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Tawhiti: An Indigenous Trauma-Informed Harm Reduction Approach to Alcohol and Other Drug Use

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Abstract

Standard harm reduction approaches to alcohol and other drug harms do not adequately meet Indigenous needs or preferences for reducing risks or improving quality of life. In this article we identify and discuss important components of an Indigenous-centred harm reduction approach to alcohol and other drug-use concerns that are evident in the literature. Four critical components of an Indigenous approach to harm reduction are:

1) *Whakapapa*: Substance use harm reduction must consider the history and relationships between culture and community-specific harms, particularly colonisation and intergenerational trauma;
2) *Huanui oranga:* Incorporating the strengths, preferences, and strategies of Indigenous communities must be included to accurately and effectively respond to substance related harms;
3) *Mauri ora, Whānau ora* and *Wai ora*: Harm reduction efforts must seek to increase quality of life as defined by Indigenous communities; and
4) *Ngā take pū o te tangata:* Harm reduction must be guided by the values and principles of Indigenous peoples.

This article describes an Indigenous, trauma-informed harm reduction approach, Pae Tata Pae Tawhiti that incorporates a well-known Māori model of health, Te Whare Tapa Whā to centre Māori concepts of wellbeing. We include an overview of intergenerational trauma and introduce TAWHITI, a set of Indigenous trauma-informed harm reduction principles for Māori. Finally, describing a workforce development model that supports the application and future evaluation of the Pae Tata Pae Tawhiti framework.

Keywords: Addictions, mental health, drug harm reduction, Māori, Indigenous trauma-informed, substance use.

Harm Reduction: Developing an Indigenous Perspective

Harm reduction approaches acknowledge that some people continue to engage in high-risk behaviour despite the occurrence of ongoing harm. As high-risk behaviours continue, harm reduction approaches emphasise reducing adverse consequences related to health, social, and economic outcomes rather than focusing on abstaining or eliminating alcohol or drug consumption (Collins et al., 2012). Harm reduction is typically used in drug and alcohol use settings and increasingly in working with eating disorders, self-harm, domestic violence, and sexual health (Cliffe et al., 2021; Hawk et al., 2017).

Standard Western harm reduction approaches work in conjunction with abstinence-based goals as part of a continuum or staged approach to intervention. Harm reduction is focused on improving quality of life, and to reduce the burden on healthcare and justice systems. Typical methods are supply and demand reduction approaches, education, and early intervention and treatment (Collins et al., 2022; van der Sterren et al., 2006). Harm reduction approaches are used at the individual level (e.g., needle exchange to reduce the occurrence of blood-borne viruses from needle sharing), community level (e.g., reducing gaming or alcohol outlets in a community), population level (e.g., media campaigns focused on reducing drink driving or tobacco smoking; and host responsibility initiatives) and law or policy initiatives (e.g., decriminalising cannabis use) (Collins et al., 2012; Collins et al., 2022; Stockings et al., 2018).

Individual, community, and population level approaches have different priorities and expectations that can affect the best possible outcome for clients. For example, strategies that focus on abstinence, banning, or stopping a behaviour may lead to unintended consequences to the individual and society. Impacts of poorly thought-out harm reduction strategies can result in criminalisation, inequitable law enforcement experiences, withdrawal related harms, and disconnection from treatment agencies and support services (Collins et al., 2022). Importantly, abstinence-based goals that focus on addressing a specific behaviour, rather than understanding the systemic or contextual issues that increase or decrease treatment engagement or maintenance, can be as harmful as the behaviour of concern. At a population level, issues of racism, discrimination and socio-economic disadvantage are known determinants of health inequity, particularly in Indigenous and ethnic minority communities (Amaro et al., 2021; Goldstein et al. 2022).

Compared to abstinence-based approaches, harm reduction is a helpful and responsive approach for those groups who experience structural inequalities, and ongoing harm and exclusion from the dominant culture's social, economic, or political privileges (Collins et al., 2022). Harm reduction, however, has been criticised as a top-down approach (public policy and population based), that lacks consideration of the needs, preferences, and voices of those affected and their communities (Collins et al., 2012; Friedman et al., 2007). Harm reduction at individual and community levels has been described as a compassionate and pragmatic approach. A pragmatic approach to harm reduction focuses on real-world, practical steps to reducing harm for people and communities (Collins et al., 2012; Collins et al., 2022). Guiding principles include pragmatism, humane values, a focus on harms, balancing costs and benefits, and prioritising immediate goals (Interagency Coalition on AIDS and Development, (ICAD) 2019; Riley et al., 1999).

Hawk et al. (2017) proposed universal harm-reduction principles applicable across conditions in healthcare settings: humanism (i.e., value, care for, respect, and dignity for family); pragmatism (focusing on what is achievable); individualism (individuals have unique needs); autonomy (individuals make their own decisions); incrementalism (taking small incremental steps towards wellbeing); and accountability without termination (individuals are not excluded for failing to achieve providers' goals). On the surface, the pragmatic approach appears helpful; however, the focus on harm reduction is guided by principles held by the practitioner and their organisation, rather than the individual or their collective. By embedding a focus on cultural values and practices in harm reduction approaches, alternative worldviews of wellbeing can emerge (Goldstein et al., 2022).

A particular concern with interventions for drug-related harm is the tendency for practitioners to use models that are reductionistic, focussing on the individual outside of their relationship with family or their community. van der Sterren and colleagues (2006) explored Indigenous people's experiences of harm reduction and noted that discussions focused more on harms related to emotional and spiritual wellbeing and lifestyle over physical harms. Strategies that focus on isolated health behaviours without also addressing the impact of systemic issues related to colonisation, interpersonal and structural racism, intergenerational trauma, poverty, homelessness, or other determinants of ill health, are seen as having limited long-term benefit (ICAD, 2019; Lavalley et al., 2020; Pihama et al., 2020). Underpinning systemic issues is the embedded, racially constructed traditions of a Western, White settler-colonial state that determines how drug-related harm should be reduced, and that prioritises some strategies, and some people, over others.

The impact of colonisation on the proliferation of alcohol in Indigenous communities and the context in which alcohol related harms flourish is well documented (Goldstein et al., 2022). Dzidowska et al. (2020) argued that disparities in alcohol use and alcohol-related harms between Indigenous peoples and the general population is the result of colonisation, intergenerational trauma, and the introduction of mass-produced alcohol. Understanding these drivers of inequities is a necessary precursor to developing solutions that are grounded in the realities of Indigenous communities.

Indigenous models of harm reduction are founded upon Indigenous learning methods, relational models, and models of wellbeing. Notably, with Indigenous communities, harm must be addressed at the intersection between an individual, their choices, their history, and their community (Dell et al., 2010; ICAD, 2019). Without understanding the individual, community and cultural preferences for engagement, and paths to wellbeing, harm reduction strategies are unlikely to be effective (Lavalley et al., 2020; Marsh et al., 2021). Harm reduction approaches that share power with Indigenous worldviews and practices enable a shift from individualistic and monocultural public health interventions that are grounded in dominant society worldviews towards participatory, equity-focused solutions (Hughes et al., 2022). Indigenous harm reduction strategies that connect treatment approaches to culture, land, community, and spiritual practices offer a culturally transformative pathway to healing (Marsh et al., 2021). The following section introduces Pae Tata Pae Tawhiti: An Indigenous framework for brief and early intervention followed by a description of intergenerational trauma and its relationship to alcohol and other drug use, and the pursuit of wellbeing.

