ATAMIRA PLATFORM

TE POU

NGO outcome measurement: Survey results

July 2026

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Preliminary findings of the survey were presented to the Platform online leaders forum (March 2026) and Navigate group (June 2026).

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Background

Non-government organisations (NGOs) play a significant role in supporting people, whānau and communities experiencing addiction and/or mental health challenges.

Outcome measurement is essential for knowing whether NGO services are making a difference in people's lives, especially outcomes self-reported by tāngata whai ora and whānau. Outcome measurement helps determine whether services are achieving equity for Māori. Outcome data also helps to tell a story of impact, value, and worth of services.

Currently there is no clear picture, single data source, or national approach to outcome measurement in Aotearoa New Zealand's mental health and addiction NGOs. *A Sound Investment: Spotlight on the Impact and Value of Mental Health and Addiction NGO Services in New Zealand* (2025) highlights the need to tell a consistent story of the impact of NGOs. To tell a coherent story, outcomes and outcome measurement need to be relevant to NGOs and the people they serve.

Atamira Platform Trust and Te Pou undertook a survey of NGO mental health and addiction services to better understand the current landscape of outcome measurement in the NGO sector. The aim was to gain a baseline understanding of outcome measurement in NGOs and inform future directions and decision making. This report describes the findings of the survey. For a discussion of what the findings mean and recommendations on next steps, refer to the complementary report *Mental Health and Addiction NGO Outcome Measurement in Aotearoa New Zealand* (Te Pou & Atamira Platform Trust, 2026).

Method

An online survey was distributed to the NGO sector via Atamira Platform Trust member's list and Te Pou e-bulletin in March 2026. Analysis used Survey Monkey and Excel. Results are reported for Kaupapa Māori and non-Kaupapa Māori services where possible.

Key findings

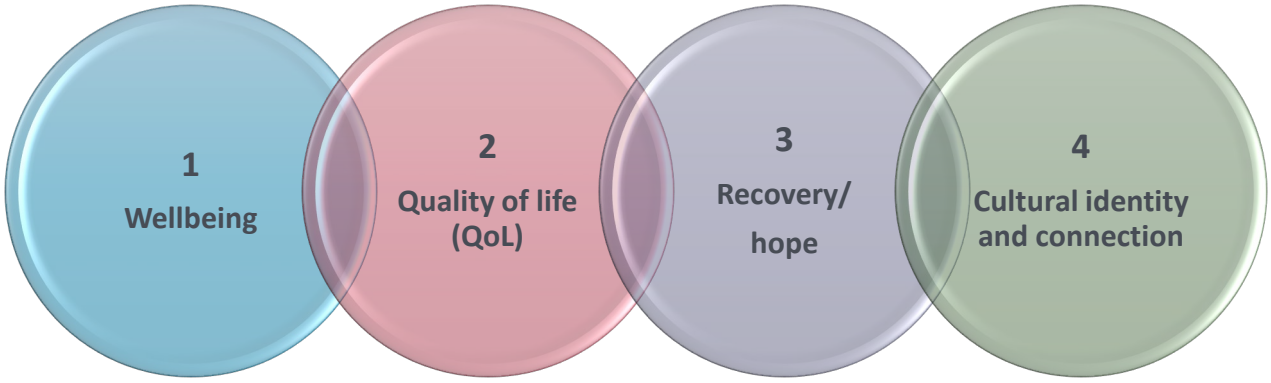
A wide range of organisations responded to the survey

- Seventy-four organisations responded to the survey with good regional representation – reflecting a high response from the 200+ mental health and addiction NGOs in Aotearoa New Zealand.
- One-quarter of respondents were Kaupapa Māori organisations. Others include but are not limited to mainstream, lived experience, and Pasifika organisations. Half were mental health organisations, one-quarter addiction, and one-quarter both mental health and addiction.

Outcome data is valued and collected across the NGO sector in diverse ways

- Outcome data is highly valued across the sector, most often being used to identify people or whānau needs, set goals, or track progress. Outcome data helps to demonstrate impact for people and whānau, and services.
- Almost all NGOs responding (96 percent) collect outcome data from any source, such as narratives and/or standardised tools. Most collect information regularly (87 percent all the time or frequently).
- Wellbeing is the most common outcome domain of interest across all organisation types. Figure 1 shows the top four ranked domains. Kaupapa Māori organisations ranked cultural identity and connection as high as wellbeing.

Figure 1: Top 4 outcome domains of interest



- Many organisations use multiple approaches to collect outcomes data. The main approaches are narrative storytelling (88 percent) standardised or other developed outcome tools (74 percent), specific key indicators (31 percent), Indigenous or cultural approaches (25 percent).
- Kaupapa Māori, addiction, larger organisations, and organisations supporting infants, children and youth (ICY, in addition to adult age groups) are more likely to use standardised tools.
- Where use of standardised tools is lower, use of narratives tends to be higher, especially for non-Kaupapa Māori, lived experience, and smaller organisations.
- The most common standardised tools used to measure outcomes from the list provided in the survey include:
  - Hua Oranga, a Māori wellbeing outcome tool (50 percent), particularly among Kaupapa Māori services and larger NGOs (50+ FTE)
  - Alcohol and Drug Outcome Measure (ADOM), a substance use and recovery outcome tool (46 percent), particularly among addiction services

- Substances and Choices Scale (SACS), a youth-specific substance use screening tool (33 percent), particularly among Kaupapa Māori, addiction services, and those who support ICY.

- The use of Hua Oranga aligns strongly with wellbeing being ranked as a top outcome domain of interest. All organisations using Hua Oranga ranked wellbeing as a highly important outcome domain. While it is well used among Kaupapa Māori organisations, around half of non-Kaupapa Māori organisations also use it. Hua Oranga is also well used across lived experience, mental health or mental health and addiction organisations, larger organisations, and organisations that support ICY.
- Use of mandatory tools (ADOM and HoNOS/HoNOSCA – Health of the Nation Outcome Scale/for children and adolescents) is higher among Kaupapa Māori compared to non-Kaupapa Māori services taking part in the survey.
- Around half of organisations use other standardised tools (54 percent), or their own tool that may have been developed internally (32 percent).

Key barriers remain to increased use of outcome measurement

- Time and capacity are the key barriers to outcome measurement, as well as systems and infrastructure (eg electronic records integration).
- Relevant, easy to use, and integrated outcome measurement tools are common enablers that address key barriers.

Organisations are generally interested in a national approach to outcome data collection and use, with key conditions

Community of practice

- More than 4 in 5 (84 percent) have some level of interest in an outcome measurement community of practice. Key conditions that need to be in place for this to work include:
  - upholding Māori data sovereignty (especially for Kaupapa Māori organisations)
  - confidentiality, privacy, and respect for the data
  - clear guidance or a framework
  - ensuring use is mutually beneficial for people and services, and use of the data for good to share learnings and improve
  - acknowledging the context of the data, and different outcomes relevant for different services.

Reporting to PRIMHD

PRIMHD is the national database collecting information on activity and outcomes in mental health and addiction services.[1]

- Organisations said ownership and security of the data, and data sovereignty[2] are the key conditions that need to be in place to improve confidence in reporting to PRIMHD. Māori data sovereignty was the top condition for Kaupapa Māori organisations.

> *"Outcome data has an important role in helping MH&A NGOs understand the impact of their work and support continuous improvement... it is important that data collection processes remain proportionate and meaningful, and do not create additional administrative burden that takes time away from direct support…to be truly valuable, it should support learning and improvement at the service level, and NGOs should receive timely insights and feedback from the data they contribute. Ensuring that outcome measures reflect recovery-focused practice and the diverse experiences of [tāngata] whaiora is also important… A collaborative approach between NGOs and national agencies in the design, interpretation, and use of outcome data will help ensure that the information collected genuinely strengthens services and outcomes for the people we support."* (non-Kaupapa Māori organisation)

Discussion

This survey of mental health and addiction NGOs provides a good overview of the current landscape of outcome data collection in Aotearoa New Zealand, which was not previously available. It shows that most NGOs collect outcome data in various ways and that it is highly valuable for people, whānau and services. There are common outcome domains of importance across the NGO sector. These are wellbeing, quality of life, recovery/ purpose/ hope, and cultural identity and connection. A wide range of standardised tools are used across the sector, with the most used tools focused on wellbeing and substance use. The high use of Hua Oranga, a Māori wellbeing tool, aligns with wellbeing as the top domain of importance, and its use in the Access and Choice programme.

There are some differences depending on service type, especially for Kaupapa Māori compared to non-Kaupapa Māori services. This highlights that many services do what is

[1] PRIMHD stands for Programme for the Integration of Mental Health Data.
[2] Data sovereignty is the concept that data is governed by the laws of the country in which it is stored. Māori data sovereignty refers to the rights Māori have to data that relates to Māori, and how it is defined, collected, accessed, interpreted, and used (Royal Society Te Apārangi, 2023). Te Tiriti o Waitangi affirms Māori rights and authority over Māori data.

best for them and the people and whānau they serve by adapting and responding to local community needs. This is a key strength of Kaupapa Māori services and the NGO sector. However, the lack of a national standardised and consistent approach makes it difficult to tell a consistent story of the impact of NGOs and determine if equitable outcomes are being achieved for people across regions and services.

Barriers to outcome measurement exist at multiple levels. Routine outcome measurement may only be possible if action is taken at all levels, including individual staff, team, organisational and system levels – with an emphasis on strengthening the organisational and system level enablers.

This survey provides a starting point for understanding outcome data collection in NGOs. This is an essential part of the picture to inform future decisions, resourcing, and infrastructure to support the implementation of routine and sustainable outcome measurement by mental health and addiction NGOs. This will support the ability of NGOs to better demonstrate their impact and, most importantly, ensure equitable outcomes for tāngata whai ora and whānau accessing services. Further exploration, such as through focus groups for specific service types, is recommended to build a more detailed, clearer picture of use. Going forward, Māori leadership and governance, and exploring culturally relevant tools are essential to ensure equitable outcomes for Māori and to uphold Te Tiriti o Waitangi.

Background

He Ara Oranga highlights the significant role mental health and addiction (MH&A) NGOs have in providing support for people, whānau, communities, and the wider mental health, addiction, and health sectors (Government Inquiry into Mental Health and Addiction, 2018).

Outcome measurement is essential for knowing whether services are making a difference in people's lives, particularly those self-reported by tāngata whai ora and whānau. This includes understanding whether services are achieving equity for Māori, which is essential for honouring Te Tiriti o Waitangi obligations. Outcome measurement involves the planned and ongoing use of tools and processes (Barr et al., 2021).

