Initial
Mental Health and Wellbeing Commission

Developing a Mental Health and Wellbeing Outcomes Framework

Summary of the data phase

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Enquiries to: kiaora@mhwc.govt.nz

Date:	3 February 2021
Author:	Tania Simmons, Data Advisor; Sharon Shea, Specialist Advisor
Peer review:	Karen Orsborn, Head of Secretariat
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Purpose

The purpose of this report is to summarise the He Ara Oranga wellbeing outcomes framework **data phase**, which looked at existing data sources to develop draft indicators and measures 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 (TAG).

This report provides an overview of a draft list of potential indicators and measures, identified data gaps and implementation, and future expectations.

Summary of process

- In February 2020, the Initial Mental Health and Wellbeing Commission (the Initial Commission) initiated the process to develop a draft outcomes and monitoring framework for mental health and wellbeing that would be suitable for the Mental Health and Wellbeing Commission (the Commission) to consider adopting, as part of the Commission's deliverables.
- This involved developing two outcomes and monitoring frameworks for the Commission to consider:
    - the He Ara Oranga wellbeing outcomes framework, a holistic outcomes framework for mental health, addiction and wellbeing; and
    - the He Ara Āwhina service monitoring framework to monitor mental health services and addiction services.
- The He Ara Oranga wellbeing outcomes framework design process included two key components: conceptual outcomes (narrative descriptions of wellbeing) and data (to monitor progress and measure performance).
- On 21 October 2020, the Initial Commission's board adopted a suite of conceptual outcomes that describe universal (whole population) and Māori (as tangata whenua) wellbeing.
- The conceptual outcomes (Appendix 1) were co-designed by an Expert Advisory Group (EAG) and consulted upon before they were recommended for adoption.[1]
- Following the design of the conceptual outcomes, a project was set up to identify a suite of data for monitoring progress and measuring performance (the data phase).
- The data phase is the subject matter of this report.

[1] He Ara Oranga wellbeing outcomes framework – Conceptual framework 12 October 2020.

Background

Initial Commission's deliverables

The Initial Commission's key deliverables include:

1. developing a draft outcomes and monitoring framework for mental health and wellbeing that would be suitable for the Commission to consider adopting.
2. begin to identify any gaps in information required to monitor performance under the draft framework and make recommendations to the Minister of Health on how these could be filled and by whom.

The final He Ara Oranga wellbeing outcomes framework (which will include conceptual outcomes and data) provides the vision and framework to achieve these deliverables.

The approach has been to develop the He Ara Oranga wellbeing outcomes framework first, followed by the He Ara Āwhina service monitoring framework, which will monitor mental health services and addiction services. The establishment of the Mental Health and Wellbeing Commission on 9 February 2021 included the transfer of the Mental Health Commissioner's monitoring functions to the Commission and formed the basis for the need for He Ara Āwhina.

The He Ara Oranga conceptual outcomes – an aspirational vision and approach

The He Ara Oranga wellbeing outcomes framework comprises a vision and a suite of wellbeing outcomes for all people in Aotearoa New Zealand. In line with He Ara Oranga (the report), the framework is designed to be both aspirational and inspirational. In short, it comprises one of several means to positively disrupt the future 'wellbeing' and mental health and addiction systems. As such, it pushes boundaries linked to wellbeing and future expectations.

Achieving a whole of population view of wellbeing is both a huge challenge and a great opportunity. There is no other framework of this kind currently in use that looks at aligning population indicators, system level measures, and tāngata whai ora measures. Our goal and opportunity are to up the 'whole system game' with front-facing action that contributes to the bigger picture of whole of population wellbeing. Our challenge, as a Commission, is how we achieve this within our functions.

The framework has three notable and unique design features:

- it is a holistic wellbeing framework with specific relevance to mental health and addiction. There is no existing framework that adopts the korowai (cloak) of wellbeing to benefit all whānau in Aotearoa and, in particular, those living with mental distress and addiction, as explicitly as ours does.

- the wellbeing outcomes are proposed to cascade from a population level through to a service level. There is no existing framework that seeks to align outcomes achievement from a whole population level through to systems and services. Most frameworks are aimed at either population OR system OR service levels.
- The wellbeing outcomes are depicted from both te ao Māori and shared wellbeing perspectives (the dual perspectives). There is no existing framework that incorporates this duality and respects both tangata whenua and tangata Tiriti perspectives.

In sum, the vision and conceptual wellbeing outcomes are as follows:

- Our vision – Tū tangata mauri ora, flourishing together.
- Wellbeing outcomes from a shared wellbeing perspective (for all people in Aotearoa):
    - being safe and nurtured
    - having what is needed
    - having one's rights and dignity fully realised
    - being connected and valued
    - healing, growth and being resilient
    - having hope and purpose
- Wellbeing outcomes from a te ao Māori perspective (for Māori as tangata whenua and others based on their self-determined sense of wellbeing):
    - whanaungatanga me te arohatanga
    - whakapuāwaitanga me te pae ora
    - tino rangatiratanga me te mana motuhake
    - ataahua o ahurea tuakiri
    - wairuatanga me te manawaroa
    - tūmanako me te ngākaupai

Each of the above wellbeing outcomes are supported by descriptions. These descriptions help to articulate 'what good looks like' conceptually, in the future.

The 'shared perspective of wellbeing' and 'te ao Māori perspective of wellbeing' should not be read as direct translations. They represent related concepts of wellbeing from different worldviews. The layers are additive – the 'shared perspective of wellbeing' may also apply to Māori (and potentially vice versa, subject to whakapapa[2]).

The conceptual He Ara Oranga wellbeing outcomes framework was approved at the Initial Commission's Board meeting on 21 October 2020. See Appendix 1 for more detail.

[2] Some te ao Māori outcomes may only apply to people with Māori whakapapa. For example, ahi kaa is a concept where Māori can trace their relationship to whenua (land) through their whakapapa linkages. Belonging, connectedness and pride with respect to whenua, whānau and whakapapa are important outcomes from a te ao Māori perspective.

Why have dual perspectives?

There are three main reasons.

First, te ao Māori worldviews acknowledge the unique position of Māori as tangata whenua and partners with the Crown through Te Tiriti o Waitangi. This reflects Māori rights as partners. The dual layering reflects the role that tangata whenua and tangata Tiriti have to play; working together to improve the collective wellbeing of all people in Aotearoa.

Second, the outcomes framework takes a whole-of-population view, but it also seeks to address the overarching question about whether we are improving equity of wellbeing outcomes for people and whānau of Aotearoa, with a focus on equity for Māori as tangata whenua. This reflects Māori needs as citizens of Aotearoa.