Pae Tata Pae Tawhiti: An Indigenous Framework for Brief and Early Intervention

The Pae Tata Pae Tawhiti framework comprises two acronyms, Tata and Tawhiti. The terms Pae Tata, Pae Tawhiti come from the *whakataukī* (proverbial saying) by Dr. Whakaari Rangitakuku Metekingi (Whanganui, Ngāti Hauiti):

> "Ko te pae tawhiti whāia kia tata, ko te pae tata, whakamaua kia tina"; seek out the distant horizons and cherish those you attain.

The term *tata* means being close, next to, or nearby. *Pae Tata*, refers to the horizon nearby that shows the achievements and challenges clients face. The term *tawhiti* means distant, far away, and widely separated in space or time. *Pae Tawhiti* refers to the distant horizons where client aspirations are located.

The Pae Tata acronym reflects practical steps to guide early and brief interventions. This includes: ***T****iro whāiti* (exploring broad concerns); ***A****ronga* (taking a close look at presenting concern); ***T****ūmanako* (exploring hope and aspirations); and ***A****nga whakamua* (developing a pathway forward). The Pae Tawhiti acronym reflects Māori principles that underpin values, behaviour and practice with Māori. These include: ***T****ū māia* (mana enhancing practice); ***A****roha* (empathy and intentional caring); ***W****hanaungatanga* (relationships and family); ***H****uritao* (facilitating reflection), ***I****nāianei* (addressing present concerns), ***T****autoko* (providing practical support), and ***I****hi* (accessing cultural pathways to wellbeing). The TAWHITI principles are discussed in more detail below.

A Trauma-Informed Approach: A Model of Intergenerational Trauma

Māori, as with other Indigenous populations, are disproportionately affected by mental health and substance use problems (Reid et al., 2014). Notably, the presence of trauma is a known precursor for mental illness, post-traumatic stress disorder (PTSD) and substance use disorders (Furber et al., 2017; Kessler et al., 2017; Read & Ouimette, 2014). Leonie Pihama (Te Ātiawa, Ngāti Māhanga, Ngā Māhanga ā Tairi) and colleagues (2020) explored existing principles guiding Western, trauma-informed approaches and found common concepts such as safety, trustworthiness, choice, collaboration, empowerment, and respect. They also noted that Western trauma-informed principles were generic, lacked a specific Māori approach and did not address the Indigenous concepts that Māori practitioners operate from.

In 2015 Takirirangi Smith (Ngāti Kahungunu, Ngāti Apa, Te Aitanga a Hauiti) described traditional concepts related to the experience, expression and processing of trauma, including historical trauma, that locates the impact of traumatic or painful events and the subsequent reactions, to the body. These include; Patu Ngākau, the traumatic event that acts to *patu* (strike) the *ngākau* (heart); *Mamae Ngākau*, (pain or grief from the trauma); *Ngākau Riri*, (anger and/or violence); *Ngākau Pouri*, (the psychological impact, at times referred to as depression and/or anxiety) and; *Whakamomori*, (to be in extreme despair or fret desperately). Whakamomori is not only an individual state of mind. It can refer to a *whānau* (extended family), *hapū* (subtribe) or *iwi* (tribe).' (Smith, 2015, pp. 264-67).

Trauma-informed harm reduction responses from an Indigenous perspective also identify and articulate how colonisation and racism create the systemic, biological, and interpersonal factors that lead to substance use issues, and other barriers to wellbeing (Kruger et al., 2004; Pihama et al., 2020). In response to systemic determinants, an Indigenous response to trauma focuses on cultural revitalisation and regeneration and considers the multigenerational importance of transmitting cultural knowledge. Situating Indigenous knowledge as a solution to trauma inherently provides a space for language and cultural dimensions of wellbeing to be centred.

There are several Māori words to describe the impact, experience and the expression of trauma in *te reo Māori* (the Māori language) sourced from oral traditions such as *pūrākau* (stories/histories), *waiata* (songs) and whakataukī. These terms are interconnected with nature and the body and provide a description or emphasise an experience. For example, *kōmingo*, which is to swirl, eddy or be disturbed, describes thoughts agitated by strong emotions, and *pouritanga* (intense sadness) which can lead to deep depression and suicidality. *Ngaukino*, where *ngau* means to be bitten, and *kino* means bad, is used to describe trauma or distress.

The Māori worldview of emotions (termed *kare ā-roto* or *aurongo*) reflects the body's response to emotions as located beyond a solely brain-based response. Other physical manifestations of emotions include *mahamaha* and *ate* (both meaning inner emotions or liver). The connection to body highlights that pain affects the body in both specific and generalised ways. A Māori worldview, which is consistent with other cultural worldviews, recognises the role of the liver as the seat of emotions, and the role of the stomach in emotional regulation or decision-making. These concepts highlight the importance of understanding that Māori may experience, acknowledge, and explore trauma and the impact of trauma through a different lens. A Western lens, facilitated through Western screening tools, may miss Indigenous experiences of trauma which can lead to reduced effectiveness in meeting Indigenous needs.

A focus on intergenerational trauma attends to the contributing and maintaining mechanisms that influence substance use: impacts of racism, poverty, inequity, stress, and limited access to opportunities to enhance identity, *mana* (prestige and spiritual authority), connection, and wellbeing. Reducing trauma and enhancing access to *mātauranga Māori* (knowledge) sources of wellbeing requires attention at the level of the individual, whānau, community and society. The intergenerational trauma model (Figure 1) illustrates the importance of a harm reduction approach that address three dimensions of wellbeing: *mauri ora* (healthy individuals), *whānau*

ora (healthy families), and *wai ora* (healthy environments) (Durie, 2009).

