

## “Before It Is Too Late”: Life, death, street performance and homelessness in Aotearoa, New Zealand

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*Nāu te rourou nāku te rourou ka ora ai te iwi*

*With your food basket and my food basket, the people will live*

### Abstract

*This article examines the creation of ‘Before It Is Too Late’, a collaborative performance project created with the Peeps- short for Peoples- living on the streets of Aotearoa, New Zealand, who identify as Māori (Indigenous New Zealanders). The Peeps face profound, persistent, unjust inequalities, inequitable mortality rates, and devaluation of their lives by the wider community. The performance project is centred on the Peeps’ perspectives and is informed by whanonga pono (Māori values) and tikanga (customs), the principles of community-based research, relational ethics, and critical performance ethnography. The project aims to initiate a conversation with health professionals to improve the quality of care provided and to ensure greater respect and dignity in relation to the death of Māori homeless people. We present the drama Before It Is Too Late that has resulted from this collaboration with the Peeps to open a transformative space for their voices, experiences, priorities, and rights to be heard and acknowledged.*

### Key words

Indigenous homelessness; performance; prevention of premature mortality; collaborative ethnography; relational ethics; drama.

## Introduction

Death inequality looms large in the lives of homeless people, exposing the disparity in the value placed upon their existence. In Aotearoa New Zealand, this reality is exemplified by an abysmal ‘gap’ of 30 years in life expectancy that separates homeless people from the general population. Within this ‘gap’, the majority of deaths (76%) are avoidable, including suicide, unmet chronic conditions and the frequent occurrence of lonely deaths in public spaces (Charvin-Fabre et al., 2020).

The intersection of marginalisation, devaluation of lives and unjust deaths raise profound questions regarding prevention, premature mortality and end-of-life care. These injustices shed light on society’s failure to care for all its members and emphasise the persistent and considerable obstacles homeless people face in accessing mainstream healthcare systems that are not designed or tailored to their needs; healthcare providers lack understanding of their realities and experiences. Māori are disproportionately affected by entrenched disparities resulting from colonisation and its lingering impacts and transgenerational trauma (Amore et al., 2021; Lawson-Te Aho et al., 2019). For many Māori, homelessness also encompasses cultural and spiritual dimensions of loss concerning the notion of home, rooted in dispossession from land and associated disconnection processes from whānau (family, extended family), tribes, knowledge, language, rituals and traditions, and spiritual resources across generations (King et al., 2016).

Performance has gained critical attention in health-based research due to its capacity to capture complexity and nuances related to sensitive health issues, such as homelessness (Clarke et al., 2005), disability situations (Shah & Greer, 2018) or the institutionalisation of the elderly with dementia (Kontos & Naglie, 2006). Through emotional, cognitive, and physical engagement with audiences, performance-based research has the potential to challenge taken-for-granted assumptions, disrupt stereotypes and processes of marginalisation, and reveal issues and challenges faced by people that might otherwise go unnoticed (Gray et al., 2003; Kontos & Naglie, 2007; Mitchell et al., 2006). Furthermore, motivated by the often-neglected responsibility of researchers to their participants, arguments have been made for disseminating findings to audiences beyond academic institutions (Boydell et al., 2012). Performance health-based researchers are committed to communicating their results in an accessible and relevant manner directly to ‘health audiences’ (e.g., health and allied professionals) to better inform positive change in healthcare practice and policy development.

This article delves into the making of *Before It Is Too Late*, a collaborative performance project created with the Peeps, a community of men and women who live on the streets of Aotearoa, New Zealand, who identify as Māori. The unique perspectives of Indigenous homeless people on death inequalities that impact them have received little attention in New Zealand research and health and palliative care discourses. With this performance project, we aimed to create a space with and for Māori people who experience homelessness and to confront dominant narratives. The resulting drama serves as an invitation and catalyst for initiating a critical conversation with healthcare professionals. It aims to promote critical reflection, raise awareness, foster dialogue, and establish trusting connections with Māori homeless communities to improve the quality of care provided. The outcome hoped for is that their end-of-life experiences are respected and honoured according to their priorities and aspirations.

Before It Is Too Late is part of a PhD study that seeks to explore the complex dynamics of life and death in the everyday experiences of Māori homeless people, recognising the omnipresence of death in their lives. The project emerged from the long-term embodiment of building trusting whanaungatanga (relationships and connections) between the first author (SCF), a non-Māori PhD student and medical doctor, and the Peeps. Recognising the profound impact of colonisation, power dynamics, injustice, cultural disruption, and systemic marginalisation on the lives of Māori homeless people, the project actively engages with these complex dynamics. It places the perspectives, priorities and aspirations of the Peeps at the forefront of the development and aims of Before It Is Too Late. By actively engaging with the Peeps’ priorities and aspirations, and centring our project within Māori world views and hauroa (holistic wellbeing), encompassing inter-related physical, spiritual, emotional, and familial dimensions of health (Durie, 1985), we aim to create a space for their voices to be heard and for their experiences to shape the study process. Aligned with the principles of relational ethics (Hodgetts et al., 2021), critical performance ethnography (Conquergood, 1991; Madison, 2020), and community-based research (Cornish et al., 2023), the project prioritises the value of experiential knowledge and mutual engagement. Moreover, it embraces culturally informed practices and values, embodying whanaungatanga, manaakitanga (kindness, care and respect), aroha (love and compassion), kōtahitanga (collective action, togetherness), whakaiti (acting towards all people with humility), and ongoing processes of learning and reflection. Together, these foundational principles, values and practices form the basis of ‘collaborative and relational ethics’ (Hodgetts et al., 2021; Lassiter, 2001) to foster positive and meaningful actions for social change based on the Peeps’ aspirations and priorities.

