

He Ara Āwhina

Pathways to Support framework

Summary of consultation with people who work in, support whānau with, or personally experience alcohol or other drug harm, gambling harm or addiction

July 2022

Acknowledgements

It has taken all kinds of people to bring together the He Ara Āwhina (Pathways to Support) framework. We honour and acknowledge the advice, expertise, and lived experience of those who have been touched by alcohol and other drug harm, gambling harm, and addiction. We want to mihi to everyone whose knowledge supported and shaped this mahi (work) - tāngata whaiora, people with lived experience of substance harm, gambling harm, and addiction, and the whānau who support them. This includes the Addiction Consumer Leadership Group, Gambling Harm lived experience group, people from the alcohol and other drug and addictions sector, and people who contributed at the very beginning of this journey by sharing thoughts and advice during the 'co-define phase'.

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Our development journey

He Ara Āwhina (Pathways to Support) framework

Te Hiringa Mahara (the Mental Health and Wellbeing Commission) was set up as one of the recommendations of [He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction \(He Ara Oranga\) \(Government Inquiry into Mental Health and Addiction, 2018\)](#). A core function of Te Hiringa Mahara is to monitor and report on mental health services and addiction services, and advocate for improvements to those services. This function was transferred from the former Mental Health Commissioner to Te Hiringa Mahara on 9 February 2021 by the [Mental Health and Wellbeing Commission Act 2020](#).

Mahi on [He Ara Āwhina](#) began with the Initial Mental Health and Wellbeing Commission working on the co-define phase in consultation with communities between October 2020 and February 2021. During the [co-define phase](#) we sought community feedback on why we should monitor mental health services and addiction services, what we should include in our monitoring approach, and how we should go about our monitoring mahi.

People told us:

- **Support starts and continues with people and communities, not services.** The former Mental Health Commissioner's framework was viewed as too narrow for us but was something that could be refined and built upon.
- **The voices of Māori and tāngata whaiora are crucial** in assessing whether services, and approaches to wellbeing, are meeting the needs of people and communities.
- **There needs to be a shared view of what 'good' or transformative services and supports look like** so we can monitor and assess performance and contribute to wellbeing outcomes.

Co-development phase March 2021 to June 2022

After the co-define phase, an [expert advisory group](#) (EAG) was established and began their mahi in September 2021, sharing expertise and perspectives to develop the framework.

The EAG included a Māori EAG roopū (group) who have led the development of the Te Ao Māori perspective for the framework.

Advice from the EAG, lived experience focus groups (from Māori, youth, mental health, addiction, and gambling harm perspectives), targeted discussions, and hui with Māori helped us develop the draft version of He Ara Āwhina.

The draft version of He Ara Āwhina went out for public consultation for six weeks from 8 March to 19 April 2022. Te Hiringa Mahara supported many ways for people to provide us feedback to ensure the framework and consultation process was accessible to everyone, especially our priority population groups (Māori, Pacific people, migrants, former refugees, rainbow communities, disabled people, rural communities, veterans, prisoners, older people, young people, children in state care, children experiencing adverse events), and people with lived experience of mental distress or addiction (or both), and the whānau, families and people who support them.

The consultation asked three main questions:

1. Does He Ara Āwhina reflect your hopes for a mental health and addiction system?
2. Is He Ara Āwhina missing anything that is important to you?
3. Is there anything else you want us to know about how we should monitor services and system transformation?

During our public consultation process we received more than 260 submissions across all priority population groups. Through an intentional kaupapa Māori engagement approach, our rangahau whānau (made up of tangata whaiora and kaupapa Māori research experts) achieved strong input by Māori, including tāngata whaiora, whānau, and Kaupapa Māori supports and services.

Te Hiringa Mahara published the final version of He Ara Āwhina on 30 June 2022. The next step is to continue mahi on the methods and measures to assess and monitor progress.