While many MH&A NGOs may use a range of outcome approaches, there is no standardised or national approach to outcome measurement across the MH&A NGO sector. No data source currently provides a complete picture of mental health and addiction outcomes for people accessing MH&A NGO services (Atamira Platform Trust, 2025). Given the current government focus on targets and outcomes, there are opportunities to better understand the role MH&A NGOs have in providing support to tāngata whai ora and their impact on people's health, hauora, and wellbeing.

Following the release of *A Sound Investment* (2025) and sector discussions, there is interest in understanding:

- what outcome tools are appropriate in different parts of the MH&A NGO sector
- how outcome data can be collected and used in ways that uphold Māori data sovereignty, and align with lived experience values
- how outcome data can be collected and used to contribute towards sector priorities and highlight the impact, value and worth of NGOs to the wider mental health and addiction sector.

Aim and objectives

This survey aims to contribute to a better understanding of outcome measurement in the MH&A NGO sector, including current outcome measurement practices, to build a baseline understanding to inform decision-making.

Key objectives are to:

- describe priority outcome domains for the MH&A NGO sector
- understand approaches to outcome measurement used, as well as outcome tools
- identify barriers and enablers to outcome measurement
- describe NGOs' interest in a community of practice and national approach to outcome data collection.

Method

Survey design and distribution

In March 2026, an online survey was undertaken of NGOs in Aotearoa New Zealand's mental health and addiction sector, regardless of whether they were currently collecting outcome data.

Atamira Platform Trust and Te Pou developed the survey. This was informed by:

- an advisory group with representatives across the NGO sector
- a literature review of NGO outcome measurement in Aotearoa New Zealand (Te Pou, 2025)
- a recent publication surveying outcome measures in psychiatry from the Royal College of Psychiatrists in the UK (Ryland et al., 2026).

Te Pou administered the survey using SurveyMonkey. Atamira Platform Trust emailed the survey to their member networks (including 137 Platform Trust and Navigate network contacts) on 2 March 2026, with weekly reminders. Te Pou also invited NGOs to take part in the survey via the Te Pou e-bulletin.

One response to the survey was requested per organisation. All questions were voluntary. The survey was open for 2 weeks, closing on 16 March 2026. Appendix A includes the survey questionnaire.

Analysis

The analyses are based on information from 74 survey responses. Subgroup analyses were undertaken in relation to different organisation types, services, organisational size and age groups (see Table 1).

Table 1: Subgroup analyses

Organisation type Note: more than one option could be chosen	Kaupapa Māori Non-Kaupapa Māori – includes mainstream, lived experience, Pasifika, Asian and self-classified other. For some questions, lived experience results are shown separately to highlight differences.
Service delivery* Note: more than one option could be chosen	Mental health only Addiction only Both mental health and addiction

Organisation size	Smaller NGOs (<50 FTEs) Larger NGOs (50+ FTEs)
Age group Note: more than one option could be chosen	Infant, child, and youth (ICY) – includes organisations that support ICY in addition to adult age groups# No-ICY – support adults or older adults only

Note. * Only 2 organisations were classed as 'other' for service delivery, so analyses were not undertaken with an 'other' group. #ICY-only organisations could not be analysed alone due to small numbers (3 organisations).

Analyses were undertaken using SurveyMonkey and Microsoft Excel. This includes descriptive statistics for quantitative data, and thematic analysis for qualitative data. Figures were rounded up to the nearest whole number. Analyses were based on all available data – not all organisations answered every question.

Limitations

The survey approach means that some caution is required when interpreting survey findings.

- Report findings reflect those who took part in the survey and may not represent the whole mental health and addiction NGO sector in Aotearoa New Zealand.
- Services could be included in more than one organisational category based on how they self-identified.
- Respondents are more likely to be organisations that are highly engaged with outcome measurement (and may be reflected in the high level and frequency of collection in results). This means we may have captured less information about data collection, barriers, and enablers from people who collect less or no outcome data.
- Respondents are likely to be organisations that are engaged with Atamira Platform Trust (as members), so we have less information from non-members.
- The survey engaged very few Pasifika organisations and no Asian-specific services.
- The survey was for organisations and didn't ask tāngata whai ora and whānau about their experiences, wants, and needs around outcome measurement.

Survey results

Seventy-four organisations responded to the survey. This is a high response from approximately 200+ NGOs in the mental health and addiction sector.

This section presents results in four parts:

- organisation demographics
- outcome domains and approaches to outcome measurement
- barriers and enablers
- a national approach, including community of practice and PRIMHD.

Part 1: Organisation demographics

A wide range of organisations responded to the survey

Figure 2 shows good regional representation from survey respondents, particularly from the Midland | Te Manawa Taki region.

Figure 2: Regional spread of organisations (73 responses)

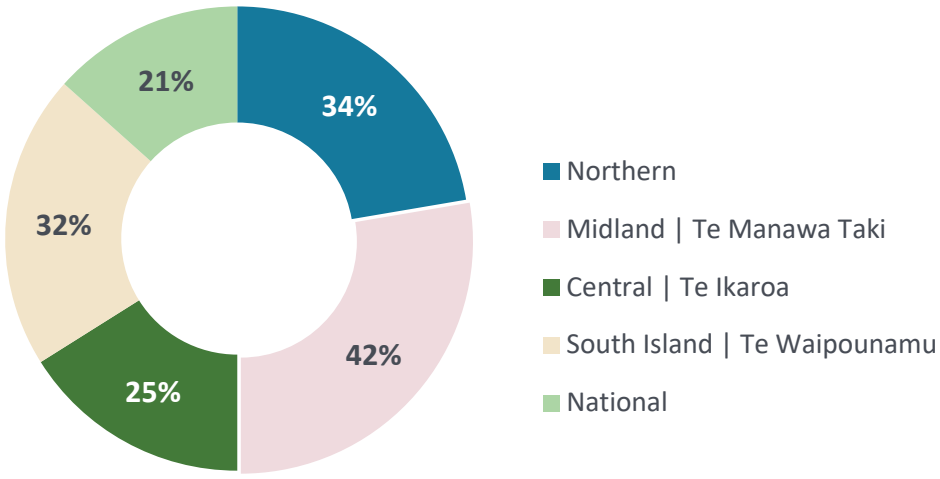
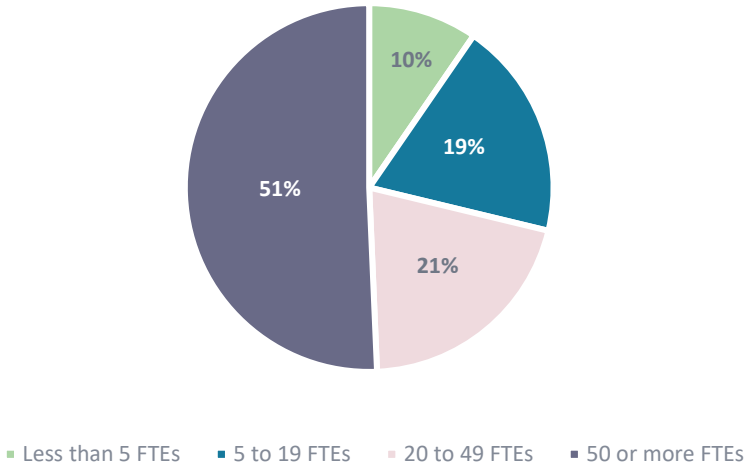


Figure 3 shows a range of organisation sizes responded, with around half larger organisations (50+ FTEs).

Figure 3: Organisation size (73 responses)



There was good representation from Kaupapa Māori organisations (26 percent), with most others from mainstream organisations (55 percent); see Table 2. Other organisations include those focused on whānau, refugees and asylum seekers, and unspecified bicultural approaches.

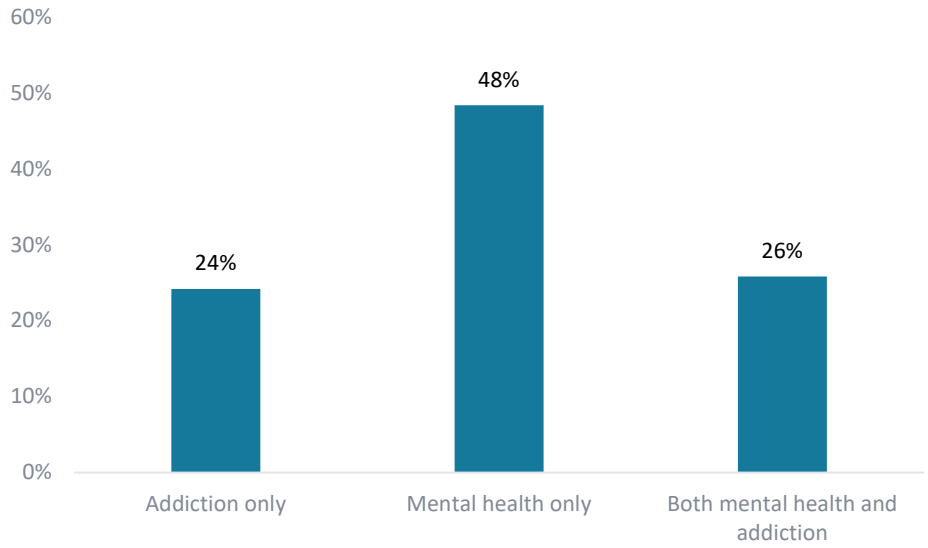
Table 2: Organisation type (73 responses)

Organisation type	Proportion (number)
Kaupapa Māori	26% (19)
Pasifika	7% (5)
Asian	1% (1)
Mainstream	55% (40)
Lived experience	16% (12)
Other	8% (6)

Note: More than one option could be chosen so results do not add to 100 percent.

Figure 4 shows around one-quarter were addiction organisations and one-half were mental health organisations, with another one-quarter focusing on both areas of service delivery. Eleven percent of mental health and/or addiction organisations also had another focus area, such as housing or social services, or disability.

Figure 4: Area of service delivery (62 responses)



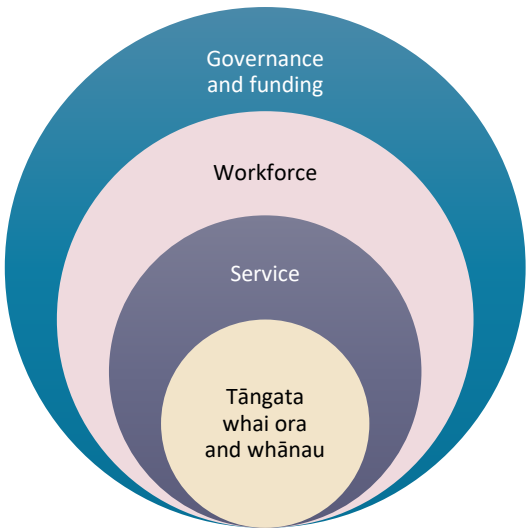
Organisations worked with a range of age groups, with around half working with infants, children, and youth (ICY) in addition to adult age groups. There were 3 ICY-specific organisations that took part.

