He Ara Āwhina

Methods and measures

Phase 1 summary

May 2023

Te Hiringa Mahara
Mental Health and
Wellbeing Commission

He Ara Awhina Methods and Measures: Phase 1 summary May 2023

A report issued by Te Hiringa Mahara - Mental Health and Wellbeing Commission.

Authored by Te Hiringa Mahara.

Te Hiringa Mahara - the Mental Health and Wellbeing Commission - was set up in February 2021 and works under the Mental Health and Wellbeing Commission Act 2020. Our purpose is to contribute to better and equitable mental health and wellbeing outcomes for people in Aotearoa New Zealand.

For more information, please visit our website: www.mental healthwc.govt.nz

The mission statement in our Strategy is "Whakawāteatia e tātou he ara oranga / clearing pathways to wellbeing for all." Te Hiringa Mahara acknowledges the inequities present in how different communities in Aotearoa experience wellbeing and that we must create the space to welcome change and transformation of the systems that support mental health and wellbeing. Transforming the ways people experience wellbeing can only be realised when the voices of those poorly served communities, including Māori and people with lived experience of distress and addiction, substance harm, or gambling harm, are prioritised.

Te Hiringa Mahara - Mental Health and Wellbeing Commission (2023). **He Ara Āwhina Methods and measures: Phase 1 summary December 2022**. Wellington: New Zealand.

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We also thank those the many people that have contributed to the development of He Ara Āwhina leading up to this point, including submitters on the He Ara Āwhina conceptual framework.

Contents

Purpose

This report summarises the development of He Ara Āwhina (Pathways to support) framework phase 1 methods and measures. In this phase we looked at existing data sources to determine methods and measures to monitor performance of the mental health and addiction system at a service level. This phase was informed by specialist advice from a technical advisory network. Here we present an overview of our process to select a suite of methods and measures (shortlist) with an initial focus on services, the identified data gaps, and future expectations.

Our journey

Initial Mental Health and Wellbeing Commission deliverables

In February 2020, the Initial Mental Health and Wellbeing Commission (the Initial Commission) began developing two outcomes and monitoring frameworks:

- He Ara Oranga wellbeing outcomes framework, that describes what ideal wellbeing looks like for all people and whānau in Aotearoa New Zealand; and
- He Ara Āwhina system monitoring framework, that describes what an ideal mental health and addiction system looks like.

The He Ara Oranga wellbeing outcomes framework provides a structure for measuring performance across the whole mental health and wellbeing system. A successful outcomes framework will determine if we are making a difference in improving mental health and wellbeing, that is, achieving the outcomes set out in He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga).

The Initial Commission was also involved in the early stages of developing the He Ara Āwhina system monitoring framework. Their early development work was handed over to Te Hiringa Mahara - Mental Health and Wellbeing Commission in February 2021 to carry forward.

Alongside these frameworks, the Initial Commission made recommendations to address information gaps to monitor performance. They also set out how measuring outcomes fits within the broader performance story of the mental health and wellbeing system.

The He Ara Oranga wellbeing outcomes framework

The He Ara Oranga wellbeing outcomes framework was developed in phases:

- Co-define (hearing views on how a framework could be developed) April 2020 to May 2020

- Conceptual framework (what is important to demonstrate success) June 2020 to September 2020. In October 2020, the Initial Commission's Board adopted the conceptual framework

- Data (how success can be measured and where data gaps exist) September 2020 to January 2021.

The framework was developed in collaboration with communities, and with guidance from experts in wellbeing and mental health.

What is different about our wellbeing outcomes framework

There are many wellbeing frameworks in use. The He Ara Oranga wellbeing outcomes framework has several points of difference.

1. It is a holistic wellbeing framework with specific relevance to mental health and addiction.

2. The wellbeing outcomes apply to everyone in Aotearoa (population-level) through to tāngata whaiora (people with lived experience of mental distress and or addiction) using mental health and addiction services (service-level).

3. The wellbeing outcomes are shown through both Te Ao Māori and shared wellbeing perspectives (the dual layering). At the time of development, there were no existing framework that incorporated this duality and respected both tangata whenua and tangata Tiriti perspectives.

He Ara Oranga wellbeing outcomes framework data phase

Following the design of the conceptual outcomes, the He Ara Oranga wellbeing outcomes framework **data phase** began in September 2020. This work looked at existing data sources to develop draft indicators and measures[1] to monitor and measure performance across the whole mental health and wellbeing system.

This phase was informed by specialist advice from two Technical Advisory Groups (TAGs) – one focused on mental health and addiction service-level data and the other on population-level data. These groups supported the Initial Commission to complete a stocktake of all data sources linked to the wellbeing outcomes in the He Ara Oranga framework.

After the stocktake, the Initial Commission identified possible population-level indicators and measures for tāngata whaiora. The data were compared against the wellbeing outcomes in the framework.

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[1] Our use of the terms indicators and measures is intentional given the application of this outcomes framework to both a population-level **and** mental health and addiction service-level. Data sources, scale, and to whom the data applies differs for indicators and measures. See our common language in Appendix 2 for more information.

These data sources were assessed against criteria agreed upon by the TAGs to decide which indicators and measures could be shortlisted. Information gaps were also identified. In February 2021, the Initial Commission Board approved the advice to Te Hiringa Mahara and the Minister of Health about identified data gaps and implementation.

To learn more about the Initial Commission's data phase, download the full report.

The work completed by the Initial Commission resulted in a shortlist of population indicators, and recommendations on the next stage of work to determine the 'vital few' indicators (based on existing data). Shortlisting mental health and addiction service-level outcome measures was more challenging and required He Ara Āwhina to be developed before it could be advanced.

Following the adoption of advice from the Initial Commission, Te Hiringa Mahara determined the final suite of population indicators to be used in their first wellbeing report, Te Rau Tira Wellbeing Outcomes Report 2021, released on 8 December 2021.

The He Ara Āwhina system monitoring framework

He Ara Āwhina is a separate but interconnected framework that will be used to assess, monitor, and advocate for improvements to the mental health and addiction system in Aotearoa, including services. He Ara Āwhina will measure and monitor the contribution of mental health services and addiction services to wellbeing outcomes and provide a credible platform for Te Hiringa Mahara to advocate for improvement to those services.

The figure below shows how the two frameworks are intended to work together to monitor performance.
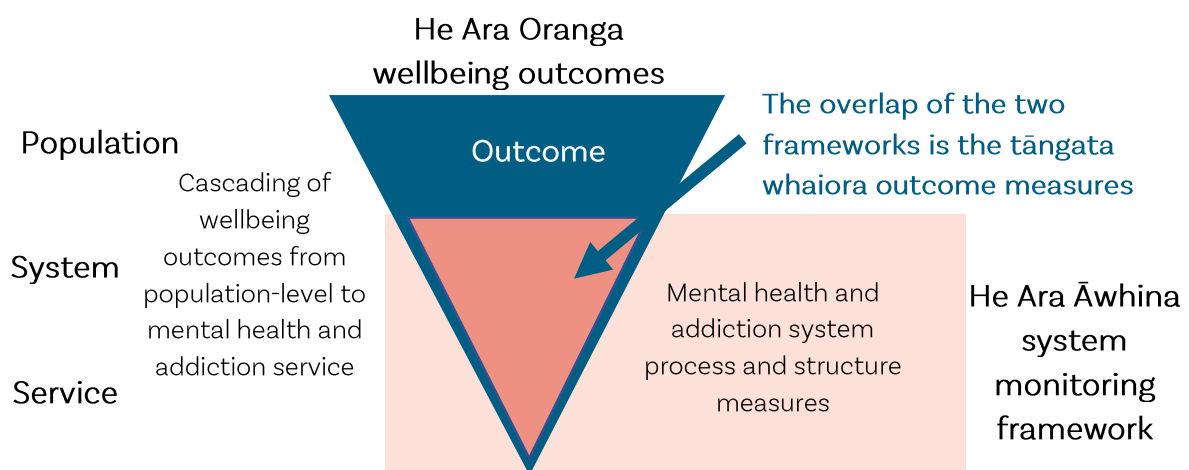
As the two frameworks have been developed sequentially rather than simultaneously, it has been important to ensure the two frameworks have a 'line of sight' between them. Continuity and overlap between the expert advisory groups and technical advisory groups for the two frameworks has been a way to ensure consistency in the

strategic and technical advice. The different roles of these two groups are outlined later in this report.

Phases of work on He Ara Āwhina

Work on He Ara Āwhina began with the Initial Commission in October 2020.

Co-define phase October 2020 – February 2021

The Initial Commission sought feedback on why we should monitor mental health services and addiction services, what we should include in our monitoring approach, and how we should go about our monitoring work.

People told us:

- **Support starts and continues with people and communities, not services.** The former Mental Health Commissioner's framework was viewed as being too narrow but was something that could be refined and built upon.

- **The voices of Māori and tāngata whaiora are crucial** in assessing whether services, and approaches to wellbeing, are meeting the needs of people and communities.

- **There needs to be a shared view of what 'good' or transformative services and supports look like** so we can monitor and assess performance and contribute to wellbeing outcomes.

Co-development phase March 2021 to June 2022

An expert advisory group (EAG) was established for He Ara Āwhina (including some members from the He Ara Oranga EAG) and began its work in September 2021, sharing expertise and perspectives to develop the framework. The EAG included a Māori EAG roopū which has supported the development of Te Ao Māori perspective for He Ara Āwhina.

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

The draft version of He Ara Āwhina went out for public consultation for six weeks from 8 March to 19 April 2022. We supported many ways for people to share feedback to ensure the framework and consultation process was accessible to everyone, especially our priority population groups.

During our public consultation process, more than 260 submissions were received across all priority population groups. Overall, people told us that He Ara Āwhina resonated with them and they liked the first-person narrative, structure, and concepts. The feedback guided us to strengthen and clarify content that was important to people.

Through a dedicated Māori engagement team, we gathered vital input from Māori, including tāngata whaiora, whānau, and kaupapa Māori supports and services. This feedback has supported He Ara Āwhina and identified concepts to be strengthened or included across both perspectives.

What people told us, and the changes made in response, are summarised in our consultation documents.

The final version of He Ara Āwhina was published 30 June 2022.

Te Hiringa Mahara released Te Huringa: Change and Transformation. Mental Health Service and Addiction Service Monitoring Report 2022 in March 2022. Te Huringa was a transitional monitoring report that used an adapted version of the former Mental Health Commissioner's framework, while we developed He Ara Āwhina as our framework for monitoring from March 2023.

Following the publication of He Ara Āwhina, a project was set up to identify a suite of methods and measures that will over time replace those used in Te Huringa. Some of the data needed to monitor under He Ara Āwhina will be available for monitoring from March 2023.

The suite of methods and measures for 2023 monitoring is the subject matter of this report.

Methods and measures development

Scope and phasing

The He Ara Āwhina system monitoring framework has a broad scope covering services and the wider system, including services funded outside of Vote Health.