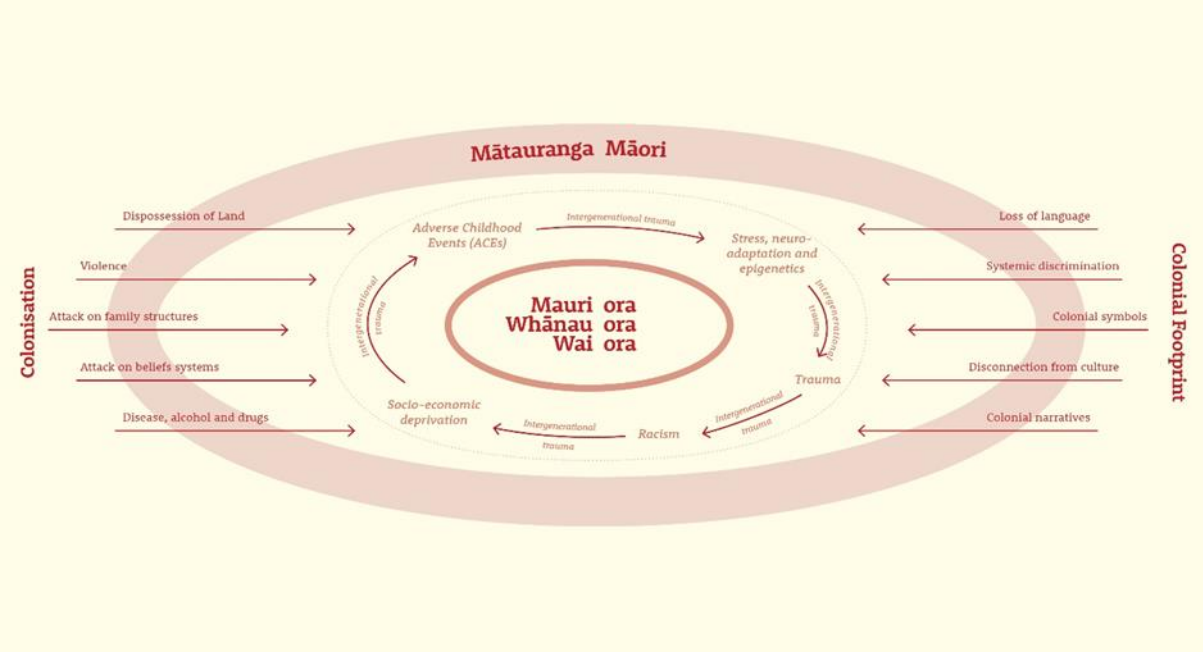

Figure 1Intergenerational Trauma Model (McLachlan, & Waitoki (2022 p.29))

In the centre of the model are mauri ora, whānau ora and wai ora. These are the core factors of wellbeing that Māori have fought for generations to maintain, with roles and energies in cultural revitalisation, survival, and wellbeing. This has occurred against the ongoing assaults of colonial trauma. The right side of the mātauranga Māori circle depicts how colonisation as an ongoing colonial footprint impacting the cycle of intergenerational trauma. This includes factors that create and maintain socio-economic deprivation, systemic discrimination, and cultural oppression. These create the foundation for the genesis of intergenerational trauma, including poverty and the breakdown of whānau systems. They also provide constant reminders of the impact of cultural disconnection from language that may lead to a lack of confidence to access or participate in whānau or hapū roles, such as going to *tangi* (funerals) or *hui* (meetings). Alcohol and other drugs, as well as their associated harms are recognised as being introduced to Māori society with the arrival of White colonists within the model of intergenerational trauma. Historical evidence notes that Māori typically consumed water, whereas White colonists not only brought alcoholic drinks and alcoholism, they also experimented widely with fruits and grains to produce alcohol. Indeed, the Māori word '*waipiro'* meaning putrid water reflected Māori distaste for wine and liquor (Hutt, 1999). Intoxication was exceedingly rare, with court records for the period 1844-48 showing that of 264 cases of drunkenness, only one was 'native' (Hutt, 1999). It should also be noted that during that time, Māori still held a degree of sovereignty over *Aotearoa* New Zealand, although following waves of White immigration and introduced diseases, Māori soon became overwhelmed. Despite continued attempts by Māori to halt the widespread availability of alcohol, tobacco, and other drugs into Māori communities (Murchie, 1984), deliberate strategies were deployed by settlers to ensure that Māori acculturated to alcohol use (Hutt, 1999). Over time, alcohol and other drugs became widespread, and due to political, social, and economic disenfranchisement, Māori found it difficult to stop the impacts on family and community structures and their inherent protective factors.

There is also strong evidence for the role of poverty in increasing the risk of exposure to alcohol and other drugs, increased use of substances as a form of coping, and increased stress and further victimisation (Lewis et al., 2018). The combined impacts of poverty and alcohol and drug use also increases the likelihood

that an individual will develop substance use and mental health issues. Studies of the relationship between socio-economic status, stress response and the development of substance use disorders are tied to factors such as minority status, experiences of racism/discrimination, and lower SES (Lewis et al., 2018). Taking a lifespan approach, the relationship between Adverse Childhood Events (ACEs) and stress, neuroadaptation and epigenetics has been shown to be part of an intergenerational cascade that affects vulnerability to, and harms from, later substance use (Amaro et al., 2021).

Figure 2 Extended Te Whare Tapa Whā (McLachlan & Waitoki, 2022, p. 17)

Mauri Ora, Whānau Ora and Wai Ora – Working Towards Wellbeing and Quality of Life

Te Whare Tapa Whā is a well-known model of Māori health (Durie, 1985). Within this model, wellbeing is recognised along four dimensions pivotal to a Māori worldview (Figure 2) that provide strength, balance, stability, and harmony (Durie, 1985, 1998). The use of a *wharenui* (house) as a metaphor for wellbeing resonates with Māori traditional concepts of *whakapapa* (genealogical relationship and history), whānau, and collective endeavour and wellbeing.

Durie's more recent work, *Mauri Ora: The metrics of flourishing* (2020), highlighted that flourishing *mauri* (life force) is an outcome of balance and harmony between the four taha (walls) of Te Whare Tapa Whā. Mauri Ora is represented at the centre of the whare tupuna. Durie also related wellbeing to the ability to return home to enable a clearing or healing process for any, or all, of the four taha. The whakataukī *'E hoki ki tōu maunga kia purea ai koe ki ngā hau o Tāwhirimātea'* (Return to your mountain to be cleansed by the winds of Tāwhirimātea) signals the importance of going to a place that is meaningful, where balance and harmony can be restored. The dimension of returning home is represented by *Tāwhirimātea* (the wind) in the upper left of Figure 2.

These concepts demonstrate the interrelated nature of wellbeing that is prioritised by Māori. To reduce trauma (including problematic substance use) and to enhance wellbeing, approaches must address the harms and protective factors across whānau (family), *hinengaro* (mental), *wairua* (spiritual) and *tinana* (physical) (Figure 2). Efforts are also needed to attend to the connection of the *tangata whaiora* (person seeking wellbeing) to the *taiao* (environment), the quality of the taiao, and activities that connect people to their whakapapa and *whenua tūpuna* (ancestral land).

One of the reasons for the wide use of Te Whare Tapa Whā across a range of settings is its simplicity (Glover, 2005; McLachlan et al., 2017). Within Pae Tata Pae Tawhiti, Te Whare Tapa Whā is used to explore a person's experience of health or any challenges; to understand drug-

specific risks and harm reduction messages; to create wellbeing plans; and to explore cultural pathways to wellbeing (Kingi, 2002, pp 275-302; McLachlan & Waitoki, 2022). The Pae Tata Pae Tawhiti framework extends Te Whare Tapa Whā to understand how risk, and protective factors are understood within a complex ecosystem.

