Malatest International

Evaluation Report:

Pregnancy and parenting services

June 2020

Prepared for:

The Ministry of Health

Acknowledgements

Thank you He Tupua Waiora, Te Ara Manapou and Te Hiringa Matua staff for sharing your PPS journeys with us. Thanks also to Waitematā staff for setting the foundations of PPS and providing support throughout. It has been a privilege to spend time with you all and hear your experiences.

We wish to especially acknowledge Te Awhimate Tawhai, loved and respected Te Hiringa Matua kaiārahi who passed away in 2019. We feel incredibly fortunate in being able to spend precious time with Te Awhimate and we learned a great deal from him. Te Awhimate could provide exactly the right example to transform and strengthen the kōrero. He left a powerful legacy in Te Hiringa Matua.

We are grateful to the wāhine toa and other PPS whānau who generously gave their time to this evaluation. We heard your stories of sadness, hope and love and we met whānau who were tenacious and strong. It was a pleasure to meet your beautiful babies. With PPS providing non-judgemental support, many whānau flourished over the period of the evaluation. Others put one foot in front of the other, achieving smaller successes and some were not ready or able to make changes.

Thanks also to the key stakeholders who provided a wider context of PPS in their communities.

We wish you all the very best for the future. Ngā mihi nui.

Malatest International

Citation: Malatest International. 2022. Evaluation report: Pregnancy and parenting services. Wellington: Ministry of Health.

Published in March 2022 by the Ministry of Health
PO Box 5013, Wellington 6140, New Zealand

ISBN 978-1-99-100797-1 (online)

This document is available at **health.govt.nz**

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Concepts and Definitions

CADS	Community Alcohol and Drug Service
CAMHs	Child and Adolescent Mental Health
CYFS	Child Youth and Family Service – now Oranga Tamariki
DHB	District Health Board
DNA	Did Not Attend
HBDHB	Hawke's Bay District Health Board
He Tupua Waiora	Northland's PPS
FIT	Feedback informed treatment
FTE	Full-time equivalent. 10 FTEs is a full-time role.
Kaiārahi	Team Leader
LMC	Lead Maternity Carer
Mahi a Atua	An Indigenous Approach to Building a Critical Mass. Wānanga for Te Hiringa Matua Mataora designed by Dr Diana Kopua and Mark Kopua
Mataora	A Mahi a Atua specialist trained via Te Kurahuna
MDT	Multi-disciplinary Team
MIMH	Maternal and Infant Mental Health teams
MSD	Ministry of Social Development
MVCOT	Ministry for Vulnerable Children/ Oranga Tamariki
NDHB	Northland District Health Board
NGO	Non-governmental organisation
NPH	Ngāti Porou Hauora
OT	Oranga Tamariki
PPS	Pregnancy and Parenting Service
PRIMHD	Programme for the Integration of Mental Health Data
Te Ara Manapou	Hawke's Bay PPS
Te Hiringa Matua	Tairāwhiti PPS
Ūe	Mataora working together
Wawata	Tairāwhiti MDT *with a twist*
Whakawātea	Celebration of whānau achievements as they graduate the service
WINZ	Work and Income New Zealand

Executive summary

In 2016, the Ministry of Health (MOH) funded three District Health Boards (DHBs) to deliver Pregnancy and Parenting Services (PPS) with the aim of reducing harm and improving the wellbeing of children.

PPS are intensive, assertive outreach case co-ordination services modelled on an approach developed by Waitematā DHB. They aim to improve outcomes for children by addressing the needs of parents and working to strengthen the family environment. PPS are for parents of children under three years old and pregnant women who are experiencing problems with alcohol and other drugs and are poorly connected to health and social services.