The authors of this article bring together diverse perspectives and experiences. Sandrine Charvin-Fabre (SCF), of Basque ethnicity, has long practised as a palliative care doctor with homeless people in her home country. She also worked alongside poor populations in multicultural settings of the South Indian Ocean area, where she practised as a General Practitioner for many years. Tess Moeke-Maxwell (TMM) is an Indigenous Kaupapa Māori end of life researcher; she is co-director of the te Ārai Palliative Care and End of Life Research Group (University of Auckland), and she is a founding member of the ACP Mana Enhancing Design Partnership team for Māori. TMM and SCF entertain a research friendship that has grown from the informal medical support that SCF provided to TMM when her newborn mokopuna (baby granddaughter) died during the COVID-19 national lockdown. Otilie Stolte is a Tauīwi/Pākehā Senior Lecturer in Psychology with 15 years of experience researching poverty and inequalities alongside Māori colleagues, and Ross Lawrenson, a Professor of Population Health researching inequities in cancer; both supervise SCF’s doctoral work. Tess Moeke-Maxwell provides cultural advice on SCF’s research project. Together, this team seeks to shed light on the experiences of Māori homeless people, initiate critical dialogue within the healthcare community, and drive positive change towards a more equitable, compassionate, respectful and inclusive approach to the end-of-life care.

Before delving into the making of the drama, we first provide a further description of the relational context in which the project developed, offering a more comprehensive understanding of its progression. SCF narrates the front part of the story in large part before we present the methodological approach, informed by Indigenous perspectives that sustain the making of Before It Is Too Late and the collaborative and relational work with the Peeps who have been at the core of its creation.

## Relational context of “Before It Is Too Late”

In early 2019, I (SCF) crossed paths with June (pseudonym) and the Peeps. June, a Māori woman, had created Cuppa Connection (fictional name), a not-for-profit organisation that provided material and human support to the Peeps. Centred on Tikanga Māori (ways of doing, being, knowing) values (Mead, 2016), June fostered whānau-like relationships with the Peeps, to uplift mana, - their authority and prestige - and provide healing and hope. I shared with June my home country, my whakapapa (genealogic ties), my PhD project, which resonates with my own story, and my desire to contribute as an ally in Aotearoa (Li et al., 2021). June invited me to volunteer at Cuppa Connection, where I am still involved as an informal doctor, providing essential care to the Peeps, such as treating foot or dermatological conditions, dressing wounds, and supporting and advocating within the mainstream healthcare sector.

Cuppa Connection operates in an open-air carpark strategically located at a crossing space in the town centre. By 2019, approximately 40-60 Peeps and volunteers congregated there weekly, defying a city-by-law banning the Peeps from the downtown area. Situated amidst the bustling hub of the bus station, restaurants, the city council and the public library, the carpark provided critical visibility to our gathering, transforming the streets into a performative site of resistance, mutual recognition, and human connections demanding action and dialogue (Madison, 2005). This visual presence and blatant occupation of space echo the spirit of Māori resistance and occupations of Bastion Point (1977-78) and Ihumātao (2016-2020). Anchored into the values of whanaungatanga, manaakitanga, aroha, and inclusiveness, the street performance evoked a “spontaneous communitas that offers the alchemy of human connection” (Madison, 2005, p.545).

In the midst of the busy noise of the town, the performance unfolds, creating its own melody, rhythm and movement. Tables are set up, hot coffees poured, a barber officiates, an outdoor library assembles, and tents and sleeping bags are provided. Waiata (Māori singing) fills the air, and a transistor plays in the background, guiding dance steps. In this liminal space, the street performance intertwines and encounters voices and acts of daring, camaraderie, resistance and hope, weaving stories, emotions, relationships and connections.

This collective gathering provided a momentary respite from the burden of exhaustion and shame, exclusion and solitude, danger and violence associated with street life, restoring the human bonds dislocated by homelessness. Disrupting the common flow and order of city life, domiciled inhabitants, as ‘spect-actors’<sup>1</sup> (Boal, 1974/1985), displayed disdain or indifference, astonishment or marks of sympathy, reflecting broader tensions that permeate New Zealand contemporary society.

In that context, I assumed a dual role of informal doctor and doctoral student. Many of the Peeps had been disengaged from the healthcare system for years, facing limited and irregular access to primary care and often resorting to emergency departments, if they sought care at all. These challenges reflect the considerable obstacles homeless people encounter when trying to access mainstream healthcare services, which arise from a complex interplay of structural, individual and inter-individual factors (Siersbaek et al., 2021). Among the commonly reported factors are fragmented healthcare and social services, mistrust towards health professionals due

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<sup>1</sup> The notion of “spect-actor” refers to audience members being not seen as passive receptacle but as co-creators of meaning and knowledge. The notion originates from Augusto Boal’s work “*Theater of the Oppressed*”, first published in 1974, aligned with movements of liberation in Latin America (Freire, 1970/2005).

to repeated experiences of racism, stigma and marginalisation, prioritisation of survival necessities such as food or shelter, and bureaucratic and financial constraints. As a result, unmet healthcare needs, fragmented care, lack of follow-up, delayed diagnosis, and ultimately preventable deaths contribute to the persisting ‘gap’ in life expectancy among homeless populations over decades (Aldridge et al., 2019; Fazel et al., 2014; Siersbaek et al., 2021). Moreover, the isolation from the mainstream healthcare system exacerbates unpredictable death trajectories, leading to sudden death and/or preventable deaths from palliative care conditions. Often, if end-of-life care is provided at all, it is inadequate (Hudson et al., 2016; Stajduhar et al., 2019).

