



Developing the He Ara Oranga wellbeing outcomes framework

Summary of what we heard through the conceptual phase consultation

17 August to 11 September 2020

Contents

Contents	2
Purpose of this report.....	3
Section 1: Summary of the feedback.....	3
Section 2: About the consultation	5
Context – the Initial Mental Health and Wellbeing Commission	5
The consultation approach for the conceptual phase.....	6
Who we heard from as part of the conceptual phase	7
Section 3: Feedback on the draft outcomes framework.....	14
Overall relevance of the draft framework & domains.....	14
Aspects of the framework that resonate with respondents and suggested changes	15
The descriptors – concepts that are missing or need greater prominence	25
Suggestions about each domain.....	29
Comments on the vision	39
Comments on the principles	42
Appendix 1 List of respondents	47

Purpose of this report

This report provides a summary of what the Initial Mental Health and Wellbeing Commission (Initial Commission) heard, during August and September 2020, from consultation on the draft He Ara Oranga wellbeing outcomes framework (the outcomes framework).

Section 1: Summary of the feedback

Overall

The overwhelming majority of the feedback was positive. Other feedback offered valuable suggestions about how to improve the framework.

The outcomes framework resonated well with most people, with the domains largely covering what wellbeing means to respondents. People supported the framework because it:

- is aspirational and takes a strengths-based approach
- includes structural and systemic factors that impact on wellbeing
- takes a broad and interconnected approach to understanding wellbeing, with relevance to mental health and addiction.

Some people suggested that the wellbeing approach may be too broad and less relevant to people living with severe mental health and addiction issues.

Respondents also considered that the framework needs to be clearer about the connection between the high-level domains and the detailed descriptors; including the distinction between domains. Also, the final framework needs to be in plain and concise language.

The dual-layered framework

Many Māori and non-Māori respondents supported the layered approach because it gives Te Tiriti 'its rightful mana and place and acknowledges the importance of Māori as tangata whenua and the Crown's Treaty partner'.

More work is needed to show how the two layers relate to each other. Some saw the 'for Māori as tangata whenua' domains having universal applicability. The layers could be renamed so that they are not framed as 'for' particular groups.

As one of the priority groups identified in the He Ara Oranga report, it was agreed that a Pacific example would be appropriate to develop in addition to the dual-layered framework. Pacific respondents said the Pacific example resonated more with them than the 'for everyone' outcomes framework. Key suggestions were to make more use of Pacific languages, use Pacific models in the descriptors, and make faith and spirituality more explicit throughout.

Specificity for particular outcomes and groups

Respondents wanted (stronger) reference in the framework to:

- addiction, substance use and gambling harm
- outcomes for people in acute mental distress or for those who had severe and enduring ill health
- the unique mental health and wellbeing needs of infants, children and youth
- outcomes for Asian communities, refugees, prisoners and their families, and the mental health and addiction workforce.

Implementation of the framework

Respondents questioned how the framework would translate into outcomes and how this framework would work with others.

Concepts that are missing or need greater prominence

Suggestions were made to refine the domain descriptors, such as: recognising colonisation and its impacts, the importance of te reo Māori in relation to wellbeing for Māori, peoples' and communities' expression of cultural values, spirituality and belonging, equity and safety, economic resources and role of socio-economic deprivation. Suggestions about specific domain concepts and descriptors are detailed in the report.

Section 2: About the consultation

Context – the Initial Mental Health and Wellbeing Commission

The Initial Commission was established in November 2019 to begin monitoring progress on the Government's response to *He Ara Oranga*¹ and to enable the permanent Mental Health and Wellbeing Commission to make swift progress when it is established.²

One of our main tasks as the Initial Commission is to develop an outcomes framework suitable for the permanent Commission to consider adopting. We also need to identify gaps in information required to monitor performance under the draft framework and make recommendations to the Minister of Health on how gaps could be filled.

We are working to develop the outcomes framework in four main phases:

- 1) *Co-define*: consider key terms and existing models and frameworks in discussion with selected stakeholders (April to May 2020).
- 2) *Conceptual phase*: develop the conceptual framework, drawing on findings from the co-define phase and other sources. Testing and refining the conceptual framework with stakeholders (June to October 2020)
- 3) *Data phase*: identify indicators, measures, data and information sources and gaps, with stakeholders (September to November 2020)
- 4) *Refine and finalise*: prepare draft for the consideration of the permanent Mental Health and Wellbeing Commission (December 2020 to January 2021).

The co-define phase

For the co-define phase in April and May 2020, we circulated a consultation document to seek views on:

- defining mental health and wellbeing
- identifying existing models and frameworks that could inform the work
- a vision for an outcomes framework
- identifying the domains of wellbeing, and
- identifying what people need to see in an outcomes framework for it to be useful.

What we heard,³ along with literature scanning and expert advice informed the conceptual components of the He Ara Oranga wellbeing outcomes framework.

¹ Report of the Government Inquiry into Mental Health and Addiction, <https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/>

² The Mental Health and Wellbeing Commission Bill had its third reading in Parliament and royal assent in June 2020. This Bill specifies the Mental Health and Wellbeing Commission, an independent crown entity, will come into force by February 2021.

³ A summary of what we heard from the co-define phase is available on the Commission's website <https://www.mhwc.govt.nz/our-work/outcomes-framework/co-define-phase/>

The consultation approach for the conceptual phase

A targeted consultation for the conceptual phase began on Monday 17 August and was open until Friday 11 September 2020 (with a further week for late responses, until 18 September 2020).⁴

We engaged through a consultation document, an online survey, dedicated seminars, focus groups, talanoa, written letters and Zoom discussions.

The consultation document

The consultation document was sent to our stakeholder list, with representation from all groups in Schedule 1a of the Mental Health and Wellbeing Commission Act 2020. This involved over 150 groups and organisations, in addition to named individuals. The distribution list was developed by combining people, groups and organisations who:

- provided a response to the 'co-define' phase of the outcomes framework;
- submitted to the Mental Health and Wellbeing Commission Bill;
- were interviewed by the Initial Commission as part of the Interim Report;
- engaged with the Initial Commission in other ways;
- were suggested additions by the Expert Advisory Group and Board; *and/or*
- were other stakeholders the Secretariat identified aiming for representation from all groups in Schedule 1a (eg, veterans).

The consultation was also advertised in the Initial Commission's other communications material (including our website, and in the Ministry of Health's Mental Health and Addiction Directorate newsletters)

Government agencies and service providers

We engaged differently for government agencies and some service providers. Approximately 45 staff from government agencies attended a seminar on 26 August 2020 (on Zoom due to COVID-19 alert levels). At the seminar we shared the purpose of the framework and how it is being developed, and asked for feedback on the draft conceptual design.

Some service providers were included in the consultation document distribution list (as described above) if the Initial Commission interviewed them for the Interim Report, or if they provided a response to the outcomes framework co-define phase.

For other services providers who were not on our distribution list, we contacted a subset of providers through established networks, specifically through the DHB Mental Health and Addiction General Manager Group. We included a request to DHB colleagues to pass the consultation information onto other service providers they work with. While this approach would not reach all service providers, the significant size of the sector precluded us from engaging more widely with service providers in the available timeframe.

We appreciate that this may have resulted in a limited perspective in some areas. The permanent Commission will continue to engage with stakeholders on the outcomes framework.

Focus groups

We planned several focus groups with Māori, Pacific peoples, and people with lived experience. In these groups we wanted to hear from people with a range of views, including lived experience of mental distress, illness and/or addiction, advisory experience, experience

⁴ We had planned to circulate the consultation document from 10 August, however due to the rapidly changing circumstances with COVID-19 alert level changes, we delayed the release, particularly as many stakeholders are in the Auckland region.

with peer support, or expertise in mental health, addiction and/or wellbeing. We held a Māori focus group, lived experience focus group, and held Pacific talanoa sessions online.

Who we heard from as part of the conceptual phase

Survey / consultation document

In total we received 86 survey / consultation document responses for analysis.⁵ This is in addition to responses received by letter, Zoom, focus group, seminars or other engagement.

The total number of responses received does not reflect the total number of people involved in providing a response (eg, an advisory group response may have collated the views of many members).

The submission form asked respondents to self-identify which population groups they identified with or represented (

⁵ Whilst 117 survey responses were received in total, we removed responses where the respondent exited the survey early – that is, did not answer any of the questions on the outcomes framework content after the 'consent' question.

Table 1). Most respondents (59/80) selected multiple groups. It is therefore not possible to present results solely for one population group. Organisational submitters were also asked to identify with a service sector(s) (

Table 2). These responses show:⁶

- 49 (61%) said they identified as or represented consumers / people with lived experience
- 46 (58%) said they identified as or represented families and whānau
- 10 (18%) said they represented addiction services
- 27 (34%) said they identified as or represented Māori perspectives, including two kaupapa Māori providers
- 17 (21%) said they identified as or represented Pacific perspectives.

⁶ For people and organisations who provided their views via Zoom discussion rather than through a written submission, we did not record responses to this question.

Table 1 Population groups represented through the survey / consultation document

Groups	N (N=80)	%
People with lived experience of mental distress, illness and/or addiction	49	61%
Families and whānau with lived experience of mental distress, illness and/or addiction	46	58%
Māori	27	34%
Pacific peoples	17	21%
Refugees and migrants	15	19%
Young people	26	33%
Rural communities	18	23%
Veterans	7	9%
Rainbow communities	13	16%
Disabled people	14	18%
Prisoners	8	10%
Older people	19	24%
Children in state care	9	11%
People who have experienced adverse childhood events	32	40%
Other*	24	30%
Total	80	100%

* Respondents specifying other were health professionals such as clinical psychologists and GPs including those working in primary mental health care; people working in Māori health research, Māori health planning and funding, and those in clinical and managerial roles in mental health and addiction services; advocates for pēpi, tamariki and their whānau/families, and advocates for survivors of sexual violence and their families and communities

We asked people to specify whether they were submitting their response as individual(s), or on behalf of an advisory group / other group, or on behalf of an organisation. The responses included:

- 44 were from an individual or individuals
- 5 were from an advisory group or other group
- 37 were on behalf of an organisation

For responses on behalf of an advisory group or an organisation,

Table 2 shows the type of organisation represented.

Table 2 Sectors represented in feedback through the consultation document

Sector (organisational respondents)	N (N=40)	%
Mental health service	7	18%
Addiction service	7	18%
District Health Board	3	8%
Non-governmental organisation	20	50%
Kaupapa Māori provider	1	3%
Government organisation	3	8%
Commissioning agency	3	8%
Primary care	2	5%
Other service provider	3	8%
Advocacy organisation	11	28%
Professional association	8	20%
Academic/research	2	5%
Other*	8	20%
Total	40	100%

* Respondents specifying other included those working in schools, and with Asian communities, providing services to survivors of sexual abuse, training providers and those representing medical specialities.

Appendix 1 gives an overview of the diversity of people, groups and organisations who responded (if they provided consent to be named).

Other sources of feedback

Other sources of feedback include a Māori focus group, a lived experience focus group, Pacific engagement, Zoom discussions and responses received in written / letter form:

- **Māori focus group:** Held via Zoom with 7 participants, with descent from 21 iwi.⁷ All of the Commission's priority groups were represented by participants – either identifying with or in a supporting role.
- **Lived experience focus group:** Held via Zoom with 7 participants.
- **Pacific engagement:** Consultation with Pacific peoples was added to interviews being carried out by a Commission board member and a member of the Commission's Expert Advisory Group. Invitations were sent out to a wide range of ethnic specific, multigenerational, multilingual, diverse sexualities and genders within the Pacific communities.

