Mental Health and Wellbeing Commission

What the Initial Commission heard and read during the He Ara Āwhina co-define phase

Summary paper

Contents

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Ngā mihi nui ki a koutou. Naku te rourou, nau te rourou, ka ora ai te iwi (traditional whakatauki).

Thank you all so much. With your food basket and our food basket, the people will thrive.

What the Initial Commission heard and read during the He Ara Āwhina co-define phase

Summary

The Initial Mental Health and Wellbeing Commission (Initial Commission) asked for feedback from the public on what a framework for monitoring mental health services and addiction services should look like. Key messages that they heard were:

- **Support starts and continues in the real world, with people in communities, not services.** The former Mental Health Commissioner's framework was considered a useful start that could be refined and built upon. However, the focus of that framework was considered too narrow for the Mental Health and Wellbeing Commission's (the Commission) role.
- **The voices of Māori and tāngata whaiora[1] need to be paramount** in assessing how well services and other approaches to wellbeing are meeting the needs of Māori and people with lived experience of mental distress and / or substance or gambling harm and those who support them.
- **There needs to be a shared understanding of what 'good' or transformative services and supports look like** so the Commission can monitor and assess performance and contribute to wellbeing outcomes. The Commission can play a leading role in filling this gap.

Background

This paper summarises what we heard and read between September 2020 and March 2021 to define together with people and communities what they wanted to see in a framework that would monitor mental health services and addiction services and advocate for improvement. The working title of the framework is He Ara Āwhina or 'pathways to support'. The framework will be used by the Mental Health and Wellbeing Commission (the Commission) to carry out some of its functions.

The co-define phase of He Ara Āwhina was led by the Initial Commission and finalised by the Commission after it was established on 9 February 2021. For simplicity, we will refer to this co-define work as being undertaken by the Initial Commission.

[1] Tāngata whaiora – people seeking wellness.

Why is He Ara Āwhina needed?

The Commission has seven functions that it must perform under section 11(1) of the Mental Health and Wellbeing Commission Act 2020 (the Act):

a. To assess and report publicly on the mental health and wellbeing of people in Aotearoa

b. To assess and report publicly on factors that affect people's mental health and wellbeing

c. To assess and report publicly on the effectiveness, efficiency, and adequacy of approaches to mental health and wellbeing

d. To make recommendations to improve the effectiveness, efficiency, and adequacy of approaches to mental health and wellbeing

e. To monitor mental health services and addiction services and to advocate for improvements to those services

f. To promote alignment, collaboration, and communication between entities involved in mental health and wellbeing

g. To advocate for the collective interests of people who experience mental distress or addiction (or both) and the persons (including family and whānau) who support them.

The Initial Commission started the development of the He Ara Āwhina framework to provide a way for the Commission to "monitor mental health services and addiction services and to advocate improvements to those services" (s11(1)(e)). This was the function of the Mental Health Commissioner under the Health and Disability Commissioner Act 1994 but has now transferred to the Commission.

The He Ara Āwhina framework will link to the Commission's He Ara Oranga wellbeing outcomes framework. The He Ara Oranga wellbeing outcomes framework provides a way for the Commission to assess and report on wellbeing outcomes for Māori as tāngata whenua and all people in Aotearoa and the factors that affect people's mental health and wellbeing (s11(1)(a), s11(1)(b)).

What did the co-define phase cover?

During the co-define phase of the He Ara Āwhina framework, the Initial Commission asked for feedback on three key questions:

1. **Why monitor?** – What is the value-add of and stakeholder expectations for the Commission in how it monitors services?
2. **Monitor what?** – What is the scope of services to be monitored and how do we define them?

3. **How to monitor?** – Is the existing Mental Health Commissioner's monitoring and advocacy framework fit for purpose? What else should be considered?

The Initial Commission asked for feedback through a discussion paper posted on the Initial Commission's website. They also emailed the discussion paper widely to their networks. Lived experience focus groups and targeted talanoa and hui, as well as two Ministry of Health workshops, were also held. Feedback was received from 97 individuals and groups representing a broad range of perspectives (see Appendix 1).

The Initial Commission also did a literature scan of frameworks and models related to monitoring mental health and addiction services, understanding complex social systems, and monitoring and assessing progress and system change (see Appendix 2). This built on literature reviewed for the development of the He Ara Oranga Wellbeing Outcomes Framework. The literature scan included frameworks and models suggested by submitters and people that took part in the co-define phase.

What the Initial Commission heard in the co-define phase

Co-define question 1: Why monitor?