The relational context of Cuppa Connection marked the starting point of a profound and enduring engagement with the Peeps, rooted in the values of whanaungatanga, manaakitanga, and the aligned cultural obligations and responsibilities. What initially started as providing basic care in the public carpark transformed into something deeper – a journey of solidarity, reciprocity, trust, and companionship that developed at its own pace over time. Throughout this shared journey, the Peeps came to know my own historical story about homelessness, which created a sense of mutual understanding and complicity. Nonetheless, I am aware of my privileges and the inherent power dynamics in our relationships. Over time, the Peeps gradually shared their many hurts, struggles, suicidal thoughts, resistance to accessing healthcare services, and their hopes. Together, we confronted the complexities of socio-cultural marginalisation, racism, misunderstanding, assumptions, and exclusion criteria within healthcare institutions and the everyday life. We faced various challenges, including the lack of material resources (e.g., phone, physical address, means of transportation) and human resources (e.g., support person). It has been, and continues to be, a reciprocal journey where the Peeps, with their generosity, have allowed me to learn and grow, gaining a deeper understanding of their unique contexts, challenges, perspectives, priorities and aspirations. Reciprocally, I provide a listening ear, medical advocacy and support.

## **The making of Before It Is Too Late**

As a non-Māori migrant doctoral student whose legitimacy to undertake research with Māori on issues affecting Māori communities is contested (Smith, 2012), SCF acknowledges the power imbalances and challenges inherent to doing research with the Peeps. Grounded in the relational ethics principle and moved by a deep sense of responsibility that emerges from whanaungatanga and companionship, SCF was committed to exploring alternatives that genuinely benefit Māori homeless communities (Hodgetts et al., 2021; Smith, 2012; Wilson, 2008) and address the cycle of death inequalities. This commitment led SCF to propose to the Peeps the idea of collaboratively creating a drama.

In this research context, the idea of a drama emerged from the embodied research practice as co-performance and co-engagement (Conquergood, 2002), forged in proximity, solidarity and humility with the Peeps. The collaborative creation of *Before It Is Too Late* was born out of the street performance of Cuppa Connection and its transformative power as an act of resistance, embodiment, mutual recognition, dialogue, and human connections (Madison, 2005). A driving force was the desire to move away from authoritative, monological, and colonial practices of representation (Conquergood, 2002; Smith, 2012). We aimed to shift away from the paternalistic act of ‘giving voices to’, which can be seen as an act of charity from the dominant to the dominated (Ahmed, 2000). As argued by Madison (2005), a street performance

is “a performance of possibility...a possibility of another strategy, for collective hope and dreams coming to fruition” (p.539). Art-based strategies (e.g., drama theatre, art exhibits) have been increasingly recognised as alternatives to bridge the knowledge-application gap by generating critical awareness regarding the relationships between social, cultural, and human contexts and care practices (Boydell et al., 2012; Conquergood 1988; Gray et al., 2003; Rossiter, 2012).

Our focus, however, goes beyond traditional performance and ethnographic approaches shaped by Western conceptions of theatre and anthropology. Instead, we aimed to create a transformative space informed by Indigenous perspectives, emphasising life and knowledge's relational, embodied and spiritual dimensions (Meyer, 2008; Smith, 2012). Performance ethnography may take on a new dimension, with the potential to become a ‘ceremony’ (Wilson, 2008), a place of well-being and healing, a participative dance that makes people feel better and happier and wants to live longer (Magnat, 2012; Wilson, 2008). Accordingly, performance may become a medium of exchange, a site of dialogue where encounters and relationships are essential to understand “into” and respond to the world differently. Health audiences are thus invited to important forms of ‘response-ability’ (Rossiter, 2012), which means the ability to respond to the dramaturgy of unequal lives and early death impacting homeless communities.

The entire performative project, its purpose, the why, and the how have been extensively discussed and collaboratively developed with the Peeps to ensure that the project is the fruit of shared, mutual, relational, and respectful understanding. Throughout these discussions, the project, including the script, was shaped with and by the Peeps’ strengths, aspirations, priorities and lived experiences. All of the decisions regarding the project were made collectively, fostering a sense of ownership and agency amongst the Peeps.

During these discussions, the Peeps addressed several key issues and areas of improvement within the healthcare system. These encompassed improving access to primary care, fostering more supportive, welcoming, respectful and humanistic environments, reducing judgmental attitudes, and simplifying enrolment and follow-up procedures, particularly for people with chronic health conditions. Mental health issues, suicide ideation and addiction were identified as critical areas, given the prevailing stigma and stereotypes of all homeless people as “drug addicts”. Further, the Peeps highlighted the conflicting responses between biomedical responses to mental health, primarily centred on ‘distributing pills’ (e.g., anti-depressants), and their own perspectives on health and wellbeing. In face-to-face moments of sharing with SCF, these conversations delved into experiences of trauma that were not being addressed collectively. Over time, some of the Peeps courageously shared some aspects of their traumatic stories that, for many, began at an early age and are deeply intertwined with the broader context of transgenerational trauma (Wirihana & Smith, 2014) and its impact on homelessness.