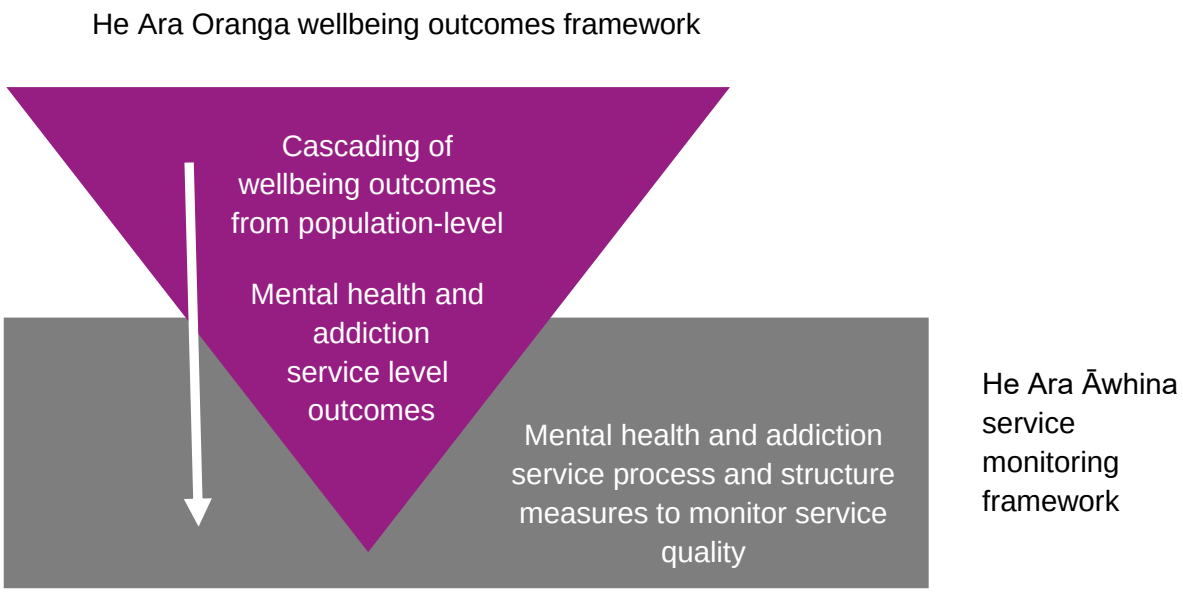
Third, the approach has wide sector support. It was recommended by the EAG, the Tangata Whai Ora Reference Group, as well as being supported by multiple external parties that the Initial Commission engaged with in 2020.

He Ara Oranga wellbeing outcomes framework and He Ara Āwhina service monitoring framework

The He Ara Āwhina service monitoring framework is a separate but interconnected framework that will monitor mental health services and addiction services and be used to advocate for improvements to those services. The development of this framework will be completed by June 2022 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 the Commission to advocate for improvement to those services.

Figure 1 shows how the two frameworks are intended to work together to monitor performance.

Figure 1 – Outcomes framework connected to service monitoring framework



As He Ara Āwhina enters the conceptual design phase, the Commission will need to ensure the two frameworks remain with a consistent line of sight. Continuity and overlap (where appropriate) between the Expert and Technical Advisory Groups for the two frameworks will be an important way to ensure consistency and a coherent logic.

The data phase

The data phase of the work began in September 2020 with the establishment of two Technical Advisory Groups (TAG–MHA focused on service level data and TAG-Population focused on population level data) to support this phase. A combined TAG meeting was held on 29 September 2020 to set the overarching approach and direction. This inaugural meeting was followed by multiple TAG-MHA and TAG-Population meetings up to December 2020.

Overarching approach

A stepped approach (see Figure 2) was used to develop the data suite that could be used to measure the He Ara Oranga wellbeing outcomes framework at population and mental health and addiction (MHA) service levels[3].

Creating a common language

The step to agree a common language and definitions was important and helped ensure the sub-groups remained aligned with their work. It is also important moving

[3] Note that we did not design at a system level due to timeframes and complexity. However, the TAG anticipates system level design in the future.

forward in terms of ensuring alignment with the He Ara Āwhina service monitoring framework, socialising the final framework and future utility.

Our approach draws on four distinct terms:

1. **Outcomes:** Narrative statements of the high-level state of wellbeing – the quality of life for people, whānau and communities. Distinct from processes – the activities, steps or outputs. The conceptual outcomes framework has key wellbeing outcomes for dual layers (as described earlier).
2. **Indicators:** Data that quantifies success (or not) at a population level (everyone) or sub-population-level (e.g. by region or by age group).
3. **Tāngata whai ora measures:** Data that quantifies success (or not) associated with people and whānau interacting with services (tāngata whai ora). For example, 'percentage of tāngata whai ora who are in stable accommodation three months after discharge'.
4. **Data:** Overarching term to include both indicators and tāngata whai ora measures. Can be quantitative and / or qualitative[4]. The data phase has focused on quantitative data to date.

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'. Our use of the terms indicators and measures draws from Results-Based Accountability[5] and is intentional given the application of this outcomes framework to both a population-level **and** MHA service-level. Data sources, scale, and to whom the data applies differs for indicators and measures.
- There is currently no definition for **mental health services and addiction services.** The He Ara Āwhina service monitoring framework work stream is in a consultation phase and asking what should be included as a mental health service and addiction service for the purpose of the Commission's s11(1)(e) function to monitor and advocate for service improvement. For the purposes of our work we are using the draft definition:

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

[4] We describe qualitative data as taking two forms. The first is data collected through survey or administrative sources which also have 'open ended' responses alongside the quantitative data. The second is data collected through other methods, such as interviews, observations, conducting focus groups, etc.

