

**Oranga Mahi – Realising Employment through Active Co-ordinated Healthcare (REACH) monitoring data analysis**

November 2019 – June 2021

**October 2022**

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**Disclaimer**

The views and interpretations in this report are those of the Research and Evaluation team and are not the official position of the Ministry of Social Development. Care has been taken to ensure that this data is as accurate as possible and that the findings are correct. However, due to the way the data has been collated, stored, and matched to MSD records, small inaccuracies may exist in the data, and subsequent findings. Therefore, findings may be subject to change.

Data in this report has been aggregated and randomly rounded to protect the privacy of participants. Further information about how we keep data private can be found at: [How we keep data private - Ministry of Social Development (msd.govt.nz)](https://www.msd.govt.nz/about-msd-and-our-work/tools/how-we-keep-data-private.html)

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# Background to Realising Employment through Active Co-ordinated Healthcare (REACH)

Realising Employment through Active Co-ordinated Healthcare (REACH) was one of several projects in the Oranga Mahi cross-agency initiative that aims to deliver change to the wellbeing of individuals, their families, and communities.

REACH was the first Oranga Mahi project to be implemented, in 2016. The joint MSD and Waikato DHB initiative assisted people on a main benefit with a medical deferral, to improve their wellbeing and return to sustainable work.

Main benefit recipients in the Waikato area were eligible for the REACH service if they were receiving a medical work deferral and:

* were not pregnant
* did not have a bipolar disorder
* did not have schizophrenia
* were not child sex offenders
* did not have a special caution alert on their MSD client record for violence
* were not trespassed from MSD sites
* were not awaiting medical treatment that would mean they could not participate in the service at that time.

In November 2019, changes were made to the REACH service. These included changes to the eligibility criteria, adjustments to the programme fund, and extending the length of service from 12 to 20 weeks. Other changes that were planned did not take place due to the impact of COVID-19.

The REACH service was ended at the end of June 2021. However, REACH continued to support participants until their service stint naturally ended after this date. This means that we are only able to include participant data until the end of June 2021, after the service officially ceased provision.

This analysis uses REACH monitoring data from between November 2019 and June 2021, supplemented with MSD administrative data, to help answer the following evaluation questions:

* are the intended MSD client groups being referred to, enrolled in, and retained on the programme?
* to what extent have participants been assigned a dedicated support team or person?
* have participants been enabled (by the dedicated support team/person) to develop wellbeing and employment goals and plans?
* are the agreed plans being implemented?
* are participants experiencing improvements in their health and wellbeing while participating in the programme?

Additionally, findings from the qualitative evaluation of REACH (published alongside this report [here](https://www.msd.govt.nz/about-msd-and-our-work/work-programmes/research/evaluation-of-oranga-mahi-trials.html)) may help to provide context to some of the findings covered here.

# Key findings from this report

### Getting people enrolled into the REACH service appeared to be challenging.

Provider data showed that just under 53 percent of people referred (192) did not end up participating in the REACH service. The most common recorded reason for people not participating was because they were unable to be contacted (34.4 percent, or 66 people). The remainder of those who did not participate either declined to do so or were declined by the REACH service for various reasons.

### For those who successfully enrolled, almost all participants had their non-MSD dedicated support teams established.

An important feature of the REACH service was the support team that should be placed around every participant. This included a Key Worker, a Living Well Coach, a General Practitioner, and an MSD Case Manager or Programme Co-ordinator. Provider data showed that almost all participants had a Key Worker, Living Well Coach and a General Practitioner in place.

### There was limited use of external service referrals and programme fund payments made for participants.

Referrals to external services and programme fund payments were two measurable indicators of whether a participant’s Wellbeing Plan was being implemented once in service.[[1]](#footnote-1) Both were tools that recipients could use to make progress towards agreed wellbeing and employment goals set out in their plans.

Provider data showed that just over 12 percent of participants had accessed external services, while just over 21 percent of participants had accessed goods or services through a programme fund payment.