Familial abuse, for example, is not an isolated issue but is interwoven in complex ways with the collective and transgenerational trauma resulting from the impacts of colonisation, which undermine the social and cultural resources to protect children and whānau (Johnson, 2009; Wirihana & Smith, 2014). Those who find themselves forced onto the streets to escape violence or placed in state care, where they often experience further abuse, often carry the burden of trauma and intricate connections, whether symbolic or tangible, with their whānau (Groot et al., 2015). In such circumstances, the perspective of death and dying can intensify or rekindle these experiences (Te Ohu Rata o Aotearoa, 2019). Indeed, for many Māori, in continuity with

life, death and dying is a relational, spiritual, and transitional journey, primarily cared for by whānau within whakapapa and honoured through *tangihanga* (death rituals and customs) (Moeke-Maxwell et al., 2014; Moeke-Maxwell et al., 2019b; Moeke-Maxwell & Nikora, 2019). Tangihanga is one of the last Māori institutions that has survived colonisation (Ngata, 2005) and is considered the ‘pinnacle’ of Māori cultural expression of deep spiritual significance (Moeke-Maxwell et al., 2019b; Nikora et al., 2010). Paratene Ngata (2005) states that through tangihanga, “the spiritual dimensions of humanity strengthen the delicate relationships between the living, ancestral and spiritual worlds” (p.31). Being farewelled as Māori, to be part of a spiritual continuity within their whakapapa, to be recalled as an ancestor, and buried on tribal lands were uncertainties that significantly penetrated the lives of many of the Peeps and often depended on the possibilities – or not – of familial reconnections and relational healing processes. Challenging the dominant assumption that quality of end-of-life care for homeless people should focus on pain and physical symptom management in shelters and healthcare settings (Podymov et al., 2006), as it is often the case with the Western notion of palliative care, the Peeps opened up the possibility of a different conversation, regarding their priorities and aspirations prior to death. This conversation cannot be separated from collective practices of love and care and their spiritual and relational experiences of the world through whakapapa, which provide and nourish a sense of belonging and spiritual continuity (Moeke-Maxwell et al., 2019a; Moeke-Maxwell et al., 2019b).

The cultural and social support provided by a ‘whānau-like’ fabric on the streets, embodying ancestral knowledge, beliefs and home-making practices (e.g., learning/reconnecting with te ao Māori and the Māori language at the public library), which play a vital role in sustaining well-being, hope and self-esteem. This perspective counters a view of homeless people as passive victims and highlights their resistance, agency, and the significance of community relationships and connections. These discussions underscored the importance of active listening and suspending judgment when confronted with the everyday lives of the Peeps, as health professionals remain poorly aware of the challenges they face and their socio-cultural contexts and life conditions on the streets.

An important ethical stance throughout the project was to avoid creating more suffering or clichés and stigma about homelessness. The script was carefully crafted, prioritising cultural humility (Danso, 2018), sensitivity and respect for the Peeps’ experiences. It moved away from a commitment to verisimilitude and realism, which raises important ethical, epistemological, and political concerns. Questions of ownership, authorship, breaches of confidentiality, the potential harm that could result from the use of direct ‘data’, and the notion of a singular and naturalistic ‘truth’ are pivotal in this context (Smith, 2012).

Aligned with the critical stance of the performance ethnography endeavour, the project embraces the creative power of performance as an interpretative and critical tool by accounting for various narratives and perspectives. SCF has drawn on her abundant field notes, and memories of shared and embodied emotions throughout the journey with the Peeps, to write a loose and preliminary script that included key messages towards more equity, compassion, respect and understanding as agreed with them. Composite characters, a dialogical plot with confronting interactions and relevant fictional situations were woven into the script to capture the nuances and complexities of the Peeps’ experiences. Moreover, to ensure the engagement and connection of future audiences in the conversation, careful consideration was given in the script crafting, to avoid a defensive stance that could obscure the messages being conveyed

(Gray & Kontos, 2015; Mitchell et al., 2006). SCF then sought collaboration with a drama teacher and students who brought their scenographic and artistic skills to enhance the emotional range and imaginative possibilities (Saldana, 2003). The script was reviewed and corrected by Moana (pseudonym) and Mark (pseudonym), two of the Peeps, before being presented with shared emotions in the community garden, where we met weekly. This collective effort aimed not only to create an engaging performance but also a heartfelt conversation with health audiences, fostering a sense of collective responsibility and care.

## Before It Is Too Late

*Narrator: Ladies and gentlemen, we now invite you on a journey with two Māori friends, Tāmāti and David (composite characters), who have decided to introduce you to the intimacy of their daily lives on the streets, to uncover the hidden part of their struggles and suffering, to share with you their hopes. Their purpose is for you to confront the unexamined assumptions about homelessness in Aotearoa New Zealand, to deeply feel with your open mind and heart their call for presence, recognition and attention (Charon, 2016) so that together you can initiate a healing conversation about life and death, about the unequal value and worthiness of their existences, from their perspectives. We hope, after Charon (2016), that you will ‘affiliate’ with Tāmāti and David to form a culturally safe community of care and connection. David is struggling with complex mental health issues and suffers a high burden of disconnection from his whānau. Tāmāti experiences significant challenges while suffering an underdiagnosed cardiovascular condition. Their bodies, their souls, and their selves tell a story – their story – that David and Tāmāti invite you to read aloud to enter in resonance with them. A glossary of Māori terms and scenographic conventions has been included at the end of the play to ease your encounter with the everyday life of the Peeps and the cultural context. The words that are marked with an asterisk refer to glossary terms. We invite you to familiarise yourself with the glossary before reading. Given the disturbances due to the COVID-19 pandemic, the performance project to be diffused to large audiences, including a video of *Before It Is Too Late*, has been delayed. Hence, a reading version, in three acts, is presented here. We now leave you, members of the audience, in the company of David and Tāmāti.*

### Act I

*Actors, all turning their backs to the audience: David, a homeless man in his 50s, a General Practitioner (GP) with a stethoscope around his neck, a woman in her 40s, a man in his 60s, a man in his 30s wearing a label on his shirt ‘Mental Health’, a woman nurse in her 50s wearing the same label, a narrator.*

### Scene 1

*Two chairs, a desk, and a computer on. The GP sits on a chair, turns to his computer, clicks on, and looks to David, who is sitting on the other chair, looking straight forward.*

GP: Medical consultation. The time is 11.30 a.m.—a jumbled monologue. David is rambling, and I can’t get a word in. Time is running short.

