MASSEY UNIVERSITY
DEPARTMENT OF MĀORI STUDIES
TE PŪMANAWA HAUORA

A FRAMEWORK FOR MEASURING MĀORI MENTAL HEALTH OUTCOMES

A Report Prepared for the Ministry of Health

by

M.H.Durie and Te K.R.Kingi

Research Report TPH 97/5

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EXECUTIVE SUMMARY

1 The Government wishes to measure the effectiveness of health services by moving to measures which reflect consumer outcomes.

2 Māori users of mental health services have also been identified as a particular group requiring priority attention.

3 In order to meet the needs of Māori, a Framework for measuring Māori mental health outcomes (MMHO) has been constructed. The MMHO Framework contains five underlying principles, three key stakeholders, four domains of outcome and five clinical endpoints.

4 The five principles are:

- wellness
- cultural integrity
- specificity
- relevance
- applicability

5 The three key stakeholders are:

- consumers
- clinicians/carers
- whānau

6 The four domains of outcome are:

- taha wairua
- taha hinengaro
- taha tinana
- taha whānau

7 The five clinical endpoints are:

- assessment
- inpatient treatment
- outpatient treatment
- community care
- discharge

8 Although consumer focused, the framework also recognises the need for both clinical and whānau perspectives.

9 By targeting particular clinical endpoints a greater degree of specificity may be attributed to the outcome of any particular intervention.

10 The five principles are consistent with Māori concepts of health and also with the needs arising from the nature of mental health disorders. The four domains appreciate that this framework has been constructed from a Māori philosophical base.

11 The framework is intended to assist with the promotion of the best possible outcome and is aligned to meet the needs of Māori consumers. It has a number of potential user groups, but will be particularly useful as a service development tool.

12 The MMHO framework, described in this Report, requires further work in order to develop a practical and valid instrument.

1.0 INTRODUCTION

1.1 Purpose of the Report

This Report describes an outcome measure for Māori users of mental health services. Although specifically focused on mental health outcomes a wider application is anticipated. The document will be of use to a broad range of health professionals, researchers and consumers of mental health services.

The tool described in this Report is a proposed measure only and has been constructed in order that further testing in clinical settings can proceed. On the basis of additional tests modification is anticipated.

1.2 Background

1.2.1 Research Issues

In 1995 Te Pūmanawa Hauora produced a Report entitled *Guidelines for Purchasing Personal Mental Health Services for Māori.* [1] The aim of the Report was to provide a conceptual and operational framework to guide purchasing strategies for Māori mental health services.

The report highlighted a number of issues concerning the mental health status of Māori. In particular, the increasing prevalence of mental illness among Māori, the high rates of re-admission to mental health facilities, and the apparent shortcomings of western based treatment models. Although a number of recommendations were made, two were of particular relevance to this Report. These were:

[1] Te Pūmanawa Hauora (1995), *Guidelines for Purchasing Personal Mental Health Services for Māori.* A report prepared for the Ministry of Health, Department of Māori Studies, Massey University, Palmerston North.

Firstly, a shift from measurements of outputs to measurements of mental health outcomes was recommended; and

Secondly, it was suggested that health outcome measures should be incorporated into purchasing contracts.

The Report further describeed why a more sophisticated approach (rather than simple output measurements) was required. The reasons given were that:

(1) current measurement tools are often imprecise;
(2) there is frequently disagreement on exactly what factors should be measured;
(3) existing measures may not adequately appreciate Māori concepts of health and well-being, and will therefore be of limited use; and
(4) social functioning (humanistic factors) should be recognised as important in terms of eventual outcome. [2]

Although falling short of actually describing an appropriate outcomes tool for Maori the six points above highlight important reasons why an outcomes measure should be developed.

The Mason report[3] was another comprehensive document that examined aspects of mental health and service development. Although the brief indicated "*...a sharply focused inquiry into the availability and delivery.... of Mental Health services in New Zealand relating to semi-acute and acute mental disorders"* [4] the nature of the inquiry

[2] Te Pūmanawa Hauora (1995), *op cit*.

[3] K. Mason (1996), *Inquiry Under Section 47 of the Health and Disability Service Act 1993 in respect of Certain Mental Health Services.* Report of the Ministerial Inquiry to the Minister of Health Hon. Jenny Shipley, Christchurch.

[4] K. Mason (1996), *op cit*.p.1.

required that it not be conducted in complete isolation from other aspects of mental health and outcome related issues.

The Mason Report considered over 700 individual submissions and gained considerable media attention. Despite making only five recommendations the report drew attention to the urgent need to both develop and implement effective mental health strategies.

Chapter 17 of the report specifically examined research and development issues and provided a list of possible research objectives and a preliminary list of 10 research themes. The themes targeted a variety of key areas, to which the development of mental health outcome measures was the first listed priority: *"The development of outcome measures for use in Mental Health services in New Zealand"* [5]

A submission from the Aotearoa Network of Psychiatric Survivors (A.N.O.P.S) further stressed the need for outcome measures that were consistent with individual needs.

ìOutcome measures for people using mental health services are importantÖWe believe that outcomes need to be generated by individuals and their unique set of needs and wishes, not by generalisations about peoples needs or by what services are willing or able to deliverî[6]

Comments from the National Association of CHE Mental Health Managers also indicated that there was a lack of national co-ordination and uniformity of service delivery in four particular areas. Of importance to this Report is point four: *ìThere is poor if any benchmarking taking place. Outcomes are not clear and services are not focused on themî*[7]

[5] K. Mason (1996), *op cit*.p.166.

[6] K. Mason (1996), *op cit*.p.89.

[7] K. Mason (1996), *op cit*.p.96.

Another publication *Nga ia o te Oranga Hinengaro Maori*[8] examined trends in Maori mental health, but also made research recommendations similar to those identified in the Mason report. However these recommendations went further, indicating that measures needed to specifically target Maori consumers: *"The nature, needs of, and outcomes for, Māori mental health consumers"*[9]

1.2.2 Government Response

The government has released two key documents that have described the importance of outcomes within the new health environment.

RHA purchasing guidelines stress the need for valid and accurate measures of mental health and to "*develop an understanding of services contribution to mental health outcomes*". [10] Even though measures have not yet been developed it is likely that outcome measures will form an important part in determining THA purchasing priorities in mental health and service development, in the near future.

Similarly the Governments coalition health agreement illustrates a commitment to health outcomes and a focus *"...on achieving health outcomes and improving the health status of the populations that they serve*". [11]

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[8] Te Puni Kökiri (1996), *Nga Ia O Te Oranga Hinengaro Māori - Trends in Māori mental health 1984-1993.* Ministry of Māori Development, Wellington.p.44.

[9] Te Puni Kökiri (1996), *op cit*.p.44.

[10] J Shipley (1996), *Policy Guidelines for Regional Health Authorities 1996/1997*, Ministry of Health, Wellington.p.14.

[11] The New Zealand First, New Zealand National Party Agreement, *Policy Area Health*, December 1996.

The need for outcome measures of health has been clearly identified. However there currently exists few accepted measures of mental health outcome and none that specifically meet the needs of Māori service users. This is of particular concern when considering the disproportionate numbers of Maori receiving treatment/care from mental health services and the cultural inputs which have been recommended for Māori consumers.

The issues so far described in this section highlight the serious need for accurate and effective mental health outcome measures for Maori users of mental health services. They further illustrates the governments commitment to achieving better mental health outcomes for Māori and mental health outcomes research.[12] The purpose of this report will be to initiate a process that will eventually lead to the construction of this tool.

1.3 Policy Issues, Health Gains and Health Outcomes

Maori health and mental health constitute two of the Government's four identified health gain priority areas.[13] In order to effectively address these the Government has adopted a

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[12] Ministry of Health (1997), *Moving Forward, The National Mental Health Plan for more and better Services,* Ministry of Health, Wellington. Also see Mental Health Commission (1997), *Blueprint for Mental Health Services in New Zealand, Working Document 1997,* Mental Health Commission, Wellington.

[13] J Shipley (1996)a, *op cit*.

range of purchasing strategies. Although six key health gain mechanisms have been identified three are of particular relevance to this research and are described below. [14]

(1) Shifting resources to where they will achieve the best health outcomes.
(2) Shifting the emphasis from inputs (such as numbers of beds) to outputs (services delivered to people) and outcomes (health gains for people).
(3) Developing strong co-operative relationships with agencies in the health and disability sectors which affect health outcomes.