In summary, one face to face and seven Zoom meetings were held. Participants included members of the Samoan, Tongan, Cook Island, and Kiribati communities and also included Samoan/Māori, Māori and Māori/Pākehā members.⁸ Key people of the various Pacific communities were involved. This included village chiefs, academic leaders, Pacific representatives from

⁷ Te Atiawa, Taranaki Whānui, Ngāti Maru ki Taranaki, Ngāti Porou, Ngāti Wehi Wehi, Ngāti Tukorehe, Ngāti Raukawa, Ngāti Tūwharetoa, Te Whānau a Rongomai Wahine, Tainui, Ngāti Haunui a Pāpārangi, Ngāti Maniapoto, Ngāti Awa, Kati Mamoe, Waitaha, Tūhoe, Ngaariki Kaiputahi, Te Aitanga a Mahaki, Ngāti Mutunga o Whare Kauri and Ngāti Urban Māori o Tāmaki Makaurau.

⁸ The non-Pacific individuals were part of the youth Zoom sessions that were held with Pacific youth as they all preferred to be interviewed together.

government departments such as Education and Corrections, non-government agencies and Pacific community providers. Consultation was also held with key Pacific leaders (and chiefs) in politics, social services and mental health. There was also a focus on hearing from the voices of our Pacific youth, bearers of wisdom (elderly) and representatives from the church and directly from key community leaders. In total, 27 people were involved in the Pacific engagement and talanoa sessions. Written feedback was also received from former Government Inquiry panel members in relation to the Pacific example.

- **Zoom discussions:** Whilst the online survey and consultation document were the preferred methods to provide feedback, six groups requested a Zoom meeting to discuss the outcomes framework and provide high-level comments.
- **Written letter:** Ten organisations sent a written letter providing broader feedback.

All these sources of engagement have been analysed to report the high-level findings in the next section 'Feedback on the draft outcomes framework'.

We are grateful to everyone who took the time to share their views and, in some cases, to gather the views of others to produce a collective response, especially during a time when New Zealand was in various levels of COVID-19 response.

We did not hear back from everyone we contacted and acknowledge the timeframes and method of engagement may not have worked for some, especially those involved in the COVID-19 response.

Section 3: Feedback on the draft outcomes framework

The following sections summarise what we heard about the draft outcomes framework. We have included the numbers of responses to the closed questions (eg, agree/disagree) to indicate the general level of support for aspects of the framework. The number of respondents who commented on each topic varied. We have not quantified the themes from respondents' comments as some responses represented multiple people.

We have quoted directly from the response documents, and from the notes made during focus groups and interviews (these were sent back to participants for checking) to provide a clear indication of what was said, and to explain proposed changes. Where there is a partial quote in the text, a footnote has been used to keep the text uncluttered.

Quotes are not attributed to named individuals but are de-identified as 'individual respondent'. Quotes are attributed to groups or organisations, with the permission of the submitter.

Overall relevance of the draft framework & domains

This section of the report combines the feedback received on the overall resonance of the framework and on how well the six areas of wellbeing cover 'what wellbeing means to you'. Respondents made very similar comments on both questions.

Figure 1 Overall resonance of the framework

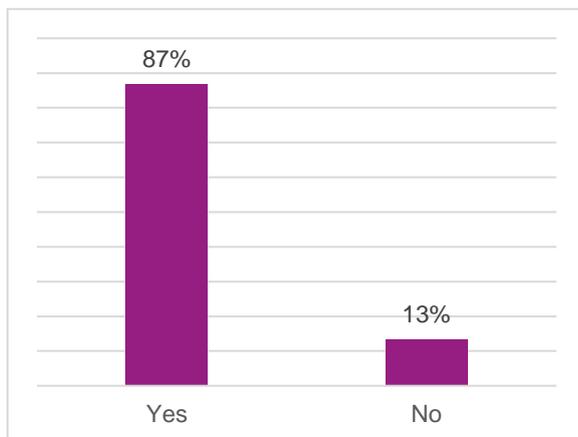
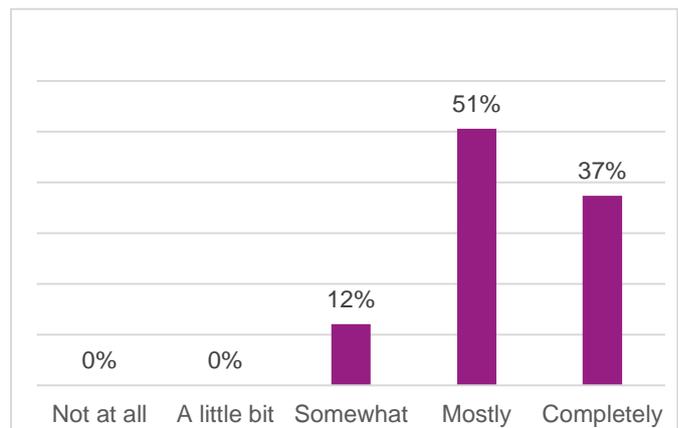


Figure 2 How well the six areas cover wellbeing



In general, the outcomes framework does resonate with people, and the six areas of wellbeing do largely cover what wellbeing means to them.

As shown in Figure 1 and Figure 2 above, most respondents (87% – 72/83) said the outcomes framework did resonate with them. All 83 respondents who answered this question considered that the six areas covered to some extent what wellbeing means to them; 88% (73/83) of those responding considered the areas mostly or completely covered what wellbeing means to them.

Aspects of the framework that resonate with respondents and suggested changes

Holistic and comprehensive

Broadly, respondents appreciated that the framework is applicable to the 'whole system'. Respondents commented favourably on the holistic approach that includes structural and systemic factors that affect wellbeing such as economic security.

The framework was also generally commended for addressing wellbeing at both an individual and a population level, and for being comprehensive and inclusive of different population groups. Many respondents appreciated that the framework recognises the difference in peoples' lived experience, and explicitly mentions aspects relevant to different communities. An example of this is discrimination experienced by the rainbow community. There was general support for the framework speaking to both individual and collective wellbeing, and for placing people in bigger social groupings: whānau, family, and community.

It covers in the broadest terms what is needed as a human being to be a well, productive and connected member of society. It covers the three areas of physical, mental and social health but also talks to being part of a greater whole. [Royal New Zealand Returned and Services Association]

Respondents were generally positive about the comprehensive scope of the domains and the recognition of the interconnectedness of the concepts. However, several respondents thought the scope of the domain concepts tried to cover too much and were too broad 'to provide meaningful comfort for [those who] should be the target of the commission's work'.⁹ It was suggested that the framework would benefit from greater clarity in the connection between the high-level domain name and the descriptors, and the distinction between areas.

There appears to be some repetition across different outcome areas, for example outcome area 5 refers to optimism and outcome area 6 refers to hope, which seem to be similar concepts; and outcome area 5 refers to freedom from discrimination, which seems to about acceptance, but being accepted is referred to in outcome area 1. [Office of the Children's Commissioner]

Aspirational and strengths-based, includes positive mental health concepts

The framework had support for including positive mental health concepts: such as development, resilience, hope, 'bounce back from adversity', meaning, purpose and self-determination.

A few respondents expressed concern that the framework may set up 'unrealistic expectations and a sense of frustration that the ideal seems too distant from the reality of life for many people'.¹⁰ It was suggested that the outcomes – although framed for 'ideals' – need to reflect reality 'and not set up a system where people feel they have failed if those ideals are not met'.¹¹

Does there need to be more emphasis on resilience through adversity? For some people, intergenerational trauma and poverty with perspectives of limited possibilities, makes it more difficult to view these areas of well-being as related to their own lives. [Mental Health Nurses Section, NZNO]

⁹ Individual respondent

¹⁰ Mental Health Nurses Section, NZNO

¹¹ Mental Health Nurses Section, NZNO

Several respondents noted that the framework should allow people to have their own goals for their lives. An example given here was from the descriptor of domain 1 for everyone in Aotearoa ('are safe and nurtured') 'Where people experience disconnection, they are enabled to reconnect with themselves, their family, whānau and communities.'¹² It was noted that reconnecting with family was not always desirable or possible.

Another respondent thought the domains did not go far enough, as they 'seem limited to recovery and maintenance and, at best, aspiration rather than achievement.'¹³

Addresses socioeconomic disadvantage

There was strong support for the explicit link in the framework between health and wellbeing and economic security. Similarly, respondents supported the link made between having economic resources and self-determination and autonomy. However, several respondents also thought socioeconomic disadvantage needed to be more strongly addressed.

It does not get down to the crux of the matter in that people need to be able to access supports in the first place. People who are already at a disadvantage in location or lack of health/technology literacy are not able to get help where they are and in the manner they need. There are so many layers of social disadvantage people have to overcome, access to government departments, healthcare, financial advice and services, communication and decent and affordable housing are all areas that need to be addressed before we can 'fix' the wellbeing issues. [Individual respondent]

The layered framework

The layered design was broadly supported by Māori and non-Māori respondents 'because it gave Te Tiriti 'its rightful mana and place in our daily lives,'¹⁴ and 'aims to uphold Te Tiriti o Waitangi, recognises Māori as tangata whenua and supports te ao Māori concepts and understandings of wellbeing.'¹⁵ The bicultural values, and complementary world views were largely considered to support all people. There was general support for the intent in the framework to acknowledge Māori as tangata whenua and the Crown's Treaty partner.

However, respondents also suggested that the presentation of this intent needs further work. The imagery used to show the draft framework showed the interconnection of the domains to some but to others it suggested a list:

While recognising the value of a representation of the framework that can fit on one A4 page, the impression is of a list of priorities or a hierarchy with respect to mental health and wellbeing. Presentation of the framework needs to offer an image that recognises how intertwined and interdependent each of the 6 areas of wellbeing are. [Tōpūtanga Tapuhi Kaitiaki o Aotearoa New Zealand Nurses Organisation (NZNO)]

It wasn't clear to all how the two layers (for tangata whenua and for everyone) related to each other. Some respondents stated that it was difficult to understand the relationship between the two layers. One respondent questioned how people of multiple ethnicities were to interpret the dual framework. Other responses showed various interpretations of the relationship between the two layers.

¹² Organisation – did not want quotes attributed

¹³ Balance Aotearoa

¹⁴ Organisation – did not consent to quotes being attributed

¹⁵ Asian Family Services

There was also a view that the ‘for Māori as tangata whenua’ domains were universal and ‘can apply to some of us non-Māori too.’¹⁶

It is important to note that the aspects of Māori wellbeing are applicable to all and should be seen as principles guiding the operation and practice of better mental health wellbeing by the Commission. [Whānau Ora Commissioning Agency]

A few respondents commented on the ‘for everyone in Aotearoa’ layer reflecting a Western world view, and in particular, an individualistic culture.

