our info to help others. I'm happy.
Yeah, it's fine. I don't mind.
It was good to get it out. So you can help people in the future.

Appendix P – Photos of Analysis

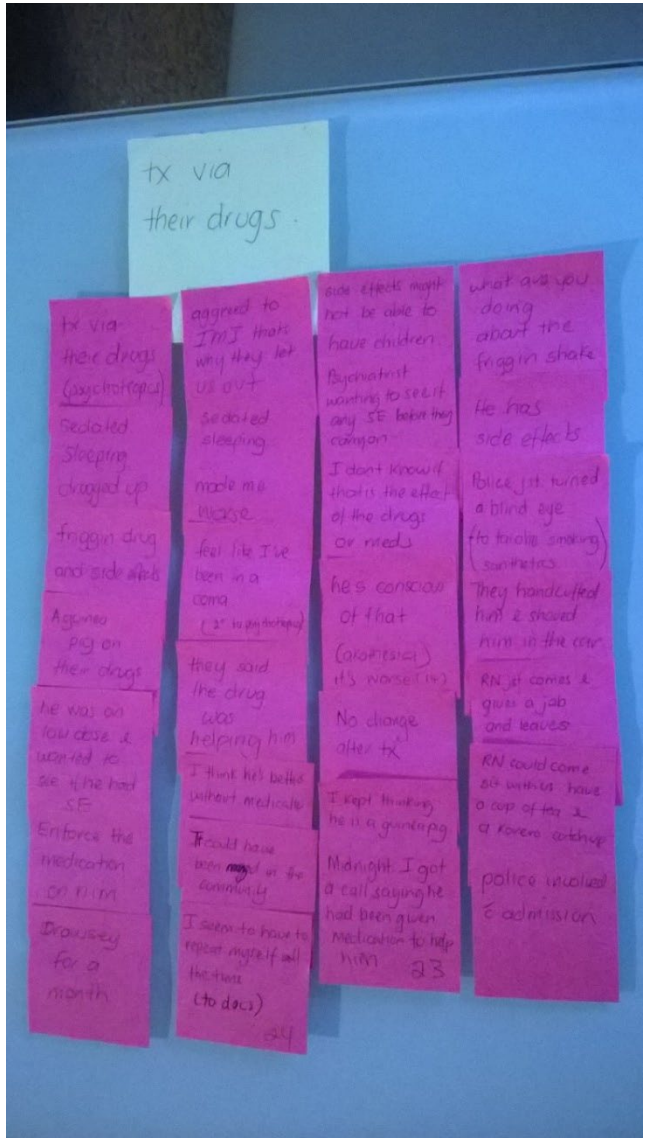


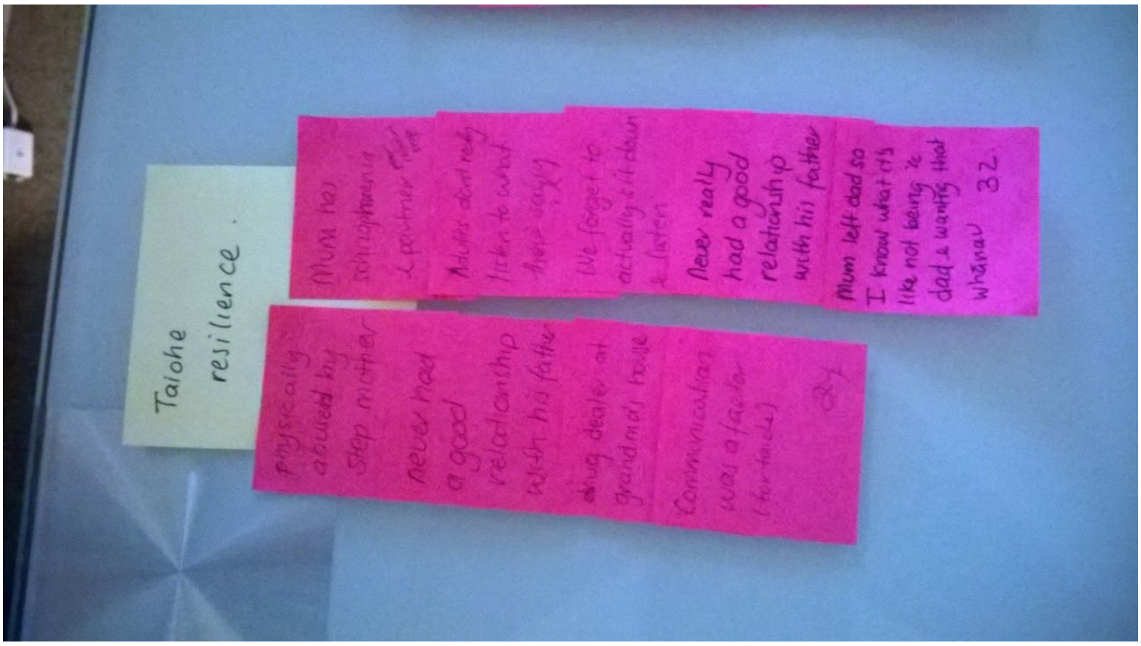

Didn't tell me what to expect

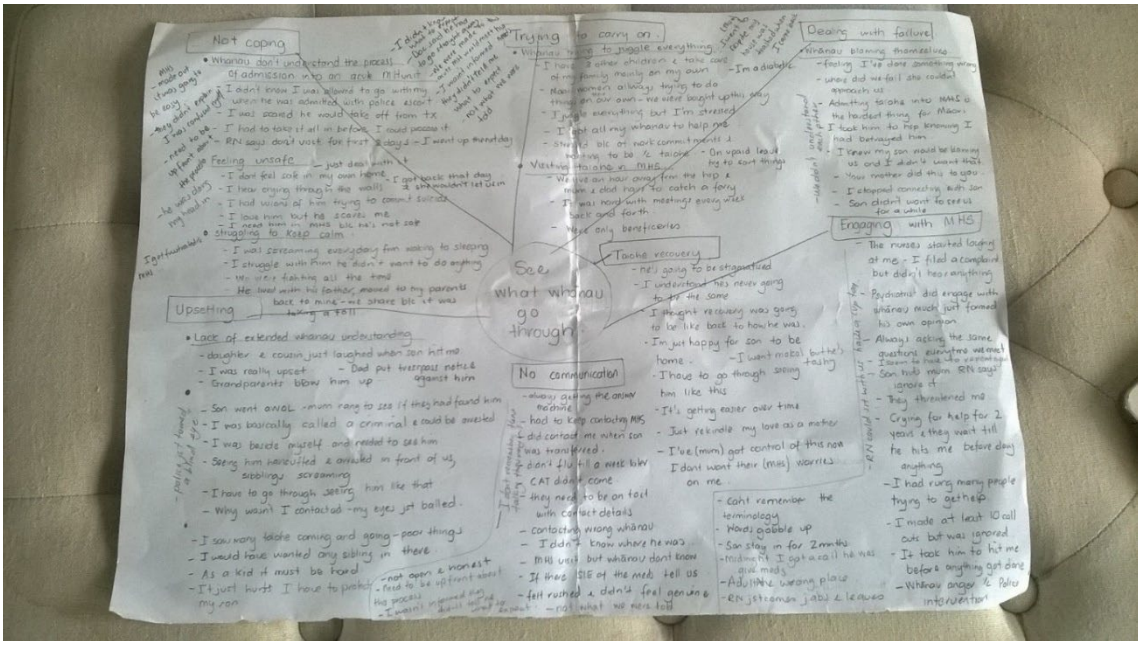

I dont know how to get him off drugs (subs)

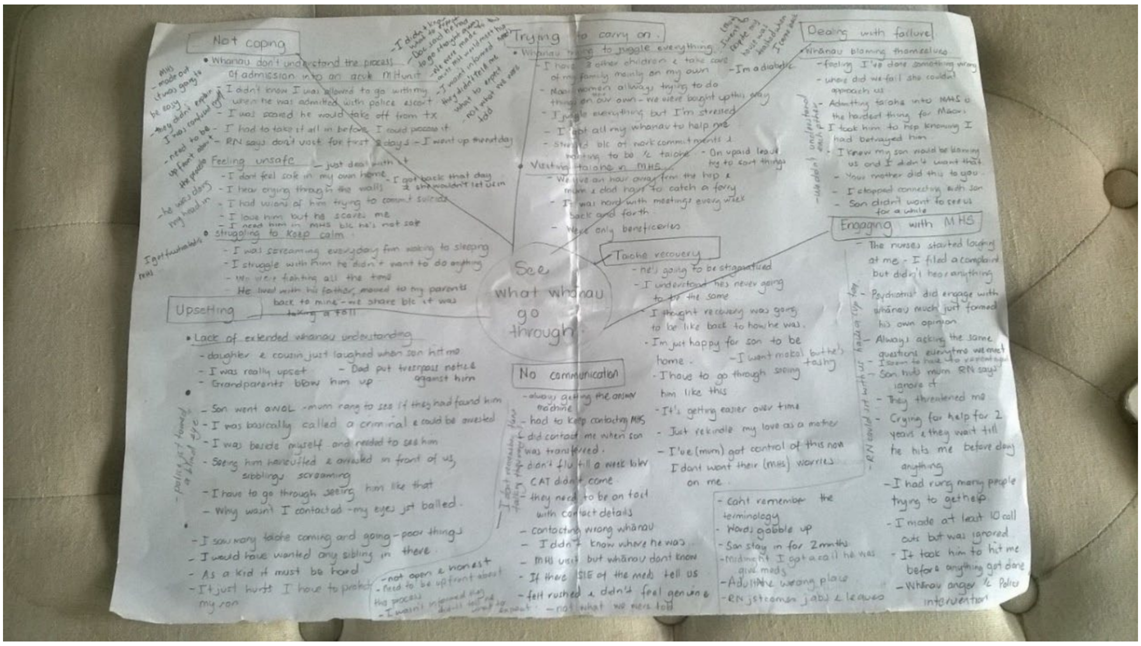

I could see the Mental health side.