The three new services were:

- **He Tupua Waiora: Northland**. The hub is based in Whangarei at the DHB and the 'spoke' supports communities in Kaitaia. He Tupua Waiora clinicians work intensively with parents spending time building relationships, providing parenting support and connecting parents and babies with other services such as housing, primary and secondary healthcare including rehabilitation services.
- **Te Ara Manapou: Hawke's Bay**. A DHB delivered service that is embedded in the community. Their base is a building designed so they can see clients and whānau on site and deliver group connections and educational programmes. Since establishment, the service has evolved from a case navigation focus to delivering parenting programmes, addictions support and counselling within the team as well as peer support and 'Connections' groups.
- **Te Hiringa Matua: Tairāwhiti**. Delivered by three community providers and led by Ngāti Porou Hauora. The service model prioritises the re-instatement of Mātauranga Māori, the elimination of institutional racism and discrimination, thereby supporting outcomes that will further whānau, hapū and iwi well-being and wellness. Te Hiringa Matua kaiārahi and kaimahi attend wānanga delivered by Te Kurahuna and deliver their own wānanga to Te Hiringa Matua whānau as well as providing one on one support. Whānau wānanga weave pūrākau to reconnect whaiora and whānau with their own stories.

The evaluation approach drew information from multiple sources

Malatest International was commissioned by MOH to provide an independent evaluation of PPS. The evaluation was collaborative and extended from the establishment phase in late 2016 to March 2020.

A logic model provided a theoretical foundation for the evaluation. Information for the evaluation was sourced from PPS and MOH data, information collected by the PPS teams, interviews with PPS teams, referrers and other community organisations, and interviews with clients and whānau.

Many clients achieved positive outcomes including those who exited early

Over the three years of the evaluation, PPS reached 446 clients and whānau. The PPS took time to establish and support provided to clients and whānau was long-term. The evaluation to the end of March 2020 provides a snap-shot in time of services that were still developing:

- 202 (45%) of clients were still being actively supported by PPS
- 67 (15%) clients had achieved their goals and were providing a safe environment for their children
- 107 (24%) clients declined or disengaged from PPS but we heard some were returning
- 70 (16%) clients left for a variety of other reasons such as moving away.

The support provided to whānau was not recorded. The evaluation findings therefore under-estimate the impact of PPS support.

PPS made a positive difference for many clients and whānau, including those who exited the services before treatment was complete. Clients and whānau described the changes they had made. Their descriptions were supported by quantitative data from Hua Oranga, ADOM (He Tupua Waiora and Te Ara Manapou) and Feedback Informed Treatment (FIT) (Te Hiringa Matua). It was important to compare changes on exit with the most negative client assessment as on entry to PPS clients may not disclose the full extent of their addiction or their child(ren)'s exposure to risk.

Positive changes for many clients were evident based on their descriptions of their achievements, from assessments using a holistic measure of wellbeing (Hua Oranga) and quantitative data about changes in addiction (ADOM) and measures included in My Outcomes by Te Hiringa Matua. The positive changes to wellbeing underpinned reductions in addiction, reductions in risk for children and re-engagement with whānau.

Importantly for improved child outcomes, many PPS clients completed parenting courses and received education or resources about family violence, child exposure to substances and safe sleeping.

PPS support improved outcomes for children

Limitations of recording systems made it difficult to accurately estimate the number of children reached by PPS. Based on information recorded by the PPS teams to the end of March 2020, He Tupua Waiora supported approximately 181 children and Te Ara Manapou supported 103 children under three including pregnancies. To July 17 2020, Te Hiringa Matua had supported 182 children under three and 238 children older than three.

Qualitative information from interviews with providers, clients and whānau provided examples of reduced risk, increased safety and more positive home environments for children. Interview findings were supported by data demonstrating decreased risks for children.

Many clients also had older children in their care. Although PPS was for children younger than three, PPS teams provided examples of benefits for older children as their parent(s) changed and became addiction free.

The PPS teams provided holistic client-centred support

Clients often connected with PPS through Oranga Tamariki or Police because they were told that managing their addiction would be a way to regain access to or custody of their children. Some self-referred, especially to Te Hiringa Matua. Clients and whānau cared deeply for their children and many knew they needed to make changes to become parents or return to parenting.

Initial engagement with clients was often difficult. Building a trusting working relationship was the first step. The needs of each client, whānau and their children were assessed by the PPS teams. Many needed support to find safe housing and adequate food before issues related to their addiction could be addressed. The PPS teams supported many clients and whānau to engage with Work and Income and housing services.

Many clients also needed advocacy in their engagement with Oranga Tamariki or with the justice system. Te Hiringa Matua and Te Ara Manapou whare became venues for Oranga Tamariki supervised visits with children. The warm, friendly environments filled with toys were described by clients as making a huge difference to their visits.