The Steering Group to oversee the implementation of the Coalition health agreement also recommended that:

"*Services should always be focused on outcomes, although it is also important to acknowledge that health status is influenced by factors beyond the health sectors control*"[15]

Outcome measures are likely to form a key part in the implementation and development of these strategies and will be necessary if Government is to achieve their identified health objectives. In addition outcome measures will be useful as a monitoring tool and may also be used as a mechanism for policy evaluation and strategic policy development. These issues are further detailed in section four of the Report.

1.4 Māori Mental Health Status

[14] J Shipley (1996), *Policy Guidelines for M‰ori Health: Nga Aratohu Kaupapahere Hauora Maori 1996/1997*, Ministry of Health, Wellington. p 12.

[15] Steering Group (1997), *Implementing the Coalition Health Agreement,* Ministry of Health, Wellington. p.7.

The Mason report concluded that " *In terms of poor mental health Māori now face an appalling situation*".[16] Further, at a recent Māori mental health hui, mental illness was described as being the number one health issue facing Māori today.[17]

The past 20 years has seen a dramatic rise in the numbers of Māori being admitted to psychiatric institutions. Although overall admissions are falling[18] Māori rates continue to increase to a level that is now two to three times higher than that of non-Māori.[19]

Re-admissions rates for Māori are estimated to be 40% higher than that of non-Māori.[20] Alcohol dependence or abuse remains the leading cause of first admission for Maori men and the second most common cause for Maori women.[21] High rates of first admissions for Māori youth are largely linked to alcohol or drug misuse[22] and further contribute to the growing concern over mental illness amongst rangatahi.[23]

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[16] K. Mason (1996), *op cit*.p.137.

[17] M.H.Durie (1997), *Puahou, A five part plan for Improving Māori Mental Health***,** A paper presented at the Māori Mental Health Summit, Wellington.

[18] Te Roopu Rangahau Hauora a Eru Pomare (1995), *Hauora M‰ori Standards of Health III - A Study of the Years 1970-1991*, G.P.Print Ltd., Wellington.

[19] Te Pūmanawa Hauora (1995), *op cit*.

[20] Te Pūmanawa Hauora(1995), *op cit*.

[21] Te Roopu Rangahau Hauora a Eru Pomare, (1995), *op cit*.

[22] Public Health Commission, (1994), *He Matariki: A Strategic Plan for Māori Health,* Public Health Commission, Wellington.

[23] M.H.Durie (1997), *op cit.*

Current evidence also suggests that Māori tend to access mental heath services at a later stage than non-Māori. This implies that treatment will often be sought at an acute stage of illness, thereby requiring ongoing, and often expensive, treatment. The resulting health outcomes are therefore likely to be less effective and may in part explain high rates of re-admission.[24]

The actual prevalence of mental illness amongst Maori is however likely to be higher than these figures would indicate. Information based on admission data does not capture the large numbers of mentally ill who do not seek treatment or who delay treatment until a late stage.[25] Other associated data sets (e.g. prison admission, suicide rates or unemployment) are often not considered but are germane to generating a comprehensive overview of mental health problems among Māori.

1.5 Consumer Health Outcomes

1.5.1 Outcome Levels

Outcome measures have been used at population, service and consumer levels. Population outcome measures are concerned with macro-data sets that give an indication of major shifts in health status (e.g. morbidity rates, life expectancies). Service outcomes measure the performance of a particular service in terms of efficiencies and effectiveness. Consumer outcomes are about individual gains (or losses) in health as a result of an intervention.

1.5.2 Characteristics of Consumer Outcomes

It is possible to identify a number of key characteristics which are likely to be particularly relevant to Māori mental health consumers.

[24] Te Roopu Rangahau Hauora a Eru Pomare (1995), *op cit.*

[25] Te Roopu Rangahau Hauora a Eru Pomare (1995), *op cit.*

Firstly, a consumer health outcome will focus on the individual and will measure the change in health of an individual;

Secondly, a consumer health outcome will be the result of an intervention or series of interventions; and

Thirdly, a consumer health outcome will be able to attribute an intervention to an outcome.[26]

The characteristics above highlight a number of issues. First, the relationship between an intervention and an outcome is important. Whatever tool is used must be able to capture this relationship. Second, an outcome will need to demonstrate a capacity to meet the objectives of a particular intervention. Defining the intervention and the objective will in turn determine what the perceived outcomes should be. Third, the focus will need to be on the individual or particular group, rather than on the illness, service, or clinical ranking of improvement.[27]

The development of an accurate mental health outcomes tool is in itself a difficult process, further complicated by attempts to incorporate Māori perspectives of health and well-being. The construction of any tool will require rigorous investigation and testing to ensure accuracy, applicability and consistency with these parameters.

[26] G Andrews, L Peters, M Teesson (1994), *The Measurement of Consumer Outcomes in Mental Health.* Australian Government Printer. Australia. Also see. B. Raphael, G Hugh, G Stewart (1996), *Mental Health Outcomes,* A paper presented at the Integrated Health Outcomes Measurement in Routine Health Care Conference, Canberra, Australia.

[27] This point is also consistent with the views expressed by A.N.O.P.S. (Aotearoa Network of Psychiatric Survivors)

2.0 METHODOLOGY

2.1 Aims and Objectives

The aim of this study is to develop a tool which can be used to measure the mental health outcomes of Māori users of mental health services. In achieving this aim a number of secondary objectives have been identified. These are:

- to locate, gather and distil literature pertaining to health outcomes;
- to analyse and summarise relevant literature;
- to incorporate Māori views and perspectives;
- to develop a framework within which culturally effective mental health outcomes can be considered;
- to make recommendations;
- to initiate a process of consultation and feedback; and
- to prepare a final draft framework for testing in clinical settings.

2.2 Methods

A variety of methods were employed to ensure that the draft framework was developed in a culturally relevant and clinically sound manner. Emphasis was initially placed on gathering as much pertinent national and international literature as possible. Despite being able to identify a number of local studies and reports, early investigations suggested that international research would prove to be most useful.

Consultation and feedback was also an essential part of formulating and galvanising the final framework. The researchers were keen to obtain as much feedback as possible and to acquire a wide range of opinion. Though impossible to obtain a total representation of views, care was taken to ensure that as many consumers, whānau and health professionals as possible, had the opportunity to input into the study. In addition the views of policy makers, providers and other researchers were included.

The following steps formed the basis of the research process:

(1) analysis of key government reports and policy statements.
(2) literature searches on outcome measures.
(3) specialist committee input.
(4) hui consultation.
(5) presentations.
(6) expert interviews.
(7) international consultation.

2.3 Analysis of Key Government Reports and Policy Statements

If the research product is to be useful, then it will need to take into account Government policy and service practices. The analysis of key Government reports and policy documents was necessary to ensure consistency and a co-ordinated approach.

2.4 Literature Searches on Outcomes Measures

There is a significant amount of literature that describes health outcomes and measurement tools. This information was analysed and forms much of the background to this report. [28]

Massey Universityís on-line databases[29] were a principal source of information. The Ministry of Healthís library was also utilised and was able to provided additional specialist health information.

[28] See Bibliography for list of references.

[29] Kea, Miro, NewzIndex, Current Contents, Uncover, First Search.

Internet searches were conducted and were co-ordinated with electronic mail networks (e-mail). Although not providing extensive amounts of useful material, the information gathered here often supplemented existing data.