The Initial Commission asked people how the Commission could best add value and how they expected the Commission to make an impact in a crowded monitoring environment. We also asked how the Commission can go about its work to monitor and advocate for services to make sure there are equitable outcomes for Māori.

The feedback we got showed people have high expectations for the Commission generally, as well as specifically in how we monitor mental health and addiction services and advocate for improvement. People spoke strongly about sector leadership, advocacy, ensuring equity for Māori, and taking a big picture system view.

Many people expect the Commission to act as a leader in the mental health and addiction sector: "We have heard equally strong calls for local led solutions as well as strong national leadership." (Hāpai te Hauora Tāpui). Some said they expect the Commission to take a collaborative approach to monitoring and build strong partnerships and relationships.

> "We would like to see ongoing communication, relationship building, and feedback sessions between the Mental Health and Wellbeing Commission and service providers." (Age Concern NZ).

People spoke a lot about advocacy. Many wanted to see us advocate on behalf of people who access, or want to access, services and hold the sector and Government to account through the Commission's monitoring function. Some expected our advocacy to lead to system change, and that this would require the Commission to provide strong and independent advice.

> "Monitoring is important so we can effect change - so we know what's not working and what we should do about it, and what is working and how it can be brought in." (Lived experience focus group member).

When talking about impact for Māori, people spoke strongly about equity for Māori and upholding Te Tiriti o Waitangi. They were clear that Māori need to be a partner in developing any monitoring and be actively involved in any data collection and interpretation so that it works for Māori.

Māori engagement needs to have 'equal explanatory power', and Māori data sovereignty needs to be paramount – the same ideas came through strongly in the Technical Advisory Group for the He Ara Oranga wellbeing outcomes framework. Some people said monitoring needed to be inclusive capturing the voices of all Māori, particularly urban Māori, and not just iwi.

> "The current system is not for us. It was set up by others to define us by their set of rules. You need to increase the engagement of Māori in systems of feedback." (Tangata whaiora Māori focus group)

A common theme across all discussion paper questions was that the Commission needs to take a holistic view of the system and focus on the social determinants of health and the health of systems and communities, as well as mental health services and addiction services. People asked us to take a wide view and monitor other services and supports that support people to be well, for example, income support services and housing providers, community activities and preventative supports, such as school mindfulness programmes and social and fitness groups. However, a large minority said the Commission needed to balance having a broad approach to monitoring wellbeing with making sure we keep our focus on mental health services and addiction services and people with the greatest mental health and addiction needs.

> "The Commission needs to stay focussed about what they're there to do - advocating for the mental health and addiction system - and not get overloaded with the monitoring function." (Tangata whaiora Māori focus group)

People asked the Commission to connect with communities and understand what is working (or not), to have a strong focus on equity. They told us we need to engage widely with Māori and other groups such as Pacific Peoples in a range of settings (communities, whānau, leaders, services, workforce etc) and partner with Māori in our monitoring design and analysis. Some people said the Commission should use its position to advocate for better data collection within the sector and track trends over time. A number told us that for monitoring to be truly valuable, we will need to engage strongly with people with lived experience about what does and doesn't work for them in service use. A few said that monitoring needs to start with a clear idea of what works for people and that the Commission should use that to inform what measures are used.

> "It's important that the conceptual drives the data. It's easy to collect quantitative measures, but that's not necessarily measuring what works." (Mental health lived experience focus group)

Co-define question 2: Monitor what?

No common definition exists for 'mental health services and addiction services'. So, the Initial Commission asked for feedback on a draft definition of this term to help define the scope of the He Ara Āwhina framework. The proposed draft definition and component parts are set out below:

Hauora services that are responsive to the wellbeing aspirations and mental health and / or addiction needs of tangata whai ora and/or their whānau

1. **Hauora services** – to be interpreted in line with the Health and Disability Commissioner Act 1994 definition of health services to include services to promote and protect health, prevent ill-health, and to treat, diagnose or rehabilitate regardless of who funds or delivers the service. Any person receiving the service would have the rights afforded to them under the Health and Disability Services Consumers' Code of Rights, including the right to complain about that service.
2. **Aspirations and needs** – focuses on what matters to tangata whai ora and /or their whānau rather than a particular service delivery model and is designed to be flexible over time as aspirations, needs, and expectations change.
3. **Tangata whai ora and / or their whānau** – services that are delivered to individuals and whānau (including in group settings) rather than the population generally.

The majority of participants supported the intent of definition proposed in the discussion paper. They said it was people-centred and moved away from a medically-centred model towards a wellbeing model of care.