Risk, Protective Factors, Harms and Harm Reduction Strategies through an Indigenous Lens

'Risk factors' refer to the resources, events, characteristics, behaviour, and pressures that contribute to the development of a substance use problem. 'Protective factors' are those factors such as resources, events, characteristics, and behaviour that protect against the development of substance use problems. Risk factors are cumulative whereby increased quantity and severity of risk factors leads to a greater likelihood of developing substance use problems (Kopak et al., 2017; National Institute on Drug Abuse, 2020). Prevention of substance use problems can include strategies that promote resilience and a secure cultural identity, which act as protective factors for psychological distress, suicidality, and adversity (Houkamau & Sibley, 2015; Muriwai et al., 2015).

Figure 3 details a summarised but not exhaustive list of risk and protective factors that are aligned with Te Whare Tapa Whā (Durie, 1985). The left side lists risk factors for developing a substance use problem; and the right-side lists protective factors against developing a substance use problem. The risks and protective factors are presented under the four headings of Te Whare Tapa Whā. The risk and protective factors presented in Figure 3 provide an example of an Indigenous perspective of harms that require acknowledgement and addressing by communities and practitioners and also the factors known to enhance the safety and wellbeing of the individual, and their whānau and community.

The Pae Tata Pae Tawhiti manual provides an outline for 7 different substances including alcohol. Figure 4 as an example outlines the key harms and harm reduction approaches for cannabis use presented within the four taha of Te Whare Tapa Whā. The harms are shown on the left side, and the harm reduction strategies are shown on the right side.

TAWHITI Indigenous Trauma-Informed Harm Reduction Principles

This section builds on the model of intergenerational trauma presented in Figure 1. TAWHITI addresses intergenerational trauma, which requires the disassembling of the colonial footprint, reflecting the original colonisation, which actively maintains colonial beliefs and persecution. Alongside this, the ongoing cultural revitalisation in Aotearoa will continue to strengthen mātauranga Māori as the encircling protector and source of healthy beliefs and practices for Māori. The TAWHITI principles are intended to guide practice towards strengthening and flourishing of mauri ora, whānau ora and wai ora.

Ngā uara me ngā matāpono Māori (Māori values and principles) provide the foundation for *tikanga* (correct behaviour and practice) ensuring ethical and effective practice. Tikanga has contributed to Māori wellbeing well before the arrival of Europeans. As an oral culture, many of the clues and specific examples of Māori values and principles are held in various oral traditions. *Kōrero whakapapa* is one example, telling stories of history, relationships, and interdependence passed across generations (Smith et al., 2021). Engaging in *kōrero whakapapa* is an important aspect of identifying and addressing intergenerational trauma experienced by whānau, hapū and iwi (Smith et al., 2021; Wirihana & Smith, 2014). Takirirangi Smith (2000) offered that kōrero whakapapa 'allows clearer understandings and provides useful insights into pre-colonial Māori philosophies which assists understanding and helps identify values which underpin transformations occurring within the contemporary context' (p. 1).

Table 2
Risk and protective factors for developing a substance use problem.

Risk Factors	Protective Factors
TAHA WHĀNAU: FAMILY AND SOCIAL WELLBEING	
• Family history of substance use problems	• Connected to marae and whenua
• Peer substance use/favourable attitudes to use	• A sense of belonging or connection to whānau, hapū, iwi
• Social disadvantage, poverty, and/or isolation	• Nurturing, supportive environments
• Inconsistent parenting styles	• Feeling safe and secure
• Poor family relationships	• Opportunities to engage in local community events and clubs
• Low school connectedness/commitment to education and/or truancy	• Respect of self and others
• Low academic achievement/poor school performance	• Pro-social peers and peer connection
• Learning difficulties	• Access to positive achievements/evaluations in school environment
• Bullying and/or peer rejection	• A positive adult relationship outside the family with teachers, coaches, and peers
• Lack of support services	• Family income
• Lack of training or employment	• Stable and affordable housing
	• Equitable access to services
TAHA HINENGARO: MENTAL AND EMOTIONAL WELLBEING	
• Racism, marginalisation, and discrimination	• Positive affect (feeling happy, interested, relaxed)
• Novelty-seeking/risk taking	• Self-confidence
• Offending and conduct disorder	• Competent social skills
• Emotional distress and stress	• Positive support networks
• Low self-esteem	• A secure sense of identity
• Poor social skills	• Participation in te ao Māori
• History of abuse or neglect	• Higher levels of education
• Experiencing symptoms of anxiety, depression, or post-traumatic stress disorder (PTSD)	• Knowledge and application of wellbeing strategies
TAHA WAIRUA: SPIRITUAL AND CULTURAL WELLBEING	
• Racism, marginalisation, and discrimination	• A positive sense of identity and belonging
• Trauma (including intergenerational)	• Collective decision-making skills
• Effects of colonisation	• Hope and faith
• Exposure to environmental toxins	• Religious beliefs, wairua connections
• Abuse of any kind	• Clean environment, stable home, and family
TAHA TINANA: PHYSICAL WELLBEING	
• Early onset of substance use	• Participation in physical sport and recreation
• Exposure to sexual abuse, neglect, or abuse	• Access to good primary care service
• Exposure to physical and psychological violence	• Food security
• Physical or medical condition	• Access to clean air and water, and a healthy environment
• Non-participation in activities (sport or social)	• Ability to sleep and rest

Figure 3 Risk and Protective Factors for Substance Use Problems Aligned with Te Whare Tapa Whā (McLachlan & Waitoki 2022)

KEY RISKS/HARMS	TE WHARE TAPA WHĀ	KEY HARM MINIMISATION TIPS FOR CONVERSATIONS
• When we start using regularly, we can spend more money on our using than on our bills and whānau. This can cause stress and strain in the whānau. • Drug testing at work can lead to loss of employment. • Users may be charged with possession of cannabis. • Driving while stoned can lead to accidents and injury.	**Taha Whānau** Family and Social Wellbeing	• Plan your session. Where you are going? How much will you use? How will you get home? Who will look after the tamariki and/or kaumātua? • Have a dedicated safe driver. • Don't smoke prior to work or study. • Carry less than 28 grams (1 ounce) of cannabis or 100 cannabis joints, as you can be charged as a supplier. • Consider stopping if your place of work or school drug tests. • Try to stop. Reduce use while pregnant and breastfeeding (express and discard the milk and replace with formula).
• Over time, cannabis can cause cancers of the respiratory system. • If someone falls unconscious after smoking synthetic cannabis, they could die.	**Taha Tinana** Physical Wellbeing	• Avoid using with alcohol, medication or other drugs. • Bush grown cannabis has lower THC than hydroponic. • Use only a small amount at a time and wait for the full effect before using more. To keep track of how much time has elapsed, use a timer. Inexperienced users should take a one-hour break between sessions.
• Being stoned when engaged in tikanga and/or on the marae may lead us to make hapa that contribute to feeling whakamā. • Sometimes, needing to use regularly can lead us to do things that are against our values, the tapu of our body, and also our consideration of others. • Being focused on cannabis can lead us to not have the motivation or focus to pursue our aspirations.	**Taha Wairua** Spiritual and Cultural Wellbeing	• Create boundaries about where, when, and with who it is safe to smoke or be around. • Spend time clarifying what is important for you. What are your values?
• Working or studying while stoned may lead to mistakes. • Young people experience greater long-term impacts than adults. • Getting high can lower motivation and concentration. • Using cannabis can worsen mental health problems.	**Taha Hinengaro** Mental and Emotional Wellbeing	• Using cannabis while your brain is developing can cause problems. • Stop if you start to feel unwell, uncomfortable, or nervous. • Don't smoke if you have been diagnosed with or experience symptoms of depression, anxiety, or psychosis. • Start with small amounts first to check its strength. Have water or a sweet drink with you. • Use only occasionally, especially if you have mental health problems.