Interview process-
A totally different person
Fighting for his freedom


tx via their drugs.
tx via their drugs (oxycontin epi)
Sedated sleeping drugged up
friggin drug and side effects
Agonied pig on their drugs
he was on low dose & wanted to see if he had SE
Enforce the medication on him
Drowsey for a month
aggreed to IMI thats why they let us out
Sedated sleeping
made me loose feel like I've been in a coma
they said the drug was helping him
I think he'll be fine without medication
It could have been managed in the community
I seem to have to repeat myself all the time (to docs)
side effects might not be able to have children
Psychiatrist wanting to see if any SE before they comm on
I don't know if that is the effect of the drugs or meds
he's conscious of that (akinetisia) it's worse (tx)
No change after tx
I kept thinking he is a gunshot pg
Midnight I got a call saying he had been given medication to help him
what are you doing about the friggin shake
he has side effects
Police jst turned a blind eye (to hands shaking sometimes)
They handcuffed him & shoved him in the car
RN jst comes & gives a jab and leaves
RN could come & tell us how to have a cup of tea & a decent catchup
police involved & admission
Mental health services helped.
Nurse good offered coffee have a rest
Being informed made me aware to keep meds under lock & key
I think he has changed since coming out of the unit
We did get a dx someday (informal)
MH A explained by doc(Y) mostly inform me
Y was awesome.
Y & nurses helpful
always kept us informed (uncle)
CFY +ve tx.
Know what to expect made me feel better
being given information
MHS made a plan for transfer pt dx
MHS helped
- getting meds
- seeing what he was going through
Y chaplain I had a go at them (nurses)
Spend time on the ward was good
I feel safe when I hear Kouldkia
Mum: come to see it's well
Maraiu but'd
I feel safe a qualified nurse I have access to
Mum reading mail or magazine
Mum services not offered
I used for a short stay
Mum: would be nice to have them in the ED
No family support
I would like to have some time (more) to myself
Have just got to where I'm at
Mum: reassurance
Physical stimulation
Smoke


Taiohe
resilience.
Mum has schizophrenia
& partner
Adults don't really listen to what their saying
We forget to actually sit down & listen
Never really had a good relationship with his father
Mum left dad so I know what it's like not being ie dad & wanting that whānau
32.
physically abused by step mother
never had a good relationship with his father
drug dealer at grandma's house
Communication was a factor (for taiohe)


Not coping
Trying to carry on
Dealing with failure
Feeling unsafe
Engaging with MHS
See what whānau go through
Upsetting
Taiohe recovery
No communication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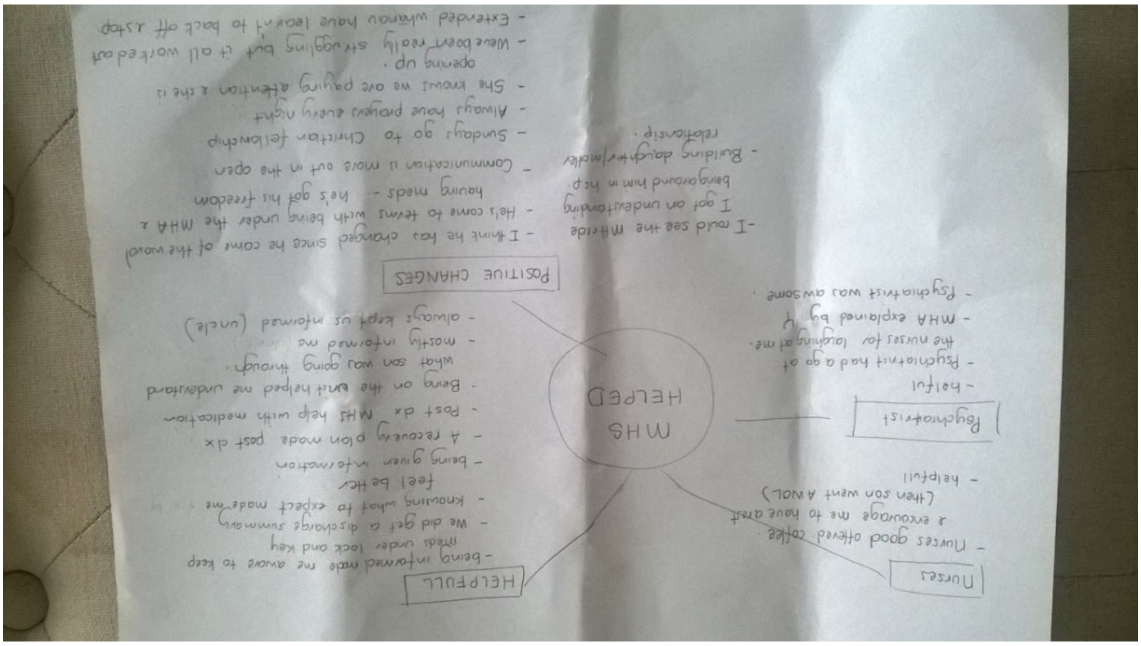
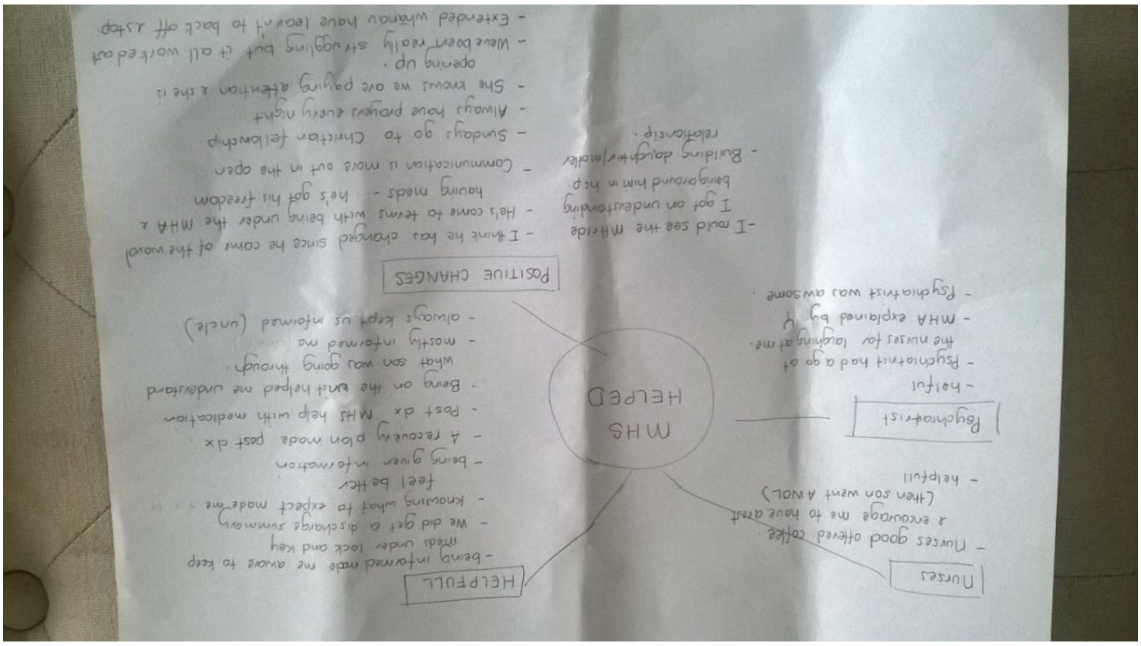
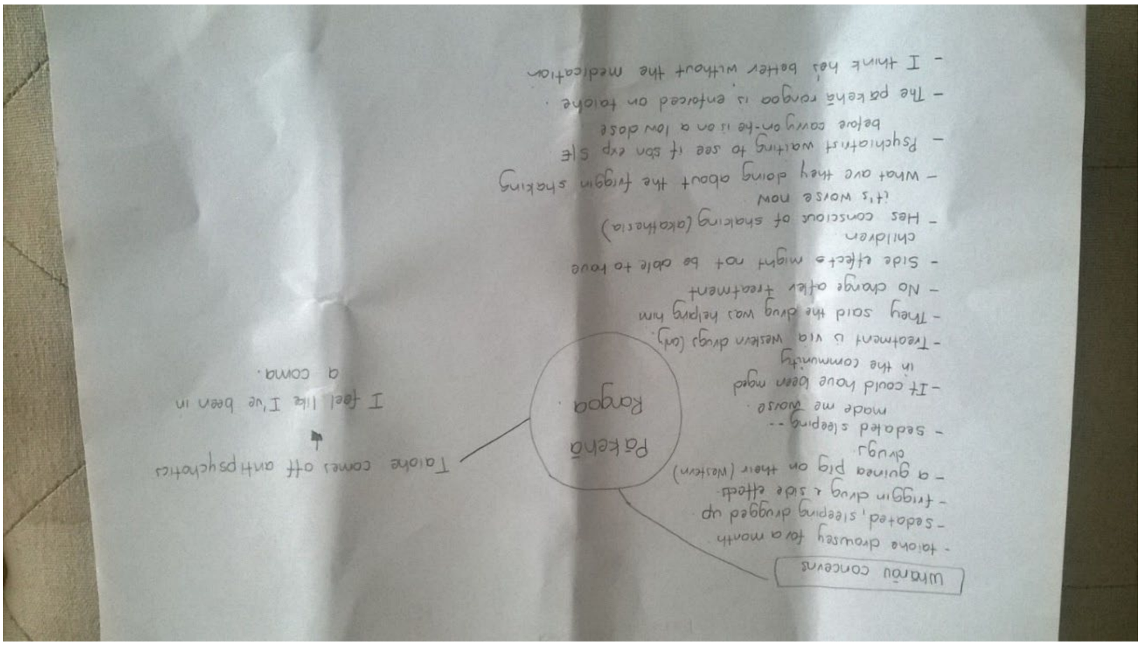
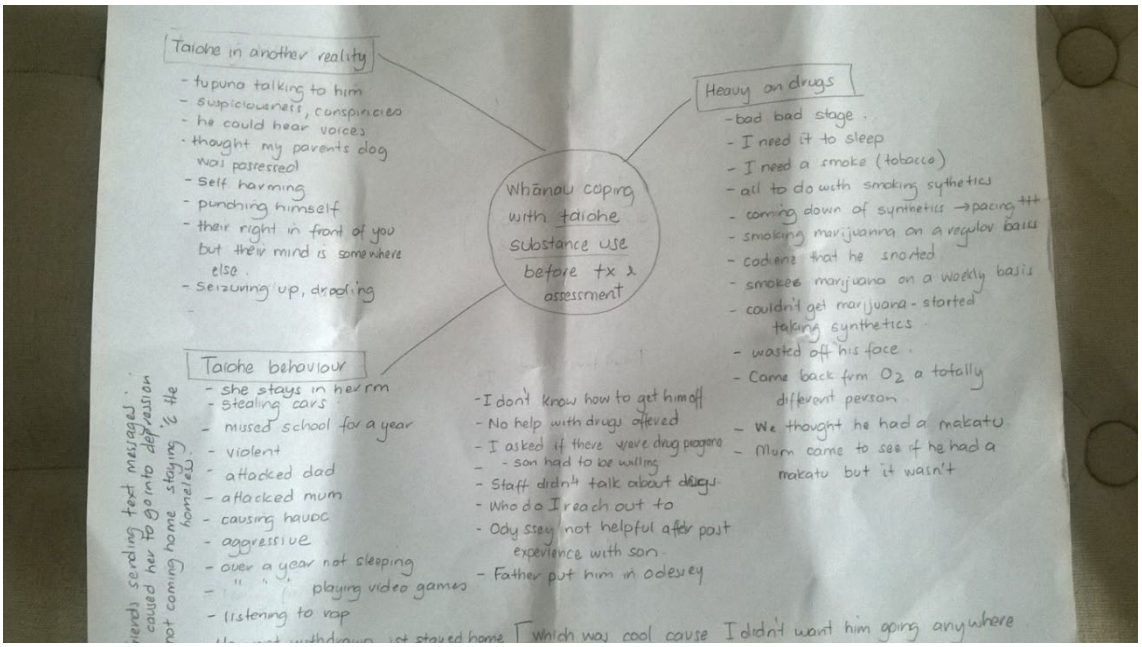
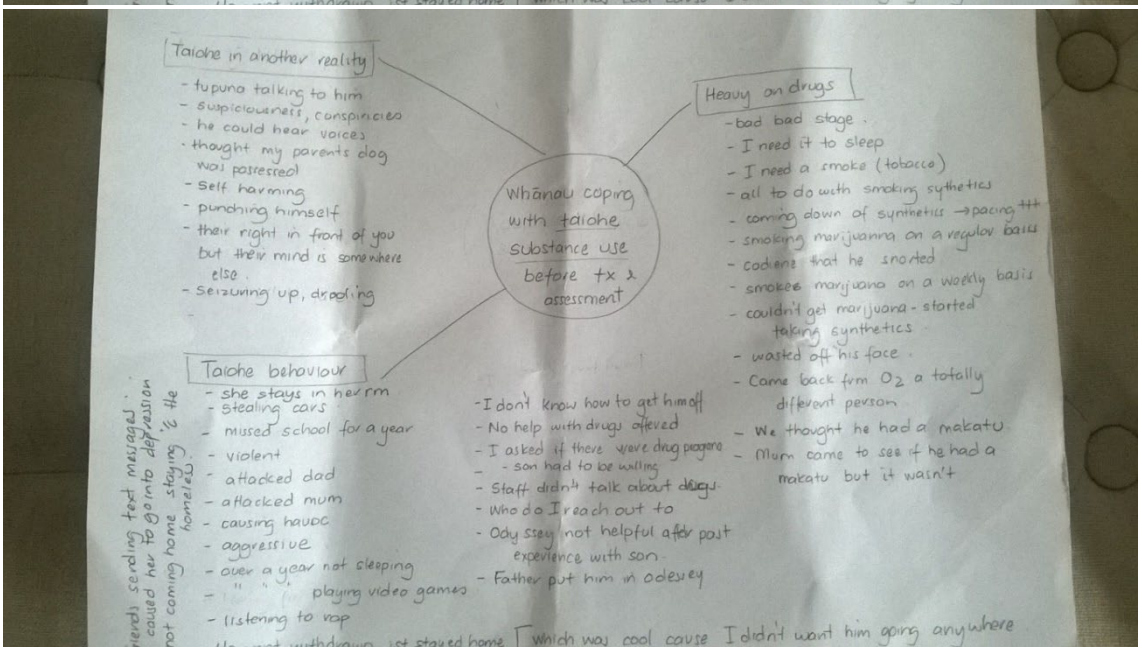