Parenting support was integral to PPS. Even clients who had been parents for some time told us how much they learned from the parenting programmes and Te Hiringa Matua Mahi a Atua wānanga. Parenting support was particularly important when children were returned to whānau.

Specialist support varied between the sites. Psychologist and psychiatrist support was built into the model but national shortages delayed recruitment. Once

appointed, the He Tupua Waiora and Te Ara Manapou teams described psychologist and psychiatrist support input as invaluable in providing advice and in a seamless connection with individual clients. Te Hiringa Matua initially had support from an indigenous psychiatrist but subsequently were not provided with consistent psychologist and psychiatrist support. Support from psychologists and psychiatrists must align with the PPS service models compounding the difficulty of recruiting people who were a good fit for the teams.

Support was long-term and progress for clients was not linear

PPS clients had complex lives and long-term support was needed for sustainable change. Some clients had been supported for over two years. PPS teams described the importance of longer-term engagement and that being able to engage with clients for as long as they needed was a strength of the service.

The non-linear recovery journey meant that some clients who had been drug or alcohol free for some time could relapse. Where other alcohol and drug services may discharge clients as soon as they became addiction free, the PPS teams continued to provide ongoing support for clients for the other changes they needed to make in their lives. Ongoing support was described by PPS teams as important to support whānau with parenting after a child had been returned to their care.

Client and whānau profiles aligned with the intention of PPS

The numbers of PPS clients increased each year as the services became established and awareness of PPS and the whānau they could support increased amongst communities and local services. After the first quarter the average number of referrals per quarter has been 11.7 for He Tupua Waiora, 12.9 for Te Ara Manapou and 15.5 for Te Hiringa Matua. As referral numbers were relatively constant, increases in the numbers of clients each year were primarily driven by the duration of support provided to clients and whānau which often exceeded one year.

The average age of clients ranged from 26 years for Te Hiringa Matua to 28 years for Te Ara Manapou. Approximately one-quarter of Te Hiringa Matua clients were younger than 20. At all three PPS, most clients (87%) were female but increasingly men were being reached.

Effective support for whānau Māori was a priority for PPS

The Waitangi Tribunal report Hauora[1] noted that all parties to that inquiry, including the Crown, were aware of the impact of the social determinants of health and the ongoing impact of colonisation and institutional racism.

PPS were reaching whānau Māori (81% of clients were Māori) and provided an opportunity to support whānau Māori in different ways from existing services. The key components of PPS enabled the teams to provide services that addressed institutional racism by treating clients with respect, listening to them, not judging them and providing a place of safety. Sustainable change was supported through connecting clients with wider supports including whānau. However, the trauma underlying family violence and family addiction meant pathways to connection and reconnection could be complex.

The three sites adapted the core components of the Waitematā model to their locality contexts

The local teams adapted the Waitematā model to meet the needs and contexts of their communities. Mentorship from Waitematā informed the development of the three new services. As the services progressed the PPS teams gained expertise and sharing information and discussing challenges became more important than mentorship.

All three teams were clear about the core components of the Waitematā model but operationalised it differently to meet the needs of local communities. The core components of PPS were:

- A multi-disciplinary team (MDT): The three PPS developed multi-disciplinary teams that worked closely together. Working together as a team was important in support for clients and risk management as different perspectives provided different insights.
- Effective leadership to form and maintain the teams and support the team members in working with clients. Support in developing their roles as leaders of MDTs was important, especially for team leaders new to leadership roles.

  The team compositions varied between locations with Te Hiringa Matua and Te Ara Manapou including non-clinical team members. All teams emphasised the importance of Māori team members and men. Te Hiringa Matua included male and female staff. A lack of male staff in the other teams was identified as a gap by clients and team members.