2.5 Specialist Committee Input

Both the project leader and research assistant were active members of various national committees. Participation in these arenas enabled relevant issues to be debated alongside other health and mental health caucuses and to test ideas from within a national forum. The committees were directly concerned with health or mental health, and/or were associated with wider issues of Māori development. This dual focus on Māori health and Māori development provided the opportunity to locate the research within a national perspective, to identify broad issues, key linkages and to compare priorities. This process also acknowledged the key relationship between Maori health and Māori development. Significant committees are listed below:

- Public Health Association of New Zealand (Māori Strategic Development Committee)
- Advisory Board to the Mental Health Commission
- Maori Mental Health Panel of Experts (Mental Health Commission)
- National Health Committee
- Māori Forum, Statistics New Zealand
- Māori Advisory Committee, Law Commission
- Steering Group to oversee Health and Disability Changes

2.6 Hui Consultation

During the course of this project the researchers attended several Māori health hui. Participation provided the opportunity to establish networks with other researchers, health professionals and consumers of mental health services. The researchers were able to use these forums as a means of obtaining feedback on the project, test key ideas and further develop the framework. Hui attended included:

- The Māori Mental Health Summit (Wellington)
- Hauora o te Hinengaro; Pathways to Māori Mental Health and Wellness(Auckland)
- Māori Mental Health Blueprint Development Hui (Auckland)
- Public Health Association Annual Conference (Hamilton)
- Strategic Mental Health Development Hui (Rotorua)
- Schizophrenia Fellowship Māori Perspectives Hui (Hamilton)

2.7 Presentations

Three presentations to research audiences were organised at Massey University in order to obtain feedback on the development of the study. These presentations attracted a range of health professionals, sociologists, consumers and students. This process allowed for direct feedback into the study and also assisted with the development of a comprehensive consultation network.

2.8 Expert Interviews

Experienced mental health outcome researchers provided further opportunity for professional and technical advice. Many of these experts were identified through the various consultation processes and hui. The researchers were also able to use their own extensive networks and contacts (a list of these individuals is contained in the consultation schedule).

2.9 International Testing

As stated previously the examination of relevant literature formed a significant part of this study. However, much of this information was based on research conducted outside New Zealand.

During the course of this project the research assistant received a Health Research Council (HRC) Travel Award. This award was specifically applied for in order to examine aspects of indigenous mental health development. Aspects of this were incorporated into the study programme. It proved to be a valuable means of establishing networks, gathering further resources, gaining an international perspective to the research and debating the relevance of culture and ethnicity to outcome measures for mental health.

3.0 OUTCOME LEVELS AND OUTCOME MEASURES

Health outcomes have a variety of connections and applications including the measurement of macro trends at population levels, service utilisation, and establishing treatment results for individual patients.

Determining which level is the most appropriate will essentially depend on the purpose of the research and the outputs that are to be achieved. Although this Report is primarily concerned with developing consumer/individual based outcomes, a brief outline of other levels of outcome is included to give context to the study.

3.1 Population Based Outcome Measures

Developing mental health outcome measures based on population indicators has particular advantages at governmental levels. The information is based on aggregated data and may be used to obtain an overview of epidemiological patterns (e.g. the prevalence of depression), trends (e.g. suicide rates), and service utilisation (e.g. hospital re- admission's).

It should be noted however that the actual prevalence of mental illness in the community cannot be accurately measured through morbidity and mortality data alone, since for the most part, the only reliable data is based on hospital discharges. Therefore available data will not reflect those individuals who may be clinically mentally ill but who do not access treatment services. [30] Nor do population based outcomes measure the level of service satisfaction, consumer outcome, the state of well-being or the results of a particular intervention.

[30] Te Roopu Rangahau Hauora ā Eru Pomare (1995), *op cit.*

A reduction in the number of yearly suicides for example, and the activities and resources used in various interventions is likely to be attributable to a number of factors (e.g. employment levels, availability of firearms or even current marital status) many of which may not be directly related to health or health policy.[31]

3.2 Input Based Measures

Inputs usually refer to interventions and processes which characterise a service. Although important for operational activities, input measures cannot measure the quality of treatment or the impact of the service on the health of a client. They may describe the capacity or even potential to effect positive change, but by themselves cannot be used as a measure of outcome.

3.3 Institution or Process Based Outcome Measures

Institution or process based outcome indicators have many of the characteristics of population based indicators. However process in this context specifically refers to the activity of the personnel within the service.

Process information is usually better recorded as data collection mechanisms simply reflect the activities of personnel. This type of information may include management systems, client to clinician ratios, frequency of client/clinician contact or contact length. Although similar to population indicators the information collected is at the service level. Developing an outcomes tool from this perspective will encounter similar problems, as process information by itself cannot describe actual health outcomes of the service or the real impact that the service has had on the health of an individual.

[31] Injury Prevention Unit (1995), *Intentional Injury in New Zealand.* Public Health Commission. Wellington

Procedures and clinical management practices peculiar to a service may be described and measured, though with little reference to the health of the individual or the health outcomes of an intervention.[32]

Process information may be useful in describing illness or symptoms and fluctuations in both. However, measuring illness patterns should not be confused with measuring health outcomes. Although reducing the symptoms of illness may be a goal of the clinician and may be considered a positive outcome, this may not be the most important priority for the consumer.[33] For example a side effect of medication may be a reduction in the clients capacity to function independently, which may in turn generate more distress than the original symptom. Although this so-called opportunity cost may be acceptable to the clinician, the client and their whānau may view it less favourably. On the other hand, sedating a potentially violent consumer may be the desired outcome of the whānau and the wider community but undesirable from a consumers point of view. Many perspectives will therefore be important to the development of the tool,[34] more so if cultural factors are to be fully recognised.

3.4 Individual or Group Based Outcome Measures

Measurement tools which are based on populations, inputs or processes, serve particular purposes. However, these are not designed to measure the result of clinical interventions in terms of improved standards of health. Population indicators are essentially too broad to be attributable on an individual or group level. Input and process indicators assume that a combination of funding and service competency will automatically result in positive consumer outcomes. That however is not always the case.

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[32] G Andrews, L Peters, M Teesson (1994), *op cit.*

[33] J. Shanks (1994), "Outcomes in Mental Health" .In, (eds.) Delamothe T., *Outcomes into Clinical Practice,* BJM Publishing Group.

[34] J. Shanks (1994), *op cit.*

Developing measures based on consumer indicators will however enable the effectiveness of treatment to be assessed, and outcomes to be determined from clinical and consumer perspectives. In addition, the perspectives of other treatment externalities such as whānau and carers, may also be considered.

4.0 PURCHASER PRINCIPLES

The background to this Report discussed government health strategies and the need to develop accurate measures of health outcomes. Section 1.3 further went on to describe policy issues and the importance of outcome based monitoring systems.

The purchasing guidelines for Maori health[35] contain draft objectives for health and disability support services. The Guidelines list *six principles for purchase decisions and... policy directions for Maori health*.[36] These principles are designed to guide RHA resource allocation decisions in order to contribute to positive health gains and include;

- Equity
- Effectiveness
- Efficiency
- Safety
- Acceptability; and
- Risk Management.

The principles of effectiveness, efficiency, safety, acceptability and risk management all have health outcome implications and appropriate mechanisms for measuring these need to be considered. Particular issues are described below.

4.1 The Principle of Effectiveness

The effectiveness principle focuses on ensuring that services result in better health outcomes and are further described as:

ìÖ*those where treatment is likely to provide a significant net health benefit. Services known to have no significant beneficial effect on people's health should not be*

[35] J Shipley (1996)b, *op cit.*

[36] J Shipley (1996)b, *op cit.* p.12.

purchased. Health gain also includes improvement to people's length and/or quality of life.î[37]

4.2 The Principle of Efficiency

The efficiency principle recognises that resources are limited and that choices will need to be made with regard to resource allocation.

ì Where a choice of effective service for addressing a given health problem exists, the most cost effective service should be chosen. RHAs should evaluate the benefits of shifting resources within a service and between a serviceí[38]

Table 3 illustrates that outcome measures may assist with resource allocation decisions, both at the service development and policy levels.

4.3 The Principle of Acceptability

The acceptability principle focuses on autonomy, respect, empowerment and participation. In addition, the purchase of services should be responsive to the cultural diversity of communities and populations. Key aspects include:

- Improving people's choice and satisfaction, and preserving personal dignity and privacy;
- Improving, informing and consulting people and communities; and
- Improving the responsiveness of services to people's diverse needs, preferences and cultural values.[39]

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[37] J Shipley (1996)b, *op cit.* p.13.

[38] J Shipley (1996)b, *op cit.* p.13.

[39] J Shipley (1996)b, *op cit.* p.13.

The application and development of a mental health outcomes tool for Maori will need to be consistent with these key aspects. Indeed its potential to respond, inform and respect one's cultural values should not be overlooked.