...‘at the expense of those whose background differs substantially from this – namely people of refugee background – many who come [from] societies that are not heavily individualised. Perhaps some recognition of this in the document would help overcome this discrepancy. [Organisation – did not consent to quotes being attributed]

One respondent saw a ‘disconnect between the outcome areas for all and Māori.’¹⁷ The te ao Māori elements were not just outcomes but values and cultural and social norms. There was also a view that the ‘for Māori’ as tangata whenua’ layer read more positively than the ‘for everyone’ layer, and appeared to be at a higher level, for example, services are not mentioned in the ‘for Māori’ layer. Also ‘for everyone’ seemed to be ‘harder’ and to have a stronger focus on socioeconomic determinants. Further there was a stronger focus on spiritual connectedness and wellbeing for Māori than for everyone, ‘which may diminish the importance of spirituality in other cultures.’¹⁸

A few respondents thought that the dual framework layered design posed some risks:

...if a layer is read in isolation then other relevant factors detailed in other frameworks are missed. This group-based separation may also overlook the impact on groups that experience overlapping and interdependent systems of discrimination or disadvantage (intersectionality) (eg, being Māori AND identifying with rainbow communities) and suggest careful consideration be given to how the frameworks can respond to the experience of intersectionality. [Mental Health Foundation]

Suggestions from some respondents for resolving these potential issues included:

- integrate aspects that are covered more strongly in the English descriptions into the outcome descriptions for Māori where relevant and move to a single framework.
- have a high-level of aspirational statements, with the next level down to describe how this applies to different population groups (including those with lived experience of mental illness, or distress and/or addiction)
- have standalone documents, rather than incorporating both together
- include discussion of the importance of Māori as a Treaty partner.

Renaming the layers was suggested so that they were not framed as ‘for’ particular groups. Examples suggested to replace the heading ‘for Māori as tangata whenua’ were:

- Te ao Māori perspectives
- Tikanga Māori framework
- Hauora Māori values framework,

¹⁶ Individual respondent

¹⁷ Whānau Ora Commissioning Agency

¹⁸ Organisation – did not consent to quotes being attributed

and 'Outcomes framework' instead of 'For Everyone'.

The Pacific example

From the talanoa – the Pacific engagement – respondents said the Pacific example resonated more with them than the dual-layered foundational outcomes framework. They felt the language was more relatable and easily understood.

However, they suggested that the Pacific example domain headings should use Pacific languages, as this would more clearly articulate the six wellbeing domains, for example:

Autonomy – I don't associate it with Pasifika language, what's stated contradicts our interconnectedness. [Pasifika engagement]

Respondents in the Pacific engagement also said that faith and spirituality needed to be more explicit – 'faith is in our DNA' – and should be incorporated into a domain name.

It is important to note that whilst there were many diverse views heard during the talanoa, it was agreed and shared with participants that key themes would be identified and reflected in the Pacific example. The Pacific example also drew on some of the work in the Ola Manuia (the Pacific Health and Wellbeing Action Plan 2020-2025), and the Lalanga Fou report from Pacific Aotearoa and the Fonofale model of Health.¹⁹

Comment about each domain in the Pacific example is included later in the report.

The models drawn on

The framework was considered by one respondent to balance the 'biomedical and biopsychosocial' concepts of health and well-being.²⁰ Another respondent endorsed the models that had been drawn on in developing the framework:

I am particularly pleased to see that Te Whare Tapa Wha and the Power, Threat, Meaning Model have been drawn on. I would like to see the latter applied in specialist mental health services (DHB) rather than the medical model. This is outdated and not holistic. [Individual respondent]

However, it was also evident from the responses that the use of models in developing the framework was an area where clarity is required. For example, one respondent, while acknowledging the excellence of Te Whare Tapa Whā as a model of health care, suggested that 'the restrictive application of one model of care could mean missed opportunities for working closely with our Māori partners in developing enduring health outcomes.'²¹

The visual design of the draft framework and translation

Several respondents suggested improvements to the visual design of the framework. For one, the linear design implied hierarchy, which could be addressed by a more circular design. Others said the current design (and particularly the colours used) was not accessible for the visually impaired and did not support clarity of content.

The format/layout is somewhat problematic, with too much information being contained within too limited a space. [Salvation Army]

One respondent considered that the Māori section could 'flow better, could be more user friendly or use connecting/connective language to inspire whānau wellbeing – it comes

¹⁹ Pulotu-Endemann, F. K., & Tu'itahi, S. (2009). *Fonofale: Model of health*. Fuimaono Karl Pulotu-Endemann.

²⁰ Salvation army

²¹ Ara Poutama Aotearoa, Department of Corrections

across as a bit cut and paste of translations of words from the dictionary, as though something is missing.¹²²

The Māori focus group also asked for particular care to be used in terms of the language chosen for the framework and for consistent translation practice. They suggested expanding on the definitions of Māori concepts and perhaps using a glossary to avoid cluttering the designed version of the framework. Similarly, one organisation asked that the 'for Māori as tangata whenua' layer be in te reo Māori, with an English translation.

Additionally, listing concepts was seen by a few respondents to be a te ao Pākehā way of grouping information:

Te reo Māori is about the words, imagery and storytelling but unfortunately the visual element of these concepts is lost in the list of concepts that are being brought together. Instead, we suggest capturing and reflecting the concepts in six short phrases that provide imagery and connotations of these te reo Māori wellbeing areas. [Age Concern New Zealand]

Plain English and simpler

Commonly, respondents said the language needed to be simpler and perhaps briefer. One respondent thought it 'kind of feels like everything was trying to be fit in, whether they fit or not.'²³ It was suggested there could be a brief plain language version with another more detailed version. Attention to grammar would also improve understanding.

[The] outcomes document should be able to use fewer words to champion the vision and key outcomes in a way which is simple and understandable ...For Alzheimers NZ's population, that means at least being able to read the document. [Alzheimers New Zealand]

There are some aspects of the language that could be improved. For example, the phrase 'For everyone in Aotearoa' is grammatically a poor fit with the verbs 'are' and 'have' in the list of outcomes. ... A better subject-verb agreement like 'Everyone in Aotearoa...has their rights and dignity upheld' or 'For everyone in Aotearoa...to be safe and nurtured' would be easier to read and understand. [Balance Aotearoa]

It was further suggested that the framework's wording be changed from plural third-person to plural first-person pronouns. This would be 'inclusive, engaging and empowering and may help the framework resonate to a wider group of people':

'Māori', 'whānau and communities', 'their', 'they' and 'people, families and communities' does not speak directly to those reading the framework. The groupings; 'Māori' and 'whānau and communities' are not as empowering as wording like 'we', 'our' and 'us'. [Age Concern New Zealand]

It was noted that the definitions for each of the domains mixed 'outputs and outcomes' language.

[For example] celebration/honouring are activities that can lead to positive mental health. Sense of community, belonging are outcomes. ...maybe that's intentional? [Organisation – did not consent to quotes being attributed]

²² New Zealand Psychological Society

²³ Individual respondent

There were also particular areas where the language needs further consideration. ‘For example, what does autonomy mean for people with disabilities?’²⁴

Editing was also noted: ‘the words tāngata (people) and tūpuna (ancestors) throughout need to include macrons (plural).’²⁵

Audience

Related to comments about the design and the language level, it was also suggested that the intended audience of the framework needs to be made clear – who is it written for and for what purpose?

Specificity for particular outcomes and groups

Respondents recommended that the framework explicitly reference the particular outcomes and groups set out below. This could be done through the descriptors, ‘to ensure these groups stay front of mind when developing measures and indicators.’²⁶ It could also be achieved through providing additional layers specific to particular groups and analysing data separately for priority groups (pending data availability).

Critical wellbeing outcomes for Māori

Respondents acknowledged that the framework includes a number of critical wellbeing outcomes particularly for Māori, for example, wairuatanga, and mana motuhake. However it was suggested that other equally critical outcomes need to be included: ‘sovereignty, rights as indigenous peoples, whakapapa, taonga tuku iho, mauri, mātauranga, intellectual sovereignty, leadership, action, indigeneity, and decolonisation.’²⁷ It was also noted by one respondent – while acknowledging the framework’s focus on outcomes rather than process – the place of rongoā Māori as the traditional system of healing for Māori should be clear.

Overall, several respondents questioned whether the framework adequately conveys the presence of health injustices and the need to address these (decolonisation). This point will be expanded on in the following discussion of the domains and descriptors.

One respondent asked the Initial Commission to explicitly articulate how mātauranga Māori will influence and be incorporated into the strategy and into practice.

Please seek to explore mātauranga Māori concepts, theories and tikanga and include explicit utilisation and examples within this work. For example, please explicitly include rongoā Māori as the customary Māori system of healing. Please include atua Māori. If we are going to talk about human health and wellbeing – please talk about Māori creation stories, please talk about Tāne and Hinetītama and Hineahuone – as these are the mātauranga topics that drive and provide foundation for all human health. [Individual respondent]

Acute mental health needs

Some respondents questioned whether there was adequate focus on outcomes for people in acute need, in mental distress or for those who had severe and enduring ill health, who need

²⁴ Organisation via discussion

²⁵ Lived experience focus group

²⁶ Australasian College for Emergency Medicine

²⁷ Individual respondent

‘a concrete and tangible’ response to support them. ‘This framework seems too distant from the reality of life for many people living with mental distress.’²⁸

Mental health is mentioned only once and at the very end of the proposed framework, yet there is clearly a demonstrated and acute need to improve mental health and non-physical wellbeing, which I thought this was really about. I would like to see more concrete outcomes that are focused on mental health and non-physical wellbeing first and foremost. [Individual respondent]

I ... worry that focusing too much on measuring vague final outcomes may result in a lack of resources for people who need more help than can be found in the community, for example people undergoing severe psychotic episodes. [Individual respondent]

Addiction

Respondents wanted the framework to have a stronger focus on addiction, substance use harm and gambling harm. Commonalities between mental health and addiction were acknowledged but so were the distinct differences. One respondent noted a wider confusion about ‘where addiction sits in relation to mental health.’²⁹

It was observed that the addiction community and people who experience substance use harm do not necessarily identify with discussion of ‘mental health’. The ‘notion of identity’³⁰ was commented on in relation to addiction recovery.

It is unclear whether addiction is implicitly included or explicitly excluded when using the term ‘mental health’? ... Adopting terms and examples that only reflect a mental health worldview can potentially reinforce these perceptions that people with addiction issues are excluded. The impact of this could be magnified if this perception is replicated throughout policy, commissioning and delivery of services across the health and social system [Addiction Consumer Leadership Group, Te Pou]

There is currently no mention of the role of drugs or alcohol. We contend that a framework on wellbeing outcomes that is to be used to support the mental health system should specifically identify protection against the harms of drugs and alcohol given the significant burden these substances have on mental health and addiction. [NZ Medical Association]

Infant and child mental health and wellbeing

Several respondents wanted children’s unique mental health and wellbeing needs to be explicit within the framework (acknowledging that pēpi and tamariki are represented implicitly as people, and as members of their whānau and families).

Nowhere in the framework are our children specified and that means they can be forgotten or only some of the age range may be considered. This is particularly important and relevant with infants and young children whose wellbeing and mental health needs get lost. We have poor data collection in this area ... It is very likely that this contributes to the paucity of planning and implementation of Infant Mental Health (IMH) despite knowledge regarding significant mental health and wellbeing concerns for infants from studies further afield and that the concerns don’t go away. [Infant Mental Health Association Aotearoa New Zealand]

²⁸ Mental Health Nurses Section, NZNO

²⁹ Individual respondent

³⁰ Addiction Consumer Leadership Group (Te Pou)

These respondents wanted infants, children and young people to be explicitly included in the framework. For example, 'include the word pēpē alongside tamariki and rangatahi'³¹ and reword the term 'people, families and communities', which is used throughout the framework to 'children, young people and adults, and their families, whānau, iwi and communities.'³²

The Office of the Children's Commissioner suggested that children and young people need to be prioritised in the framework because:

Children and young people are a priority group in the Mental Health and Wellbeing Commission Act 2020;

They are experiencing high and increasing levels of mental distress;

Interventions in early childhood offer the greatest potential to improve population wellbeing; and

Children and young people have unique rights [under UNCRC] and views about their own wellbeing that need to be heard.