A large minority were concerned at the narrow definition. They were concerned that it excluded public and population health approaches and asked the Commission to explain how it would assess these approaches. Many thought the scope of the He Ara Āwhina framework should align with all the approaches the Commission is required to assess, monitor, and report on in its legislation. Some thought there was a risk in separating out services as it could continue to reinforce a medical model. These people represented lived experience voices, health professional bodies, and organisations who undertake health promotion.

> "Make sure the Mental Health and Wellbeing Commission takes off blinkers and focuses on society in context not services, then can work out what to do more or less of." (Lived experience mental health focus group)

Representatives from the Outcomes Framework Service-Level Technical Advisory Group and our lived experience focus groups spoke strongly about how people are agents of their wellbeing, not services. Causation attributed to services should therefore be undertaken cautiously and with acknowledgement of the contribution of wider factors and approaches, such as community and social sports groups.

On the other hand, some others were concerned that the definition was too broad, difficult to understand, and would take attention and accountability away from specialist services, as well as potentially swamp the Commission's work programme. These people generally represented voices of lived experience. An example narrower definition was "services that provide, as their core activity, assessment or treatment or support to people affected by addiction and mental health issues".

Talanoa and hui participants, among others, recommended the Commission continuously review what they monitor as communities and services evolve.

People made suggestions to improve / change the proposed definition, including:

- simplify and shorten the definition, including to remove and / or language
- ensure language is inclusive of infants, children and young people
- develop separate Te Reo and English translations as opposed to Māori kupu (words) in Pākehā sentences
- "Oranga Tāngata me Oranga Whānau" (peoples' wellbeing, family wellbeing)
- clarify what is in and out, including to be explicit to include Emergency Department, Education, Social, and Corrections services that respond to mental health and addiction need as well as health promotion and prevention. Alternatively, if excluded, to clarify how the Commission will monitor these services
- unpack what is meant by 'responsive' to reflect the involvement, governance, or leadership of Māori and communities

- include language of co-existing problems
- seek sector review, particularly with Māori providers
- consider the appropriateness of 'responsive' as it speaks to the quality of the service rather than whether it is in scope for monitoring – e.g. have DHBs been culturally responsive to Māori?
- talk about people rather than tangata whai ora and their whānau – it's about anyone entering services.

Co-define question 3: How to monitor?

> "Monitoring needs to make the invisible visible, capture stories, experience and narrative, not just data" – Oral submission, Yellow Brick Road, Carers NZ and NZ Carers Alliance
>
> "Monitoring should…progress towards change to the kinds of aspirational services we want" – Te Hiringa Hauora

The Initial Commission asked for feedback on whether the former Mental Health Commissioner's monitoring framework was fit for purpose for the Mental Health and Wellbeing Commission. They also asked what other frameworks could be considered and what a successful Te Tiriti o Waitangi partnership approach to monitoring could look like.

The former Mental Health Commissioner's framework draws on consumer and whānau feedback, sector engagement, complaints' data, and performance information to assess six monitoring domains – each of which have a range of data sources sitting under them:

- Can I get help for my needs?
- Am I helped to be well?
- Am I a partner in my care?
- Am I safe in services?
- Do services work well for me?
- Do services work well for everyone?

The monitoring domains and supporting measures were developed with consumer, whānau, and wider mental health and addiction sector input, drawing from health quality measures used by the Health Quality and Safety Commission (safety, patient experience, effectiveness, equity, timeliness / access, efficiency).

The majority of people thought the former Mental Health Commissioner's monitoring questions resonated with them and covered important aspects of service quality. However, many also called for a focus that was wider than just services, so that monitoring can support the re-shaping of models of care and feed into wider systems' change.

> "Want to see bigger communities not necessarily bigger services or more primary health services" (Tangata whaiora Māori focus group).
>
> "Monitor how legislation, policy and practice line up, not just services" (Alcohol and other drugs lived experience focus group).
>
> "Consider levers for change / understand change management – hard work to make more flexible services, they keep being funded as they are because it's hard to change funding" (Gambling harm lived experience focus group)

People in our lived experience focus groups said it was important to address attitudes, stigma, and discrimination in services as well as in the community, particularly structural racism and unconscious bias and addiction and gambling harm. People asked the Commission to monitor to make sure services and supports embrace and respond to a diversity of need, including harm reduction approaches, rather than pushing the 'abstinence paradigm'. They also spoke about the need for people to have advocates / facilitators to help them navigate the systems and services they needed to interact with to get the support they need.

People identified gaps and suggested a number of changes to the wording of the monitoring questions. Many said the Commission needed to monitor the system's leadership in Te Tiriti o Waitangi, cultural responsiveness, cultural safety, and equity for Māori and that monitoring for other priority groups needed to be stronger.