Part 2: Outcome domains and approaches to outcome measurement

Outcome data is most used and valued at the tāngata whai ora and whānau level

Organisations were asked about the value of outcome data, and how standardised outcome tools are used at the levels shown in Figure 5.

Figure 5: Levels of outcome data use



Most organisations use tools to identify people or whānau needs, set goals, or track people's progress. Organisations say that outcomes help demonstrate real impact for people, and ensure support is driven by whānau voice.

"Allows whānau voice to drive outcomes as appropriate and at the speed of whānau." (Kaupapa Māori organisation)

"Adds to and supports the story of recovery, giving [tāngata] whaiora confidence and belief." (Kaupapa Māori organisation)

"…It provides evidence of change over time, highlighting improvements in wellbeing, independence, and community connection." (Non-Kaupapa Māori organisation)

"It provides hope… and can help tāngata whai ora recognise their progress." (Non-Kaupapa Māori organisation)

Outcome data is used at other levels, including service improvement, workforce development, and governance and funding. Services say this helps identify where they can improve support, tell a story of the impact of their service (including to funders), and target impactful services.

"Outcome data is valuable to services because it shows the real impact of the work being done, rather than just the activities delivered. While outputs might tell how many people used the service, outcome data shows how people's lives changed as a result. This helps demonstrate whether the service is actually making a difference." (Kaupapa Māori organisation)

"Outcome data is also important for telling the story of services to stakeholders. Funders, partners, and the community want to know that resources are being used effectively. By presenting outcome data, a service can provide evidence that its programs are working and achieving meaningful results. This can support funding applications, reporting requirements, and strategic planning." (Kaupapa Māori organisation)

Almost all NGOs collect outcome data

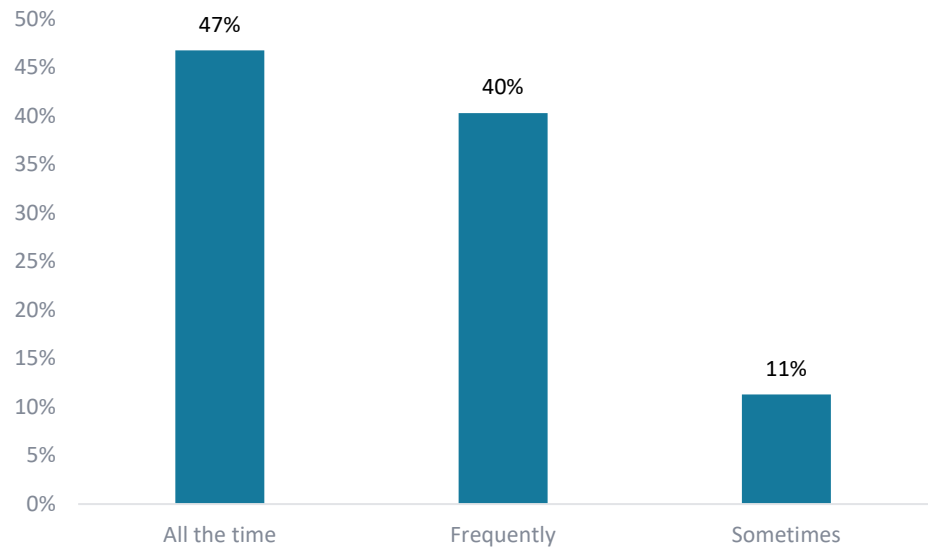
Organisations were asked whether they collect outcome data from any source, and how frequently. This includes data from standardised tools, narratives, Indigenous models, or any other approach. Nearly all organisations collect outcome data from any source.

96%

collect outcome data from any source

Eighty-seven percent collect outcome data regularly (all the time or frequently), and 11 percent sometimes, see Figure 6.

Figure 6: Frequency of outcome data collection (62 responses)



- There were no big differences in how frequently outcome data were collected across different types of organisations, though addiction services were more likely to collect outcome data all the time compared to mental health services (57 percent vs 39 percent). This likely reflects the mandatory requirement of community addiction services to offer the ADOM.

Wellbeing is the most common outcome domain of interest

Organisations were asked about the most important outcome domains of interest to the people they serve. The top four overall are wellbeing, quality of life, recovery/purpose/hope, and cultural identity and connection. Table 3 shows the proportion of each organisation type that ranked each domain as highly important. It shows that:

- wellbeing and quality of life are consistently the top ranked domains across organisation types
- cultural identity and wellbeing are ranked as the most important (alongside wellbeing) by all Kaupapa Māori organisations
- Kaupapa Māori organisations and addiction organisations are more likely to rank other outcomes such as symptoms, functioning, and risk and safety as highly important alongside the more holistic outcomes listed above
- though not an outcome domain, many organisations (75 percent) also ranked experience of treatment/services as high, especially Kaupapa Māori (90 percent) and addiction organisations (100 percent)
- the lowest ranked domain overall was physical health.

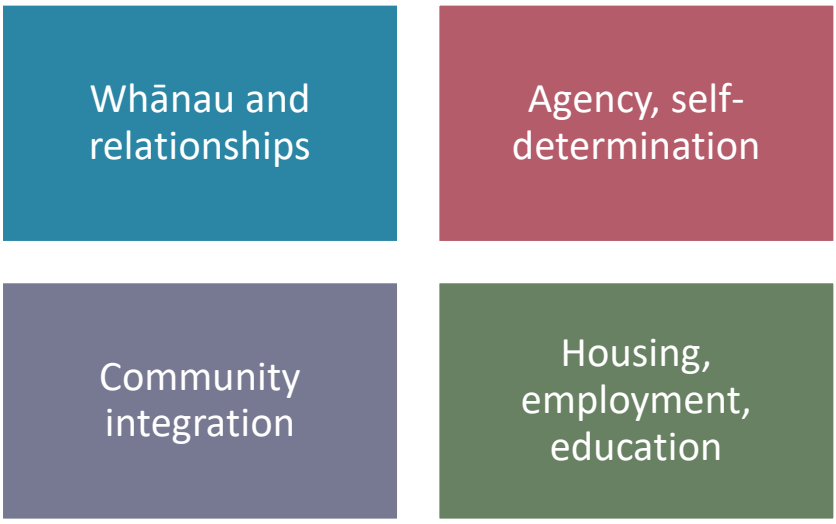
Table 3: Domains rated as highly important by organisation type (71 responses)

	Overall	Kaupapa Māori	Non-Kaupapa Māori	Addiction	Mental health	Small (<50 FTE)	Large (50+ FTE)	Lived experience	ICY
Wellbeing	97%	100%	96%	100%	97%	95%	100%	100%	97%
Quality of life	93%	95%	93%	100%	97%	91%	95%	100%	95%
Recovery/healing/hope/purpose	89%	95%	87%	93%	83%	85%	92%	90%	84%
Cultural identity and connection	83%	100%	78%	93%	79%	73%	92%	70%	89%
Environment and social factors	75%	74%	73%	87%	79%	65%	84%	70%	81%
Risk and safety	71%	95%	64%	93%	59%	68%	73%	50%	84%
Functioning and impairment	72%	95%	66%	87%	69%	59%	84%	40%	78%
Symptoms	66%	95%	58%	93%	48%	59%	73%	50%	81%
Physical health	59%	90%	51%	67%	59%	47%	70%	40%	70%
Experience of treatment/services	76%	90%	72%	100%	59%	70%	81%	70%	81%

Note. ICY = infants, children and youth.

Organisations were asked about other domains they felt were important that weren't asked about in the survey. Figure 7 shows other key domains, covering a range of holistic factors related to hauora and wellbeing (see Appendix B for a full list). Some organisations listed other important factors such as transitions between services.

Figure 7: Some other key outcome domains of interest



A range of approaches are used to collect outcome data

The main approaches used to collect outcome data include narrative storytelling (88 percent), outcome measurement tools (standardised or others like those developed by the organisation; 74 percent), specific key indicators (31 percent), and Indigenous or cultural approaches (25 percent).

Many organisations use multiple approaches to outcome collection, such as standardised tools complemented by narratives.

Table 4 looks at approaches used by different types of organisations. It shows that:

- use of narratives is high across different types of organisations
- Kaupapa Māori organisations are more likely to use standardised tools from those asked about, as well as other tools that may include those developed by their organisation, compared to non-Kaupapa Māori organisations
- addiction, or both mental health and addiction organisations are more likely to use standardised tools compared to mental health only organisations
- larger organisations are more likely to use standardised tools compared to smaller organisations
- organisations supporting ICY are more likely to use standardised tools compared to others

- when use of standardised tools is lower, use of narratives tends to be relatively higher, especially for non-Kaupapa Māori, lived experience, and smaller organisations
- Indigenous or cultural tools or approaches are used most in Kaupapa Māori organisations.

Table 4: Outcome data collection method by organisation characteristics (56 to 70 responses)

