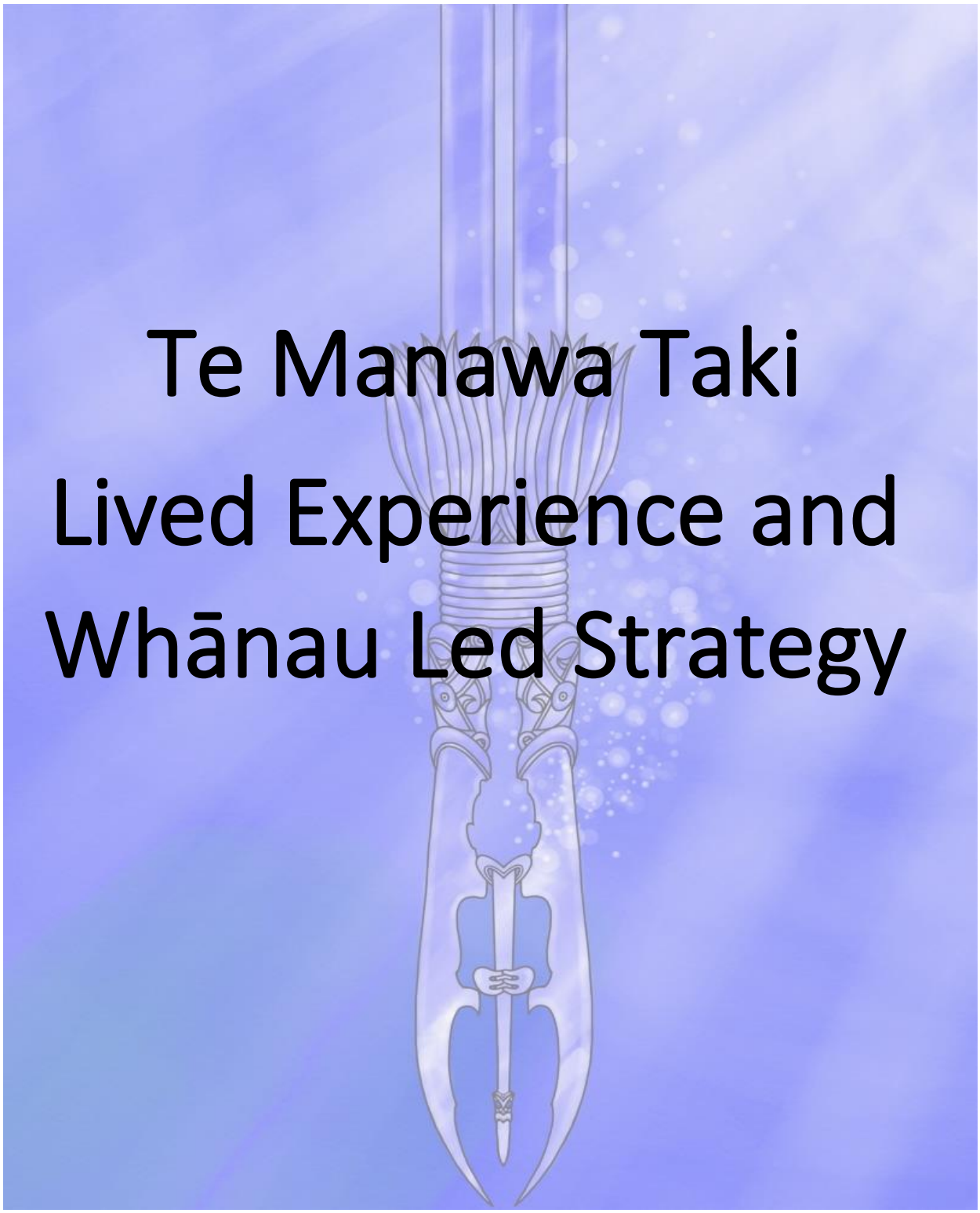
TE MANAWA TAKI

Whānau Te Tiriti o Waitangi Support Networks

Mental Health & Addiction Wellbeing Regional Network



Te Manawa Taki Lived Experience and Whānau Led Strategy

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Whakataukī

Whakatōngia te aroha hai oranga mo te whānau,
Whakatōngia te kohara kia awe ai te iwi

Plant the seed of love so that the whānau will survive,
plant the seed of passion to give strength to iwi

Te Pā Harakeke

The pāharakeke is synonymous to describing whānau within a metaphoric notion. Using the pāharakeke as the logo for the Network groups, depicts that the person is at the centre and supported by the whānau surrounding them, and with the lens of continuous safety, growth and development.

The use of the word whānau is deliberate as it describes the person in the singular and incorporates the identified whānau as a collective. By doing this it incorporates all people that are connected to the person and their individual or collective journey, therefore centering whānau as the smallest unit.

Te Tiriti o Waitangi

Te Manawa Taki as a collective of providers of mental health and addiction services recognises its obligations under Te Tiriti o Waitangi to enable Māori to live longer, healthier, and more independent lives, achieving equitable health and wellbeing as Māori (Ministry of Health,2020).

The Te Tiriti o Waitangi principles for application in mental health and addiction services and other health and disability services include:

Tino rangatiratanga
Providing for Māori self-determination and mana motuhake in the design, delivery, and monitoring of mental health and addiction services.

Protection
Taking all practicable steps to achieve equitable health outcomes for Māori. This includes ensuring that the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity are communicated to the government, and Treaty partners.

Options and choice
Providing for and properly resourcing kaupapa Māori mental health and addiction services. Ensuring that all mental health and addiction services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.

Partnership
Working in partnership with Māori in the governance, design, delivery and monitoring of mental health and addiction services – Māori as co-designers and co-producers of services for Māori.

Equity
Being committed to achieving equitable health outcomes for Māori.

Responding to Te Tiriti obligations as articulated in *Whakamaua: Māori Health Action Plan 2020-2025* has positive implications for the way services are designed, developed, delivered, and evaluated in Te Manawa Taki. This includes the development and implementation of this Te Manawa Taki lived experience and whānau led strategy (Ministry of Health, 2020).

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1. Executive Summary

"Lived experience and whānau led roles are experts in the field"

The aim of this project is to develop a strategy and framework for lived experience and whānau provision of service across Te Manawa Taki mental health and addiction services. This would include attention to Te Tiriti o Waitangi and show funders and providers how best to invest and transform the mental health and addiction continuum informed by lived experience and whānau.

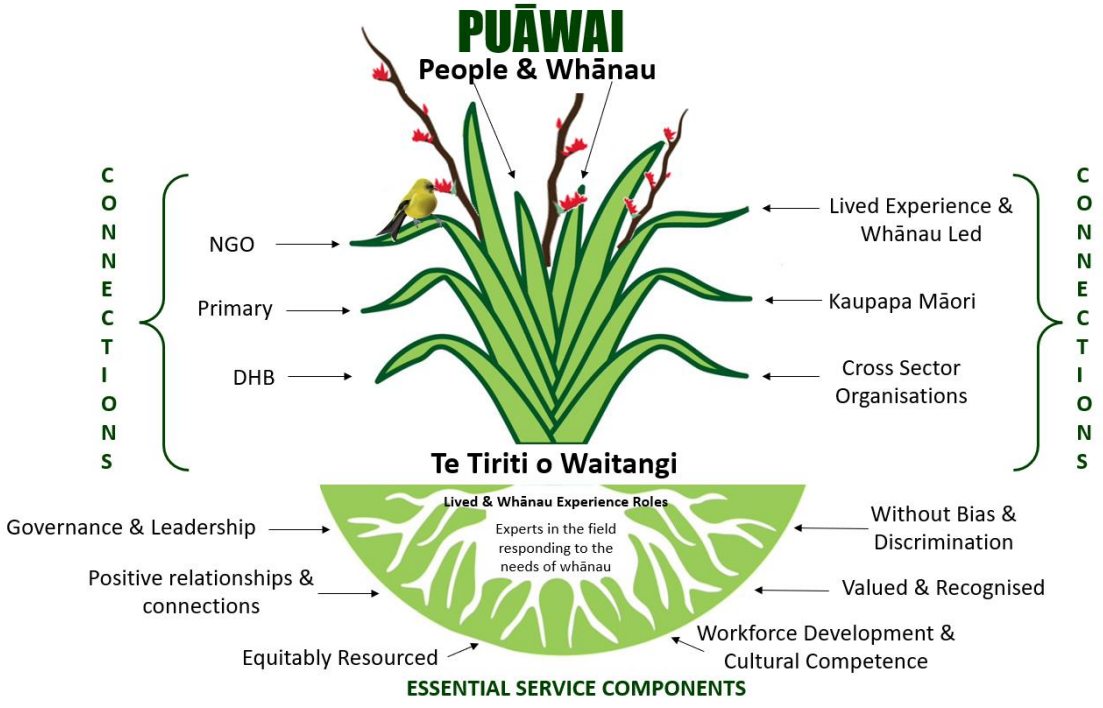
Information was gathered using different approaches such as a literature scan, stocktakes and service site visits to understand current systems inclusion of lived experience and whānau innovation, and how this might be applied in Te Manawa Taki's services and organisations at governance and operations.

Key themes were revealed from the information gathered, confirming that there is huge potential in acknowledging, valuing, celebrating, and investing in the lived experience expertise and more specifically peer and whānau roles. Further to this, the development of specific Kaupapa Māori lived experience and whānau led investment is warranted.

A framework has been developed that incorporates these themes providing strategic direction and guidance for flourishing lived experience and whānau roles. The Puāwai represents people and their whānau receiving services that are connected and coordinated across traditional sector boundaries and divisions, internally and externally. For people and their whānau to grow and flourish certain connected components are required as detailed in the framework. The root network at the bottom of the framework depicts the essential elements that are needed when investing in a Lived Experience and or Whānau service. Implementing this framework is highly recommended. Refer to Section 10.

Figure 1

Figure 1: Te Manawa Taki Peer & Whānau Led Framework



Peer Support Group

"Peer support of where unstable people meet
But all in all, we all come to greet and treat
Some people come and go
There are the originals from way back long ago
Peer support stick to the needs of support
They cannot do everything your needs ask
But they try to put you first if it is in their jurisdiction.
There are group sessions where we talk about
Similar stories that we have lived
Some of us are survivors and know the shocks and
Brunt's of the extremities of mental health long lived."

(Steven Herewini, Opotiki peer group, July 2021)

2. Introduction

"As much as possible, all servants are chosen from the category of mental patients. They are at any rate better suited to this demanding work because they are usually more gentle, honest, and humane" — Jean Baptiste Pussin, in a 1793 letter to Philippe Pine

The purpose of the Te Manawa Taki Lived experience and Whānau Led strategy is to:

1. provide a regional framework to provide guidance and direction to Te Manawa Taki region for the expected growth of the lived experience and whānau workforce
2. to strengthen systems of inclusion of lived experience expertise
3. to influence and drive new initiatives
4. transform existing service provision through co-create methodology.

To inform this strategy an understanding of the current lived experience and whānau provision of service and relevant workforce development opportunities across Te Manawa Taki region, current systems of inclusion of expertise-by-experience and innovation was sought both internally and externally to the region.

This strategy development has been informed by the following guiding documents:

- Te Piko o te Māhuri – Midland Youth Wellbeing Framework (2019)
- Taiahaha Taiahaha – Midland Māori Wellbeing Framework (2020)
- Uhi Wero, Uhi Taia – Midland Addiction Wellbeing Framework (2020)
- Te Aho Tāhuhu – Midland Whānau Wellbeing Framework (2020)
- Ministry of Health Whakamaua: Māori Health Action Plan 2020-2025 (July 2020)
- The Health and Disability Strategy Review (2020)
- Consumer, Peer Support and Lived Experience MH&A Workforce Development Strategy: 2020-2025, Te Pou
- He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction, Ministry of Health (2018)
- Engaging with Consumers, Health Quality & Safety Commission (2015)
- Midland MH&A Service Users Competency Framework (2014)
- National Family Whānau Advisor Competencies, Matua Raki (2014)
- Involving Families Guidance Notes, Ministry of Health (2000)
- Ministry of Health Guidelines for Consumer Participation (1995)
- Peer Support and Advocacy Services – Te Whare Awhiora, Hauora Tairāwhiti & Te Kupenga Net Trust (2018)
- Rangahaua Te Kuwatawata: The Te Kuwatawata Evaluation (2019), Hauora Tairāwhiti
- Consumer Participation Policy, Taranaki DHB (2019)
- Ahi Ka Waikeria Foundation document (2021)
- Te Ara Tauwhirotanga Mental health and addictions model of care. Year One in Review. Lakes DHB (2020).

Expected outcomes of the implementation of this strategy are outlined in the project scope. (See Appendix B)

3. Background

Achieving best possible health outcomes, promoting and protecting health and well-being, assisting and aiding recovery are all fundamental tasks of mental health and addiction professionals. However these tasks may be undertaken in generic ways ignoring ethnicity or nationality, culture, or identity, socio-economic or demographic profiles. When this occurs using generic universal approaches to health care results in inequitable health outcomes. To address equity in health outcomes Te Manawa Taki needs:

- Greater participation with Māori
- More resourcing to rural areas where Māori reside
- Equitable distribution of choice and access practices to Māori with the highest needs
- Application of learning to Māori service development which includes a working definition for lived experience
- Reconciliation of the equity journey within collective consciousness[1]

The Te Manawa Taki Five Core Equity statements for mental health and addiction were derived from overwhelming feedback from whānau.