> "the monitoring framework needs to be rigorously embedded in Te Ao Māori, holistic, and unreservedly underpinned by the needs and aspirations of whānau, whilst also accounting for their lived reality" (Hāpai te Hauora Tāpui).

People also said we need to take a human rights approach and measure key service inputs and change management levers such as leadership, workforce health, and adequacy / flow of resourcing and planning. They believed it was critical for the Commission to hold the views and experiences of people with lived experience and Māori.

Several people thought the individualistic and adult nature of the 'I / me' questions should be changed so that it was inclusive of whānau and support networks, infants, and young people: "everyone comes with people around them" (gambling harm lived experience focus group). Some people said that whānau should be the centre of the questions to reflect their agency in their wellbeing journey, with services acting as a facilitator.

> "The framing of the questions, tastes to me of a patient needing services, doesn't speak to someone who has the right to be met in their distress" (Lived experience mental health focus group)

In relation to specific monitoring questions:

- **'Can I get help for my needs?'** – a few people questioned whether 'help' was too paternalistic, and suggested we use the word 'support' instead. Some also said that the question should be changed to reflect the importance of timeliness – one person suggesting 'can I get help when I need it?'. A number of people said we need to capture demand for preventative services – i.e. those who are wanting to access services but can't – as well as the different ways that people engage with services.
- **'Am I helped to be well?'** – was questioned in lived experience focus groups and other feedback as implying that services are the input that makes a difference for people's wellness when many other factors influence wellbeing. Also assumes that people are 'unwell' because they have ongoing mental health needs and are accessing services. Alternative phrasing included 'Am I empowered to be well?' and 'Am I helped to live the life I want?'.
- **'Am I a partner in my care?'** – a few people thought the word 'partner' may not be a good choice of words for those who have had negative relationship experiences. They suggested alternatives such as 'full', 'leading' or 'equal' partners. They also questioned whether the word 'partner' gave enough agency to people and whānau.

  > "Am I a partner in my care? - This question needs to centre the needs of whānau rather than seeing them elevated to the same level of the practitioner. Their care needs to be centred on them, with clinicians merely facilitating space for their own exploration and hauora journey" (Hāpai te Hauora Tāpui)

- **'Am I safe in services?'** – several people thought this question was too broad and that there needs to be a clear definition of what is meant by 'safe' including cultural safety, physical safety, and mana-enhancing and trauma-informed care, as well as supported decision-making and positive risk-taking as alternatives to compulsory treatment and restrictive treatment practice.
- **'Do services work well for everyone?'** – people said that this question requires an equity and life course lens to assess service performance across population groups and identity communities.

Many people told us we need to capture what is important for people and their vision of a 'good' service / what could be – "What's the distance between what's been provided now, and what's needed?" (Lived experience mental health focus group). They also said we need to understand what is working in communities, as well as services. People told us it was important to capture people's experiences, but to be mindful that complaints do not always present an accurate picture of reality. They reminded us that people don't always feel safe to complain, particularly where a power imbalance exists.

People told us about aspects of service that should be monitored and described how they might be measured (many of which are currently measured in the former Mental Health Commissioner's framework), including:

- demand, unmet need, accessibility to a range of services, barriers to access - for disabled people and people with English as a second language - and wait times
- strengths-based approaches and supporting positive risk taking
- mana-enhancing and trauma-informed care, feeling listened to, respected, upholding people's rights
- lived experience, Māori and Pacific Peoples representation in leadership and the workforce
- self-determination and autonomy to receive the support people want
- advocacy / facilitation support for people to access / navigate systems
- cultural pathways through services, and use of tools, such as cultural statements, to inform decisions made under the Mental Health (Compulsory Assessment and Treatment) Act 1992
- growth of kaupapa Māori services and tracking the change / involvement in governance and oversight by Māori
- support for whānau / families
- addressing causes of distress and trauma
- monitoring Community Treatment Orders, seclusion and restraint
- sector and community partners and inter-sectorial responses.

A number of people asked us to be mindful that collecting and reporting data would not create an administrative burden for services. They suggested we align with existing data collection and reporting processes, wherever possible.

To ensure our monitoring approach is grounded in Te Tiriti o Waitangi, people said we need to:

- recognise, understand and engage with diverse representations, perspectives, experiences, and needs of Māori, noting that mainstream services need to work for Māori alongside kaupapa Māori services
- advocate and monitor for ways of working where Māori have governance and oversight of services that engage Māori
- speak with Māori health workers, Māori health services and iwi representatives on DHBs to understand what works
- involve Māori in how we collect and interpret data
- ensure any Māori data collected includes Māori data sovereignty and equal explanatory power
- be conscious of the frameworks we apply to monitoring to ensure they reflect a Te Tiriti o Waitangi and equity lens.