DAVID (*agitated*): All this shit, it’s hurting me all the time.

Playing on my mind. Family hurts. I walked away from them.

Now, they’ve come back into my life. The hurt’s back with them.



I’ve been to the police about that just recently.

‘You’re a disgrace to your whānau’. I can’t be a disgrace to my whānau. We’re all fucking offenders and bloody liars.

Going to the cops, it’s the only bit of safety I have.

Now they’ve heard from the law. Get it through the courts. I’ll pay the punishment. Better than the shit I’m having.

They’re going to bury me. Bury me somewhere.

The police, I’ve got a better deal out of them. I seem to be catching all the fucking trouble for this shit.

The pills? Not taken for months, they don’t fucking work on me! But if I don’t take them at all, shit gets real fucked up.

Alcohol? Two years sober.

Drugs? Weed, smoking tinny, no worries.

GP: The monologue continues with the ghosts in his head, with the darkness. There has been no counselling, no aid. Time is over now. 11.45 am.

*David takes the script while standing up. He returns, striding to align with the row of actors, turning back to the audience. The doctor stays on his chair, holding his head in his hands.*

## Scene 2

*All actors turn their back to the audience, except David, who is lying on a bed.*

NARRATOR: A small and dark, dingy room in a boarding housing. Flickering light, a single bed. No other furniture. 4 pm the same day.

*David lies perfectly still on his bed, grounded with a blanket over his head. Only his shoes exposed.*

*The woman turns to the audience, walks slowly and knocks on a door. No noise. She knocks again, louder. She waits—an eternity of one minute. Carefully, the woman opens the door and enters into the room. Dead silence. She reaches the bed and stops. Waits again. Looks back at the door, and hesitates. She wipes her hands on her pants, several times. She leans over and delicately lifts the blanket to the level of the head.*

*David opens his eyes and pops up on the edge of the bed like a Jack-in-a-box, ready to move on.*

THE WOMAN: Jesus! You scared me!

*A slightly curved man, in his 60s, wearing old pants, a khaki tee-shirt, and bare feet, passes along the stage.*

THE MAN (*continuously repeating*): What’s my name? What’s my name? What’s my name?

DAVID (*exasperated*): Shut up! You’re going to give me a headache. I can’t hear myself think. Get out of here!

*The man disappears, leaving the stage.*

DAVID (*angrily*): They're putting a lot of crazy guys here. It's not right for me when they throw them in here. You don't wanna talk to people who are talking crap all the time.

*David puts his head in his hands.*

DAVID (*distressed*): My head is in a really bad place. I don't know which way to move, which way to turn. All this shit, it's hitting me like a sack of bricks. It's all coming down on me, and I can't do anything about it. I feel really down and about to give up. Here is where the unwanted people go. I need help, I went for help, and I'm still here. Nothing has changed.

*David and the woman slowly return to align with the other actors, turning their backs to the audience.*

### Scene 3

*Three chairs are arranged in a circle. David sits on a chair. The nurse and the young man sit in front of David, widely distanced from him. The man types continuously on a laptop, laying on his knees. A table with a medical tray, an injection, a phone.*

NARRATOR: 7.30 pm the same day in an acute mental health service.

DAVID (*begging*): You're going to put me in the ward. I'm really sick. I don't know what I wanna do with myself. I'm three seconds away from throwing myself off a bridge.

*The man is still typing. The phone rings, the woman nurse answers.*

NURSE (*turning to David*): Sorry, David, it's very complicated, but we can't admit you tonight on the ward. But we can discuss other options.

*David stays silent, crosses arms, bends forward and looks at his feet.*

*The nurse stands up, prepares an injection, and then takes the injection to David.*

NURSE (*pulling down David's sleeve*): Here we are. You should feel better tonight. Tomorrow, mental health will contact you for the follow-up, right?

DAVID (*resigned*): How? With what?

*The nurse looks at David emphatically but has no answer for him. Staff members return to the row of actors, then David. All turn their back to the audience.*

## Act II

*Actors: Tāmami is a homeless man in his 50s, a nurse, a doctor in his 50s (stethoscope around his neck), a triage nurse, an Emergency Department (ED) health practitioner in his 60s wearing a hospital scrub, a lady well dressed, wearing flashy red lipstick and a showy pearl necklace, a narrator; Voices in the head (3 people, A, B, C). Same dispositions as Act I, all actors turn their back to the audience when they are not acting.*

### Scene 1

*Tāmami and the nurse are sitting on chairs. A table with a computer on. A phone.*

NARRATOR: A medical consultation in a community primary care organisation. Time is 8.30 am.

NURSE: Kia ora\*

TĀMATI: Kia ora

NURSE (*cheerfully*): Seems I’ve seen you before or your cousin, maybe? Are your whānau\* coming from Nūhaka?

TĀMATI: Yeah.

*Tāmami rubs his scalp with his hand.*

NURSE: Did you fall?

TĀMATI: Um... Yeah.

NURSE: When was that?

VOICES IN THE HEAD (*3 people, insistently, turning around Tamami*): When? When? When?

TĀMATI: Um... Three... or maybe four months ago.

VOICES IN THE HEAD\* (*3 people, insistently, turning around Tamami*): Why? Why come today? Not another day?

TĀMATI (*rubbing his scalp again*): Um... I feel like there’s something wrong in my head. It’s moving, you know, like water running down my face.

NURSE: How did this happen?

VOICES IN THE HEAD\* (*anxiously, turning again around Tamami*): How? How? How?