MHS HELPED
Nurses
- Nurses good offered coffee & encourage me to have a rest (then son went AWOL)
- helpfull
Psychiatrist
- helful
- Psychiatrist had a go at the nurses for laughing at me.
- MHA explained by Y
- Psychiatrist was awsome.
HELPFULL
- being informed made me aware to keep meds under lock and key
- We did get a discharge summary
- knowing what to expect made me feel better
- being given information
- A recovery plan made post dx
- Post dx MHS help with medication
- Being on the unit helped me understand what son was going through.
- mostly informed me
- always kept us informed (uncle)
POSITIVE CHANGES
- I think he has changed since he come of the ward
- He's come to terms with being under the MHA & having meds - he's got his freedom
- Communication is more out in the open
- Sundays go to Christian fellowship
- Always have prayers every night
- She knows we are paying attention & she is opening up.
- We've been really struggling but it all worked out
- Extended whānau have learn't to back off & stop
- I could see the Mftride I got an understanding being around him in hsp.
- Building daughter/mother relationship.




Pākehā Rongoa.
Whānau concerns
- taiohe drowsey for a month
- Sedated, sleeping drugged up
- friggin drug & side effects.
- a guinea pig on their (Western) drugs
- sedated sleeping -- made me worse.
- It could have been managed in the community
- Treatment is via western drugs (only).
- They said the drug was helping him
- No change after treatment
- Side effects might not be able to have children
- Hes conscious of shaking (akathesia) it's worse now
- What are they doing about the friggin shaking
- Psychiatrist waiting to see if son exp S/E before carry on - he is on a low dose
- The pākehā rongoa is enforced on taiohe.
- I think he's better without the medication
Taiohe comes off antipsychotics
I feel like I've been in a coma.


Taiohe in another reality
- tupuna talking to him
- suspiciousness, conspiricies
- he could hear voices
- thought my parents dog was possessed
- self harming
- punching himself
- their right in front of you but their mind is somewhere else.
- seizuring up, drooling
Heavy on drugs
-bad bad stage.
- I need it to sleep
- I need a smoke (tobacco)
- all to do with smoking sythetics
- coming down of synthetics → pacing +++
- smoking marijuana on a regular basis
- codeine that he snorted
- smokes marijuana on a weekly basis
- couldn't get marijuana - started taking synthetics
- wasted off his face.
- Came back from O2 a totally different person
- We thought he had a makatu
- Mum came to see if he had a makatu but it wasn't
Whānau coping with taiohe substance use before tx & assessment
Taiohe behaviour
- she stays in her rm
- stealing cars
- missed school for a year
- violent
- attacked dad
- attacked mum
- causing havoc
- aggressive
- over a year not sleeping
- " " playing video games
- listening to rap
-I don't know how to get him off
- No help with drugs offered
- I asked if there were drug programs - son had to be willing
- Staff didn't talk about drugs
- Who do I reach out to
- Ody ssey not helpful after past experience with son
- Father put him in odessey
which was cool cause I didn't want him going anywhere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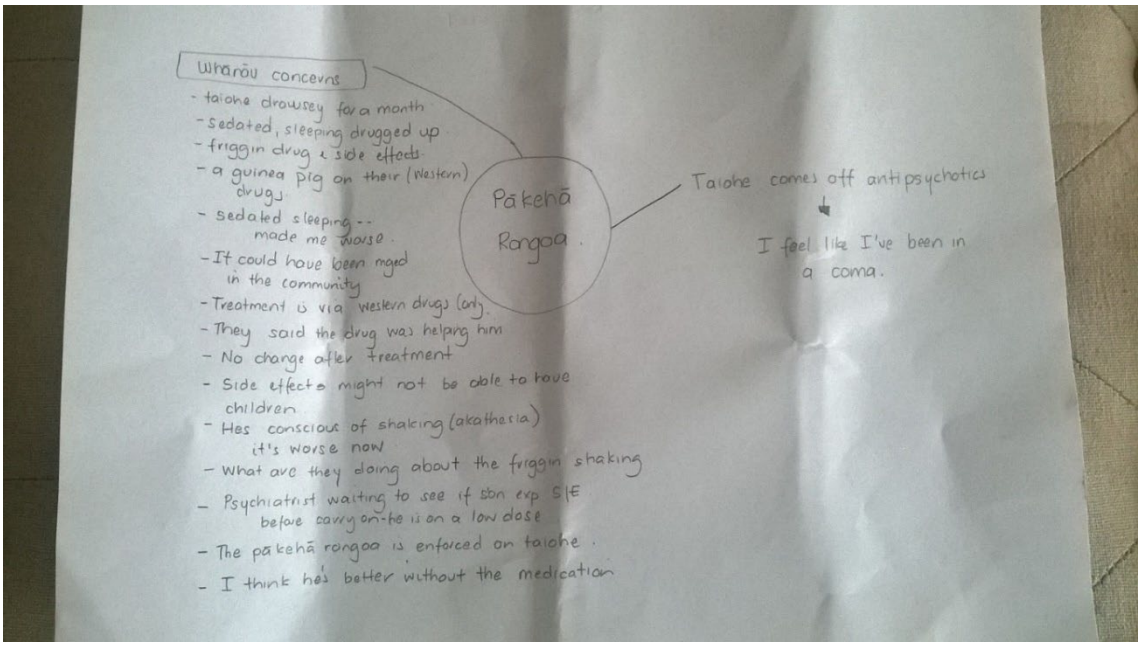
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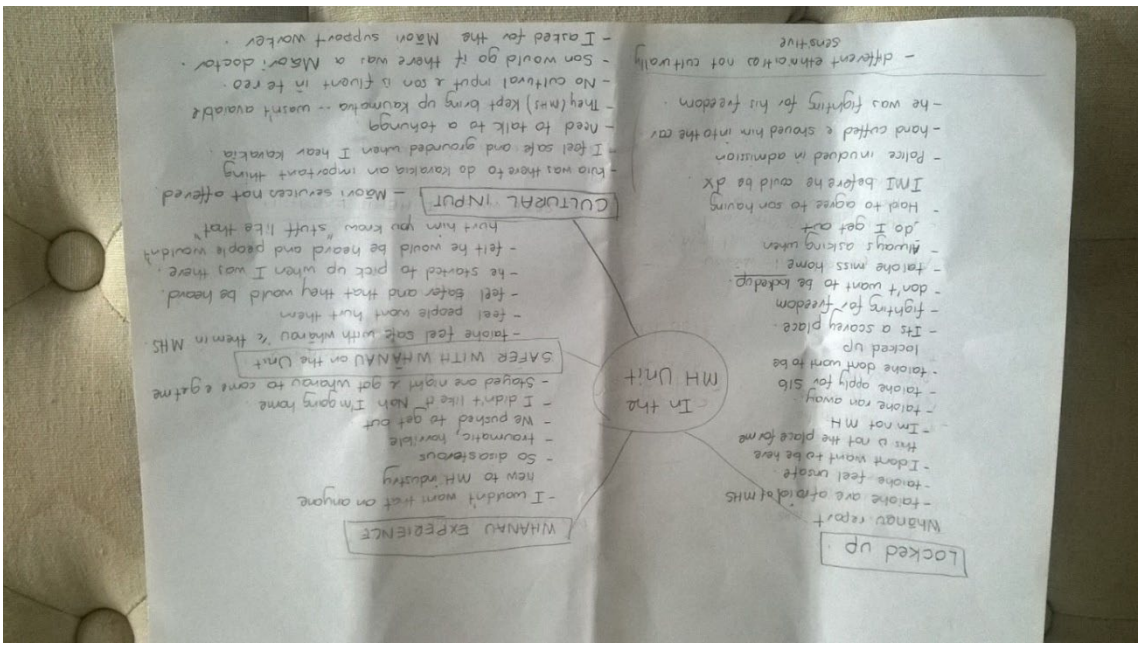
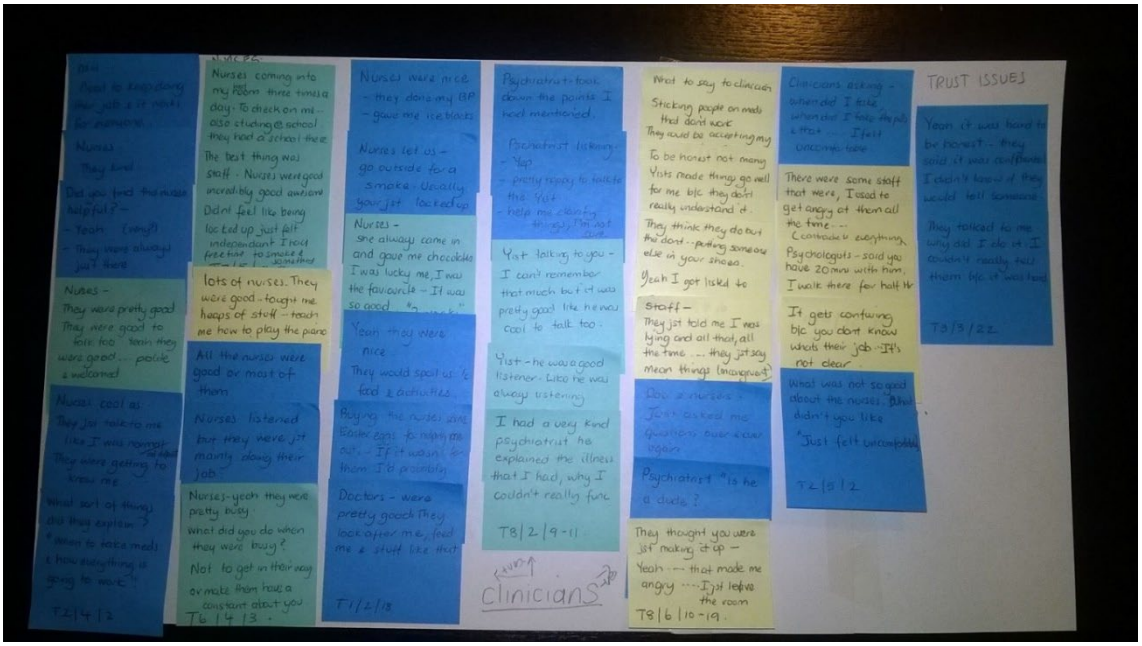