The current paper

This paper summarises what we heard from people with experience of substance harm or gambling harm; whānau members or supporters of someone with experience of substance harm, or gambling harm, or addictions; people providing addiction supports and services; organisations that advocate for the collective interests of people who are experiencing substance harm, or gambling harm, or addiction; and policy makers or commissioners of these services.

Many people and whānau shared their experience with both addiction and distress. We also heard from organisations that support people with addiction, distress or both. Given this, many submissions talked about both mental health and addiction. To elevate what we heard about addictions in particular, this paper primarily summarises what we heard about alcohol and other drug (AOD) harm, gambling harm, and addiction services and supports.

To receive a complete understanding of what submitters said about He Ara Āwhina, this paper is designed to be read alongside three other summary reports that include

what we heard from Māori, people with lived experience, and everyone - tāngata whaiora, whānau, and their supports, people providing mental health or addiction supports and services, and policy makers or commissioners of services.

What we heard and how this changed the framework

General comments about He Ara Āwhina

We received a substantial amount of feedback from people with lived experience of substance, or gambling harm, or addiction, and the people who support them (93 submissions), as well as organisations who were supporting or representing people experiencing addictions (81 submissions) during the six-week consultation process.

Many whānau, tāngata whaiora, and people with lived experience of addictions felt hopeful when engaging with the draft framework. It resonates with people and they like the first-person narrative, structure, and concepts.

This is where we want to be - I loved the framework. (Addictions Consumer Leadership Group hui)

It is very ambitious and idealistic. It captures holistic care on a wider scale. If it can be achieved, then it'd be fantastic! (Addiction service)

We also received positive feedback on the two perspectives, particularly in our prioritisation for Te Ao Māori.

As an addictions service provider, we see the disproportionate impact of addictions on Māori, so we are pleased to see He Ara Āwhina's bi-cultural framework and the emphasis on Te Tiriti o Waitangi. (Addiction service, advocacy organisation)

...we strongly support the two 'voices' put forward in the framework to ensure that the Te Ao Māori perspective comes through loud and clear. (Advocacy organisation)

However, there were some concerns the framework is too aspirational, and there needed to be a pathway to show how the system can move toward realising He Ara Āwhina.

It's very aspirational, which isn't a bad thing, but it could almost be too aspirational... do we need to see more of a breakdown of these goals, intermediary steps of how we are going to get there? The Commission needs to be clear in communicating around the

framework that we are a long way off some of these aspirational visions at the moment – so that people feel validated. (Addictions Consumer Leadership Group hui)

Like that the framework is aspirational but removed from current realities of the sector - currently funding models narrows what services can do - they want to focus on housing, for example, but restricted by funding and clients get stuck in the middle. We need collaborative procurement models that allow services to work together. (Alcohol and other drug sector hui)

There were also some concerns the draft framework was difficult to understand and the language across the framework needed to be consistent. Changes were made to address this.

Consistency of language across the framework is needed.
(Consumer leadership group)

Scope of framework

People endorsed the wide scope of the framework, noting that the system is not just made up of services. People also wanted more focus on harm reduction, prevention, resources, anti-stigma initiatives, addiction services, timeliness, whānau and community authority, and varied models of support. Further details of how we incorporated this feedback into the framework can be found below.

People raised concerns about the challenges of measuring wider social, economic, environmental, and cultural determinants that sit outside of the mental health and addictions sector, particularly those within justice, education, and the wider health system.

In response to consultation feedback we have linked the [He Ara Oranga wellbeing outcomes framework \(He Ara Oranga\)](#) under the 'Effectiveness' domain. This framework was developed by the Initial Mental Health and Wellbeing Commission and describes what ideal wellbeing looks like for all people and whānau in Aotearoa and measures many of the social determinants of health. He Ara Oranga and He Ara Āwhina are partner frameworks that are designed to work together. As a result of the feedback gained through the consultation period, we have developed a document that explains [how the two frameworks work together](#).

Submitters also requested broadening the definition of addiction to include other behaviours.