TĀMATI: Um.... I fell down .... Um... Three times that day, like getting sucked into a black hole. (*Rubbing now his right leg*) And my legs feel like jelly.

NURSE (*looking at Tāmami, smiling with complicity*): You look very TIRED.

TĀMATI (*smiling*): No, I’m fine.

NURSE (*insistently*): No, you’re NOT. You’re tired. Do you understand what I mean? There’s no GP here, so I’m sending you to a GP clinic. It will be free the first time, you understand?

*The nurse and Tāmami hug.*

NARRATOR: Consultation is over. The time is 10 am.

*The nurse returns with the actors, all turning their backs to the audience. Tāmami stays on stage, sitting on his chair and slowly falling asleep.*

## Scene 2

*A table. Tāmami sleeps on a chair, slightly snoring.*

NARRATOR: A GP clinic, same day. The time is 10.30 am.

*Dramatic pause\**

NARRATOR: Still in the GP clinic. The time is 12 pm.

*The doctor turns to the audience, walks toward Tāmāti and clears his throat loudly.*

*Tāmāti sits up on his chair, surprised.*

DOCTOR: Why are you coming today for something that happened four months ago?

TĀMATI (*to himself*): Fuck, it's always been the same question .... (*louder*) Um... you know, it's like something wrong with inside my head, like moving inside. And also, I feel .... Um .... (*determined*) TIRED and also, it's SORE.

*Medical examination takes place.*

DOCTOR: Well, I will call the ED and see if you can get a CT scan for today and email ED the form.

TĀMATI: Hospital? Is there anywhere else I can go?

VOICES IN THE HEAD\* (3 people): A: That's where Dad died B: They left him C: He died alone.

NARRATOR: Consultation is over; the time is 12.30 p.m.

*The doctor moves back to the backstage, back to the audience. Tāmāti walks on stage.*

### Scene 3

*A chair.*

NARRATOR: Emergency Department, 10 km away. People are sitting on a row of old grey plastic chairs, waiting. A TV screen displays the same programme over and over. One hears routine hospital noises, including the sound of sliding doors and ambulance sirens. The time is 1.30 pm.

*The triage nurse turns to the audience and walks toward the front stage.*

TRIAGE NURSE: Why are you here today for a fall that happened four months ago?

TĀMATI (*hesitating*): Um.... I've been to the GP. He told me to come here.

TRIAGE NURSE (*exasperated*): Wait here.

*She disappears on the backstage for a while. Tāmāti is anxious. The triage nurse comes back, holding a piece of paper in her hand.*

TRIAGE NURSE: Go to the reception. Then, wait until we call you, but it could take a few hours. It will depend on the flow of patients needing REAL URGENT care.

*Tāmāti sits on the chair. The triage nurse goes back to the line, turning her back to the audience.*

NARRATOR: The time is 4 pm. (*Dramatic pause*). The time is 5 pm. The CT scan has been performed. (*Dramatic pause*). The time is 7 pm.

*Sound effects include the noise of beeping machines and curtains on the metallic rods.*

*The young doctor turns to the audience, walks to Tāmāti, and stands in front of him. He holds a folder in his hands.*

ED DOCTOR (*reading aloud and quickly*): Your CT scan has shown that there was neither involution of the parenchyma overlying the alveolar interstitial space nor any infarction of vital structures or dysfunction of intra capillary pressures (*looking at Tāmāti and cheerfully*), which is GREAT! But we still don’t know the reason you fell down so many times. We need to do more tests. So, go visit your GP first, then he’ll refer you to the specialist.

TĀMATI (*looking all around, hesitating, with a stifling voice*): I’m not with a GP.

ED DOCTOR: I see, but ED cannot do the referral. It’s the process. You need to be referred by a GP so we can organise the follow-up if you need treatment and so forth. Does it make sense?

*The ED doctor goes back to the lines of actors, turning his back to the audience.*

NARRATOR: The time is 8 pm. It is a dark and freezing winter night on the streets.

TĀMATI (*standing up and rolling a cigarette*): Fucking seven hours worrying with just a glass of water. I’m fucking hungry now. Holly shit, I missed dinner at St Mary’s church. (*lamenting*) It’s the best feed of the week. There’s always this old lady with her cake. It gets me wired for the night. She knows how to pile on the sugar. At least, I can stay awake for as long as I can and feel a bit safe with all these guys just hanging around waiting to steal my stuff and trying to give me a hiding.

#### Scene 4

*TĀMATI and the NURSE sit on chairs. A table, a computer, a phone.*

NARRATOR: Back to the community primary care organisation, one week later. The time is 9 am.

TĀMATI: Kia ora\*

NURSE: Kia ora, Tāmāti. Lovely to see you again. How are you going today? You’re looking much better.

TĀMATI: Yeah. I feel relieved. I was really worried. I didn’t understand all their medical stuff, but it seemed all good. I need more help from a specialist, though. At the hospital, they asked me to enrol with a GP. I don’t know how to do that. I haven’t been to a GP for so long now. The last time was maybe 5 or 6 years ago in Wellington.

NURSE: Oh, that’s quite a long time ago. First, you need official documents: An ID photo, a birth certificate, and evidence of your address; for example, an electric bill or a tenant agreement showing you have an address. Or a sworn statement from a friend or a member of your whānau that certifies you live with them, but anyway, you’ll have to provide an invoice or an official document with their names and addresses on it.

TĀMATI (*taking out of his pocket an ID and showing it to the nurse*): Does the photo on here work?