1. **Mana Motuhake** – providing choice for whānau as determined by whānau and is accessible for ALL whānau regardless of circumstances. Mana Motuhake is evidence based and measured against the Articles of Te Tiriti o Waitangi.
2. **Mo te Katoa** (for everyone) - the right fit and connection for our whānau. Demonstrating tika, pono and aroha evidenced through naturally occurring action and assessment.
3. **Matakite** – flexible, adaptive, agile services that are close to the ground to whānau needs which includes and validates the natural intuitive ability of all to work alongside our whānau.
4. **Tikanga and Kawa Based** – is determined as a whānau knowing, grounded in indigenous collective ideology, informed by traditions of time and space.
5. **Wairuatanga** – heal the wairua; heal the whānau.

(Te Aho Tāhuhu- Whānau Wellbeing Framework, 2018; Te Piko o te Māhuri- Youth Wellbeing Framework, 2019; Taiahaha Taiahaha- Māori Wellbeing Framework, 2020; Uhi Wero Uhi Taia- Reconnecting Addiction to Wellbeing, 2020).

Over the past 10 years there has been significant work undertaken in the area of lived experience and whānau under titles such as consumer, service user, peer support, and family support. The release of the Ministry of Health's 1995 Guidelines to Consumer Participation brought with it the contracting of Consumer and Family Advisors in each of the District Health Boards. Further to this, the Te Manawa Taki region consulted extensively with lived experience and whānau, and developed Support Worker Competencies in 2012. This information gathered was utilised to inform the national Consumer, Peer Support, Lived Experience Workforce Development Strategy produced by Te Pou (2020).

While there is a national strategy document highlighting the value of peer and whānau led services, variation in application persists across DHBs in Te Manawa Taki and beyond. This includes how people

[1] "Through our initiatives, The **Collective Consciousness** is leveraging technology to make quality, **equity** and access an **equal** right for the underserved". http://www.collectiveconsciousness.

with lived experience and their whānau are involved in governance, policy, planning and service development. However some initial work has been undertaken in Te Manawa Taki to progress authentic co-design and partnerships with people of lived experience.

He Ara Oranga (2019) is explicit about the need to develop peer and whānau led services. In response to the challenge that He Ara Oranga brought, Te Manawa Taki region held four wānanga for lived experience and whānau to articulate how they viewed services should be delivered. The four wānanga covered:

1. Whānau – Te Aho Tāhuhu
2. Youth – Te Piko o te Māhuri
3. Māori – Taiahaha Taiahaha
4. Addiction – Uhi Wero Uhi Taia

Wānanga participants put forward four main principles for future service development:

1. Placing whānau[2] at the centre
2. Services tailored to meet the needs of whānau
3. All whānau matter
4. Whānau wellbeing, recovery, lives and statement of intent are all important

For the Te Manawa Taki region, it is timely that we review what we currently have, how well it is working and what is possible for lived experience and whānau led services. Additionally, by identifying and understanding how other providers have tackled barriers and challenges to achieve innovative services we might learn and grow further informing the Te Manawa Taki Lived experience and Whānau Led Strategy.

[2] NB: The term "Whānau" is used to describe family / significant others as well as people with lived experience, including whaiora, clients, peers and/or those affected by other's mental health and addiction distress. Whānau do not have to be blood relatives and may include friends, partners, significant others and/or blood relatives.

4. The Approach

To develop this strategy a project scope was prepared, presented, and approved by Te Manawa Taki Clinical Governance. An expert steering group was established made up of a representative membership from each Te Manawa Taki rohe and meetings commenced to guide and direct developments.

Communications about the project and more specifically strategy development occurred using network meetings, a survey monkey, zoom meetings, emails and Te Manawa Taki Mental Health and Addiction (MH&A) website.

A scan of the literature was undertaken to gather relevant research evidence from New Zealand and internationally. This was themed and presented along with findings.

Identifying exemplar stakeholders for consultation to inform developments was important, particularly where it was known that innovative work was occurring. Subsequently, a schedule of site visits and interviews in Te Manawa Taki region and beyond was developed.

In the collection of data from the visits and interviews it was clearly understood by those leading and participating in the processes that has whakapapa, a history that belongs to people. Information is personal to them, and interviewers are the invited guests into their world. The absolute right to consent, use and storage of data ultimately must remain the property of the person and this was made clear in all processes. Data Equity insists that full disclosure for the use of personal data must be sought and clearly understood. Data Equity ensures Rangatiratanga for the whānau concerned. Articles 2 and 3 in Te Tiriti o Waitangi reinforces possession and sovereignty of Mana Motuhake. Additionally, The Privacy Act (2020) NZ gives surety to all citizens of New Zealand for the protection of personal information.

The stakeholder data collected was themed and presented, along with the findings from other project processes such as the literature scan, stocktakes of current workforce, training, and education opportunities, DHB lived experience inclusion processes, and utilisation of peer run or peer support and whānau services.

This all informed the developments of Te Manawa Taki lived experience and whānau led strategy document complete with a regional framework to aid implementation and purchasing

This document was subjected to comprehensive sector consultation prior to sign off by Te Manawa Taki Clinical Governance.

5. The Literature

In reviewing the literature key words *lived experience, consumer, peer support, whānau representatives, mental health and addiction* were used to search several databases for material published in the past ten years from New Zealand and internationally.

A mix of literature was found with a dominance of articles from United Kingdom (UK) and more commonly about lived mental health experience.

The literature finding has been grouped in the following areas: Lived experience, Peer support, Mental health, Addiction, Forensic settings, whānau, and workforce.

Lived experience

In the context of this project lived experience refers to a personal mental health and or addiction experience. After decades of people with mental health and addiction experience being labelled and marginalised by society, lived experience does matter. People become experts by their own experience (O'Hagan, 2009; Te Pou o te Whakaaro Nui, 2020). Experts with lived experience must be supported to be successful in these roles (Jamieson, 2020).

The New Zealand government recognised the importance of lived experience in its national inquiry into mental health He Ara Oranga and want lived experience valued and included in partnership from conceptual design to delivery (Department of Internal Affairs, 2018).

Peer Support

Early understandings of peer support are about people with lived experience sharing their experiences, challenges, learning and achievements with others. Deegan (1997) writes about this valued support of others occurring in informal friendship groups or more formal structured services. Such mutual support has been thought as pivotal in dealing with traumas, loss and other life experiences.

Mental health peer support

Establishment of peer support work and consumer advice and advocacy in statutory agencies such as health services commenced in the 1990s. Subsequent guidance on how this is provided has been produced by several countries, England, Scotland United States as well as here in New Zealand (O'Hagan, 2009; Repper, 2013).

Repper and Watson (2018) explored peer support as a key element in a rehabilitation service finding people sharing their lived experience with a shared understanding, respect and empowerment providing emotional and practical support.

The effectiveness of peer support was revealed in a synthesis of peer support worker experiences. Active engagement using lived experience supports a therapeutic model of care and creates collaboration rather than separation with traditional professional groups. Peer workers have felt stigma and discrimination in their work yet their contribution is unique and of value (MacLellan et al, 2015).

Evaluation of a peer led alternative to acute inpatient setting showed that service users valued the alternative support and it reduced their distress. Acute care provided in a home like environment supporting self determination and recovery (Te Pou, 2017).

Peer support was found to demonstrate a reduction in hospital admissions and improvements in wellbeing for those people they worked with (Repper & Carter, 2011).

Intentional peer support is an evolved model with a focus on a partnership inviting both peer support worker and receiver to inspire one another to learn and grow. Relationship and connection are developed to support and challenge (Mead et al, 2001).

Peer support help lines known as warm lines run by peer support workers have developed over the years and become more accessible and free to those who access (Mental Health Foundation, 2021).

Recovery colleges have been established in many countries including New Zealand to support people with their mental wellbeing. The four guiding principles include co-production, education, inclusion and a recovery focus. Online courses and accessible resources are provided in an accessible way to promote mental health literacy. Curriculum development is informed by lived experience (Anfossi, 2017).

Addiction

A third of all professionals in the addiction sector indicate that they bring to their roles lived experience of addiction. However recognition of a lived experience or peer support workforce in addiction services has been much slower to progress than in the mental health sector (Te Pou, 2018).

Te Pou worked closely with the Salvation Army at the Bridge programme in Christchurch on a successful pilot which saw peer support workers trained to use the alcohol and drug outcome measure tool (ADOM). The pilot resulted in peer support workers being trained and therefore able to use the tool. Peer support workers felt valued, and their voices heard particularly when able to participate fully in the team (Te Pou, 2019).

Other developments from a peer perspective include the citizen's project, a group- based peer led programme was designed and delivered at the Programme for Recovery and Community Health (PRCH) at Yale University, Connecticut USA (Bellamy et al 2012). Odyssey and Mind and Body in Auckland New Zealand formed a partnership to deliver a similar programme with an emphasis on peers assisting peers to engage in community as citizens (Hamer et al, 2020).

Forensic settings

Forensic peer specialists were engaged to support those leaving prison with the aim of reducing reoffending. The specialist was part of a Forensic peer support programme providing emotional and psychosocial support, and achieving positive results (Bellamy et al 2019).

Peer Star's peer support programme in Delaware County, USA demonstrated positive results regarding it as a powerful new alternative for people in the criminal justice system with mental health

and addiction issues. 'Been there, know how, we will do it together' was a key message of the peer support worker (Rowe et al, 2007; Rowe et al, 2011).

Whānau

Various support groups for whānau and families of those experiencing mental health or addiction issues have been provided over the years and these groups have evolved like other forms of service delivery. Support in Mind Scotland is a not for profit organisation for families experiencing mental illness. It's governance board has a majority of family lived experience members. Services provided include information, advice, support, outreach and training for families (Support in Mind, n.d.).

Schizophrenia Fellowship rebranded in some parts of New Zealand as Yellow Brick Road, and emphasises the importance of empowerment, knowledge, advocacy, and support to whānau towards achieving mental wellbeing (Yellow Brick Road, 2021).

There were several support groups for people bereaved by suicide including The Mental Health Foundation, Skylight Trust and the Ministry of Health. They all provide resources and contact information to support whānau bereaved by suicide (Mental Health Foundation, 2021).

Lived experience from a whānau perspective can be direct contact such as a whānau support worker, or more system focused such as whānau advisor roles. In New Zealand, each district health board (DHB) Provider and Funder arms decide what roles they will invest in or purchase from NGOs, and the descriptors can be found in the Nationwide Service Framework Library (NSFL) (NSFL,2020)

Workforce

A workforce survey undertaken by Te Pou in 2014 found 5-6% of the NGO MHA workforce were peer workers. 82% in mental health and 18% in addiction settings. Of 187 full time equivalents of NGO Peer Support workers, 27% were located in the Midland region (Te Pou, 2017). The survey was repeated in 2018. Findings included:

- The NGO mental health and addiction workforce had grown by around 7 per cent since 2014.
- NGOs were delivering services to more people.
- There was little real increase in health contract funding received by NGOs over the past 4 years.
- The workforce composition across clinical, non-clinical and administration and management role groups remained similar to 2014 (Te Pou o te Whakaaro Nui, 2018).

Workforce turnover in mental health and addiction services was found to be high at 23% compared to the New Zealand average of 19%. A change in workforce configuration was apparent with an increase in peer support workers and Dapaanz registered professionals, and a decrease in support workers and nurses (Te Pou o te Whakaaro Nui, 2018).

Te Pou (2020) described the lived experience workforce as fitting into one of two roles; those who work directly with people such as peer advocates and support workers, and those that support the system such as Consumer and Whānau advisors.

Interestingly in DHB workforce reporting lived experience and whānau roles are harder to identify amongst workforce categories. However in NGO reporting there is greater clarity across the categories of lived experience for example as discussed in Te Pou's workforce survey in 2018 those in peer and whānau roles in NGOs could be identified. In DHBs this was not so easy as roles were often categorised in management and administration codes across provider arm services delivering alcohol and other drug, forensic mental health, and mental health services to adults (people aged 18 and older).

In the 2018 survey of DHB workforce it was found:

- the mental health and addiction workforce had grown by about nine percent since 2014
- more people were receiving services (Te Pou o te Whakaaro Nui, 2019)
- an increase in support worker and enrolled nurse roles
- workforce turnover was less than in NGO at 12 percent

Workforce competencies

The development of revised national competencies for mental health and addiction consumer, peer support and lived experience workforce occurred more recently with a webinar delivered by Te Pou in 2021. The workforce roles the competencies applied to include:

- peer support workers (peer navigator, peer recovery coach, peer recovery guide, peer mentor, voice worker or peer support specialist)
- consumer advocates and advisors
- consumer, peer and service user educators
- consumer, peer and service user researchers and evaluators
- consumer, peer and service user auditors
- consumer, peer and service user supervisors

(Te Pou, 2021).

There are three levels of competency:

1. **Essential** – People need to demonstrate this level of competency when they start their job.
2. **Enhanced** – At the enhanced level people need to demonstrate a higher level of understanding of the competency.
3. **Leader** – Leaders and influencers need to demonstrate this level of competency.
    - Value mutuality
    - Learning from experience
    - Participation
    - Authentic in our relationships
    - Self determination
    - Equity
    - Hope and well-being

We take time to get to know people and what is important to them. We build positive and authentic relationships.

- *We learn from others, and we share our own learning.*
- *We use respectful language.*

- *We respect that people can have different beliefs about wellbeing.*

Te Pou worked with the mental health and addiction sector to develop Family Advisor role competencies (Te Pou o te Whakaaro Nui, 2014). These were made available to support some consistency in the way the roles were deployed in the sector.

The literature has provided much evidence confirming that lived experience and whānau roles are experts by experience and have much to offer the mental health and addiction field. These roles have been adopted in many Western countries as well as here in New Zealand. The roles are viewed as a valued part of a multi-disciplinary treatment, care and or support team for people experiencing mental health and or addiction issues. Additionally, a strength in organisational governance and operational leadership.

However it is acknowledged that lived experience and whānau roles must be supported with relevant training, coaching, mentoring, supervision and support. Competency frameworks have been developed to enhance this.