4.4 The Principle of Risk Management

The principle of risk management identifies the need to analyse risk and to develop risk management strategies. Key aspects of this are:

- Managing service risks to populations and consumers; and
- Ensuring objectives are achieved within available funding and without exposing the taxpayer to greater fiscal burdens in the future.

In addition it is also stated that:

Appropriate tools to manage financial risk include forecasting, budgeting, monitoring and providing risk reserves[40]

Mental health outcome measures will assist purchasers to monitor services and allocate resources in an efficient manner. It is also likely that the tool will provide information relevant to future funding options by justifying purchasing decisions.

[40] J Shipley (1996)b, *op cit.* p.13.

5.0 MENTAL HEALTH OUTCOMES

Although various outcome measures have been discussed, questions remain and continue to be advanced about what constitutes an ideal outcome measure and what factors should be taken into account. Although the construction of measures such as HONOS[41], SF-36[42], WHOQOL[43] and others have provided useful tools in certain situations, they are not universally accepted as accurate or capable of wide applicability.

5.1 Problems

Measuring mental health outcomes will be difficult for a number of reasons. Unlike other physical ailments, mental illnesses may not present categoric evidence of a treatment related outcome. For example, if a tumour is removed and the client suffers no other physical or emotional consequences and no return of the tumour five years later, then the treatment is deemed a success and the outcome is positive. Likewise if a fractured leg is reset, pinned and the client later returns to full physical function then the outcome is also clear.

Mental health outcomes however are more difficult to accurately ascertain and will require a combination of clinical assessment and consumer perspectives. A clinician will be able to prescribe treatment and monitor progress based on symptoms and the clients change in condition. However, and as we have discussed, a change in symptom does not always equate with a change in health outcome. In addition, assessing responses to treatment should also take into account factors which impact on the health of the client, outside formal treatment.

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[41] Health of the Nation Outcome Scales (College Research Unit)

[42] Short Form 36 (Rand Corporation, Medical Outcomes Trust)

[43] World Health Organisation Quality of Life Instruments.

Mental health outcomes provide further challenges. Such as;

- outcomes may not be clearly obvious;
- the client may never expect to become well again;
- the prescribed treatment may require a lifetime of ongoing care;
- the gap between an intervention and a good outcome may be lengthy; and
- other external factors (e.g. interpersonal relationships) may be more significant determinants of health than the clinical intervention.

Cultural factors also become relevant. A good outcome in one culture, may not be regarded positively in another. Further, some cultures may attribute change to other sources even when there has been a significant/major clinical intervention.

Despite these problems, it has been possible to identify a number of key characteristics widely associated with the construction of mental health outcome measures. These are summarised in Table 1.

Table 1

Key Characteristics of a Mental Health Outcomes Tool[44]

CHARACTERISTIC	DEFINITION
Applicable	• The tool must be relevant to consumers.
Acceptable	• The tool should be brief and user friendly.
Practical	• The tool needs to be easily applied in clinical practice, with minimal cost. Data input and interpretation should be simple as should training in the use of the tool.
Reliable	• The tool must be reliable and clinically sound.
Valid	• The tool must measure what it is designed to.
Sensitive to Change	• The tool must be able to detect and measure change over time.

The challenge to this research has been to meet the characteristics described in Table 1 while at the same time satisfying the cultural requirements of Māori service users.

[44] Table 1 has been developed based on information contained in; G Andrews, L Peters, M Teesson (1994), *The Measurement of Consumer Outcomes in Mental Health.* Australian Government Printer. Australia.

5.2 Applicability

Table 1 described some of the key characteristics of a mental health outcomes measure and also highlighted the importance of developing a tool that is applicable and acceptable to all consumers. Table 2 describes some of these issues in greater detail and further highlights problems associated with constructing an outcome measurement tool.

Table 2.

Requirements of a Mental Health Outcomes Tool

ASPECT	REQUIREMENT
Condition	• The tool must be able to be applied regardless of severity of condition.
Duration	• Some clients will require long-term/ongoing treatment while others will not. The tool will need to accommodate varying treatment durations.
Age	• The tool will need to be effective regardless of age.
Gender	• Characteristics of some mental illnesses will be determined by gender. This should not impact on the effectiveness of the tool.
Environment	• The tool will need to consider and take into account environmental externalities (factors that impact on the client outside the formal treatment programme).
Treatment	• The tool must be able to be applied regardless of the treatment plan. The type of treatment (or prescribed medication) should not determine the effectiveness of the tool.
Culture	• It is now well accepted that culture and health are closely linked. Any outcome tool will need to allow for the expression of the cultural background of the client. In addition, it should not be assumed that culture will be based purely on ethnicity and include such things as religious beliefs or social class.
Client Needs	• Assumptions should not be made as to what outcomes the client will prefer (e.g. Social Interaction, Whānau relationships).
Administration	• Despite being consumer focused it cannot be assumed that all clients will be able to effectively use or self-administer the tool.

Bias in any of these areas will impact on the accuracy of the tool, its capacity to draw individual comparison and therefore its usefulness as a measure.

5.3 Why Measure Mental Health Outcomes?

There are a number of groups who will benefit from mental health outcome measures. As already discussed, consumers, clinicians and whānau will be key stakeholders. There are however others who will have a significant interest. They are described in Table 3.[45]

Table 3

Users of Mental Health Outcome Measures

FOCUS	PURPOSE
Consumers	• Monitoring of progress. • Inform clinician of progress. • Decide which service to attend.
Whānau	• Informed about the progress of the client and their capacity to assist with the treatment and rehabilitation process.
Carers	• Monitor the progress of the consumer. • Decide which service is the most appropriate.
Health Professionals	• Monitor consumer progress. • Monitor their own performance. • Data available to make treatment decisions.
Local Management	• Inform decision about staff deployment and development. • Inform decisions about which treatments should be supported. • Measure the load on the service. • Measure the overall effectiveness of the service.
Policy	• Information useful for policy development. • What services, or mixture of services, have been most effective for which clients. • What purchasing approaches have been the most useful for consumer needs.

[45] G Andrews, L Peters, M Teesson (1994), *op cit.* Also see Te Pūmanawa Hauora (1995), *op cit.* and S Hallwright (1997) Discussion Paper: Outcomes in Mental Health.

6.0 MAORI HEALTH OUTCOMES

The health outcomes described in this study will inevitably be client focused. Although it is reasonable to conclude that a positive outcome will be the desired result for all consumers, what is less certain are the factors or components that will be considered indicative of a good outcome.

Individual priorities or perspectives on health will influence views, although it is reasonable to expect that all clients will express similar overall health outcome priorities (e.g. to be free from illness or to be able to function normally). What needs to be considered in the context of this study is the impact that cultural perspectives of health and well-being will have on determining health outcome criteria.

6.1 Culture and Health

The relationship between culture and health is now well accepted. Mental health services need to ensure that the cultural needs of their clients are met and that cultural components are applied in a manner that will increase the potential for positive health outcomes.[46]

The cultural requirements of clients need to be addressed at all levels of the service from referral through to discharge or follow-up. A co-ordinated assessment process should therefore be adopted, remembering that not all Maori clients will benefit from identical cultural inputs or that they will be similarly comfortable within the same cultural settings. Like clinical treatment, cultural input will have its greatest impact when applied by suitably qualified personnel. It is equally important that appropriately qualified staff are available to administer cultural components of treatment.[47]

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[46] Te Pūmanawa Hauora (1995), *op cit.* p. 19. Also see American Psychiatric Association (1994), *DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, 4th ed,* American Psychiatric Association, Washington DC. pp 843- 849.

[47] M.H.Durie (1996) , *M‰ori Cultural Identity and itís Implications for Mental Health Services,* Department of M‰ori Studies, Massey University, Palmerston North.

6.2 Māori Perspectives of Health

Whare Tapa Wha is an accepted model for describing the Maori concept of health. It comprises four inter-related components:

- taha wairua (spiritual well-being);
- taha hinengaro (mental well-being);
- taha tinana (physical well-being); and
- taha whānau (the relationship between family and health).