We focus on alcohol, drugs and gambling – but we need to include pornography, eating disorders and other addictions that are less commonly focussed on. (Government organisation)

In response to this feedback, and other feedback around clarifying what terms mean to people, we have developed a [‘guide to language in He Ara Āwhina.’](#) In this, we have clarified that addiction services include those that support non-substance addictions.

The goal for He Ara Āwhina

People in general liked the use of ‘whānau dynamic’ but believed it needed to be explained further. Our challenge was to balance this need for further explanation with other people’s desire for ‘less words’ in the framework. In response, we have published a [guide to language](#) to accompany He Ara Āwhina to provide further clarity around what is meant by ‘whānau dynamic’ and other terms used in the framework.

There was mostly broad support for the ‘whānau dynamic’ goal of He Ara Awhina, though some found the goal confusing, or thought it was not meaningful for AOD harm.

Also, there was feedback raised during our engagement that the goal needed to be more meaningful for people with lived experience of substance harm. The second line of the goal was reframed to bring the aspirational “We lead our wellbeing and recovery” to the beginning of the goal, followed by “All whānau can navigate distress, reduce harm from substances and harm from gambling.”

Equity

Equity for Māori

Many submissions highlighted the inequitable burden alcohol and other drugs have on Māori.

Alcohol and other drug (AOD) misuse has significant impacts on whānau and communities and is a major concern amongst Māori. The greater level of substance misuse in the Māori population reflects the history of colonisation, continual impacts of an unequal society upon Māori, and our subsequent oppression in New Zealand society. There is entrenched social and economic marginalisation, experienced across generations of Māori that requires holistic and long term funded strategies to address the underlying social determinants of Māori ill health. (Addictions workforce organisation)

The principles of Te Tiriti o Waitangi means comprehensive strategies must be developed to address longstanding inequities in alcohol-related harm between Māori and non-Māori. (Addictions service)

Feedback emphasised the importance of our system being truly grounded in Te Tiriti o Waitangi, and the need to decolonise practices. Because of this feedback we strengthened this language in the framework.

We especially support the commitment to te Tiriti o Waitangi and the ability for whānau to self-determine their pathways to wellbeing. (Addictions workforce organisation)

I love the Tiriti foundation of everything. We have always said that consumer empowerment faces similar barriers to tangata motuhake and if you get it right for Māori you get it right for everyone. (tāngata whaiora, person with lived experience of addiction)

This feedback emphasised the importance of having a mental health and addiction system that is respectful and values diversity. Te Tiriti o Waitangi was already included in the framework, as was: **Services take action to decolonise practise, increase workforce diversity, apply an intersectional lens, and address inequities and institutional racism.**

This includes understanding the history of Aotearoa and acknowledging the impacts of colonisation and intergenerational trauma for tāngata whenua. In response to feedback, we have added: **The impacts of colonisation and intergenerational trauma are acknowledged and understood.**

Visibility of population groups

We received feedback from whānau, tāngata whaiora, and representatives from a variety of different organisations and communities who thought a more targeted approach was needed to meet the needs of the priority population groups mentioned in He Ara Oranga (Government Inquiry into Mental Health and Addiction, 2018). Most commonly people wanted more visibility within the framework to support those who have been disadvantaged by the system due to systemic racism, discrimination, and other barriers. Visibility was also important to acknowledge the experiences of those who have not been seen because previous monitoring has not always collected information about some population groups.

Personally interested in equity for people with disabilities – that word (disabilities) isn't mentioned in the framework – it's invisible. (Alcohol and other drug sector hui)

There is no reference to LGBTIQ+ (Rainbow) communities within the framework, a key demographic impacted by alcohol and other drug related harms. (Advocacy organisation)

We would like to see equity for other communities mentioned by name. (Advocacy organisation)

In response to this feedback, we strengthened the importance of having equity for everyone, no matter what someone's diagnosis, ethnicity, age, identity, or disability is under the 'Equity' domain of He Ara Āwhina. This concept was added:

We are valued for who we are. We are not disadvantaged by our diagnosis, ethnicity, age, identity, or disabilities.