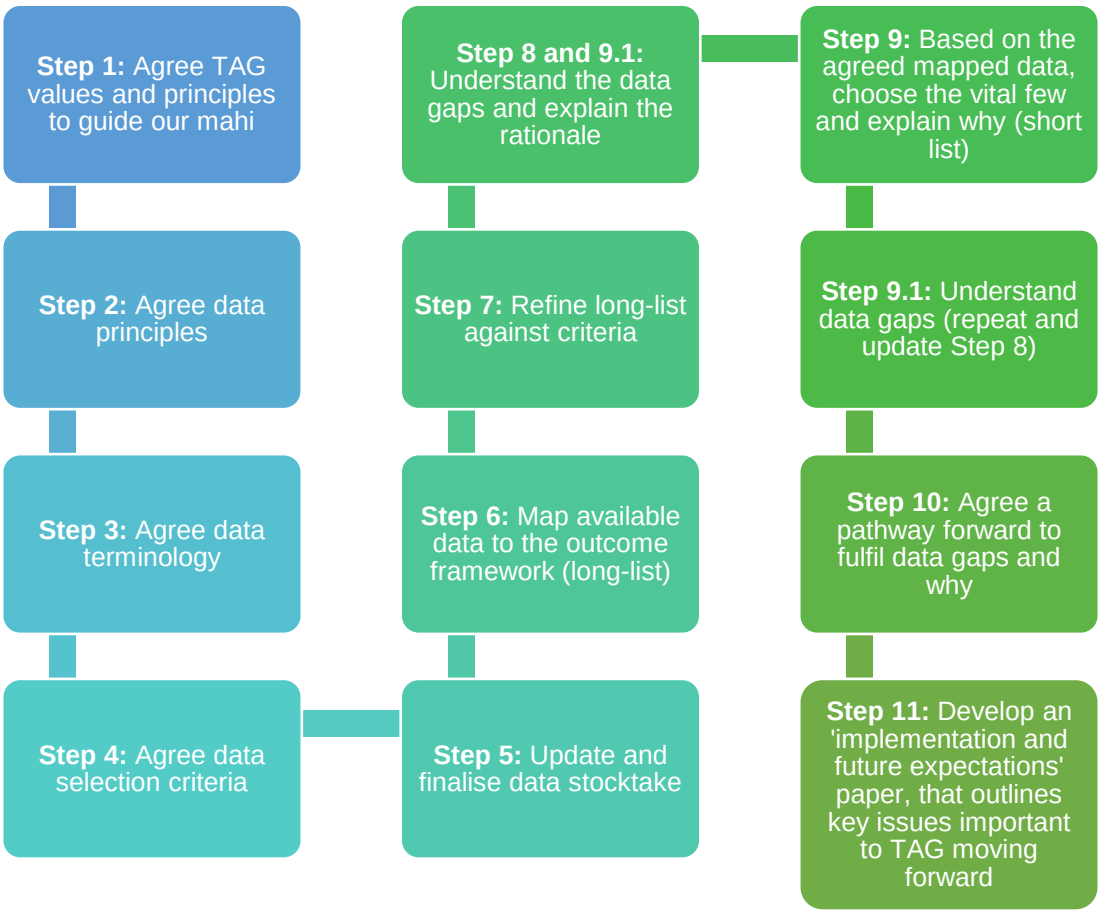
[5] https://www.procurement.govt.nz/procurement/specialised-procurement/social-services-procurement/developing-a-social-services-procurement-plan/how-to-measure-outcomes-and-outputs/

Data stocktake, criteria and understanding data gaps

The TAGs contributed to an initial stocktake of current sources of data linked to the wellbeing outcomes, at both a population level and mental health and addiction (MHA) service level. This enabled the Secretariat to prepare 'long lists' of existing and, therefore, potential population level indicators and tāngata whai ora measures. The data were mapped against the twelve outcome domains. There were significantly more data sources for population indicators than for tāngata whai ora measures.

The 'long lists' were assessed against agreed criteria to determine which indicators and measures might be shortlisted, and where information gaps exist.

Figure 2: Stepped approach to develop population indicators and tāngata whai ora measures for He Ara Oranga wellbeing outcomes framework



The 'steps' were not necessarily sequential, with tasks completed in parallel. Through all steps, priority was given to Te Tiriti o Waitangi opportunities, equity and the opportunity to support 'best possible' data for the Mental Health and Wellbeing Commission priority groups[6]. Whilst the two TAGs met separately from meeting two onwards, we worked to ensure alignment between the sub-groups.

[6] https://www.parliament.nz/en/pb/sc/reports/document/SCR_96349/mental-health-and-wellbeing-commission-bill

Where possible, we remained connected with the He Ara Āwhina service monitoring framework work, including providing positive feedback supporting the proposed definition of a mental health service and addiction service.

Choosing the short list of data

The process to shortlist the indicators and measures has been complex and within the challenging 12-week timeframe we managed to achieve a lot with the TAGs assistance. However, there is further work to do. This is an evolving process where the indicators and measures will continue to be refined over time.

Population level indicators

For the population indicators, we had almost 100 data sources and 420+ potential indicators[7] to assess against our criteria shown below.

Criteria
Te Tiriti o Waitangi – data that is important for Māori as tangata whenua and how it is measured
Timely – available without too long a delay and can provide information on changes over time. Subject to availability cycle being complete.
Strengths-based data - where possible, however it is recognised that deficit-based data can reflect another view of the 'picture'
Understandable – easy to interpret and understand
Meaningful – considered as meaningful and with utility to support wellbeing (based on broad support, a life course perspective, and outcomes meaningful to people / whānau with lived experience perspectives)
Relevant – directly relevant to the concept being measured
Aggregated and disaggregated – • able to be disaggregated for priority groups and geographic region, where possible • able to be aggregated with reasonable consistency in collection (in cases of service-level measures) and data collected across Aotearoa, rather than just one specific region or local council, where possible
Whānau data – appropriate unit of measurement – collective, not just individual data. Any data available at household level that also identifies the ethnicity of the household.
Alignment between population and service outcomes – there is logical alignment between population outcomes data and service level outcomes data.

[7] Only quantitative indicators are included.

Criteria
This reflects a ‘line of sight’ or contributory relationship between the two levels of wellbeing (but not necessarily attribution). This supports the logic that outcome-focused services contribute to improved population wellbeing but are not solely accountable for achieving population outcomes.

So far, the shortlisting process has resulted in 63 indicators (see Appendix 2) mapped to our 12 outcome domains for the Commission to consider. Many of these indicators obviously relate to mental wellbeing, others are broader social determinants that affect our mental wellbeing. For example, people living in crowded households are more likely to report mental health problems than those not living in crowded housing.

It should be noted that there is a reliance on the General Social Survey for the indicator data.

To finalise the indicators, the next stage of work needed is:

- a comprehensive application of Te Tiriti o Waitangi criteria. As a bare minimum, we have assessed whether the potential indicators capture Level 1 ethnicity for Māori, but this is not an adequate application of this criteria. This requires specialist advice and resource. We would recommend a small group of three to four people (including our specialist advisor, Sharon Shea, Shea Pita & Associates Ltd) come together to review the shortlist and further refine. Stats NZ has a Māori data analyst that can be accessed. Māori data sovereignty and governance needs to be considered as well.
- Application of the final criteria ‘alignment between population and service outcomes’, once we have the MHA service level measures shortlisted. To ensure that the data at every level remains connected, we will need to make sure that we sense-check the relationships as we choose and/or design indicator and measure data sets.

It is important to remember that all indicators are proxies for population outcomes - i.e. there is no single indicator that can measure the population outcome(s) - the aspirational conceptual domains.

Table 1 shows how the layers of indicators and measures work together to determine wellbeing outcomes.

Table 1: How the outcomes, indicators and tāngata whai ora measures work together

		Domains of wellbeing outcomes e.g. Have what they need		
Population	All people in Aotearoa	Common alignment of wellbeing outcomes and descriptions across the layers. Concept of the wellbeing domain is consistent across the layers, but data collection / data source, scale and whom data apply will differ from population-level to tāngata whai ora level. Examples are provided for one wellbeing domain – 'have what	Percentage of people in long term rental (12 months or more) or home ownership	'Cascading' Line of Sight
Māori	Māori		Māori 'slice' of population indicator	
Sub-population priority group	e.g. Pacific peoples, rainbow community		Pacific peoples' 'slice' of population indicator	
Tāngata whai ora using mental health and addiction services	e.g. people who use specialist MHA services, people who visit GP for mental health reasons		Percentage of people discharged from MHA services across the country who are in stable accommodation at three months after discharge	
Tāngata whai ora priority group	e.g. Pacific peoples, rainbow community		Pacific peoples' 'slice' of performance measure	

MHA service level measures

The work to shortlist the MHA service level measures has been more challenging. This was expected due to data source limitations from an 'outcomes' perspective. There are significantly less existing, common, or collection at scale data sources (compared to population indicators), with only 13 identified (so far) as outcomes measure sources, and 237[8] potential measures to assess against our criteria shown above[9].