The approach to the development of both of our monitoring frameworks has been from 'ends' to 'means' rather than 'means' to 'ends'. This means that the system aspirations people have described drive the long-term goals for monitoring, rather than currently available information.

However, this means that only some of the data[2] needed are available for our monitoring from March 2023. Other methods and measures need a longer timeframe for development as the data is not readily available nationally, is not consistent or does not exist.

We have taken a phased approach to the work. Also, to achieve the required timing for data requests for our 2023 monitoring, we narrowed the scope of Phase 1 of this work programme to a suite of methods and measures focused on services.

The development phases are:

- Phase 1 – service-level measures, including tāngata whaiora outcome measures, using data available within our timeframe for 2023 monitoring.
    - Data availability will be a significant filter
    - While our focus will be on service-level, we expect some system-level measures to be confirmed during the Phase one process.
- Phase 2 – service and broader system measures, including tāngata whaiora outcome measures.
    - Broader focus
    - Continued development of service measures
- Phase 3 – completion of priority methods and measures that require a longer timeframe due to data gaps, engagement, and / or alignment needs.

Tāngata whaiora outcome measures

The Initial Commission began but did not complete the development of service-level outcome measures for the He Ara Oranga wellbeing outcome framework as He Ara Āwhina needed to be developed further.

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[2] Data includes all methods and measures, quantitative and qualitative.

The tāngata whaiora outcome measures are mutual to both the He Ara Āwhina and He Ara Oranga frameworks. Hence, it is timely to continue this component of work, for both He Ara Oranga and He Ara Āwhina, alongside the broader suite of measures for He Ara Āwhina and include them in the Phase 1 scope as part of this project.

Phase 1 deliverables

The key deliverables for this phase are:

a. a suite of methods and measures ('Shortlist') to be developed by mid-November 2022 (the latest time for data requests) to enable monitoring and reporting from March 2023.

b. a report summarising phase 1 of the development, the current shortlist, advice for Phases 2 and 3, and the Technical advisory network's views on how the mental health and addiction system could prioritise and address the data gaps (this document).

Technical advisory network

The sheer breadth of He Ara Āwhina created challenges in terms of the range of data expertise needed to guide our work and resulting large size of the potential group. We also needed to ensure continuity through an overlap of membership from our EAG and the He Ara Oranga framework TAGs. Given targeted expertise was necessary at times, we also respected members' time and felt long meetings with all members was not the optimum use of their time. To address the predicted problems a technical advisory network (TAN) was established to enable a more extensive range of experts to come together as a formal network for our work, but operating in a more agile manner that was less time consuming for them.

The technical advisory network, chaired by Sharon Shea, was established to:

a. provide advice and expertise on methods, measures, data sources and data gaps

b. support the development of a Te Ao Māori perspective alongside a shared perspective

c. provide a network to connect with to sense-check some of the data for the 2023 monitoring reporting.

The TAN comprised 24 members with wide expertise. We will add members as needed for new areas of expertise in future phases.

Te Hiringa Mahara is committed to being an organisation grounded in Te Tiriti o Waitangi. This means acting as authentic partners with tangata whenua through all aspects of our work. Our TAN approach enables a Māori roopū from within the TAN to meet and develop the methods and measures for the Te Ao Māori perspective. This

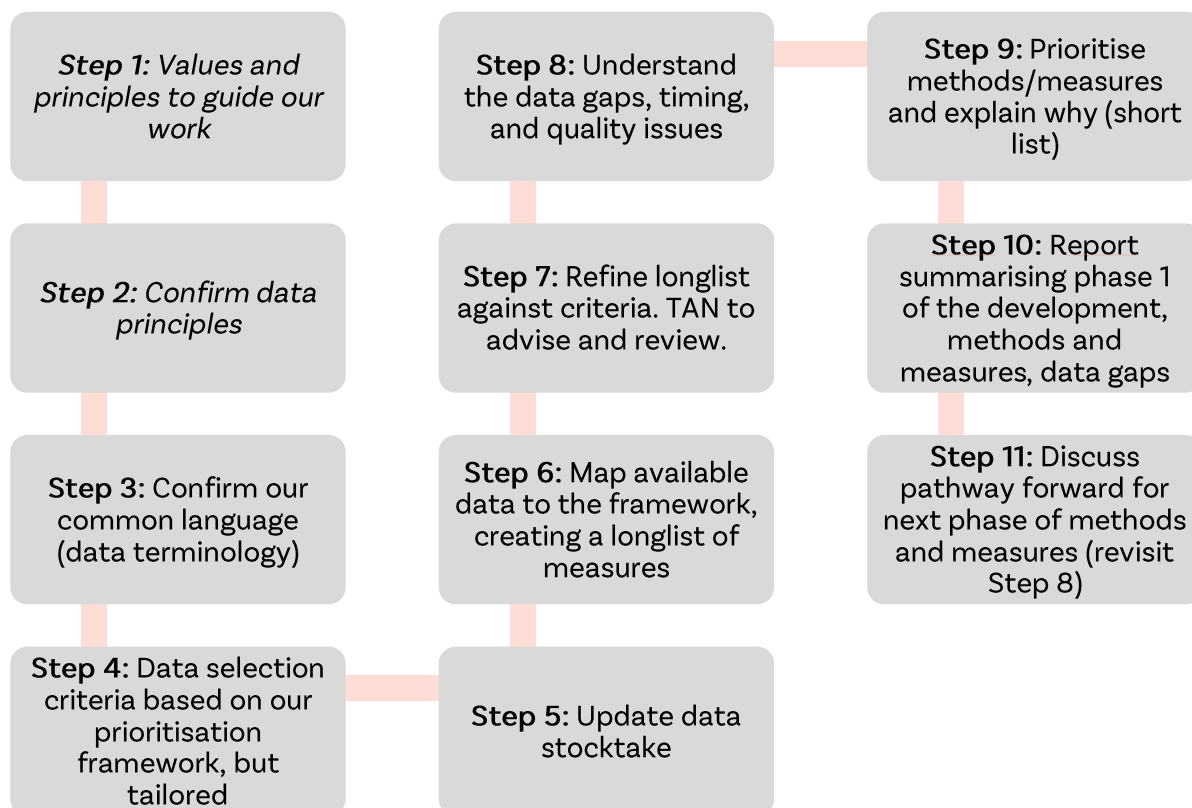mana motuhake, self determination process, allows Māori to lead the development of a system to monitor desirable oranga (wellbeing) outcomes for Māori.

Te Hiringa Mahara is also committed to prioritising the voices and interests of people who experience mental distress, substance harm, gambling harm or addiction. The TAN approach enables a lived experience group to meet and focus on what's important for people with lived experience.

Phase 1 shortlist process

Overarching approach

A stepped[3] approach was used to develop the data suite for Phase 1 of He Ara Āwhina methods and measures. These steps are fully explained in Appendix 1.

Step 1: Values and principles to guide our work	**Step 8:** Understand the data gaps, timing, and quality issues	**Step 9:** Prioritise methods/measures and explain why (short list)
Step 2: Confirm data principles	**Step 7:** Refine longlist against criteria. TAN to advise and review.	**Step 10:** Report summarising phase 1 of the development, methods and measures, data gaps
Step 3: Confirm our common language (data terminology)	**Step 6:** Map available data to the framework, creating a longlist of measures	**Step 11:** Discuss pathway forward for next phase of methods and measures (revisit Step 8)
Step 4: Data selection criteria based on our prioritisation framework, but tailored	**Step 5:** Update data stocktake	

What we have now

Longlist

The result of this process is that we have a rich measures library of information – a living file (including secondary qualitative sources) for future reporting purposes. As of December 2022, there are 951 measures in the 'longlist' (118 qualitative and 833 quantitative), including 58 possible tāngata whaiora outcome measures aligned to He Ara Āwhina and a further 51 aligned to He Ara Oranga, from over 170 data sources.

Shortlist

Through applying the prioritisation and evaluation criteria there are now 133 unique shortlisted measures from over 30 data sources. These are shown in Appendix 4. Note that the 133 includes all Te Huringa and Access and Choice programme measures previously reported by Te Hiringa Mahara for continuity. (Note that 20 of

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[3] Steps 1 and 2 shown in italics were pre-determined by Te Hiringa Mahara rather than agreed by the TAN.

these measures are in the shortlist because they have been reported in Access and Choice 2022 or will be reported for continuity purposes in Te Huringa Tuarua 2023.)

Across all the domains we have 202 measures as many measures have been mapped to more than one domain outcome.

Understanding the data gaps

Our understanding of the data gaps is a work in progress given that we have focused on only some of He Ara Āwhina system aspirations for Phase 1. As we worked our way through assessing the data sources and potential measures, we have identified data gaps and work needed. Much of this is consistent with what we found during the He Ara Oranga wellbeing outcomes framework data phase.

Te Ao Māori data

Across the indicators and measures there are significantly fewer potential data sources for Te Ao Māori outcomes. While we can 'slice' measures in the 'shared perspective layer' for Māori using the ethnicity data field, this does not tell us enough from a Te Ao Māori perspective of services or wellbeing.

The lack of Te Ao Māori data is a concern given persistent inequities in the prevalence of mental health conditions, addiction, and treatment for Māori and the place of Māori as tangata whenua (partners with the Crown).

Māori data refers to data produced by Māori or data that is about Māori and the environments with which Māori have relationships (Te Mana Raraunga, nd). There is a difference between measuring the wellbeing of Māori (as a population) and measuring Māori wellbeing through a Māori values approach. While there is an abundance of research in the former space, there is far less in the latter (Independent Māori Statutory Board, 2019).

There are major structural challenges to measuring and monitoring Māori wellbeing. Many of the agencies and organisations that collect, or steward Māori data lack the capability or capacity to apply a Te Ao Māori lens to their data collection or analysis. More fundamentally, they do not have active Māori data governance mechanisms and, thus, lack a transparent mechanism for Māori influence.

Overall, this is a significant barrier and risk for Te Hiringa Mahara; it is also an issue that affects multiple government agencies. Te Hiringa Mahara can champion better data collection for Māori and play a key leadership role moving forward. This is, in our view, a significant opportunity.

Whānau-level data

Consistent with the lack of Te Ao Māori data overall, whānau-level data is rare at the mental health and addiction service level for measures. The New Zealand household is frequently adopted as a unit of measurement, and there is virtually no quantitative data available about whānau (particularly, as defined by tangata whaiora or ethnic groups). In the absence of whānau-level data, evidence based on New Zealand households and families is used to inform strategy development, planning, priority-

setting, decision-making, policy, and delivery. While there is data available on Māori families at the household level, this does not provide data about 'whānau', as 'family' and 'whānau' are not interchangeable (Social Policy Evaluation and Research Unit, 2014).

Priority groups

Our data evaluation criteria applied to the potential measures consider whether they can monitor services for priority groups of people. There are gaps in terms of our ability to monitor services across many of the priority groups as either identifying data is not collected, or priority group specific data is collected in a limited and ad hoc manner. Demographic information such as ethnicity, gender, and age are the only reliable, routinely collected identifiers.