NURSE: Yeah, sure. It's great you have that because it would have cost you at least \$55 more to get another ID. For the birth certificate, you can order it online. It costs \$33. I'm not sure if you can get it through email, though. You'll probably need an address to get it. Or you can go to WINZ\* if you are on the benefit. They may provide you with a copy, but not all GPs accept a copy. Otherwise, WINZ will retain the cost on your benefit. Do you have any documents to show evidence of an address?

TĀMATI (*laughing, sarcastically*): Lucky I'm on the waiting list for housing. It's only been FOURTEEN months. I'm stuck in this town for now. *Pause*. Yeah, I'll get a piece of paper with an address on it.

NURSE: Perfect. Where is this address?

TĀMATI (*hesitating*): Um .... 24 Lake Road.

NURSE: I know that place. It's not that far from Central Care Clinic. Should we try this one?

TĀMATI: Um... I'd prefer the medical centre near the church on Greenwood Road.

NURSE: I know what you mean, but with the address on Lake Road, unfortunately, you can't go there. You'd need to find a GP near Lake Road. It's zoned (*looking at the computer*). Not that much, around there. I can give a call to Central Care Clinic and see if they accept new clients.

*The nurse gives a call, another one, another one. Soundscape of recorded voices saying, "We don't take any new clients. We don't take any new clients. We don't take any new clients".*

NURSE: Finally! So, you have an appointment booked for next Friday, the 23<sup>rd</sup>, at 9.15 a.m. at Compass Health on Bolton Street. That's near the Warehouse\*. Don't forget, bring all the documents with you. Good luck.

*Hugs. Tāmati returns to the lines of actors, back to the audience. The nurse stays on her chair, holding her head in her hands.*

NARRATOR: The time is 10.30 am.

## Scene 5

*A lady stands behind a table with food and a pile of plates. A chair.*

NARRATOR: Friday the 23<sup>rd</sup>, time is 9 am. A foyer of a church.

LADY: Good morning, let me guess.... Tama?

TĀMATI: Good morning. My name is Tāmati.

LADY: I was so close (*laughing*) it's quite hard to remember all the Māori names. (*Declaiming loudly*) Today, we have: Hot handmade pancakes with fresh fruit salad and topped with cream. Can I serve you a plate?

*Tāmati sits and eats his pancakes in silence. Then disappears backstage. A soundscape of recorded shower noise. Tāmati back on the front stage, smoking a cigarette.*

TĀMATI: It feels like I can forget about that GP appointment and go find somewhere to relax. For sure, that lady doesn't even remember my name. But at least, she didn't start her sentence with, "Hi, homeless guy! ". Where can I go?

VOICES IN THE HEAD\*: A (*severely*): WINZ\*?; B (*more neutral*): Church? C (*nicely*): Public Library?

TĀMATI: There will be some mates at the library. What’s the day today? Friday. Bloody Hell! There’s that security guard. He hates us, always yelling: Why should I let you come in? Why should I have to help you, eh? Bloody bastard! I’m fed up with all their questions.

*Tāmāti turns alternatively to the voices in the head.*

VOICES IN THE HEAD\* (*insistently*): A: Do you have an address? B: Do you have a paper with an address? C: Do you take any drugs or alcohol? A: Are you on the benefit? B: Which category? C: When did you fall? A: Why are you coming today?

TĀMATI: I feel like shit all the time.

VOICES IN THE HEAD\*: A: Housing first\*? B: Salvation Army? C: Hot pools\*?

TĀMATI: I would have had a great time at our hot pools and freed my shoulders from pain. But that’s always the same shit. Too many rich people lived around the area, and the council closed it. Like it’s in our DNA to be underdogs. Fuck you.

VOICES IN THE HEAD: A: Citizen’ Advice Bureau\*? B: Pak’n Save\*? C: Gardening?

TĀMATI: That’s a great spot, the garden, the one of connection. Relax, smoke cigarettes, and have a chat with the bros. Yeah, feels like I’m the king of the street, (*smiling*), a luxury streey in my Mercedes, eating the potatoes of our whēnua\*. Better than the fucking sandwiches they serve at the soup kitchen! I’m the boss. I’ll protect the bros from all these crazy fucking gangs. Bloody dealers! They won’t get us.

### Act III

*Actors: David and Tāmāti sit on the floor. Recorded soundscape of street noise. A chorus\* (5 people) in line turns to the audience. One holds money in his hands, another one a pizza box.*

NARRATOR: Time is endless.

CHORUS (*pushing aside one another*): A: Give them money; B: No, food; C: Make them invisible D: Visible; E: Give them nothing.

DAVID (*coughing a lot*): Fucking shit, I feel like I’m dying.

TĀMATI: Hey, Bro. Not yet, not the right time. Not the right place.

DAVID: That’s the one. I can’t afford to go back to my whānau\*. It’ll kill me. Even away from them, I’m going to get hurt. Look at me, Bro. When I got off the streets, I was nearly dead. Now my sanity has returned away from them. And right now, I’m feeling good about my achievement. I mean, I used to wake up on the streets and say to myself, I’m going to get more cans. If I have three cans, I’m certainly going to end up in a coffin, so I’d go and buy just two so I wouldn’t kill myself on the spot knowing I was that close to fucking death. I’d still go and get two cans and not three. If I was still alive after those two cans, I’d go over and get that third can.

*Dramatic pause\**

TĀMATI: Seven years I didn’t see my kids and my moko\*. It’s just like I know them, but I don’t know them. I mean, I can’t even go back to see my whānau\*.

DAVID: Do you remember Jack, the bro who died from cancer, last Christmas? He moved back to Wellington to care for his mum. She had cancer. He did all he could for her, trying to make her life on Earth as comfortable as possible. He gave up his job and all sorts. And holy shit, she's back in heaven now and him too. He was floating around, staying at friends' places here and there, trying to sort out a rental without a job.