The shortlisting process has begun but requires another round of review following the TAG-MHAs final meeting on 18 December 2020.

To finalise the measures, the next stage of work needed is:

- another round of assessment against the criteria, following the latest TAG-MHAs feedback;
- a comprehensive application of Te Tiriti o Waitangi criteria (combined process as suggested above for the indicators);

[8] The stock take of potential data sources, indicators and measures is an evolving list.

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

- an agreed mental health services and addiction services definition before the tangata whai ora measures can be finalised. The He Ara Āwhina framework's co-design process should have this agreed by February 2021; and
- application of the final criteria 'alignment between population and service outcomes'. To ensure that the data at every level remains connected, we will need to make sure that we sense-check the relationships as we choose and/or design indicator and measure data sets. As a minimum, there should be a positive 'connection' or contribution relationship between data at every level; as a maximum, there will be clarity about causation and / or attribution.

Understanding the data gaps

As we worked our way through assessing the data sources and potential indicators and measures with the TAGs, we have been able to identify data gaps and work needed moving forward.

There were obvious gaps in terms of a true wellbeing approach to outcomes. The identified data gaps are described below.

Te Ao Māori outcomes

Across both the indicators and measures there are significantly fewer potential data sources for te ao Māori outcomes. In addition, where these data sources do exist, they are collected far less frequently than indicators and measures for 'everyone'. Appendix 2 shows the timeliness of the data sources for the shortlisted indicators. While we can 'slice' indicators and 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 wellbeing'.

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

According to the 2019 / 20 New Zealand Health Survey[10], Māori adults were 1.9 times as likely to have experienced psychological distress[11] as non-Māori adults.

> "Māori data refers to data produced by Māori or data that is about Māori and the environments Māori have relationships with.[12] 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."[13]

[10] https://www.health.govt.nz/publication/annual-update-key-results-2019-20-new-zealand-health-survey

[11] Definition - Psychological, or mental, distress (aged 15+ years) refers to a person's experience of symptoms such as anxiety, psychological fatigue, or depression in the past four weeks

[12] Te Mana Raraunga - the Māori Data Sovereignty Network https://www.temanararaunga.maori.nz/

[13] Data Issues of Significance, Independent Māori Statutory Board 2019, p 7.

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 lack active Māori data governance mechanisms and, thus, lack a transparent mechanism for Māori influence.

Overall, this is a significant barrier and risk for the Commission; it is also an intersectoral issue that affects multiple government agencies. The Commission 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 outcome data, whānau-level data is rare at the MHA 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 whai ora 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.[14]

Priority groups

A number of the criteria applied to the potential indicators and measures consider whether they can monitor wellbeing outcomes for priority groups of people. At a population level shortlisted indicators and measures were relevant to outcome concepts and will be relevant to 'everyone'. There are, however, big gaps in terms of our ability monitor and measure wellbeing outcomes 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. Ethnicity is the only reliable, routinely collected identifier.

MHA service level data sources limited and narrow in scope

There are significantly more population level data sources suitable for measuring wellbeing outcomes than MHA service level data sources. In addition to this, the MHA service measures mainly focus on specialist services. They are fit for the purpose for which they were developed and intended but less suitable for monitoring wellbeing outcomes (in accordance with the Commission's functions). Also, many of the MHA service level tools are clinically oriented assessment or screening tools, and some are adapted for individual needs.

[14] https://thehub.swa.govt.nz/assets/Uploads/Whanau-rangatiratanga-frameworks-summary.pdf

While MHA 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.

Strengths-based

The conceptual framework is strengths-based and positively framed. It depicts an intentional future state. Within the MHA service level measures, there were substantially more deficit-based measures, at around 70 per cent of those assessed. This reduced the number of measures suitable for the framework. However, the TAGs also felt that including some deficit-based indicators and measures could add balance. Therefore, this reduced the impact of this issue on the shortlists, but the issue of a comparative dearth of strengths-based vs deficit-based remains.

Timeliness

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

Collection - there is very useful data that is captured on a very infrequent basis (e.g. Te Kupenga). There are indicators and measures that rate highly against many of our criteria but are collected too infrequently to be of 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. At the moment, in any given year, data will be six to 12 months old before it is complete, able to be analysed, and considered accurate.

We do 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 wellbeing outcome data is a gap at this point in time. As the Government continues to invest significant amounts to deliver new integrated primary mental health and addiction services (IPMHAS) it is important that suitable outcome measures that enable measurement across the priority groups are in place, and data is collected and accessible in a timely manner. The Ministry of Health is working to roll out the new contracts and establish a data reporting mechanism.

As at the end of October 2020, IPMHAS are being implemented in 117 GP sites across 15 District Health Boards (DHBs). The programme provides new roles at GP sites - these are Health Improvement Practitioners (HIPs) and Health Coaches (HC) and/or Support Workers (SW). By the end of October 2020, there were 78 active HIPs and 117 active Health Coaches/Support Workers delivering IPMHAS. Collectively they have delivered 54,499 sessions. As at the end of October 2020, the Ministry of Health estimate coverage of 780,000 people. By June 2021, they estimate IPMHAS will reach an enrolled population of around 1.5 million people in Aotearoa. As part of this initiative, work is also underway to establish new primary mental health and addiction services in kaupapa Māori, Pacific and youth settings.

Outcome measures are collected at most appointments for the HIP role and intermittently for the HCs. For HIPs, the measures used are Hua Oranga for Māori or others where appropriate (but there is a specific version of Hua Oranga in use that differs from secondary services), the DUKE for adults, and the Strengths & Difficulties Questionnaire (SDQ) for children and young people. Some areas use the same options for HCs, and use is variable for SWs. Some areas use Hua Oranga for all HCs.

Detailed NHI-based information with contact and outcome information is to be reported monthly and the Ministry of Health has developed an interim reporting system to capture the data – with a manual spreadsheet or the option of an Excel extract from their own client management systems. This is submitted securely and then stored in a spreadsheet in the data warehouse. A reporting system is in the proof of concept phase.

Emergency Departments (ED)

Prior to the access and choice investment by Government, access at the specialist and crisis end of services had been increasing. Mental health-related ED presentations nearly doubled and wait times in ED for an inpatient bed grew five-fold between 2017 and 2018, and police events related to mental distress or suicide attempts continue to increase.[15] Emergency medicine and police representatives expressed concern that after-hours the ED is the default place for people to go.