We also added 'identity' as a term in our guide to understanding language in He Ara Āwhina as well as detailed examples of the groups that this includes.

Stigma, prejudice, and discrimination

A number of people and organisations highlighted that stigma, prejudice, and discrimination negatively impacts people experiencing substance harm, gambling harm, or addiction. Stigma and prejudice are significant barriers to care and people's wellbeing. The illegal nature of some substances can make it difficult to seek support and can make it difficult to have honest conversations about their drug use, which can affect the care they receive.

Drug use issues tend to be far more stigmatised than mental health issues. For example, a person may feel able to discuss their anxiety levels openly with a medical practitioner, but not feel able to bring up their methamphetamine use. We need dedicated monitoring and approaches to stigma, to track how it is experienced by tāngata whaiora.... We recommend tightening the language however, to ensure the proposed strategies to combat stigma are implemented and have the desired impact. (Advocacy organisation)

Glad to see stigma included. AOD is behind Mental Health with stigma - encourage strengthening this. Drug use and the stigma for people use substances is not just on individuals, but also affects their social network and friends and family. (Alcohol and other drug sector hui)

The draft framework already included: **Strategies are led by those of us with experience of distress, gambling harm, alcohol harm, and harm from other drugs to eliminate prejudice, self-stigma and discrimination.**

In response to feedback that the language around addressing stigma should be stronger, we have added that this work should be funded and evaluated.

Health-based approaches

Laws reform and policies

Tāngata whaiora and organisations pointed out the significant burden alcohol has on the population, and the importance of having laws that reduce harm from alcohol, other drugs, and gambling.

Hazardous and harmful alcohol use is identified as a major contributor to inequities and is amenable to healthy public policy. (Addictions service)

The high level of alcohol use, alcohol-related harm and alcohol-related inequities demonstrates the failure of our liquor laws to minimise the (unequal) harm from alcohol. (Advocacy organisation)

... there's also not that much continuity or connectedness between city councils... a lot of gambling and substance use or alcohol-related policy is really different...it's about having that hopeful connectedness between policy instances across the whole country and their different monitoring frameworks within the systems that they work. (Consumer advisors hui)

There was support for the inclusion of alcohol and other drug law reform that prioritises human rights, wellbeing, and equity. People emphasised that the recommendations in He Ara Oranga for laws that take a health approach to drug use have not been implemented (Government Inquiry into Mental Health and Addiction, 2018).

Positive to see people being diverted from the justice system when experiencing addiction - it is not helpful to just punish people. (Person with lived experience of addiction)

Criminalisation of drug use actively perpetuates harm for people who use drugs, and serves no clear purpose that could justify its continued use. Despite the recommendations supporting drug law reform in He Ara Oranga, little progress has been made to address this. (Advocacy organisation)

Alcohol use and addiction is heavily influenced by the commercial environment. The three greatest drivers of alcohol use and harm lie in the environment: the low price of alcohol, its high availability and pervasive marketing. These factors are inequitably concentrated in New Zealand's lowest socio-economic communities. (Advocacy organisation)

In response to this feedback, we have strengthened the statement on law reform to include the word **timely**:

We benefit from timely mental health, alcohol, gambling, and drug law reform that puts human rights, wellbeing and equity at the heart.

Prevention

People with lived experience of substance harm as well as advocacy organisations supported the inclusion of prevention in the framework to stop harms from alcohol and other drugs occurring in the first place.

Why do you wait until people are unwell, rather than preventing them from being sick? (Addictions practitioner)

As the Mental Health and Addictions Report, He Ara Oranga, recommends, we need to focus more on healthy approaches to drugs and alcohol for the whole population, and provide support options well before an individual starts to experience serious problems. This is more effective and more compassionate – not to mention cheaper – than waiting to be the ambulance at the bottom of the cliff. (Advocacy organisation)

Prevention and early intervention are particularly important given the challenges and costs associated with intervening in alcohol dependence at later years. Prevention can mitigate substantial suffering by individuals, whānau and communities. It can save lives. (Advocacy organisation)

Harm reduction

There was support for the inclusion of harm reduction within the framework, and organisations noted that harm reduction is consistent with mana motuhake and self-determination.