### Just under two-thirds of participants who had exited the REACH service had successfully completed the service.

By successfully completing the service, a participant had either achieved their desired outcomes (such as getting into sustainable employment, improving their health and wellbeing, or enrolling in study), or had completed the maximum service duration. This is important from an intervention perspective, as the desired outcomes of REACH are linked to the successful completion of the service. In total, 153 participants had exited the REACH service by the end of June 2021. Little information is available in the data on why a third exited without completing the service, only that 13.7% were dismissed by the provider and 7.8% withdrew.[[2]](#footnote-2)

### Fewer Māori participants successfully completed the REACH service than expected.

Just under 43 percent among Māori participants completed the service, compared to 65 percent overall. It is unclear in the data why this might be, however findings from the qualitative component of the evaluation may provide more insights into this finding.[[3]](#footnote-3)

### Nonetheless, most participants reported improved outcomes several domains of wellbeing (using self-reported Wellbeing Star data).

One potential outcome of the REACH service was that it would contribute to improved health and wellbeing for participants.

As part of measuring participants’ health and wellbeing, the Wellbeing Star tool was used to measure people’s wellbeing across eight categories, these being: “Your lifestyle”, “Looking after yourself”, “Managing symptoms”, “Work, volunteering, and other activities”, “Money”, “Where you live”, “Family and friends”, and “Feeling positive”.[[4]](#footnote-4) However, there are limitations to this analysis as we can neither construct a comparison group nor account for other life events which may have impact on wellbeing improvements over time.

In five of the eight Wellbeing Star categories, most participants reported an improvement between first and second Wellbeing Star entries. These categories were: “Your lifestyle”, “Looking after yourself”, “Managing symptoms”, “Work, volunteering, and other activities” and “Feeling Positive”.

### We were unable to look at medium to long-term outcomes such as detailed employment, income, education, or health outcomes as part of this analysis.

However, future work using the Integrated Data Infrastructure will explore participants’ outcomes, after a longer follow-up period (preferably two to three years). This analysis will help to provide detailed insight into the impact of the REACH service on detailed employment, income, education, and health outcomes, which will help to determine whether the service is delivering its stated objectives.

# Are the intended MSD client groups being referred to, enrolled in, and retained in REACH?

Between 2016 and 30 June 2021, main benefit recipients in the Waikato area were eligible for the REACH service if they were receiving a medical work deferral and:

* were not pregnant
* did not have a bipolar disorder
* did not have schizophrenia
* were not child sex offenders
* did not have a special caution alert on their MSD client record for violence
* were not trespassed from MSD sites
* were not awaiting medical treatment that would mean they could not participate in the service at that time.

This analysis focuses on the period 18 November 2019 to the end of June 2021, as changes to the REACH service were introduced in November 2019.

### Between 18 November 2019 and the end of June 2021, there were 363 referrals to the REACH service.

Of those, just over 47 percent of people (171) were successfully enrolled into the service.[[5]](#footnote-5)

### Just under 60 percent of participants (102) were aged 34 and under.

The remaining 40 percent of participants (66) were relatively evenly spread across the 35 to 44, 45 to 54, and 55 to 64 age groups (Figure 1).

Figure : Participants by age group.

In contrast, Figure 2 shows that as at the end of June 2021 Jobseeker Support – Health Conditions and Disabilities, and Supported Living Payment – Health Conditions and Disabilities recipients in the region were typically older, with over half of the recipients being aged between 45 and 64 years old.

Figure : Recipients of a Health Conditions and Disabilities main benefit in the Waikato MSD region as at the end of June 2021, by age group.

Here, the difference between overall enrolled REACH participants (Figure 1), and Waikato MSD region Health Conditions and Disabilities recipients (Figure 2) was statistically significant.[[6]](#footnote-6)

### Just over 75 percent of participants (120) identified as European.

Additionally, around 32 percent of REACH participants (51) identified as Māori (Figure 3).

Figure : Participants by total response ethnicity grouping. [[7]](#footnote-7),[[8]](#footnote-8)

Note: There were 159 participants with a recorded ethnicity (which the calculations above are based off), and 12 respondents who did not have an ethnicity recorded in MSD source systems.