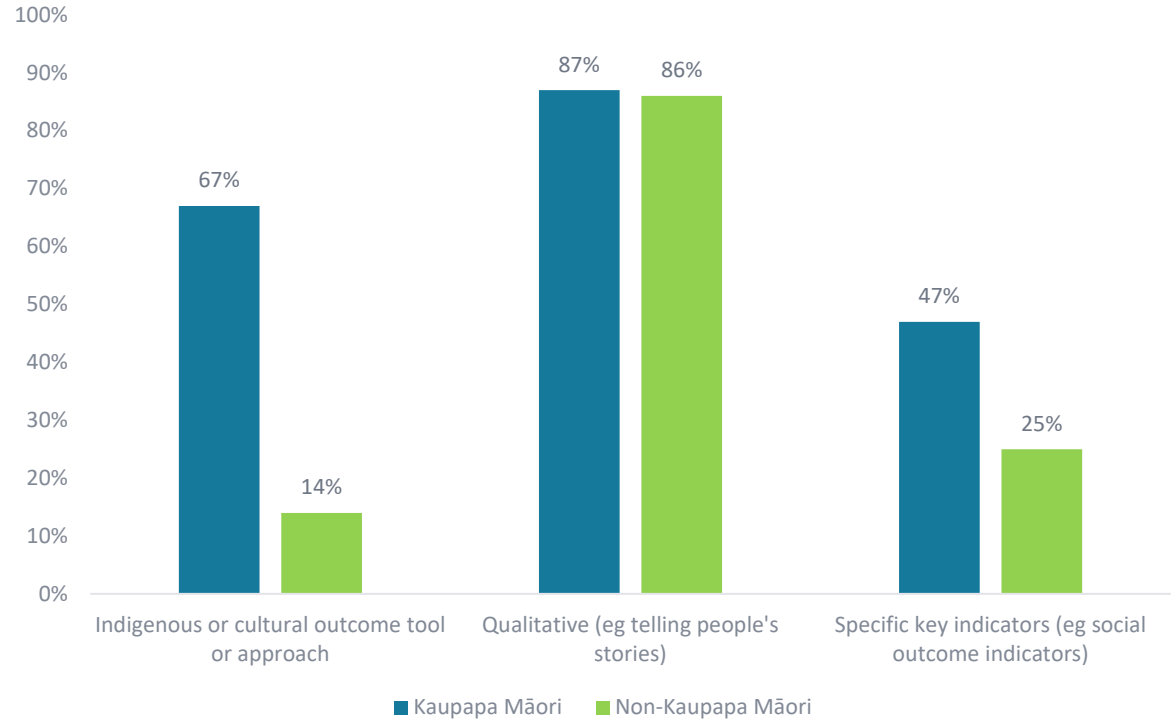
	Standard-ised tool	Own tool	Narratives	Indigenous or cultural tool/ approach	Specific key indicators
Overall	74%	32%	88%	25%	31%
Kaupapa Māori	84%	47%	87%	67%	47%
Non-Kaupapa Māori	71%	30%	86%	14%	25%
Addiction	80%	27%	87%	13%	13%
Mental health	68%	21%	72%	17%	24%
MH&A	93%	38%	69%	38%	31%
Lived experience	67%	57%	86%	29%	29%
Smaller NGOs*	60%	24%	93%	14%	21%
Larger NGOs**	89%	41%	82%	37%	41%
ICY	85%	26%	63%	26%	26%

Note. * Less than 50 FTEs. ** Fifty or more FTEs; MH&A = mental health and addiction. ICY = infants, children and youth.

Narrative storytelling is a common approach used alongside or instead of standardised tools

Narrative storytelling is common alongside the use of standardised tools or other approaches. Most organisations that don't use standardised outcome tools (15 NGOs), use narrative/storytelling to collect outcome data instead (87 percent). Half of these use narrative approaches as their only way of collecting outcome data. Figure 8 shows other approaches aside from standardised tools.

Figure 8: Outcome data collection approaches not including standardised tools (56 responses)



- Surveys and evaluations are common ways that people collect narratives. Other narrative approaches include interviews/conversations, goal setting, or contractual reporting.
- It was noted that around half of the surveys or evaluations focus on experience of services rather than outcomes. However, most of the organisations collecting experience of service surveys do so in addition to the collection of outcome data. Only one organisation said they collected outcome data where experience of service was the only data collected.

Three-quarters of NGOs collect outcome data using standardised validated tools

Organisations were asked which common standardised and validated tools they use from a set list (see Appendix C). Three-quarters (74 percent) of NGOs surveyed use a standardised tool. Results show a wide range of standardised tools are used across NGOs – while some are specifically designed as outcome tools, others are screening tools. The most common tools used among NGOs reporting to the survey are:

- Hua Oranga, a Māori outcome wellbeing tool (50 percent), particularly among Kaupapa Māori and larger NGO (50+ FTE) services
- the Alcohol and Drug Outcome Measure (ADOM), a substance use and recovery tool (46 percent), particularly among addiction services

- Substances and Choices Scale (SACS), a youth-specific substance use screening tool (33 percent), particularly among Kaupapa Māori and addiction services, and those who support ICY.

The use of Hua Oranga aligns strongly with wellbeing being ranked as a top outcome domain of interest. All organisations using Hua Oranga ranked wellbeing as a highly important outcome domain.

Many organisations used more than one tool from the list, with a range from one to seven listed tools per organisation.

Table 5 shows the top nine tools across different organisations. It shows that:

- Hua Oranga use is highest among Kaupapa Māori organisations, but half of non-Kaupapa Māori organisations also use the tool
- Hua Oranga is well used across lived experience, mental health, larger organisations, and organisations that support ICY
- larger organisations are more likely to use the ADOM.

Appendix C shows the proportion of other listed tools. Appendix D shows levels of use for commonly used outcome tools.

Table 5: Commonly used tools by organisation characteristics (46 responses)

Tool	Overall use	Kaupapa Māori	Non-Kaupapa Māori	Lived exp	Addiction	Mental health	Small <50 FTEs	Large 50+ FTEs	ICY
Hua Oranga	50%	67%	49%	60%	33%	58%	22%	70%	59%
ADOM	46%	58%	40%	20%	67%	26%	33%	52%	45%
SACS	33%	50%	29%	20%	33%	21%	33%	33%	41%
SDQ	22%	33%	17%	-	8%	21%	17%	26%	28%
K10	22%	33%	20%	20%	17%	21%	22%	22%	31%
HoNOS	20%	33%	14%	-	17%	26%	17%	22%	24%
GAD-7	15%	42%	9%	60%	8%	16%	11%	19%	10%
HoNOSCA	13%	25%	9%	-	8%	11%	6%	19%	17%
Recovery Star /Outcome Star	13%	17%	14%	40%	-	21%	11%	15%	14%

Note. Lived exp = lived experience; ICY = infants, children, and youth.

Of the 15 NGOs who said they didn't use standardised tools:

- 93 percent collect outcome data in other ways, most commonly through narratives
- 78 percent are smaller organisations (less than 50 FTEs)
- 56 percent are mainstream organisations
- 67 percent are focused on mental health service delivery.

Tools mapped to domains

Table 6 maps the commonly used tools for ICY and adults against the top-rated domains. Domains are shown along the top row, and each of the commonly used tools are shown in the first column. A dot represents where the tool includes the domain of interest within its content. Hua Oranga, while focused on wellbeing, covers all four domains that organisations rated highly important.

Table 6: Standardised tools mapped to outcome domains

	Wellbeing	Quality of life	Recovery purpose hope	Cultural identity	Environment and social factors	Risk and safety	Function	Symptoms	Physical health
ICY tools									
SACS		■				■	■		
SDQ		■					■	■	
HoNOSCA					■	■	■	■	■
Adult tools									
ADOM	■		■		■	■	■	■	■
Hua Oranga	■	■	■	■			■		■
K10							■	■	
HoNOS					■	■	■	■	■
GAD-7							■	■	
Recovery/ Outcome Star	■		■		■		■	■	■

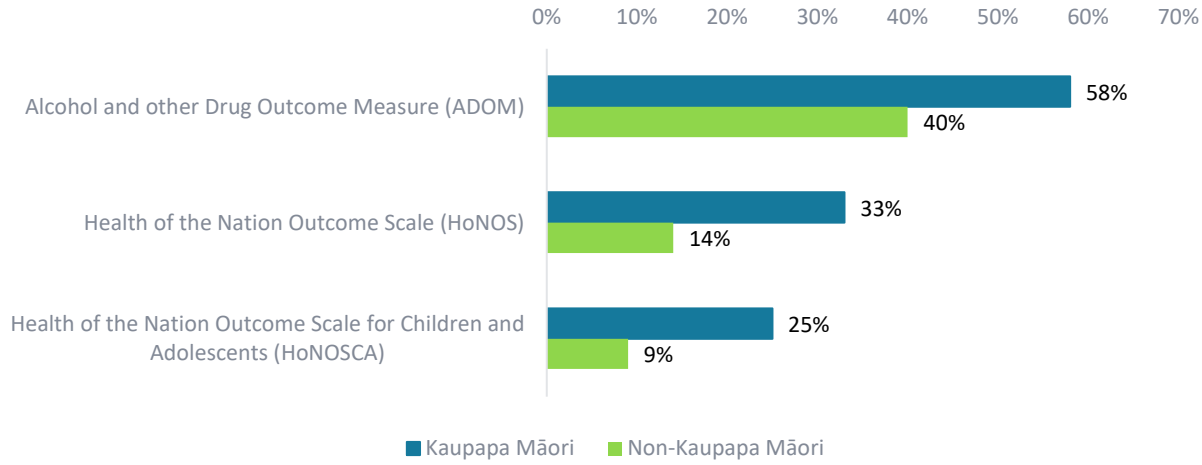
Note. ICY = infants, children and youth.

Mandatory tool use

There are two mandated tools in Aotearoa New Zealand's mental health and addiction services. These are HoNOS/HoNOSCA in specialist mental health services (mandated for use) and ADOM for community addiction services (mandated to be offered).

Figure 9 shows that mandatory tool use is higher in Kaupapa Māori services.

Figure 9: Mandatory tool use Kaupapa Māori vs non-Kaupapa Māori (46 responses)



Mandatory tools are used more in larger organisations, and organisations offering services to youth in addition to adults/older adults. A large proportion (85 percent) of Kaupapa Māori organisations responding to the survey are also large organisations.

Around half of organisations use other standardised tools

Organisations were asked about any other standardised tools they use that were not listed in the survey. Fifty-four percent use another type of tool or cultural framework, and of these, around three-quarters use another tool in addition to tools already included in the list. Examples of other tools are shown below grouped by common topics.

Non-Kaupapa Māori organisations were more likely to say they use other standardised tools compared to Kaupapa Māori organisations (60 vs 33 percent), and addiction organisations compared to mental health organisations (67 vs 53 percent).

Wellbeing or Quality of life tools such as adapted versions of the WHOQOL, Psychosocial Wellbeing Index, whānau/relationship assessments or spiritual wellbeing tools. Particularly among mental health organisations.	**Addiction** tools such as the AUDIT for alcohol use, gambling tools like the EIGHT or GSAS, or other substance-dependence tools such as the SDS. Particularly among addiction or combined mental health and addiction organisations.
Mental health tools such as the PTSD screening scale or the DASS.[2] Particularly among mental health organisations.	**Social or whānau outcome** tools such as Home and Tenancy Star, Work and Social Adjustment Scale, and MacMaster Family Assessment Device.

Note. AUDIT = Alcohol Use Disorder Identification Test. EIGHT = Early Intervention Gambling Health Test. GSAS = Gambling Symptom Assessment Scale. SDS = Severity of Substance Dependence. PTSD = Post traumatic stress disorder. DASS = Depression, Anxiety, and Stress Scales.

- Cultural tools or frameworks were commonly mentioned, including Te Whare Tapa Whā, Whānau Ora framework, or Afiya assessment (Islamic framework). These are used in both Kaupapa Māori and non-Kaupapa Māori services.
- Two organisations who said they used a different standardised tool mentioned service experience surveys rather than outcome tools.
- Organisations mentioned more than 40 other tools or frameworks. See Appendix E for the full list.