In the MH Unit
Locked up
Whānau report
- told he ove of to told at MHS
- told he feel unsafe
- I don't want to be here
this is not the place for me
- I'm not MH
- told he ran away
- told he oppiy for SIB
- told he don't want to be locked up
- fighting for freedom
- told he miss home
- always asking when do I get out
- Had to agree to 5 on hourly IMI before he could be DX
- Police involved in admission
- hand cuffed & shoved him into the car
- he was fighting for his freedom
- different ethnicity not culturally sensitive
WHANAU EXPERIENCE
- I wouldn't want it on anyone new to MH industry
- So distasteful
- traumatic, horrible
- We pushed to get out
- I didn't like it. Nah I'm going home
- Stayed one night & got whanau to come & get me
SAFER WITH WHANAU on the Unit
- told he feel safe with whanau & them in MHS
- feel people want hurt them
- feel safer and that they would be heard.
- he started to piss up when I was there.
- felt he would be heard and people wouldn't hurt him cos you know "stuff like that"
CULTURAL INPUT
- Māori services not offered
- Kuia was there to do karakia on important thing
- I feel safe and grounded when I hear karakia
- Need to talk to a tohunga
- They (MHS) kept bring up kaumatua -- wasn't available
- No cultural input & son is fluent in te reo.
- Son would go if there was a Māori doctor.
- I asked for the Māori support worker.