Specificity for other groups

Several respondents pointed to the need to include Asian communities. This was centred on the size and expected growth of the Asian population in New Zealand, and the current lack of specific mental health strategies and policies for Asian people on a national level.

We would also like to highlight that Asian peoples need to be identified as a priority group. Statistics New Zealand projects that by 2023, Asian people will become the second largest ethnic population group in New Zealand following Europeans. However, there are no mental health strategies or policies in place for Asian peoples on a national level. This has led to little funding and support to improve current services for Asians, which have maintained significant service gaps and unmet needs within Asian communities. It is also important to clarify that the under-utilisation of primary health and mental health services of Asian peoples does not mean that Asians have better health than other ethnic groups. As a service provider for Asian peoples, we can attest that this is certainly not the case. [Asian Family Services]

Prisoners – and their families – were also noted as a particularly vulnerable group. Ara Poutama Department of Corrections noted that of the just under 38,000 people in its care or management, over 52% identify as Māori, and many of these people, and their whānau, live with mental distress, illness and/or addiction.

Given the Commission's focus on vulnerable groups, we ask that the people in our care are given a clear line of sight in the mahi as they are more vulnerable to mental ill health than most other populations.

Refugees were another group that respondents wanted to be more visible in the framework.

Previously refugee status peoples require more attention in respect to mental health and wellbeing, especially if they have experienced severe trauma, language barriers and have major cultural differences. [South Dunedin Schools Cluster]

³¹ Infant Mental Health Association Aotearoa New Zealand

³² Office of the Children's Commissioner

The lack of mention of the workforce was noted by several respondents. This was not only in relation to the wellbeing of the workforce but also because an adequately funded and resourced workforce is required to support and implement these strategies and policies.

It was suggested that a useful next step in the development of the framework might be working alongside the identified priority groups to truly understand what these concepts and their descriptions looks like for these communities.

For example, while 'having their rights and dignity upheld' is an appropriate and pragmatic concept, human rights is an individualist western concept and does not include the collective nature of Pacific culture and thinking. Community consultation at this level, which could helpfully follow a participant action research methodology, could help to ensure the vision for mental health and wellbeing as set out in He Ara Oranga is accurately captured in the framework (eg, Chapter 3 especially Whakawātea te Ara (3.4) and Vai Niu (3.5)). [Mental Health Foundation]

Implementation of the framework

Respondents had questions about implementation of the framework. It was difficult for people to see how the framework would translate into outcomes. For example, 'it feels too conceptual to be able to be implemented.'³³ Respondents questioned how it would be applied practically, and how health professionals and others would report on broad and subjective outcomes. It was noted that in the Child and Youth Wellbeing framework 'you could consider an issue and assign it to a domain, but you cannot do that in this draft framework. This may make it harder to use.'³⁴

While acknowledging that the next phase in the development of the framework is to design indicators and measures, respondents wanted a clearer link between the concepts in the outcomes framework and the possible outcomes.

The Commission must be able to demonstrate that their work is contributing to improved mental wellbeing outcomes and have in place methodology to evaluate progress. This information is needed to support the Commission's ongoing work and survival as without this data; it may be challenging to demonstrate return on investment and effectiveness. [The Royal Australian and New Zealand College of Psychiatrists]

The real test of these areas is whether they will make change... It might be useful to get an indication of what changes are envisaged, how (what mechanisms), and within what timelines. [Organisation – did not consent to quotes being attributed]

One respondent suggested more concrete outcomes could include greater support for improved emotional intelligence skills, better support for employers to respond to mental health issues in their workforce, improved recovery services, and having a more fully-skilled health care work force. Indicating the (evidence-based) key drivers that most improve wellbeing would be useful.

For the future Mental Health and Wellbeing Commission to make a real difference, it will need to focus more resources on those areas that materially drive subjective wellbeing. Without a clear understanding of what makes significant difference, future Mental Health and Wellbeing Commission work runs the risk that equal activity is done in each area, but there is not much progress lifting the average

³³ Platform Trust

³⁴ Organisation via discussion

subjective wellbeing of all New Zealanders. [Loneliness New Zealand Charitable Trust]

I hope that the framework will be attached to a plan which has a realistic chance of meeting the outcomes. This will require wide ranging investment if we are to overcome the childhood adverse experiences which contribute so greatly to mental health problems and addiction. [Auckland Sexual Abuse HELP Foundation]

It was suggested that the framework would be 'clearer and easier to measure if the individual level factors were separated from the structural and systemic factors.'³⁵

Several respondents noted that significant change in the health and disability sector would be required if the intent of the framework was to be realised, including significant cross-sectorial collaboration. The massive investment required to reach these outcomes was noted. Some wondered how the Commission would get buy-in, and how this would be sustained through successive governments.

Given the size of the task ahead, one respondent remarked 'Please keep it as simple and do-able as possible. I do understand you want to meet everyone's aspirations as much as possible, but they are infinite. Just helping everyone be well enough to do the ordinary things of life and feel they belong would be marvelous.'³⁶

Respondents commented on the lack of data making it difficult to set national benchmarks and institute accountability. It was also noted that that the measurement could be very intrusive into people's lives.

One respondent pointed to implementation and monitoring being equally conducted by Māori 'to truly reflect the overarching principles and concepts from our culture and ensure they do not lose their mana and meaning.'³⁷

People also questioned how this framework would work with others, for example, the Child and Youth Wellbeing Outcomes Framework.

³⁵ Office of the Children's Commissioner

³⁶ Individual respondent

³⁷ Individual respondent

The descriptors – concepts that are missing or need greater prominence

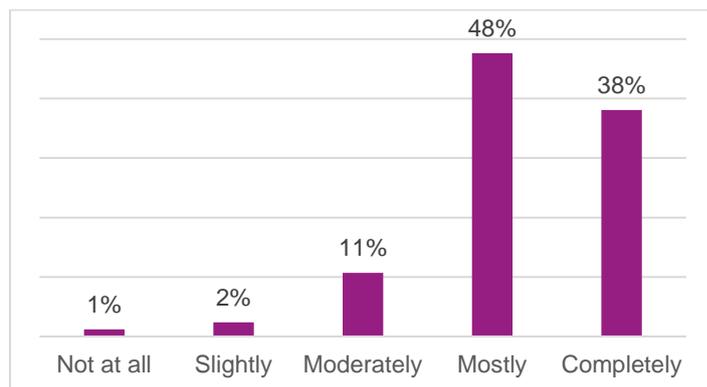
We have identified six interconnected areas of wellbeing:

For Māori as tangata whenua ...	For everyone in Aotearoa
<i>whakaaetanga (acceptance) and manaakitanga (love and compassion)</i>	<i>are safe and nurtured</i>
<i>oranga (wellbeing)</i>	<i>are healthy</i>
<i>rangatiratanga (autonomy), mana motuhake (authority) and whakaute (respect)</i>	<i>have their rights and dignity upheld</i>
<i>whanaungatanga (connection and belonging)</i>	<i>are connected and contributing</i>
<i>wairuatanga (spirituality) and manawaroa (resilience)</i>	<i>are resilient and can heal and grow</i>
<i>rangatiratanga (autonomy), mana motuhake (authority) and whakanuitanga (celebration and honouring)</i>	<i>have hope, purpose and autonomy</i>

How well do the statements under each of the six areas describe what wellbeing means to you?

Most respondents (86% – 72/84) said the descriptors under each domain mostly or completely described what wellbeing mean to them (Figure 3 below). Respondents also provided comment on the concepts they considered to be missing or needing greater prominence in the descriptors. These comments are discussed below.

Figure 3 How well the statements under each of the six areas describe wellbeing



The impact of colonisation

Several respondents wanted colonisation and its impacts to be explicitly referenced in the framework.

We cannot ignore the ongoing impacts of colonisation within a contemporary framework. Colonisation is the disease Māori suffer from most in contemporary Aotearoa. Our broad health indicators describe the illnesses of oppression –

poverty, suppression, oppression, disconnection, intellectual denial. In addition to traditional understandings of wellbeing and what constitutes healing – we must now position colonisation and systemic oppression of mātauranga and tikanga Māori as health emergencies. This therefore demands health tools, activities, strategies and outcomes that are decolonial, liberatory, and mana enhancing. [Individual respondent]

Te reo Māori

Several respondents asked for stronger and explicit reference to te reo Māori and the importance of te reo Māori in relation to wellbeing for Māori.

The 'Māori as tangata whenua' layer should explicitly identify Māori reo (we note language is included in the 'other' layer). [Mental Health Foundation]

[We] recommend reference to the important role that te reo Māori plays in this endeavour... The reclamation and revitalisation of te reo Māori goes hand in hand with the mental health and wellbeing outcomes identified for Māori and others in the He Ara Oranga framework. We therefore recommend that having increased opportunities to communicate in home and heart languages from the earliest opportunity is made explicit within the framework. [Talking Matters Community Activator – Māori]

Expression and preservation of cultural values and traditions

Respondents pointed to the need for explicit reference to peoples' and communities' expression of cultural values.

We would like to see explicit recognition of the importance of empowering and enabling ethnic peoples and communities to express and preserve their cultural values and traditions as these are important protective factors against poor mental wellness. These are best supported through community ownership and leadership, and through effective relationships in a community setting. We acknowledge that the importance of culture and connection to it and each other in cultural communities has been captured in the framework. However, it is the element of being able to express this as set out above, which we see as important. This also better aligns with how culture is recognised and protected through human rights frameworks, ie. not just as products, but through their outward achievement through enabled expression. [Organisation – did not consent to quotes being attributed]

Equity

Respondents, including the Māori focus group, commented on the need for equity to be added as a domain. They suggested that there should be a new domain entirely on equity as it is so important that it shouldn't just be text underneath a domain.

An additional area of wellbeing could be added for Māori as tangata whenua – oritētanga (equity). From a population health perspective, this would better reflect our obligations under Article 3 of te Tiriti o Waitangi to achieve equity in health outcomes between Māori and non-Māori. [Organisation – did not consent to quotes being attributed]

This included specifying equitable access to quality healthcare.

Include an outcome for equitable access to quality healthcare, which we would interpret as availability and equitable funding of kaupapa Māori services and for Pacific people to access not only culturally appropriate services but ones that provide relevant, safe and effective options (see Vai Niu 3.5, Chapter 3, He Ara Oranga) [Mental Health Foundation]

It was also noted that equity of outcomes would not be achieved without equity of input from the parties affected.

There is an entrenched disparity between the voices of consumers and family/whānau, and those of management, clinicians and government departments. Those from groups seeking improvement need more than just words when it comes to having an impact, it is not enough to have a seat at the table if you are only being given crumbs. Equity is not just something taken into account at grass roots level, it needs to be built into every layer of support from those delivering to management, governance and funding levels. [Individual respondent]

Access to quality and safe services

One respondent noted that timeliness is an important part of access to support: 'throughout the discussion of desired outcomes there is no reference to timeliness.'³⁸ Choice of services, supports and systems was also important.

Respondents discussed safety largely in relation to having safe and appropriate services, but also about people not being taken advantage of. The Māori focus group suggested several possible terms:

- Whai ora whānau – no further harm coming to the person. Whai ora means seeking wellbeing but doing it without any further harm, so seeking wellbeing and reducing harm; whānau ora is the same in a sense but this is specifically about reducing harm.
- Kaua e tūkino – do no further harm.
- Whakatoihara kore – no negative action.