6. Current situation

Stocktake information about Te Manawa Taki mental health and addiction workforce in dedicated lived experience, and whānau roles was sought from across the region. It was found that lived experience and whānau roles were either working directly with people or working on or in the system. This was consistent with Te Pou workforce survey finding (Midland Regional Mental Health and Addiction Network, 2019; Te Pou, 2018). The types of roles deployed were more commonly:

- Peer support workers
- Peer specialists
- Consumer advocates
- Consumer advisors or consultants
- Consumer, peer, service user educators
- Consumer, peer, service user researchers and evaluators
- Consumer and service user auditors
- Whānau support workers
- Whānau advisors

Organisations' investment in these roles varied and unfortunately workforce stocktakes had not captured the types or volumes at local DHB level. How these roles are coded in DHBs and NGOs at the local level is inconsistent and therefore makes analysis and any comparisons unhelpful.

Those employed in mental health and addiction roles yet also having lived experience had not been identified in any of the reports considered.

Training and education opportunities for those in mental health and addiction lived experience and whānau roles varied across Te Manawa Taki and include:

- Careerforce apprenticeship based training (Certificate in Health and Wellbeing, Peer Support Level 4)
- Tertiary provider Whitireia (Certificate in Health and Wellbeing, Peer Support Level 4)
- University managed programmes in mental health and/or addiction
- Locally led training

Te Manawa Taki mental health and addiction networks are in place - a national trail blazer from initial investment to the well establishing performing networks in 2021. Unfortunately similar networks have not been established locally at all DHBs. Lived experience and whānau roles can be quite isolated and may feel like a lone voice in some DHB environments.

7. Innovations

In Te Manawa Taki and in other New Zealand regions there are services demonstrating success in the way they include lived experience and whānau roles in their services. Site visits to 10 services were conducted in Auckland and Te Manawa Taki this year to explore how services achieved success, and what were the challenges and learning. Key objectives of the visits included:

- Increased lived experience and whānau expert roles in the Te Manawa Taki region.
- Exploration of lived experience and whānau experience training and education for the Te Manawa Taki region.
- Exploration of informal and formal innovations within and outside the Te Manawa Taki region for lived experience / whānau led services.
- Development of a regional framework that transforms current delivery and which drives and informs new initiatives across the continuum of care (from where whānau are seen, to the board room).
- Development of Kaupapa Māori lived experience and whānau led support within services.

1. Site Visits

Service	DHB area	Descriptor
Odyssey Peer support services	Auckland	Peer support workers supporting people experiencing addiction issues, and engaging them in treatment, in several settings.

In Auckland Odyssey an addiction provider has peer support workers involved in services in different settings. There is a community-based peer support team and peer support delivered within prisons at Auckland, Wiri and Springhill.

The community-based service includes case management and peer support for people living with drug, alcohol, and addiction challenges. Their work is carried out in several environments including via phone and email and video-link from their office, prison visits, residential services visits, community settings, pick-ups and drop-offs for appointments and meetings, facilitated meetings, whatever it takes!!

The Peer Team, work alongside clinicians in the true sense, and there is very much a level playing field. They work in partnership with mutual respect for the skills each brings. They challenge each other and are prepared to be challenged. The uniqueness in their work comes from the inclusive way they operate.

Lived experience (peers and whānau) are engaged at all levels of the organisation.

A recent innovation is the shared facilitation of groups by clinicians and peers. Working well, new planned groups will also be facilitated in this way.

Odyssey recognises there is a lot of value in the Peer Worker and the lived experience is a strength when it comes to engaging. The 'been there done that' scenario is a powerful place to work from as it is authentic and grounding.

The Peer Team's work is demanding and intense, and not for everyone. Their average case load is up to 25 people and case may be complex. The team is faced with the same issues as other providers, such as accommodation or housing shortages for placements, the need for more resourcing, working extra hours at times, and being time poor.

Service	DHB area	Descriptor
Alcohol and Drug Court (collaborative with Odyssey, Higher Ground, Salvation Army, Wings)	Auckland	Peer support workers supporting people that present before the courts regarding alcohol and other drug charges

Addiction organisations in Auckland collaborate to support the Alcohol and Drug Court, and peer support roles are critical to operations.

The Auckland Drug Court began as a pilot in 2012. It was initiated by Judge Lisa Tremewan and Judge Emma Aitken who were instrumental in introducing the idea into New Zealand after seeing its success in America. Three other judges are involved in the Drug Court process in Auckland and Waitakere: Judge David Sharp, Judge Emma Parsons, and Judge Diane Partridge.

There have been 237 people graduate from the Auckland Drug Courts since its inception.
The Drug Court Team includes:

The Judge

- The Police Prosecutor
- The Lawyers
- The Case Managers
- The Court-Coordinators
- Pou Oranga (Māori cultural support and advisor, who is living in recovery) Peer Support workers (who are living in recovery)
- Probation Officers
- Restorative Justice Officers.
- Peer Support Team

The Drug Court team members work together to aid the Drug Court Judges judicial decision-making process. The Drug Court is now a permanent fixture in both Auckland and Waitakere. A new Drug Court is being opened in Hamilton in June 2021 and another is planned for Hawkes Bay.

Each of the court programmes is capped at 50 participants. Those who emerge successfully from the programme "graduate" to a community-based and monitored sentence where the judges continue to oversee expected progress following graduation from the court. They are generally expected to be working or studying by the time they graduate, with many graduates studying to take up positions as peer support workers or treatment practitioners in the recovery sector.

The Drug Court is an option for long-term offenders who have been in the prison system, and their offending has been fuelled by unresolved alcohol and other drug addiction. There are criteria the offenders must meet in order to be regarded as high risk and non-compliant.

Service	DHB area	Descriptor
Manaaki Ora (adult, youth, whare, prison)	Lakes	Peer support workers and some kaimahi with lived experience supporting people and their whānau. Kaupapa Māori service

Manaaki Ora Trust stems from the integration of Tipu Ora and Te Utuhina Manaakitanga in 2012 — two established and successful health groups — to provide a response to health (addictions) and meet changing demands and economic challenges. As a single governance group with shared infrastructure and services, Manaaki Ora ensures Tipu Ora and Te Utuhina remain as high performing service providers that utilise kaupapa Māori approaches, Te Arawa tikanga, and strong models of health practice. Therefore, Manaaki Ora Trust delivers a range of health (addictions), social and education services utilising a kaupapa Māori approach.

Manaaki Ora Trust is an organisation that has grown from Te Arawa history and aspirations of oranga (wellbeing). Te Tauaki o Houmaitawhiti included the message 'to seek a safe and peaceful future and let old age be our fate'. The rising to the setting of the sun is a metaphor for the life course and reflects a vision for the future as they seek to support wellbeing for all people of all ages within the rohe. This provides pursuit of wellbeing for people (Whai Ora) living with life stressors, addictions, and mental illness (Te Utuhina based services), to grow wellbeing for people and whānau of all ages (Tipu Ora) and to nurture wellbeing for all through strategic leadership, innovation, and integration (Manaaki Ora). In assisting to achieve this vision they utilise the Powhiri Poutama framework approach and it's seven stages (Karakia, Mihi, Whakapuaki, Whakatangi, Whakarata, Whakaora and Whakaoti), where effective communication is enhanced with youth via a relationship on personal, social and spiritual levels.

Awhi whānau group - 'Te Whānau Manawaroa', is a Proceeds of Crime initiative where the peer workers, alongside practitioner whānau workers, work in conjunction with Police who identify addictions and contact Manaaki Ora to come into the cells. This entails working with wāhine and with tāne separately, and together as a whānau. Whānau is extended to include significant others.

Service	DHB area	Descriptor
Lifewise Trust	Lakes	Peers workers and kaimahi with lived experience supporting those in emergency housing support worker

Lifewise is part of the Methodist Mission and in 2009 the modest parish in Rotorua had small Mental health contracts. Under the mantel of Pihopa Kingi they joined Auckland based Lifewise Trust and formed Lifewise Trust Rotorua. Lifewise (Rotorua) is a 17-bed supported accommodation Mental Health and Addictions Residential Provider. They deliver emergency housing for up to 14 days, Transitional housing for up to 12 months, Pre-Treatment up to 3 months, Post Treatment up to 6 weeks. Staffing and support is available 24/7.

Lived Experience is fully incorporated within the management structure, and the service has been co-designed with those with lived experience and their whānau.

Staff safety is important, and Lifewise cares, supports and nurtures their staff.

Service	DHB area	Descriptor
Te Kupenga Net Trust • Te Waharoa	Tairāwhiti	Two services in Tairāwhiti visited: Te Waharoa Kaimahi with lived experience and cultural skills using Wānanga approaches in a single point of entry service. Te Kupenga Net Trust Kaupapa Māori service providing peer, whānau and cultural support services.

Te Waharoa is a joint venture contract between Hauora Tairāwhiti and Te Kupenga Net Trust and has been developed out of a pilot project called Te Kuwatawata which ran from 2017 – 2019.

The Te Waharoa service has a framework that places whānau wellbeing at the very centre of all the activities at the whare so that everyone, no matter where or who they are, can confidently get help when and where they need it. This is modelled after the way in which Te Kupenga Net Trust as the dedicated Peer Support and Advocacy NGO practices. "Wānanga" is the approach which places Whānau to be in control of what happens and allows whānau to be the key decision makers in their care. This is proving to be an effective joint venture with the lack of DNAs, high staff retention rate, and positive service culture.

At Te Waharoa, there is daily Karakia which is regarded as central to staff / whānau wellbeing. At this time any issues can be safely raised and resolved and a "check in" process can occur. Staff/whānau always work in pairs and not in isolation. A debrief process often occurs after a wānanga and this is an opportunity for reflection, support and checking each other's wairua is intact and safe. Staff can have mirimiri onsite, as part of self- care and personal wellbeing.

Mātauranga (knowledge/understanding) Māori principles are modelled at every level of the service. All staff seem to be aware of their functions and roles and this is all underpinned by whānau.

It is also important to acknowledge Te Waharoa seeks to address inequity and institutional racism within current systems, this is intentional and unconditional. Māori world view and tikanga is central to all that is done at the service.

Service	DHB area	Descriptor
Centre 401	Waikato	Kaimahi with lived experience Membership

Centre 401 was initiated in 1990 and incorporated in 1994 as a Charitable Trust with fundamental philosophy and aims of self-help and self-determination for individual consumers of the mental health system.

Centre 401 located in the centre of Kirikiriroa/Hamilton, is a completely tangata whaiora owned and operated service. The ethos of Centre 401 is self-determination, self-help and recovery promotion; the staff at Centre 401 apply wisdom from their own learned experience to walk alongside whaiora in their recovery journey. **Waikato Mental Health and Addictions Systems Review 2020 page 70**

People who access the Centre do so by way of self-referral and join the membership of Te Whare Whaa Rau Ma Tahi and have access to integrated recovery and employment peer support services.

The Centre Service Director meets people new to the service ensuring essentials for healthy living are in place and links with helpful services are made. Coordination functions occur through use of a Consult Framework, delegation to the support team, an information exchange Say So mechanism and Harm warden notification.

The Centre has been a provider of Advocacy service for people who are past and present consumers of the mental health system for over 30 years. Since 2004 Centre 401 Trust secured a Peer Facilitation to provide support to peers through their recovery journeys. The now named quest service has continued to support peers to connect health and community services and the venture aspect of the service provides arenas for events and learning.

Te Whare Whaa Rau Ma Tahi, Centre 401 also provides a range of one to one and workshop services to support people to with their physical, mental and emotional health care including Health Watch, Change Challenge and School of Emotions. Other workshops provide opportunity to provide Consumer input into local planning and reviews including Brainwave, Citizen Say and Community EQUIP.

The centre is a pioneer in the field of Mental Health Peer Support Supported Employment Services. The employment service was established in 1997, founded on the ASENZ Principles.

People who are participants in the membership of Te Whare Whaa Rau Ma Tahi have access to these Peer Support services free of charge, by way of appointment. People may also access drop in facilities to have a cuppa and connect informally for peer support. There is a charge of pay $1 per day to cover the cost of refreshments.

Centre 401 established 'He Roopu Manaakitanga', with the approval and support of the local iwi, Ngaati Maahanga. They recognise they are not a kaupapa service but do have responsibility to Te Tiriti o Waitangi and support their people in their push for 'mana motuhake' (self-determination). Some staff and Members are members of He Roopu Manaakitanga and the influence of this Roopu is evident throughout the Centre.

Centre 401 is quite a remarkable service run by people who are passionate about what they do and who have all walked a similar journey as the people who come to them seeking support.

Service	DHB area	Descriptor
Te Awhi Mai	Waikato	Peers working alongside clinicians as kaimahi team 10 bed high and complex alternative to acute inpatient service Kaupapa Māori service

Te Awhi Mai is an alternative to acute inpatient service that has been operating for the past 12 months and is staffed by mainly peers. For the ten beds, there is one registered nurse on duty per shift and several peers. This enables more 1:1 time with people and individualised support to participate in recovery activities.

Te Awhi Mai emphasises the reconnection with whānau as part of people's recovery journey however due to the short time frames of engagement their input tends to be around their whānau member. Tū Whānau are involved in deciding what programmes are needed such as weaving, exercise, mindfulness, and meditation.

This is a Kaupapa Māori service. All the peer support team are Māori, and the work aligns with Te Whare Tapa Whā.

Service	DHB area	Descriptor
Tui Ora	Taranaki	Facilitated peer and whānau groups, kaimahi with lived experience Kaupapa Māori service

This is a Kaupapa Māori service so Iwi and Hapu are an integral aspect of the service. Kaumatua and Kuia uphold this Kaupapa within the service and support staff to work from a Te Ao Māori perspective. With a community hub like environment there appears to be plenty of potential for collaboration and a more seamless model of care for whai ora.