Nurses coming into my room three times a day: to check on me -- also studying @ school they had a school there
The best thing was staff - Nurses were good incredibly good awesome
Didn't feel like being locked up just felt independant I was free has to smoke & [illegible]
Nurses were nice - they done my BP - gave me ice blocks
Nurses let us - go outside for a smoke - Usually your just locked up
Nurses - she always came in and gave me chocolate I was lucky me, I was the favourite - If was so good
Psychiatrist - took down the points I had mentioned
Psychiatrist listening - Yep - pretty happy to talk to this Visit - help me clear my things, I'm just
Visit talking to you - I can't remember that much but it was pretty good like he was cool to talk too
Visit - he was a good listener - Like he was always listening
I had a very kind psychiatrist he explained the illness that I had, why I couldn't really func
T8|2|9-11
Clinicians
What to say to clinician
Sticking people on meds that don't work
They would be accepting my
To be honest not many Visits made things go well for me b/c they don't really understand it.
They think they do but they don't - putting someone else in your shoes.
Yeah I got asked to
Staff - They just told me I was lying and all that, all the time ... they just say mean things (unexpect
Doc + nurses - Just asked me questions over & over again
Psychiatrist - is he a dude?
They thought you were just making it up - Yeah ... that made me angry ... I just leave the room
T8|6|10-19.
Clinicians asking - when did I take ... when did I take the pills & that ... I felt uncomfortable
There were some staff that were, I used to get angry at them all the time ... Controlled everything
Psychologists - said you have 20 mins with him. I walk there for half hr
It gets confusing b/c you don't know whats their job - It's not clear
What was not so good about the nurses - Blood didn't you like "Just felt uncomfortable
T2|8|2
TRUST ISSUES
Yeah it was hard to be honest - they said it was confidential I didn't know if they would tell someone
They talked to me why did I do it & I couldn't really tell them b/c it was too
T8|3|22
Nurses - They were pretty good They were good to talk too Yeah they were good ... polite & welcomed
Nurses - cool as - They just talk to me like I was normal They were getting to know me
What sort of things did they explain - ? when to take meds? & how everything is going to work?
T2|4|2
lots of nurses. They were good - taught me heaps of stuff - teach me how to play the piano
All the nurses were good or most of them
Nurses listened but they were just mainly doing their job
Nurses - yeah they were pretty busy What did you do when they were busy? Not to get in their way or make them have a constant about you
T6|4|13.
Buying the nurses stuff Bribe eggs to play me pool - If it wasn't for them I'd probably
Doctors - were pretty good They look after me, feed me & stuff like that
T1|2|13
Did you find the nurses helpful? - Yeah (very!) - They were always just there
Nurses - They were pretty good They were good to talk too Yeah they were good ... polite & welcomed
Nurses - cool as - They just talk to me like I was normal They were getting to know me
What sort of things did they explain - ? when to take meds? & how everything is going to work?
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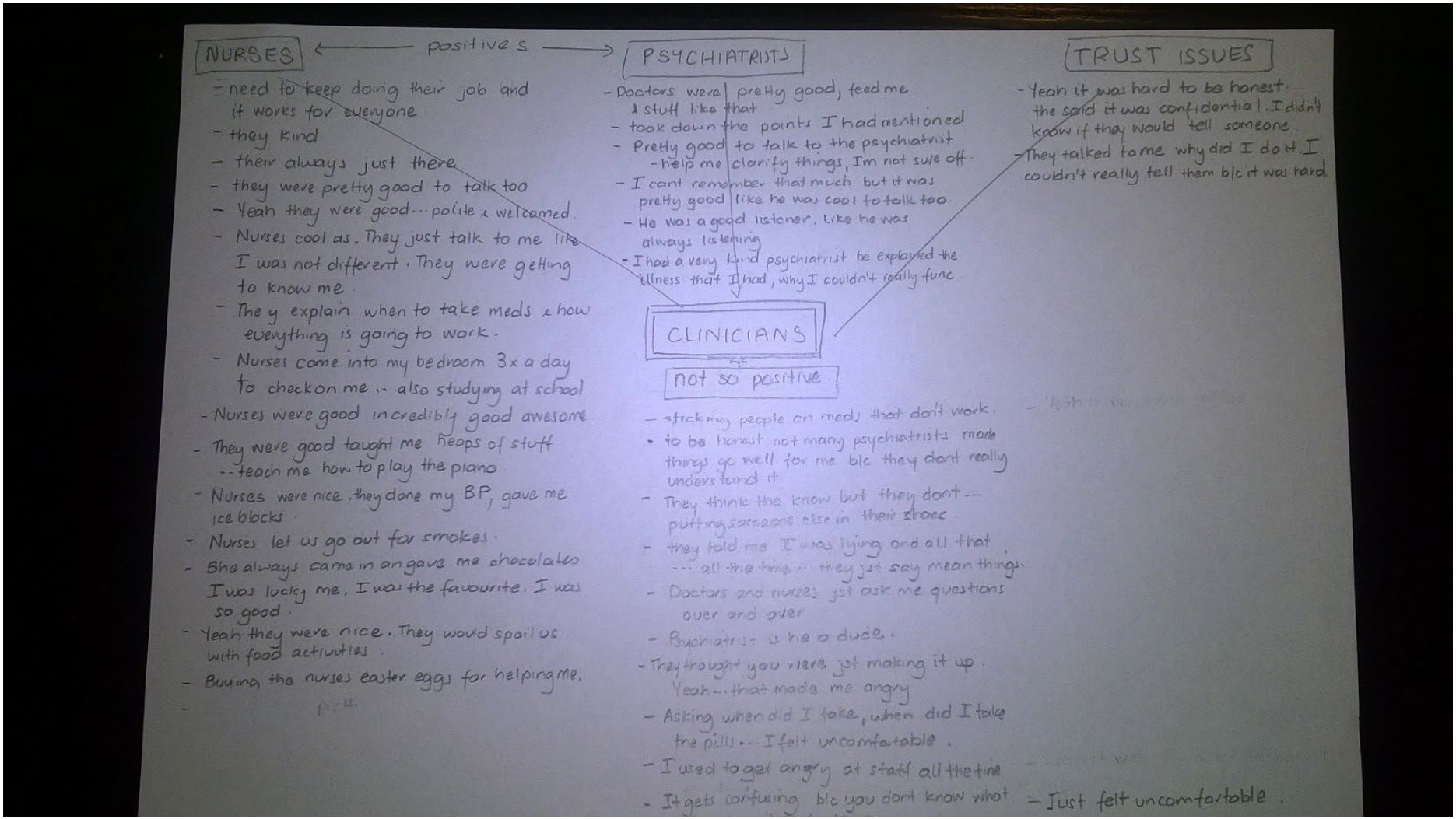
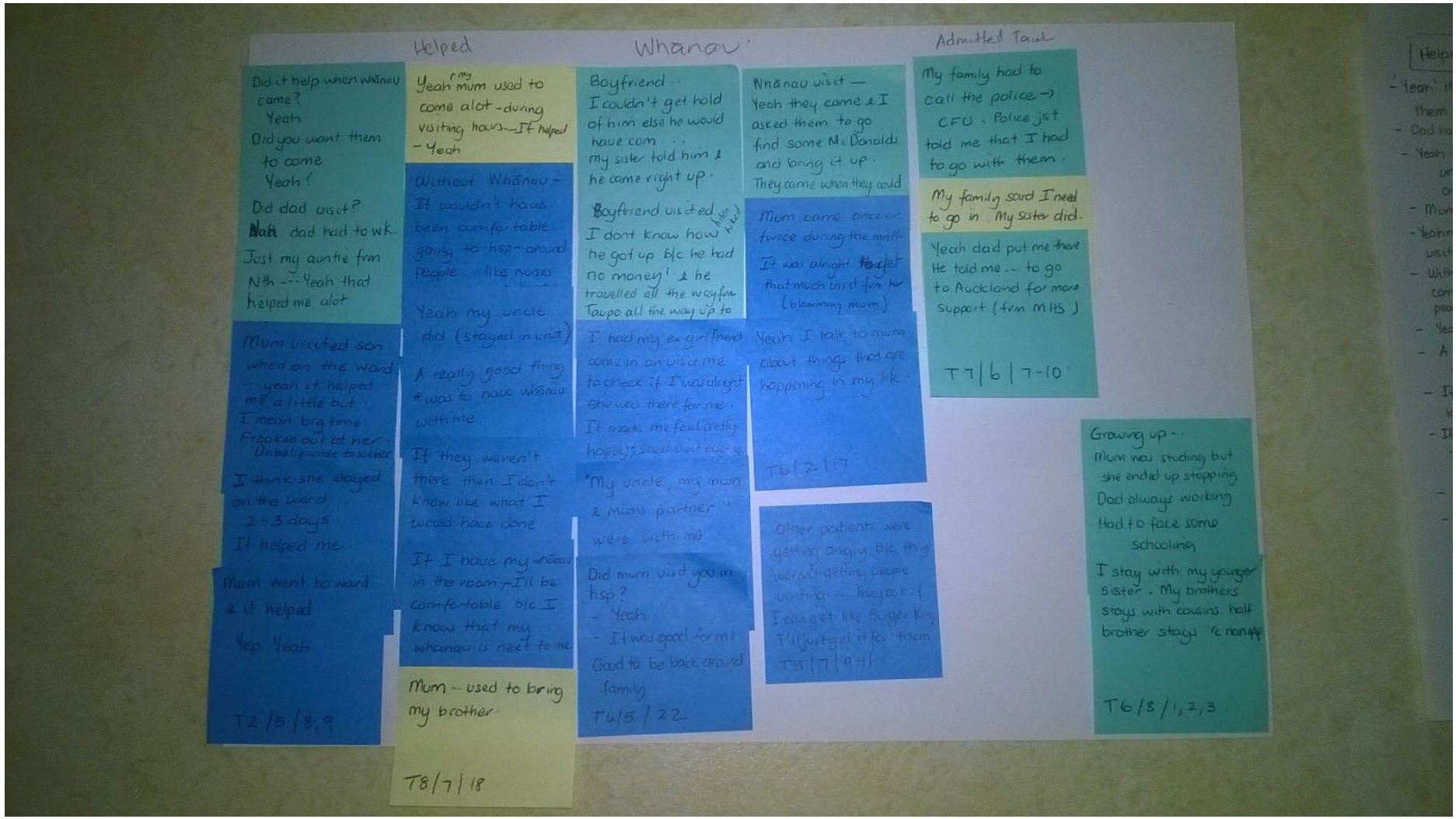
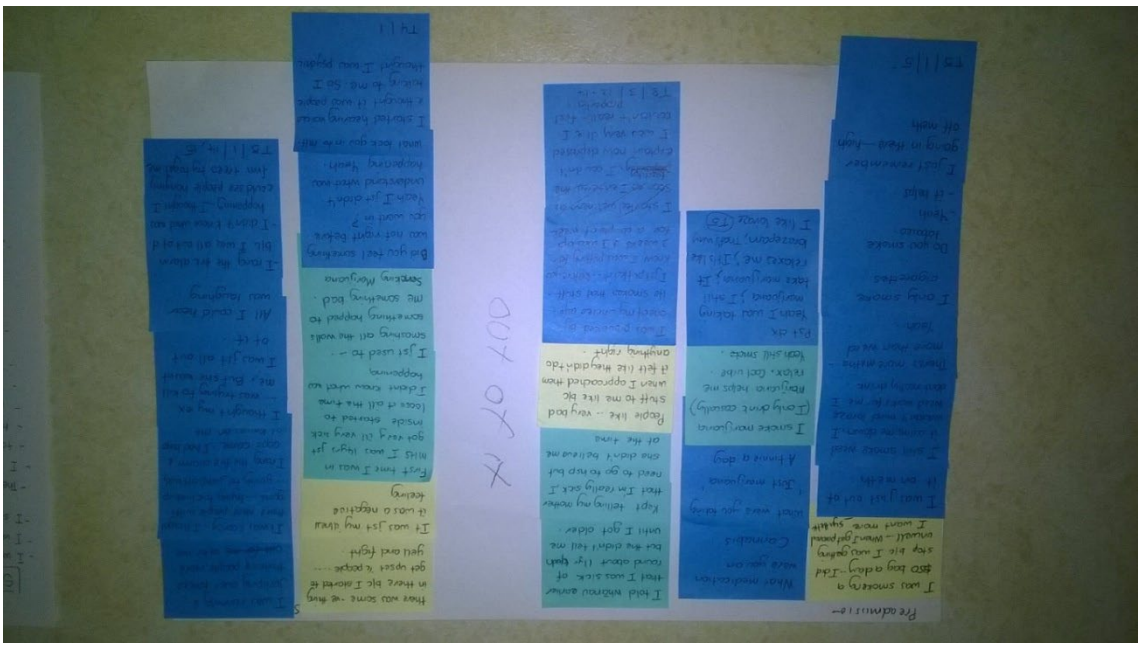
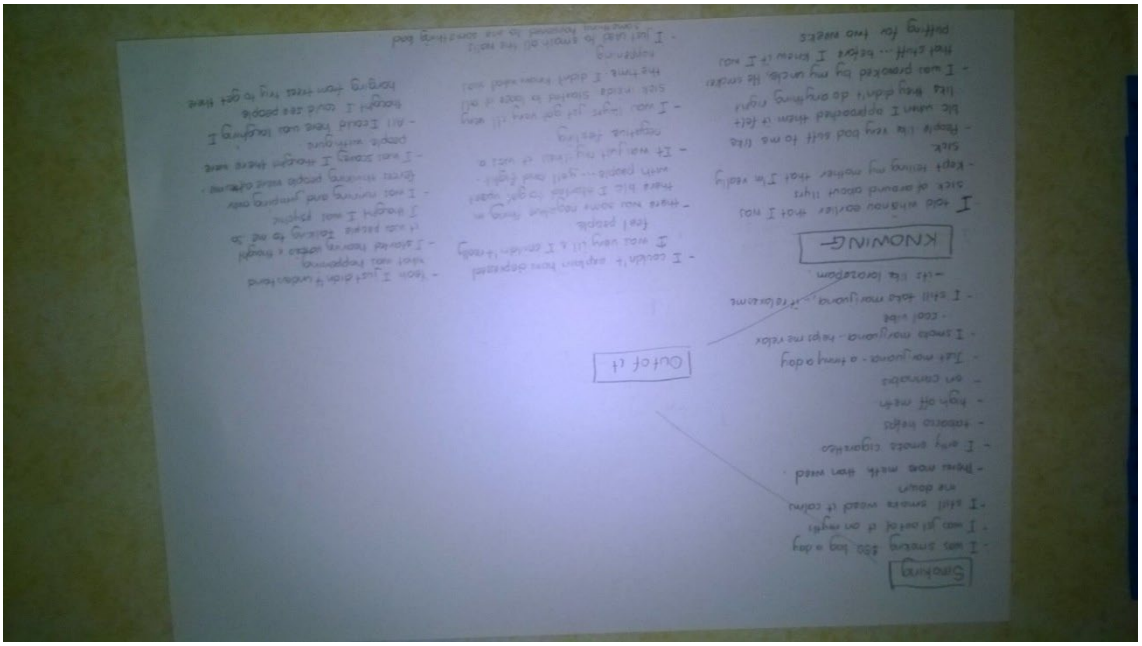
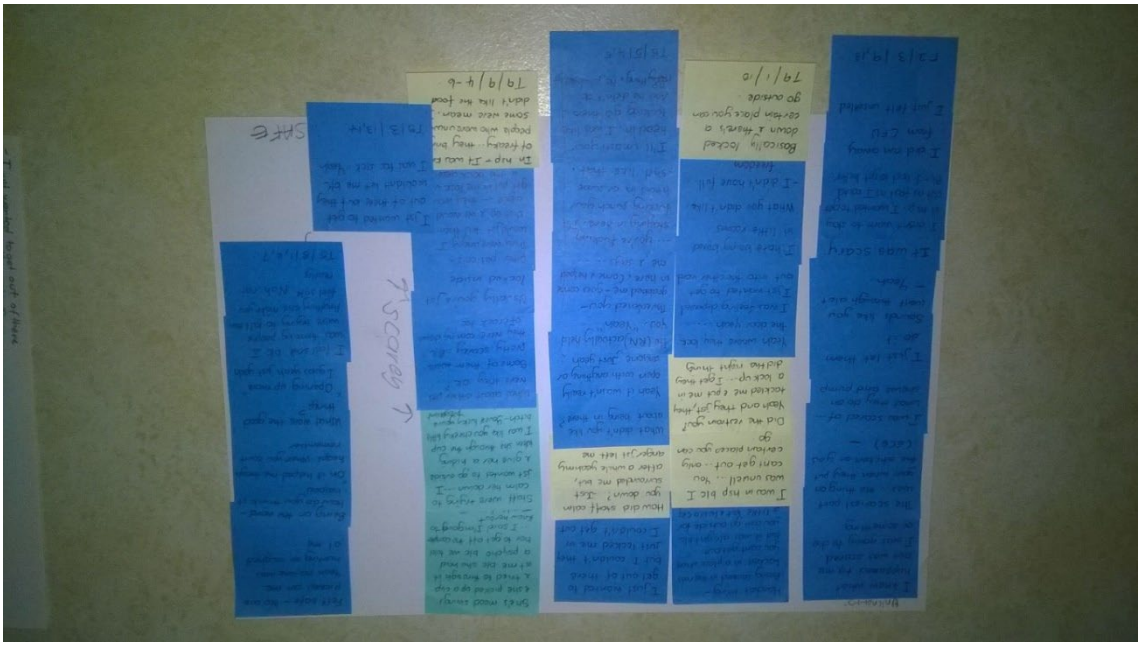
T2|4|2