Economic resources and socio-economic outcomes

Respondents wanted a stronger focus on economic resources and socio-economic outcomes. This includes adequate and equitable access to technology and internet, income equality, civic engagement, and leisure and recreation ('It doesn't address some of the fundamental outcomes people say they want like secure housing, jobs and equitable access to goods and services'³⁹).

Again economic power is underemphasised, particularly for Māori, given the historical context. Being able to provide for family is a minimum. Having an abundance of resources and equal opportunities should be the aim, not subsistence. [Balance Aotearoa]

It does not get down to the crux of the matter in that people need to be able to access supports in the first place. People who are already at a disadvantage in location or lack of health/technology literacy are not able to get help where they are and in the manner they need. There are so many layers of social disadvantage people have to overcome, access to government departments, healthcare, financial advice and services, communication and decent and

³⁸ New Zealand Psychological Society

³⁹ Platform Trust

affordable housing are all areas that need to be addressed before we can 'fix' the wellbeing issues. [Individual respondent]

Social cohesion

Commenting on the importance of social cohesion and mental wellbeing in relation to COVID-19, the New Zealand College of Public Health Medicine recommended that social cohesion be more strongly embedded in the framework.

New Zealand's cohesiveness was evident in the early responses to COVID-19. However, this has been challenged since then as decisions made by the Government, individuals and businesses have created tensions in the face of different views of the best path forward and wellbeing is affected. To achieve social cohesion, constructive and inclusive decision-making processes are needed that empower communities and foster co-determination; this could be better reflected in the outcomes framework to promote mental wellbeing as we move forward. The NZCPHM acknowledges that the six wellbeing areas includes the concepts of whanaungatanga (connection and belonging) for Māori and the importance of connection and contribution to communities for everyone in Aotearoa. However, we suggest that these areas of wellbeing are further explored to reflect the need order to foster the five key components of social cohesion, as outlined in the Koi Tū report – belonging, inclusion, participation, recognition, and legitimacy. [New Zealand College of Public Health Medicine]

Spirituality

Several respondents wanted to see spirituality and belonging given more prominence in the 'for everyone in Aotearoa' layer. As noted previously, respondents in the Pacific engagement said that faith and spirituality needed to be more explicit and should be incorporated into a domain name.

Confidence

One respondent suggested that confidence was an important concept to explicitly reference.

This state of confidence is important, because it is what supports people to engage and seek support through the available avenues when they need this, ie, to access mental health and addiction services. For Pacific Peoples, this state of being confident also supports them to create and deliver their own solutions. [Organisation – did not consent to quotes being attributed]

Self-actualisation

There was discussion in the lived experience focus group and from other respondents about including self-actualisation⁴⁰ as a concept. Some thought it missing, others questioned whether people always have to want self-actualisation? ('Isn't this a really Western concept 'fulfilment of talents and potentials' – I think it is pretty individualist culture.'⁴¹)

⁴⁰ 'A person's desire to use all their abilities to achieve and be everything that they possibly can. The expression is used by Maslow in his theory of human motivation.'

<https://dictionary.cambridge.org/dictionary/english/self-actualization>

⁴¹ Lived experience focus group

Identity and meaning

Some respondents from lived experience perspectives felt the notion of identity and meaning was not reflected as strongly as it should, particularly as these are strong elements of addiction recovery frameworks.

They (esp. Identity and Meaning) are not adequately articulated within the six interconnected areas of wellbeing. [Addiction Consumer Leadership Group, Te Pou]

We heard in the lived experience focus group how some of the concepts are too individualist and could be framed instead in terms of reaching for dreams and goals.

Play

The New Zealand Psychological Society noted that the concept of play is missing.

For children the ability (space, time, permission) to play is vital for mental health and wellbeing. It is also a very important aspect of adult wellbeing that is often overlooked. [New Zealand Psychological Society]

Ancestral lands

One respondent considered it important to include actions for engaging with and using ancestral lands.

This may include enacting kaitiakitanga, enacting kai gathering, enacting rongoā practices. [Individual respondent]

Environment

Several respondents wanted the natural environment to have a greater emphasis due to its important for everybody's wellbeing.

While there are several references to the environment across a number of areas in the framework, there is no mention of climate change or planetary health (which includes climate change but also the integrity of natural ecosystems, use of land, pollution, biodiversity, health of the oceans and rivers, etc). We suggest that it would be useful for the framework to specifically identify planetary health given its central importance to human health and wellbeing. [New Zealand Medical Association]

Suggestions about each domain

Domain 1 for Māori as tangata whenua – whakaaetanga (acceptance) and manaakitanga (love and compassion)

Further to the comments about the need for care with the language, respondents had specific questions about the term used in this domain.

We would also query what is meant by whakaaetanga? This term typically means that you are agreeing or that you're compliant rather than 'acceptance'. We are assuming this is intended to mean acceptance from others (as opposed to stigma)? Furthermore, whakaaetanga could be explained in the diagram and linked to wellbeing. [New Zealand Psychological Society]

In relation to the description of 'whakaaetanga and manaakitanga', while we do not deny that ritenga Māori, tikanga Māori and mātauranga Māori certainly fall under the ambit of manaakitanga, they are equally as descriptive of wairuatanga because they provide the connection between te ira tangata (the human aspect) and te ira atua (the divine aspect), yet remain unmentioned in that area. Perhaps this tends to highlight the arbitrary distinctions which can be made where 'areas of wellbeing' are separated. [Te Pūtahitanga o Te Waipounamu]

Domain 1 for Pacific peoples – safe and nurtured

Respondents suggested using more accessible and inclusive language. Pacific languages would best express cultural principles (eg, va, feagaiga (Samoan)). It was a common feature throughout all of the talanoa sessions that the descriptor should include reference to faith and spirituality.

Respondents noted that communities are very diverse. They suggested that the descriptor could be more inclusive when referencing diversity (within Pacific cultures and for those 'part Pasifika and part non-Pasifika') and locality (eg, New Zealand born and Island born). The descriptor should also recognise that Pacific peoples live (and move) in Aotearoa and across the Pacific.

The definition of 'cohesion' was questioned, in the sentence 'Pacific communities maintain their cohesion and cultural integrity with strong relationships'. It was suggested this should be 'social cohesion'. Another suggestion was to replace 'cohesion' with 'collectivity'.

Domain 1 for everyone in Aotearoa – safe and nurtured

There was wide support for the use of the word nurtured, however some respondents felt other words would be more suitable:

'Nurture' speaks more to younger age groups and 'support' or 'interdependence' may be more relatable concepts for adults and older age groups. Simply changing the wording from 'nurtured' to 'supported' could open engagement with a wider group of people. [Age Concern NZ]

I feel it is important for all people in Aotearoa to feel acceptance, love and compassion, think they are better words than safe and nurtured. [Individual respondent]

Several respondents saw safety as separate from nurture. There could even be a tension between these concepts. As discussed previously (see page 26) safety could be woven throughout the domains or be a separate domain.

Although appreciating the positive language used in the framework, some participants in the lived experience focus group wanted to see freedom from violence and abuse as a specific outcome in the framework. This domain should also cover having a safe place to go, and safety in services. One respondent suggested adding integrity to this domain.

In relation to the previously noted point that it was not always desirable or possible to 'reconnect people with their family', a small change was suggested, such as 'People have a sense of security and belonging in a family and/or social group...'.⁴² Such a change would

⁴² Organisation – did not consent to quotes being attributed

leave space for alternative ways of being. Similarly, participants in the Pacific engagement suggested including other whānau-like groups such as church communities.

In relation to the sentence 'People have the economic resources needed to provide for their children, grandchildren, and other dependants.' It was suggested that this be restated to read 'People have the economic resources needed to provide for themselves, their children, grandchildren, and other dependants.'⁴³ This amendment related to many children and young people needing (and being entitled to) independent economic resources (including children in state care).

Thinking about the outcome 'People have a sense of security and belonging in a family and social group, and can form meaningful relationships', one respondent noted that belonging while critically important, could be difficult for some people if they don't feel they belong anywhere. The lived experience focus group noted belonging was not only an ethnic or geographic concept, however 'as Pākehā it can be difficult to claim belonging, not to Europe or to here – it's difficult for New Zealanders, and would be great to talk about more'.

There was also a suggestion that environmental health was referenced under this domain 'similar to how it is mentioned in the te ao Māori side, as statistics ...[show] that anxiety about climate change and generational climate grief is cited by rangatahi as one of the largest challenges for their mental health.'⁴⁴

Domain 2 for Māori as tangata whenua – oranga

The focus on equitable health outcomes for Māori was strongly supported. However, the descriptor for this domain was thought vague by some. Rewording was suggested:

The first sentence of the descriptor does not make sense as pae ora ('healthy futures') is not something that we can 'enjoy' or experience in the present moment as we only exist in the present moment. It is rather, something that we work towards. The belief is that healthy individuals, healthy whānau, and healthy environments collectively contribute towards building a healthy future. It is understood that in order to build a healthy future then it is necessary to have healthy individuals, healthy families, and healthy environments. [Individual respondent]

It was suggested that the descriptor could be further strengthened by providing detail or an example of what constitutes a healthy individual, healthy family and healthy environment. For example, food, shelter, warmth, exercise, sleep, social relationships etc.

It was also suggested by one respondent that the phrase 'unfair differences' in the text could be amended to better reflect the otherwise generally positive framing of the descriptors.

Domain 2 for Pacific peoples – are healthy

The descriptor in the Pacific example resonated for respondents, but people wanted several concepts to be explicitly captured. Most prominently, spirituality and faith which 'contributes solutions to individuals and families'. Equity was highlighted as integral to being healthy, for example, 'equitable educational outcomes'. The natural environment should also be referenced in this domain as it 'plays a huge part in how we see the world'.

⁴³ Organisation – did not consent to quotes being attributed

⁴⁴ InsideOUT Kōaro

Some respondents preferred a reference to emotions rather than mental health and wanted to see a greater emphasis on emotional wellbeing. In the feedback, people also questioned the connection between the outcomes framework and actual support for people experiencing acute mental distress or addiction issues: 'When there is an episode, what support is there during those periods?'⁴⁵ It was noted that networks of support should be culturally relevant and appropriate.

Domain 2 for everyone in Aotearoa – are healthy

'Are healthy' was thought by one respondent to be too ambiguous and open to interpretation. This needed to be more specific. A few respondents suggested that 'enjoys the best possible health' is better aligned with the descriptor as it reflects continual improvement.

People can be 'healthy' as defined by 'no immediate need for medical intervention' and remain at risk from existing mild conditions, delayed 'elective' surgery, poverty, deprivation, etc. But if they are to 'enjoy the best possible health' then there is a continual process of improvement that takes account of how the person feels about that process. 'Healthy' does not communicate that concept adequately. [Balance Aotearoa]]

However, it was also suggested that this domain descriptor should be reviewed from the perspective of people who live with permanent disability or chronic health conditions.

It was considered important by several respondents to make explicit reference to equity of physical health.

People accessing secondary mental health and addiction services have more than twice the mortality rate than the general population and people with experiences labelled as psychosis have more than three times the overall risk of premature death, and the workforce and system play a major role in addressing this health inequity. Physical health equity for this group often goes unrecognised in many parts of the health system. [Mental Health Foundation]

Include (amongst other things) access to quality health care (access to and quality of physical health care are known to be major barriers to physical health equity. [The Wise Group]

A few respondents suggested mental health should be prioritised, for example: 'I would like to see more concrete outcomes that are focused on mental health and non-physical wellbeing first and foremost.'⁴⁶

It was also noted that the concept of psychological wellbeing should be explicit.