Figure 4 below shows that the ethnicity grouping of participants was slightly different to the ethnicity grouping of Jobseeker Support – Health Conditions and Disabilities, and Supported Living Payment – Health Conditions and Disabilities recipients as at the end of June 2021. This difference was statistically significant for the European ethnicity grouping.[[9]](#footnote-9)

Figure : Recipients of a Health Conditions and Disabilities main benefit in the Waikato MSD region, as at the end of June 2021, by total response ethnicity grouping. [[10]](#footnote-10)

Note: There were 13,290 participants with a recorded ethnicity (which the calculations above are based off), and 579 respondents who did not have an ethnicity recorded in MSD source systems.

### Just over 54 percent of participants (93) identified as male.

The remaining participants (78) identified as female (Figure 5).

Figure : Participants by gender.

A similar gender breakdown is apparent in Figure 6 which shows the gender of Jobseeker Support – Health Conditions and Disabilities, and Supported Living Payment – Health Conditions and Disabilities recipients, in the Waikato MSD region as at the end of June 2021.

Figure : Recipients of a Health Conditions and Disabilities main benefit in the Waikato MSD region, as at the end of June 2021, by gender.

### Most participants (150) were single and not in a partnership at their time of enrolment.[[11]](#footnote-11)

In contrast, just over nine percent of participants (15) were in a partnership. This trend is reflective of the partnership status of benefit recipients as a population.[[12]](#footnote-12)

Figure : Participants by partnership status.

### Most participants (126) were receiving Jobseeker Support – Health Conditions and Disabilities on the date they were referred for REACH.

This finding is expected because people had to be in receipt of a benefit with a medical work deferral to meet the eligibility criteria for REACH.

People receiving Jobseeker Support – Health Conditions and Disabilities, or Supported Living Payment – Health Conditions and Disabilities, almost always have a medical work deferral (rare exceptions usually relate to the partners of people receiving these benefits). People receiving other benefits can also apply for a medical work deferral depending on their circumstances, though these are usually handled through a different process.

Figure 8 shows that in addition to the participants receiving Jobseeker Support – Health Conditions and Disabilities, a further 14 percent of participants (24) were receiving Supported Living Payment – Health Conditions and Disabilities.

Figure : Participants by benefit type.[[13]](#footnote-13)

### Just under 60 percent of participants (102) had a mental health related condition listed on their current medical certificate as at their referral date for REACH.[[14]](#footnote-14)

Just under 16 percent of participants (27) did not have any health conditions recorded in MSD’s systems, while 10.5 percent of participants (18) had a musculoskeletal or connective tissue disease recorded on their current medical certificate.

Figure : Selected health conditions listed on participants current medical certificates as at their referral date.[[15]](#footnote-15)

### Almost all participants (165) were successfully enrolled into the REACH service within 40 days of referral.

Just over 49 percent of the participants (84) were enrolled within nine days of referral to REACH. The median time between referral to enrolment was 11 days. The range was between zero and 40 days for almost all the participants, with a small outlier group (of six participants) experiencing a wait longer than 70 days (Figure 10). Some possible reasons for the delay could include: COVID-19 impacts, the triage process, and service capacity.

Figure : Distribution of time from referral to enrolment.

### Following a referral, 53 percent of people referred (192) did not participate in REACH.

Of these people, 34 percent (66) were unable to be contacted. The remaining 66 percent (126) did not participate in REACH because they either declined to participate or were declined by the REACH service after initial conversations.

Just under 29 percent of this group chose not to participate (36 people). This was followed by “wrong timing” (23.8 percent, or 30 people) and “other reasons” (19.0 percent, or 24 people) (Table 1).

**Table 1: Reasons for not participating in REACH following a referral.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Reason for not participating in REACH** | **Number** | **Percentage** | **Percentage of “declines”** |
| Unable to be contacted | 66 | 34.4% | n/a |
| *Declined to participate or were declined* | *126* | *65.6%* | *100.0%* |
|  Chose not to participate | 36 | 18.8% | 28.6% |
|  Wrong timing | 30 | 15.6% | 23.8% |
|  Other reasons | 24 | 12.5% | 19.0% |
|  Not suitable | 12 | 6.3% | 9.5% |
|  Medical reason | 12 | 6.3% | 9.5% |
|  Other services more appropriate | 6 | 3.1% | 4.8% |
|  Moved out of area | 6 | 3.1% | 4.8% |
| **Total** | **192** | **100.0%** | **100.0%** |

Note: Percentages may not add to 100 percent due to rounding.