Alcohol and other drugs (AOD)

Few AOD specific measures have been identified through our shortlisting process. Once we are working with the Phase 1 measure data we will look to disaggregate, where possible, AOD specific services for monitoring purposes. The result of this process will help identify priorities for our Phase 2 work.

Outcome measures - service level data sources limited and narrow in scope

There are significantly more population-level data sources suitable for measuring wellbeing outcomes than mental health and addiction service-level data sources. In addition, the mental health and addiction service measures mainly focus on specialist services. They are fit for the purpose they were developed and intended but less suitable for monitoring wellbeing outcomes. Also, many mental health and addiction service level tools are clinically oriented assessment or screening tools, and some are adapted for individual needs.

While mental health and addiction service level tools such as the Alcohol and Drug Outcome Measure (ADOM) or Health of the Nation Outcome Scales (HoNOS) are intended to measure outcomes this is reliant, like many other tools, on their use in accordance with their guidelines. For example, if data is only collected when a person enters a service and not collected at subsequent intervals, we cannot determine their change in wellbeing and, therefore, the outcome. Also, not all potential data is available in national collections.

Our TAN lived experience group advised that HoNOS outcome measures should not be shortlisted and consequently these have not been included in our 2023 measures.

Timeliness

There are two key issues related to timeliness across the potential data sources – timeliness of collection and timeliness of access.

Collection - very useful data is captured on an infrequent basis (e.g., Te Kupenga). Some indicators and measures rate highly against our criteria but are collected too infrequently which limits their value for a monitoring framework.

Access - while some data is collected frequently, access is a challenge. Data may not be stored nationally, or there is a significant delay before it is available for national use and considered to have adequate data quality, or it is not an easy process to request the data from the national source. Now, in any given year, data may be six to 12 months old before it is complete, able to be analysed, and considered accurate.

We acknowledge that online tools to access nationally stored data are growing in availability across government agencies, which could significantly improve access.

Primary care

Primary care mental health and addiction service and wellbeing outcome data is a gap at this point, although we expect to see data improvements over the next two years. As Te Whatu Ora continues to invest significant amounts to deliver mental health and addiction services such as IPMHAS in primary and community settings, it is important that suitable process, structure and outcome measures that enable measurement across the priority groups are in place, and data is collected and accessible in a timely manner. See our Access and Choice Programme: Report on the first three years for further information.

Tāngata whaiora and whānau feedback

There is a clear measurement gap with how supports and services engage with, and incorporate tāngata whaiora and whānau feedback, as well as clinical evidence, and innovation. Related to this, we don't have visibility of the processes in place to restore relationships when harm occurs and how the lessons from such events are incorporated into practice.

Outcome concept gaps

Our work so far has highlighted the following measurement gaps that we need to revisit in Phase 2:

- There are many measurement gaps relevant to Te Ao Māori perspective, particularly (but not only) relating to Mana Whānau / Whanaungatanga.
- Participation & leadership - tāngata whaiora and whānau lead and co-produce policies, supports and services, responses, models of care, research, and training.

- Connected care - effective connections between mental health services, addiction services and physical healthcare help us stay physically well.
- Effectiveness - our strengths and recovery stories are recognised and celebrated.
- Equity - we benefit from timely mental health, alcohol, gambling, and drug law reform that puts human rights, wellbeing and equity at the heart.

Health promotion and prevention

He Ara Āwhina contains outcome statements relating to health promotion and prevention. This is an aspect of health service delivery and is within scope for Phase 1 of methods and measures. Health promotion also has a line of sight to the population indicators in He Ara Oranga. However, measures in this space are limited both in New Zealand and internationally.

We have looked more closely at potential measures in our longlist however none of the suggested measures have been fully developed. This means the data is not available, is one off, not nationally consistent, or requires assembling from several sources. This will need to be a development focus in Phase 2.

An example of this is access to Māori mama pēpi parenting programmes (Tūpuna parenting). There are a few great programmes around, but they are typically small and not widely available.

Implementation and future expectations

The purpose of this section is to outline a range of opportunities identified by our external advisors to address data gaps and about how to implement the framework. It reflects the combined commitment of the advisory groups to support the role of Te Hiringa Mahara and desire to implement the frameworks in a sustainable and effective way.

Whānau and tāngata whaiora are their own agents of change

The advisory groups agreed that agency and strengths of people must be recognised as part of this work. This means that while providers have a positive role to play, supporting people to achieve their self-determined outcomes, people are leaders and experts in their own health and wellbeing. Providers should not detract from, reduce, or override agency. More discussion is required about respecting whānau agency and provider roles.

Courage and commitment to "hold the kaupapa line"

New Zealand's public sector and health system is acknowledged as having great intent with poor implementation (Health and Disability System Review, 2020). Some of the existing measures would be more useful with better implementation and / or adherence to guidelines. Implementation (and ongoing utility) of new frameworks, tools, or measures is usually challenging. We can develop the best framework possible but if implementation isn't accurate, widespread, or accepted by users, data quality issues will remain.

Working within complex systems, it is often hard work to bring multiple partners together, over a sustained period to implement an outcome-focused approach and to 'flip the script.' He Ara Oranga advised that "investing in change itself is important. The speed and consistency of uptake of innovation or change is greatly improved by having implementation support" (Paterson et al, 2018, p.119). We encourage Te Hiringa Mahara to maintain its māia (courage and commitment) to shift the system from transactional to outcomes-focused within the kaupapa of Wellbeing.

It's about agile change management - within the kaupapa

Agility is the ability to assess, reassess, move, and adapt based on evidence and reliable advice. It also means that a 'speed bump' is a learning experience, not a reason for wholesale change or an absolute failure per se. Change management is about partnering with others to effect multiple means to make a change that is jointly agreed is important.

Learning, adapting, and partnering are all great change management techniques and will be important in the future to "hold the kaupapa line". The TAN Chair suggests that the outcome framework is much more than outcomes; it is a guide which enables Te Hiringa Mahara to shift the way the whole system can work better for whānau and tāngata whaiora.

Understand and support clear accountability

Implementation requires clarity about who is accountable for what, at multiple levels, e.g., from population to system and services. It also requires clarity about shared accountability versus sole. In this regard, it is suggested that if systems are to change for the better, accountability must be shared across multiple partners for population and system level outcomes. In addition, 'sole' accountability must also be clarified. This complementary type of accountability supports high-performing providers, agencies, and, indeed, Te Hiringa Mahara, holding accountability to deliver outcomes or results linked to its role, scope, and function. Robust accountability mechanisms will include clarity about levers to influence success.

This is especially important while the health reforms are implemented as functions and people have moved from one entity to another, and there is a lack of clarity at this point in time as to who is responsible for some functions.

An influencer not a funder

Te Hiringa Mahara is not a funder. However, it is expected to understand and comment upon mental health and wellbeing, which is strongly influenced by multiple funders' decision-making. Therefore, Te Hiringa Mahara has a role to influence and partner with many for a common good.

The advisors acknowledge the influencer role and support the ability of Te Hiringa Mahara to articulate what good looks like and measure the same. Advanced negotiation and partnering skills will be required to ensure multiple partners work together to achieve improved and equitable wellbeing.

Full application of He Ara Āwhina

It is expected that as the methods and measures phases progress, Te Hiringa Mahara will work towards all system aspirations described in He Ara Āwhina being measured in some way. This may be achieved through quantitative or qualitative methods in accordance with the Monitoring Strategy. However, we need to ensure a better balance of qualitative information and quantitative information given Phase 1 and 2023 monitoring reporting will predominantly be quantitative due to availability and timing.

Te Ao Māori perspective

The TAN Māori roopū noted that many of the shortlisted measures for 2023 monitoring have been produced by their relevant sources for some time. The TAN Māori roopū expectation of Te Hiringa Mahara is that an effective monitoring process meets Māori aspirations articulated through the foundation measures.

Data is key – but there are many gaps and opportunities

Monocultural data design, collection and use is an unacceptable barrier to progress. It is generally accepted in the public sector that a monocultural lens does not serve this country well; especially when it comes to tackling persistent and unacceptable inequities for Māori as tangata whenua and for all Aotearoa citizens. As a result of our work on the frameworks, it was obvious that, overall, data sets have been prioritised, developed, collected, and analysed from a predominantly monocultural (western) perspective. Most readily available data is not collective (such as outcomes for whānau), it does not readily reflect an equity perspective across the life course; and it reflects a monocultural view of what is important.

It is acknowledged that over the last 5 to 10 years, there has been a shift in the sector's desire to have more kaupapa Māori data, for example, and data that is specific to other ethnic groups and worldviews. However, the pace of change is slow and inconsistent.

The advisory groups are concerned about the lack of readily available, culturally informed and wellbeing-focused data in the health system and across multiple systems that influence determinants of health outcomes and wellbeing (such as health, education, Māori development, and others).

In sum, the 'quick fix' is to analyse existing data by ethnicity. It is helpful in many ways, but it is not the full solution. Considerable investment in new and regular wellbeing data sets are required (without losing the opportunity to use the best of what is currently available).

Balance of strength and deficit-based measures

While many measures are strengths-based, the TAN Māori roopū believe the inclusion of reporting on deficit-based measures such as adverse incidents for Māori in services, complaints processes, and review processes are essential. This view is supported by the earlier TAGs and our EAG.

Te Kupenga

The TAN Māori roopū agree the lack of readily available, culturally informed, and wellbeing-focused data in the health system continues to be a concern. Te Kupenga provides hope and a promise to address this, and provides a picture of the social, cultural, and economic well-being of Māori in Aotearoa, including information from a Māori cultural perspective (Stats NZ, 2020). Te Kupenga is a post-censal survey of

adults (aged 15 years and over), meaning the survey sample is selected from people who identify as having Māori ethnicity and descent on their census form, so only those who complete the census are placed to participate.

Te Kupenga provides key statistics on four areas of Māori cultural wellbeing:

- wairuatanga (spirituality)
- tikanga (Māori customs and practices)
- Te reo Māori (the Māori language)
- whanaungatanga (social connectedness).

The survey's content recognises practices and wellbeing outcomes specific to Māori culture, the knowledge and use of the Māori language, connection to marae, and whānau wellbeing. The survey also highlights health outcomes and wellbeing determinants, such as health, education, and Māori development.

The TAN Māori roopū viewed more frequent and ongoing capture of this data as essential. The last Te Kupenga survey was conducted in 2018.

Hua Oranga

Hua Oranga is an instrument for recording culturally informed and wellbeing-focused data (www.oradatabase.co.nz). It is the only Māori-specific outcomes measurement instrument based on Te Whare Tapa Whā. Hua Oranga has not been included in the shortlisted outcome measures at this point as it is regarded as a Phase 2 instrument due to a lack of national consistency and use. However, the TAN Māori roopū, particularly Professor Te Kani Kingi, with his and their expertise in Hua Oranga, advises that the readiness of Hua Oranga for inclusion should be prioritised.