Literally, Whare Tapa Wha translates as the four sides of a house, each linked and each co-dependent in terms of creating a sustainable structure. The model illustrates that Maori health and well-being is viewed holistically and that all components of health (taha wairua, taha hinengaro, taha tinana and taha whānau) need to be addressed and sustained in order to create a totally healthy person. Accordingly, if any one of the components is deficient this will negatively impact on a persons health and the capacity to become well.[48]

6.3 SF-36 and Māori Health Outcomes

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[48] M.H.Durie (1994), *Whaiora; M‰ori Health Development*, Oxford University Press, Auckland, New Zealand. pp 69-75.

SF-36 is a commonly used measure for assessing self perceived health status. This tool has been validated for a number of populations; however no study has specifically validated it for Māori.[49]

Although evidence suggests that the tool is appropriate for a wide range of medical and psychiatric groups, there are indications that it can be problematic for some groups such as the elderly, those poorly educated or in poverty, and those with both medical and psychiatric co-mobidities.[50] As we have anticipated that these groups will form at least some part of the target group, it was decided not to entirely adopt, the SF-36 framework. Despite this, the SF-36 framework has been a valuable resource to the research team.

6.4 Clinical Outcome Tools

A number of clinical outcome related measures are available including BASIS[51] and the Mental Health Inventory.[52] They are most useful to clinicians concerned with monitoring the progress of an illness and are important to assess the effectiveness of treatment. However they are not always practical, may be time consuming, and do not take full account of consumer family views.

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[49] N.B. both the Ministry of Health and midland RHA have tested and validated SF-36 for the general population.

[50] C.A.McHorney et.al (1994), The MOS 36-item Short Form Health Survey (SF-36):III. Tests of Data Quality, Scaling Assumptions, and Reality Across Diverse Patient Groups. In *Medical Care, Vol 32, No 1, pp 40-66.* Philadelphia.

[51] More information on this measure may be obtained from: Susan V. Eisen (Ph.D), Mc Lean Hospital, 115 Mill St, Belmont Massachusetts.

[52] Further information on this measure may be obtained from: The RAND Corporation, 1700 Main St, PO Box 2138, Santa Monica.

7.0 CONSUMER PERSPECTIVES

This Report has adopted a consumer centred approach to the development of outcome measures in mental health. Although other key stakeholders will necessarily be involved, the perspective of the consumer will be critical to the process.

7.1 Condition Variables

Table 2 briefly described some of the problems associated with constructing a measure that is capable of meeting the diverse needs of all consumers, especially the need for a tool which could be applied to a range of clients with a variety of individual needs and conditions.

Depending on the nature of the illness, some clients may never be able to effectively use an outcomes tool, no matter how user-friendly. In addition it is reasonable to expect that not all clients will be able to make an accurate assessment of their personal well-being and may in fact provide information that is divorced from reality.

Obviously, an outcomes tool will need to address these issues and provide solutions which on the one hand incorporate consumer perspectives and on the other provide an accurate assessment of health outcomes. Although difficult, it is likely that by balancing consumer perspectives with those of clinicians and whānau, an overall assessment may be obtained.

7.2 Best Outcomes

Often the views and perspectives of consumers will differ significantly from the clinician, whānau and wider community. Indeed it is reasonable to expect that a consensus view of a best outcome may not be achievable. For example, a clinician may develop a treatment plan that is consistent with achieving symptom reduction through medication. However the effects of medication may not be acceptable to the whānau or client, and the outcome would be regarded by them in less favourable terms. As such the outcome perspective of

all interest groups may not be identical. A process and framework therefore needs to be established whereby competing views may be assessed and given appropriate weighting.

7.3 Cultural Realities

Cultural assessment will form a critical part in ensuring that Maori clients receive the most appropriate and effective treatment plan. However, it should not be assumed that all Maori clients will benefit from similar cultural inputs or that a Māori cultural focus will automatically have a positive impact on health. For example, if the client has a limited understanding of cultural paradigms, but is nevertheless prescribed a treatment plan that incorporates high cultural input, it may result in the client feeling alienated and inadequate, further aggravating the existing condition. The important point is that outcome measures should be consumer focused without preconceived ideas of appropriateness or orientation.[53]

[53] The diverse nature of Māori society needs to be recognised.

8.0 CLINICAL PERSPECTIVES

The importance of culture to treatment and improved standards of health has been stressed throughout this Report. However cultural responsiveness will not in itself be able to guarantee the range of care required by Maori clients.

In order to provide an effective treatment plan it will be necessary for cultural inputs to be balanced with sound clinical practice. Indeed it should also be stressed that both a sound clinical plan and a cultural treatment plan should be made available to Maori consumers; each is considered equally important.

Outcome measures should not be divorced from clinical perspectives or views about well-being which are derived from the absence of illness. Anti-depressant medication is a good example of this. While a consumer may describe a high level of well-being and a good outcome from treatment, a clinician might be concerned about the level of elation and the associated risk taking behaviour and poor judgement. In this case, the consumers assessment of outcome by itself, would distort the actual situation. A further example can be found in balancing one set of problems against another. Side effects from major tranquillisers, for example, may distress a patient to a point that any advantages from treatment are masked by severe extra pyramidal symptoms. A clinician might well be mindful of those effects but inclined to the view that they represent the lesser of the two evils. Then, it becomes a question of weighing immediate discomfort against long-term benefits.

9.0 WHĀNAU PERSPECTIVES

Social functioning and other environmental externalities have been identified as important factors which need to be considered as part of an outcomes measure.

Providing an assessment of the quality of wider interaction is, however, problematic because neither the client nor the clinician will always be in a position to provide a total assessment of social functioning or describe the types of environmental externalities that may impact on the clients condition, outside the formal treatment situation. Indeed many environmental factors may never be considered. Despite this, it is possible to account for some contingencies by accessing the views and perspectives of those that have the most contact with the client in social settings - the whānau.

Under usual conditions it will be the client's whānau who will provide most knowledge about interaction in the community and who will normally create the environmental conditions which will have greatest impact on the condition of the client.

9.1 Defining Whānau

Whānau is a term that is difficult to define within a contemporary context. For some it will necessarily be based on whakapapa and genealogical links, others however will view it more as a relationship determined by a common interest or purpose.[54] In terms of health it is also reasonable to conclude that whānau may include carers, partners and/or others who have a direct impact on their well-being. Regardless any definition should be guided by individuals and their personal perspectives of what whānau might mean to them.

[54] J Metge (1995), *New Growth from Old: The Whānau in the Modern World*. G.P. Print, Wellington.

A number of contemporary writers such as Smith[55], Durie[56], Metge[57] and Walker[58] have all commented on the key functioning characteristics of the whānau. Whilst each raise similar issues, a consensus about a whānau construct has yet to be established.

In 1996 Te Pūmanawa Hauora developed a framework that aimed to conceptualise whānaungatanga.[59] The Whakapiripiri Whānau Framework[60] although specifically targeting whakapapa[61] based definitions of whānau, also examines concepts that may be applied to more wider/contemporary definitions. The key characteristics of the framework are described in Table 4.

[55] G.H. Smith (1995), "Whakaoho Whānau", in, *He Pūkenga Körero*, Department of Māori Studies, Massey University, Palmerston North. pp.18-36

[56] M.H. Durie (1994), *Whānau, Whānaungatanga and Health Development*, Paper presented at the Public Health Association Conference 1 June 1994, Palmerston North, Department of Māori Studies, Massey University, Palmerston North.

[57] J Metge (1995), *op cit.*

[58] R Walker (1990), *Ka Whawhai Tönu Mātau: Struggle Without End*, Penguin Books, Auckland. p.63.

[59] Kinship; See R Fleming (1997), *The Common Purse: Income Sharing in New Zealand Families,* Auckland University Press, Auckland. p 168.

[60] Te Pūmanawa Hauora (1996), *Oranga Whānau: Māori Health and Well-being, and Whānau*, Department of Māori Studies, Massey University, Palmerston North.p. 32.

[61] In this context "whakapapa" refers to families that are linked by a common ancestor.

Table 4.