There is currently a lack of data through the national non-admitted patient collection (NNPAC) on people presenting to New Zealand EDs for mental health-related reasons. The rollout of SNOMED CT is mandatory for all DHBs from 2021, and this clinical terminology should provide meaningful analysis for ED attendances in the future.

[15] https://www.police.govt.nz/about-us/statistics-and-publications/data-and-statistics/demand-and-activity

Implementation and future expectations

The purpose of this section is to outline a range of opportunities identified by the EAG, the TAGs and/or the Chair of the advisory groups (Sharon Shea) about how to implement the framework. It reflects the combined commitment of the advisory groups to support the Commission's role and desire to implement the outcome framework in a sustainable and effective way. These opportunities are in addition to, or may expand, other opportunities and commentary in the earlier part of this report; they should be seen as additive.

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[16]. Some of the existing wellbeing 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 of time 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".[17] The TAGs encourage the Commission to maintain its 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 TAG Chair suggests that the outcome framework is much more than outcomes; it is a guide which enables the Commission to shift the way the whole system can work better for whānau and tangata whai ora.

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[16] See the New Zealand Health & Disability System Review Reports for recent evidence about this in the health system. Source: https://systemreview.health.govt.nz/final-report/. Accessed January 2021.
[17] He Ara Oranga, p119.

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[18]. 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, the Commission, 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.

What's my contribution – 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. Somewhat similar to logic model thinking linked to "if and then", 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).

An Influencer vs a funder and roles to play

The Commission is not a funder. However, it is expected to understand and comment upon Wellbeing, which is strongly influenced by multiple funder decision-making. Therefore, the Commission has a role to influence and partner with many for a common good, which is articulated via its national wellbeing outcome framework (as one of several tools in its kete).

The TAGs acknowledge the Influence role and support the Commission's ability to articulate what good looks like and measure the same. Advanced negotiation and partnering skills will be required to ensure multiple partners do work together to achieve Wellbeing. A key partner is the Ministry of Health, as they develop outcome measures and data sets from a wellbeing perspective, such as those being rolled out for the IPMHAS.

[18] This is a key message from the Results Based Accountability outcome method adopted by MBIE and other New Zealand agencies per Streamlined Contracting and other strategies. See: https://www.procurement.govt.nz/procurement/specialised-procurement/social-services-procurement/developing-a-social-services-procurement-plan/how-to-measure-outcomes-and-outputs/. Accessed January 2021.

A common language is required so we talk to each other, not past each other

There is no consistent or common language about outcomes in the sector. Multiple initiatives fail for this reason. The Commission should champion a common language across all its work.

From ends to means; not means to ends[19]

The advisory groups talked about an outcome-focused approach and the difference between ends and means. If we agree that ends are outcomes, the means are how we get there (e.g. what we buy, what we deliver, how we deliver, to whom, etc.).

The advisory groups adopted an 'ends to means' approach to their work, because when you start with what you want to achieve, then you customise the 'how' accordingly. If we continually start with means first, we miss the opportunity to critique it from an outcomes' perspective.

Accordingly, it is envisaged that, over time, the outcomes framework will drive the design of the most effective means, which range from services through to policy, process, and clinical practice.

Whānau and tāngata whai ora 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 (and arguably are paid to fulfil this role), 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.

Data is key – but there are many gaps and opportunities

Monocultural prioritisation of 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 New Zealand citizens. As a result of this work, it was very obvious that, overall, data sets have been prioritised, developed, collected, and analysed from a predominantly monocultural (western) perspective. Most readily available data is based on individual issues and is not collective, such as wellbeing outcomes by whānau; it is deficit focused compared to being strength-based, it does not readily reflect an equity perspective across the life course; and it reflects a monocultural view of what is important compared to what is culturally important to non-western peoples.

[19] A principle from RBA.

It is acknowledged that over the last 5-10 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. A case in point is Te Kupenga, which is an excellent survey of wellbeing from a kaupapa Māori perspective.

However, the pace of change is slow. It is patchy and inconsistent – e.g. Te Kupenga survey data has been collected in 2013 and 2018 (but is only funded for every 10 years), which in the advisory groups' view, is not frequent enough.

The advisory groups are very 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 the best' that is currently available[20]).

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.

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

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 the Ministry of Health. This will help us to develop preventative approaches, and with 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.

In the interim, we understand the Ministry of Health is reviewing data sets already available within the health system and across the social, education, and justice sectors. We would encourage the increased frequency of the Mental Health module within the New Zealand Health Survey while this recommendation is progressed.

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[20] We note that some deficit-based data is valuable (such as mortality and morbidity data) as it provides insight into what is not working. We need a balance between strengths and deficit, which gives us a robust view of Wellbeing.

Understanding how well services and supports are meeting peoples' needs requires fit-for-purpose, real-time information

Collecting fit-for-purpose, real-time information at service delivery level and, in particular, in primary care requires substantial work. The development of consistent data infrastructures that can be used by a range of contracted services will be important for enabling access to real-time data that is consistent and connected across providers. The Ministry of Health is investing in improved data through the primary mental health initiatives – working with primary care to access NHI-based reporting of access to services, reasons for service use, visits, reported helpfulness and outcomes. This information will be able to be analysed for different ages, ethnicities, and priority groups. It will be important to ensure systematic access to this information and we understand this is currently in a proof of concept phase.

The General Social Survey provides a significant number of indicators that map well to the outcome concepts. However, this survey needs to be more frequent. We would recommend it is conducted annually.