> "Be connected to the community – ask iwi, ask people" (Tangata whaiora Māori focus group)

People told us to continue to draw from the voices and stories of Māori who submitted to the 2018 Government Inquiry into Mental Health and Addiction.

From the talanoa and hui, people asked that a Pacific Peoples example be developed, as was developed for the He Ara Oranga wellbeing outcomes framework. People spoke of the importance of gathering and assessing information in a culturally appropriate and safe way, so the findings are authentic.

People recommended we draw from a range of other frameworks and models, including existing mental health and wellbeing frameworks, socio-ecological models of health, and theories of social change. These are summarised in Appendix 3.

ENDS

Appendix 1

Groups that made submissions during the He Ara Āwhina co-define phase

During the co-define phase, we received feedback from 97 individuals and groups representing a broad range of perspectives (September 2020 – March 2021):

- 22 people took part in four tāngata whaiora focus groups representing Māori, mental health, addiction, and gambling harm. Some of these participants also had a shared identity with Pacific Peoples, rainbow, disability, and / or migrant communities.
- 18 people, who identified as Māori or Pacific peoples, attended talanoa and hui. Participants came from a range of backgrounds, including youth and community leaders, health workers, and people with lived experience of mental distress and / or addiction.
- Six oral submissions (four of these provided lived experience perspectives from carers of people living with mental health and addiction challenges)
- 51 written submissions sent by either email or Survey Monkey.

We also had two workshop sessions with the Ministry of Health's Mental Health and Addiction Directorate Leadership Team, and 19 informal conversations with individuals, groups, and organisations with insights into mental health and addiction. These helped shape the discussion paper and our thinking. We spoke to the Technical Advisory Group for the He Ara Oranga wellbeing outcomes framework, national consumer bodies, Ngā Hau e Whā and the National Association of Mental Health Services Consumer Advisors (NAMHSCA), as well as representatives from Werry Workforce Whāraurau, Drug and Alcohol Practitioners' Association of Aotearoa New Zealand (DAPAANZ), Te Kete Pounamu, and the Equally Well Collaborative, among others.

Of the written and oral submissions, there were 13 from individuals and 44 from organisations including consumer advocacy organisations, service providers, workforce organisations, and Government. We asked them to identify the perspectives they were representing or supporting. Most said they represented or supported people with lived experience of mental health and addiction and their whānau and families, over one third said they represented Māori, and one fifth said they represented young people, and people from rural communities.