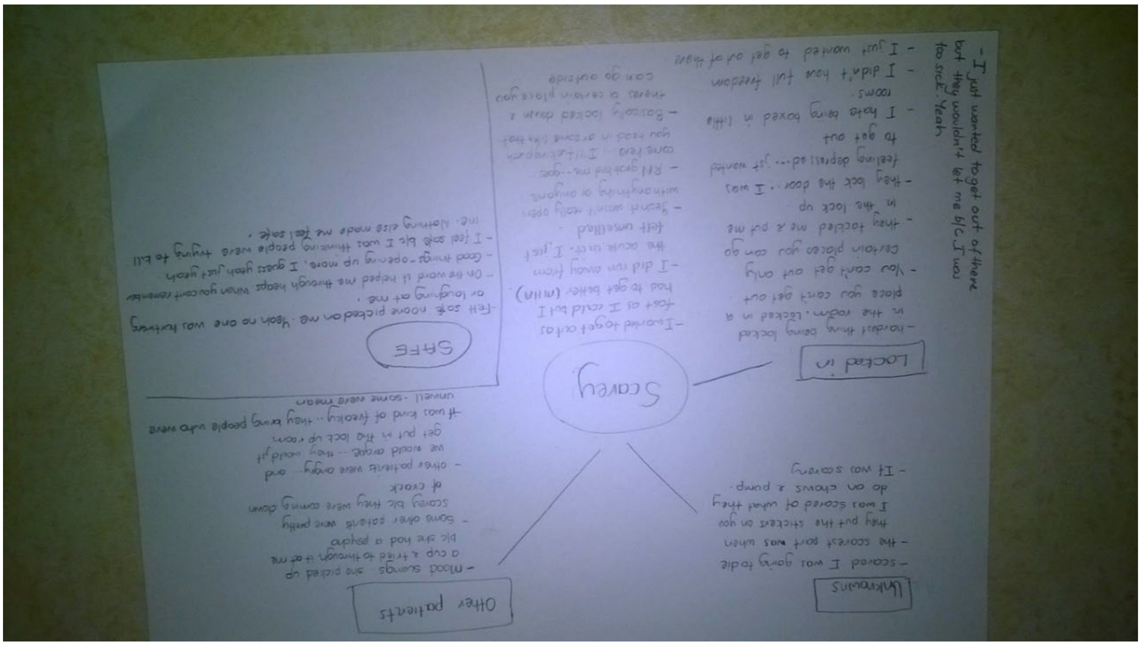

NURSES
positives
PSYCHIATRISTS
TRUST ISSUES
- need to keep doing their job and it works for everyone
- they kind
- their always just there
- they were pretty good to talk too
- Yeah they were good... polite & welcomed.
- Nurses cool as. They just talk to me like I was not different. They were getting to know me.
- They explain when to take meds & how everything is going to work.
- Nurses come into my bedroom 3x a day to check on me :- also studying at school
- Nurses were good incredibly good awesome
- They were good taught me heaps of stuff --teach me how to play the piano
- Nurses were nice, they done my BP, gave me ice blocks.
- Nurses let us go out for smokes.
- She always came in an gave me chocolates I was lucky me, I was the favourite, I was so good.
- Yeah they were nice. They would spoil us with food activities.
- Buying the nurses easter eggs for helping me.
- Doctors were pretty good, feed me & stuff like that
- took down the points I had mentioned
- Pretty good to talk to the psychiatrist - help me clarify things, I'm not sure off.
- I cant remember that much but it was pretty good like he was cool to talk too.
- He was a good listener. Like he was always listening
- I had a very kind psychiatrist he explained the illness that I had, why I couldn't really func
CLINICIANS
not so positive
- Yeah it was hard to be honest... the said it was confidential. I didn't know if they would tell someone.
- They talked to me why did I do it. I couldn't really tell them b/c it was hard.
- striking people on meds that don't work.
- to be honest not many psychiatrists made things go well for me b/c they dont really understand it
- They think the know but they dont... putting someone else in their shoes.
- they told me I was lying and all that ... all the time ... they just say mean things.
- Doctors and nurses just ask me questions over and over
- Psychiatrist is he a dude.
- They thought you were just making it up. Yeah... that made me angry
- Asking when did I take, when did I take the pills... I felt uncomfotable.
- I used to get angry at staff all the time
- It gets confusing b/c you dont know what
- Just felt uncomfortable.


Helped
Whanau
Admitted Task
Did it help when whānau came?
Yeah
Did you want them to come
Yeah!
Did dad visit?
Nah dad had to wk.
Just my auntie from Nth --- Yeah that helped me alot
Yeah my mum used to come alot - during visiting hours --- It helped
- Yeah
Without Whānau - It wouldn't have been comfortable going to hosp - around people -- like nurses
Yeah my uncle did (stayed in unit)
A really good thing was to have whānau with me
If they weren't there then I don't know like what I would have done
If I have my whānau in the room - I'll be comfortable b/c I know that my whanau is next to me
Mum -- used to bring my brother.
T8/7/18
Boyfriend -- I couldn't get hold of him else he would have com -- my sister told him & he came right up.
Boyfriend visited
I dont know how he got up b/c he had no money! & he travelled all the way from Taupo all the way up to
I had my ex girlfriend come in an visit me to check if I was alright She was there for me. It made me feel pretty happy; she'd visit every
"My uncle, my mum & mums partner" were with me
Did mum visit you in hosp?
- Yeah
- It was good for me
Good to be back around family
T4/5/22.
Whānau visit —
Yeah they came & I asked them to go find some McDonalds and bring it up.
They came when they could
Mum came once or twice during the math
It was alright to get that much visit from her (blaming mum)
Yeah I talk to mum about things that are happening in my life
T6/2/17
Other patients were getting angry b/c they weren't getting people visiting -- They took it I could get like Burger King I'll just get it for them
T3/7/9-11
My family had to call the police -> CFU. Police just told me that I had to go with them.
My family said I need to go in. My sister did.
Yeah dad put me there He told me -- to go to Auckland for more support (from MHS)
T7/6/7-10
Growing up -- Mum was studing but she ended up stopping Dad always working Had to face some schooling
I stay with my younger sister. My brothers stays with cousins half brother stays w/ nanny
T6/8/1,2,3
Mum visited son when on the ward -- yeah it helped me a little bit. I mean big time Freaked out at her. Unbelievable together
I think she stayed on the ward 2-3 days
It helped me
Mum went to ward & it helped
Yep Yeah
T2/9/8,9