For instance under 'are healthy' there is reference to healthy kai, and you could then say 'healthy and psychologically safe homes,' (as well as) safe physical activity and economic security. There are no doubt homes with plenty of money but where too much family violence is part of the picture. Yes, psychological wellbeing is part of being resilient etc but it is not specifically noted. [Individual respondent]

Referring to the need to explicitly address infants, children and young people in the framework (and acknowledging the framework refers to a life course approach), it was

⁴⁵ Feedback from the Pacific engagement.

⁴⁶ Individual respondent

suggested that the wording under 'Are healthy' be amended to '...retain their wellness across their life course, starting from conception.'⁴⁷

Having a relationship with oneself that is compassionate and respectful was another aspect that could be added to this domain.

*We can have everything in our communities, families, learn about emotions, have support etc, but if we are not able to be in relationship kindly with ourselves we can still experience immense and life ruining distress – definitely not wellbeing.
[Individual respondent]*

It was pointed out that social determinants such as healthy homes contribute to good health and that people need information to be healthy. The framework could incorporate more mental health promotion elements, 'for example promoting good behaviours as protective factors for mental health and wellbeing.'⁴⁸

It was also noted in relation to the phrase 'equity of health', that equity was not used in reference to other areas in a similar way.

It would be good to expand the phrase equity of health so that it encompasses wellbeing in its fullest sense, and in particular, mental wellbeing and addiction, either in this section or incorporate it into other areas. [Te Hiringa Haurora – Health Promotion Agency]

Domain 3 for Māori as tangata whenua – rangatiratanga (autonomy), mana motuhake (authority) and whakaute (respect)

Rangatiratanga

Many respondents, including those in the Māori focus group, questioned the repetition of rangatiratanga in domains 3 and 6.

For Māori as tangata whenua there appears to be two wellbeing areas (the third and sixth in list) that are the same with a slight variation (whakaute and whakanuitanga), however a clear distinction is made in their corresponding descriptions. A suggestion to change the third wellbeing area title to better represent the corresponding description and to make distinct from the sixth wellbeing area. [Individual respondent]

The Māori focus group also asked that the title of Domain 3 be tino rangatiratanga:

Why would you want two domains with rangatiratanga? There's only one class of tino rangatiratanga.

Rights

Respondents questioned the statement 'Whānau legal, human, cultural and other rights framed by Te Tiriti o Waitangi are protected and privileged'. 'Privileged' was not the right term. 'Valued' or 'realised' were considered more appropriate.

This descriptor should reflect that 'wellbeing' means [Māori] have access to timely and appropriate mental health care.

The rangatiratanga domain should also encompass whānau being self-managing. I don't feel we are ever truly 'autonomous'. We are all part of a whānau/community

⁴⁷ Organisation – did not consent to quotes being attributed

⁴⁸ Canterbury District Health Board

ecosystem and if we want long term, sustainable change for individuals, we need to make sure that they are in supportive environments. [Organisation – did not consent to quotes being attributed]

Domain 3 for Pacific peoples – have their rights and dignity upheld

Respondents strongly supported the importance of referring to dignity in the framework. Cultural norms and values being accepted and respected by other cultures was also important. Participants wanted the framework to recognise the multiple identities of people and the diversity in Pacific communities while maintaining unity. References to racism and discrimination ('Pacific peoples and families live free from discrimination and racism') should be kept in this domain.

Domain 3 for everyone in Aotearoa – have their rights and dignity upheld

Realisation of rights

Having one's rights and dignity upheld was seen as different to having one's right and dignity fully realised. Being aspirational, full realisation of rights and dignity was seen as a more appropriate outcome. It was also noted that human rights are primarily based on an individualistic ideology, which is inherently a Western concept. 'Thus, it does not fully capture how groups from collectivist culture and thinking, such as Asian and Pasifika, envision this concept.'⁴⁹

It was suggested that this domain could reflect (as could others) that wellbeing means 'people, families and communities have access to timely and appropriate mental health care' as a right.⁵⁰ One respondent thought that 'Communities, institutions and services support people' should be included in the descriptor for Domain 3 'perhaps by saying something like "communities, institutions and services are available to support people while maintaining their dignity and human rights". This would make it clearer that people would not lose their ability to get help in hospitals 'and end up instead in the prison system.'⁵¹

Additionally, the Mental Health Foundation suggested that the domain descriptor could include the examples of minimising coercive treatment and eliminating seclusion practices (related to use of the Mental Health (Compulsory Assessment and Treatment) Act).

Stigma and discrimination

The Canterbury DHB recommended that the framework include an explicit mention of stigma associated with mental illness and distress. Further to this, another respondent considered stigma 'isn't the issue, prejudice and discrimination is. Stigma implies shame, and we should be proud of our lived experiences.'⁵²

There were conflicting views on naming forms of discrimination in the descriptor. Some respondents valued the explicit inclusion. For example:

We really appreciate the explicit rainbow inclusion as asked for in our previous submission, it will make a material difference to how this framework supports rainbow communities. [InsideOUT]

⁴⁹ Asian Family Services

⁵⁰ Australasian College for Emergency Medicine

⁵¹ Individual respondent

⁵² Changing Minds

Others felt that naming specific groups could inadvertently exclude some groups. Also, the descriptor used terms which may not be widely understood. It was suggested instead that the descriptor refer more broadly to valuing diversity and practicing inclusion.

We disagree with naming the phobias and 'isms' under have their rights and dignity upheld as this inadvertently excludes/includes; also suggest using plain English rather than terms like 'sanism' which is not a readily understood term or concept. Basically, a society that values diversity and practices inclusion can eliminate stigma and discrimination for everyone in Aotearoa. [Addiction Consumer Leadership Group (Te Pou)]

One respondent considered that that this domain should reference systems and services both within and outside the health sector (eg, education, police, criminal justice) being culturally safe and free from racism and discrimination; 'otherwise it suggests racism exists in communities or some other place in society and is not also institutionalised.'⁵³

It was further suggested that the International Guidelines on Human Rights and Drug Policy (2019) inform the work of the Commission as relates to people who use drugs and alcohol and have addiction issues: "Rights and dignity upheld" – this is the elephant in the room for many people with addiction issues, particularly people who use drugs.'⁵⁴

Values

It was suggested there should be a clear and explicit recognition of the importance of 'values', particularly cultural values included in the 'rights and dignity' outcome area.

Presently, this is to be inferred by the current framing. An acknowledgment of the importance of being empowered and enabled to express and preserve important cultural values and norms could be included in the framework. We note, this approach is also reflective of an important protective factor for Pacific peoples' wellbeing. [Organisation – did not wish to have quotes attributed]

Domain 4 for Māori as tangata whenua – whanaungatanga (connection and belonging)

The importance of whanaungatanga was emphasised 'because it is about identity as well as connection and belonging and identity is at the heart of wellbeing and therefore mental health.'⁵⁵

Whanaungatanga in the descriptor was seen by one respondent to equate appropriately with the 'for everyone' descriptor:

Connection and belonging is defined and where whānau thrive in an environment of arohatanga (the practice of love.) and where collective flourishing can occur. Overarching this is the idea that all people are valued and able to function in their chosen roles as in education, volunteering, and employment and contributing to thriving communities. These communities can celebrate strengths and practice empathy and compassion [Organisation – did not provide consent to be named]

Another respondent thought the descriptor suggested that whanaungatanga as a source of wellbeing is available only to whānau:

⁵³ Mental Health Foundation

⁵⁴ Addiction Consumer Leadership Group (Te Pou)

⁵⁵ Tōpūtanga Tapuhi Kaitiaki o Aotearoa New Zealand Nurses Organisation

The 'whanaungatanga' area of wellbeing tends to emphasise it as a source of wellbeing which is available only to whānau; however, as our experience bears out whanaungatanga is a source of wellbeing to many people connected even beyond whakapapa. That is not to understate the role of whānau in keeping people well and supporting recovery, but to equally state the value of whakapapa-like relationships where whanaungatanga can support wellbeing. [Te Pūtahitanga o Te Waipounamu]

It was suggested that this descriptor might be strengthened by expressing 'Te mana kaha o te whānau – the influence and strength of the whānau. This reflects that the whānau itself needs to exercise its rangatiratanga as well as rely on "hope"'.⁵⁶

Domain 4 for Pacific peoples – are connected and contributing

Respondents supported 'connection' as a concept ('to yourself, your spirit, your aiga, community'). 'Va' should therefore be included in the descriptor. This domain had general support, with respondents emphasising it needed to situate Pacific cultures with the collective rather than with the self (individual).

Respondents suggested including a physical element to living well. They further suggested using emotional rather than mental wellbeing ('Holistic wellbeing: culture, physical, emotional, spiritual, identity'). Identity is defined by a number of different layers including age and social group.

With reference to the expression of Pacific cultures, respondents noted that expression of knowledge could be oral (through languages) and visual and that sports could be included as an expression of Pacific cultures.

Domain 4 for everyone – are connected and contributing

Respondents questioned who would define 'contributing' and judge what is or is not considered to be contributing. It was suggested that '[Is] connected and valued' might be better aligned with the full description of the domain.⁵⁷ Similarly participants in the Pacific engagement considered 'valued' instead of 'recognised' made more sense (eg, 'you don't need to be acknowledged, but the contribution of others should be valued').

It was suggested that identity should be included in this domain. That is, people and families are celebrated for their diversity and are connected to their culture, language, beliefs, religion, and/or spirituality which supports self-determined *identity* and wellbeing.

In relation to celebrating and acknowledging diversity, it was noted that the descriptor needs to ensure the inclusion of different groups to have power and influence in decision-making. 'Recognising and celebrating diversity, is not the same as inclusion and different groups having power and influence in decision-making.'⁵⁸ It was suggested that this concept be amended to explicitly support Māori and other groups having greater participation and influence in decision-making for their communities and wider systems: 'We would like to see a wellbeing outcome for Māori to influence decision-making at all levels (not just in their own communities) and be supported by tau iwi and non-Maori institutions to do this.'⁵⁹

⁵⁶ Organisation, did not provide consent to attribute quotes.

⁵⁷ Balance Aotearoa

⁵⁸ Asian Family Services

⁵⁹ Mental Health Foundation

One respondent questioned the place of environment in this domain ('out of place'⁶⁰), suggesting it may fit better under Domain 2 – are healthy.

Domain 5 for Māori as tangata whenua – wairuatanga (spirituality) and manawaroa (resilience)

The Māori focus group (and others) welcomed the inclusion of this domain and noted it was 'an expression of article 4, a right to express beliefs and a way of living'. They also noted that in a mainstream environment, for example in DHBs, 'this is something that is misinterpreted, misunderstood because it's intangible. It's hard to do this.' However, it was considered that there are practical ways of supporting the expression of wairuatanga and identifying activities that are done to maintain that balance. Related to this last point, other respondents commented on the difficulty of measuring this concept in the outcomes framework.

Although one respondent suggested separating wairuatanga and manawaroa, others saw value in these terms being together.