Table 1: Groups and organisations who provided a submission

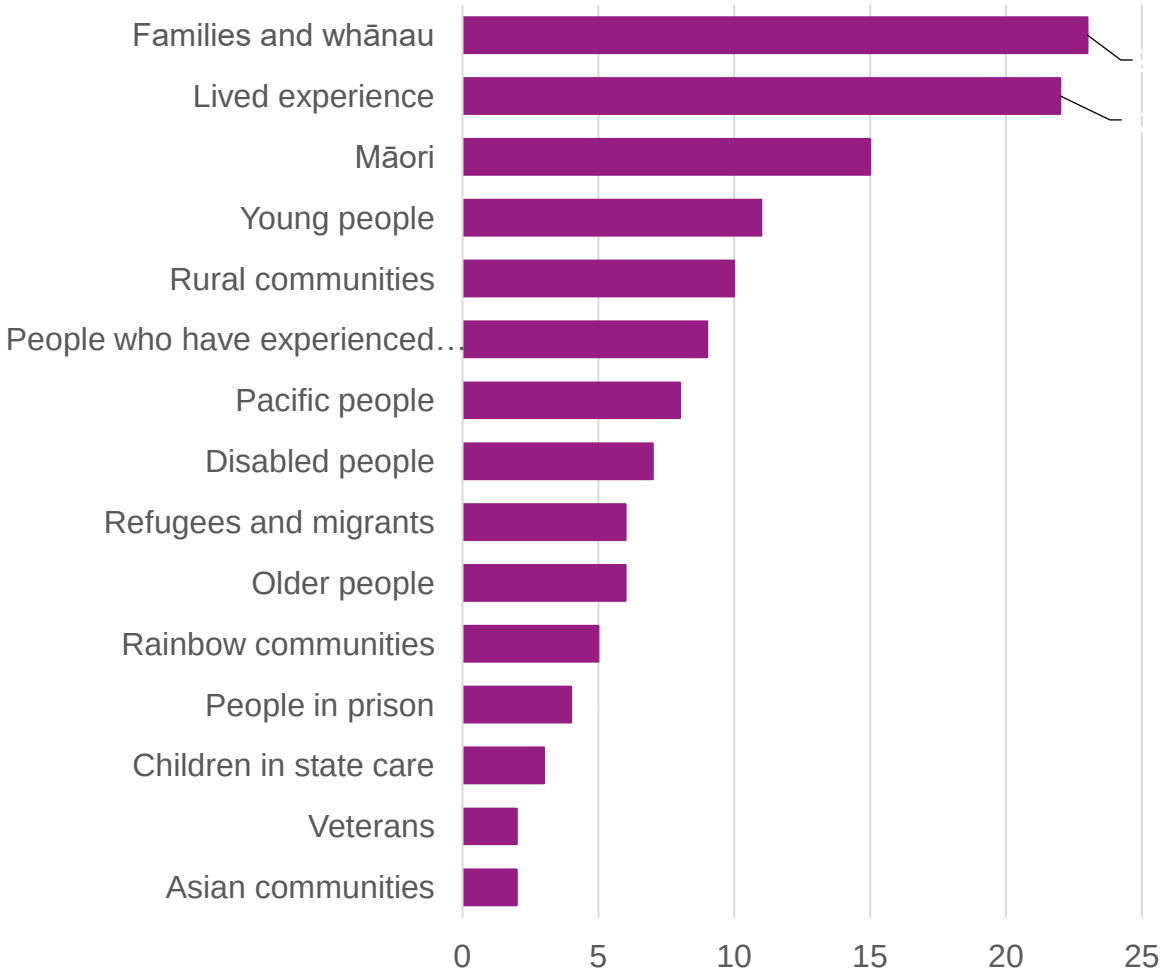
Consumer organisation: 4
Alzheimers New Zealand
Disabled Persons Assembly NZ
Infant Mental Health Association Aotearoa New Zealand
New Zealand Eating Disorders Carer Support Group
DHB: 2
Mental Health and Addictions Bay of Plenty DHB
South Island Alliance
Government: 5
Office of the Health and Disability Commissioner (HDC)
Te Hiringa Hauora / Health Promotion Agency
Kāinga Ora
Ministry of Health
Talking Matters
NGO/Services: 22
Age Concern New Zealand
Ashburn Clinic
Asian Family Services
Carers New Zealand
Family group (online support group)
Family Works, Presbyterian Support Otago
Hāpai te Hauora Tāpui
Kirikiriroa Family Services Trust
LINC Support Services
Loneliness NZ
Mental Health Foundation of New Zealand
Mind and Body
Moana House, Dunedin
Public Health South
Red Cross
Te Pou
Volunteer South
WEKA
WellSouth
Whanganui Community Living Trust
Yellow Brick Road
Youthline Otago / Southland
Peak body: 1
Arataohi

Professional organisation: 12

Addiction Consumer Leadership Group
Australasian College for Emergency Medicine
New Zealand College of Public Health Medicine
New Zealand Medical Association
New Zealand Nurses Organisation
New Zealand Nurses Organisation, Mental Health section
Public Service Association
Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Royal Australian and New Zealand College of Psychiatrists
Royal New Zealand College of General Practitioners
Rural Women NZ
Taieri College

Individuals: 13

Figure 2: Groups that submitters identified as either representing or supporting



Appendix 2

Summary of literature scan

The Initial Commission did a literature scan, building on literature reviewed for the He Ara Oranga wellbeing outcomes framework[2]. The below table represents a selection of key frameworks considered by the Initial Commission.

Key frameworks	What is it?
Health strategies	
Te Tiriti o Waitangi Framework Ministry of Health	The Ministry of Health's Te Tiriti o Waitangi Framework shows the Crown's Te Tiriti o Waitangi obligations in the context of the health and disability system.
He Korowai Oranga (Māori Health Strategy) and **Whakamua Māori Health Action Plan 2020 -2025** Ministry of Health	He Korowai Oranga is a high-level strategy that supports the Ministry of Health and district health boards (DHBs) to improve Māori outcomes. Pae Ora (Healthy Futures) is the Government's vision and aim for the refreshed strategy. The implementation plan for He Korowai Oranga is Whakamua Māori Health Action Plan 2020-2025
Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025 Ministry of Health	Ola Manuia sets out priority outcomes and actions for the next five years to improve the health and wellbeing of our vibrant and growing Pacific population living in Aotearoa New Zealand. The plan can be used as a tool for planning, prioritising actions, and developing new and innovative methods of delivering results to improve Pacific health.