Currently in the development they are working on increasing the voice of the CAPS team members regionally and nationally as well as within the DHB governance structures.

On the ground efforts include Canine and Equine Therapy, working with whānau by facilitating peer groups going for walks, getting out in nature and casual chats.

Service	DHB area	Descriptor
Families Overcoming Addiction	Taranaki	Those with lived experience facilitating whānau support group

The service itself is an innovation that has transformed the delivery of support for whānau of those with addiction. It was originally delivered by the DHB but became its own entity sponsored by other organisations, purely whānau governed, driven, and led. The service has been running independently for 3 years and receives some DHB funding.

Programmes are provided as well as support groups facilitated.

Service	DHB area	Descriptor
Turning Point	Bay of Plenty	Peer support worker led using intentional peer support model

An Intentional peer support worker is based within the Bay of Plenty DHB addiction service because of a pilot project. The primary role is to work alongside individuals and groups of people referred to

Bay of Plenty addiction service who experience mental distress to help resolve hope and personal power, and to inspire them to move forward with their lives, with peer support.

Challenges include funding constraints and accessing cultural advice.

2. Findings

Kaimahi with lived experience and whānau workers in the services visited demonstrated that while meeting contractual and legislative requirements was important their commitment to the people that they served went beyond this. They paid tribute to the learning that was part of their unique lived experience and had assisted them on their pathway to recovery. It was this that they shared freely with others in their mahi.

The findings have been grouped under 13 headings consistent with the site visit questionnaire.

2.1 Nature of Services

All ten services visited were engaged in care and support for tāngata whai ora and whānau who experienced mental health and or addiction issues. At times services were tempted to receive all those who attended however recognised that this would negatively impact their service delivery.

Two services had an accommodation component and also provided support in the community. One service provided accommodation as an integral part of care and support. The remaining seven services were community based and delivered services in different ways to achieve a similar goal of improved outcomes for tāngata whai ora and whānau.

"The Peer Team plus the café which is run by employees with lived experience. They also train people with lived experience to achieve unit standards which leads to employment. The café staff turn - over as they go on to other employment and new people join, as it's a social enterprise"[3].

Four of the services were Kaupapa Māori and six services were mainstream.

One service was a collaborative, delivered with the contributions of several organisations unlike the other nine that were organisational specific.

2.2 Service Components

All services employed kaimahi and it would appear that most received a wage for work undertaken. However two services engaged trainees or graduates of the programmes as part of the service team. Other services engaged volunteers.

"Lack of funds meant challenges to employ a full-time Kaumatua for cultural advice. Therefore, currently we have filled this vacancy with a volunteer"[4].

[3] Odyssey
[4] Turning Point

Specific service components varied. The three services with an accommodation component were accessible 24/7. Most community services were accessible on a Monday to Friday basis. Some services were accessible by referral from another agency or clinician, and others were self-referral. Most services regarded people and their whānau as a receiver of the service. However in one service tāngata whai ora became members of the "club".

""Whānaungatanga is applied as part of an intensive induction"[5]

2.3 Features of the service

Services all demonstrated relationships and connection both formal and informal with other providers within their districts. In most services there was a dependency on another provider or funding organisation as a referral source.

Some services had a formal collaborative partnership with other provider organisations to deliver the service, and others used informal partnerships to strengthen their offering to tāngata whai ora and whānau.

2.4 Service frameworks

Service frameworks and models of care varied. Sometimes an international framework or model provided the evidence to support the national or local framework. Sometimes examples of national or local policy were informing developments. In the absence of a framework, some services applied sets of principles and tested new ways of working.

One service was more overt about their model of care and the body of evidence supporting it such as intentional peer support[6]. Another service was modelled on the USA drug court programmes and contextualised for application in New Zealand, and another on the Community Therapeutic model.

National frameworks applied included Let's get real, Health and Disability Service Standards, and Code of Rights.

Kaupapa Māori services had well established Te Ao Māori frameworks and models in place to respond to mental health and addiction issues. This included Pōwhiri Poutama framework approach and its seven stages (Karakia, Mihi, Whakapuaki, Whakatangi, Whakarata, Whakaora and Whakaoti)[7], and in some services Te Whare Tapa Whā framework was used[8]. At Te Kupenga Net Trust mātauranga (knowledge/understanding) Māori principles were modelled at every level of the service from governance to delivery.

"***Māori world view and tikanga is central to all that is done at the service"[9].***

[5] Centre 401

[6] Intentional peer support Aotearoa NZ is connected directly with the international intentional peer support organisation in the USA. Turning Point- Recovery services in Bay of Plenty, New Zealand.

[7] Manaaki Ora

[8] Te Awhi Mai

[9] Te Kupenga Net Trust

Tracking the whakapapa of negative behaviours back to the original trauma was sometimes done to help people attack, identify, confront, and process trauma. They referred to this as the 'puku mahi', aimed at stabilising the two parts of who we are: Ira Atua and Ira Tangata (Ira – gene, Atua – cultural, never dies and Tangata – physical, nature[10]).

Pūrākau and story- telling as a therapeutic intervention were used by some services[11].

Local policies found helpful by services included Whānau participation policy, Whānau and Whai ora rights, Māori participation policy and Wellbeing strategies. Of note Lakes DHB developed Te Ara Tauwhirotanga – mental health and addictions model of care (2020).

"Let's get real enables people to walk the talk and have the conversations. It is the guiding principle that improves connections, understanding, and enhancing confidence to effectively support mental health and addictions needs[12]".

"The framework includes the use of story- telling via mediums such as art, the stories of our gods / atua" and the pūrākau of Tipuna"[13].

"A pursuit of wellbeing for people living with life stressors, addictions, and mental health, to grow wellbeing for people and whānau of all ages and to nurture wellbeing for all through strategic leadership, innovation, and integration"[14].

2.5 Management and governance

Most services recognised the importance of lived experience at every level of the organisation, guiding and directing developments and decision-making. Some services proudly shared that lived experience was visible from the boardroom in governance to the front line as in operational delivery. This was emulated at national and regional levels with greater representation of lived experience in peer and whānau roles.

- ***"Peers and whānau are engaged at all levels of the service"[15].***
- ***"Lived Experience is fully incorporated within the management structure"[16].***
- ***"Peer support workers and whānau sit together and discuss best practice initiatives, and then sit with management, saying 'this is what we think needs to happen"[17].***
- ***"Lived experience is like the backbone of the organisation; keeps it upright"[18].***

There did appear to be flatter organisational structures across services with less hierarchy.

- ***"This flat business model has abolished any hierarchical or tiered management structures, "all are equal here"[19].***

[10] Manaaki Ora
[11] Manaaki Ora
[12] Lifewise Trust
[13] Te Kupenga Net Trust
[14] Manaaki Ora
[15] Te Kupenga Net Trust
[16] Lifewise Trust
[17] Lifewise Trust
[18] Manaaki Ora
[19] Te Waharoa

2.6 Workforce

All ten services employed kaimahi for the delivery of services. There was deliberate recruitment and an increase in peer and whānau roles amongst teams. One service reported at least 35% of kaimahi were dedicated lived experience workers. Another service shared that lived experience roles had only been established and funded more recently. And another that further funding was sought for more lived experience roles.

Two services operated with 100% lived experience workforce from board level to operations[20].

The skill set and prerequisites of kaimahi, and the roles, functions and activities undertaken varied. In some services those with lived experience needed to be substance free before becoming employed kaimahi.

In some services more formal qualifications were required or an agreement to engage in this such as Career Force Level 4 Community Support Work Health and Wellbeing qualification (offered in Te Manawa Taki by two organisations: Careerforce and Whitireia). In one organisation staff were offered MAPA (de-escalation) training, Marae-based learning, and Addiction 101. In another organisation Intentional Peer Support training was offered. Furthermore, a certificate and diploma in 'Manaaki Ora – Whānau Ora' was undertaken and additional training made available in motivational interviewing, facilitating, and presenting. Another staff member was studying towards Te Takitaki through Moana House (Otago Polytechnic). Lived experience was acknowledged as a qualification that should be valued.

Ways of working varied along a continuum from role-specific set tasks to more integrated. Sometimes it was shared working, task dependent working or working alongside. In some services lived experience roles were included as part of an inter-disciplinary team and these roles did not work in isolation. The notion that clinicians do all the triage and assessments, and make the placement decisions was no longer the situation in some services.

Peer workers in some services managed a case load of up to 25 people.

Pay parity while an issue in some services, one service shared that peer support workers were paid similar to other support workers.

Services provided their perspectives about workforce as quoted below.

One service stressed the importance of nurturing their workforce:

- ***"A great deal of importance is placed on mentoring and support for the peer workforce ….that nurturing their workforce "has to be the pulse of everything we do".***[21]

Another service recognised the benefits of peer workers sharing from their lived experience, with the right attitude and without judgement.

[20] Centre 401, Families overcoming addiction
[21] Lifewise Trust

- ***"Peer workers were straight talkers without judgement"[22].***
- ***"Workers who are "innovative, fearless" and with the right attitude; making sure peers feel like they are one of the team, and that other staff fully understand this[23]".***

In some services peer workers had distinct tasks as a significant member of an interprofessional team

- ***"RNs and Psychiatrist leading clinical work and Peer workers leading programmes and activities"[24].***
- ***"The Peer Team, work alongside clinicians in the true sense. It is very much a level playing field. They are based in the same room together, travel together, brainstorm cases together, agree on solutions, and plan together based on mutual respect. Eat together, laugh together, and support each other"[25].***

2.7 Kaupapa Māori

Four of the ten services were Kaupapa Māori services and provided services to Māori by Māori. However non- Māori were not excluded.

As discussed under frameworks, a range of Kaupapa Māori models and cultural approaches were utilised to meet whānau need. These services stressed the importance of whānau and connecting with whānau. However some services were keen to extend current service provision to include greater whānau engagement, whānau roles and whānau programmes.

Tracking whakapapa was thought relevant to identify trauma and focus on healing. Sometimes this trauma had been dampened by the use of alcohol and other drugs. Identifying and confronting it provided the opportunity to process and deal with it in a culturally appropriate way.

Powhiri Poutama is a model used that weaves the cultural with the clinical in the delivery of addiction treatment. Mason Durie's model Te Whare Tapa Whā is also utilised. Karakia, waiata, whānaungatanga and engagement with Te Ao Māori are integral to Kaupapa Māori delivery. Other models and approaches such as Pūrākau and wānanga are discussed in the Kaupapa Māori section of this document.

Most mainstream services recognised the importance of Māori representation at every level of the service organisation. However not all achieved that. Some were reliant on cultural advisor input and volunteers or the support of other organisations.

- ***"The peer workers said the service is by Māori for Māori, but you do not have to be Māori to use the service"[26].***
- ***"They spoke of the importance of connecting back to whānau and iwi"[27].***

[22] Lifewise Trust
[23] Lifewise Trust
[24] Te Awhi Mai
[25] Odyssey Auckland
[26] Manaaki Ora
[27] Manaaki Ora

- ***"Some staff and Members who are Māori belong to Te Roopu Manaakitanga" "[28].***
- ***"A culturally diverse workforce with significant Māori representation"[29].***
- ***"A combined therapy approach which aims to be peer led, culturally led, and clinically sound. Strong emphasis is put on discharge planning, attempting to restore or strengthen whānau connections. They encourage people to ask 'who am I?' and to be who they are"[30].***

2.8 Professional Development

All services offered kaimahi professional development of some kind. This varied greatly. It seemed that there was no one programme that suited everyone. Generally services sought to access a variety of professional development opportunities to achieve best fit for individual kaimahi and the service.

One service supported all employed kaimahi to complete the Career Force Level 4 Community Support Work Health and Wellbeing qualification. Another offered a level 2 certificate in peer support as an in-house training. No one single recognised peer support training was advocated although the Level 4 certificate in peer support seemed popular and is linked to national pay parity negotiations. This is discussed further in Section 8. Priority was given first to lived experience and then other more formal qualifications second.

Of relevance is the idea of a more indigenous-dynamic approach, labelled pūrākau-ology, discussed by Kaupapa Māori providers and identified on the site visits**.** This is about traditional Māori story telling used as an intervention.

2.9 Strategies for creation

While funding was considered a great enabler, there was often little money to try something different or establish a new service. Some organisations had been fortunate with one-off funding and others had reconfigured current services.

Some services suggested that they needed to be prepared to change the way they worked, be more flexible and agile.

"being responsive, available, and flexible to meet people's needs..."[31]

2.10 Innovations

Consistent with national trends services demonstrated a shift away from traditional service delivery models, and the skill set of the past, to making greater investment in peer support. This signalled the value and significance of peer and whānau lived experience roles across services.

Lived experience has been a feature in mental health and addiction services for many years. More specifically in addiction services workers from a range of disciplines often also had lived experience.

[28] Centre 401
[29] Centre 401
[30] Te Awhi Mai
[31] Lifewise Trust

Designated peer support roles have been established more recently in mental health and addiction services and becoming more common.

- "***the service encourages and shares hope (not the mess) by showing how the peer workforce overcame and became good role models"[32].***

2.11 Transformation

Some services described transforming lives when those with lived experience were role models to those at different stages of their recovery journey.

- ***The day I was an 'invited spectator' (31/03/2021) four Peer Workers were invited at different stages of the afternoons proceedings to tell their story. They have all been through the system and are now working in the Peer Team. Their stories are very moving. They spoke about how long they had been substance free. They told of how life was for them when they were using. Of how they lived and felt. How they lost so much including their children, their whānau, their self-esteem, their dignity, their mana, plus. These stories were powerful and a shining example to the participants on how it could be for them if they were successful in turning their own lives around[33].***
- ***Tū Whānau talked about the ambience. The Aroha, the people, the environment, quiet rural setting, diversity of people, the dynamics of the different people, "Pulled me out of the rut I was in", "Made me feel safe"[34].***

2.12 Benefits

The site visits provided evidence of more affordable, accessible and effective service delivery models in action with improved outcomes for whānau. The people and whānau accessing services found them more respectful and more likely to include whānau in a meaningful way.