Harm reduction as a concept acknowledges there will always be people who use drugs, and many will not want to stop or reduce their use. Rather than focusing on abstinence as the only goal, harm reduction aims to reduce the harm from drug use, for example by preventing infection, hospitalisations and deaths. (Advocacy organisation)

Mana motuhake and self determination relate to harm reduction – it's about people being able to decide what wellbeing looks like to them. (Addictions Consumer Leadership Group hui)

Peers with experience of addiction also encouraged us to look at our understanding of 'harm reduction' and to use this language in the broad way as was intended. Changes across the framework reflect this valued feedback.

I get nervous when harm reduction feels like it is being framed up for people who are considered “mild to moderate”. When harm reduction was first used, it was with people who had significant issues going on and people who would fall through the cracks. Harm reduction is a philosophy and a way of working that is about upholding peoples' rights. (Addictions Consumer Leadership Group hui)

It would be useful to have a clear definition of “harm reduction” to accompany this document... I don't know if the framework is for me,

if it isn't clear around what is meant by harm reduction. (Addictions Consumer Leadership Group hui)

[harm reduction is] around working with people where they're at and reducing harm as they see it, which is very different to how somebody working with them may see it. (Lived experience group hui)

It's an opportunity to actually embrace harm reduction in the true intent of what it is supposed to be. And when it was introduced into the addiction sector in the nineties, it was like a splitting sector, which isn't helpful... It's actually about what works for the person. (Lived experience group hui)

In response, our [guide to language in He Ara Āwhina](#) includes a definition of harm reduction based on Lenton and Single (1998). We also included harm reduction in education, workforce, and options.

More options and support

Access and options

People talked about the importance of options in care, and people being able to access the care they want. We heard that these supports should be available to people in their communities.

For veterans, PTSD is a huge issue – this often leads to addiction and alcohol abuse. Veterans are not given the right tools to manage PTSD. (Addictions service)

For many tāngata whaiora, we support they are also in the justice system with restrictions and limitations to movements and activities. Criminal and offending history also contribute to accessibility to programs and supports that are needed. (Addiction service)

Easily accessed urgent response sites are needed. (Whānau of someone with lived experience of addiction)

More help when person has decided to change too long waiting times. It's seems faster if courts send you there. (Person with lived experience of addiction)

In response, we added the following in the 'Access and Options' domain:
We define what our experiences, needs and aspirations are. We can access different options and learn what works and doesn't work for us.

In particular, many people talked about the importance of home detox services.

Home detox services particularly for rural areas, GP's and pharmacies to have more knowledge in a collaborative support plan for the individual to gain trust/commitment in the detox plan to enable a better outcome for wellbeing change. (Person with lived experience of addiction)

Need to include responsible prescribing and monitoring of prescription use, especially for people experiencing addiction. (Whānau of someone with lived experience of addiction)

In response we explicitly included 'home-based supports' in the 'Access and Options' domain:

Options include community and home-based supports, kaupapa Māori, peer-led, harm reduction, and family-based supports and services.

Support for whānau, and supporters

We also received substantial feedback about how important supports and services are for whānau, tamariki, parents, and friends of tāngata whaiora.

AOD care needs to provide wrap around support for tangata whaiora AND whānau Families need access to support, that isn't just group therapy (support needs to be tailored to peoples needs and circumstances). Getting support for whānau is a long, tiring and hard battle for whānau. (Whānau of someone with lived experience of addiction)

One of the key missing supports in this space is training, advice and information that can help friends and whānau to support their loved ones adequately without the need to involve formal (and more expensive) services, or as a complement to those services. (Advocacy organisation)

Having access to supports that can assist with employment, education, and parenting roles as well as supports for whānau were important themes that came through, particularly from tāngata whaiora. Additions were included into He Ara Āwhina under 'Access and Options' to ensure that this can be measured:

Our friends and whānau have meaningful choice of supports and services.