Improving data quality

To improve our ability to monitor services across many of the priority groups, there needs to be a continued focus on improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections, i.e., the quality of the Programme for the Integration of Mental Health data (PRIMHD).

Data access

Enabling people to easily access their healthcare information

When consulting on He Ara Āwhina people clearly told us they wanted better access to their health information. Currently, health and wellbeing information is stored in different places, in different formats, and can be difficult to access and use effectively.

As a solution to this, Te Whatu Ora has the Hira programme in progress. Hira is intended to be the connector of people's health and wellbeing information. It will enable information to be pulled from different systems to create a single view. Te

Hiringa Mahara will continue to engage with the Hira programme. We see value in Hira also being able to drive data improvements for people (identity, accuracy etc).

Te Hiringa Mahara having timely access to data
While some data is collected frequently, access is a challenge. The Mental Health and Wellbeing Commission Act 2020 grants us statutory powers to request information. Information is critical for us to be able to perform our functions to monitor mental health and addiction services as well as to assess and report publicly on the effectiveness, efficiency, and adequacy of approaches to mental health and wellbeing – a lack of information significantly compromises our ability to fulfil our legislative functions.

We will continue working with agencies to ensure we have timely access to information to fulfil our future monitoring and reporting obligations.

Points of difference data sets can be a rich source for all
Iwi and other stakeholders, such as NGOs, are developing rich and high-quality data sets that are not yet visible to others. It makes sense to partner with others to broaden our data reach (where appropriate and agreed) to support wellbeing analysis. More work is required to explore this opportunity and some agencies are already in this space, e.g., Social Wellbeing Agency. Critical issues, such as Māori data sovereignty, will also need to be explored.

Growth of the Māori data analytics workforce is needed
Given that many agencies and organisations that collect or steward Māori data lack the capability or capacity to apply a Te Ao Māori lens to their data collection or analysis, there needs to be a focus on growing Māori data analytics capability and capacity from a Te Ao Māori perspective. This development should be identified within the comprehensive workforce strategy and roadmap Te Hiringa Mahara considers is needed to address the persistent mental health and addiction workforce shortages.

Addressing non-response bias in surveys
The TAN noted that non-response bias in surveys for people with serious mental health and addiction needs is an issue, as is the extent to which their outcomes are not adequately represented. Survey methods need to consider ways to increase survey participation for people with lived experience of mental distress and addiction.

For Māori, the pathologising of tamariki, the aversion by Māori to such a process, and the labelling of Māori are a reality. Our kōrero must be considerate of that fact.

It is vital that we have a clear picture of the nature and prevalence of mental disorder, distress, and addiction in Aotearoa

The development of an in-depth epidemiological survey (He Ara Oranga recommendation 11) will take time and resources but should be funded and prioritised within Manatū Hauora | Ministry of Health. This data will help us develop preventative approaches, and planning and organising services. Without current information, we cannot adequately assess unmet need and the extent to which resources are being directed, for the greatest effect; funders and providers cannot plan for and organise services in a way that best meets needs; and preventative approaches cannot be targeted for best effect.

Te Rau Hinengaro: The New Zealand Mental Health Survey was conducted in late 2003 and 2004, published in 2006, and remains the basis for in-depth prevalence data (Oakley Brown et al, 2006).

Whakamaua: Māori Health Action Plan 2020-2025

Whakamaua: Māori Health Action Plan 2020-2025 (Ministry of Health, 2020) is the implementation plan for He Korowai Oranga, New Zealand's Māori Health Strategy. It will help us achieve better health outcomes. The Whakamaua Research and Evaluation is underway. Whakamaua dashboard provides an update of the data collection that will be relevant to this project.

Health promotion and prevention

Health promotion and Primary prevention are critical to maintaining wellbeing. Te Hiringa Hauora | Health Promotion Agency (www.hpa.org.nz), a crown entity leads and supports activities for the following purposes:

- promoting health and wellbeing and encouraging healthy lifestyles
- preventing disease, illness, and injury
- enabling environments that support health and wellbeing and healthy lifestyles; and
- reducing personal, social, and economic harm.

Nōku te Ao has been developed from the Like Minds / Like Mine Programme that was first established in 1997 by Manatū Hauora and has thrived through the ongoing partnerships with people with lived experience of mental distress, and with Māori and with Pasifika communities. Nōku te Ao aims to increase social inclusion and reduce stigma and discrimination against people with experience of mental illness and distress.

Te Hiringa Hauora has, with the help of several partners, developed a new strategic direction for Nōku te Ao for 2021-2026. This includes a greater focus on kaupapa

Māori, and a shared objective of Te Hiringa Hauora and its partners to participate, collaborate, and work together to achieve the Nōku te Ao strategy. Te Hiringa Hauora has committed to develop reciprocal, equal relationships with all providers within Nōku te Ao, so all partners can contribute effectively toward the new strategic direction.

A number of partners have been engaged to assist Te Hiringa Hauora to give effect to the Nōku te Ao strategy:

- Social Action Grants – Mental Health Foundation
- Settings-based Education for Social Change – Te Rau Ora and Te Kete Pounamu
- Social Movement Initiative – Mental Health Foundation, Ngā Hau e Whā, and Hāpai te Hauora
- Media monitoring and awards – Mental Health Foundation
- Programme evaluation – Te Werohau, Te Whare Wananga o Awanui a Rangi
- Programme research - Te Whare Wananga o Te Awanui a Rangi; and
- Capacity building – Oi Collective http://oicollective.co.nz/mahi/

A significant number of the TAN Māori roopū, Professor Te Kani Kingi, Dr Jordan Waiti, Leilani Maraku and Suaree Borrell, have working knowledge and or lead some of the Noku te Ao Strategy initiatives. This is an opportunity for Te Hiringa Mahara to connect with partners and work together to achieve improved and equitable wellbeing.

Knowing the 'line of sight' improves the probability of success

Sustainable and effective outcome frameworks for complex systems connect the dots between population, systems and services. They attempt to understand contribution linkages – such as an agreement that if we fund and deliver these service outcomes, we are contributing to improved system level outcomes and, in turn, population level outcomes. Similar to logic model "if / then" statements, the opportunity is to continue to test and refine why and what we fund from a cascaded outcomes perspective (both from population to services and service to populations).

Next steps

Developing the methods and measures will be an iterative process – the methods and measures list will evolve over time, so it remains relevant and current.

Phase 1

Te Huringa Tuarua 2023 – Mental health and addiction services monitoring report

Te Huringa Tuarua 2023 includes a summary report and three focus reports:

- Admission of young people to adult inpatient mental health services (published on 17 May 2023).
- Kaupapa Māori services, which will be published late June 2023.
- Compulsory community treatment orders, which will be published in July 2023.

The summary report will sit alongside an online dashboard, which is currently under development. The dashboard will contain detailed data aligned to the He Ara Āwhina framework to explore, filter, and analyse data. The online dashboard format will enable new data to be updated frequently, and for measures to be added as they are developed. It will also enable greater specificity to provide data for our priority populations (where data is available).

Phases 2 and 3

The future development phases for He Ara Āwhina methods and measures are:

- Phase 2 – service and broader system measures, including tāngata whaiora outcomes measures.
- Phase 3 – completion of priority methods and measures that require a more extended timeframe due to data gaps, engagement, and / or alignment needs.

We anticipate that Phase 2 work will begin in early 2024 due to a significant Mental Health and Addiction team work programme for 2022/23.

We will need to review our TAN membership before we commence Phase 2 and confirm whether existing members are able to continue with the work, and seek members for any new areas of expertise.

These next phases of methods and measures work (when there is a more complete suite of measures across the framework) will include a targeted consultation process to ensure we are using the measures and measures that are meaningful and important to people.

'Vital few' measures

Once Phase 2 is complete, our long-term goal is to identify the 'vital few' measures (there's no magic number for these) that we would encourage the system to focus on. We will need to take a matrix approach to ensure:

- these measures will cover all He Ara Āwhina system aspirations
- we can monitor equity of outcomes for as many priority groups of people as possible, prioritising where the greatest inequity is
- we have data which focuses on key wellbeing markers across a life course is optimal (and likely to be a work in progress linked to people who use mental health and addiction services).
- there is a 'line of sight' between Mental Health and Addiction system performance and the He Ara Oranga wellbeing outcomes framework outcome indicators and measures.

We will be selective and measure only what is most important and relevant; a 'vital few' set of indicators and measures are preferred that are evidence-based. This process will enable the system, which is currently overburdened, to identify and focus on the most critical areas to address.

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Appendix 1: Phase 1 shortlist process

Step 1 - Our Pou Rama

Our Pou Rama is standing strong, grounded in Te Tiriti o Waitangi. It is supported by Whāinga Tāhuhu - our vision, Whakatakanga - our mission and Ngā uaratanga - our values. Our Pou Rama shines bright on who we are, where we focus and what we must do.

The tikanga values of our Pou Rama define the culture of Te Hiringa Mahara and how our people act and work. These are the values that guide our work.

Tūhonotanga: we are inclusive, connected, and stronger for it.

Māia: we are courageous and speak up about what is important to people.

Māramatanga: we learn by listening, seek knowledge, and use it for good.

Tika: we are fair and respectful in supporting pathways to wellbeing.

Aroha: we work with compassion – we care about the work we do and the people of Aotearoa.

Step 2 - Data principles

In addition to our Pou Rama, the following sets out our approach to data for this work:

- Conceptual drives the data, not data drives the conceptual (ends to means, rather than means to ends).

- Measure only what is most important and relevant; a 'vital few' set of indicators is preferred (with caution to prevent a reductionist approach as wellbeing is multi-faceted) that are evidence-based.

- Acknowledge that not everything important is currently measured. Seek to address data gaps going forward.[4]

- Honour principles and practices of data sovereignty.[5]

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[4] We will be on the beginning of an emerging wellbeing focused data development journey (particularly for mental health and addiction services)
[5] Refer to Te Mana Raraunga, the Māori Data Sovereignty Network for guidance.

- Honour policies of data protection and use.[6]

- Strive to measure outcomes, across short-term to long-term.

- Data which focuses on key wellbeing markers across a life course is optimal (and likely to be a work in progress linked to people who use mental health and addiction services).

These data principles were determined during the development of the He Ara Oranga wellbeing outcomes framework and remain relevant for the He Ara Āwhina framework.

Step 3 - Creating a common language

We have developed a common language for use when discussing the He Ara Oranga wellbeing outcomes framework and He Ara Āwhina system monitoring framework. The purpose of the common language is to enable us to talk to each other, rather than past each other. This supports better conversations and the ability to achieve our common purpose. It is also essential moving forward in terms of ensuring alignment between our frameworks, socialising the frameworks, and future use.

Our approach draws on these distinct terms:

1. **Outcomes:** Narrative statements of wellbeing that reflect the quality of life and aspirations for people, whānau, and communities.

2. **Outcome data:** Data describing the change for tāngata whaiora using services (the 'ends'). May be Outcome indicators or Outcome measures.