Services dealt with real-life issues in their communities and responded to unmet need.

- ***"peer workers spoke about how the service is set up like a comfortable home, with feelings of being loved and connected, and that this was an important aspect as people had often been distanced and disconnected from whānau, and in some cases homeless"[35].***
- ***"a remarkable service run by people who are passionate about what they do and who have all walked a similar journey as the people who come to them seeking support"[36].***
- ***"This was a lovely warm environment with a small group of people dedicated to their mahi, community based and complimentary to clinical mental health and addiction services"[37].***

[32] Lifewise Trust
[33] Odyssey
[34] Te Awhi Mai
[35] Lifewise Trust
[36] Centre 401
[37] Turning Point

- ***"Our current mental health and addiction system could learn a lot from the places I visited on how to celebrate, awhi, respect, and enhance the mana of the awesome people who require our services"[38].***

  "Too often I see people being 'talked at, or down too' by clinicians. If I were a service user and I was being treated like that, would I want to engage? Would I want to continue seeing the person who treated me like that?? Na"[39].

2.13 Challenges

Services shared their concerns about funding arrangements not always being conducive to effective service delivery. Annual funding cycles and tight contract terms sometimes for only 12- month periods created challenges for services seeking to be sustainable. Onerous monitoring and reporting and audit also added to the burden.

Establishment processes, meeting compliance requirements and costs sometimes overwhelmed, and what it takes to establish a new service in workforce and resources was not adequately provided for in the funding arrangements. Administration support, quality and risk expertise and other supports to service infrastructure was not always considered or funded.

Transparent career pathways for those in lived experience and whānau roles was thought to be lacking. The progression from a peer support worker or a lived experience advisor was unclear and varied from organisation to organisation.

Understanding lived experience and how it adds value and significance to the service was not always well articulated and it was suggested that there may be tensions internally and externally to the organisation. In one service roles were not always well understood and boundaries were unclear. This negatively affected relationships and referral pathways.

- ***"The biggest bureaucratic barriers are often needed to be surmounted before any actual mahi is begun"[40].***

The ten site visits as detailed in this section proved worthwhile in providing a snapshot of innovative and creative services delivered in Te Manawa Taki and Auckland with lived experience at all levels of the continuum. The next sections discuss the implications of what was found.

[38] Odyssey
[39] Brian Thomas
[40] Centre 401

8. Kaupapa Māori

Te Manawa Taki Regional Equity Plan (2020-2025) states " Equity for Māori recognises the value of tikanga (values and practices) and mātauranga Māori (world view/traditional knowledge). We will integrate te Ao Māori into systems design, health policy, models of care and delivery of all health services".

Four exemplar Kaupapa Māori services specifically by Māori for Māori with Māori models of care and treatment were included in the site visits. Māori also governed these organisations holding the majority of seats on governing Boards. Services avoided traditional hospital settings for delivery preferring community based more peaceful locations. Some services were more te Ao Māori integrated than others, and several different Kaupapa Māori models and approaches were applied. The specific models are described in Section 7.

In one service iwi, hapu and whānau were linked in the following ways:

"Te Roopu Matua is the Iwi Health Providers and Te Kupenga Net Trust is part of this group

- ***Toitu Iwi Leadership is now part of the Community Health Development arena and Te Kupenga through Te Roopu Matua is active in this space.***
- ***Hapu and whānau especially in the rural areas are requesting more interface with our service as we believe in immediate response to whānau.***
- ***Tohunga within the service are whānau hapu and iwi leaders in their own capacity outside of work and the whare for whānau to enjoy***
- ***Community events are often held within the whare without charge. This is not only open to other services, but arts groups and leading events within town"[41].***

Non-Māori were also welcomed at Kaupapa Māori services.

Some non-Kaupapa Māori services had made efforts to improve their environments, to be more culturally welcoming with Māori images and signage in Te Reo. Other services had appointed cultural advisors and cultural teams to walk alongside Māori and their whānau and support navigation through the services. Te Ao Māori practices seemed more familiar and more accessible in these services than in the past. Practices such as wānanga[42] and pūrākau were more common as interventions. It was expected that Māori would access services according to the service entry criteria.

Local research with a thematic analysis had recently been published identifying six themes or pathways towards wellbeing for Māori. The researchers provided guidance for practitioners on how to actively engage Māori in pathways to wellbeing (McLachlan et al, 2021). This guidance may be helpful to services, particularly those with challenges engaging Māori.

There was another service type that was seen on the site visits and that was a Kaupapa Māori unit functioning within a non- Kaupapa Māori or mainstream service. It appeared that the unit was able

[41] Te Kupenga Net Trust
[42] Te Kupenga Net Trust

to provide an effective cultural and clinical service for Māori operating within a mainstream service-stating 'whatever it takes for whānau'. However Māori were not present at governance and senior management levels for strategy and decision-making[43].

Those conducting the site visits found the challenges faced by Kaupapa Māori services were real and not assumed. Kaupapa Māori services were often reliant on other service providers (usually DHBs) to refer people and whānau to them. Sometimes referral rates declined for no apparent reason, impacting service funding. It was suggested that relationships and trust amongst all parties were important to maintain referral pathways and to ensure people received the care and support they needed. Mechanisms to promote improved communication and manage any conflicts were found to be beneficial.

Sometimes initiatives were funded with one off funding or from under-spend and this was not uncommon amongst Kaupapa Māori providers. This type of funding makes recruitment and retention of the required skilled workforce more problematic. Sustaining the gains achieved by an innovative initiative is difficult once the funding ends.

Kaupapa Māori and smaller providers were challenged with workforce issues, and increasing infrastructure costs. However remaining a smaller provider had its benefits for those receiving the service such as delivered in more individualised and relational ways, as demonstrated on the site visits.

[43] Lifewise Trust

9. Implications for Workforce

The site visits explored many of the issues affecting the peer and whānau workforce. Services recognised the importance of recruiting and retaining the right people. As workforce stocktakes showed there has been some reconfiguring of workforce mix and more specifically an increase in peer support workers (Te Pou, 2019).

Most services appeared to understand the value in investing in the lived experience and whānau workforce with induction and orientation processes and supervision in place. It was recognised that peer support workers could be more vulnerable in sharing their own personal stories of recovery and supporting others. Therefore providing the right support, coaching and mentoring seemed worthwhile for wellbeing.

Lived experience was the priority and a point of difference rather than other qualifications. However there are remuneration implications. In national pay parity negotiations when rates were determined for support workers in the New Zealand Health and Disability sector there was not the corresponding NZQA accredited qualification to include the peer support workforce. It would seem that once the peer workforce is NZQA qualified (Level 4 certificate) they will be able to attract a comparable wage consistent with this remuneration framework.

Dapaanz recognises peer support workers. Membership as an endorsed support worker is available for support workers and peer support workers – a level 4 qualification is recommended but not required. However workers need to be under the supervision of a Dapaanz accredited supervisor to work in addiction. (Dapaanz, n.d.).

Having fun and enjoying work did feature amongst many of the services visited, and there seemed to be more of a sense of team. This was particularly evident where there was a group of peer support workers or those with lived experience.

Lived experience is a vital component of the mental health and addiction workforce.

10. Components of a Te Manawa Taki Framework

"Lived experience and whānau led roles are experts in the field"[44]

In this project to develop the lived experience and whānau led strategy, nine clear themes emerged from the literature, stocktakes, and site visits. These themes were considered key to successful, sustainable lived experience and whānau led roles and services in Te Manawa Taki. They include:

1. <u>Lived Experience and Whānau Experience Valued and Recognised</u>

Genuinely value the lived experience and whānau experience as experts 'seated at the table' informing every level of the mental health and addiction continuum including governance and operations. The exemplar services have demonstrated the benefits to health outcomes when the lived experience is central and a significant component of the service. Added value and efficiencies due to lived experience were apparent at points of contact.

2. <u>Connected</u>

Ensure those in lived experience and whānau roles are connected smoothly as critical components of service planning, design, delivery, and evaluation. Health needs are part of a broader hierarchy of needs impacted by social determinants. Therefore, services and roles benefit from connection across sector including health and social agencies, to support meeting the needs of people and their whānau.

3. <u>Culturally Competent</u>

Ensure all lived experience and whānau roles develop cultural literacy[45] to engage and respond to others in culturally more appropriate and competent ways. Cultural literacy and competence is required at a governance level right through to operations for those who walk alongside whānau in services.

4. <u>Without Bias and Discrimination</u>

Actively engage those with lived and whānau experience without bias and discrimination. Services must identify the bias and discrimination that exists and actively take measures to increase awareness and change behaviours, systems, and processes to minimise any potential impacts.

5. <u>Resourced and Supported</u>

Resource and support lived experience and whānau roles to function effectively and sustainably in services. While in some services those accessing services progress to support others as part of their own recovery, recognition, and establishment of paid resourced and supported roles are required for the service delivery to be sustained.

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[44] Te Manawa Taki Project scope document 2021

[45] Ability to understand the history and traditions of a group of people from any given culture. Being able to engage with these traditions' activities in cultural spaces. Culture is how a group of people live which includes their language, arts, science, beliefs and practice and their understanding of their environment.

6. Trained

Lived experience and whānau roles require the appropriate fit for purpose professional development and education to be successful in services. This may require investment in the recognised Level 4 Certificate. Culturally specific training should be accessed for services delivered to Māori.

7. Access to Role Models, Supervision, Mentors

Lived experience and whānau roles require access to coaching, mentoring and supervision. This is a non-negotiable requirement to ensure they maintain their personal wellbeing and achieve professionally.

8. Governance

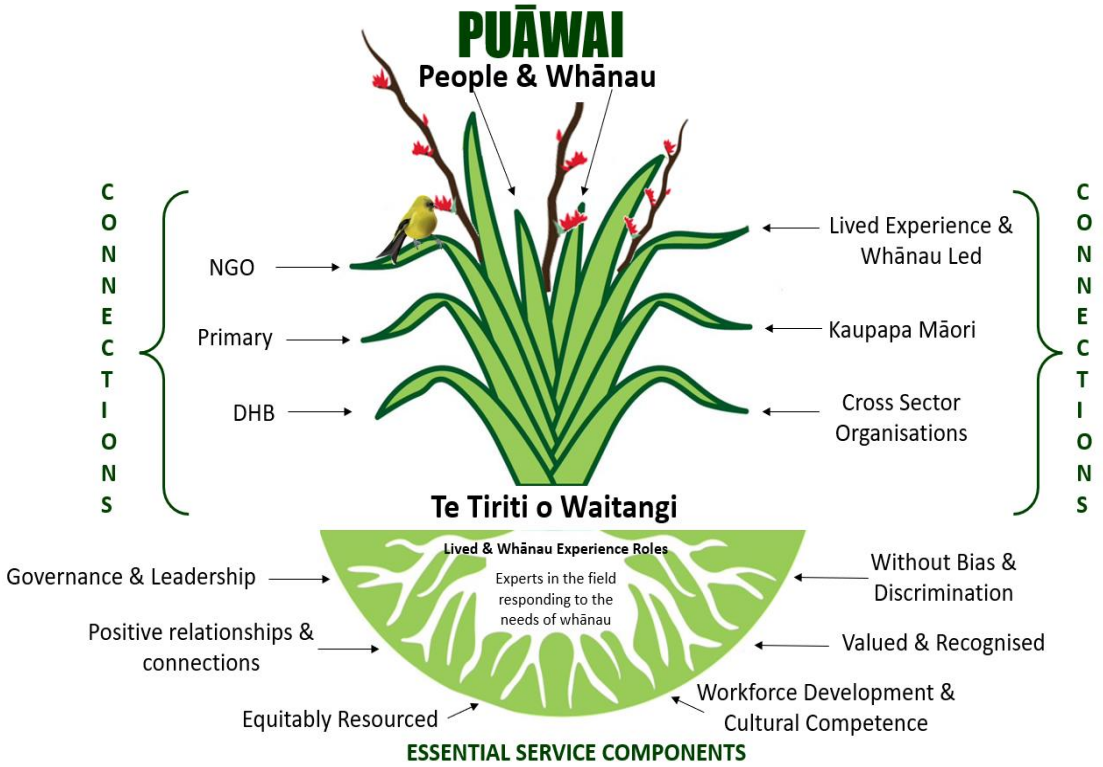
Engage lived experience and whānau at the governance level to ensure the voice of lived experience and whānau experience informs strategy and decision-making. Ensure there is also an increased presence of Māori at the governance level, particularly when Māori are over-represented in health need.

9. Leadership

Lived experience and whānau roles must be visible in leadership at every level, guiding, directing, and shaping the way services are planned, developed, implemented, and evaluated.

Figure 2 Shows the components in the framework that will achieve flourishing Lived experience and Whānau experience roles and services.

Figure 2: Te Manawa Taki Peer & Whānau Led Framework



11. Conclusion and Recommendations

This project has confirmed that there is huge potential acknowledging, valuing, celebrating and investing in lived experience and whānau roles in Te Manawa Taki mental health and addiction services from governance to operations.

The literature showed us that internationally and here in New Zealand there is evidence that lived experience and whānau roles have positive benefits for those who require mental health and addiction services.

Exploring current stocktake data about lived experience and whānau roles confirmed data gaps and potential opportunities to collect and analyse information about these roles and the services they are part of. This information would support proposals for further growth and development.

Site visits to ten exemplar services revealed many positive outcomes because of the presence of lived experience and whānau roles. More specifically the four Kaupapa Māori services provided learning of cultural models and approaches that were demonstrating improved outcomes for Māori.