People also called out the need for parenting support for people experiencing substance harm.

It will be important to name family and parenting Support more clearly in the framework. People are scared of losing their parenting rights substance use has been the number one reason for notification to OT. (Addictions Consumer Leadership Group hui)

My withdrawal from methadone was 12 weeks of hardly being able to walk, eat or sleep and six months until any normality returned. I needed daily support at home to raise my children... The support wasn't there from the addiction and mental health system, or any community outreach programmes. I did it alone. I did get better and kept my kids and they thrived... Young mothers and parents need to have viable options for withdrawal and home help. (tāngata whaiora, person with lived experience of addiction)

Additions were included into He Ara Āwhina under 'Access and Options' to ensure that this can be measured:

We can access support to stay in, or return to our work, education, or parenting roles.

Choice-based models

We received recommendations to strengthen existing wording around appropriate and effective investment in the system. This included choice-based models of support and a variety of funding models. These were seen as key resources needed to support communities, whānau, volunteers, and peer support workers in their response to distress and harm reduction.

I like the inclusion of individual and whanau funding models.
(Addictions Consumer Leadership Group hui)

Investment is needed to support people at all levels of drug use. In particular, the government should be held to account for investing in harm reduction. (Advocacy organisation)

There needs to be transparency of investment in AOD harm to ensure equitable funding for kaupapa Māori services. (Addictions workforce organisation)

Roles should be based in places that people go - not in services.
(Addictions Consumer Leadership Group hui)

He Ara Āwhina now reflects this hope for the future - to have **funding models recognise and value volunteers, whānau peers and community support groups**. He Ara Āwhina also reflects that the system should provide individualised funding and whānau funding models.

Participation and rights

Participation and leadership

People with lived experience and addictions service providers both provided feedback around balancing decision making in times where this may be difficult.

My own experience is that, while self-determination and leadership, is desirable, there are times when one is not able to determine the way forward or make an informed decision. I suspect that who leads on what is context specific. This, obviously, does not simplify monitoring, but where complexity is necessary, that is the way it should be and the quality of decision making about leadership is what should be monitored. (Tāngata whaiora)

How does the framework balance the knowledge between lived experience and trained health professionals? (Addictions service)

The draft framework already contained language indicating that people should be leaders in their own care and make their own decisions. We have also added text highlighting the importance of people being able to access their own health care information and supporting people to make informed decisions, including decisions about their care, wellbeing, and recovery: **We can easily access our healthcare information. There is education and support to self-advocate and make informed decisions.**

Safety and rights

We heard from both government organisations and people with lived experience that eliminating coercive practises was crucial, and we would need to make sure that addictions services, such as opioid substitution therapy services, knew that this applied to them as well. There are expectations on culture change away from punitive approaches.

In my experience clinical leadership can be risk averse especially where issues are framed up as ‘risk to the community’. This can have implications for the way staff interact with people, but also can have implications for some treatment approaches as well – particularly thinking about Opioid Substitution Treatment. (Addictions Consumer Leadership Group hui)

it'd be nice to have a clearer description of what coercive practices might look like ... Otherwise, people will tend to think, “Oh, that’s just about seclusion.” I think it’s far broader than that. (Lived experience group hui)

In response, our [guide to language in He Ara Āwhina](#) includes a definition of what we mean when we refer to coercive practices.

Workforce

Capacity and capability

Advocacy groups and consumer leaders told us to highlight issues around workforce development and resourcing to effectively address shortages in the addiction sector.

Attracting and retaining people to the workforce and providing the supports that they need is the biggest concern for Addiction sector. (Addictions Consumer Leadership Group hui)

Significant gaps in workforce are a key and pressing concern in the addiction sector, after long-term underinvestment. (Advocacy organisation)

These same groups told us how investment is needed for the addictions workforce to deliver the support people need. In particular, people told us investment is needed for whānau to support their loved ones.