Reasons may not be mutually exclusive; we recommend that clearer classifications are used in future services to correctly capture the range of reasons those referred to the service may not ultimately take part.

Additionally, we are unable to dive further into understanding the specific circumstances which led to people being unable to be contacted, declining to participate in REACH, or having their referral declined. The qualitative evaluation findings may be better able to answer these questions.

### As at the end of June 2021, just over 89 percent of participants (153) had exited the REACH service.

Most exits were because the participant had completed service duration or achieved desired outcomes (64.7 percent, or 99 participants).

The next most common reasons for exit were “provider dismissed client” (13.7 percent, or 21 participants) and “client withdrew” (7.8 percent, or 12 participants).

**Table 2: Exits, by reason.**

|  |  |  |
| --- | --- | --- |
| **Exit reason** | **Number** | **Percentage** |
| Completed service duration/Achieved desired outcomes | 99 | 64.7% |
| Provider dismissed client | 21 | 13.7% |
| Client withdrew | 12 | 7.8% |
| Medical reason | 9 | 5.9% |
| Unknown/Client disengaged/Other reasons | 9 | 5.9% |
| **Total** | **153** | **100.0%** |

Note: Percentages may not add to 100 percent due to rounding. Numbers may not add to totals due to random rounding.

We are unable to dive further into understanding the specific circumstances which led to people exiting the REACH service, due to data availability. The qualitative evaluation findings may be better able to answer these questions.[[16]](#footnote-16)

### Fewer Māori participants than expected successfully completed the service, compared to exited participants overall.[[17]](#footnote-17)

Table 3 shows exit rates for those who completed the service, and those that did not complete the service, across age, total response ethnic groups, gender, and selected health conditions. Most of the categories did not show results that were much different from the overall rates. However, we did find that Māori participants who had exited were statistically much less likely to complete the service when compared to exited participants overall.[[18]](#footnote-18)

**Table 3: Exits, by exit reason grouping and demographic variables.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Category** | **Completed** | **Not completed** | **Total** |
| **Age as at enrolment** |
| 18 to 34 | 63 (67.7%) | 30 (32.3%) | **93 (100.0%)** |
| 35 to 64 | 36 (60.0%) | 24 (40.0%) | **60 (100.0%)** |
| **Selected total response ethnic groups as at enrolment** |
| European | 75 (69.4%) | 33 (30.6%) | **108 (100.0%)** |
| Māori18 | 18 (42.9%) | 24 (57.1%) | **42 (100.0%)** |
| **Gender as at enrolment** |
| Female | 39 (59.1%) | 27 (40.9%) | **66 (100.0%)** |
| Male | 60 (69.0%) | 27 (31.0%) | **87 (100.0%)** |
| **Selected health conditions on medical certificate at referral date** |
| Mental health conditions | 57 (63.3%) | 33 (36.7%) | **90 (100.0%)** |
| **Total** | **99 (64.7%)** | **54 (35.3%)** | **153 (100.0%)** |

Note: Percentages may not add to 100 percent due to rounding.

### Just over 60 percent of participants (93) spent between 60 and 150 days in the REACH service from enrolment to exit.

From enrolment, participants are normally able to receive the REACH service for 20 weeks, or 140 days. However, events such as COVID-19 lockdowns meant that some participants may have received the service for a longer period.

The median time between enrolment and exit was 91.5 days. The range was between 0 and 224 days, with no clear outlier clusters (Figure 11).

Figure : Distribution of time from enrolment to exit.

# To what extent have participants been assigned a dedicated support team or person?

### Almost all participants had been assigned their non-MSD support people.

As part of the design of the REACH service, participants received a range of supports while in the service. A key part of this was the team that was assigned to working with the participants. This team included:

* a Key Worker, who would meet with clients weekly and use Cognitive Behavioural Techniques to support clients to improve their wellbeing and achieve their goals
* a Living Well Coach, who supported participants to establish healthy routines. A participant could contact their Living Well Coach up to three times a day, with one of the contacts being face to face
* the participants General Practitioner, who helped the participant manage their health and get any health services they needed
* an MSD Case Manager or Programme Co-ordinator, who would work with the participant and their key worker to support participants to access further support services, as well as helping the participant to prepare and look for work.