One-third of organisations use or developed their own tool

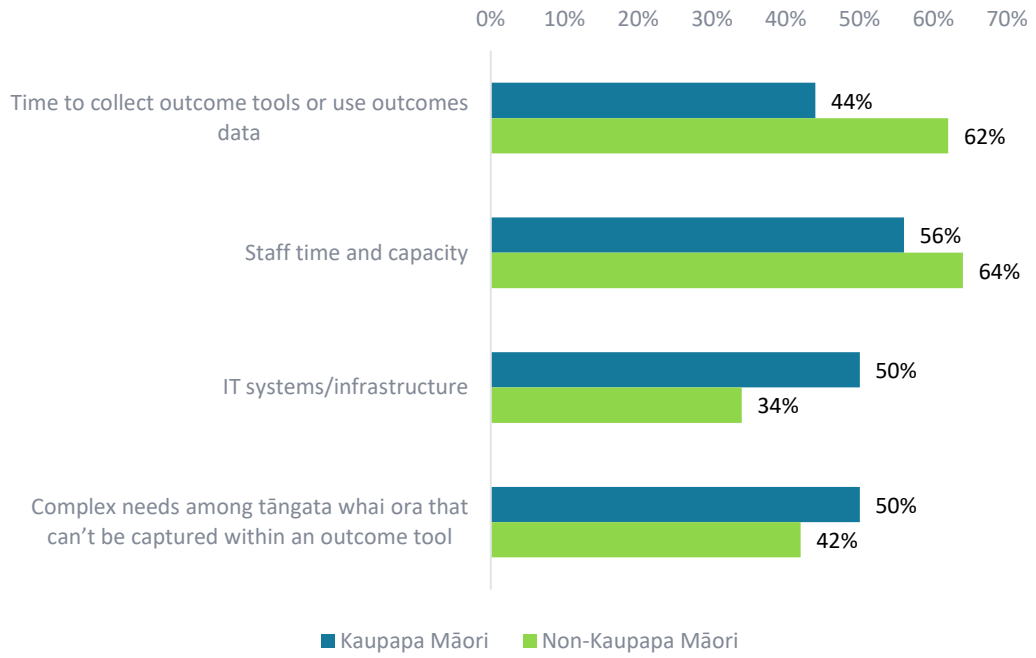
One-third (32 percent) of organisations use or developed their own tool. Of these, Kaupapa Māori organisations (47 vs 30 percent non-Kaupapa Māori), larger organisations (41 vs 24 percent small), mental health and addiction combined organisations (38 vs 21 percent mental health, 27 percent addiction), and lived experience organisations (57 percent) were more likely to say that they use or developed their own tool.

Part 3: Barriers and enablers

Time and capacity are common barriers to outcome data collection

While barriers are similar between Kaupapa-Māori and non-Kaupapa Māori organisations, Kaupapa Māori organisations are more likely to say systemic issues are barriers, such as a lack of IT systems/infrastructure, see Figure 10.

Figure 10: Key barriers to outcome data collection (63 responses)



- One-third of organisations felt a lack of culturally relevant tools and limited understanding or training of outcome tools were barriers.
- There were few differences between larger and smaller organisations, though larger organisations were more likely to say complex needs are a barrier, while smaller organisations were more likely to say lack of organisational support or guidance is a barrier.
- There were few differences between mental health and addiction organisations, though addiction organisations were more likely to say IT systems/infrastructure were a barrier.
- Services supporting ICY were less likely to say time was a barrier and more likely to say that limited understanding of available tools or lack of organisational support or guidance are barriers compared to services for adult age groups.
- A range of other barriers were mentioned related to costs, processes, implementation, variability in the NGO sector, lack of tools for more specific services such as whānau services, and lack of standardised or mandated approaches. A few organisations saw limited value in collecting outcome data.

"Variation among outcomes, within services and within individual experiences. Difficulty bridging tools that are specific enough to be meaningful, and broad enough to be comparable." (Mental health organisation)

"Lack of consistency at a national level … It would reduce wastage and save considerable mahi if we standardised our approaches across the sector." (Mental health organisation)

"Introduction to new tools added can take a while to understand and put into action." (Kaupapa Māori organisation)

Appendix F contains a full breakdown of barriers by organisation characteristics.

Relevant, easy to use, and integrated tools are common enablers for outcome tool use

The top enablers overall were integration of tools into electronic records, tools that are quick and easy to use, training to build confidence and understanding, and tools that look at outcomes relevant to the people accessing NGO services.

While the top enablers are similar between Kaupapa-Māori and non-Kaupapa Māori organisations, Kaupapa Māori organisations are more likely to say electronic integration (including apps or tablets to collect data and integration into electronic records) are an enabler; see Figure 11.

Figure 11: Top 5 enablers - Kaupapa Māori vs non-Kaupapa Māori organisations (60 responses)

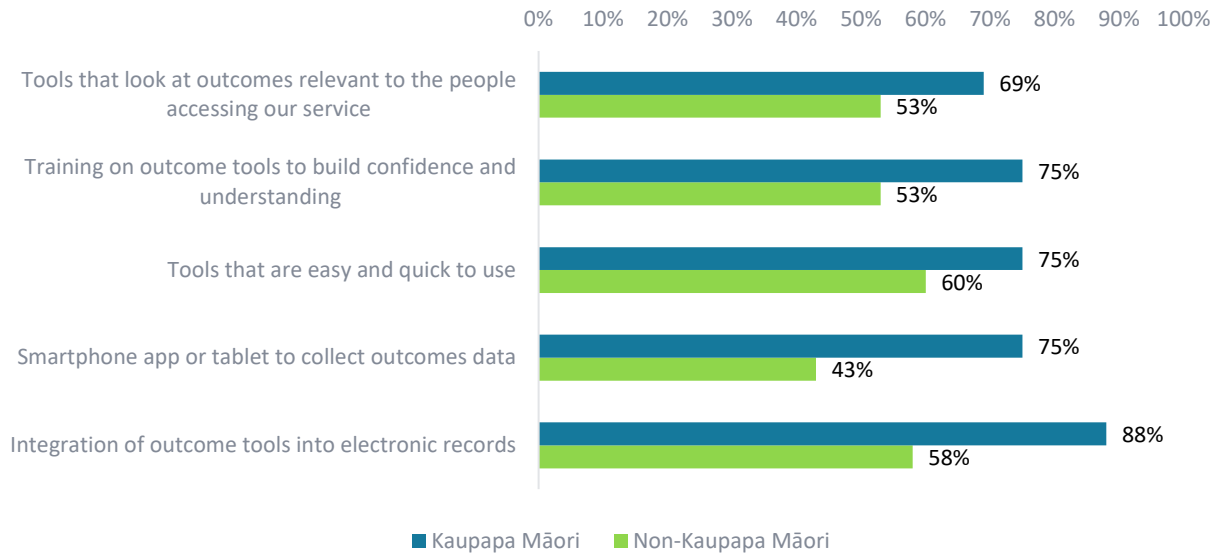
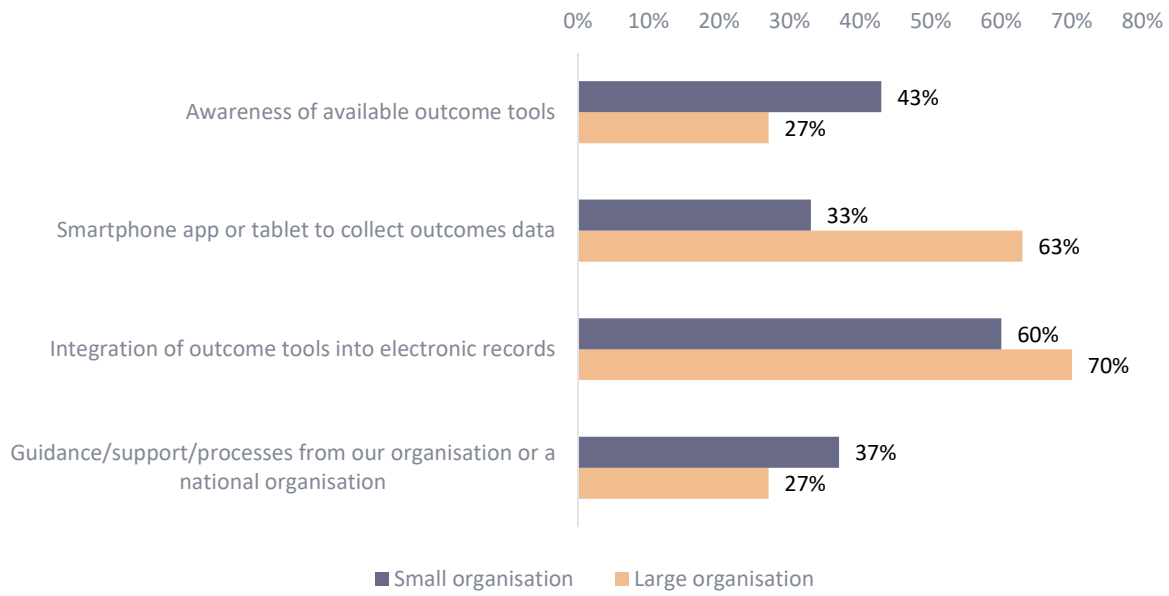


Figure 12 indicates organisation size influenced some enablers, particularly having a smartphone app to collect data.[3] For example, awareness of available tools would support greater outcome data collection in smaller organisations. Other enablers not shown below had similar responses regardless of organisation size.

Figure 12: Enablers with differences by organisation size (60 responses)



- Addiction organisations were more likely to say guidance or support, quick and easy, as well as relevant tools, a mechanism for collation, or awareness of outcome tools are enablers compared to mental health organisations.
- Organisations supporting ICY were more likely to say integration of tools into electronic records and guidance or support were key enablers compared to organisations that only support adult age groups.

"A mandated evidence-based tool." (non-Kaupapa Māori organisation)

"Reduction in other reporting to be able to shift resources and capacity." (Addiction and mental health organisation)

"Service contracts need to make adequate provision for organisations to establish outcome measurement systems and practices: time for tool design, implementation,

[3] This is based on 30 small organisations and 30 large organisations who answered this question.

data collection, analysis and reporting, and data governance." (Lived experience organisation)

"Overarching agreement on a national dataset for outcome measurement with freedom for specific outcome measurement tools that meet the needs of diverse organisations." (Lived experience organisation)

Appendix G contains a full breakdown of enablers by organisation characteristics.