Principles and Health Implications of Whānau

PRINCIPLES	HEALTH IMPLICATIONS
Tātau Tātau (collective responsibility)	• Healthy Development. • Access to informal health support. • Reduction in levels of stress. • Access to resources to promote a healthy lifestyle. • Safe environment.
Mana Tiaki (guardianship)	• Health Development. • Improved mental well-being. • Access to resources to promote a healthy lifestyle. • Enhanced quality of life. • Enhanced spiritual well-being.
Manaakitanga (caring)	• Enhanced quality of life. • Healthy Lifestyles. • Healthy policy development. • Healthy practices. • Models for health promotion.
Whakamana (enablement)	• Healthy development. • Improved mental health. • Access to health services. • Access to resources to promote good health. • Health promotion.
Whakatakoto Tūtoro (planning)	• Opportunities for early intervention. • Healthy policy development. • Access to resources to promote good health. • Improved access to health services. • Planning for health needs.
Whai Wāhitanga (participation)	• Improved access to health services. • Healthy lifestyles. • Health promotion. • Access to resources to promote good health. • Informal health support.

Although the above table gives some indication as to the capacity of the whānau to promote good health and well-being, it needs to be recognised however that not all whānau will be able to function in a positive way. Further, their ability to effectively promote a healthy environment will not always be the same.

Whānau will in fact be faced with a range of contingencies (e.g. income, housing, composition of members, support networks etc.) that will be particular to their situation and which will inevitably impact on their potential to provide a healthy environment.

In terms of mental health services, whānau participation is likely to be particularly useful at the assessment phase and when determining cultural assessment. Input into other levels of treatment may also be beneficial.[62] This will need to be determined on a case by case basis and balanced against all other relevant factors[63] such as client or whānau preference.

9.2 Health Outcomes and Whānau

In section 6.2 of this Report, Maori concepts of health and the particular role of whānau were discussed. It is suggested that regardless of individual perspectives, the whānau are likely to have an important role to play in the overall health outcome of the client and should be considered when designing models of health that are appropriate for Maori.

Factors such as, living conditions, economic status and access to support network have the potential to either hinder or assist treatment. Some environmental factors may never be accurately accounted for or able to be fully considered. However, as Table 4 illustrates, many aspects of client social interactions will be known to whānau.

[62] Te Pūmanawa Hauora (1995), *op cit.*

[63] Relevant details on this may be found in section 6.4 of the above document.

In summary, an outcomes measurement tool for Maori will need to incorporate the perspectives of whānau in order to:

(a) ensure consistency with Maori concepts of health,

(b) account for some of the factors which impact on the outcome of the client, outside formal treatment processes; and

(c) balance the sometimes conflicting views of client and clinician.

10.0 CLINICAL ENDPOINTS

Section three of this report outlined the various levels at which outcomes could be measured and the reasoning for adopting a consumer focused approach. Likewise, the treatment process may also be broken down into identifiable components or clinical endpoints. These components may also be used as markers where outcomes can be assessed.

Targeting an outcome measure to each of these levels will enable a greater degree of certainty in associating an intervention to an outcome. It is therefore more likely to provide accuracy, responsiveness and utility as a service development and outcomes tool. Five components of care/treatment relevant to this study have been identified. These are:

- assessment;
- inpatient treatment;
- outpatient treatment;
- community care; and
- discharge.

While it is accepted that not all clients will progress through these treatment phases (or that all of these services will be available) this should not effect the application of the tool or its effectiveness. Targeting specific clinical endpoints will ensure that outcome measures have a greater likelihood of being linked to a specific intervention and will overcome the difficulty of waiting (possibly for months, or even years) before the treatment is completed. The focus on clinical endpoints also recognises that different sections of a service might be responsible for different service components - and purchasing strategies might well favour a modular approach to the purchase of mental health services.

10.1 The Assessment Phase

Assessment is a critical point in any mental health service. A culturally appropriate mental health assessment, combined with clinical examination will ensure that the needs of the client are understood and a treatment plan developed accordingly. If the assessment is inadequate or inappropriate then the treatment and eventual outcome will also be flawed.

The outcome of the assessment process will be measured both in terms of the quality of information obtained (by the clinician, in order to make a diagnostic formulation) and the understanding which client and whānau receive about the problem (in order to choose a treatment option), as well as the effective implementation of any recommendations.

10.2 Inpatient Treatment Phase

Most existing outcome measures target the inpatient treatment phase for the measurement of outcomes. But because this treatment phase can be prolonged, and cover several weeks or months, it is critical that outcomes be measured regularly during the treatment process in order to assess the progress of the client and to recommend alternative plans of action, if necessary.

10.3 Outpatient Treatment Phase

The health reforms, the move toward de-institutionalisation and the consequential growth of community mental health care services, give some indication as to the important role of outpatient care and management.

Rather than being placed within specialised psychiatric institutions many clients will be referred to a residential centre for ongoing treatment within an environment that is less intensive (and restrictive) than a specialised hospital. Hospital based out patient clinics, therapy at mental health centres, and domiciliary visits, provide opportunities for ongoing treatment. The outcomes of such interventions warrant attention, as much as inpatient care.

Monitoring outcomes at this level is particularly important when considering the trend towards de-institutionalisation. Outcomes will also provide information relevant to service development and the effectiveness of services. This is critical when considering the growth and development of Maori service providers.

10.4 Community Care Phase

For a large number of Maori clients it will be the whānau or other non-health professionals who will be responsible for care outside formal treatment. Despite having ongoing mental health problems many clients will not need specialist full-time treatment and will only require regular, intermittent contact. General practitioners, or other health care workers who are not part of the mental health team may be more involved.

10.5 Discharge

Discharge has been identified as the last phase in the formal treatment process. Therefore it is critical that an assessment is made at this point. It is important to consider however that for some clients, a complete discharge will never occur. In addition, it cannot be assumed that all clients will follow a similar pattern of discharge or that non-compliance will prejudice a deliberate discharge decision.

11.0 THE MĀORI MENTAL HEALTH OUTCOMES FRAMEWORK

11.1 A Four Part Framework

A four-part framework is proposed to measure mental health outcomes for Māori. It is derived from: five principles, three key stakeholders, four domains of outcome, and five clinical endpoints. For convenience it is referred to as the MMHO framework.[64]

11.2 Fundamental Principles

Five principles underlie the proposed MMHO Framework. They are consistent with the principles identified in section four and section 10 of this Report and also take into account the particular needs of Māori as well as the needs arising from the nature of mental health disorders and the context within which interventions take place. The 5 principles are;

- wellness;
- cultural integrity;
- specificity;
- relevance; and
- applicability.

11.2.1 Wellness

The absence of signs and symptoms of illness is not the same as wellness. The underlying premise in the MMHO framework is that wellness, not simply the removal of symptoms, should be the aim of an intervention. While this approach is consistent with a holistic framework, it should be noted, however, that wellness depends on many more variables than can reasonably be expected of a treatment or care service. Clinicians may rightly argue that their field of expertise addresses only one aspect of wellness (such as the removal of symptoms) and that they are insufficiently resourced to address the wider social, economic and cultural issues which, together, lead to wellness. Models of disease

[64] Māori mental health outcomes.

remission, however, focus on the signs and symptoms of disorder, rather than the capacity to function in a dignified and meaningful way. For that reason, the intention of introducing the principle of wellness is to indicate that in the end, consumers are interested in being able to enjoy a meaningful life, with or without symptoms. Symptom ablation may be a less important goal than simply being well.

11.2.2 Cultural Integrity

The importance of culture to the experience of mental disorder and to the recovery process has already been noted. Interventions should be delivered in a manner which will not compromise cultural norms, unless those norms themselves are inconsistent with good health. And, far from expecting clients to conform to a single cultural norm, the outcome of interventions should be able to reaffirm cultural beliefs and lifestyles. In other words, after a period of treatment and/or care, the client should feel stronger in terms of culture and cultural identity. Treatment services may regard cultural affirmation as outside the primary aim of a mental health service, but if wellness is the goal, then culture cannot be ignored. Presumptions about a client's cultural background (as distinct from ethnicity) can be misleading and in an earlier Report the importance of assessing culture in terms of an individual's actual situation was stressed.[65]

11.2.3 Specificity

To overcome the difficulties in matching outcomes to interventions, or outcomes according to single perspectives, a more specific approach is recommended. Three areas requiring greater specificity are age, stakeholders and clinical endpoints. Outcomes for children need special consideration and should take account of development needs as well as communication preferences. Stakeholder specificity is further discussed later in this section. The important point is that, although the views of consumers, clinicians, and whānau are likely to be quite different, together they give a global representation of the situation. The third area of specificity is clinical endpoints. Because they represent quite

[65] Te Pūmanawa Hauora (1995), *op cit.*

distinct phases of treatment/care, five endpoints can be identified, each with different expectations and objectives. In turn, the desired outcomes from each phase require separate consideration.