Kaupapa Māori services demonstrated a weaving together of clinical and cultural approaches to engage and support people and their whānau to achieve recovery. It was recognised that people had different needs and a range of approaches was necessary for a 'best fit' response. Māori in lived experienced roles were critical to this response. Therefore development of specific Kaupapa Māori lived experience and whānau led roles should be a priority in all mental health and addiction services to improve outcomes for Māori.

Lived experience roles in the services visited were more often planned and deliberate, with several services signalling they were keen to recruit more roles and seeking further funding. There was recognition of the value lived experience added to the workforce team, and a better understanding of individual and collective roles and responsibilities. Teams worked together with shared goals and expected outcomes.

A framework with nine components for the successful and sustainable application of lived experience and whānau roles in Te Manawa Taki mental health and addiction services has evolved, informed by the work undertaken in this project. Transformation of the health system would benefit from inclusion of this framework to ensure services become more accessible, affordable, and effective for people and their whānau.

Recommendations:

1. This Te Manawa Taki lived experience and whānau led strategy is approved by the regional Ngā Kōpara o te Rito (Lived and Whānau Experience), Te Huinga o Ngā Pou Hauora (Māori), He Kāwai Herenga (Strategic Leadership) and Clinical Governance Advisory.

2. This strategy is presented to regional GMs Māori, GMs Strategy and Funding and Chief Executives for approval

3. An action plan is developed for the implementation of the Te Manawa Taki Lived Experience and Whānau Led Strategy, with the following actions:

    3.1 There is visible commitment and allocated investment to implement this framework for lived experience and whānau led roles in Te Manawa Taki mental health and addiction services at governance and operational levels.

    3.2 Kaupapa Māori services' integrated clinical and cultural approaches and models of care informed by lived and whānau experience are promoted.

    3.3 A professional career pathway (including training programmes, coaching and supervision) for lived experience and whānau led roles is developed and supported.

    3.4 Networks for lived experience and whānau roles are strengthened.

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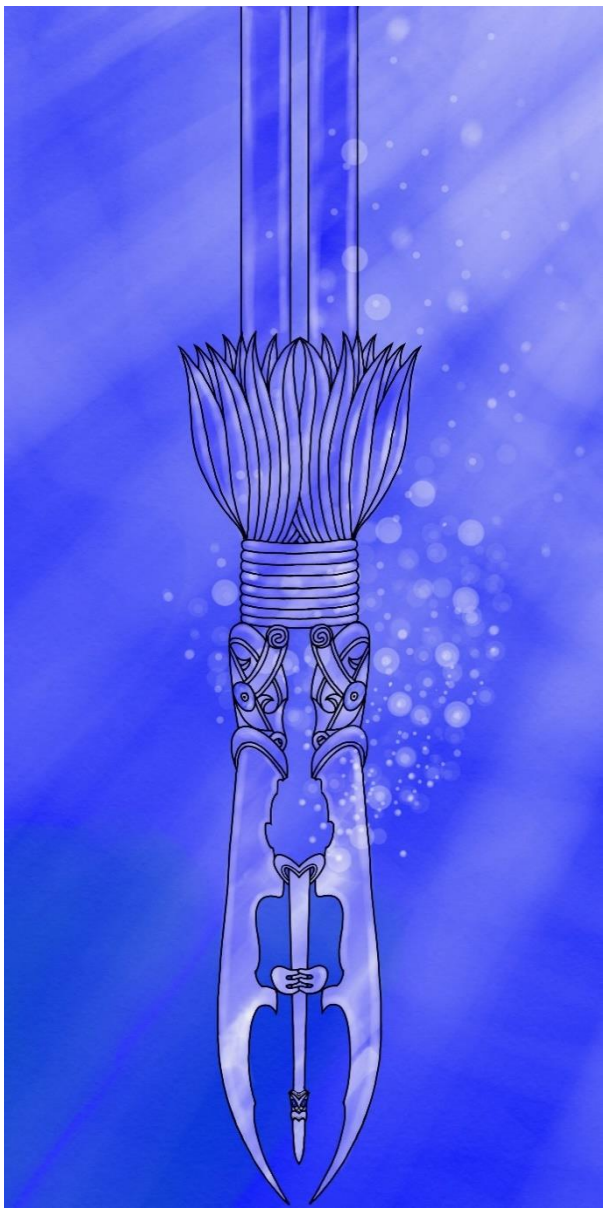
13. Appendices

Appendix A: Cover Page Design – Taiahaha Taiahaha



"Taiahaha Taiahaha" is a summoning of people: **The first taiaha** (prominent), is an outline of a taiaha and incorporates all aspects of a taiaha: the tinana (the body), the awe (feather plume), the taura (to hold the awe on), an upoko (the head) and an arero (the tongue).

The **Arero** in this case is made up of a figure, a silhouetted figure where we are not looking to define it but where we are looking to support that figure to find itself.

So, the whole concept comes together to reveal how we can help the figure to rediscover itself and so it stands in **Matauri** (silhouette).

To look in on oneself

To recognise what has been

To acknowledge what is to come

To realise it is an undefined realm of potential being

The **Upoko** is in two parts that is suggesting support for that figure can come from various places and many angles. In terms of our 5 kupu, there are numerous aspects to this which, in all probability, there will be multiple alternatives that can help that figure to find itself. These include family, clinical support or whatever appropriate support there may be.

All of this is bound together to form one taiaha with a **Taura** that is holding an **Awe -** an "awe", in terms that it is creating an obvious presence that relates to the "whakama" korero. This is something that is real and natural for people and there must be a showing of that, a revelation for us that the awe wraps around the **Tinana** which also has a void in it. That void comes down to create a **Poutokomanawa** figure at the bottom.

A poutokomanawa references that taonga in our wharenui that holds the whole framework of our whare up. The Tāhuhu, which runs and holds the mātauranga of that whare, has a poutokomanawa to hold it up. This then becomes the heart replicating that the heart of our thinking sits with that whānau (mana tangata - one of the kupu) to self-determine what their treatment and support should look like and so it is targeted by them for them (mana Motuhake - another of the kupu).

Inside of that, the figure has a waha (a mouth) with the ability to articulate korero. The bubbles show the breath (articulation) and where it catches the rays of the sun, through the water, it creates little sparks of light (potential) as the figure begins to find itself. You could say that this is getting into the realm of "te ao wairua" – a sense of participation of them finding a resolve for themselves through all the assistance and support. Out of this grows their own taiaha, **the second taiahaha**, that provides a sense of empowerment and a sense of identity where they can grasp it and own it.

It sits in water that relates back to the fluid nature of how support should be e.g. when things are going well then you carry on with that but when they are not you change into other things, rediscover and set new pathways and goals. The difficulty around that is how tough it is for services to be fluid, but the whānau should always feel that there is sense of fluidity about finding themselves.

The whole thing is obviously around M.A.O.R.I. (one of the kupu), a Māori kaupapa. In terms of the appearance there is a sense of whakatau wairua, there is a balance and a sense of peace, a sense of grace, a sense of elegance that fits in there in terms of how we deal with wairua of our kaupapa.

Appendix B: Te Manawa Taki Lived Experience, Peer and Whānau Led Service Strategy Project Scope

Project Title	**Te Manawa Taki Lived Experience, Peer and Whānau Led Service Strategy**
Prepared by	Eseta Nonu-Reid – Regional Director MH&A, **Nga Kōpara o te Rito:** Jimi Ropiha-Stewart, Jim Dickinson, Sarah Gillingham (Taranaki), Ann Grennell (Waikato), Jordy Bealing, Wi Te Tau Huata (Lakes), Arana Pearson, Brian Thomas (BOP), Lisa Baty, Herewini Rangi, Guy Baker, Hine Moeke-Murray (Tairawhiti)
Date	March 2021
Version	Final
Project Statement	This project is being undertaken to validate the premise that lived experience, peer and whānau led roles are experts in their field. To do that we need to understand the current lived experience, peer and whānau provision of service and relevant workforce development opportunities across the Te Manawa Taki region, current systems of inclusion of expertise-by-experience and innovation both inside and outside of the region. Thereby informing the development of a regional framework that aims to grow the lived experience, peer and whānau workforce; strengthen systems of inclusion of lived experience expertise; influence and drive new initiatives; and transforming existing service provision through codesign.
Objectives	The project will provide: 1. Increased lived experience, peer and whānau expert roles in the Te Manawa Taki region 2. Exploration of lived experience, peer and whānau experience training and education for the Te Manawa Taki region 3. Exploration of informal and formal innovations that are in existence within and outside the Te Manawa Taki region for peer / whānau led services 4. Development of a regional framework that transforms current delivery and which drives and informs new initiatives across the continuum of care (from where whānau are seen, to the board room) 5. Development of Kaupapa Māori lived experience, peer and whānau led support within mainstream services and Kaupapa Māori led services

Strategic Accountability	The project will be guided by: • Te Piko o te Māhuri – Midland Youth Wellbeing Framework (2019) • Taiahaha Taiahaha – Midland Māori Wellbeing Framework (2020) • Uhi Wero, Uhi Taia – Midland Addiction Wellbeing Framework (2020) • Te Aho Tāhuhu – Midland Whānau Wellbeing Framework (2020) • Ministry of Health Whakamaua: Māori Health Action Plan 2020-2025 (July 2020) • The Health and Disability Strategy Review (2020) • Consumer, Peer Support and Lived Experience MH&A Workforce Development Strategy: 2020-2025, Te Pou • He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction, Ministry of Health (2018) • More Than Numbers Workforce Stocktake, Te Pou (2018) • Te Ara Tauwhirotanga – Model of Care for Mental Health and Addiction, Lakes DHB (2018) • Mental Health and Addiction Workforce Action Plan 2017 – 2021, Ministry of Health (2018) • Engaging with Consumers, Health Quality & Safety Commission (2015) • Midland MH&A Service Users Competency Framework (2014) • National Family Whānau Advisor Competencies, Matua Raki (2014) • Involving Families Guidance Notes, Ministry of Health (2000) • Ministry of Health Guidelines for Consumer Participation (1995) • Peer / Lived Experience Workforce • Counties Manukau Model - Cassandra Laskey • Peer Support and Advocacy Services – Te Whare Awhiora, Hauora Tairawhiti & Te Kupenga Net Trust • Whānau Engagement in Mental Health & Addiction Services, Hauora Tairawhiti • Whānau Family Participation and Inclusion in Mental Health & Addiction Services, Hauora Tairawhiti • Family & Whānau Individual Counselling – Alcohol & Drug, Taranaki DHB • Family and Whānau Participation Mental Health & Addiction Service, Taranaki DHB • Consumer Participation Policy, Taranaki DHB (2019) • MHSOP – Family / Whānau Involvement with the Care of the Client, Taranaki DHB • Ahi Ka Waikeria Foundation document, 2021 • Auckland & Waitakere Drug Courts

Background

Over the last 10 years there has been a significant amount of work undertaken in the area of consumer, service user and family support. The release of the Ministry of Health's 1995 Guidelines to Consumer Participation bought with it the contracting of Consumer and Family Advisors in each of the District Health Boards. Further to this, the Te Manawa Taki region consulted extensively with whānau lived experience and whānau and developed Support Worker Competencies in 2012. The information gathered was utilised to inform the national Consumer, Peer Support, Lived Experience Workforce Development Strategy produced by Te Pou (2020).

Where there has been a significant amount of work put into developing a national strategy document around the value of peer and whānau led services, there is still variation across DHBs and how people with lived experience and their whānau are involved in governance, policy, planning and service development. That said, some initial work has been undertaken in Te Manawa Taki to progress true co-design and partnerships.

He Ara Oranga (2019) is explicit about the need to develop peer and whānau led services. In response to the challenge that He Ara Oranga bought, the Te Manawa Taki region held four wānanga for whānau and whānau lived experience to articulate how they view services should be delivered. The four wānanga covered:

1. Whānau – Te Aho Tāhuhu
2. Youth – Te Piko o te Māhuri
3. Māori – Taiahaha Taiahaha
4. Addiction – Uhi Wero Uhi Taia

Four main principles for service development going forward came from the wānanga's:

1. Placing whānau at the centre
2. Services tailored to meet the needs of whānau
3. All whānau matter
4. Whānau wellbeing, recovery, lives and statement of intent are all important

For the Te Manawa Taki region, it is timely that we review what we have, how well it is working and what is possible by identifying pockets of innovations that are occurring in order to further develop a current Lived Experience, Peer and Whānau Led Strategy.

Approach	The approach will include the following processes: • Develop a draft Project Scope • Approval from Clinical Governance • Identify Project Consultation to help drive us to our destination • Establish an expert steering group • Consult with stakeholders (whānau and live experience) and regional networks when final draft is completed • Final report for Clinical Governance's approval • Publish report
The project will include	• Literature review • Site visits and interviews • Stocktake of current workforce (training and education opportunities, dedicated Māori lived experience workforce advisors) • Stocktake of Te Manawa Taki DHB processes of inclusion of lived experience (compensation for those included / support – valuing unpaid/paid workforce) • Current level usage of peer run / peer support and whānau services • Current funding and FTE • Define peer, whānau and lived experience (Define codesign e.g. Consultation)
The project will not include	• Any unrelated deliverables to the project
Completion Criteria	The project will be completed once the project report has been signed off by the Project Sponsor, the MR Clinical Governance Network and MR Portfolio Managers Network.
Internal Stakeholders	• Project Sponsor, Eseta Nonu-Reid • Ngā Kōpara o te Rito – Midland Whānau / Lived Experience • Te Huinga o Ngā Pou Hauora – Midland Māori

External Stakeholders

- Midland Addiction
- Midland Workforce
- Waikeria Prison
- Waikato Drug Court
- Others as identified during the process

Implications for Māori and Pacific

[46]The fundamental task of health professionals is to promote and protect health and well-being, to assist and aid recovery and to ensure that the best possible health outcomes are achieved. This is a constant and indiscriminate objective – one which is blind to ethnicity or nationality, culture, or identity, socio-economic or demographic profiles. The mistake however is when these generic objectives for health and well-being are translated into generic approaches for health service delivery, treatment, and care. Aligned with this is the flawed assumption that treating people the same will somehow translate into similar health outcomes.