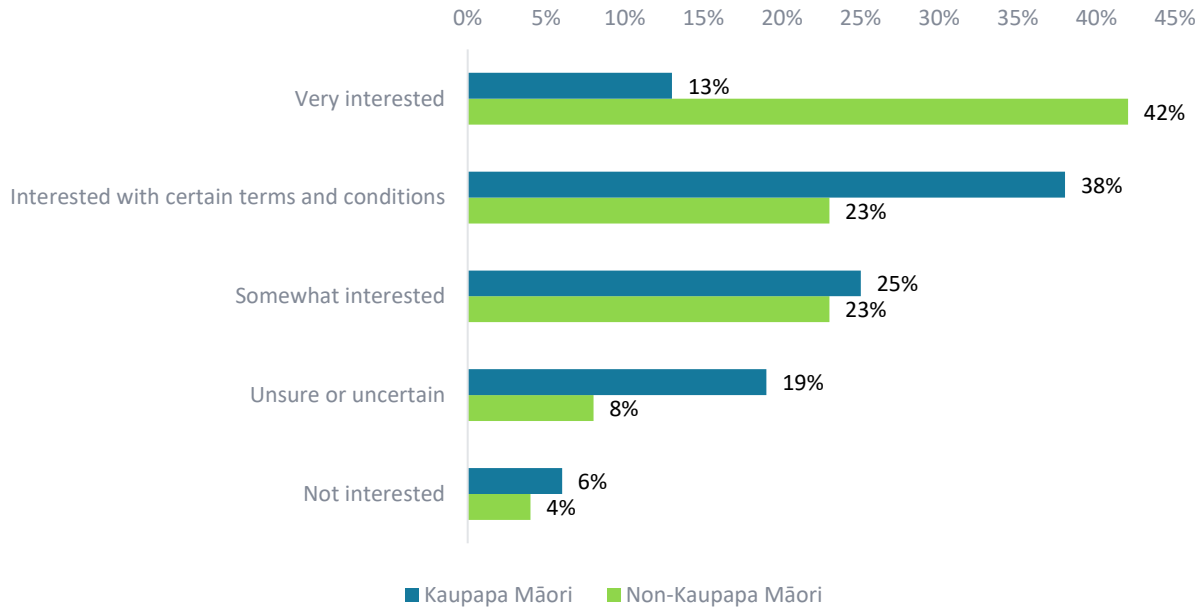
Part 4: A national approach to aggregated outcome data

Organisations are generally interested in a community of practice

Organisations were asked if they were interested in a community of practice (CoP) for outcome data. Eighty-four percent had some level of interest. One-third were very interested, and one-quarter with certain terms and conditions.

- Kaupapa Māori and addiction organisations were more likely to say they are interested with certain terms and conditions (38 percent Kaupapa Māori vs 23 percent non-Kaupapa Māori; 40 percent addiction vs 14 percent mental health). Figure 13 shows Kaupapa and non-Kaupapa Māori responses.

Figure 13: Interest in a community of practice Kaupapa Māori vs non-Kaupapa Māori organisations (61 responses)



Organisations were asked about expectations for shared access and use of aggregated outcome data as part of a community of practice. The key conditions relate to confidentiality and privacy, respectful and ethical use of data, as well as using the information to improve services rather than adopting a punitive approach; see Figure 14. Kaupapa Māori organisations were most likely to say that respect for people and upholding data sovereignty principles were key expectations.

Figure 14: Key expectations and conditions for a community of practice for outcome data (53 responses)

"As an NGO, we expect shared access to aggregated outcome data to support collective learning, transparency, and continuous improvement. The data should be used ethically and responsibly to identify trends, inform decision-making, and share effective practices across organisations. I value clear governance around data privacy, respectful interpretation of results, and collaborative discussion that focuses on improving outcomes for the communities we serve rather than comparing or judging individual organisations." (Kaupapa Māori organisation)

"Our expectation would be that any shared access to aggregated outcome data is managed within a clear framework that prioritises confidentiality, responsible use of data, and sector learning. Aggregated data should be de-identified and used in a way that supports collective understanding of trends, strengths, and areas for improvement across the sector." (non-Kaupapa Māori organisation)

A few organisations emphasised:

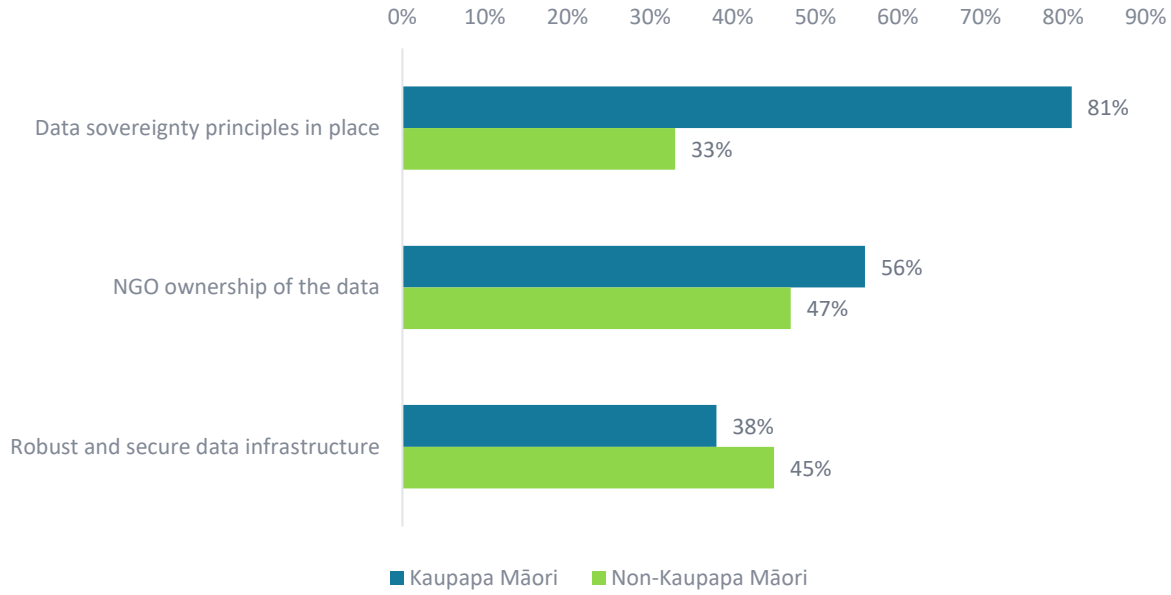
- the need to build on existing infrastructure rather than start from scratch
- that due to their small area of practice they use different tools than others in the sector which makes it difficult to join and compare with a community of practice (for example, gambling or whānau organisation)
- they would be interested in more specific community of practice groups, such as a lived experience group, or a Kaupapa Māori group.

Ownership, security, and data sovereignty are the top conditions to build confidence in reporting to PRIMHD

Organisations were asked their top three conditions to increase confidence in reporting to PRIMHD (Programme for the Integration of Mental Health Data). PRIMHD is the national database collecting information on activity and outcomes in mental health and addiction services. It is used to report on what services are being provided, who is providing the services, and what outcomes are being achieved for tāngata whai ora across Aotearoa New Zealand.

Figure 15 shows the top three conditions for reporting to PRIMHD for Kaupapa Māori and non-Kaupapa Māori services. Data sovereignty was the top condition for Kaupapa Māori organisations.

Figure 15: Top 3 conditions for reporting to PRIMHD – Kaupapa Māori vs non-Kaupapa Māori (62 responses)



Other findings include:

- while not as high as Kaupapa Māori organisations overall, ICY organisations also had data sovereignty as the top condition (45 percent; compared to 26 percent of organisations that don't support ICY)
- smaller organisations were more likely to say NGO ownership of the data compared to larger organisations (58 vs 42 percent respectively), and addiction organisations compared to mental health (60 vs 41 percent)
- consent for using the outcome data collected (both for its intended purpose and for other purposes) was the top condition for lived experience organisations (80 percent)
- three organisations do not support reporting to PRIMHD under any conditions
- other concerns outside of the survey list include specialised organisations feeling like standardised approaches may not be relevant for them, collecting and reporting data but not getting any feedback on what happens with the data, and data needing to be collected for a reason and having a clear purpose.

> *"How will a standardised approach across the whole sector manage risks of diluting outcomes and/or requiring organisations to implement tools that are not meaningful to their practice?"* (Mainstream organisation)
>
> *"If there is a mandated expectation to collect outcomes, [tāngata] whai ora will need to be informed but what of their rights to decline? Does that mean they do not access service? Health New Zealand would not get accurate statistics if a whai ora declines which would create inequities."* (Addiction organisation)

All terms and conditions by organisation characteristics are shown in Appendix H.

Discussion

This report describes the findings from the NGO outcome measurement survey and provides the first overview of the NGO outcome measurement landscape in Aotearoa New Zealand. It shows that most NGOs collect outcome data in various ways, and it is highly valuable for people, whānau, and telling the story of NGOs.

There are common outcome domains of importance across the NGO sector. These are wellbeing, quality of life, recovery/purpose/hope, and cultural identity and connection. A wide range of standardised tools are used across the sector, with the most used tools focused on wellbeing and substance use. The high use of Hua Oranga, a Māori wellbeing outcome tool, aligns with wellbeing as the top domain of importance. While there are commonalities, the diverse use of tools and approaches makes a consistent national approach more challenging.

There are some differences depending on service type, especially for Kaupapa Māori and non-Kaupapa Māori organisations. This highlights that many services do what is best for them and the people and whānau they serve by adapting and responding to local community needs. This is a key strength of Kaupapa Māori services and the NGO sector. However, the lack of a national standardised and consistent approach makes it difficult to tell a consistent story of the impact of NGOs and determine if equitable outcomes are being achieved for people across regions and services.

To support a consistent, standardised, and national approach, a range of barriers need to be addressed. This includes having time and capacity to collect and use outcomes. Similarly, enablers relate to ease of use. This indicates factors influencing outcome measurement are bi-directional in that they can act as either barriers or enablers. These are similar findings from a UK survey of outcome collection among psychiatrists (Ryland et al., 2026), highlighting that there are many shared barriers across the sector. Routine outcome measurement may only be possible if action is taken at all levels including individual staff, team, organisational and system levels – with an emphasis on strengthening the organisational and system level enablers.

The survey findings are an essential part of the picture to inform future decisions, resourcing, and infrastructure to support the implementation of routine and sustainable outcome measurement by mental health and addiction NGOs. This will support the ability of NGOs to better demonstrate their impact and, most importantly, ensure equitable outcomes for tāngata whai ora and whānau accessing services.

Further exploration of the outcome measurement landscape is recommended, particularly with Kaupapa Māori, Pasifika, Asian, lived experience, ICY, and addiction organisations. Going forward, it is imperative to uphold Te Tiriti o Waitangi by ensuring Māori leadership and governance, integrating Māori data sovereignty principles, exploring culturally relevant tools for Māori, and using outcome measurement to ensure equitable outcomes for Māori.