3. **Indicators:** Data that quantifies success (or not) at a **population level** (everyone) or **sub-population-level** (e.g., everyone in a region or age group). Indicators are distinct from measures, which relate to data at a system or service level.

   It is important to distinguish between **Indicators** and **Measures** as although they are both data sets, they measure different types or levels of outcomes.

4. **Measures (process and structure):** Data describing how outcomes are achieved through processes and structures (the 'means'). Processes are the workings of the system – the activities, steps or outputs that contribute to outcomes. Structures are the system's attributes, such as capacity, financing, workforce, facilities, etc.

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[6] See the Data Protection and Use Policy (Social Wellbeing Agency, 2022). This policy was developed by the Social Wellbeing Agency to guide respectful, trusted, and transparent use of people's data and information.

5. **Data:** Overarching term to include all methods and measures. It can be quantitative and / or qualitative.

All common language terms are listed in Appendix 2.

It is important to note that definitions of indicators and measures vary between different outcome framework development approaches. For example, the Child and Youth wellbeing outcomes framework defines indicators as 'an analysis, or data narrative,' and measures as the 'specific way that an indicator is measured.' We have drawn from multiple outcome methodologies, including Results-Based Accountability (RBA), logic models, and theory of change.

Step 4 - Prioritisation framework / Evaluation criteria

Our Monitoring Strategy, approved by the Board of Te Hiringa Mahara in June 2022, determines our approach to monitoring, assessing, and reporting. The data selection criteria used are based on our prioritisation framework tailored for this work.

Prioritising what we monitor

We draw from our overarching approach to prioritising our work. This framework sets out that our two frameworks are core work, and additional areas are discretionary work, as aligned to our legislation requirements:

Core	Discretionary
• He Ara Oranga wellbeing outcomes framework • He Ara Āwhina system monitoring framework • Monitoring ourselves	• Special 'ad-hoc' topics

We use the prioritisation framework to determine what components to monitor *within* the core list, and what topics to monitor on the discretionary list. Overarching the prioritisation approach is whether the proposed topic contributes to better and equitable mental health and wellbeing outcomes. From here, we apply the prioritisation criteria:

- Will the proposed topic target Māori mental health and wellbeing outcomes?
- Is the proposed topic important to people and whānau with lived experience?
- Will the investment in the monitoring topic have an impact?
- Does the topic offer opportunities to reduce inequities?

- Does the topic align with our strategy priorities, advocacy agendas, and government priorities?

Prioritisation will also be informed by the practical reality of data availability. To assess the compiled longlist of potential measures we have focused on the highlighted prioritisation criteria above to give greater weighting and the data evaluation criteria below:

Frequency – is the data collected with reasonable frequency to support monitoring over time. In some cases, infrequent data may connect with other data for monitoring and reporting purposes and uphold our data principles.

Timeliness - available without too long a delay and can provide information on changes over time.

Nationally consistent – the data enables us to monitor and assess the system aspirations for all people in Aotearoa.

Aggregated and disaggregated –

- able to be disaggregated for mental health services, alcohol and other drug (AOD) services, priority groups[7] and geographic regions, where possible

- able to be aggregated with reasonable consistency in the collection (in cases of service-level measures) and data collected across Aotearoa, rather than just one specific region or district, where possible

In future phases of work, when determining our 'vital few' measures, we will apply the other prioritisation criteria e.g., whether a measure highlights inequity, whether the measure provides a 'line of sight' between the two frameworks, appropriate balance of strengths vs deficit-based measures etc.

Steps 5 and 6 - Compiling a longlist of measures

A comprehensive review of existing data sources (step 5) was conducted to compile a longlist of potential measures relevant to monitoring the performance of the mental health and addiction system. The measures have all been mapped (step 6) to He Ara Āwhina system aspirations and the concept they enable us to monitor.

It's important to note that some measures are quite fluid and can measure several system aspirations. These measures are mapped to multiple concepts. For example:

Measure - % of people aged under 25 years able to access specialist mental health services within three weeks of referral	
Te Ao Māori perspective	Shared perspective

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[7] See Schedule 2, Mental Health and Wellbeing Commission Act 2020.

Mana Motuhake	Access and options
Whānau have timely access to and choice of supports and services, inclusive of rongoā Māori	We have meaningful choice in supports and services when we are experiencing any level of distress, substance, or gambling harm. These are accessible when we need them, without barriers
Whānau determine, design and co-create supports and services that whakamana the aspirations of Māori	
Whānau lead trauma-responsive approaches to develop and strengthen resilience	

This process resulted in the longlist sent to the TAN in September 2022 of **787 potential measures** from over **150 data sources**. This result included potential tāngata whaiora outcome measures.

Work completed by the Initial Commission in late 2020 resulted in the beginning of a tāngata whaiora outcome measures data stocktake. There are significantly fewer existing, common, or collection at-scale data sources for tāngata whaiora outcome measures compared to population indicators or process and structure measures[8].

Steps 7 and 8 - Expert review of the longlist

The TAN individually reviewed the longlist and suggested aggregating some measures and adding some new ones. Some data gaps were also noted.

Importance for Māori and importance for people with lived experience of mental health and addiction, are prioritised criteria for Te Hiringa Mahara. Members from the TAN self-nominated for the Māori roopū and lived experience group to review the potential measures from these perspectives.

Te Ao Māori perspective

Te Ao Māori perspective for He Ara Āwhina has been developed by Māori, with Māori, for Māori. The He Ara Āwhina EAG includes a Māori roopū which has provided oversight and advice for the development of Te Ao Māori perspective for He Ara Āwhina. Similarly, Ngā Ringa Raupā, comprised of Te Hiringa Mahara Kaitohu Māori |

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[8] It is anticipated that there is a wide range of this type of data collected by Districts and other funders/providers that we have limited visibility of.

Director Māori and Māori staff, also provided oversight and collective expertise on Te Tiriti o Waitangi, Māori equity, and improving Māori health outcomes.

Ngā Ringa Raupā and the EAG Māori roopū both supported the separate Māori engagement and consultation process. Through a dedicated Māori engagement team, we gathered vital input from Māori, including tāngata whaiora, whānau, and kaupapa Māori supports and services before finalising He Ara Āwhina.

In November 2022 our TAN Māori roopū formed (including some members of the EAG Māori roopū). The roopū and our Māori data expert, Dr Kahu McClintock, worked with Te Hiringa Mahara alongside the TAN Chair, Sharon Shea, and the project team. The tasks included:

- reviewing the draft longlist of measures, focusing on Te Ao Māori perspective, and continuing to develop the measures library and thinking
- preparing for and facilitating the TAN Māori roopū to seek their advice on what is essential for Māori to measure in the Phase 1 suite of measures for 2023 monitoring. Measures with data that are nationally consistent and available now were prioritised
- compiling advice on future expectations, e.g., what should be measured for Māori
- summary information from the TAN Māori roopū advice was to be combined with the lived experience sub-group advice; other criteria were also to be applied.

Applying the Te Ao Māori perspective of He Ara Āwhina, three TAN Māori roopū hui confirmed the outcome concept priorities and scope for Phase 1 2023 (see Appendix 3). The Māori roopū also considered lived experience outcome concept priorities selected for the shared perspective and identified further priorities important to Māori. A final hui looked at the resulting shortlisted measures after applying the prioritisation to the longlist.

Measures available identified in the measures library for Te Ao Māori perspective were discussed, and the roopū verified mapping to the system aspirations (sometimes referred to as domains) and their outcome concept priorities, including essential measurements from the shared perspective.

TAN Māori roopū discussion also noted the data gaps: what should the system be collecting and reporting on that isn't available for monitoring?

Lived experience sub-group

The TAN lived experience sub-group was convened and facilitated by our lived experience principal advisers Kelly Pope and Guy Baker. The process for their work was similar to that of the Māori roopū. Three hui were held to determine lived experience outcome concept priorities for 2023 monitoring from the shared perspective of He Ara Āwhina, and a final hui looked at the resulting shortlisted

measures after applying the prioritisation to the longlist. See Appendix 3 for the selected priorities.

Step 9 - Applying criteria to prioritise a shortlist

At this point in the process there were over 900 measures to prioritise for the 2023 shortlist. We needed to think about the best way to work with the TAN groups and the Te Hiringa Mahara monitoring project required a smaller number of measures for 2023. The solution was to take an outcome concept-based approach (as outlined above) to filter the potential measures.

The TAN Māori roopū agreed on up to two primary and secondary concepts from each system aspiration (domain) in Te Ao Māori layer of the framework. The roopū then identified new measures and some measures from the shared layer that contributed to Te Ao Māori domains.

Similarly, the lived experience subgroup agreed on up to two primary and secondary concepts from each domain in the shared layer of the framework to focus our monitoring on initially.

The project scope and data evaluation criteria were also applied to the primary concept list:

- Phase 1: was the data specific to mental health and addiction services?
- Data availability: would we have recent data by the end of 2022?
- Could we aggregate and disaggregate the data?
- Nationally consistent: would the data tell the story for all of Aotearoa?

Appendix 2: Common language

Terms	Description
Addiction services	Services that exist to respond to the experiences, needs, and aspirations of tāngata whaiora and whānau who experience harm from substances or harm from gambling, substance addiction, or non-substance addiction.
Assessment	Making a judgement about the nature or quality of something.
Data	Overarching term to include all methods and measures. Can be quantitative and / or qualitative. Primary data is data we directly collect through focus groups, interviews, etc. Secondary data is from published articles, other agencies' monitoring, etc.
Deficit-based	Data that reflects a deficit-based lens (compared to strengths). For us, deficit-based data measures are those that measure what is not working for people and in particular, risk factors. For example, hazardous drinking is a deficit-based measure and is an evidence-based risk factor for mental health and addictions.
Ends to Means	In our monitoring work 'Ends' relates to wellbeing (as described in the He Ara Oranga wellbeing outcomes framework), and 'Means' relates to how wellbeing is achieved (including through the provision of supports and services described in He Ara Āwhina). The 'Ends to Means' conversation may also occur when discussing other 'levels' of outcome e.g., when discussing a service. The Ends are the service provider's tāngata whaiora outcomes delivered, and the Means are how that provider delivers their specific services.
Indicators[9]	Data that quantifies success (or not) at a **population level** (everyone) or **sub-population-level** (e.g., everyone in a region or age group). Indicators are distinct from measures, which relate to data at a system or service level (see 'measures' below).