- More participation
- More resourcing to rural areas where Māori and Pacific reside
- Choice & access practice is equitably distributed to Māori & Pacific with the highest needs
- Implications of Māori & Pacific service development learning from whānau which includes a working definition for lived experience
- Reconciliation of the journey within collective consciousness

The Te Manawa Taki Five Core Equity statements for mental health and addiction was derived from the overwhelming feedback from whānau.

Mana Motuhake – providing choice for whānau as determined by whānau and is accessible for **ALL** whānau regardless of circumstances. Mana Motuhake is evidence based and measured against the Articles of Te Tiriti o Waitangi.

1. **Mo te Katoa (for everyone)** - the right fit and connection for our whānau. Demonstrating tika, pono and aroha evidenced through naturally occurring action and assessment.
2. **Matakite** – flexible, adaptive, agile services that are close to the ground to whānau needs which includes and validates the natural intuitive ability of all to work alongside our whānau.
3. **Tikanga and Kawa Based** – is determined as a whānau knowing, grounded in indigenous collective ideology, informed by traditions of time and space.
4. **Wairuatanga** – heal the wairua; heal the whānau.

[46] The Treaty of Waitangi; A Framework for Māori health Development – Te K.R.Kingi Te Pumanawa Hauora School of Māori Studies Massey University WELLINGTON

IM Implications

- The collection of data is often viewed as impersonal and generic, used to inform and provide a snapshot of trends and analysis. What must be clearly identified and understood, is human data has whakapapa, a history that belongs to people. People are taonga, treasured living beings. Their information is personal to them and we are the invited guests into their world. The absolute right to consent, use and storage of data ultimately must remain the property of the person. Data Equity insists that full disclosure for the use of personal data must be sought and clearly understood. The Privacy Act (2020) NZ gives surety to all citizens of New Zealand for the protection of personal information. Data Equity ensures Rangatiratanga for the whānau concerned. Articles 2 and 3 o Te Tiriti o Waitangi reinforces possession and sovereignty of Mana Motuhake.
- The regional network meetings, Survey Monkey, Zoom, email and Midland MH&A website will be utilised to convey information about the project to the sector
- All project meetings will be undertaken via Zoom

Resources and Project Structure

The project will be led by Deirdre Mulligan Project Manager.

Project relationships and linkages

Other projects or initiatives that this project relates to and key contact people that provide liaison:

Project	**Contact**
Support for Whānau Impacted by Methamphetamine (Tairāwhiti)	Leslynne Jackson
Immediate Response to Addiction (Tairāwhiti)	Hine Moeke-Murray Cilla Allen
Peer Workforce Development	Jordy Bealing and Michael O'Connell
Consumer Participation Framework	Jordy Bealing and Michael O'Connell
BOP MH&A Transformation Phase II	Caleb Putt
Cross Sector Governance Group (eg. Ngahere project)	Justin and Jimi

Financial Summary

Budget (one-off costs)

Costing Activity	Indicative Costs
Project Costs	$10,000.00 - $15,000.00
Disbursement	NA
Site Visits to Auckland and Midland – travel (flights and rentals) and accommodation estimates	$4,000.00
Contingency	$1,000.00
TOTAL	$20,000.00

Ongoing cost: Nil

Cost Savings: Unable to determine the cost of all 5 DHBs undertaking this piece of work

Risk management

Risks associated with the project.	Risk Mitigation
1. Delays in receiving information from the various information sources – **High** 2. Resistance to the project being undertaken – LOW 3. Representation from the whole region may not occur bring a regional voice or be equitable – Medium 4. COVID19 lockdown may prevent the ability to consult widely with whānau - **High**	• Build enough time into project plan or renegotiate timeframes with project sponsor • Discuss this with the Project Sponsor, and use regional networks to support the project • Follow up with each DHB. Allow time for each DHB to recommend participants. • Provide options for consultation, for example Survey Monkey, Zoom, Video Conferencing, telephone calling.

Risks the region is exposed to if the project does not proceed:

- Impedes the progression of work needed to effectively respond to the national Mental Health and Addiction Workforce Action Plan 2017 – 2021, and the four Midland regional wellbeing frameworks that outline the aspirations of whānau
- Impedes preparation in response to the changes that He Ara Oranga and H&D reviews are proposing, especially keeping people and their lived experience at the centre
- Impedes an opportunity to develop a stocktake of current FTE and allocated funding, and education and training opportunities across the Te Manawa Taki region
- Impedes an opportunity to learn of lived experience, peer and whānau innovations occurring outside of the Te Manawa Taki region
- Impedes effective planning for the future
- Impedes the development of growing the lived experience, peer and whānau workforce
- Impedes the development of lived experience, peer and whānau led initiatives
- Impedes the development of a regional framework that aims to transform existing service provision and drive new initiatives
- Impedes the development of the lived experience, peer and whānau expert evidence base

Quality	Quality will be facilitated through • Monthly project reports • Minuted Zoom meetings with Project Steering Group

Project Opportunities & Benefits

Using and Doing

Advantages (Benefits & Rewards)	Challenges / Disadvantages (Cost & Risk)
• Transparency about what is currently being done in the equity space and provide a framework for addressing inequity • Responds to the aspirations of whānau as identified within the four Midland regional wellbeing frameworks • Prepares us for the changes that He Ara Oranga and the H&D review is proposing • Enriched understanding of what is available within our region • Provides as a learning opportunity to explore innovations outside of the region • Information and knowledge gained enables effective 'people at the centre' planning for the future • Enables the development of peer and whānau led initiatives • Maximises workforce development opportunities • Drive the transformation of current service provision • Contributes to building the lived experience, peer and whānau expert evidence base • The evidence base enables the lived experience, peer and whānau workforce to have a stronger position within the sector • Pay parity and reimbursement equality	• None – 'The question is no longer whether we can afford to engage consumers, but rather, what is the growing cost of continuing to avoid consumer engagement in our health care system' • It will cost money to do this project

Not Using and Not Doing

Advantages (Benefits & Rewards)	Challenges / Disadvantages (Cost & Risk)
• Cost saving of $15,000.00 - $25,000.00 and time saving in the short term	See above: Pg.6 Risks the region is exposed to if the project does not proceed

Assumptions	The following assumptions have been made: • That the regional framework will transform current service delivery, drive and inform new initiatives across the sector. • That the project will result in an increase of lived experienced, peer and whānau expert roles in the Te Manawa Taki region • That further funding is available to develop the lived experience, peer and whānau provision of service • That providers will share information needed for the project (i.e. innovations, stocktake of relevant FTE and allocated funding) • That providers approve the site visits and interviews • That providers and staff will make themselves available for site visits and interviews
Constraints	No constraints identified
Communication Plan	The project Communication Plan includes: • Draft project scope will be consulted with each of the relevant regional networks and approved by Clinical Governance • Monthly project reports will be circulated to each regional network • Midland MH&A website will be fully utilised www.midlandmentalhealthnetwork.co.nz • Midland MH&A Newsletters will have project progress reports • Final report will be published once signed by Clinical Governance
Sign-off (signatures required	

Project Consultant	Date
Project Sponsor: Eseta Nonu-Reid	Date
Clinical Governance Chair: Dr Sharat Shetty	Date
GMs Māori Health Lead: Phyllis Tangitu	Date

Appendix C: Site Visit Questionnaire

Site Visit Pro-Forma Report Template

Service Profile of Site Visited

Name of report team writers (people who visited)	
Name/ address of service:	
Date visited site:	
How many lived experience/peer/whānau roles/FTE do you have?	

Management and Governance

How has your service incorporated peer and whānau experience in its management and governance structures?
Please share your service framework that helps engage whānau and peers in service delivery at all levels?

Lived Experience Participation

Lived experience participation (both formal and informal participation) has been increased in the service delivery in the following ways: •

Workforce Development

Training and education is provided for lived experience peer and whānau roles in the following ways: •

Mentoring and support is provided for lived experience peer and whānau roles in the following ways:

-

Kaupapa Māori

Kaupapa Māori lived experience and whānau roles are incorporated in the service in the following ways:

-

Iwi, hapu and whānau are linked with the service in the following ways:

-

Innovations that have Transformed Service Delivery

Service delivery has been transformed by the following learnings and innovations:

-

Visitor Reflection and Comment for the Project

Appendix D: Lived & Whānau Experience Consultation Document

Mental Health & Addiction Wellbeing Regional Network

Manaakitanga • Kotahitanga • Whakawhanaungatanga • Rangatiratanga

Te Manawa Taki Lived and Whānau Strategy Framework

"Lived experience and whānau led roles are experts in the field"[47]

In this project to develop the lived experience and whānau led strategy, nine clear themes emerged from the literature, stocktakes, and site visits. These themes were considered key to successful, sustainable lived experience and whānau led roles in Te Manawa Taki. (see Figure 1) They include:

10. <u>Lived Experience and Whānau Experience Valued and Recognised</u>

Genuinely value the lived experience and whānau experience as experts 'seated at the table' informing every level of the mental health and addiction continuum including governance and operations. The exemplar services have demonstrated the benefits to health outcomes when the lived experience is central and a significant component of the service. Added value and efficiencies due to lived experience were apparent at points of contact.

11. <u>Connected</u>

Ensure those in lived experience and whānau roles are connected smoothly as critical components of service planning, design, delivery, and evaluation. Health needs are part of a broader hierarchy of needs impacted by social determinants. Therefore, services and roles benefit from connection across sector including health and social agencies, to support meeting the needs of people and their whānau.

12. <u>Culturally Competent</u>

Ensure all lived experience and whānau roles develop cultural literacy[48] to engage and respond to others in culturally more appropriate and competent ways. Cultural literacy and competence is required at a governance level right through to operations for those who walk alongside whānau in services.

13. <u>Without Bias and Discrimination</u>

Actively engage those with lived and whānau experience without bias and discrimination. Services must identify the bias and discrimination that exists and actively take measures to increase awareness and change behaviours, systems, and processes to minimise any potential impacts.

[47] Te Manawa Taki Project scope document 2021

[48] Ability to understand the history and traditions of a group of people from any given culture. Being able to engage with these traditions' activities in cultural spaces. Culture is how a group of people live which includes their language, arts, science, beliefs and practice and their understanding of their environment.

14. Resourced and Supported

Resource and support lived experience and whānau roles to function effectively and sustainably in services. While in some services those accessing services progress to support others as part of their own recovery, recognition, and establishment of paid resourced and supported roles are required for the service delivery to be sustained.

15. Trained

Lived experience and whānau roles require the appropriate fit for purpose professional development and education to be successful in services. This may require investment in the recognised Level 4 Certificate. Culturally specific training should be accessed for services delivered to Māori.

16. Access to Role Models, Supervision, Mentors

Lived experience and whānau roles require access to coaching, mentoring and supervision. This is a non-negotiable requirement to ensure they maintain their personal wellbeing and achieve professionally.

17. Governance

Engage lived experience and whānau at the governance level to ensure the voice of lived experience and whānau experience informs strategy and decision-making. Ensure there is also an increased presence of Māori at the governance level, particularly when Māori are over-represented in health need.

18. Leadership

Lived experience and whānau roles must be visible in leadership at every level, guiding, directing, and shaping the way services are planned, developed, implemented, and evaluated.

Recommendations:

4. This Te Manawa Taki lived experience and whānau led strategy is approved by the regional Ngā Kōpara o te Rito (Lived and Whānau Experience), Te Huinga o Ngā Pou Hauora (Māori), He Kāwai Herenga (Strategic Leadership) and Clinical Governance Advisory.

5. This strategy is presented to regional GMs Māori, GMs Strategy and Funding and Chief Executives for approval

6. An action plan is developed for the implementation of the Te Manawa Taki Lived Experience and Whānau Led Strategy, with the following actions:

    6.1 There is visible commitment and allocated investment to implement this framework for lived experience and whānau led roles in Te Manawa Taki mental health and addiction services at governance and operational levels.