Figure 4 Harms from cannabis use and key harm minimisation tips aligned with Te Whare Tapa Wha (McLachlan & Waitoki, 2022, p. 65)

Many of these values such as kōrero whakapapa, have been located within successful Māori initiatives focused on reclaiming and regenerating mātauranga Māori and wellbeing. Graham Smith (1997) identified six principles which were essential in the successful initiatives of *Kōhanga Reo* (Māori early childhood centres), and *Kura Kaupapa Māori* (Māori medium education). The principles are *Tino Rangatiratanga* (relative autonomy); *Taonga tuku iho* (cultural aspirations); *Ako Māori* (culturally preferred pedagogy); *Kia piki ake i ngā raruraru o te kainga* (mediation of socio-economic factors); Whānau (extended family management); *Kaupapa* (collective vision), discussed in more detail below.

Smith's (1997) principles were used in part of an analysis developing a set of 8 kaupapa Māori principles for trauma-informed healing created by Pihama et al., (2020). They demonstrate the practical aspects of addressing trauma through Māori cultural values including: *Rangatiratanga* (sovereignty); Mauri Ora (thriving life essence); *Tikanga* (customary protocols); and Te Reo Māori, to guide practitioners and provide insight into culturally embedded belief systems and preferred pathways to wellbeing. These principles are discussed in relation to the TAWHITI Indigenous Trauma-Informed principles described below.

TAWHITI is an acronym for the principles of the Pae Tata Pae Tawhiti framework, developed for practitioners to provide a Māori-centred approach to address alcohol and other drug use harms whilst working towards mauri ora, whānau ora and wai ora. The following section introduces the TAWHITI Indigenous trauma-informed harm reduction principles, and briefly discusses each principle. This discussion will reflect both the role of this in addressing the harms associated with alcohol and other drug use; and discuss these in relation to addressing trauma, a well-established contributing and maintaining factor for alcohol and other drug and mental health concerns.

TAWHITI

T represents the principle *Tū Māia*. Tū means to stand (Williams, 2010), and it is the shortened name for *Tūmatauenga*, who is the *atua* (deity) of warfare and humankind (Paki, 2017). *Māia* means brave, bold, and capable (Williams, 2010). Tū Māia can be seen as standing with confidence. Within the Pae Tata, Pae Tawhiti framework, Tū Māia is underpinned by recognising and respecting the mana of the person you are working with (including their whānau), and their journey thus far. Mana enhancing and mana maintaining practices are built on a foundation of a therapeutic relationship that reinforces whānau as the solution finders, decision makers, and holders of responsibility for their independent choices. This principle aligns strongly with the kaupapa Māori principle of 'Tino Rangatiratanga: The relative autonomy principle' (Smith, 1997). Tū Māia aligns with and extends upon the harm reduction principles of humanism, individualism, and autonomy (Riley et al., 1999; Hawk et al., 2017). *Tu Maia* also aligns with Māori trauma-informed healing principles of 'Rangatiratanga', 'Mana Tangata' and 'Mauri ora' (Pihama et al., 2020), particularly practices that support tangata whaiora to maintain control over the narration of their own journey, and practices where practitioners stepping aside so tangata whaiora can leave services when they are ready and likewise return when they choose to. This principle extends Western trauma-informed principles of empowerment and voice and choice (SAMHSA, 2014) and respect, choice, and empowerment (Institute of Trauma and Trauma Informed Care (ITTIC), 2015).

A represents the principle of Aroha. *Aro* means to attend to; to favour, and to keep in the forefront of our mind; and *Hā* means the breath and the spirit of the communications. Aroha brings together the spirit (the character) of communication and actions between people (Paki, 2017) that, when working well, develops, maintains, and supports the integrity and balance of a relationship. Within the Pae Tata, Pae Tawhiti framework, aroha encourages practitioners to understand the lived experiences of participants and their whānau and to be able to express empathy for them. It also involves teaching participants to understand and express empathy for the challenges ahead of them. Aroha aligns with Māori trauma-informed healing principles of 'Kia Piki Ake i ngā Raruraru o te Kāinga' and 'Mauri ora', particularly practices associated with facilitating the mourning process to farewell trauma and to *mihi* (greet) and give ceremony to them and welcome the person back

to wellbeing (Pihama et al., 2020). Aroha extends the harm reduction principles of compassion, humanism, and accountability without termination (Riley et al., 1999; Hawk et al., 2017). It aligns with Western trauma-informed principles of safety and trustworthiness (SAMHSA, 2014; ITTIC, 2015).

W represents the principle of Whanaungatanga, described variously as relationship, kinship, and as a sense of familial connection (Mead, 2016; Moorfield, 2000). Unlike the Western idea of the nuclear family, within a Māori worldview, family can extend to those who are closely connected to you by genealogy, and those who are remotely related. More modern perspectives of whānau include whānau kaupapa to refer to those who share a common interest or group membership (for example, church, sports, or school). Whanaungatanga refers to connecting to shared experiences and working together to create a sense of belonging that is more than just a relational alliance. In the Pae Tata, Pae Tawhiti framework, Whanaungatanga reinforces the need for practitioners to engage with whānau networks to better understand the context, needs, and available supports to healing pathways for the person and their whānau. This also means identifying where bonds need to be reaffirmed or healed. This principle aligns strongly with the Kaupapa Māori Principle of 'Whānau: the extended family management principle' (Smith, 1997). This principle also aligns with Māori trauma-informed healing principles of 'Whakapapa and Whanaungatanga' and 'Mauri ora', particularly practices associated with facilitating the reconnection to support systems, to ancestral links and connections that ignite mauri ora (Pihama et al., 2020). Also aligned with Western trauma-informed principles of collaboration, mutuality, and safety safety and trustworthiness (SAMHSA, 2014; ITTIC, 2015).

H represents the principle of *Huritao* (also known as *noho puku* or wānanga) can be understood by *huri* (to turn around) and *tao* (to weigh down; to balance, as in a waka) (Moorfield, 2011). *Huritao* encourages *kaimahi* (workers) to facilitate *wānanga*, a process where the person, their whānau, and support workers, can develop a shared understanding. In relation to a mana-enhancing, harm reduction approach, including reflection on the harms being experienced in relation to the person's substance use, their challenges in making change, and their motivation and commitment towards their *tūmanako* (aspirations). Huritao aligns with and extends upon the harm reduction principles of pragmatism, focus on harms, balancing costs and benefits and prioritising immediate goals (Riley et al., 1999; Hawk et al., 2017). Huritao aligns with principles of 'Tikanga and Te Reo' and 'Mauri ora', particularly providing a process by which to draw forward their own voice, their own song, and to help them mourn and farewell the trauma (Pihama et al., 2020). This aligns with Western trauma-informed principles of collaboration, empowerment, and respect (SAMHSA, 2014; ITTIC, 2015).