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[9] We have drawn from multiple outcome methodologies, including Results-Based Accountability (RBA), Logic Model, and Theory of Change. Some of our common language has been adapted from RBA. For more information on use of RBA see https://www.procurement.govt.nz/procurement/specialised-procurement/social-services-procurement/developing-a-social-services-procurement-plan/how-to-measure-outcomes-and-outputs/

Terms	Description
	It is important to distinguish between **Indicators** and **Measures** as, although they are both data sets, they measure different types or levels of outcomes.
Measures	Refer to Process and structure measures (below).
Mental health and addiction system	The mental health and addiction system includes all people, supports, and services that respond to the experiences, needs, and aspirations of people and whānau who experience distress, harm from substance use or harm from gambling (or a combination of these). The mental health and addiction system is part of the wellbeing system.
Mental health services	Services that exist to respond to the experiences, needs, and aspirations of tāngata whaiora and whānau who experience distress.
Methods	Overarching term for a range of methods we use for monitoring. These can include structured engagement (following our qualitative guidelines), indicators, measures, case studies, and research / literature.
Monitoring	Watching something over time to see how it develops, and to inform any necessary changes.
Outcome data	Data describing the change for tāngata whaiora who are using services (the 'ends'). May be Outcome indicators or Outcome measures.
[Conceptual] Outcomes	Narrative statements of wellbeing that reflect the quality of life and aspirations for people, whānau, and communities. There are 12 conceptual outcomes in the He Ara Oranga wellbeing outcome framework.
Process and structure measures	Data describing how outcomes are achieved through processes and structures (the 'means'). Processes are the workings of the system – the activities, steps or outputs that contribute to outcomes. Structures are the attributes of the system, such as capacity, financing, workforce, facilities, etc.
Strengths-based	Data that reflects a strengths-based lens (compared to deficit). For us, strengths-based data measures what is working for people, particularly, protective factors. For example, cultural connection for tangata whenua is an evidence-based protective factor for mental health and addictions.
Tāngata whaiora	Tāngata whaiora can be people of any age or ethnicity seeking wellbeing or support, including people who have recent or current experience of distress, harm from substance use or harm from gambling (or a combination of these).

Terms	Description
	Tāngata whaiora include people who have accessed or are accessing supports and services, and people who want mental health or addiction support but are not accessing supports or services.
Wellbeing systems	The wellbeing systems include all people, services, and supports that contribute to the holistic wellbeing of people, whānau, and communities across many areas and populations in Aotearoa. Wellbeing systems are wider than health and include amongst other things, education, whānau ora, social services, and mental health and addiction.
Whānau	Whānau has its whakapapa (history) and origins located firmly in Te Ao Māori (Māori worldview) and refers specifically to blood connections that exist between generations of lineage that descend from Atua Māori. Whānau is now also commonly used to include people who have close relationships and / or who come together with a common purpose. Tāngata whaiora can determine who their whānau and / or kaupapa whānau is when they are seeking or receiving support.
Workforce/s	Workforces include clinical, kaiāwhina, peer, and cultural roles across a diverse range of support and service settings.

Appendix 3: Outcome priorities for 2023 monitoring

Blue highlights are primary concepts for 2023; grey highlights are highly valued but secondary. It is important to note that not all outcome concepts selected are present in the final shortlist. Some are not included due to lack of available data.

Te Ao Māori Perspective

Mana Whakahaere – We (whānau) experience Tino Rangatiratanga and feel that Te Tiriti o Waitangi is actively embedded in the mental health and addiction system and services.
Te Tiriti o Waitangi is the foundation to develop legislation and policy.

Whānau develop strategies to address inequities across social determinants of health to achieve equitable wellbeing outcomes.

Whānau lead mental health and wellbeing resource and policy decision-making at every level.

Mātauranga Māori is recognised and valued alongside clinical views as integral to all that occurs within the system.

Māori are enabled to monitor compliance to Te Tiriti o Waitangi to address institutional racism and inequities in resourcing across the system.

Māori data are protected, and outcomes and measures are defined and determined by whānau.

Mana Motuhake – We lead and self-determine our pathways to pae ora, mauri ora and whānau ora.
Whānau participate and lead locally, regionally, and nationally.

Whānau determine, design and co-create supports and services that whakamana the aspirations of Māori.

Whānau feedback is prioritised, and we lead the design of supports and services, delivery, and policy decision improvements.

Whānau lead trauma-responsive approaches to develop and strengthen resilience.

Whānau wānanga solutions to experiences of distress, substance and gambling harm to determine supports and services.

Whānau are enabled to be innovative and entrepreneurial.

Manawa Ora / Tūmanako – We have the right to choose supports and services that respond to our experiences, needs, and aspirations.

Whānau have timely access to and choice of supports and services, inclusive of rongoā Māori.

Whānau determine all workforce needs to ensure autonomy from prejudice and bias.

Whānau determine responses to substance and gambling harm.

Whānau, hapū, and iwi are enabled to respond to experiences, hopes, aspirations, and needs of Māori.

Whānau determine pathways identifying kaupapa Māori, iwi Māori, and whānau-led supports that are equitably resourced in our hapori.

Tino rangatiratanga is embraced in services, enabling mana motuhake.

Whānau are resourced equitably to deliver timely supports and services determined by whānau.

Mana Tangata / Tū Tangata Mauri Ora – We have a mental health and addiction system that is culturally, spiritually, relationally, and physically safe.
Te Ao Māori is embedded in services to ensure culturally safe engagement that is holistic and healing.

Mana whānau and the right to Tino Rangatiratanga is acknowledged and valued in services.

Whānau report positive experiences of seeking and receiving support that is free from prejudice, discrimination, and racism.

Whānau lead strategies that address the effects of colonisation and intergenerational trauma.

Whānau experience support that prioritises wairuatanga, whānau, and physical wellbeing.

Cultural assessments, approaches, and practises are valued as taonga tuku iho, and are respected equal to clinical approaches.

Coercive practices, including solitary confinement (seclusion), are eliminated.

Mana Whānau / Whanaungatanga – We have access to supports and services that enable connection to our whānau, whakapapa, hapū, and iwi.
Whakawhanaungatanga is valued in services to enable authentic relationships with whānau.

Whānau are connected to support that contributes to Mauri ora.

Whānau can access timely information, resourcing and supports, including digital support.

Whānau experience reciprocal opportunities to contribute to pae ora – koha mai, koha atu.

Whānau experience supports and services that acknowledge and value the importance of connection to whenua, whakapapa and ngā atua.

Whānau determine training and resources needed to extend workforce capability and capacity.

Kotahitanga – We want supports and services to work collectively and cohesively to make a meaningful difference for us.
Whānau define wellbeing and recovery pathways are valued and respected.

Mātauranga Māori is equally valued alongside other worldviews.

Māori values are reflected in services as evidenced by whānau.

Whānau strengths are illuminated and prioritised to effect meaningful difference and enable us to realise our full potential.

Whānau experience environments that are culturally safe and enabled to facilitate restoration processes, including pae oranga to address disparities inherent in criminal justice approaches.

Whānau experience opportunities to further education and employment aspirations.

Shared Perspective

Equity – We (tāngata whaiora) want a mental health and addiction system that supports all of us and our whānau equitably.
The mental health and addiction system fulfils Te Tiriti o Waitangi obligations.

Policy and laws effectively minimise the social, economic, environmental, and commercial determinants of distress, substance and gambling harm, and enable equitable wellbeing.

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

Services take action to decolonise practise, increase workforce diversity, apply an intersectional lens, and address inequities and institutional racism.

Promotion and prevention strategies support equity.

Investment in supports and services improves equity of access and outcomes.

The justice system actively diverts and connects us to health and wellbeing supports and services when we are experiencing distress, substance or gambling harm.

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

Participation and leadership – We lead and self-determine our pathways through distress, substance, or gambling harm to wellbeing and recovery.
We work in a wide range of leadership roles, where our lived experience, whānau experience, community connections and diversity are valued.

Resourcing enables diverse, quality and sustainable leadership, and supports emerging leaders.

Strategies are led by those of us with experience of distress, gambling harm, alcohol harm, and harm from other drugs to eliminate prejudice, self-stigma and discrimination. This work is funded and evaluated.

Tāngata whaiora and whānau lead and co-produce policies, supports and services, responses, models of care, research, and training.

When using supports and services, we are leaders in our care and decision-making. We can easily access our healthcare information. There is education and support to self-advocate and make informed decisions.

Our engagement and feedback actively shapes supports, services, workforce, training, and policy.

Access and options – We have the right to choose supports and services, when and where we need them, that respond to our experiences, needs, and aspirations, and believe in our capacity to thrive.
We define what our experiences, needs and aspirations are. We can access different options and learn what works and doesn't work for us.

All supports and services are trauma-informed, culturally responsive and support our wairua, values and strengths.

We have meaningful choice in supports and services when we are experiencing any level of distress, substance, or gambling harm. These are accessible when we need them, without barriers.

Options include community and home-based supports, kaupapa Māori, peer-led, harm reduction, and family-based supports and services. We can access support to stay in, or return to our work, education, or parenting roles.

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

We have access to environments and supports that provide listening, respite, and healing.

The system increasingly provides choice-based models of support, such as individualised funding and whānau funding models.

Communities are enabled and resourced to develop and deliver their own responses to distress, trauma, harm from alcohol, other drugs, or gambling. Funding models recognise and value volunteers, whānau, peers, and community support groups.

Community connections are an accessible 'first port of call' and an enduring resource, including non-biomedical and culturally grounded support.

We can access navigators and peer advocates to walk alongside us in our journeys.

Safety and rights – We want a mental health and addiction system that understands and upholds our cultural, spiritual, relational, and physical safety, and our human rights.
The culture of the mental health and addiction system is relational, respectful, and values diversity. The impacts of colonisation and intergenerational trauma are acknowledged and understood.

Coercive practises, including solitary confinement (seclusion), are eliminated.

Supports and services actively promote our individual and collective rights and our self-determination.

Tāngata whaiora and whānau report trust and validation in supports and services that are trauma-responsive, free from prejudice, discrimination, punitive practises, and racism.

We have access to advocacy support when we need it, and timely resolution of complaints.

Processes are in place to restore relationships when harm occurs, enabling transparency, learning and improvement.

Our workforces are safe, cared for and well-resourced to support us and our whānau. Training and leadership enable harm reduction practices and holistic safety. Risk taking is seen as essential for recovery.

Medication is prescribed safely, and we have support if we choose to come off psychiatric medication.

Evidence-based harm minimisation practices are used in places where people gamble, use alcohol, or use other drugs.

Connected care – We want supports and services to work collectively and cohesively for us, and see us as valued members of whānau, communities, and society.
All tāngata whaiora and whānau can access culturally and linguistically appropriate tools and information to respond to distress, reflect on and minimise harm from alcohol, other drugs, or gambling, find support, and lead our wellbeing and recovery.

Services communicate well with us, our whānau, and with each other. Our workforces are knowledgeable, skilled, empowered and fully culturally competent.

Services connect us with housing and social services, and to cultural, wairua, environment, whānau and community supports and resources.

Effective connections between mental health services, addiction services and physical healthcare help us stay physically well.

We experience reciprocal opportunities to contribute to mental health and wellbeing. Our knowledge of recovery is valued.

Education effectively develops critical thinking skills that enable us to reduce harm from alcohol, other drugs and gambling and navigate distress.

Our communities and whānau understand and can respond to distress, substance harm, and gambling harm in compassionate, non-punitive, and inclusive ways.