In keeping with the aspirational language used in the framework, it was suggested that in the descriptor, the word 'restored' be changed to something more positive.⁶¹

Domain 5 for Pacific peoples – are resilient and can heal and grow

Respondents emphasised family and faith being the strongest links to resilience and growth. They supported the acknowledgement of a Pacific world view and of diversity within communities. Participants commented on Pacific peoples seeing stressors as the norm, and not thinking they needed help. It was noted that people may be afraid to speak out for fear of being considered weak, or because of concerns about confidentiality – 'everyone knows one another so you don't want to seek support anyway.' The framework should support talking about and relating one's situation, for example, Pacific communities modelling drawing on their strengths in response to stressors. The maintenance of cultural ties and practice was integral to this.

Domain 5 for everyone – are resilient and can heal and grow

There was some reservation expressed by respondents about the use of resilience as a wellbeing domain, particularly from respondents with lived experience perspectives. This reservation was centred on the view that individuals should not have to be continually resilient. The descriptor should acknowledge the validity of unpleasant states of being. One respondent suggested amending the domain to 'hope, purpose and autonomy to live their best lives'.

The framework identifies resilience and bouncing back from adversity, but we suggest these terms should reflect a more up-to-date and nuanced description of resilience. ... the concept of resilience is moving away from locating and identifying adversity as a necessary condition in order to contrast the skills of resilience towards the capacity to draw upon resources to sustain wellbeing. This sees wellbeing as a collective experience and resource with many determinants

⁶⁰ Organisation – did not consent to quotes being attributed

⁶¹ The descriptor reads 'Taonga Māori are restored and Māori have a unique relationship and spiritual connection to the taiao (environment), their whenua (land), whakapapa (genealogy) and whānau.

beyond the individual, and that does not require adversity to measure whether a person (or community) is resilient. It also doesn't implicitly suggest that a return to 'normal' or an earlier state is the requisite for success and flourishing. For many individuals this may not be possible after trauma or adversity (or desirable perhaps). This was a key learning for communities and populations following the earthquakes in Canterbury where All Right? now use the term 'adaptability' and 'adaptation' as a more realistic objective/outcome. [Mental Health Foundation]

The lived experience focus group suggested that if resilience was used, then the term 'bounce back' should not be: a better term may be 'moving through.' Another respondent wanted the sentence to read '... bounce back from adversity and distress.'⁶² This phrasing was seen to better reflect the need for the ongoing management of mental wellbeing.

The lived experience group also discussed resilience and autonomy going hand in hand (having power over choices):

In clinical services you get told or forced and then expected to be resilient, but for me resilience comes from being responsibility for choices, having options in first place – so having [autonomy and resilience] separate doesn't really fit.

It was suggested by another respondent that the descriptor be explicitly widened to include the whole of life.

Growth may relate to intergenerational groups but it does have connotations of youth and childhood. A simple addition to the wellbeing area from; 'resilient and can heal and grow' to 'resilient and can heal and grow with change' adjusts the context from youth and childhood to any time in life when change occurs. [Age Concern]

Respondents also suggested that the descriptor acknowledge the significant impact of childhood deprivation.

Boundaries were discussed under this domain. It was considered very important that people's boundaries were respected as boundaries tie into safety, 'people need to be able to relax, to be safe, let their guard down.'⁶³ This descriptor should therefore include text about healthy or effective or mutually beneficial boundaries being held by the community

Abuse and control happen because boundaries are not such that people can have respect and autonomy for individuals. Mutually beneficial might be an important word here given the really different cultural lens on how relationships work. [Lived experience focus group]

Domain 6 for Māori as tangata whenua – rangatiratanga (autonomy), mana motuhake (authority) and whakanuitanga (celebration and honouring)

Given the duplication of domains 3 and 6 (discussed in this report on page 33), the Māori focus group suggested that this domain build on hope and purpose. 'That things will get better for Māori. A strengths-base.'

One respondent questioned whether self-development was covered in this domain.

Not sure if 'autonomy and authority' cover the idea of self-development, extending ourselves, learning and growing. [Individual respondent]

⁶² Te Hīringa Haurora Health Promotion Agency

⁶³ Lived experience focus group

Domain 6 for Pacific peoples – have hope, purpose and autonomy

Respondents agreed that interdependence⁶⁴ reflects familial and community relationships. Reflecting the emphasis on the diversity of Pacific communities, respondents suggested that the framework be amended to ‘Pacific peoples and families have hope and faith to lead lives that serve their families, *communities* and identities’.

Domain 6 for everyone – have hope, purpose and autonomy

Several amendments were suggested for this descriptor.

Respondents suggested adding children and young people to the outcome area and including the language of the Child and Youth Wellbeing Strategy – ‘involved and empowered’.⁶⁵

Addiction was also noted as missing from the descriptor. The sentence beginning ‘Communities of belonging...’ could be amended to ‘Communities of belonging, such as rainbow communities and consumer communities *such as addiction, mental health, and gambling harm* have agency ...’.⁶⁶

A community of belonging is a collective identity and resonates strongly within addiction recovery communities and aligns with the CHIME framework. [Addiction Consumer Leadership Group (Te Pou)]

Others preferred not to use the term ‘consumer’ in the descriptor. Clarification of how communities will be supported and empowered to create positive change, to avoid victim blaming, was also asked for.

Comments on the vision

Our ‘vision’ is one sentence that describes what we hope the future state of mental health and wellbeing will be in Aotearoa. The proposed vision for the Initial Mental Health and Wellbeing Commission and the outcomes framework is: ‘Tū tangata mauri ora, flourishing together’

Do you think this is a suitable aspirational vision?

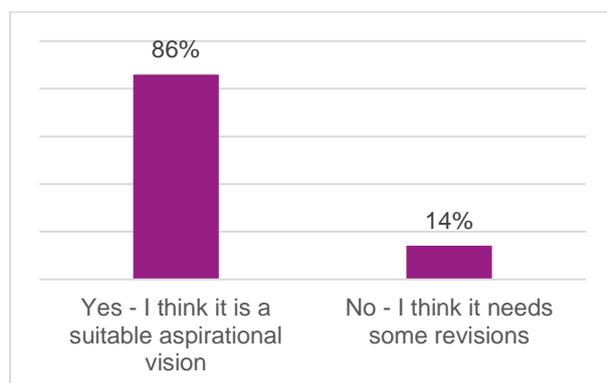
The vision of ‘Tū tangata mauri ora, flourishing together’ was generally supported. Most respondents (86% – 73 of the 85 who answered this question) said it was a suitable aspirational vision. Eighty percent (39/49) of the respondents who identified with or represented people with lived experience of mental distress, illness and/or addiction considered it was a suitable aspirational vision.

⁶⁴ In relation to the statement in the framework ‘Pacific peoples and families lead interdependent lives with one another and their communities in Aotearoa and across the ‘sea of islands’.’

⁶⁵ Office of the Children’s Commissioner

⁶⁶ Addiction Consumer Leadership Group (Te Pou)

Figure 4 Is 'Tū tangata mauri ora, flourishing together' a suitable aspirational vision?



Aspects of the vision that were supported

Simple and concise

There was appreciation for having a simple, concise vision statement.

It is concise and inclusive. [Te Pou Addiction Consumer Leadership Group]

We are supportive of your vision statement; 'Tū tangata mauri ora, flourishing together' which is simple, powerful and integrative [Age Concern New Zealand]

I like the simplicity. Inclusive of all. [Individual respondent]

Flourishing

Most respondents liked the word 'flourishing' as an aspirational concept to strive for.

I really like the term 'flourishing' as it captures not just surviving and coping but aspiring for more [Organisation – did not consent to quotes being attributed]

The use of flourishing helpfully reflects that one can have or attain wellbeing while at the same time experience mental illness or distress. [Mental Health Foundation]

The word flourishing captures more than just the word 'improved' or 'thriving' – in fact, flourishing sounds almost joyful and that's what we want whānau to feel – together. [Individual respondent]

Interconnectedness and collective

The emphasis on the collective and interconnected nature of wellbeing was supported.

Recognises the interconnectedness of people and desire for all to be doing well, not just surviving. [New Zealand Psychological Society]

Flourishing Together implies not only holistic well-being on our own terms but a collective purpose and vision. He waka eke noa. [Changing Minds]

[It] emphasises meaningful social connection [Loneliness New Zealand Charitable Trust]

The vision is inclusive including everyone implying that we are all into this together regardless where you are in your recovery [Maraeroa Marae Association Incorporated]

Te reo Māori and English side-by-side

Respondents welcomed the pairing of te reo Māori and English side-by-side.

The statement demonstrates the uniqueness of Aotearoa with 'te reo' and English side by side, is inclusive of everyone, succinct, and promotes hope and new growth. [Individual respondent]

Well for me it is wonderful, I love the blend of both Māori and English [Individual respondent]

Other words

Some respondents commented on the appropriate choice of words 'mauri ora' and welcomed the lack of reference to 'mental'.

'Mauri ora' is the best description of health and wellbeing. A society where all people of Aotearoa have mauri ora – and are 'flourishing together' – is a vision that we support. [Te Pūtahitanga o Te Waipounamu]

[It does not] use the word 'mental' which is a positive. For many years tangata whai ora and whānau have voiced that they do not like the word 'mental' and have suggested to get rid of it as it has a stigma attached to it and carries a negative stereotype. [Individual respondent]

Why some respondents did not support the vision

Challenge with 'flourishing' and needs to be more specific to mental illness

As noted earlier, most respondents liked the word 'flourishing'. However, some respondents felt that flourishing can mean different things for different people. Also, flourishing is something that individuals may not have personal control over.

Flourishing together.... We all flourish at different rates and in different ways. What if it was more about helping each other to flourish? [Organisation – did not consent to quotes being attributed]

Flourishing has some negative connotations as it may imply that one has personal control of whether one is flourishing or languishing. [Organisation – did not consent to quotes being attributed]

Respondents who did not support the vision also provided the rationale that it needs to reflect the experience of people experiencing mental illness.

It needs to be more specific to mental health and (non-physical) wellbeing. Currently it reads as a great slogan for the something like the NZ government as a whole. [Individual respondent]

Some of us will not be flourishing, and that vision just makes us feel more inadequate or that the Commission is about people who are pretty well anyway, and does not apply to us. We need something more focused on people being able to be well – all people being able to be well. [Individual respondent]

Flourishing is another warm fuzzy word which does not necessarily resonate with people who are struggling with adversity. [Individual respondent]

It's simple and clear but it sounds a bit cheesy for people experiencing mental illness considering we're still under the biomedical model and have not progressed to the next model. [Individual respondent]

One respondent felt the vision statement needs to be more explicit about who is flourishing, and suggested it be changed to ‘Flourishing together as individuals, members of families, and communities of Aotearoa.’⁶⁷

Another respondent wanted more detail on the process behind developing this vision statement.