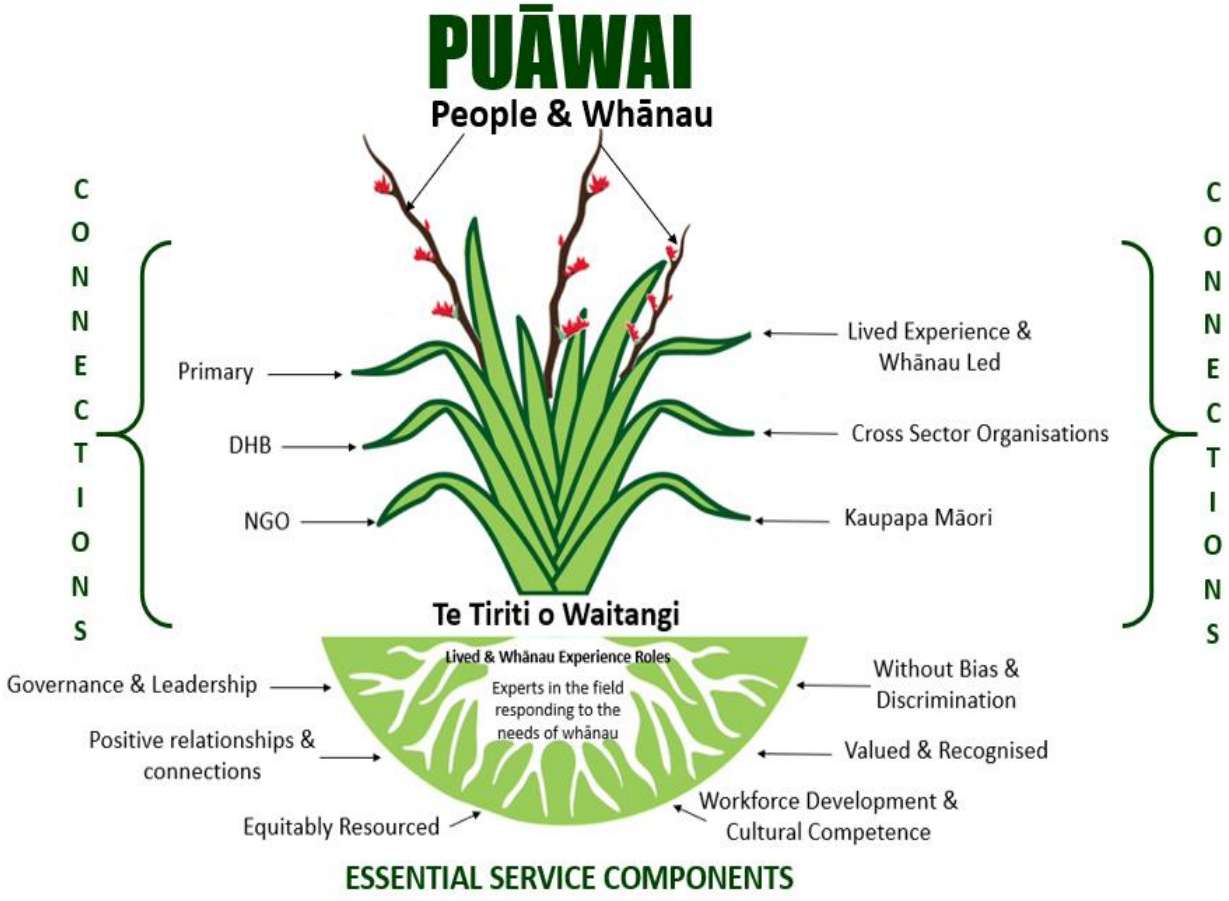
    6.2 Kaupapa Māori services' integrated clinical and cultural approaches and models of care informed by lived and whānau experience are promoted.

6.3 A professional career pathway (including training programmes, coaching and supervision) for lived experience and whānau led roles is developed and supported.

6.4 Networks for lived experience and whānau roles are strengthened.

Figure 1: Shows the components in the framework that will achieve flourishing Lived experience and Whānau experience roles and services.

Figure 1: Te Manawa Taki Peer & Whānau Led Framework



Appendix E: Lived & Whānau Experience Consultation Feedback

Feedback to Lived & Whānau Experience Strategy Consultation

Waikato

- Thanks for the document. I feel the have pretty much got the korero which was discussed at the hui in Rotorua. Its imprerative when working alongside whānau with Mental Health we look at the whānau as a whole whether its the child or a parent.

- To have a Social Worker walk alongside them during the process guiding the whānau to resources and other supports within the community.

- Kia Ora Ann well I have read the Te Manawa Taki scope document 2021. I concur to this document as it does reflect 9 areas in which our lived experience as Māori are faced with every day, my question at this point is, where to from here, it will be interesting to hear or see the outcome of this document. My humble gratitude to all those who took part in creating this document and team that presented this kaupapa through the country.

- After reading the full document and reflecting on my voice and the voices of my fellow colleagues of whom we all have lived/whānau experience I/we endorse the document as a true reflection of my voice/our voices. More in particular the voices of whānau of children/young people. I/we endorse lived experience and whānau lived experience are learned knowledge, skills, understanding, cultural competencies that cannot be learned from any textbook and will be a significant systemic component to future shaping of the current mental health system/work force to Mental Health well-being.

Taranaki

- This looks great, I support this all the way! I'd love for us to have some peer support roles in our service in future.
- This is such a beautiful model with solid principles. I do hope it is adopted by all DHB's and Māori Health Services in the future and the document isn't just filed.
- Congratulations Sarah and team - ultra nga mihi.
- Have read the attached strategy document, am happy with what's in it. Keep me posted how this is received at our DHB, I would be interested to hear.
- At the risk of being repetitive (because I've said this before in the past) the families that I work with strongly identify as people with lived experience. So the language is confusing to them. I understand "Lived and Whānau Experience" but many people who do not work in the MH&A system do not. I frequently have to explain DHB jargon to families. It's disappointing to have to do so in regard to a document which is actually about them. It may be a small point, but one worth making.

- I do find it a little disheartening that this project is still at this very early developmental stage and at this point, given the passage of time since He Ara Oranga recommendations were released, we are still talking about basic standards for engaging people and their whānau with lived experience as service leaders.
- Sorry, I don't mean to be a party-pooper. This is just frustrating. But it is good to see the work progressing and the main body of the document looks good.
- Thanks for being a trooper.

Bay of Plenty

1. I am unsure if/how this informs me for my job as a FL trustee.
2. Regarding Section 9 (governance) - you know how hard we have tried to obtain Māori input to our governance table and processes, and I am not sure what else we can do .....
3. Good luck with dealing with it .....

To explain:

We have had three Māori trustees over the last five years, but they don't stick around for some reason. They are well accepted, included, and haven't complained at all, just don't seem to want to be there for the long haul

Here is the feedback from our meeting this morning about the Strategy Framework, all the feedback directly relates to the graphic at the bottom:

- The arrows at the top pointing down from words *People* and *Whānau* gives the impression that it's people services on one side (with primary, DHB & NGO) and whānau services on the other (with lived experience, cross-sector & kaupapa Māori)
- Clarify what is meant by primary, is that PHO? Or use primary and secondary, rather than primary and DHB
- We understand the acronyms but will everyone? Acronyms exclude people from the system
- Suggest having an appendix to expand on what is meant with terms such as: primary, cross-sector etc
- Puāwai: have an explanation for the kupu, provide some context on what the word means and why they used it.
- At first found the graphic slightly confusing but if a little bit more explanation and context is added it will be good.

Lakes

- Can't see anything to change or add
- Themes and recommendations all look good
- In the harakeke roots "experts in the field responding to needs of whānau" suggested a change to "responding to the needs of service users, consumers and whānau"
- Talked about the languaging and the importance of moving away from old terms such as consumer

Ngā Kōpara o te Rito

Bay of Plenty sent to 69 people and trustees only received one reply – will redistribute and send through feedback by due date. Shared with peer group, no negative feedback, sent it wider but no further feedback received

Waikato – Due to Covid every is working away from the office, team has struggled to get right contact details of family members – still awaiting feedback and will submit by due date

Tairāwhiti – sent to peer coordinators via their managers, received not feedback as yet. Again the consultation came about a day before lockdown. Sent to wānanga attendees with outline of purpose of email and asked the question "Do you feel this strategy still reflect the voices from wānanga?" – received comments:

- Ae, the info of the whānau is still relevant for strategic work frame be a question being asked and explored. Our hauora world is evolving based on TKNT & Te Waharoa operations as our service is continuing to agitate whānau to better outcomes
- This is a great document that continues to represent whānau voice and aspiration of inclusiveness to lead the way
- Yes, very good
- That was a while ago – is it still relevant today?

Taranaki – sent out to in her district, there is support from Taranaki for peer and lived experience workforce. Will redistribute and provide feedback by due date

Lakes – sent to 20 people, with an addition two to distribute to. Received one response.

Distributed the consultation document to Caro Swanson & Rhonda Robertson who are keen to do a webinar with us re project

- Add to the agenda for to identify who from this group should represent this document re webinar. Start to put it out there reminding people we did a wānanga for peer and whānau (this is the first action to realise the moemoea from wānanga)

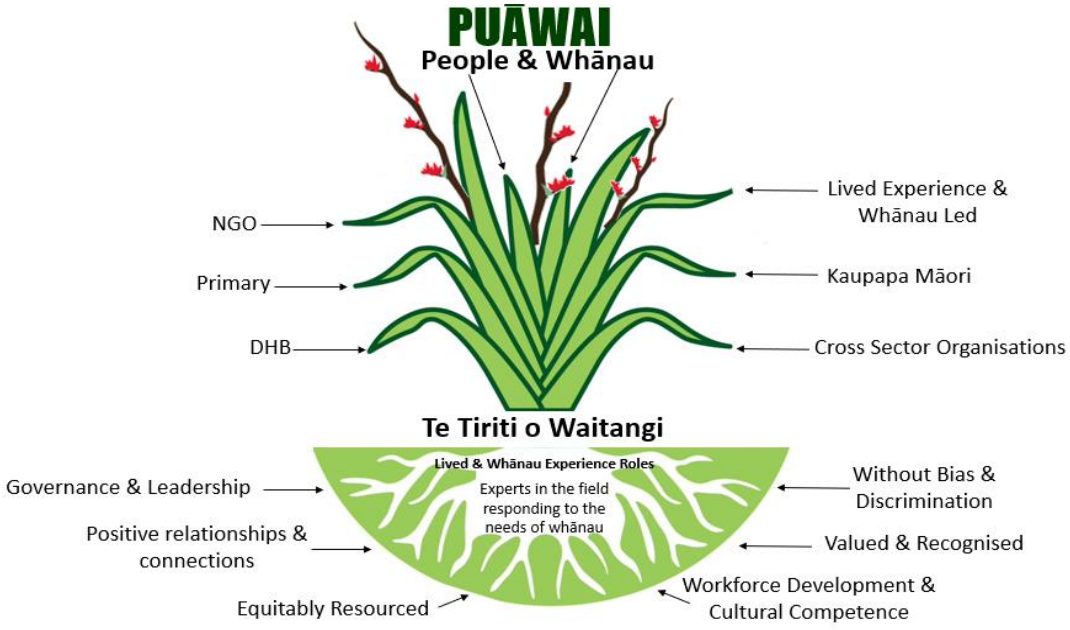
Harakeke will be updated to be more prominent and inside roots represent new beginnings is where we see lived experience and whānau sitting

Te Huinga o Nga Pou Hauora

- Whānau can see their voices are reflected in the next steps of the document
- Great document that continues to represent the whānau voice to lead the way

He Kawai Herenga

- Overall a great document
- Harakeke needs to align with Tikanga Māori therefore need to rejig framework for alignment



Appendix F: Glossary

Abbreviation	
DHB	District Health Board
NGO	Non-Government Organisation
PHO	Primary Health Organisation

Te Reo Māori Term	English Terminology
Atua	Supernatural being, an ancestor with continuing influence, deity, ghost, object of superstitious regard. Many Māori trace their ancestry from *atua* in their *whakapapa* and they are regarded as ancestors with influence over particular domains. These *atua* also were a way of rationalising and perceiving the world. Normally invisible, *atua* may have visible representations.
Cross-sectorial	Across more than on government agency e.g. Health, Corrections, Oranga Tamariki etc
Harakeke	Flax plant
Ira Atua	Supernatural element, immortality
Ira Tangata	Human element, mortality
Kaimahi	Worker, staff
Karakia	Ritual (e.g. chant, prayer) to facilitate safe transition between spaces
Kaupapa	Strategy, philosophy
Kaumātua	Elder (not gender specific)
Kaupapa Maori	Maori approach, principles and ideology
Kawa	Protocol eg. the procedures of the marae and *wharenui*, those related to formal activities such as *pōhiri*, speeches and *mihimihi*
Manaakitanga	Hospitality, kindness, blessing
Mana Motuhake	Autonomy – providing choice for whānau as determined by whānau and is accessible for ALL whānau regardless of circumstances
Matakite	Prophetic, visionary, predictive, prophetical
Mihi	To greet, pay tribute and acknowledge
Mo te Katoa	For everyone
Pāharakeke	Flax bush, generations – sometimes used as a metaphor to represent the whānau and the gene pools inherited by children from their two parents and the passing of attributes down the generations.
Puāwai	To blossom, come to fruition – for this document it depicts whānau flourishing and being the driver in their journey surround by services that will assist in the journey
Pūrākau	Myth and ancient stories
Tangata	People
Tane	Male

Te Reo Māori Term	English Terminology
Te Whare Tapa Wha	Te whare tapa whā is **a model of the 4 dimensions of wellbeing developed by Sir Mason Durie in 1984** to provide a Māori perspective on health. The 4 dimensions are: taha tinana (physical wellbeing) taha hinengaro (mental wellbeing) ... taha whānau (family wellbeing).
Tikanga	Customary practice and procedures that uphold whānau need and cultural expectation in the circumstances according to Te Ao Māori
Tīpuna / Tūpuna	Ancestor; source of future generations
Wāhine	Female, women
Wairuatanga	Spirituality
Wānanga	Traditional institution of esoteric learning; Integrated shared learning process
Whakapapa	Process of intergenerational transmission; Genealogy, ancestry
Whakaora	To restore health
Whakaoti	Completion
Whakapuaki	To express and reveal
Whakarata	To pacify, make responsive, control
Whakatangi	To cause sound, cause to cry
Whānau	The term "Whānau" is used to describe family as well as people with lived experience, including whaiora, clients, peers and/or those affected by other's MHA. Whānau do not have to be blood relatives and may include friends, partners, significant others and/or blood relatives.
Whanaungatanga	Relationship, kinship, sense of family connection - a relationship through shared experiences and working together which provides people with a sense of belonging. It develops as a result of kinship rights and obligations, which also serve to strengthen each member of the kin group. It also extends to others to whom one develops a close familial, friendship or reciprocal relationship.
Whānau Ora	Whānau Ora is a major contemporary indigenous health initiative in New Zealand, driven by Māori cultural values. Its core goal is to empower communities and extended families to support families within the community context rather than individuals within an institutional context