Analysis showed that over 98 percent of participants had been assigned to their non-MSD support people and had a named General Practitioner or General Practice.[[19]](#footnote-19)

However, the available data does not allow us to establish whether all the participants were assigned to MSD Case Managers or Programme Co-ordinators. This means we are unable to fully answer the question of whether participants had been assigned a dedicated support team or person.

# Have participants been enabled (by the dedicated support team/person) to develop wellbeing and employment goals and plans?

### Most participants (150) had a Wellbeing Plan in place as at the end of June 2021, with most of these being completed within a month of enrolment.

An important part of the REACH service is the development of a Wellbeing Plan. The Wellbeing Plan was an individually tailored plan to help participants towards achieving their goals and aspirations. Just under 88 percent of participants (150) had a Wellbeing Plan in place as at the end of June 2021. Of the 12 percent (18) who did not have a plan in place, half were dismissed from REACH, while the rest exited for other reasons.

Out of participants with a Wellbeing Plan, the median time between enrolment and the Wellbeing Plan being completed was seven days. Sixty-four percent of participants had a completed Wellbeing Plan within 10 days, increasing to 92 percent within 30 days (Figure 12). Eight percent of participants (12) had more than a month pass between enrolment and a completed Wellbeing Plan.

These delays could possibly be attributed to events like COVID-19 lockdowns and restrictions, or cold and flu prevention measures, which mean that staff and participants were unable to meet to complete their Wellbeing Plan. These delays could also be attributed to other administrative factors that are not contained within the data.

Figure : Distribution of time between enrolment and Wellbeing Plan completed.

# Are the agreed plans being implemented?

There are two measures available in the REACH monitoring data which can help to answer this question. One measure is the additional external services accessed by participants, and the other is the number of programme fund grants that have been accessed. Both are tools that clients can use to make progress towards agreed wellbeing and employment goals set out in their plans. Additionally, implementing these plans may also involve actions wider than these measures that are not captured in the data.

As at the end of June 2021, just over 12 percent of participants (21) had accessed external services.

Participants’ support teams would put them in touch with external services to provide additional support or assistance where needed. Due to the small number of external services being accessed, further breakdown of these services is unavailable for this report.

### As at the end of June 2021, there have been 39 programme fund payments made for REACH participants, amounting to $11,161.

The programme fund for REACH was a fund that could be used for things that would support the participant to work. While there was general guidance around how the payment could be used, each case was assessed on its own merits before a decision was made. This meant the payment could flex to accommodate for specific participant needs. Payments using the programme fund were made from REACH directly to the provider of the good or service being purchased.

Programme fund payments were made to 21.1 percent of participants (36). The average payment was $286.

As no information is available on what the specific payments were for, further analysis is not possible for this.

# Are participants experiencing improvements in their health and wellbeing while in REACH?

There are two ‘before’ and ‘after’ measures that are available to help answer this question. The Wellbeing Star scores that have been provided in the REACH monitoring data, and the known health conditions held in MSD administrative systems at different points of time. These are imperfect measures, as they are unable to determine the extent of change in health or wellbeing, only that a change may have occurred.

This ‘before’ and ‘after’ analysis has a key limitation: a person’s situation at the start of their time in the REACH service may have been related to a crisis event, or another event, that triggered the referral to the REACH service. This means that the ‘after’ result could be a regression towards that person’s usual situation, and not necessarily a reflection of the services impact. Additionally, without a comparison group, it is difficult to determine how much of any change is down to the REACH service, or what would have happened anyway without the service. Therefore, any findings in this section should be treated as indicative, rather than conclusive, findings.

### Most participants (147) had at least one Wellbeing Star score recorded as at the end of June 2021.

The Wellbeing Star is a tool that was designed for people with a health condition or disability to help support and measure their progress towards achieving their goals.[[20]](#footnote-20)

For REACH, there was no set guidance as to how often Wellbeing Star assessments were to be completed. However, as a rule of thumb, these were generally expected to be completed at around enrolment and exit.