Comments on the principles

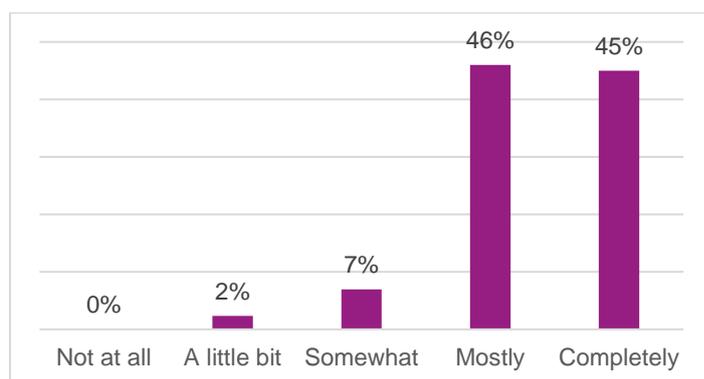
The outcomes framework and all the work of the Initial Commission draws on overarching principles. These are:

- *Te Tiriti o Waitangi paves our way, and the Māori-Crown partnership is our foundation*
- *Wellbeing for all is our goal*
- *We uphold multiple knowledges, including Mātauranga Māori, and share power*
- *We put people, whānau and communities at the centre of all our work*
- *Our priorities are guided by the voices of lived experience, Māori, Pacific peoples and other groups who experience poorer wellbeing outcomes*
- *We take holistic approaches that enhance wellbeing*
- *We carry the spirit and voices of He Ara Oranga, Oranga Tāngata, Oranga Whānau and the Mental Health Inquiry Pacific Report*
- *Our work makes a difference*
- *Our work is accessible to all*

How well do you think these principles are reflected in the draft outcomes framework?

Most respondents felt the principles were ‘mostly’ or ‘completely’ reflected in the draft outcomes framework (91% – 77 of the 85 who answered this question).

Figure 5 How well the Initial Commission's principles are reflected in the draft outcomes framework



Unless they answered ‘completely’ respondents were asked to explain how the principles could be better reflected in the outcomes framework. Responses to this question showed two interpretations of the question:

1. Asking about whether the principles are reflected in the draft outcomes framework; or

⁶⁷ Organisation – did not consent to quotes being attributed

2. Asking them to comment on the appropriateness of the listed principles.

We acknowledge the lack of clarity on this question. Whilst the intent was asking about the former rather than the latter, we have also analysed the comments received about the broader appropriateness of the principles.

Comments on how the principles could be better reflected in the outcomes framework

Te Tiriti o Waitangi paves our way, and the Māori-Crown partnership is our foundation

A few respondents provided suggestions about how this principle could be better reflected in the draft outcomes framework. This included referencing system transformation (such as strengthening the role of kaupapa Māori and Whānau Ora approaches), renaming the dual-layers in line with Te Tiriti o Waitangi, and changing the domain title to reflect tino rangatiratanga.

The draft outcomes framework does not necessarily give a sense of the 'difference' needed for the kāwanatanga system to meet its shortcomings where affirmative action is not taken. I appreciate that actually the outcomes framework does a good a job at removing the system from the picture so that people and whānau are rather its centre of focus. It may, however, be useful to reference system transformation, which you might do in terms of te Tiriti o Waitangi. [Te Pūtahitanga o Te Waipounamu]

Another way to acknowledge that Mana Tiriti helps frame the outcomes framework might be to name the section 'For everyone' as 'Tangata Tiriti' instead, just as the 'For Māori' section is named for 'Tangata Whenua'. [Te Pūtahitanga o Te Waipounamu]

Tino rangatiratanga for Māori should be reflected as also connected to the Treaty of Waitangi, as the Articles of the Treaty explicitly contains such recognition. [Organisation – did not consent to quotes being attributed]

Wellbeing for all is our goal

Against the principle 'wellbeing for all is our goal', some respondents suggested that more priority groups need to be explicitly mentioned.

Wellbeing for all is our goal – include more priority groups, including Asian peoples. [Asian Family Services]

Explicitly mention rainbow and disabled peoples as priority groups rather than being included in 'other groups'. This makes the framework more accountable to these communities which are of similar population size to Māori and Pacific peoples. [InsideOUT]

Tamariki should be valued as a priority group and that a focus on the mental health and wellbeing of infants is made explicit [Talking Matters]

Respondents also considered that the framework should more strongly reflect the needs of people with serious mental illness and addiction issues.

He Ara Oranga does not strongly articulate the needs and aspirations of people living with serious mental health and addiction issues therefore we suggest these consumers are given greater consideration within the document [The Royal Australian and New Zealand College of Psychiatrists]

We take holistic approaches that enhance wellbeing

Whilst there was general support for the emphasis on social determinants that impact on wellbeing, one respondent felt this principle could be better reflected with more reference to addiction and a whole-of-system approach.

Addiction is only mentioned once in the document. Addiction, namely the misuse of alcohol, has a huge influence on the wellbeing of the individual and wellbeing of his/her contacts. Alcohol misuse contributes to both physical and mental injuries across the spectrum of New Zealand society. To improve our wellbeing the normalisation of alcohol in our society needs to be challenged. Other drugs such as cannabis, methamphetamine and tobacco should also be included in this document as these too have a detrimental impact on people's wellbeing. [The Royal Australian and New Zealand College of Psychiatrists]

A holistic approach involving social services, education, ACC and various health providers will be required to improve the wellbeing of [very unwell] consumers who have enduring mental health problems. It is unclear how these consumers' wellbeing is addressed within the Framework. [The Royal Australian and New Zealand College of Psychiatrists]

We uphold multiple knowledges, including Mātauranga Māori, and share power

One respondent noted that bringing to light Mātauranga Māori includes the conceptualisation of wellbeing being dependent and explicitly linked with the natural environment.

Mātauranga Māori teaches us that atua Māori (eg, Ranginui, Papatuanuku, Tāne, Tāwhirimātea) who are also deities and guardians of the elements of the natural environment – are our ancestors. Explicitly, Māori are the direct descendants of atua Māori – the natural environment. ... What this means is that we understand that our wellbeing as humans, and as Māori is dependent on and explicitly linked to our interaction with and the wellbeing of the natural environment. [Individual respondent]

Our work is accessible to all

The consultation modes and the designed outcomes framework were not considered to be accessible to all.

'Our work is accessible to all'. Accessibility requires consideration in how it can be viewed (print and/or digitally) and understood for people with disabilities or non-English speakers. [Age Concern New Zealand]

[Your] work is not accessible to all as not everyone knows about it or can access it in remote or impoverished areas. [Individual respondent]

Our work makes a difference

Respondents reflected that the principle 'our work makes a difference' cannot be known until the outcomes framework is implemented.

(Our work makes a difference for example) is implied and is actually outcome based, so won't be apparent until actual plans are in place [Royal New Zealand Returned and Services Association]

Comments on the appropriateness of the listed principles more broadly

For respondents who interpreted this question more broadly about the appropriateness of the listed principles, the following themes came through.

Concern with the 'wellbeing for all' principle

One respondent was concerned that 'wellbeing for all is our goal' loses focus on people with serious mental illness and addiction issues.

'Wellbeing for all is our goal' should not be the goal in the case of the commission. The target audience should be those that suffer the most. [Individual respondent]

Areas to strengthen in the principles

Equity

We heard how a principle on equity of outcomes for Māori should be added or made explicit within the existing principles.

A further principle of achieving equity of mental health outcomes for all is our goal could be added to better reflect an aspiration for better, fairer and more equitable mental health outcomes between Māori and other New Zealanders. [Organisation – did not consent to quotes being attributed]

Other principles the Commission could consider include: equity and fairness (although these are implicit in some of the current principles). [Mental Health Foundation]

Human rights approach

One respondent felt it was an omission that a human rights approach was not referenced in the principles.

[There is] no mention of a human rights approach. [Balance Aotearoa]

Whānau voice

Whilst the principle of being guided by the voices of lived experience was welcomed, some felt that this needed to also include whānau voice.

It does not seem that the whānau voice is reflected in the decision making or priority setting process. [Individual respondent]

I think there should be some inclusion of the importance of whānau and other caregivers in the section on lived experience. [Individual respondent]

Whole-of-systems approach

It was noted that a whole-of-system approach is needed to achieve the outcomes set out in the outcomes framework.

Other principles the Commission could consider include: taking a whole-of-systems approach [Mental Health Foundation]

We need other agencies involved like MSD, Corrections, Justice as it often feels we are alone on this journey. [Individual respondent]

Wording changes to current principles

Alongside the above suggestions on principle concepts, there were some detailed wording suggestions. These include:

Suggest adding 'resources'. 'We uphold multiple knowledges, including Mātauranga Māori, sharing power and resources. [Te Pou Addiction Consumer Leadership Group]

You might want to say that 'our work makes a positive difference' – instead of just a difference. [Individual respondent]

The voice of lived experience includes all people maybe groups don't need to be specified. If we keep listing groups that should be included it is a negative way of saying they are excluded unless specified. [Individual respondent]

Some questions were raised around clarity on what these principles mean in practice.

*We put people, whānau and communities at the centre of all our work – this means different things to different people. To what extent do people, whānau and communities get to experience choice and control over what happens?
[Organisation – did not consent to quotes being attributed]*

We think that further consideration is needed to explain what is meant by accessible to all – will individuals [and whānau] be able to attend meetings, read minutes, have access to all documents held by the Commission? [Supporting Families]

Appendix 1 List of respondents

This appendix lists those who responded through the consultation document, survey and written letter and who provided consent to being named. Participants in the focus groups, Zoom discussions and Pacific talanoa are not listed.

Individual submitters

Angus Maxwell	Lisa Baty
Annmaree Kingi	Liz Mangan
Beverley Raimona	Ioia Halaholo
Bonnie McLean	Lynere Wilson
Chris Bean	M Sands
Deb Lee	Martha Savage
Dr Erena Wikaire	Maryse Stanton
Eileen Wolland	Michelle Brewerton
Ellen Duckworth	Monica Liva
Jacqueline Ryan	Ngaira Te Ahu
Janet Peters	Owen Lloyd
Jenny Wolf	Paul Matthews
Josiah Tualamali'i and Dr Jemaima Tiatia-Seath	Sherida Davy
Justin Clinton-Gohdes	Tina Berryman-Kamp
Leigh Murray	Tina Simcock

+ 16 other individual submitters who did not wish to be named

Groups or organisations

Addiction Consumer Leadership Group (Te Pou)
Age Concern New Zealand
Alzheimers New Zealand
Ara Poutama Aotearoa, Department of Corrections
Asian Family Services
Auckland Sexual Abuse HELP Foundation
Australasian College for Emergency Medicine
Awareness Canterbury
Balance Aotearoa
Canterbury District Health Board
Changing Minds
Enrolled Nurse Section NZNO
Health Action Trust (Nelson)
Health and Disability Commissioner
Health Quality & Safety Commission
Healthcare NZ
Infant Mental Health Association Aotearoa New Zealand (The NZ Affiliate of the World Association for Infant Mental Health)
InsideOUT Kōaro
Loneliness New Zealand Charitable Trust
Maraeroa Marae Association Incorporated (Maraeroa Marae Health Clinic)
Mental Health Foundation
Mental Health Nurses Section, NZNO

Ministry for Pacific Peoples
Ministry of Health
New Zealand College of Public Health Medicine
New Zealand Psychological Society
New Zealand Red Cross
New Zealand Medical Association
Odyssey House Trust
Office of the Children's Commissioner
Oranga Tamariki
Platform Trust
Royal New Zealand College of General Practitioners
Royal New Zealand Returned and Services Association
South Dunedin schools cluster
Supporting Families
Talking Matters
Te Hā Oranga
Te Hiringa Hauora Health Promotion Agency
Te Pūtahitanga o Te Waipounamu
The No Duff Charitable Trust
The Royal Australian and New Zealand College of Psychiatrists
The Salvation Army, Addictions, Supportive Accommodation, Reintegration
and Palliative Care Services
The Wise Group
Tōpūtanga Tapuhi Kaitiaki o Aotearoa New Zealand Nurses Organisation
Volunteer South
VOYCE Whakarongo Mai
Werry Workforce
Whānau Ora Commissioning Agency
+ 5 other organisations that did not wish to be named