TĀMATI: Yeah, I remember Jack. He was a good dude. It was too late when they found his cancer. One day, I was putting up with that fucking pain in my shoulder. "Eh, Bro, I have a talent with spiritual healing. I ain't been doing it for a long time now cos... um... I burnt someone one time with too much heat". He was doing by heat, and he just wanted to give me a bit of that gift. He put all his energy on my shoulder, heated up and heated up and suppressed it. Far out, that was great stuff. And always putting aroha\* in all he did.

DAVID: And now he's dead too. He never saw his moko before dying. And he never got his campervan or to travel around the country.

TĀMATI: You're right, Bro. Just don't feel it. I'll give my body to medical training, so it will cost nothing to my whānau\*.

DAVID: I'm planning that day too. I don't want my family at my funeral. I don't care about their protocol or whatever.

TĀMATI: Bro, we're a kind of family, right? Don't give up on life. Not time for your wairua\*.

DAVID: That's true.

*Dramatic pause\**

DAVID: I'm used to talking bad about my whānau\* and that is because I miss them, and I love them so much. That's why I'm talking like that. They're all having difficult times. Do you remember that guy last week at the community meal? The bros were fighting. "You're all one. You don't need to fight. Choose aroha". That's not true, bro. I can't choose aroha cos I don't know what's going on with that.

TĀMATI: Stop mixing up your mind, Bro! Let's go for a meal and see if there are some new faces coming.

DAVID: No, Bro. I want to go forward with Hoani Waititi's book. It's really intellect, man, this guy's books. I'm getting it straight away. Te Reo\*, that's in my DNA and something I love, made up of structure. I even caught out a kaumātua\*one day. He was wrong about connecting the noun with the verb. Without a connector, your sentence is dead straight away.

TĀMATI (*standing up*): Sweet as. I'm not that clever, man.

*He leaves the stage.*

DAVID (*to himself*): Connecting .... or .... Dying straight away.

*A tui\* sings. David smiles at the sky and then leaves the stage.*

## Conclusion

In the pursuit of anti-oppressive research practice, critical performance ethnographic inquiry has usefully provided a meaningful methodology, allowing the voices of the Peeps to be heard



by healthcare and allied professionals. The perspectives and concerns of the Peeps are of central importance as a deliberate attempt to build respect, inclusiveness, equity, fairness and a collective commitment forged with Māori homeless communities. This commitment aims to enhance the quality of care provided and support their wellbeing and end-of-life experiences in accordance with the priorities, aspirations and rights of the communities. To bring the project *Before It Is Too Late* to fruition, the next step involves producing a video recording of the drama and disseminating it among healthcare and allied professionals. This dissemination will provide a platform for audiences to offer comments and feedback. Notably, several professionals on the ground have already expressed interest in the project and its potential to shed light on the challenges faced by the Peeps within mainstream healthcare services that perpetuate unequal and ineffective care.

## Glossary

**Alienation effect:** Device of distancing audiences from emotional identification with dramatic action for the purpose of making political or social comments through drama (e.g., the position of actors turning their backs to the audience).

**Aroha:** Love and compassion.

**Citizen’s Advice Bureau:** Charitable organisation that provides free and independent legal information and advice.

**Chorus:** Convention in which a group of people provides a spoken explanation or commentary on the current action.

**Dramatic pause:** A beat or two of silence to heighten the anticipation of the reveal or that can also be used after the reveal.

**Hot Pools:** For generations, Māori have used thermal waters for medical purposes such as skin and rheumatic conditions.

**Housing First:** Agency that provides housing assistance with a focus on recovery, community inclusiveness, and self-determination.

**Kaumātua:** Elders. Kaumātua have an important role within their whānau and tribes, including preserving traditions and knowledge, providing leadership, and nourishing the younger generations.

**Kia ora:** Informal way to say hello.

**Moko:** Māori abbreviation for mokopuna, which means grandchildren.

**Pak’n Save:** Large discount grocery store.

**Te Reo Māori:** Māori language. Until recently, Te Reo Māori was threatened with disappearance due to the assimilation policies over the course of the 20<sup>th</sup> Century that discouraged Māori from speaking their own language. It is considered now as an essential element of cultural reconnection and central to health and well-being. Te Reo Māori was recognised as an official New Zealand language in 1987.

**Tui:** Endemic bird with two voice boxes in one body, enabling it to sing in two realms simultaneously. Tui are a metaphor for diversity, polyvocality and possibility.

**Voices in the head:** Refer to actors voicing the inner thoughts of a character.

**Wairua:** Spirit. A foundational aspect of Māori metaphysics and Māori health, the spirit of a person exists before birth, transits during the physical life to return to the spiritual realm at the time of death. Dying is thus experienced as a spiritual and transitional journey.

**Warehouse:** Large discount retail store.

**Whānau:** Extended family network. First link of Māori societal organisation committed to provide collective health and wellbeing, secure identity, intergenerational transfers of knowledge and experience, and cultural heritage. Seriously dislocated by the colonization process, the notion of whānau is nowadays the focus of health policies to support healing, development, and empowerment processes of Māori communities.

**Whenua:** Land. It must be understood as a place of physical, social, cultural and spiritual nourishment, connections, and belonging.

**WINZ:** Acronym for Work and Income New Zealand. A welfare agency provides people with limited financial, employment, health disability and housing assistance. For Māori street people, attending WINZ is a prerequisite to getting assistance. However, it remains an unpleasant, bureaucratic and judgmental experience.

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## Ethical Approval

This work has been approved by the Human and Research Ethics Committee of the University of Waikato (HREC 2019#80).

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## Conflict of interest

Nil

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