I represents the principle of *Ināianei*, often used to define now or presently (Moorfield, 2011). Takirirangi Smith (2000) identified when engaging with oral traditions, time and space are linked together, and the past is always accessible and near. The lessons from our whakapapa, our experience, and what we see before us are used to deal with those issues, so they do not emerge in the unseen future. Ināianei encourages practitioners to focus on breaking down complex problems into some first steps, including moving them from their current place to safer options in a step-by-step manner. We learn from the past as we move forward and address concerns of safety and stability. This includes practical goal setting to decrease risks, increasing wellbeing, and, where necessary, gathering close to our supports. This aligns strongly with the kaupapa Māori principle of 'Kia piki ake i ngā raruraru o te kainga: The mediation of socio-economic factors' (Smith, 1997). Ināianei also aligns with and extends upon the harm reduction principles of pragmatism, focus on harms, balancing costs, and benefits, prioritising immediate goals and incrementalism (Riley et al., 1999; Hawk et al., 2017). Ināianei aligns with Māori trauma-informed healing principles of 'Kāti te patu ngākau' and 'barriers to kaupapa Māori informed care', particularly providing a process to identify risk and present harms, and addressing these so healing can begin. Ināianei also enables focus on addressing institutional racism and challenges to accessing culturally appropriate services (Pihama et al., 2020). This aligns with Western trauma-

informed principle of safety (SAMHSA, 2014; ITTIC, 2015).

T represents the principle of *Tautoko* that means 'to prop up and support', and 'keep at a distance' (Williams, 2010, p. 404). Tautoko encourages practitioners to consider issues of equity, access, and advocacy. A focus must be on identifying the internal resources of the whānau including *ngā pūkenga* (skills), *ngā uara* (values) *me* (and) *ngā mātāpono* (principles) within themselves that they can draw on. Similarly, the external resources of the whānau – which are practical supports that the person and their whānau need or can draw upon to assist in their healing journey. Tautoko also reminds practitioners about boundaries and Tū Māia, to not overstep the abilities and priorities of the whānau. Clear communication, case management practices, collaboration with whānau, support networks, and services are key to effective support. As with the Ināianei principle, Tautoko aligns strongly with the kaupapa Māori principle of 'Kia piki ake i ngā raruraru o te kainga: The mediation of socio-economic factors' (Smith, 1997). Tautoko aligns with and extends upon the harm reduction principles of pragmatism, focus on harms, prioritising immediate goals and incrementalism (Riley et al., 1999; Hawk et al., 2017). Tautoko aligns to the Māori trauma-informed healing principles of 'Mauri ora', 'Tikanga and Te reo' and 'Barriers to kaupapa Māori informed care', particularly providing a process to support those who seek to return home; providing access to Māori cultural experts so their journey in mana continues; providing keys to unlocking barriers to self-care; standing aside when they show readiness to depart; leaving out a return pass so they can come back for a top up; and addressing institutional racism and challenges to accessing culturally appropriate services (Pihama et al., 2020). This aligns with Western trauma-informed principles of choice, collaboration, and empowerment (SAMHSA, 2014; ITTIC, 2015).

I represents the principle of *Ihi* is often described as a sunbeam or ray of light (noun) or essential force, excitement, thrill, or power (Moorfield, 2011). Ihi encourages practitioners to explore Māori pathways to wellbeing, looking beyond problems to solutions and mana enhancing practices. Ihi incorporates the reflection of experiences, learning about new or untapped pathways in the person's communities, and the importance of practitioners, community leaders, and whānau in guiding encounters. The Ihi principle is supported in Pae Tata Pae Tawhiti model with 6 Māori pathways to wellbeing (McLachlan et al., 2021) comprising: Te reo Māori , Whakapapa, Taiao, *Wairua* (spirituality), *Mahi-a-toi* (Māori arts and recreation) and *Take pū whānau* (Familial values).The Ihi principle aligns strongly with the kaupapa Māori principles of 'Taonga tuku iho: The cultural aspirations principle' and 'Ako Māori: Culturally preferred pedagogy' (Smith, 1997). Ihi also aligns with Māori trauma-informed healing principles of 'Whakapapa and whanaungatanga', 'Tikanga and te reo', 'Mana tangata' and 'Mauri ora', particularly providing a process by which to wrap their stories around them so they hear their ancestors and revitalise tikanga to help navigate the future; *he rongoā te reo* (language as a healing agent) and providing access to Māori cultural experts. Ihi also invokes the power of healing through *rongoā* (traditional healing) practices (Pihama et al., 2020). From a Māori perspective, this reflects aspects of the Western trauma-informed principle of safety, voice, choice, empowerment, and respect (SAMHSA, 2014; ITTIC, 2015; and Cultural, Historical, and Gender Issues (SAMHSA, 2014).

The TAWHITI Indigenous trauma-informed principles outlined above provide a comprehensive set of principles that can guide practice with Māori seeking to reduce harms, including intergenerational trauma and substance use, whilst on a journey towards comprehensive wellbeing, mauri ora. The concepts of Whanaungatanga and Ihi identify two concepts that are common across Māori trauma-informed healing principles and kaupapa Māori theory principles, however these principles may not align to Western concepts of trauma-informed care or harm reduction. It is important to note that TAWHITI not only provides two additional concepts important to a trauma-informed harm reduction approach, but each Māori principle comes from mātauranga Māori. The concepts are valid and should not be viewed as a translation of Western principles.

Delivering an Indigenous Trauma-Informed Harm Reduction Training to a Diverse Workforce.

The Pae Tata Pae Tawhiti training was funded by the New Zealand Ministry of Health for delivery to Māori and non-Māori practitioners working within the primary mental health and addiction sectors. The training has received New Zealand Qualifications Authority (NZQA) accreditation as a level 5 micro-credential 'Apply Māori principles and practice within early and brief interventions for mental health and addiction'. The training includes increasing knowledge of the principles, engaging in discussion and shared learning of local knowledge; and understanding of local pūrākau that underpin each of the TAWHITI principles. On completion of this training, practitioners are further supported and supervised in applying the TAWHITI principles to their practice.

The next steps in the development of the TAWHITI Indigenous trauma-informed harm reduction framework involves an evaluation of the training (initial online and in-person training). Evaluation will explore whether ongoing monthly live skills sessions are effective in embedding knowledge; developing practitioner skills within and across organisations; and whether practising in groups influences outcome. In late 2023, the authors released a Māori software application 'Pari Kawau' to support the evaluation of practitioner live-skills session observations. The application allows users to log their observations into the application to demonstrate their progress in learning Pae Tata Pae Tawhiti skills and principles. The application also enables the user to provide commentary on their observations of their peers practice sessions, which they then share (peer co-learning). This approach allows practitioners to reflect on their practice, provide information to discuss in supervision, set practice goals, and observe improvement in practice over time. Pae Tata Pae Tawhiti also provides a recognised qualification to grow and upskill the workforce, contributing directly to government policy aims of increasing the number of practitioners able to work with Māori.