Effectiveness – Supports, services and policy must make a meaningful difference in our lives, so that we are self-determining and thriving.
We benefit from dedicated action across government to prevent suicide, distress, substance harm and gambling harm, and to eliminate the physical health, income, and wellbeing inequities we experience.

A range of supports and services for tāngata whaiora and whānau are appropriately funded and staffed to provide high quality support.

Supports and services adapt to evidence, innovation, and best practise from clinical, mātauranga Māori and peer worldviews.

Supports and services effectively contribute to our holistic wellbeing, address wider causes and consequences of distress, and support us to regain and maintain hope, purpose, and valued roles in our whānau and communities.

Physical health services provide us with excellent care, address access barriers, biases, and diagnostic overshadowing.

Safe processes, support and resources exist for tāngata whaiora and whānau to openly discuss any concerns about distress, or harm from substance use, or gambling.

Our strengths and recovery stories are recognised and celebrated.

We experience self-defined recovery and holistic wellbeing (see He Ara Oranga wellbeing outcomes framework).

Appendix 4: Methods and measures shortlist

This list contains 133 unique measures. It includes the measures in Te Huringa and the Access and Choice programme report 2022.

Many measures are duplicated in the presentation by domain below due to mapping to multiple domains. Note there is inconsistent expression of measures and some varying levels of aggregation need to be addressed as we work on our vital few measures.

Five measures in blue text are tāngata whaiora outcome measures. See Appendix 5 for the full list which includes He Ara Oranga tāngata whaiora outcome measures.

Framework domain	ID	Measure
Kotahitanga	1019	# and % of kaupapa Māori NGO MHA services
	1020	Funding committed & funding allocated for Kaupapa Māori primary & community MHA services
	1022	Funding committed & funding allocated for IPMHA, Kaupapa Māori, Pacific, Youth services
	1023	Kaupapa Māori primary & community MHA services - service activity (people seen, sessions delivered)
	1024	IPMHA, Kaupapa Māori, Pacific, Youth services - service activity (people seen, sessions delivered)
	1072	% of complaints about coordination of care between different service providers
	1073	% of complaints that were about coordination or inappropriate follow up by service providers
	1244	Availability of Kaupapa Māori primary & community MHA services (population / service coverage)
	1245	FTE of staff contracted (funded) and staff employed into IPMHA, Kaupapa Māori, Pacific, Youth service delivery positions by roles
	1264	[A measure from Te Pou NGO survey relating to cultural roles in the MHA workforce to be developed]
Mana Motuhake	1084	FTE of staff contracted (funded) and staff employed into IPMHA, Kaupapa Māori, Pacific, Youth service delivery positions by roles
	1085	FTE of staff contracted (funded) and staff employed into IPMHA, Kaupapa Māori, Pacific, Youth service delivery positions by roles
	1086	FTE of staff contracted (funded) and staff employed into IPMHA, Kaupapa Māori, Pacific, Youth service delivery positions by roles
	1087	% of complaints about mental health and addiction services about access to those services

Framework domain	ID	Measure
	1090	% of people aged under 25 years able to access specialist mental health services within three weeks of referral
	1092	# and % of kaupapa Māori NGO MHA services
	1094	# of treatment days delivered across 11 different specialist mental health and addiction services (total treatment days) (Individual treatment sessions, Community support, Coordination of care, Contacts with family / whānau, Group programmes, Crisis attendances, Day programmes, Peer support contacts, Māori specific interventions, Pacific specific interventions, Opioid substitution treatment service)
	1109	# of treatment days involving family and whānau provided by services
	1111	% of tāngata whaiora and whānau who report that their plan is reviewed regularly
	1114	% of tāngata whaiora and whānau who report they feel involved in decisions about their care
	1208	Complete roll-out of the Access and Choice programme for primary mental health and addiction support services so that access is available for 325,000 people per year by the end of June 2024
	1237	# of treatment days involving family and whānau provided by services
	1259	% of total mental health workforce accounted for by the mental health peer workforce
Mana Tangata / Tū Tangata Mauri Ora	1028	# scholarships/bursaries each year and total $ value for Māori students pursuing a career in MHA
	1031	[A measure from Te Pou NGO survey relating to cultural roles in the MHA workforce to be developed]
	1105	# of places for Māori and Pacific cultural competence training each year
	1121	Average length of detention under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017
	1122	Length of time spent subject to community orders (section 29) under the Mental Health Act for Māori, Pacific peoples and people of other ethnicities
	1123	Length of time spent subject to inpatient orders (section 30) under the Mental Health Act for Māori, Pacific peoples and people of other ethnicities
	1124	# of people required to undergo assessment under sections 11, 13 and 14(4) of the Mental Health Act
	1156	# of serious adverse events (suspected suicide, serious self-harm, and serious adverse behaviour) are reported in mental health and addiction services (DHBs only)
	1170	Vacancy rate in the NGO MHA workforce
	1171	[Narrative relating to developments with Te Rau Ora's Whanau Workforce Development Programme]
	1174	% of complaints about mental health and addiction services that include issues with communication

Framework domain	ID	Measure
	1175	% of complaints about mental health and addiction services were about inadequate or inappropriate care
	1200	# of FTE rongoā Māori practitioner vacancies in NGOs A&D services
	1201	# of FTE rongoā Māori practitioner vacancies in NGOs MH services
	1202	# of FTE rongoā Māori practitioners employed in NGOs A&D services
	1203	# of FTE rongoā Māori practitioners employed in NGOs MH services
	1214	% of spend of HNZ total budget on mental health [& total spend]
	1257	% of complaints about coordination of care between different service providers
	1258	% of complaints that were about coordination or inappropriate follow up by service providers
	1340	% of Māori in Te Whatu Ora (former DHB) MHA workforce
	1343	[Narrative from or link to Te Rau Ora report on school pipeline for Māori into health & social care careers - findings apply to employment opportunities more generally, could also draw on their analysis of the broader Māori workforce)
Mana Whakahaere	1193	[Possible measures from Te Rau Ora's survey of public health contracting]
	1249	Funding committed & funding allocated for Kaupapa Māori primary & community MHA services
	1250	Funding committed & funding allocated for IPMHA, Kaupapa Māori, Pacific, Youth services
	1261	# scholarships/bursaries each year and total $ value for Māori students pursuing a career in MHA
Mana Whānau / Whanaungatanga	1195	% of Māori in Te Whatu Ora (former DHB) MHA workforce compared with the percentage of Māori in the population
	1251	Funding committed & funding allocated for IPMHA, Kaupapa Māori, Pacific, Youth services
	1252	Kaupapa Māori primary & community MHA services - service activity (people seen, sessions delivered)
	1253	IPMHA/Kaupapa Māori/ Pacific/ Youth services - service activity (people seen, sessions delivered)
	1278	# of treatment days involving family and whānau provided by services
	1279	% of tāngata whaiora and whānau who report that their plan is reviewed regularly
	1280	% of tāngata whaiora and whānau who report they feel involved in decisions about their care
Manawa Ora / Tūmanako	164	Kaupapa Māori primary & community MHA services - service activity (people seen, sessions delivered)

Framework domain	ID	Measure
	813	[Narrative or possible measures from Te Rau Ora He Ara Waiora Report from a small-scale survey of kaimahi in AOD services]
	1095	Funding committed & funding allocated for Kaupapa Māori primary & community MHA services
	1097	Funding committed & funding allocated for IPMHA, Kaupapa Māori, Pacific, Youth services
	1098	Investment in workforce development
	1100	Presenting issues to IPMHA services
	1101	Spending on mental health and addiction services (HNZ & MHA & MoH expenditure) disaggregated by specified services, and total expenditure for Māori MHA services or teams (both DHB and NGO)
	1102	Kaupapa Māori primary & community MHA services - service activity (people seen, sessions delivered)
	1103	IPMHA/Kaupapa Māori/ Pacific/ Youth services - service activity (people seen, sessions delivered)
	1199	FTE of staff contracted (funded) and staff employed into Kaupapa Māori primary & community MHA service delivery positions by roles
	1307	Funding committed & funding allocated for Kaupapa Māori primary & community MHA services
	1308	Funding committed & funding allocated for IPMHA, Kaupapa Māori, Pacific, Youth services
	1310	Investment in workforce development
	1312	Presenting issues to IPMHA services
	1313	Spending on mental health and addiction services (HNZ & MHA & MoH expenditure) disaggregated by specified services, and total expenditure for Māori MHA services or teams (both DHB and NGO)
	1314	Kaupapa Māori primary & community MHA services - service activity (people seen, sessions delivered)
	1315	IPMHA/Kaupapa Māori/ Pacific/ Youth services - service activity (people seen, sessions delivered)
	1344	Funding committed & funding allocated for IPMHA, Kaupapa Māori, Pacific, Youth services
Access & options	21	# of people using acute inpatient care
	43	FTE of staff contracted (funded) and staff employed into IPMHA, Kaupapa Māori, Pacific, Youth service delivery positions by roles
	48	# of bed nights used in acute inpatient care
	49	# of people using rehabilitation or residential care
	50	# of bed nights used in rehabilitation or residential care
	51	# of people using crisis respite care
	52	# of bed nights used in crisis respite care
	53	# of people using forensic secure inpatient services
	54	# of bed nights used in forensic secure inpatient services

Framework domain	ID	Measure
	55	# of people using substance use medical withdrawal management (detoxification)
	56	# of bed nights used in substance use medical withdrawal management (detoxification)
	57	# of people using substance use residential treatment
	58	# of bed nights used in substance use residential treatment
	59	% of complaints about mental health and addiction services about access to those services
	73	# & rate of Police events related to mental distress or suicide attempts (contacts that police code as related to either "mental health" 1M or "attempted suicide" 1X)
	74	% of people aged under 25 years able to access specialist mental health services within three weeks of referral
	77	% waiting (≤48 hours, ≤3 weeks, ≤8 weeks) to access DHB mental health services following first referral
	78	% waiting (≤48 hours, ≤3 weeks and ≤8 weeks) to access addiction services following first referral
	84	Average wait times in ED for a mental health related inpatient bed
	85	Average wait times with support calls (all Whakarongorau call platforms, not texts)
	89	% of the population seen by MH&A services (DHBs, NGOs and all services) broken down by Child & youth (0 -19); Adult (20-64); Older adult (65+); Māori, Pacific)
	93	# & rate of tāngata whai ora with recorded NGO activity in the 28 days before an inpatient stay
	95	# and % of kaupapa Māori NGO MHA services
	97	# and % of Pasifika led NGO MHA services
	109	# of initial dispensings of mental health and substance use medications - antidepressants
	110	# of initial dispensings of mental health and substance use medications - antipsychotics
	111	# of initial dispensings of mental health and substance use medications - anxiolytics
	112	# of initial dispensings of opioid substitution treatment for opioid dependence
	113	# of people receiving opioid substitution treatment in primary care (may be coded as GP case management?)
	114	# of people currently on waiting list for opioid substitution treatment
	115	Average length of time on waiting list for opioid substitution treatment
	117	# of opioid substitution treatment places available
	122	# of people accessing primary mental health services (% population)
	123	# of people accessing specialist mental health and addiction services (% population) (disaggregated by each type and Māori and non-Māori MHA services)