One approach to determining if participants’ health and wellbeing has changed while in REACH is by analysing the changes between Wellbeing Star scores in individual categories. This will give us a sense of whether individual components of wellbeing improved during participants’ time in REACH. However, due to the nature of the data, it is unclear whether these differences represent small or large differences in wellbeing.

There were 246 unique Wellbeing Star scores recorded, belonging to 86 percent of participants (147). Of those participants, 67.3 percent (99) have had a second entry recorded. These second entries were recorded an average of 102 days after the first entry.[[21]](#footnote-21) No participants had a third entry recorded. We therefore analyse 99 sets of scores in the following section.

### In five of the eight categories, most participants experienced a positive change in their score between their first and second entries.

These categories were: “Your Lifestyle”, “Looking After Yourself”, “Managing Symptoms”, “Work, Volunteering, Other Activities” and “Feeling Positive” (Table 4).

For the most part, these categories are suggestive of potential changes in wellbeing due to behavioural aspects of the REACH service.

REACH did not improve wellbeing in relation to material factors, such as a participant’s income, or their housing situation, except for “Work, Volunteering, Other Activities”.

This is expected, as the service was not designed to explicitly improve participants’ material wellbeing. Additionally, due to the short-term duration of the service, there may not have been enough time to effect positive changes in these categories in a way that could be captured by the Wellbeing Star tool.

However, even though most participants with two Wellbeing Star scores did not report a positive change in the “Money”, “Family and Friends”, and “Where You Live” categories, there was still a sizable group of participants that did report a positive change.

**Table 4: Change in Wellbeing Star category scores between first and second score (n = 99).**

|  |  |  |
| --- | --- | --- |
| **Category** | **Percentage (number) that reported a decrease or no change in category score** | **Percentage (number) that reported a positive change in category score** |
| **1: Your Lifestyle** | 27.3% (27) | 72.7% (72) |
| **2: Looking After Yourself** | 42.4% (42) | 57.6% (57) |
| **3: Managing Symptoms** | 33.3% (33) | 66.7% (66) |
| **4: Work, Volunteering, Other Activities** | 33.3% (33) | 66.7% (66) |
| **5: Money** | 57.6% (57) | 42.4% (42) |
| **6: Where You Live** | 75.8% (75) | 24.2% (24) |
| **7: Family and Friends** | 51.5% (51) | 48.5% (48) |
| **8: Feeling Positive** | 27.3% (27) | 72.7% (72) |

Note: Percentages may not add to 100 percent due to rounding.

### There was no significant change in which health conditions or disabilities were being reported on participants’ medical certificates.

The evaluation planned to use any change in the health conditions or disabilities reported on medical certificates as an indication of potential changes in participants’ health and wellbeing. However, the requirement to provide a medical certificate for existing MSD benefit recipients with a medical deferral was removed in response to the impacts of COVID-19.[[22]](#footnote-22) This requirement was never reintroduced while REACH was still in service due to policy changes that were introduced in early 2022.[[23]](#footnote-23) This means that participants who may have otherwise provided a medical certificate that would have removed health conditions or cleared them to work, may not have done so.

However, Figure 13 below shows that between referral and exit, there were some small shifts in the number of participants reporting specific health conditions or disabilities. However, none of these shifts were statistically significant.

Figure : Proportion of participants reporting specific health conditions or disabilities, as at referral and exit for participants with an exit date (n = 153).[[24]](#footnote-24), [[25]](#footnote-25)

1. Further information about what programme fund grants were spent on is not available for this report. [↑](#footnote-ref-1)
2. Some participants were yet to exit the REACH service at the time of data collection, but gradually exited in the weeks following as the service was wound down. Information on these participants and their exits is unavailable for this report. [↑](#footnote-ref-2)
3. A separate Kaupapa Māori strand of the evaluation is looking at how well Oranga Mahi services meets the needs of Maōri. [↑](#footnote-ref-3)
4. More information about the Wellbeing Star tool can be found at: <https://www.outcomesstar.org.uk/using-the-star/see-the-stars/well-being-star/> [↑](#footnote-ref-4)
5. It was possible for participants to be enrolled within the service twice. For simplicity, we count these double enrolments separately in our data, as the participant’s circumstances may have changed between enrolments [↑](#footnote-ref-5)
6. *X2* (*df* = 4, *N* = 171) = 107.35, *p* < 0.001\* – base calculation done with non-randomly rounded figures [↑](#footnote-ref-6)
7. Total response ethnicity means that if a person identifies with more than one ethnic group, they are counted