Conclusion

As a Māori model of practice, Pae Tata Pae Tawhiti offers a unique approach to harm reduction and trauma-informed care that recognises Indigenous knowledge and practice as vital to Māori flourishing. An Indigenous trauma-informed approach also acknowledges the role of intergenerational trauma in alcohol and drug problems. However, solutions that reframe the language used to describe trauma impacts are also necessary. For example, Whakapapa: Substance use harm reduction must consider the history and relationships between culture and community-specific harms, particularly colonisation and intergenerational trauma; *Huanui oranga*: Incorporating the strengths, preferences, and strategies of Indigenous communities must be included to accurately and effectively respond to substance related harms; Mauri ora, Whānau ora and Wai ora: Harm reduction efforts must seek to increase quality of life as defined by Indigenous communities; and Ngā take pū o te tangata: Harm reduction must be guided by the values and principles of Indigenous peoples. These terms locate wellness in Māori cultural concepts. Moving beyond static notions of harm-reduction, Indigenous responses are primarily about wellbeing for Māori in ways that prioritise the right to live our best lives.

References

Amaro, H., Sanchez, M., Bautista, T., & Cox, R. (2021). Social vulnerabilities for substance use: Stressors, socially toxic environments, and discrimination and racism. *Neuropharmacology, 188*, 108518. https://doi.org/10.1016/j.neuropharm.2021.108518

Cliffe, C., Pitman, A., Sedgwick, R., Pritchard, M., Dutta, R., & Rowe, S. (2021). Harm minimisation for the management of self-harm: A mixed-methods analysis of electronic health records in secondary mental healthcare. *BJPsych Open, 7*(4), e116. https://doi.org/10.1192/bjo.2021.946

Collins, S. E., Clifasefi, S. L., Logan, D. E., Samples, L. S., Somers, J. M., & Marlatt, G. A. (2012). Current status, historical highlights, and basic principles of harm reduction. In G. A. Marlatt, M. E. Larimer, & K. Witkiewitz (Eds.),

Harm reduction: Pragmatic strategies for managing high-risk behaviors (pp. 3–35). The Guilford Press.

Collins, S., Clifasefi, S., Williams, G., & Black Bear, L. (2022). Community-based harm reduction approaches for alcohol use disorder. In J. Tucker & K. Witkiewitz (Eds.), *Dynamic pathways to recovery from alcohol use disorder: Meaning and methods* (pp. 218–238). Cambridge University Press. https://doi.org/10.1017/9781108976213

Dell, C., & Lyons, T., & Cayer, K. (2010). The role of 'Kijigabandan' and 'Manadjitowin' in understanding harm reduction policies and programs for aboriginal peoples. *Native Social Work Journal, 7*, 109–138.

Durie, M. (1985). A Māori perspective of health. *Social Science & Medicine. 20*(5), 483–486.

Durie, M. H. (1998). *Whaiora: Māori health development* (2nd ed.). Oxford University Press.

Durie, M. (2009, July 7). *Pae ora Māori horizons 2020 and beyond* [Lecture Transcript]. Massey University. http://www.massey.ac.nz/massey/fms/Te%20Mata%20O%20Te%20Tau/Publications%20-%20Mason/Pae%20Ora%20-%20Maori%20Health%20Horizons.pdf

Durie, M. (2020). *Mauri Ora: The metrics of flourishing*. Compass Seminars.

Dzidowska, M., Lee, K., Conigrave, J. H., Dobbins, T. A., Hummerston, B., Wilson, S., Haber, P. S., Gray, D., & Conigrave, K. M. (2022). Support for Aboriginal health services in reducing harms from alcohol: 2-year service provision outcomes in a cluster randomized trial. *Addiction, 117*(3), 796–803. https://doi.org/10.1111/add.15712

Friedman, S. R., de Jong, W., Rossi, D., Touzé, G., Rockwell, R., Des Jarlais, D. C., & Furber, G., Leach, M., Guy, S., & Segal, L. (2017). Developing a broad categorisation scheme to describe risk factors for mental illness, for use in prevention policy and planning. *The Australian and New Zealand Journal of Psychiatry, 51*(3), 230–240. https://doi.org/10.1177/0004867416642844

Glover, M. (2005). Analyzing Smoking Using Te Whare Tapa Whā. *New Zealand Journal of Psychology*, 34(1), 13-19.

Goldstein, S. C., Spillane, N. S., Nalven, T., & Weiss, N. H. (2022). Harm reduction acceptability and feasibility in a North American indigenous reserve community. *Journal of Community Psychology, 50*(8), 3607–3624. https://doi.org/10.1002/jcop.22859

Hawk, M., Coulter, R. W. S., Egan, J. E., Fisk, S., Friedman, M. R., Tula, M., & Kinsky, S. (2017). Harm reduction principles for healthcare settings. *Harm Reduction Journal, 14*, 1-9. https://doi.org/10.1186/s12954-017-0196-4

Houkamau, C. A., Sibley, C. G. (2015). The Revised multidimensional model of Māori identity and cultural engagement (MMM-ICE2). *Social Indicators Research*, 122(1), 279-296.

Hughes, M., Suhail-Sindhu, S., Namirembe, S., Jordan, A., Medlock, M., Tookes, H. E., Turner, J., & Gonzalez-Zuniga, P. (2022). The crucial role of Black, Latinx, and Indigenous leadership in harm reduction and addiction treatment. *American Journal of Public Health, 112*(S2), S136–S139. https://doi.org/10.2105/AJPH.2022.306807

Hutt, M. (Ed.). (1999). *Te iwi Maori me te inu waipiro: He tuhituhinga hitori (Maori & alcohol: A history)*. Health Services Research Centre for Kaunihera Whakatupato Waipiro o Aotearoa/Alcohol Advisory Council of New Zealand (ALAC).

Interagency Coalition on AIDS and Development, (ICAD) (2019). *Indigenous Harm Reduction: Reducing the Harms of Colonialism*. Policy Brief. http://www.icad-cisd.com/pdf/Publications/Indigenous-Harm-Reduction-Policy-Brief.pdf

Institute of Trauma and Trauma Informed Care. (2015). *What is trauma informed care?* http://socialwork.buffalo.edu/social-research/institutes-centers/institute-ontrauma-and-trauma-informed-care/what-is-trauma-informed-care.html (ITTIC).