[2] See literature identified as part of the He Ara Oranga Wellbeing Outcomes Framework co-define phase here: https://www.mhwc.govt.nz/assets/Outcomes-framework/Co-define-Report-on-Responses_Online-Version.pdf.

Key frameworks	What is it?
Government mental health and wellbeing frameworks	
Kia kaha, kia maia, Kia ora Aotearoa: Covid-19 psychosocial and mental wellbeing plan Ministry of Health	Kia Kaha is intended to support alignment across all organisations nationally and locally that contribute to mental wellbeing. Kia Kaha is the first stage in a longer-term pathway to implement the Government's response to He Ara Oranga and to transform New Zealand's approach to mental wellbeing.
Living Standards Framework Treasury	The Living Standards Framework helps policy makers to think about how policy decisions impact four dimensions that affect wellbeing - human, social, natural and financial/physical.
Child and Youth Wellbeing Outcomes Framework and **Ecological model** Department of Prime Minister and Cabinet	The Child and Youth Wellbeing Outcomes Framework sets out six high-level, interconnected outcomes and the range of social, economic and environmental factors that are needed for child and youth health and wellbeing. The ecological model, adapted from Bronfenbrenner's Ecological Systems Theory provides a way of thinking about the different roles and responsibilities for children and young people. It depicts different levels of social influences around a child.
Wellbeing measurement approach Social Investment Agency	The wellbeing measurement approach for investing in social wellbeing defines wellbeing and considers it across 12 domains.
Every Life Matters – He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and	He Tapu te Oranga o ia Tangata Framework is an approach to prevent suicide in Aotearoa New Zealand

Key frameworks	What is it?
Suicide Prevention Action Plan 2019–2024 Ministry of Health	
Strategy to Prevent and Minimise Gambling Harm 2019/20 to 2021/22 Ministry of Health	The strategy sets out the Ministry's approach to and budget for funding and coordinating services to prevent and minimise gambling harm during the three-year period starting 1 July 2019.
He Tangata: Mental Health and Wellbeing Outcome Framework Ministry of Health	Consultation draft 2017 and He Tangata intro. Not finalised. Drafts were provided to the Mental Health and Addiction Inquiry.
Socio-ecological models	
Whanau Ora Whanauora.nz	A way of delivering social services that places whānau at the centre and takes a holistic view of family wellbeing. Whānau Ora ensures the collective capacity within all whānau to problem solve, to nurture each other and to realise aspirations.
Te whare tapa whā Sir Mason Durie	Te whare tapa whā is a model of the four dimensions of wellbeing, developed by Sir Mason Durie in 1984, to provide a Māori perspective on health. The four dimensions are, taha tinana (physical wellbeing), taha hinengaro (mental wellbeing), taha wairua (spiritual wellbeing), and taha whānau (family wellbeing).
Pacific models and frameworks Cited in Kingi-Ulu'ave, D, Faleafa, M, Brown, T, and Daniela-Wong, E, "Connecting culture	There are a number of models of wellbeing that express the diverse cultures of the Pacific. The models have elements in common, both with each other, and with Māori worldviews, in that they are collective and relational. Six core values have been identified as being common to Pacific peoples: tapu (sacred bonds), alofa

Key frameworks	What is it?
and care: Clinical practice with Pasifika people". In Waitoki, WW, Feather, JS, Robertson, NR, Rucklidge, JJ (eds), Professional Practice of Psychology in Aotearoa New Zealand (3rd ed). Wellington: NZ Psychological Society; 2016	(love and compassion), fa'aaloalo (respect and deference), fa'amaualalo (humility), tautua (reciprocal service), and aiga (family). Wellbeing is attained when all of these values are in balance. A lack of balance between these values creates stress and may result in a person becoming unwell.
The Big Community wheel of responses and workforces The Wellbeing Manifesto	The Big Community Wheel replaces 'Big Psychiatry' with 'Big Community', so everyone with mental distress and addiction has open access to a comprehensive range of supports to improve life and health outcomes throughout a person's life.
NGO developed frameworks	
Let's get real Te Pou	Let's get real is a framework from Te Pou that describes the values, attitudes, knowledge and skills required for working effectively with people and whānau experiencing mental distress and / or addiction.
On Track Te Pou and Platform Trust	On Track is a roadmap for mental health and addiction non-government organisation providers as they work to transform supports and services.
Joining the Dots Lattice Consulting	Joining the dots is a framework to inform system-level change in the mental health and addiction sector in New Zealand.
Theories of social change	
Kaupapa Māori theory	As an analytical approach Kaupapa Māori is about thinking critically, including developing a critique of Pākehā (non-Māori) constructions and definitions of Māori