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Appendices

Appendix A: Survey

This Appendix contains the survey questions.

Section A: General information about your organisation

To begin, this information is for analytical purposes only so we can assess how well responses reflect the diversity of MH&A NGO services.

1. What is your organisation size (Total FTEs for your organisation - employed and vacant)?

◦ Less than 5 FTEs

◦ 5 to 19 FTEs

◦ 20 to 49 FTEs

◦ 50 or more FTEs

2. How would you mainly characterise your organisation? (Multiple options)

◦ Kaupapa Māori

◦ Pasifika

◦ Asian

◦ Mainstream

◦ Lived experience

◦ Other (please specify)

3. What is your main area of service delivery? (Multiple options)

◦ Addiction

◦ Mental health

◦ Other

4. What age groups does your organisation mainly work with? (Multiple options)

◦ Infant, child, or youth

◦ Adults

◦ Older people (65 years and over)

5. In what region(s) does your organisation provide MH&A services?

◦ Northern region (Te Tai Tokerau Northland, Waitematā, Te Toka Tumai Auckland, Counties Manukau)

◦ Midland | Te Manawa Taki (Waikato, Lakes, Bay of Plenty, Tairāwhiti, Taranaki)

◦ Central | Te Ikaroa (MidCentral, Whanganui, Capital & Coast/Hutt Valley, Hawkes Bay, Wairarapa)

◦ South Island | Te Waipounamu (Canterbury, West Coast, Nelson Marlborough, Southern, South Canterbury)

◦ National

Section B: Outcome domains

Next, we are interested in the relative importance of areas of a person's wellbeing or recovery journey to your organisation that may be captured through outcome tools. Please answer this section regardless of whether your organisation currently captures this data.

6. Please rate each outcome domain in terms of importance to your organisation.

	Not at all	Low	Moderate	High
Wellbeing eg spiritual, mental, physical and whānau /social /interpersonal wellbeing				
Quality of life eg positive mental health and satisfaction with life				
Cultural identity and connection				
Recovery, healing, hope, purpose, or growth				
Symptoms eg distress, anxiety, problematic or hazardous alcohol and drug use				
Functioning and impairment eg impact on people's daily life including study or work, relationships, selfcare, and everyday tasks				
Physical health eg physical symptoms or chronic health problems, such as high blood pressure and cholesterol, pain, respiratory conditions, infections, oral health				
Risk and safety eg risks related to harm to self or others, including impulsivity				
Environmental and social factors eg employment, housing and social support systems				
Experience of treatment/services				

7. Are there any other important outcome domains not listed above?

Section C: Outcome data collection

In this section, we are interested to hear from all MH&A NGOs - irrespective of whether your organisation collects any outcome data (including from validated tools). We understand there are a range of reasons that MH&A NGOs may or may not collect outcomes data and we are interested to find out more.

8. Do you collect any outcome data in your organisation? This can be from any source such as an outcome tool, conversations and stories, or key indicators.

◦ Yes

◦ No, but we intend to in the future

◦ No

◦ Don't know/unsure

9. Do you use any outcome tools in your organisation? (This includes validated and structured tools eg Hua Oranga, WHO-QOL-BREF, ADOM, or those developed by your organisation).

◦ Yes

◦ No

◦ Unsure/don't know

Validated and structured outcome tools

Next, we would like to ask about specific validated and structured outcome tools your organisation uses to help people, whānau and staff see the trajectory of someone's wellbeing or recovery.

Below are some common tools that organisations may use.

10. Do you use any of the following outcome tools in your organisation? These are grouped by child & youth, addiction, and mental health. Tick all that apply.

◦ Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA)

◦ Parents' Evaluation of Developmental Status (PEDS)

◦ Parent-Infant Relationship Global Assessment Scale (PIR GAS)

◦ Strengths and Difficulties Questionnaire (SDQ)

◦ Substances and Choices Scale (SACS)

◦ Alcohol and other Drug Outcome Measure (ADOM)

◦ Brief Assessment of Recovery Capital (BARC-10)

◦ Short Alcohol Withdrawal Scale (SAWS)

◦ DUKE health profile

◦ Health of the Nation Outcome Scale (HoNOS)

◦ Hua Oranga

◦ General Anxiety Disorder (GAD-7)

◦ Kessler-10 (K10)

◦ Outcome Rating Scale (ORS)

◦ Patient Health Questionnaire (PHQ-9)

◦ Recovery Star/Outcome Star

◦ World Health Organization Quality of Life (WHOQOL-BREF)

◦ Other (please include the full name of the tool(s))

11. How does your organisation use outcome data from validated tools? Tick all that apply.

	Identify people or whānau needs or set goals	Track progress of people or whānau	Service delivery and improvement, quality assurance, or benchmarking	Workforce development – including reflective practice	Governance, contractual requirements, or funding decisions
Alcohol and other Drug Outcome Measure (ADOM)					
Health of the Nation Outcome Scale (HoNOS)					
Outcome Rating Scale (ORS)					
Patient Health Questionnaire (PHQ-9)					
Recovery Star/Outcome Star					
World Health Organization Quality of Life (WHO-QOL-BREF)					

Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA)					
Parents' Evaluation of Developmental Status (PEDS)					
Parent-Infant Relationship Global Assessment Scale (PIR GAS)					
Strengths and Difficulties Questionnaire (SDQ)					
Substances and Choices Scale (SACS)					
Brief Assessment of Recovery Capital (BARC-10)					
Short Alcohol Withdrawal Scale (SAWS)					
DUKE health profile					
Hua Oranga					
General Anxiety Disorder (GAD-7)					
Kessler-10 (K10)					
[Other]					

12. Please indicate if your organisation uses any other approaches to collect outcome data.

◦ Another outcome tool developed by our NGO (not mentioned above)

◦ Indigenous or cultural outcome tool or approach

◦ Qualitative (eg telling people's stories)

◦ Specific key indicators (eg social outcome indicators)

◦ No, we don't use any other approaches

Please provide more details about the approaches you use, including the full name of other tools.

13. How frequently does your organisation collect outcome data from all sources?

◦ All the time

◦ Frequently

◦ Sometimes

◦ Rarely or never

◦ Don’t know/not applicable

You are welcome to elaborate on your answer.

14. What is the value of outcome data to your service in telling your story?

15. Please add any further comments about your experience of collecting or using outcome data.

Enablers and barriers

Please answer this section regardless of whether your organisation uses outcome tools.

16. What are the barriers to using outcome tools in your organisation? (If NOT using, which of these barriers are preventing use; if using, are there any barriers that impact on routine or frequent use) Tick all that apply.

◦ Time to collect outcome tools or use outcomes data

◦ Staff time and capacity

◦ IT systems/infrastructure

◦ Complex needs among tāngata whai ora that can’t be captured within an outcome tool

◦ Lack of culturally relevant tools

◦ Limited understanding or training of outcome tools available

◦ Lack of organisational support, guidance or policies

◦ Other (please specify)

17. What would support increased use of outcome tools in your organisation? (If NOT using what would help you to start; if using, what would make use easier?) Tick all that apply.

◦ Guidance/support/processes from our organisation or a national organisation

◦ Integration of outcome tools into electronic records

◦ Smartphone app or tablet to collect outcomes data

◦ Mechanism for collating/analysing/processing outcomes data

◦ Tools that are easy and quick to use

◦ Training on outcome tools to build confidence and understanding

◦ Awareness of available outcome tools

◦ Tools that look at outcomes relevant to the people accessing our service

◦ Other (please specify)

Section D - Exploring the possibilities for developing NGO Communities of Practice

A Community of Practice is usually designed so that participants can share best practices, foster collaboration, solve problems and learn from one another.

The following questions seek to understand the level of interest, readiness and support for MH&A NGOs to participate in a Community of Practice that includes the organisation's aggregated outcome data - noting that the benefits to MH&A NGOs would need to outweigh the costs and the risks.

18. Is your organisation interested in participating in a Community of Practice that includes the use of aggregated MH&A NGO outcome data (similar to the MH NGO Benchmarking Club)?

◦ Not interested

◦ Unsure or uncertain

◦ Somewhat interested

◦ Interested with certain terms and conditions

◦ Very interested

◦ Not applicable

You are welcome to elaborate on your answer, particularly if your organisation is NOT interested in participating in a Community of Practice.

19. What are your expectations for shared access and use of your organisation's aggregated outcome data as a member of a Community of Practice?

Section E: A national approach

20. A national approach to outcome data relies on a set of standards for national collection and reporting, as well as guidance for use. With a nationally mandated and standardised MH&A outcome data system in mind, please indicate the top three terms and conditions that would need to be in place to give your organisation confidence in reporting your outcome data to PRIMHD.

◦ Do not support reporting outcome data to PRIMHD under any conditions

◦ Robust and secure data infrastructure

◦ Data sovereignty principles in place

◦ NGO governance model

◦ NGO ownership of the data

◦ Formalised data sharing agreements

◦ Data quality controls

◦ Data security and protection provisions

◦ Consent for use and reuse

◦ Production of data insights for NGOs

◦ Other (please specify)

21. Is there anything else that you want to tell us about the collection and use of outcome data by MH&A NGOs?

Appendix B: Other outcome domains

This Appendix lists all other domains that organisations said were important, that weren't listed as an option in the survey. Table 7 looks at domains for Kaupapa Māori and non-Kaupapa Māori services. Some are more related to experience of service rather than outcomes.

Table 7: Other outcome domains of interest

Kaupapa Māori services	Non-Kaupapa Māori services
Community connectedness and engagement	Whānau involvement
Housing	Work and employment
Education and training	Living skills
Social wellbeing	Community connection
Addiction including gambling harm	Identity/self-esteem
Income and employment	Trust/hope
Whānau relationships	Use of time
Violence and abuse	Responsive relationships
Justice and community reintegration	Self-efficacy, self-determination, belonging
Pregnancy and parenting	Experiences of stigma and discrimination
Agency, voice, choice, and control, and confidence to use voice	Safety in daily life
Autonomy and independence	Housing
Navigating services	Education
Supporting kaumātua, including elder abuse and dementia	Social/cultural connection
Supporting rangatahi transitions under Oranga Tamariki care and school attendance	

Appendix C: Standardised outcome tools

The first part of this Appendix includes a list of tools asked about in the survey.

- ICY tools: Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA), Parents' Evaluation of Developmental Status (PEDS), Parent-Infant Relationship Global Assessment Scale (PIR GAS), Strengths and Difficulties Questionnaire (SDQ), Substances and Choices Scale (SACS).
- Addiction tools: Alcohol and Drug Outcome Measure (ADOM), Brief Assessment of Recovery Capital (BARC-10), Short Alcohol Withdrawal Scale (SAWS).
- Mental health and wellbeing tools: DUKE health profile, Health of the Nation Outcome Scale (HoNOS), Hua Oranga, General Anxiety Disorder (GAD-7), Kessler-10 (K10), Outcome Rating Scale (ORS), Patient Health Questionnaire (PHQ-9), Recovery Star/Outcome Star, World Health Organization Quality of Life (WHOQOL-BREF).