Kessler, R. C., Aguilar-Gaxiola, S., Alonso, J., Benjet, C., Bromet, E. J., Cardoso, G., Degenhardt, L., de Girolamo, G., Dinolova, R. V., Ferry, F., Florescu, S., Gureje, O., Haro, J. M., Huang, Y., Karam, E. G., Kawakami, N., Lee, S., Lepine, J. P., Levinson, D., Navarro-Mateu, F., … Koenen, K. C. (2017). Trauma and PTSD in

the WHO world mental health surveys. *Eur J Psychotraumatology, 8(*5), 1353383. https://doi.org/10.1080/20008198.2017.1353383

Kingi, T.R., (2002). *Hua Oranga: Best Health Outcomes for Māori* [Doctoral thesis in Māori Studies, Massey University]. Massey Research Online. https://mro.massey.ac.nz/items/297c7e77-a9a2-46db-bd46-0bcab5e9bbda

Kopak, A., Proctor, S., & Hoffmann, N. (2017). The cumulative risk associated with demographic background characteristics among substance use treatment patients. *Addiction Research & Theory, 25*(3), 216-224. https://doi.org/10.1080/16066359.2016.1265109

Kruger, T., Pitman, M., Grennell, D., McDonald, T., Mariu, D., Pōmare, A., Mita, T., Maihi, M., & Lawson-Te Aho, K. (2004). *Transforming whānau violence – A conceptual framework. An updated version of the report from the former Second Māori Taskforce on Whānau Violence* (2nd ed.). Te Puni Kokiri.

Lavalley, J., Kastor, S., Tourangeau, M., Goodman, A., & Kerr, T. (2020). You just have to have other models, our DNA is different: The experiences of indigenous people who use illicit drugs and/or alcohol accessing substance use treatment. *Harm Reduction Journal, 17*(1), 1-10. https://doi.org/10.1186/s12954-020-00366-3

Lewis, B., Hoffman, L., Garcia, C. C., & Nixon, S. J. (2018). Race and socioeconomic status in substance use progression and treatment entry. *Journal of Ethnicity in Substance Abuse, 17*(2), 150–166. https://doi.org/10.1080/15332640.2017.1336959

Marsh, T. N., Eshakakogan, C., Eibl, J. K., Spence, M., Morin, K. A., Gauthier, G. J., & Marsh, D. C. (2021). A study protocol for a quasi-experimental community trial evaluating the integration of indigenous healing practices and a harm reduction approach with principles of seeking safety in an indigenous residential treatment program in Northern Ontario. *Harm Reduction Journal, 18*(1), 1-9. https://doi.org/10.1186/s12954-021-00483-7

McLachlan, A., Wirihana,R., & Huriwai, T. (2017). Whai tikanga: The application of a culturally relevant value centred approach. *New Zealand Journal of Psychology, 46(3)*, 46–54.

McLachlan, A. D., Waitoki, W., Harris, P., & Jones, H. (2021). Whiti te Rā: A guide to connecting Māori to traditional wellbeing pathways. *Journal of Indigenous Wellbeing, 6*(1), 78–97.

McLachlan, A., & Waitoki, W. (2022). *Pae Tata, Pae Tawhiti. Engaging with whānau to explore waipiro me te tarau kino and its harms to create pathways to whakaora.* Unpublished. Whare Tukutuku.

Mead, H. M. (2016). *Tikanga Māori: Living by Māori Values.* Huia Publishers.

Moorfield, J. C. (2000). *Ngā kupu me ngā tikanga.* Pearson Education New Zealand.

Moorfield, J. C., (Ed.) (2011). *Te Aka Māori-English, English-Māori Dictionary* (3rd ed.).

Pearson.

Murchie, (1984). *Rapuora: Health and Maori women.* Te Rōpū Wāhine Māori Toko i te Ora.

Muriwai, E., Houkamau, C. A., Sibley, C. G. (2015). Culture as cure? The protective function of Māori cultural efficacy on psychological distress. *New Zealand Journal of Psychology, 44*(2), 14–24.

National Institute on Drug Abuse. (2020). *What are risk factors and protective factors?* https://nida.nih.gov/publications/preventing-drug-use-among-children-adolescents/chapter-1-risk-factors-protective-factors/what-are-risk-factors

Ouimette, P., & Read, J. P. (Eds.). (2014). *Trauma and Substance Abuse: Causes, Consequences, and Treatment of Comorbid Disorders*. American Psychological Association. http://www.jstor.org/stable/j.ctv1chs2wp

Paki, M. (2017). *He Māori ahau? A journey in a search for identity through the lenses of an iwi member.* [Unpublished Doctoral thesis]. Te Whare Wānanga o Awanuiārangi.

Pihama, L., Smith, L., Cameron, N., Te Nana, R., Kohu-Morgan, H., Skipper, H., & Mataki, T.

(2020). *He Oranga Ngākau: Māori approaches to trauma informed care*. Te Kotahi Research Institute.

Read, J., & Ouimette, P. (2014). Introduction. In P. Ouimette & J. P. Read (Eds.), *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders* (pp. 3–8). American Psychological Association. http://www.jstor.org/stable/j.ctv1chs2wp.4

Reid, J., Taylor-Moore, K., & Varona, G. (2014). Towards a social-structural model for understanding current disparities in Maori health and well-being. *Journal of Loss & Trauma, 19*(6), 514–536. https://doi.org/10.1080/15325024.2013.809295

Riley, D., Sawka, E., Conley, P., Hewitt, D., Mitic, W., Poulin, C., Room, R., Single, E., & Topp, J. (1999). Harm reduction: Concepts and practice. A policy discussion paper. *Substance Use and Misuse*, 34(1), 9−24.

Substance Abuse and Mental Health Services Administration (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach.* HHS Publication No. (SMA) 14-4884.

Smith, C., Wirihana, R., & Smith, T. (2021). Māori Indigenous healing practices in Aotearoa (New Zealand). In R. Moodley, E. Lee & J. Van Der Tempel (Eds), *The Routledge international handbook of race, culture and mental health* (pp. 530-540). Routledge.

Smith, G. H. (1997). *The development of Kaupapa Māori: Theory and Praxis*. [Doctoral thesis, University of Auckland].Research Space https://researchspace.auckland.ac.nz/handle/2292/623.

Smith, T. (2000). Nga tini ahuatanga o whakapapa korero. *Educational Philosophy and Theory, 32*(1), 53–60. https://doi.org/10.1111/j.1469-5812.2000.tb00432.x

Smith, T. (2015). He Kokonga Whare. In L. Pihama, H. SKipper, & J. Tipene (Eds.), *He Manawa Whenua, e Kore e Mimiti Indigenous Centred Knowledge-Unlimited Potential* (pp. 255–274). Te Kotahi Research Institute.

Stockings, E., Bartlem, K., Hall, A., Hodder, R., Gilligan, C., Wiggers, J., Sherker, S., & Wolfendon, L. (2018). Whole-of-community interventions to reduce population-level harms arising from alcohol and other drug use. *Addiction, 113*(11), 1984–2018. https://doi.org/10.1111/add.14277

van der Sterren, A. E., Anderson, I. P., & Thorpe, L. G. (2006). 'Individual' harms, Community 'harms': Reconciling Indigenous values with drug harm minimisation policy. *Drug and Alcohol Review, 25*(3), 219–225. https://doi.org/10.1080/09595230600644681

Williams, H. W. (2010). *Dictionary of the Māori language.* Government Printers

Wirihana, R., Smith, C. (2014). Historical trauma, healing and wellbeing in Māori communities. *MAI Journal, 3*(3), 197–210.

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