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[1] https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf

- PPS team members who were committed to their roles. Although the work could be very rewarding it could also be very difficult. Team members needed access to good professional development and supervision to manage the personal challenges of their roles.
- A strengths-based treatment model. The way PPS were delivered was important to clients. Clients consistently described the importance of trust and feeling listened to and respected. Once they had engaged with clients, the teams provided holistic and whānau focused support.
- Intensive outreach to engage with clients and whānau in different settings including in their homes. PPS were described by referrers, clients, whānau and the teams as *not giving up.*
- Smaller PPS caseloads that allowed PPS teams to work more effectively with whānau. The PPS specification capped caseloads at 12 per key worker. In the 19/20 financial year, caseloads ranged between 8 and 12 per clients per key worker/Mataora. More time with each client aimed to contribute to sustainable change and avoid the *'churn'* of clients coming in and out of the same services.
- Active risk assessment through MDT meetings for each client/whānau as frequently as needed, but at least three-monthly.
- Long-term support to develop sustainable change. For Te Hiringa Matua, priorities included connecting or re-connecting whānau with te ao Māori.

PPS is resource intensive but has substantial direct and indirect benefits

The budget to deliver PPS was $1 million per year for each PPS to support 100 clients and their whānau. The first clients were supported in April 2017 and referrals had built up in all three services by the start of the October quarter 2017.

PPS service delivery is resource intensive. The evaluation confirms low client caseloads are an essential component of the PPS model and are required to enable intensive outreach and to build trust and engagement. Becoming and remaining addiction free also requires long-term support.

Exposure of children to alcohol and/or drugs in pregnancy, infancy and early childhood is associated with life-long disparities in health, social and employment outcomes that are likely to continue to impact future generations. PPS were funded on the premise that they had the potential to reach children most at risk of adverse outcomes due to exposure to risk factors including parental addiction and poor parenting. The benefits of PPS are difficult to monetise as many are indirect and long-term. However, the target group has been reached and the evaluation demonstrates improved outcomes for PPS clients and whānau.

Expanding and transferring PPS to new sites

The positive outcomes of PPS for clients, whānau and children support the extension of the services at the current sites and to additional locations. However, PPS is effective because it supports clients differently to other services. The core components of the PPS model – the multi-disciplinary focus, the intensive outreach, the strengths-based treatment model that respects clients and moves at their pace and risk assessment processes – are all essential in reaching and supporting the target group. Delivering the core components of PPS requires low caseloads, experienced and well-resourced and supported teams. As PPS become business as usual services in the pilot sites the risk of pressure to increase caseloads must be resisted.

The three PPS sites also demonstrated the need for local adaptation of the PPS model while retaining the core components. Te Hiringa Matua demonstrated the effectiveness of a kaupapa Māori approach for whānau Māori to reinstate Mātauranga Māori and reduce the impacts of colonisation on whānau Māori. Learning from the Te Hiringa Matua service model and expanding it to increase access for whānau Māori provides an opportunity to meet Tiriti o Waitangi obligations to provide equity for Māori.

1. The Pregnancy and Parenting Pilots

Key messages:

Three new Pregnancy and Parenting Services (PPS) have been established modelled on a service developed by Waitematā:

- He Tupua Waiora in Northland
- Te Ara Manapou in Hawke's Bay
- Te Hiringa Matua in Tairāwhiti.

PPS support parents of children under three-years-old and pregnant women experiencing problems with alcohol and other drugs, and who are poorly connected to health and social services.

Waitematā District Health Board Community Alcohol and Drug Service developed a pregnancy and parenting service (PPS): an intensive assertive outreach case co-ordination service for parents of children under three-years-old and pregnant women experiencing problems with alcohol and other drugs, and who are poorly connected to health and social services. PPS aims to reduce harm and improve the wellbeing of children by addressing the needs of parents and working to strengthen the family environment. Findings from a 2015 process evaluation, suggested that the Waitematā PPS model of service demonstrated a promising approach to reducing harm for children at risk and supporting equity of access to addiction treatment[2].

Budget 2016 announced a new funding package to enable replication of the Waitematā PPS in three additional District Health Boards (DHBs) for four years, targeting a further 300 women and their whānau. Budget 2019 further extended PPS to two additional DHBs. DHBs were selected using data taken from the Integrated Data Infrastructure (IDI) for children aged 0 – 5 to identify those with high rates of two or more of four risk factors indicative of potentially adverse outcomes for youth: long-term benefit receipt; Oranga Tamariki findings of abuse or neglect; mothers with low educational attainment; caregivers with Corrections history.