More work to do at the systems-level

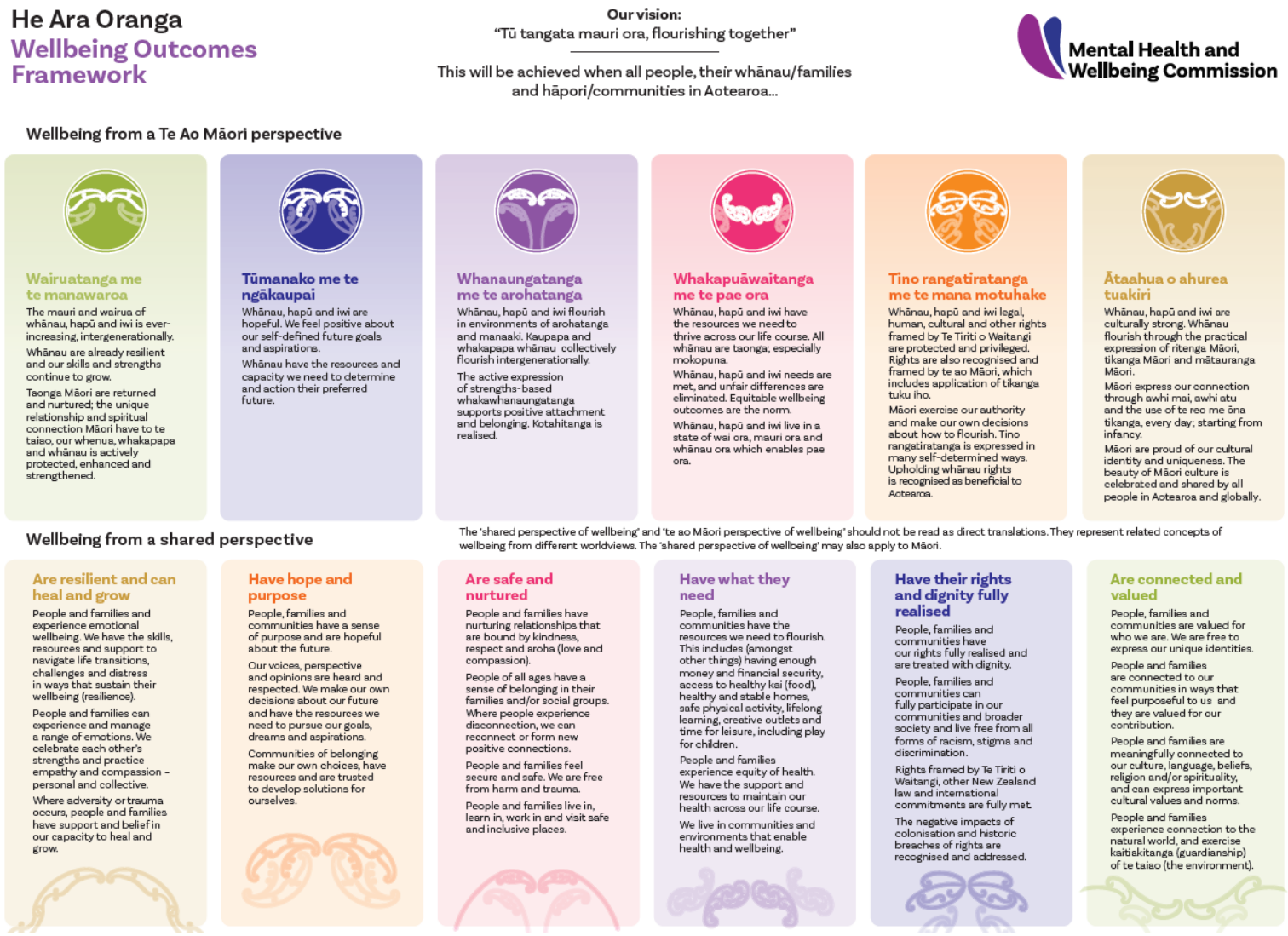
The advisory groups have designed the outcomes framework and discussed prospective data sets at a population and service level only. The systems level needs to be designed but was out of scope for our work, due to time constraints.

Next steps

The He Ara Oranga wellbeing outcomes framework is at the final stages of development and will hand over to the Commission in February 2021. Steps beyond February are subject to the direction of the Commission and their work programme. The Commission needs to consider how it gives effect to the proposed framework, such as bringing together different data sets, analysis, and reporting. We acknowledge the sheer amount and complexity of the work required to implement the outcomes framework. This will need to be connected with the overarching implementation roadmap (once developed) for He Ara Oranga's 38 recommendations.

The Commission will need to ensure the He Ara Oranga wellbeing outcomes framework and the He Ara Āwhina service monitoring framework remain consistent and connected with each other.

Appendix 1 - The He Ara Oranga conceptual wellbeing outcomes framework (English and Te Reo Māori)



Te Pou Tarāwaho o Ngā Putanga Koiora o He Ara Oranga

Te Whakakitenga:
"Tū tangata mauri ora"

Ka tatū tēnei mō ngā tāngata , ngā whānau me ngā hapori o Aotearoa, inā ka...

Mental Health and Wellbeing Commission

Te toiora mai i te tirohanga a Te Ao Māori

Wairuatanga me te manawaroa

Ka piki te mauri me te wairua o ngā whānau, ngā hapū me ngā iwi, tuku iho ki ngā reanga

Kua manawaroa ngā whānau, ā, ka tipu haere tonu ngā pūkenga me ngā kaha.

Ka whakahokia atu ngā Taonga Māori kia tiakina e tātou; ka haumarutia te hononga ahurea me te hononga wairua a te Māori ki te taiao, me ō tātou whenua, ā, ka āta tiakina, ka whakapakaringia, ka whakakahangia hoki ngā whānau.

Tūmanako me te ngākaupai

E kauae runga ana ngā whānau, ngā hapū me ngā iwi. E whakaaro pai ana ki te huarahi e takahia ana e tātou kia eke ai ngā wawata.

Kei ngā whānau ngā rauemi me ngā āheitanga ki te whakatau me te whakarite i ō rātou ake anamata.

Whanaungatanga me te arohatanga

Ka matomato te tipu a ngā whānau, ngā hapū me ngā iwi i roto i te taiao o te arohatanga me te manaaki. Ka matomato te tipu o ngā kaupapa me ngā reanga katoa o te whakapapa whānau.

Ka whakatauiratia ngā torokaha o te whakawhanaungatanga hei taunaki i te hononga ngākaupai me te noho tau. Ka whakatinanahia te Kotahitanga.

Whakapuāwaitanga me te pae ora

Ka riro i ngā whānau, ngā hapū me ngā iwi ngā rauemi kia haruru hauora nui. He taonga ngā whānau katoa; tae rawa iho ki ngā mokopuna. Ka tatū ngā hiahia a ngā whānau, ngā hapū me ngā iwi, ā, ka mukua atu ngā tāwēwētanga whakatakē. Ka noho māori ngā putanga toiora taurite. Ka noho ngā whānau, ngā hapū me ngā iwi i raro i te maru o te wai ora, te mauri ora me te whānau ora hei whakaputa i te pae ora.

Tino rangatiratanga me te mana motuhake

Ka haumarutia, ka whakatiketikehia ngā ture o ngā whānau, ngā hapū me ngā iwi, tae atu ki ērā o te ira tangata, o te ahurea me ētahi atu mōtika e hangaia mai ana i Te Tiriti o Waitangi. Kia whakamanahia hoki ngā mana o te ao Māori pērā i te karawhiu i te tikanga tuku iho.

Ka whai rangatiratanga te iwi Māori ki te whakatau i ō tātou ake take e matomato ai. Ka whakapuakina te tino rangatiratanga i ngā āhua katoa. Ki te whakamanahia ngā mōtika o te whānau, ka pai atu a Aotearoa.

Ātaahua o ahurea tuakiri

E pakari ana te ahurea o ngā whānau, ngā hapū me ngā iwi. Ka matomato te tipu o te whānau mā te whakatinana i te ritenga Māori, te tikanga Māori me te mātauranga Māori.

Ka whakapuakina e te Māori ngā hononga mā te tikanga awhi mai, awhi atu, me te whakamahi i te reo me ōna tikanga, i te ao i te pō; mai i te wā e poniponi ana.