The main body of the report shows the top nine tools used by organisation characteristics. The second part of this Appendix shows the proportion of use for all other standardised tools listed in the survey. These are not broken down by organisation characteristics due to small numbers.

Table 8: Use of less common standardised outcome tools

Tool Overall use	% used	Any key differences by organisation type
Outcome Rating Scale (ORS)	11%	Mental health, mental health and addiction combined, and lived experience most likely to use
World Health Organization Quality of Life (WHOQOL-BREF)	11%	Lived experience organisations most likely to use
Patient Health Questionnaire (PHQ-9)	9%	Kaupapa Māori organisations most likely to use
Short Alcohol Withdrawal Scale (SAWS)	9%	Kaupapa Māori organisations most likely to use
DUKE health profile	7%	Mental health and addiction combined organisations most likely to use

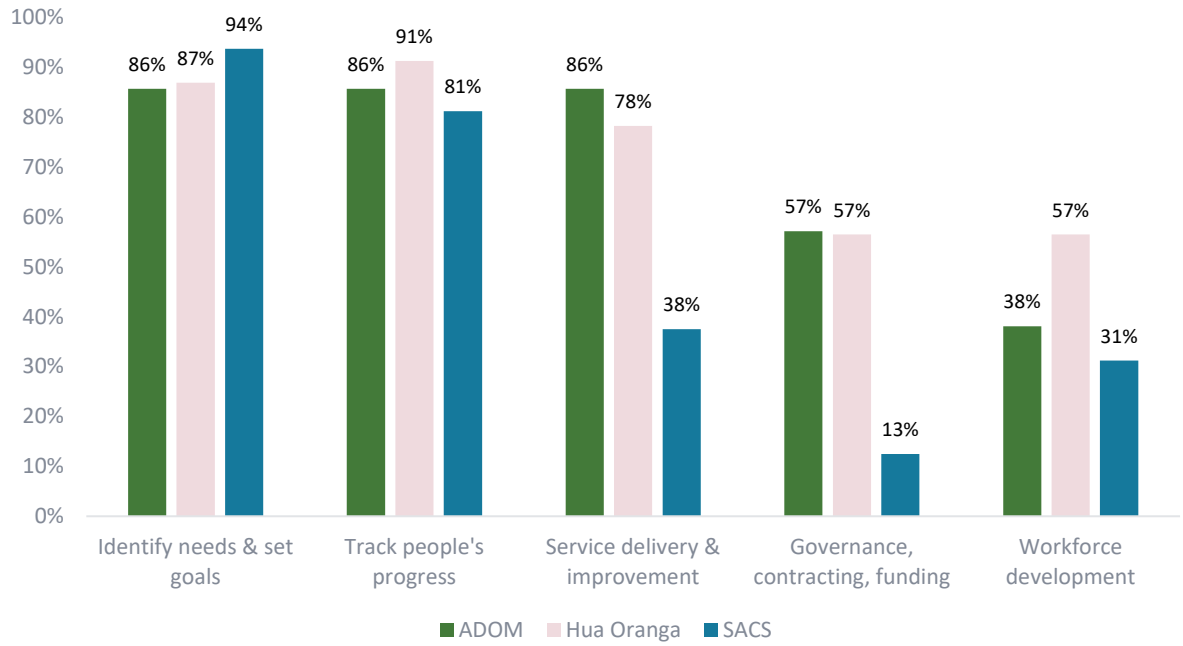
Brief Assessment of Recovery Capital (BARC-10)	4%	-
Parent-Infant Relationship Global Assessment Scale (PIR GAS)	2%	-

Appendix D: Levels of use – outcome tools

This Appendix includes more information about use of outcome data at different levels by organisations characteristics, focusing on the top three commonly used tools - Hua Oranga, Alcohol and Drug Outcome Measure (ADOM), and Substances and Choices Scale (SACS).

Figure 16 shows how the top three tools are used. It emphasises that use at the individual/whānau levels is more common than service, workforce, or governance levels overall. ADOM and Hua Oranga are more likely to be used at wider levels compared to the SACS. This may reflect reporting requirements such as the mandation of the ADOM, and recommendations for Hua Oranga as part of the Access and Choice programme.

Figure 16: Outcome data use from top 3 used standardised tools (46 responses)



Appendix E: Other tools

Many organisations said they used standardised tools that weren't listed in the survey. This Appendix contains a list of all other tools or frameworks grouped by topic; see Table 9.

Table 9: Other tools or frameworks used not listed in the survey

Wellbeing or QOL tools	❯ Personal Wellbeing Index ❯ Hauora a toi – My plan ❯ WHOQOL - adapted ❯ Spiritual Assessment (HPRS) ❯ European Health Interview Survey - Quality of Life
Addiction tools	❯ Alcohol Use Disorder Identification Test ❯ Alcohol, Smoking and Substance Involvement Screening Test ❯ Severity of Dependence Scales ❯ Craving Scale ❯ Maudsley Addiction Profile ❯ Therapeutic Community Client Assessment Inventory ❯ Leeds Dependence Questionnaire ❯ Early Intervention Gambling Health Test ❯ 5-Step Method Family Member Questionnaire ❯ Gambling Symptom Assessment Scale
Mental health tools	❯ PTSD Scale (PCL-5) ❯ Mood Assessment Index (MAI) ❯ Depression, Anxiety & Stress Scale (DASS-21) ❯ Personality Inventory ❯ Eating Attitudes Test ❯ Self-Harm Inventory (SHI) ❯ Beck Depression Inventory ❯ Difficulties in Emotion Regulation Scale

	❯ Multidimensional Inventory of Dissociation ❯ Borderline Symptom List
Cultural frameworks	❯ Te Awa ❯ Iti Kahurangi ❯ Whānau Ora Progression Framework ❯ Afiya Assessment ❯ Te Whare Tapa Whā ❯ Kirimana Oranga Whānau
Social outcome tools	❯ Outcomes Star - Home Star ❯ Outcome Star - Tenancy Star ❯ Work and Social Adjustment Scale
Family, whānau, or youth	❯ Postpartum Bonding Questionnaire ❯ Karitane Parenting Confidence Scale ❯ Adult-Adolescent Parenting Inventory ❯ Child PTSD Symptom Scale ❯ MacMaster Family Assessment Device ❯ Revised Children's Anxiety and Depression Scale
Other	❯ Mayo Portland (brain injury) ❯ Sensory Profile ❯ Montreal Cognitive Assessment ❯ Feedback or experience of service survey ❯ Performance monitoring reporting

Appendix F: Barriers

This Appendix looks at the full list of barriers by organisation characteristics; see Table 10.

Table 10: Barriers by organisation characteristics (63 responses)

Barriers	Overall	Kaupapa Māori	Non-Kaupapa Māori	Lived exp	Addiction	Mental health	MH&A	Small <50 FTEs	Large 50+ FTEs	ICY
Staff time and capacity	62%	56%	64%	80%	53%	55%	69%	59%	65%	42%
Time to collect or use outcome data	57%	44%	62%	90%	47%	52%	69%	60%	55%	45%
Complex needs among tāngata whai ora	41%	50%	42%	70%	40%	34%	56%	34%	48%	29%
IT systems or infrastructure	38%	50%	34%	50%	47%	28%	38%	38%	39%	34%
Limited understanding or training of outcome tools available	29%	25%	30%	30%	27%	31%	19%	28%	29%	32%
Lack of culturally relevant tools	27%	38%	26%	40%	27%	24%	19%	22%	32%	26%
Lack of organisational support, guidance or policies	16%	13%	18%	20%	13%	17%	13%	22%	10%	24%

Appendix G: Enablers

This Appendix looks at the full list of enablers by organisation characteristics; see Table 11.

Table 11: Enablers by organisation characteristics (60 responses)

Enablers	Overall	Kaupapa Māori	Non-Kaupapa Māori	Lived exp	Addiction	Mental health	MH&A	Small <50 FTEs	Large 50+ FTEs	ICY
Integration of outcome tools into electronic records	65%	88%	58%	60%	53%	48%	81%	60%	70%	61%
Tools that are easy and quick to use	63%	75%	60%	80%	67%	45%	69%	60%	67%	50%
Training on outcome tools to build confidence and understanding	58%	75%	53%	50%	40%	52%	56%	60%	57%	53%
Tools that look at outcomes relevant to the people accessing our service	58%	69%	53%	50%	60%	48%	50%	57%	60%	47%
Smartphone app or tablet to collect outcomes data	48%	75%	43%	50%	40%	34%	62%	33%	63%	39%
Mechanism for collating/ analysing/ outcomes data	47%	50%	45%	60%	53%	34%	44%	47%	47%	39%
Awareness of available outcome tools	35%	38%	34%	50%	40%	24%	31%	43%	27%	32%
Guidance/ support/ processes from our organisation or a national organisation	32%	44%	28%	60%	47%	14%	31%	37%	27%	34%

Appendix H: All conditions for reporting to PRIMHD

This Appendix looks at the full list of terms and conditions for reporting to PRIMHD by organisation characteristics; see Table 12.

Table 12: Terms and conditions for reporting to PRIMHD (62 responses)

Condition	Overall	Kaupapa Māori	Non-Kaupapa Māori	Lived exp	Addiction	Mental health	MH&A	Small <50 FTEs	Large 50+ FTEs	ICY
NGO ownership of the data	50%	56%	47%	50%	60%	41%	50%	58%	42%	37%
Data sovereignty principles in place	42%	81%	33%	60%	20%	24%	75%	32%	52%	45%
Robust and secure data infrastructure	42%	38%	45%	40%	27%	45%	44%	39%	45%	37%
Production of data insights for NGOs	40%	19%	47%	50%	33%	41%	44%	36%	45%	39%
Data security and protection provisions	39%	31%	43%	40%	33%	31%	56%	39%	39%	32%
Consent for use and reuse	37%	25%	45%	80%	40%	28%	44%	42%	32%	21%
Formalised data sharing agreements	27%	25%	29%	30%	27%	21%	44%	36%	19%	29%
NGO governance model	19%	19%	18%	10%	20%	21%	19%	16%	23%	16%
Data quality controls	16%	13%	18%	20%	7%	17%	25%	19%	13%	18%
Do not support reporting to PRIMHD under any conditions	5%	19%	0	0	13%	0%	6%	3%	6%	5%