The selected DHBs were:

- Northland – characterised by a high proportion of Māori, a high proportion of economically deprived communities and a dispersed rural population.
- Tairāwhiti – characterised by a high proportion of Māori, the highest level of economic deprivation, and a dispersed rural population.
- Hawke's Bay – characterised by rural and urban populations and a mix of very low and very high socioeconomic localities.

[2] Paula Parsonage. (2015). Waitematā DHB CADS Pregnancy and Parenting Service: Process evaluation. Wellington: Health Promotion Agency.

He Tupua Waiora (Northland DHB): reflecting the concept of growth and moving from the darkness into healing.

Northland DHB launched their PPS in April 2017 and was the first service to begin seeing clients. He Tupua Waiora sits within the Northland DHB and has close links to the maternal mental health team. The He Tupua Waiora team implemented their PPS to broadly mirror the Waitematā model while building connections to local services in Whangarei and Kaitaia.

The Northland service was designed as a 'hub and spoke' model with the 'hub' in Whangarei and the 'spoke' in Kaitaia. This approach aimed to remove travel barriers for whānau based in Kaitaia, while also recognising the need for a PPS team to be located near to clients. He Tupua Waiora stressed throughout the evaluation that despite their hub and spoke model, there were gaps in services for whānau who lived in the mid-North region.

Differences for Northland included geographical spread and smaller communities where people are connected by whakapapa and share experiences of health and social services. The He Tupua Waiora team often described *the Northland way*, where building relationships and *doing what you say you will do* was critical to reaching clients.

The team leader and team invested time in the early stages of the service connecting with other services and agencies to promote He Tupua Waiora and get to know what other services provided. This assisted with referrals to and from the service. Referral processes were modified in the early stages of the service so women who were referred to the service did not have to consent to be contacted by PPS to explain the service. This cut down on time spent connecting with women who were not ready for the service.

Lower caseloads meant He Tupua Waiora clinicians could spend time getting to know clients and build trusting relationships with them. Clients told us the team taking the time to go for a walk with them or having a chat over coffee helped them to feel listened to and valued, many for the first time. He Tupua Waiora started coffee groups for mums, most of whom had previously been isolated and never had the opportunity to be with other parents in a non-judgemental environment.

He Tupua Waiora clients were supported in a range of ways. Most completed Circle of Security training led by He Tupua Waiora key workers, which helped them to understand parenting and attachment. Clients who were ready were referred to rehabilitation and were regularly visited while they were in rehab and on their release. They were supported in their engagements with Oranga Tamariki and other government agencies. During the evaluation a number of clients whose children had been uplifted were able to have their children back in their care and continued to be supported by He Tupua Waiora while they settled the children at home.

Key stakeholders told us the service was life-changing for the clients they shared with He Tupua Waiora. An Oranga Tamariki representative said that when children were unsafe and uplifted, He Tupua Waiora prepared the mother for this and supported her throughout and after the uplift. Women's Refuge valued the consistency and continuity of the support provided by He Tupua Waiora, as well as timely access to a psychiatrist.

He Tupua Waiora were positive for the future. At the end of the evaluation period, they reflected on examples of clients who had turned their lives around and whose children were thriving. The team included an occupational therapist, counsellor and a psychologist and they valued the different skills available to clients.

However, moving forward, He Tupua Waiora identified a risk of their service being treated the same way as other mental health services, so they were mindful of reminding other services about how PPS is different. Other risks were the continuing increase in meth use and increasing demand for limited beds in rehabilitation facilities. There was ongoing unmet need for PPS in the mid-North.

Te Ara Manapou (Hawke's Bay DHB): Path of sustenance

Te Ara Manapou was launched in July 2017. The service was named by a local kaumatua – Te Ara Manapou means the 'path of sustenance'. The name not only represents the birthing of children but the parent sustaining the postnatal life of the child. With 'manapou' there is also an emphasis towards the self-responsibility of growing strong towards independence, which can be related to both parent and child.

Te Ara Manapou adapted the Waitematā service model to meet the needs of their community – the urban populations of Napier and Hastings with the majority from areas with a New Zealand deprivation index of 8-10 (the most deprived areas). Te Ara Manapou design was influenced by the smaller size of the community and the existing depth of relationships with local services and stakeholders. The development activities included workshops with local NGO providers and other organisations that may refer to Te Ara Manapou.