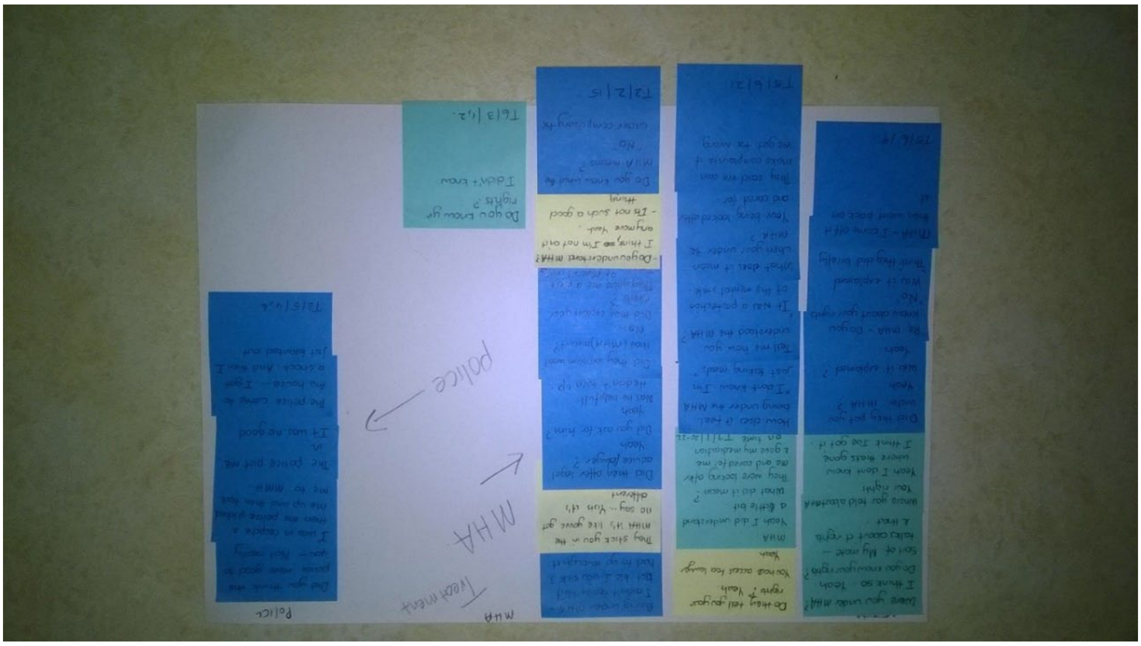




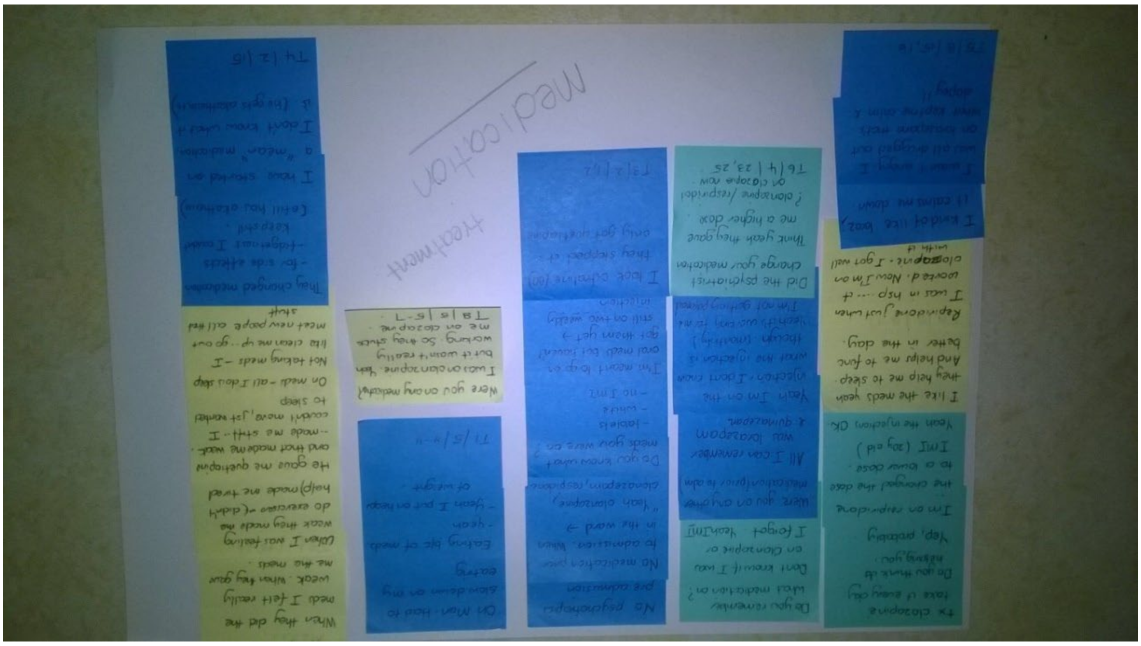




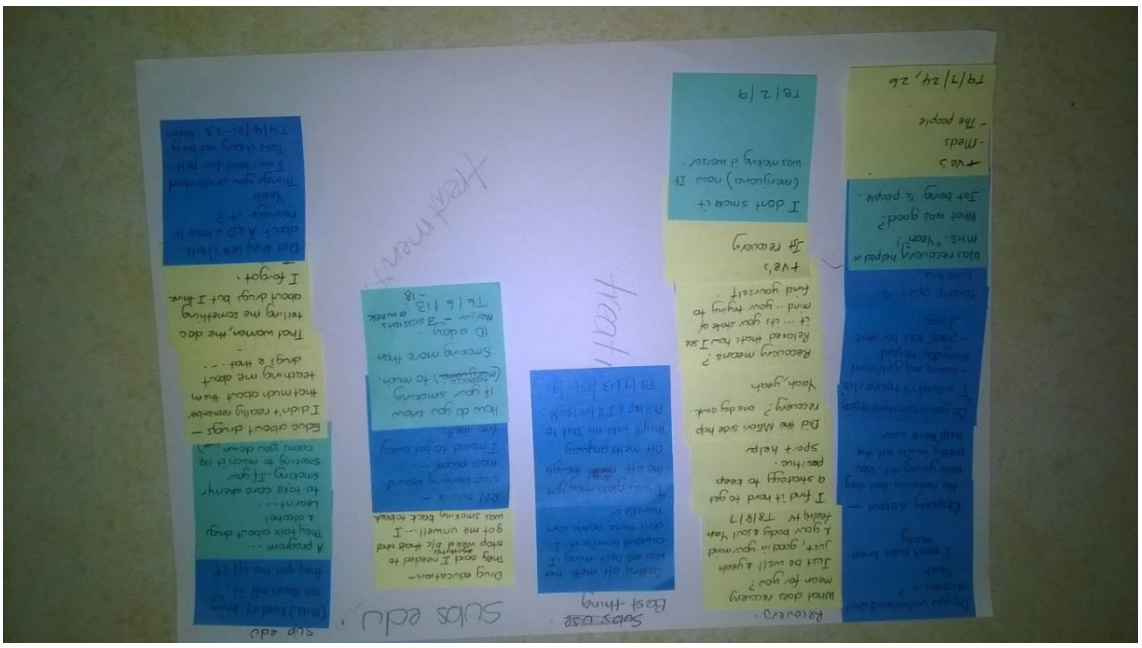
Scarey
Locked in
SAFE
Unknowns
Other patients