E whakahī ana te Māori ki tōna ahurea tuakiri me tōna motuhaketanga. Ka whakanui, ka whiua te ataahua o te ahurea Māori e ngā tāngata katoa i Aotearoa, huri noa i te ao.

Te toiora mai i te tirohanga takirua

Manawaroa kia tipu kia ora

Ka rongo ngā tāngata me ngā whānau i te toiora kareāroto. Kia tino riro mai i a tātou ngā pūkenga, ngā rauemi me ngā tautoko hei tāroi i ngā auheke, i ngā taero me ngā ngaru whakapuke o te wā, e pakari ake ai te toiora (manawaroa).

Ka rongo, ka tāroi hoki ngā tāngata me ngā whānau i ngā tūmomo kareāroto. Ka whakanuia ngā kaha a ētahi, ka whakatinana hoki i te aroha me te ngākau māhaki - ā-takitahi, ā-takitini hoki.

Ahakoa ki hea rongohia ai te taumaha me te ngaukino rānei, ka whai tautoko, ka whai pono hoki ngā tangata. me ngā whānau i tō.

Manako, ka whai tikanga

Ka whai tikanga ngā tāngata, ngā whānau me ngā hapori, ā, e aro whakamua ana ki tua.

Ka rongohia, ka whakautetia ō tātou whakaaro, kōrero hoki. Ko tātou tonu ka whakatau i ō tātou take e pā ana ki ō tātou anamata, ā, kia riro mai ngā rauemi hei aru i ngā whāinga, ngā moemoeā me ngā wawata.

Ko ngā hapori manaaki ka whakatau i ō rātou ake kōwhiringa, ka riro rauemi hoki, ā, ka whakaponotia rātou ki te kimi i te huarahi tika.

Noho haumaru, ka noho āhuru

Ka noho āhuru ngā hononga a ngā tāngata me ngā whānau, i roto i te māhaki, te whakaute me te aroha.

Ka mauri tau ngā reanga tāngata katoa i roto i ō rātou whānau/rōpū pāpori rānei. Mēnā kei konā te tangata e noho momotu ana, hei konā anō mātou hei tūhono, hei hanga rānei i ngā hononga pai.

Ka noho haumaru te tangata me ngā whānau. Ka noho kore here i ngā kino me ngā pāmamae

Ka noho, ka mahi, ka haere hoki te tangata ki ngā wāhi haumaru.

Riro mai i tā rātou i hiahia ai

Ka riro i ngā tāngata me ngā whānau ngā rauemi kia matomato. Kei roto i tēnei (me ētahi atu mea) ko te pūtea, ko te haumaru pūtea, ko te whai wāhi ki ngā kai hauora, ki ngā kāinga ora, ki ngā mahi korikori haere, ki ngā akoranga pūmau, ki ngā toa auaha, me te whai wā anō ki ngā ngahau pērā i te tākaro tahi me ngā tamariki.

Ka whai wheako te tangata me ngā whānau ki te hauora taurite. Ka whai tautoko, ka whai rauemi hoki ki te whakanoho i te hauora puta noa i ō tātou oranga.

Ka noho ki ngā hapori me ngā taiao whakakaha i te hauora me te toiora.

Whai kiko tō rātou mana

Ka whai mana ngā mōtika o te tangata, ngā whānau me ngā hapori, ā, ka noho rangatira rātou.

Ka whai wāhi ngā tāngata, ngā whānau me ngā hapori ki te hapori whānui me te noho wātea i te kaikiri, te ngaukino me te whakaparahako.

Kia pūmau tonu ki ngā mōtika i hangaia i Te Tiriti o Waitangi, i ngā ture whaipānga o Aotearoa me te ao hoki.

Ka whakatikahia atu ngā pānga kino o te whakawaimehatanga me ngā takahitanga mōtika ō mua.

Tūhono, ka whai mana

Ka whai uara te tuakiri o te tangata, ngā whānau me ngā hapori. E wātea ana ki te whakapuaki i ō tātou tuakiri ahurea.

Ka tūhono te tangata me ngā whānau ki ō tātou hapori i runga i te wairua whai take ā ka uaratia tātou i ngā whai wāhitanga atu.

E whai hononga hōhonu ana ngā tāngata me ngā whānau ki ō tātou ahurea, reo, whakapono, hāhi, wairuatanga rānei, ā ka taea te whakapuaki i ngā uara me ngā mahi ahurea.

Ka rongo ngā tāngata me ngā whānau i te hononga ki te ao tūroa, me te whakamahi anō i te kaitiakitanga o te taiao.

Appendix 2 – Draft population indicators

Domain	Outcome concept	Potential indicator	Data source	Timing
DS1: are safe and nurtured	**Feel secure and safe**	Percentage of people reported high levels of trust in most other people	**General Social Survey**	two years
	Free from harm and trauma	Rate of injuries per 100,000 people	**Ministry of Health, Mortality Collection and National Minimum Dataset**	Annual
		Percentage of people who experienced a violent interpersonal offence in the last 12 months	**NZ Crime and Victims Survey**	Annual
	Live in, learn in, work in and visit safe and inclusive places	Injury prevalence: Rate of people per 1,000 full-time equivalent employees who have had a claim accepted for a work-related injury	**ACC**	Annual
		Rate of people per 100,000 who have been injured or died in a motor vehicle traffic incident	**NZ Transport Agency**	Annual
	Nurturing relationships	Percentage of adults who felt lonely at least some time in the last four weeks	**General Social Survey**	two years
		Percentage of people who rated their family wellbeing highly	**General Social Survey**	two years

Domain	Outcome concept	Potential indicator	Data source	Timing
DS2: have what they need	**Access to healthy kai (food)**	Percentage of people who have gone 'a little' or 'a lot' without fresh fruit and vegetables in last 12 months to keep costs down	**Household Economic Survey**	Annual
	Equity of health	Percentage of adults who rated their health status as good, very good or excellent	**NZ Health Survey**	Annual
	Having enough money and financial security	Percentage of adults who report they do not have enough money to meet everyday needs	**Household Economic Survey**	Annual
		Percentage of households who felt their household income was enough or more than enough to meet their everyday needs	**Household Economic Survey**	Annual
	Healthy and stable homes	Household crowding	**Census** **General Social Survey**	Annual
		Housing tenure (owned, not owned)	**General Social Survey**	two years
		Housing affordability - scale based measure (0-10)	**General Social Survey**	two years
	Lifelong learning	Percentage of people enrolled in any study (formal, informal, non-formal)	**Household Labour Force Survey**	Quarterly
		Rate of participation in tertiary study	**Ministry of Education**	Annual