11.2.4 Relevance

Outcome measures should be relevant to purchasing, service delivery, and ongoing arrangements for care and should be relevant to Māori consumers. Outcome measures can be useful not only to consumers and whānau, but also to clinicians and purchasers. They should be able to give an indication of the success of treatment/care, an indication of the need for another opinion, or an indication of the need to modify treatment. Further, in time, they should be able to help consumers make informed choices about the value and suitability of services. Outcome measures will be especially useful to funding agencies, providing an outcome based rationale as opposed to an outputs schedule.

11.2.5 Applicability

To be useful, an outcome measure must be applicable to the key stakeholders, the context within which mental health services operate, and Māori cultural preferences. It must be manageable, not intrusive, and easy to interpret. Demands on clinical time should not be excessive, nor should consumers or whānau be expected to spend long periods of time filling in forms. Similarly, because self administration is important to the process, a readily understood format is required. The views of consumers whose illness interferes with sound judgement or understanding, should be balanced by the views of whānau and clinicians/carers.

11.3 Key Stakeholders

It has already been emphasised that mental health outcomes should take into account the views of clinicians, consumers and families. In this respect an outcome measure is not the same as a patient satisfaction measure, or a clinical rating scale, or a family opinion about a treatment process. Although the tension between these sometimes conflicting views may not be easy to reconcile, this framework prescribes a global picture of

outcome requiring at least consumer and clinical views and preferably whānau views as well.

11.3.1 Clinical Views

While a clinical team approach is the rule, for each phase of mental health care and treatment a responsible clinician should be identified. The responsible clinician might be any one of the professional team; in some cases it will be a psychiatrist, in others a community nurse, or a psychologist, or an occupational therapist. Clinical views about outcome need not necessarily reflect a team view but should reflect a responsible professional view and should be based on a widely accepted criteria. While clinical views will inevitably focus on a particular diagnostic grouping, clinicians must also exercise judgement about the relationship of the disorder to other aspects of healthy living. In this respect, clinicians must at least be aware of the actual world of the patient so that the impact of ill health can be assessed in a meaningful way. The framework proposed in the Report, and the suggested schedules, will not remove the need for more detailed clinical outcomes measures.

11.3.2 Consumer Views

Not all consumers will be in a position to make helpful comments about outcomes. There are some mental disorders which remove any sense of reality testing to the point that judgement is significantly impaired. However, consumer views are critical to the determination of outcomes and it is recommended that, despite the clinical state, every effort be made to ascertain consumer views. Subsequently these might be balanced by other views, but the starting point ought to be that the views of all consumers will be valued.

11.3.3 Whānau Views

There are three difficulties in seeking whānau views. First, some consumers do not want whānau to be involved in the treatment process and their confidentiality needs to respected. Second, whānau themselves may be reluctant to take part in the process. And, as already noted there is some debate about who constitutes a whānau and whether the

metaphorical whānau is as relevant as the whakapapa whānau. Those issues aside, whānau views are important because they may act to balance limited clinical perspectives, as well as bringing a degree of realism to the consumers opinions. In addition, whānau are probably well placed to comment on the significance of cultural matters as they affect a particular client.

11.4 Domains of Outcome

In an attempt to measure outcomes over a range of functions, and to link client outcomes with both cultural and social realities, it has been helpful to consider the Māori perspective of health. Although in this study, the particular focus is on mental health, outcomes should not be confined to measures of mental health but should acknowledge the interaction of the various components of health - taha wairua, taha hinengaro, taha tinana taha whānau. This holistic approach also recognises that the separation of mental and emotional health from physical health and social functioning introduces an artificial divide that is inconsistent with modern notions of mind/body interaction, and Māori views on health. The domains of outcome encompassed in the measure include biological, psychological, behavioural, spiritual, social and cultural domains. More detailed outcomes, such as HONOS, which relate specifically to mental disorders, may be used to supplement the MMHO Framework schedules and SF 36 as well as SF 12 similarly provide more detailed measures in certain spheres. However, the intention in the Framework is to provide a manageable approach which can be used by consumers, whānau and clinicians.

11.4.1 Taha Wairua

Of all domains, spirituality is probably the most difficult to define. It has many connotations including the experience of mutually rewarding encounters between people, a sense of communion with the environment, access to heritage, and cultural integrity. Cultural appropriateness is as much a comment on the recognition of spirituality as it is on the delivery of services. Indeed, at the heart of spirituality is a cultural ethos within which a person's identity unfolds.

11.4.2 Taha Hinengaro

Psychological and behavioural outcomes are subsumed by the concept of taha hinengaro. Relating to thoughts, feelings and subsequent behaviour, this domain has received the most sustained focus from mental health clinicians and researchers. Essentially, when interventions involve ego-alien or culturally-threatening processes, then outcomes will be deemed unsatisfactory from the consumer's perspective and often by the whānau as well.

11.4.3 Taha Tinana

Health interventions should aim to improve overall standards of health. Mental health care and treatment should not neglect physical health nor contribute unnecessarily to physical discomfort, or increased risks to physical well-being. Co-morbidities (e.g. alcohol misuse and liver disease) demand a multi-disciplinary approach, while the contribution of mental disorders to poor physical health or the exacerbation of mental disorders by impaired physical functioning require a holistic approach to care and treatment.

11.4.4 Taha Whānau

The balance between healthy individuation and whānau interaction is a key consideration for well-being. Many western views of independence are antithetical to Māori understandings of social cohesion and identity. Strengthened whānau ties may be seen as evidence of a successful outcome for Māori, while, conversely, an undue emphasis on self sufficiency, might be regarded as an undesirable outcome. Quite apart from involvement with relatives and friends, taha whānau also represents social outcomes in the broader context of human relationships and social functioning.

11.5 Clinical Endpoints

Difficulties in linking treatment/care to outcomes because of the time lag (between intake and discharge) can be partly overcome by measuring outcome after significant clinical endpoints. Five clinical endpoints, discussed in section 10 of the Report, have been identified (i.e. assessment, inpatient treatment, outpatient treatment, community care and discharge from treatment/care).

11.5.1 Assessment

The first step in the process of treatment and care is assessment. Although assessment does not by itself constitute a treatment method, it may nonetheless be therapeutic, leading to a sense of relief. Nor does assessment inevitably mean that treatment is necessary. Instead, it might simply confirm that treatment is not indicated or that the problem is likely to resolve spontaneously. An assessment process should lead to a better informed patient who is able to make choices about treatment, either personally or through the whānau.

11.5.2 Inpatient Treatment

Admission to hospital is not the most frequent recommendation after assessment, but when it does occur it constitutes a significant event which can be clearly delineated from other treatments. Often, the inpatient treatment team is different from those involved in follow-up care and a separate outcome measure is therefore warranted at the time of discharge from hospital.

11.5.3 Outpatient Treatment

Ongoing treatment from a specialist at an outpatient level may be brief or long term. It is recommended in this Report that outcomes be assessed at the time of discharge (or transfer to another service) or at six monthly intervals. Outpatient treatment presumes that the patient is living in the community and that there is a higher level of independence.

11.5.4 Community Care

Many consumers receive help through various types of community care, including domiciliary visits, residential accommodation, day care, and home help. Often community care extends over a period of years and clients may escape any form of regular review. Again six monthly outcome assessments are recommended.

11.5.5 Discharge from Treatment/Care

The final discharge from the mental health system is a major endpoint which provides an opportunity for comment on outcomes. However, the further away in time the discharge point is from the assessment, the more difficult it is to attribute an outcome to treatment. And, even after discharge, it is possible that the full benefits of treatment will not have been fully realised.