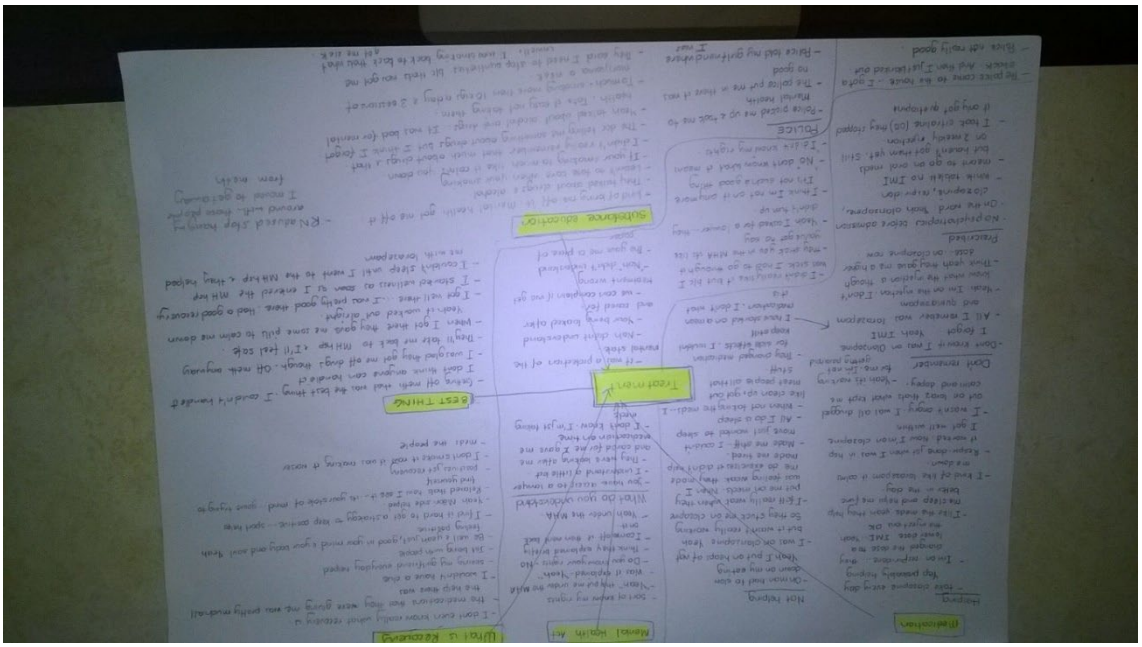


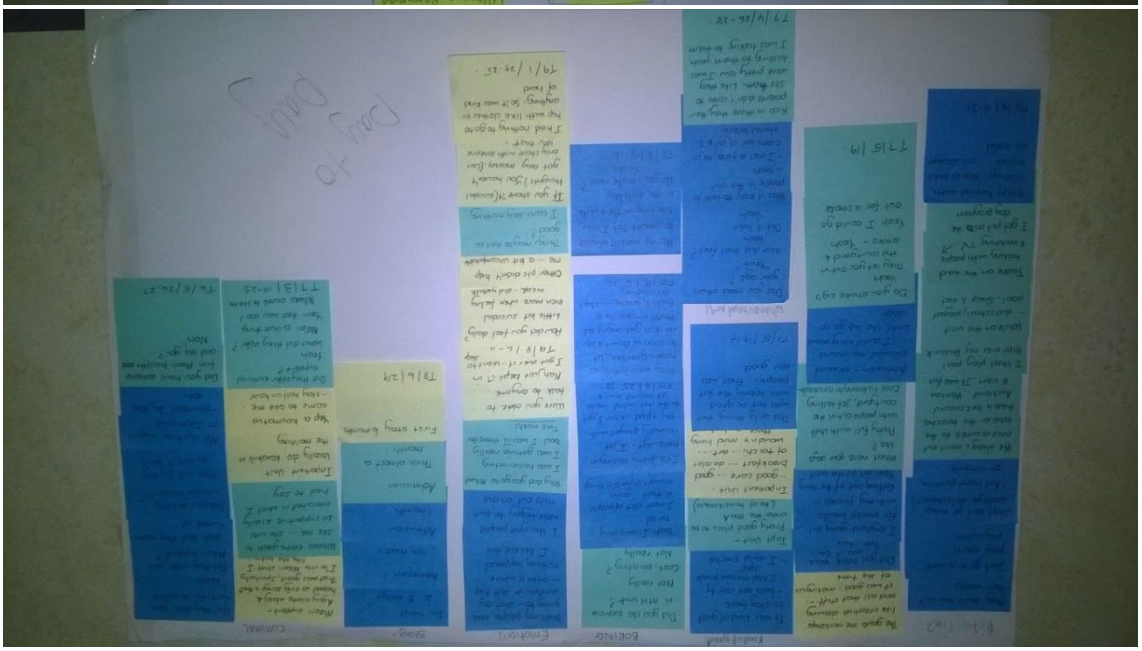
MHA
Treatment
police
Police

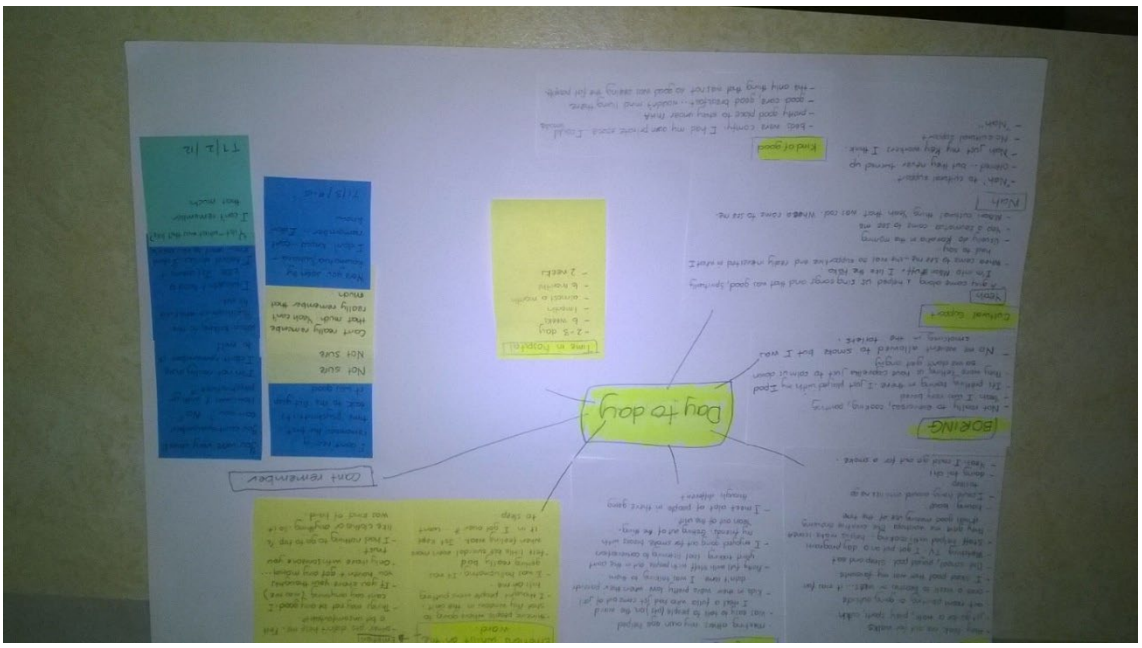


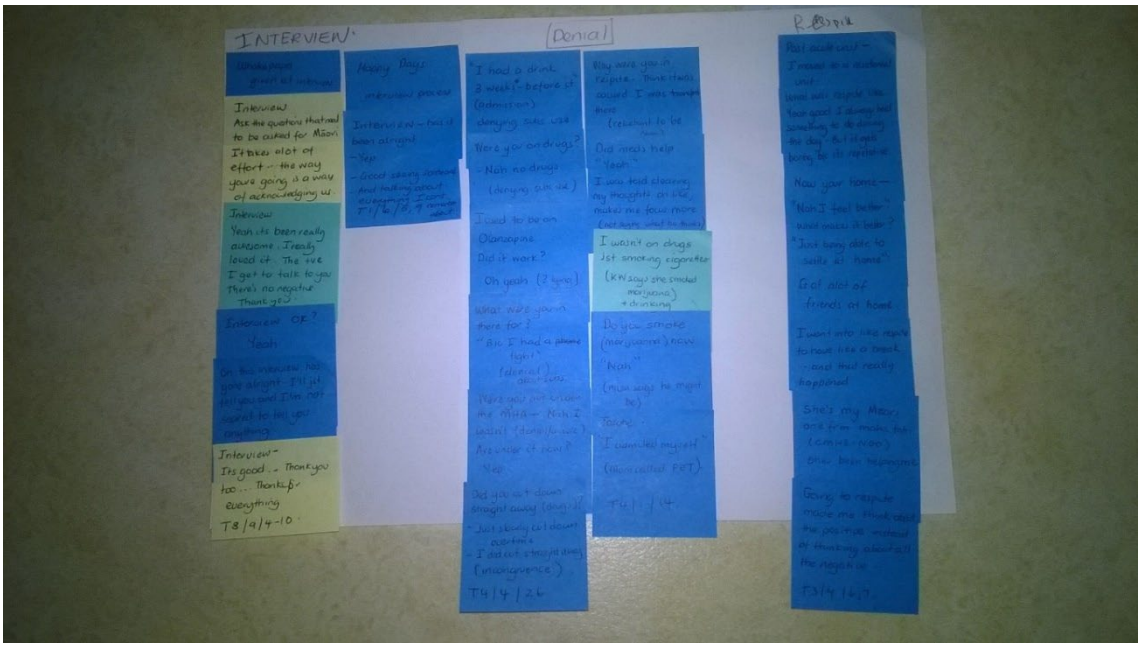
medication
treatment

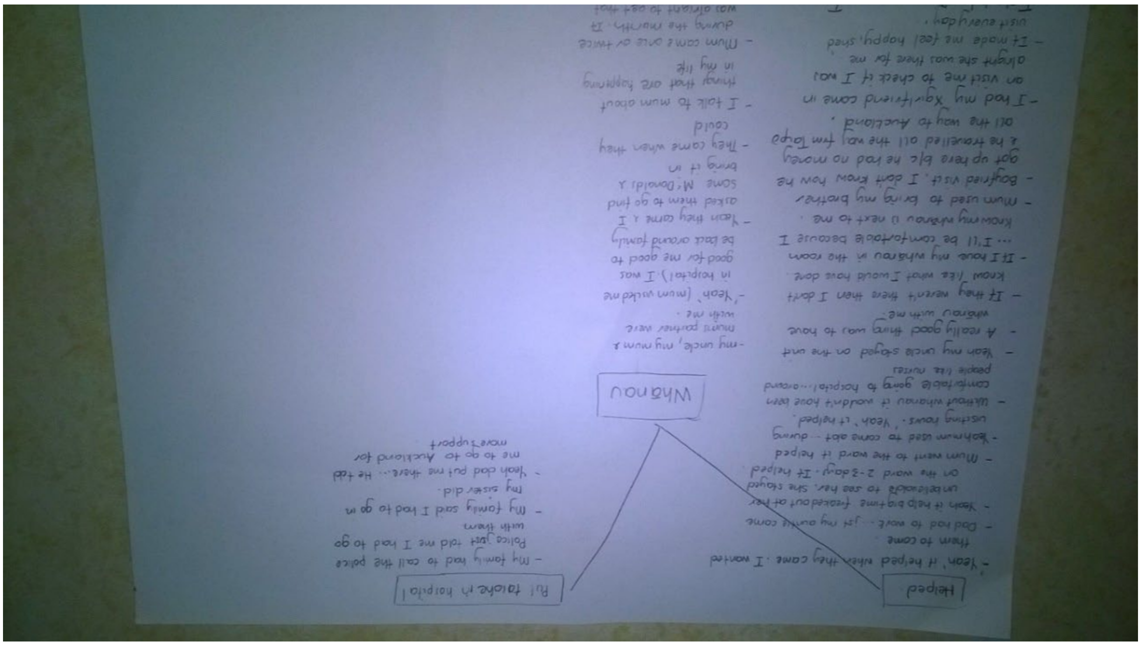


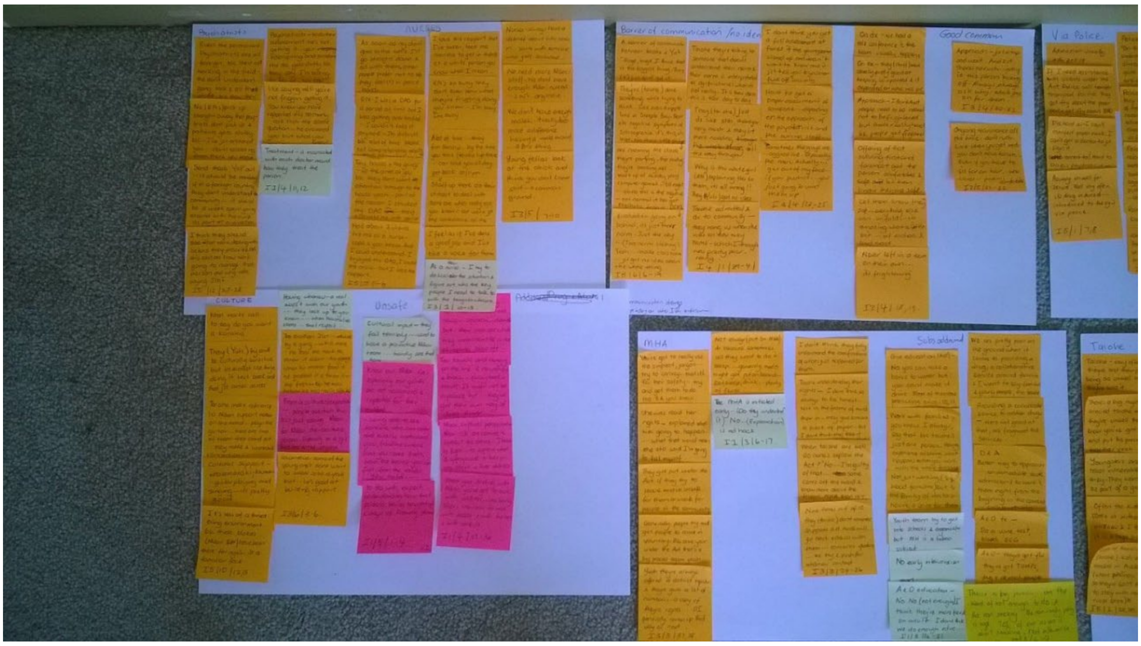





Don't remember
Not sure
Not sure
Boring
Kind of good


INTERVIEW
Denial
Nearly Days
Interview
Ask the question that need to be asked for Māori
It takes alot of effort - the way you're going is a way of acknowledging us.
Interview
Yeah its been really awesome. I really loved it. The we I get to talk to you there's no negative Thankyou
Interview OK?
Yeah
So the interview has gone alright. I'll let you and I'm not allowed to tell you anything
Interview -
Its good. - Thankyou too... Thankyou everything
T8/9/4-10
Interview - first it went alright
- Yep
- Good seeing Jordan And talking about everything. I love T/6/8/9 things
I had a drink 2 weeks before it (Admission)
denying substance use
Were you on drugs?
Nah no drugs
(denying substance use)
I used to be on Olanzapine
Did it work?
Oh yeah (2 times)
What were you in there for?
"Ah I had a mental breakdown" - Nah I wasn't (denying substance use)
Are you in it now?
Yep
Did you sit down straight away (drug)?
- Just slowly sit down and relax
- I do sit a little bit (drug) (unintelligence)
T4/4/24
Why were you in respite - Think I was scared I was trapped there
(resistant to be here)
Did meds help
Yeah
I was told clearing my thoughts on bike makes me focus more
I wasn't on drugs just smoking cigarettes
(KW says she smoked marijuana)
+ drinking
Do you smoke (marijuana) now
Nah
(Must still be high)
Future
I cancelled my appt
(Also called FET)
T4/4/24
Relapse
Post suicide call - I missed out on a residential unit
Some will relate this to a post I always had something to do during the day - But it gets boring to sit inside
Now your home -
"Nah I feel better"
What makes it better?
"Just being able to settle at home"
Lot of alot of friends at home
I went into this room to have like a think - and that really happened
She's my Mauri one from - makes me Learn - Mauri - Ora - Wairua - Hinengaro
Going to respite made me think about the positive instead of thinking about all the negative
T3/4/24


Helped
- 'Yeah' it helped when they came. I wanted them to come.
- Dad had to work... just my aunty come.
- Yeah it help big time. freaked out at her unbelievable to see her. She stayed on the ward 2-3 days. It helped.
- Mum went to the ward it helped
- Yeah mum used to come alot... during visiting hours. 'Yeah' it helped.
- Without whānau it wouldn't have been comfortable going to hospital... around people like nurses
- Yeah my uncle stayed on the unit
- A really good thing was to have whānau with me.
- If they weren't there then I don't know like what I would have done.
- If I have my whānau in the room ... I'll be comfortable because I know my whānau is next to me.
- Mum used to bring my brother
- Boyfriend visit. I don't know how he got up here b/c he had no money & he travelled all the way frm Taupo all the way to Auckland.
- I had my Xgirlfriend come in an visit me to check if I was alright she was there for me
- It made me feel happy, she'd visit every day.
Whānau
Put taiohe in hospital
- My family had to call the police Police just told me I had to go with them.
- My family said I had to go in my sister did.
- Yeah dad put me there... He told me to go to Auckland for more support
- my uncle, my mum & mum's partner were with me.
- 'Yeah' (mum visited me in hospital) I was good for me good to be back around family
- Yeah they came & I asked them to go find some McDonalds & bring it in
- They came when they could
- I talk to mum about things that are happening in my life
- Mum came once or twice during the month. It was alright to get that


Culture
Whakamā
MHA
Subsidiary
Taiohe
Barrier of communication
Good Connections
Via Police

Appendix Q – Drop-in Counselling Service

AUT

Memorandum

To	Debra Gerrard
From	Stella McFarlane
Cc	
Subject	Counselling for research participants
Date	18th December 2015

Dear Debra

As manager of AUT Health Counselling and Wellbeing, I would like to confirm that we are able to offer confidential counselling support for the participants in your AUT research project entitled:

"The experiences of taiohe and their whānau when taiohe enter acute mental health services under the influence of alcohol and/or drugs (taiohe are young Māori between the ages 16y to 24y)

The free counselling, for participants who require it, will be provided by our professional counsellors for a maximum of three sessions and must be in relation to issues arising from their participation in your research project.

Please inform your participants:

- They will need to drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment
- They will need to let the receptionist know that they are a research participant
- They will need to provide your contact details to confirm this
- They can find out more information about our counsellors and counselling on our website http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing

Current AUT students also have access to our counsellors and online counselling as part of our normal service delivery.

Yours sincerely

Stella McFarlane

Manager

Stella McFarlane
Practice manager, Health, Counselling and Wellbeing
stella.mcfarlane@aut.ac.nz