Adequate investment in the drug-related workforce is essential. We appreciate the several mentions of workforce in the framework, including that whānau should determine workforce needs; that the workforce needs to be diverse to reflect the people using services; and that whānau insights should inform workforce training and education. (Advocacy organisation)

We have all these aspirations, including in the framework, around how we are going to engage with family and whanau, but in reality there are very limited fte for roles around whanau Support and Engagement, or whanau participation and leadership, so resourcing these roles and processes becomes the first step – there will need to be a lot done here. (Addictions Consumer Leadership Group hui)

While the framework already included words around a well-resourced workforce, we have added that this workforce should be safe and cared for: **Our workforces are safe, cared for and well-resourced to support us and our whānau.**

People with experience of addiction, and people from the AOD sector, told us how crucial it is to increase peer support, particularly peer-led alternatives, as well as the number of peers in all services, including hospitals.

Peer support has been around a long time, but is not well recognised in frameworks. (Alcohol and other drug sector hui)

There doesn't seem to be a consistent investment currently in peer-led alternatives, in any way. Why aren't we looking at investing in peer options? This needs to come through more strongly in the

framework, and in the system transformation. (Consumer Network hui).

In response to this feedback, we have added text saying funding models should recognise non-clinical forms of support, including peers: **Funding models recognise and value volunteers, whānau, peers, and community support groups.**

System leadership

We heard from people with lived experience and advocacy groups how important it is for people with lived experience and whānau to have a role in leadership at all levels of the system, and for communities to lead local decision making.

it would be helpful (or should be highlighted) if leadership positions in organisations were those with lived experiences to help break the stigma. There are too many people in leadership roles who do not understand the fundamentals of addiction/substance misuse. This goes for Boards, too. (Person with lived experience of addiction)

[organisation] hopes to see a system that values diverse views in the mental health, substance and gambling harm services where tangata whaiora and whānau leadership are encouraged and inclusive. (Addictions service)

[organisation] strongly supports the need for whānau leadership in local, district, regional, and national decision-making roles to enable self-determination. (Advocacy organisation).

Te Hiringa Mahara have acknowledged that resourcing and support is needed to grow lived experience and whānau leadership. The framework upholds the need for feedback, engagement, participation and leadership. In response to feedback, we have added that this should be resourced: **Resourcing enables diverse, quality and sustainable leadership, and supports emerging leaders.**

How are we using the feedback?

Feedback throughout the consultation process not only influenced the final He Ara Āwhina framework but also highlighted where there needed to be supporting resources and promotion of existing documents. We also received feedback that will be impactful in the methods and measurements phase of He Ara Āwhina.

Common language

It was clear from the feedback that we need key terms explained to help people understand and interpret the framework. Some of these terms are below:

- mental health and addiction system
- mental health services
- addiction services
- distress
- mental health and addiction supports
- whānau
- tāngata whaiora
- coercive practises
- harm reduction.

These can all be found in our Guide to language in He Ara Āwhina:

<https://www.mhwc.govt.nz/assets/He-Ara-Awhina/Guide-to-language-in-HAA/Guide-to-language-in-He-Ara-Awhina.pdf>.

Wellbeing outcomes

We noticed in the feedback that people either misunderstood the scope of the framework or wanted the incorporation of wellbeing outcomes, including other social determinants of health and wellbeing. This highlighted the need for engagement on the [He Ara Oranga wellbeing outcomes framework](#) that was developed by the Initial Mental Health and Wellbeing Commission and published June 2021. He Ara Oranga has been re-published alongside He Ara Āwhina, and includes material to demonstrate how the [two frameworks are designed to work together](#).

High expectations of methods and measurements phase

Throughout the consultation, interests and concerns were raised about how the aspirational statements of He Ara Āwhina will be actioned, measured, and monitored. People were interested to know about data availability and the specific indicators that would be used to monitor progress. We have taken this feedback on board as we commence mahi in the measurement and monitoring phase of the project.

What next?

Te Hiringa Mahara have redrafted and published two versions of He Ara Āwhina – a summary version that is focused on the system aspirations, and the full framework that includes detailed descriptions of what an ideal mental health and addiction system looks like.