Key frameworks	What is it?
	and affirming the importance of Māori self-definitions and self-valuations. This description is taken from Katoa Ltd, an indigenous research organisation that undertakes Kaupapa Māori research and evaluation established by Dr Fiona Cram. Graham Hingangaroa Smith (1997) highlights six elements integral to Kaupapa Māori as a theory of change. These are: • Tino Rangatiratanga (relative autonomy principle) • Taonga tuku iho (cultural aspirations principle) • Ako Māori (culturally preferred pedagogy) • Kia piki ake i nga raruraru o te kainga (mediation of socio-economic factors) • Whānau (extended family management principle) • Kaupapa (collective vision principle).
Results based accountability	Results Based Accountability (RBA) encourages a range of partners to share their ideas about what works to do better. Adds programme level accountability.
Collective impact	Collective impact is a collaborative approach to address complex social issues, through having: a common agenda; continuous communication; mutually reinforcing activities; backbone support; and shared measurement.
The constellation model of collaborative social change	The constellation model is a framework to effectively bring diverse partners from multiple fields together to solve complex and pressing social problems. It promotes lightweight governance, action-focused teams, and third-party coordination to solve concrete problems within the context of a rapidly changing, complex ecosystem.

Key frameworks	What is it?
Expired / Draft	
Mental Health and Addiction Services Monitoring and Advocacy framework Mental Health Commissioner	A framework to monitor mental health and addiction services. This function was transferred from the Office of the Health and Disability Commissioner (HDC) to the Commission on 9 February 2021. The Mental Health Commissioner's final monitoring and advocacy report was released June 2020
Mental Health and Addiction (MHA) Workforce Action Plan 2017-2021	An updated MHA workforce outcomes approach for the NZ Health Strategy.
Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 Ministry of Health	Mental Health and Addiction Service Development Plan from the Ministry of Health
Blueprint II Mental Health Commission	Blueprint II was a ten-year vision that encompasses all of government, providing guidance on what is required to meet future mental health system needs and how to make the changes called for.
The National Drug Policy 2015-2020 Ministry of Health	The National Drug Policy 2015-2020 was the guiding document for policies and practices responding to alcohol and other drug issues. There are currently no plans for an update.
Breaking the cycle our drug and alcohol strategy through to 2020 Department of Corrections	Breaking the cycle sets out Corrections' plan for managing and treating alcohol and other drugs' misuse among offenders over the coming years. The strategy is structured around the three key pillars set out in the Policy: demand reduction, supply control, and problem limitation.

Key frameworks	What is it?
International frameworks	
Australia	Mental health and suicide prevention monitoring and reporting framework enables the Commission to undertake national independent monitoring and reporting on mental health and suicide prevention.
	National Strategic Framework or Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017 – 2023 is intended to guide and inform Aboriginal and Torres Strait Islander mental health and wellbeing reforms.
United Kingdom	Care Quality Commission has five key questions they ask to monitor services: are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well led?
World economic forum	The Global Framework for Youth Mental Health early psychosis model highlights that early detection and response are likely to result in a better prognosis, as well as less disability and disengagement. It says care should be integrated, based in primary care, accessible, youth-centred, youth friendly, community embedded, and evidence-based.
OECD	PREMs / PROMs are patient-reported indicators of health system performance largely relating to patient-reported experience measures (PREMs - whether the patient feels they were adequately involved in important decisions about their care), and patient-reported outcome measures (PROMs - whether the patient is free of pain after an operation care).
WHO	The Mental Health Action Plan 2013 – 2020 provides a framework to improve mental health, providing actions for member states and the secretariat.

Key frameworks	What is it?
United Nations	The International Guidelines on Human Rights and Drug Policy provide a comprehensive set of international legal standards for placing human dignity and sustainable development at the centre of Member State responses to illicit drug economies.
	The Sustainable Development Goals are a collection of 17 interlinked global goals designed to achieve a better and more sustainable future for all by 2030.
	The Convention on the Rights of Persons with Disabilities adopts a broad categorisation of persons with disabilities and reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms.
	The Declaration on the Rights of Indigenous Peoples says indigenous peoples have the right to fully enjoy, as a collective or as individuals, all human rights and fundamental freedoms.
	The Convention on the Rights of the Child affirms the civil, political, social, economic, health and cultural rights of children.
	The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment says people should be free from torture and other cruel, inhuman or degrading treatment or punishment.