Domain	Outcome concept	Potential indicator	Data source	Timing
	Live in communities and environments that enable health and wellbeing	Percentage of New Zealanders who have safe drinking water	**Ministry of Health, Drinking Water**	Annual
		Alcohol license density	**Massey University**	Annual
	Safe physical activity	Physical activity (did 2.5+ hours of physical activity per week)	**NZ Health Survey**	Annual
	Support and resources to maintain their health across life course	Percentage of people who have 'a little' or 'a lot' postponed or put off visits to the doctor to keep costs down	**Household Economic Survey**	Annual
		Unmet need for GP due to cost	**NZ Health Survey**	Annual
		Percentage of adults meeting sleep recommendations	**NZ Health Survey**	Annual
		Percentage of children meeting sleep recommendations	**NZ Health Survey**	Annual
	Time for leisure	Percentage of people satisfied or very satisfied with their work-life balance	**Labour market statistics (Survey of working life); Part of core GSS**	two years

Domain	Outcome concept	Potential indicator	Data source	Timing
			content from 2021	
		Percentage of people who feel had enough leisure time	**General Social Survey**	two years
DS3: have their rights and dignity fully realised	**Live free from racism, stigma and discrimination**	Percentage of people who reported experiencing discrimination in the last 12 months	**General Social Survey**	two years
		Experience of racism	**NZ Health Survey**	Module
DS4: are connected and valued	**Connected to communities in ways purposeful to them (education, employment, volunteering, parenting and/or caregiving)**	Percentage of people who felt satisfied or very satisfied with their job in the last four weeks	**General Social Survey**	two years
	Connected to culture, language, beliefs, religion and/or spirituality	Percentage of population who can speak the first language (excluding English) of their ethnic group	**Census**	five years
	Valued for who you are - free to express their unique identities	Percentage of people who reported that it was easy or very easy to be themselves in New Zealand	**General Social Survey**	two years

Domain	Outcome concept	Potential indicator	Data source	Timing
DS5: are resilient and can heal and grow	**Emotional wellbeing**	Positive mental wellbeing (WHO-5)	**General Social Survey**	two years
		Percentage of people reporting psychological distress in the last 4 weeks (high or very high probability of anxiety or depressive disorder, K10 score ≥12	**NZ Health Survey**	Annual
		Self-rated health	**NZ Health Survey**	Annual
	Skills, resources and support to navigate life transitions, challenges and distress	Percentage of people who said it would be 'very easy' or 'easy' to talk to someone if they felt down or a bit depressed	**General Social Survey**	two years
		Percentage of hazardous drinkers (AUDIT score ≥8, among total population)	**NZ Health Survey**	Annual
DS6: have hope and purpose	**Communities of belonging making their own choices, have resources and are trusted to develop solutions for themselves**	Disaggregated 'percentage of people who feel they have control over their lives' by priority groups (where possible)	**General Social Survey**	two years
	Hopeful about the future	Percentage of people who think they will feel satisfied with their life in five years' time	**General Social Survey**	two years

Domain	Outcome concept	Potential indicator	Data source	Timing
	Make their own decisions about their future	Percentage of people who feel they have control over their lives	**General Social Survey**	two years
	Sense of purpose	Percentage of people who reported a high sense of purpose	**General Social Survey**	two years
	Voices, perspective and opinions are heard and respected	Percentage of enrolled electors who vote in the general election	**Electoral Commission**	three years
DT1: whanaungatanga me te arohatanga	**Active expression of strengths-based whakawhanaungatanga supports positive attachment and belonging**	Whānau relationships are positive, functional and uplifting of all members.	**Te Kupenga**	five years
	Flourish in environments of arohatanga (care, love and compassion) and manaaki (protection, respect, generosity)	Percentage of Māori who find it very easy or easy to find someone to support them in times of need	**Te Kupenga**	five years
		Whānau wellbeing	**Te Kupenga**	five years
DT2: whakapuāwaitanga me te pae ora	**Equitable wellbeing outcomes are the norm**	Percentage of Māori children (aged 0-17 years) living below the 60 percent income poverty threshold after housing costs	**Household Economic Survey**	Annual

Domain	Outcome concept	Potential indicator	Data source	Timing
		Percentage of Māori secondary school leavers who left school with a qualification at NCEA level 2 or above	**Ministry of Education, Schooling Statistics**	Annual
	Live in state of wai ora, mauri ora and whānau ora which enables pae ora	Percentage of Māori who rate their own health as excellent or very good	**NZ Health Survey**	Annual
DT3: tino rangatiratanga me te mana motuhake	**Can exercise their authority and make their own decisions about how to flourish**	Percentage of Māori registered with an iwi	**Te Kupenga**	five years
		Percentage of Māori voting age population who voted in the general election	**Electoral Commission**	three years
		Percentage of Māori eligible to vote in iwi election who did so	**Te Kupenga**	six years
	Tino rangatiratanga is expressed in many self-determined ways	Percentage of Māori in management positions	**Census**	five years
		Growth in the Māori economy	**NZIER**	Once in 2010
DT4: ataahua o ahurea tuakiri	**Beauty of Māori culture is celebrated and**	Percentage of people who agree or strongly agree that government should encourage and	**General Social Survey**	two years

Domain	Outcome concept	Potential indicator	Data source	Timing
	shared by all New Zealanders and globally	support the use of te reo Māori in everyday situations		
		Percentage of people who agree or strongly agree that all people in New Zealand should understand te reo Māori and English [or Agree/Strongly agree 'It would be good if all people living in New Zealand spoke Māori and English']	**General Social Survey**	two years
	Culturally strong - flourish through the practical expression of ritenga Māori, tikanga Māori and mātauranga Māori	Percentage of Māori students engaged in Te Reo Māori at NCEA Level 1, 2 and 3	**Ministry of Education, Māori language in education series**	Annual
		Marae visits in the past 12 months	**Te Kupenga**	five years
	Express their connection through awhi mai, awhi atu (reciprocal support)	Percentage of Māori who have worked voluntarily for, or through, any organisation, group or marae	**Te Kupenga**	five years
	Proud of cultural identity and uniqueness	Percentage of Māori who think it is very important or quite important to be involved in things to do with Māori culture	**Te Kupenga**	five years

Domain	Outcome concept	Potential indicator	Data source	Timing
	Use of te reo me ōna tikanga, every day; starting from infancy	Percentage of Māori students enrolled in kura kaupapa Māori and kura teina	**Ministry of Education, Schooling Statistics**	Annual
		Percentage of Māori who are able to have a conversation in Māori about a lot of everyday things	**General Social Survey**	two years
		Ability to speak te reo Māori	**Te Kupenga**	five years
DT5: wairuatanga me te manawaroa	**Unique relationship and spiritual connection to te taiao, whenua and whakapapa and whānau is actively protected, enhanced and strengthened**	Knowledge of own iwi and hapū	**Te Kupenga**	five years
DT6: tūmanako me te ngākaupai	**Are hopeful**	Percentage of Māori who think things are getting better for their whānau	**Te Kupenga**	five years
Overall subjective measures	**Overall subjective measures**	Percentage of people who rated their life satisfaction highly	**General Social Survey**	two years