We will use He Ara Āwhina to:

- monitor mental health and addiction services
- monitor changes as the mental health and addiction system transforms
- advocate for improvements to the mental health and addiction system and services.

He Ara Āwhina will be used alongside the He Ara Oranga wellbeing outcomes framework, which will be used more broadly to monitor wellbeing.

He Ara Āwhina is intended to be enduring, with a long lifespan. It will be ‘living’ and evolve over time so that content and measures are relevant and current.

Measurement under He Ara Āwhina will have a life course approach and apply to all ages including infants, young people, adults, and older adults.

Te Hiringa Mahara acknowledges the feedback we received through consultation that to achieve the goal of He Ara Āwhina, the framework needs to be extended to accountability of other sectors. Whānau and tāngata whaiora often have complex dynamics impacting their experiences of distress, substance harm and / or gambling harm, and overall wellbeing that are related to other areas of their lives.

The mental health and addiction system has a critical role to contribute towards the wellbeing of tāngata whaiora and whānau. However, it cannot achieve wellbeing outcomes on its own. Wellbeing is broad with many determinants, and there are many other systems also contributing towards wellbeing. Achieving the aspirations in both He Ara Āwhina and He Ara Oranga wellbeing outcomes framework requires a collaborative approach, so working with other sectors is an important part of the implementation process.

Methods and measurement phase and future reporting

The methods and measurement phase has started and will be guided by Te Hiringa Mahara monitoring strategy, strategic direction from our EAG, and Ngā Ringa Raupā (comprised of Te Hiringa Mahara Chief Advisor Māori and Māori staff), technical direction from a new advisory network, and insights from our public consultation process about what people want to see measured and their expectations for how we monitor.

People who have shared an interest in He Ara Āwhina will continue to be involved in this mahi and we will continue to share information to help people understand how we will monitor using the framework. This next phase will be given an appropriate process, timeframe, and capacity. Tāngata whenua must be involved in leading the development of Māori methods and measures. The Te Ao Māori perspective of the framework includes concepts that speak to this in 'Mana Whakahaere'.

He Ara Āwhina methods and measures once developed will over time replace those used in [Te Huringa: Change and Transformation – Mental health service and addiction service monitoring report 2022](#). Some of the data needed to monitor under He Ara Āwhina will be available from March 2023. Other methods and measures will need a longer timeframe for development as the data does not exist or is not easily available nationally.

References

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Appendix 1

Methodology

We applied an intentional approach to ensure we received a diverse range of views to inform the He Ara Āwhina framework - shared perspective. Therefore, multiple options for participation in the consultation process were supported. This included:

- A proactive hui approach, involving invitations nationwide, encouraging participation at either a number of online hui being held, or
- 1:1 hui
- Phone calls
- Online survey
- Email submissions
- Post submissions.

Where permission was granted, hui were recorded and transcribed. All submissions were saved in a secure location that only a few people could access on a need-to-know basis.

Submissions were analysed and coded using NVivo. This involved identifying whether a submission was from a tangata whaiora or individual; whānau, family members, or supporter; or an organisation or group, and whether they identified as tāngata whaiora or had lived experience of distress or addiction (or both). Sections from every submission were coded to the most relevant domain, with some being coded to more than one. Themes were then drawn out of the data, which influenced the changes in the final He Ara Āwhina framework.

Appendix 2

Total number of submissions with lived experience of addiction

	Tangata whaiora	Whānau	Organisation	Not specified	Totals
Lived experience of both distress and addiction					
Hui	-	-	17	-	17
Email	2	-	7	-	9
Online form	8	5	5	1	19
Total	10	5	29	1	45
Lived experience of addiction					
Hui	-	-	17	-	17
Email	2	-	7	-	9
Online form	9	6	6	1	22
Total	11	6	30	1	48

Total number of organisations and groups representing people with lived experience of addiction

Hui	23
Email	46
Online form	12
Total	81