11.6 Framework Summary

The MMHO Framework

Principles	*Stakeholders*	*Domains of Outcome*	*Clinical Endpoints*
Wellness	Consumer	Taha wairua	Assessment
Cultural integrity	Clinician/carer	Taha hinengaro	Inpatient Treatment
Specificity	Whānau	Taha tinana	Outpatient Treatment
Relevance		Taha Whānau	Community Care
Applicability			Discharge

12.0 OUTCOME SCHEDULES

12.1 Generic Baseline Schedule

For each clinical endpoint, the essential questions revolve around the views of the key stakeholders regarding the four domains of outcome. The following generic schedule is suggested as a baseline, to be adapted for each clinical endpoint.

12.1.1 Consumer Schedule

Consumer	Baseline Questions
Taha Wairua	Has the intervention made you feel stronger in yourself as a Māori ?
Taha Hinengaro	Has the intervention led to an improvement in the way you think, feel and act?
Taha Tinana	Has the intervention resulted in an improvement in your physical health ?
Taha Whānau	Has the intervention led to an improvement in the way you get on with others, especially your whānau ?

12.1.2 Whānau Schedule

Whānau	Baseline Questions
Taha Wairua	Has the intervention made your relative stronger in his/herself as a Māori ?
Taha Hinengaro	As a result of the intervention has your relatives patterns of thinking and behaviour improved ?
Taha Tinana	Has the intervention resulted in an improved standard of physical health for your relative?
Taha Whānau	As a result of the intervention, do you feel that your relative is more appropriate socially, including with the whānau ?

12.1.3 Clinical Schedule

Clinician	Baseline Questions
Taha Wairua	Did your intervention result in the patient being stronger in him/herself as a Māori ?
Taha Hinengaro	As a result of the intervention have the patients overall thoughts, feelings and behaviour become more appropriate ?
Taha Tinana	As a result of the intervention has the patients physical health improved ?
Taha Whānau	As a result of the intervention has the patients social and whānau functioning improved?

12.2 Assumptions

The format for the baseline schedules presumes:

- "*.... stronger in yourself (his/herself) as a Māori. "* is a reflection of spirituality in so far as spiritual dimensions embrace concepts of identity, a sense of inner security, relationships with the environment, cultural heritage and personal beliefs.
- "*... an improvement in the way you (her/she) gets on with others..."* is aimed at exploring social relationships within and outside of the family.
- detailed results are not sought.
- global impressions are encouraged.

12.3 Measuring Responses

For each response a five point scale is recommended. This scale is designed to measure both positive and negative outcomes of intervention as well as no change. In line with the recommendations made in Table 1 the scale has been kept simple and user friendly. Scale 1 may be used for questions pertaining to taha hinengaro, taha tinana and taha whānau. Scale 2 is to be used exclusively for questions relating to taha wairua. If the respondent does not know or is unsure of the outcome, then an alternative response

"*Unsure/ Don't Know"* may be made. Clinical testing of the measure will result in appropriate weightings being developed.

Scale 1

-2 -1 0 1 2

|_____|_____|_____|_____|

Much Worse Worse No Change Better Much Better

Unsure/Don't Know ( )

Scale 2

-2 -1 0 1 2

|_____|_____|_____|_____|

Much Weaker Weaker No Change Stronger Much Stronger

Unsure/Don't Know ( )

12.4 Baseline Modification

For each of the five clinical endpoints, the baseline questions should be modified to reflect the objectives of the particular intervention. It needs to be emphasised that the MMHO framework is consumer orientated and does not replace the need for more detailed outcome statements relevant to clinical interests. However, MMHO will provide clinicians with an easily administered tool that can supplement other measures within a Māori contextual paradigm.

13.0 CONCLUSIONS

13.1 Existing Tools

Although outcome measurements have been strongly advanced at policy and purchaser levels, there is no agreement about the most suitable tool for measuring outcomes, especially in mental health and especially for Māori. Problems with outcome measures are associated with the large number of variables (within and outside of clinical settings) which may influence outcome, but also with the long time intervals between an intervention and the measurement of an outcome. Moreover, the criteria for determining what constitutes a good outcome may vary according to cultural, personal and family perspectives. Various measures are currently in use and it is recommended that the value of each in particular situations be further clarified.

13.2 Range of Outcome Levels

Further difficulties with outcome measures are linked to the range of levels at which outcomes may be measured and the purpose for which measurements are made. Outcomes at population, service and process levels provide information required for macro and micro planning but do not necessarily give any indication of progress at personal levels.

The focus of the MMHO framework is very much at the personal level and requires clinicians and whānau to rate outcome according to a Māori cultural perspective and their relevance to consumers.

13.3 Māori Perspectives of Outcome

The four domains of outcome used in the MMHO framework go beyond conventional considerations of mental health to embrace spiritual, physical, and social dimensions, as well as the more usual areas of psychological and social functioning. The focus is deliberately not on the presence or absence of symptoms, or on concepts of absolute recovery, rather it is on the attainment of balance between the four domains of outcome (i.e. wairua, tinana, hinengaro and whānau).

13.4 A Targeted Approach

In order to reduce ambiguities resulting from long time delays (between entry to the mental health system and exit from it), a focus on readily defined clinical endpoints enables outcomes to be more easily linked to components of treatment/care. While a number of clinical endpoints could be identified, MMHO recognises five key endpoints - assessment, inpatient treatment, outpatient treatment, community care and final discharge. There is no reason, however, why additional particular endpoints, could not be subjected to the same enquiry (e.g. a prescribed course of medication, a defined period of counselling or ECT treatment). By the same token when treatment is limited to only one endpoint (such as assessment), a measure of outcome for that component is still important.

13.5 Application of the Framework

The MMHO framework described in this Report attempts to bring together principles (relevant to outcome measures), the views of key stakeholders, the important domains of outcome (appropriate for Māori) and the need to focus on particular clinical endpoints. The framework is consistent with the need for simplicity, global impressions and a consumer focus.

From the framework it has been possible to suggest a generic baseline schedule which can be utilised to guide the development of schedules appropriate to specific endpoints.

13.6 Further Work

Further work is required to develop the framework and it is recommended that its application be tested in a variety of clinical/care situations.

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CONSULTATION SCHEDULE

Expert Interviews

Prof Robb Kydd	Dept of Psychiatry and Behavioural Science (University of Auckland)
Dr Nick Argile	Dept of Psychiatry and Behavioural Science (University of Auckland)
Paul Hirini	Dept of Psychology (Massey University)
Materoa Marr	Manager Acute Services (Manawaroa)

International Consultation

Linda Day	Health Canada (Vancouver)
Dr Lorne Meginbir	Psychologist (Vancouver)
Darlene Mosely	Health Worker (Victoria,Canada)
Bill White	Native Liaison Officer (Victoria Uni,Canada)
Dr Philip Cook	Child/Youth Studies (Victoria Uni, Canada)
Dr John Casken	Dept of Public Health (University of Hawaii)
Dr James Winters	Clinical Psychologist (Honolulu)
Dr Linda Nahulu	Psychiatrist (University of Hawai'i)
Dr Bill Rezentes	Clinical Psychologist (Honolulu)
Kamana'o Pono Crabb	Clinical Psychologist (Honolulu)
Prof Kekuni Blasdel	Medical Practitioner (Honolulu)

Māori Health Providers

Hauora o te Hinengago	Palmerston North Hospital
Hauora Waikato	Hamilton
Te Korowai o te Aroha	Thames
Te Tatau Pounamu	Te Puke

Presentations

Prof Mason Durie	The Development of Culturally Appropriate Mental Health Outcomes for Māori.
Te Kani Kingi	A Discussion and Feedback on the Māori Mental Health Outcomes Study.
Te Kani Kingi	Culturally Effective Health Outcomes.

Policy Groups and Planners

Ministry of Health	Wellington
Mental Health Commission	Wellington
Schizophrenia Fellowship	Hamilton

Specialist Committee Input

Public Health Association	Wellington
Mental Health Commission (advisory)	Wellington
Māori Panel of Mental Health Experts	Wellington
National Health Committee	Wellington
Māori Forum, Statistics New Zealand	Wellington
Māori Advisory Committee, Law Commission	Wellington
Steering Group to oversee Health and Disability Changes	Wellington

Hui

Māori Mental Health Summit	Wellington
Hauora o te Hinengaro	Auckland
Mental Health Purchasing Strategies	Rotorua
Māori Mental Health Blueprint Hui	Auckland
Public Health Assn Annual Conference	Hamilton

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