in each applicable group. [↑](#footnote-ref-7)
8. Pacific Peoples, Asian, Middle Eastern/Latin American/African (MELAA) and Other are excluded from this plot as there were very small numbers of participants in these ethnic groups. [↑](#footnote-ref-8)
9. European: *X2* (*df* = 4, *N* = 171) = 11.04, *p* < 0.001\* – base calculation done with non-randomly rounded figures and excludes people with an unspecified ethnicity [↑](#footnote-ref-9)
10. See footnote 8. [↑](#footnote-ref-10)
11. This measure uses MSD relationship data. [↑](#footnote-ref-11)
12. See page 12 of: <https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/evaluation/family-packages/2021/monitoring-the-families-package-and-changes-to-income-support-from-2018-to-2021.pdf> [↑](#footnote-ref-12)
13. “Cannot be matched” here describes participants that exist in the monitoring data but cannot be successfully linked to an MSD record for the purposes of this analysis. [↑](#footnote-ref-13)
14. In this section, the health conditions presented are based on the READ or SNOWMED codes provided to MSD by a General Practitioner on a Work Capacity Medical Certificate and stored in the SINC (SWIFTT Incapacity) dataset in MSD’s Integrated Analysis Platform. These counts are total response, and so therefore the totals and percentages may not add up to the total number of participants and 100 percent respectively. Some participants may have medical conditions recorded in other parts of MSD’s data systems that are not captured here or did not have a current medical certificate loaded into the system. [↑](#footnote-ref-14)
15. Some health conditions are not listed in this graph due to very small numbers of participants reporting those conditions. These include: “symptoms, signs and ill-defined conditions”, “injury and poisoning”, “neoplasms” and “genitourinary system diseases”. [↑](#footnote-ref-15)
16. The qualitative evaluation included interviews with REACH clients who had exited the service, and discussons with REACH staff and MSD stakeholders to explore the referral and enrolment process. [↑](#footnote-ref-16)
17. A “completed” exit in this section includes the exit reasons: “completed service duration” and “achieved desired outcomes”. A “not completed” or “early exit” includes all of the other exit reasons listed in Table 2 on the previous page. [↑](#footnote-ref-17)
18. *X2* (*df* = 1, *N* = 42) = 7.72, *p* = 0.006 – based on non-randomly rounded figures [↑](#footnote-ref-18)
19. Due to the small number of participants that had not been assigned to their support teams, further information about why that might be is unavailable to protect participant confidentiality. [↑](#footnote-ref-19)
20. More information about the Wellbeing Star tool, including how it works, can be found at: <https://www.outcomesstar.org.uk/using-the-star/see-the-stars/well-being-star/> [↑](#footnote-ref-20)
21. There was a standard deviation of 37.4 days for this measurement. [↑](#footnote-ref-21)
22. See: <https://carematters.org.nz/information-from-ministry-of-social-development-msd/> [↑](#footnote-ref-22)
23. See: <https://msd.govt.nz/about-msd-and-our-work/newsroom/budget/2021/factsheets/improving-work-capacity-medical-certificates.html> [↑](#footnote-ref-23)
24. In this section, the health conditions presented are based on the READ or SNOWMED codes provided to MSD by a General Practitioner on a Work Capacity Medical Certificate and stored in the SINC (SWIFTT Incapacity) dataset in MSD’s Integrated Analysis Platform. These counts are total response, and so therefore the totals and percentages may not add up to the total number of participants and 100 percent respectively. Some participants may have medical conditions recorded in other parts of MSD’s data systems that are not captured here or did not have a current medical certificate loaded into the system. [↑](#footnote-ref-24)
25. Some health conditions are not listed in this graph due to very small numbers of participants reporting those conditions. These include: “symptoms, signs and ill-defined conditions”, “injury and poisoning”, “neoplasms” and “genitourinary system diseases”. [↑](#footnote-ref-25)