Framework domain	ID	Measure
	124	# of people contacting national mental health and addiction telehealth services (# of unique users and # of total contacts) - 1737 / Need to talk, 1737 Peer support, Alcohol and drug helpline, Depression helpline, Gambling helpline, [Other Whakarongorau MHA telehealth services as suggested]
	125	# of people contacting national mental health and addiction telehealth services (# of unique users) and # of total contacts - Alcohol and other drug helplines (Living Sober, The Level)
	126	# of people contacting national mental health and addiction telehealth services (# of unique users) and # of total contacts - Depression helpline
	127	# of people contacting national mental health and addiction telehealth services (# of unique users) and # of total contacts - Gambling helpline
	128	# of people using national mental health and addiction online platforms (# of unique visitors); and # of total sessions
	131	# of treatment days delivered across 11 different specialist mental health and addiction services (total treatment days) (Individual treatment sessions, Community support, Coordination of care, Contacts with family / whānau, Group programmes, Crisis attendances, Day programmes, Peer support contacts, Māori specific interventions, Pacific specific interventions, Opioid substitution treatment service)
	134	% of people accessing specialist MHA services that did so with an NGO service (Includes people who saw both an NGO and DHB)
	136	% of people with/without self-reported long term MHA condition reporting whether in the last 12 months, there was a time when they wanted health care from a GP or nurse, but couldn't get it
	139	[Access to primary mental health and addiction services - this measure is currently in development]
	142	Availability of IPMHA services (population / service coverage)
	143	Availability of Pacific primary & community MHA services (population / service coverage)
	145	Availability of Youth primary & community MHA services (population / service coverage)
	148	Average length of residential rehabilitation facility stay
	149	Average length of stay in an inpatient unit
	161	Investment ($) in workforce development
	162	Presenting issues to IPMHA services
	163	Spending on mental health and addiction services (HNZ & MoH expenditure) disaggregated by specified services, and as % of total HNZ & MoH spend

Framework domain	ID	Measure
	166	IPMHA/Kaupapa Māori/ Pacific/ Youth services - service activity (people seen, sessions delivered)
	168	# of mental health related calls to Police for service
	837	% of unique service users accessing specialist mental health and addiction services
	839	Complete roll-out of the Access and Choice programme for primary mental health and addiction support services so that access is available for 325,000 people per year by the end of June 2024
	858	# of DAPAANZ registered addiction practitioners
	944	[PRIMHD data – T codes: Contact with family/whānau, consumer not present T32, Contact with family/whānau, tangata whaiora/consumer present T36, Support for family/whānau T47, Support for Children of Parents with Mental Illness and Addictions (COPMIA) T49 and Support for Parents with Mental Illness and Addictions T50]
	1348	Number of 1737 complex callers (defined as calls lasting longer than 25 minutes)
	1349	Number of 1737 frequent callers (defined as people who call 20 or more times a month)
Connected care	177	% of people that went back into an inpatient unit within 28 days of being discharged
	179	% of complaints about coordination of care between different service providers
	180	% of complaints that were about coordination or inappropriate follow up by service providers
	182	% of tāngata whaiora and family and whānau who report that the people they see communicate with each other when they need them to
	183	% of tāngata whaiora have a transition plan on discharge from community care
	185	% of tāngata whaiora have a transition plan on discharge from an inpatient unit
	198	# and % of tāngata whaiora followed up within 7 days of leaving hospital
	202	# of places for Māori and Pacific cultural competence training each year
	203	# scholarships/bursaries each year and total $ value for Māori students pursuing a career in MHA
	204	# scholarships/bursaries each year and total $ value for Pacific students pursuing a career in MHA
	208	[A measure from Te Pou NGO survey relating to cultural roles in MHA workforce to be developed]
	602	# of treatment days involving family and whānau provided by services
Effectiveness	16	% of total mental health workforce accounted for by the mental health peer workforce
	155	Funding committed & funding allocated for Access & choice programme (service type, workforce development and enabler) - Summary level funding measure

Framework domain	ID	Measure
	157	Funding committed & funding allocated for IPMHA, Kaupapa Māori, Pacific, Youth services
	160	Investment in workforce development
	228	% of NGO MHA service funding from charity and fundraising
	273	# of treatment days provided by services to support family and whānau, including children
	274	# of treatment days provided to support tāngata whaiora in their role as parents or caregivers
	410	% of tāngata whaiora and their whānau who report they would recommend the service to friends or family if they needed similar care or treatment
	415	Average self-rated increase in tāngata whaiora satisfaction towards achieving recovery goals (addiction services)
	529	% of tāngata whaiora with a supplementary consumer record who are in PT/FT employment or in education or in training
	539	% of tāngata whaiora (with a supplementary consumer record) who have independent / supported / no accommodation
Equity	576	% of Māori and other under-represented groups in the regulated and unregulated (MHA) health workforce, compared with % of the total population
	577	% of NGO MHA services actively developing lived experience/Māori cultural/Pacific cultural roles
	583	Māori ICAMH/AOD workforce by occupation
	584	Māori, Pacific, Asian population service user & workforce comparisons
	588	People who need mental health services receive them (comparing service uptake against known estimates of prevalence)
	922	[Training data – workforce participating in training by Le Va re working with Pacific people, Te Rau Ora / Te Kete Pounamu re working with Māori, Te Pou re working with people with addiction, Whāraurau re working with young people, disability focussed training e.g., kia noho Rangatira ai tatou, InsideOUT rainbow competency training for mental health staff, possibly use rainbow tick accreditation]
	924	[Funding for by-Māori-for-Māori services]
Participation & leadership	604	% of tāngata whaiora and whānau who report that their plan is reviewed regularly
	605	% of tāngata whaiora and whānau who report they feel involved in decisions about their care
	616	% of people with/without self-reported long term MHA condition reporting whether in the last 12 months, they were involved as much as they wanted to be in decisions about the best medicine(s) for them

Framework domain	ID	Measure
	734	% of complaints about mental health and addiction services that include issues with communication
	735	% of complaints about mental health and addiction services were about inadequate or inappropriate care
	836	% did not attend community MHA services
Safety & rights	118	# of involuntary discharges from opioid substitution (methadone) treatment [/ total # of people in programme]
	641	# of people subject to Mental Health Act (s29) community treatment orders and indefinite community treatment orders (by ethnicity, gender and age groups). Also # of people (by ethnicity, gender and age groups) subject to Mental Health Act (s29) community treatment orders and indefinite community treatment orders per 100,000 population
	643	# of CTOs made under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017
	644	# of people detained under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017
	646	# of people in inpatient units put in solitary confinement (seclusion) by adult, forensic, intellectual disability and youth services, and region; and rate per 100,000 population disaggregated by ethnicity, gender, age group, inpatient services
	648	# of times solitary confinement used in inpatient units (people may have more than one solitary confinement event)
	651	# and % of applications for MHA (s29 and s30) compulsory treatment orders or extensions granted or granted with consent, dismissed or struck out
	652	% of solitary confinement events in inpatient units that last less than 24 hours
	659	Average # of Mental Health Act (s29) community treatment orders and indefinite community treatment orders on a given day, per 100,000 population
	660	Average length of detention under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017
	661	Average length of time spent subject to Mental Health Act (s29) community treatment orders and indefinite community treatment orders for Māori, Pacific peoples and people of other ethnicities
	662	Average length of time spent subject to MHA (s30) inpatient orders for Māori, Pacific peoples and people of other ethnicities
	664	# of people required to undergo assessment under sections 11, 13 and 14(4) of the Mental Health Act
	671	# of people subject to MHA (s30) inpatient treatment orders and indefinite inpatient treatment orders by ethnicity, age group and gender; and # of people subject

Framework domain	ID	Measure
		to MHA (s30) inpatient treatment orders and indefinite inpatient treatment orders per 100,000 population by ethnicity, age group and gender
	674	# of seclusion events in adult inpatient services per 100,000 population by ethnicity, age group and sex
	677	% of people with inpatient admissions that spent time in seclusion in adult inpatient services by ethnicity and sex
	714	# of serious adverse events (suspected suicide, serious self-harm, and serious adverse behaviour) are reported in mental health and addiction services (DHBs only)
	730	Vacancy rate in the NGO MHA workforce
	838	# of vacant MHA FTE by role
	866	% of people with/without self-reported long term MHA condition reporting whether in the last 12 months, they were involved as much as they wanted to be in decisions about the best medicine(s) for them
	1332	% of Māori in Te Whatu Ora (former DHB) workforce

Appendix 5: Tāngata whaiora outcomes

This list includes both He Ara Oranga and He Ara Āwhina potential tāngata whaiora outcome measures.

Framework	Domains	ID	Measure
He Ara Āwhina			
Shared	Effectiveness	**410**	% of tāngata whaiora and their whānau who report they would recommend the service to friends or family if they needed similar care or treatment
		415	Average self-rated increase in tāngata whaiora satisfaction towards achieving recovery goals (addiction services)
		529	% of tāngata whaiora are in employment or in education or in training
		539	% of tāngata whaiora who have independent / supported / no accommodation
	Equity	**588**	People who need mental health services receive them (Comparing service uptake against known estimates of prevalence)
He Ara Oranga			
Te Ao Māori	Tino rangatiratanga me te mana Motuhake	**2025**	% of Māori tāngata whaiora who are registered with an iwi
	Tūmanako me te ngākaupai	**2038**	% of Māori tāngata whaiora who think things are getting better for their whānau
	Whakaora, whakatipu, kia manawaroa	**2029**	% of Māori tāngata whaiora who are te reo speakers
		2033	% of Māori tāngata whaiora who think it is important to be involved in things to do with Māori culture
		2054	% of tāngata whaiora Māori students who are enrolled in kura kaupapa Māori and kura teina
	Whakapuāwaitanga me te pae ora	**2055**	% of tāngata whaiora Māori secondary school leavers left school with a qualification at NCEA level 2 or above
	Whanaungatanga me te arohatanga	**2036**	% of Māori tāngata whaiora who think their whānau are doing well
Shared	Being safe and nurtured	**2051**	% of tāngata whaiora who report feeling lonely a little or none or of the time in the last four weeks
	Having hope and purpose	**2056**	% of tāngata whaiora who report life is worthwhile
	Having one's rights and dignity fully realised	**2001**	% of tāngata whaiora who reported experiencing discrimination in the last year

Framework	Domains	ID	Measure
	Having what is needed	**2003**	% of tāngata whaiora enrolled in any study whether formal or informal
		2011	% of tāngata whaiora who undertake 2.5 + hours of physical activity per week
		2017	% of tāngata whaiora who felt their income was enough or more than enough to meet their everyday needs
	Healing, growth and being resilient	**2053**	% of tāngata whaiora who said it would be 'very easy' or 'easy' to talk to someone if they felt down or a bit depressed