Te Ara Manapou sits within the Community Mental Health Service at Hawke's Bay District Health Board (HBDHB). In the early stages of service design, the DHB recognised and emphasised the need for a community-based service. There were challenges and advantages for Te Ara Manapou in providing a community-based service within a DHB. The advantages were the existing DHB governance and infrastructure and easier access to DHB services such as the Māori Health Service and the consumer advocate for mental health and addictions. Challenges included setting up a different service model in a DHB context and introducing new roles to the DHB such as a peer support worker.

Separation from the DHB and a non-institutionalised image was achieved by outfitting a building close to the DHB campus. A pou, Te ingoa o te Pou Whakairo was gifted from the inmates of the local prison and sits in front of the building. Inclusion of whānau rooms allows the team to see clients and whānau on site, to run group sessions and for parents to have Oranga Tamariki supervised visits with their children. The team are now co-located with the DHB maternal mental health team and a Māori consumer advocate.

Te Ara Manapou did not appoint all team members at the start of the service. This has provided flexibility in developing the team. The original team leader left and was replaced by a senior member within the team. Initial focus on one key worker per client has extended to a wider team support for clients but still in the context of one key worker. As well as client and whānau meetings at Te Ara Manapou, the team also meet whānau in the community and visit them in their homes. There is always food available at Te Ara Manapou and when the team visit clients they often take along home baking and other things they know whānau need. A Connections group provides a forum for current and past clients to meet, support each other and develop skills such as cooking.

As the team has grown in number and as team members have been appointed with different expertise, there has been increased in-house delivery of programmes including the Circle of Security parenting programme and addiction support. The team work closely with a psychiatrist and a clinical psychologist with child development expertise. The addition of the psychiatrist and a clinical psychologist to the team has strengthened the MDT meetings and improved access to their support for clients.

The team have embedded tikanga Māori in their work through the support of DHB Māori teams, employing Māori staff and developing links with local Māori services and marae.

Te Ara Manapou has strong local networks and is part of local cross-agency groups that identify whānau who need support. Local organisations spoke very highly about the support Te Ara Manapou provides to clients. Increasing the number of people Te Ara Manapou could support was their only suggestion to strengthen the service.

Te Hiringa Matua (Hauora Tairāwhiti): the Power of the Parent

Te Hiringa Matua is delivered by three kaupapa Māori providers: Turanga Health, Ngāti Porou Hauora (NPH) and Te Aitanga o Hauiti Hauora. Ngāti Porou Hauora is the lead provider for the delivery of Te Hiringa Matua. A governance group Te Roopu Matua sits across the project and includes representation from the different providers, Te Kurahuna and the DHB. Services were to be delivered to the whole DHB region. Hauora Tairāwhiti considered the new service should sit within an NGO because of the need to effectively engage whānau and to avoid replicating the past mistakes of mainstream models. Devolving the contract to an NGO meant investing time in developing the PPS model.

Te Hiringa Matua service design and delivery included prioritising the re-instatement of Mātauranga Māori, the elimination of institutional racism, and of discrimination, thereby supporting outcomes that would further whānau, hapū and iwi wellbeing and wellness to achieve hauora. Te Hiringa Matua team members were named Mataora by Te Kurahuna. They were change makers and included artists with Mātauranga Māori knowledge and expertise as well as clinician backgrounds. Mataora participated in Mahi a Atua[3] wānanga delivered by Te Kurahuna which informed the clinical approach of Te Hiringa Matua and the development of specific pathways of care for whānau.

Te Hiringa Matua aimed to improve communication with language that made sense and had meaning to whānau. The focus was on outcomes and a safe environment for pēpi, tamariki and mokopuna to grow by recreating natural processes and taonga. For example, learning pūrākau, waiata, making wahakura, establishing gardens and practicing romiromi. The team began holding weekly wānanga for whānau in Gisborne and extended this to rural areas, but were challenged by travelling long distances and finding venues in isolated communities.

Whānau who attended wānanga were welcomed through the ōkawa process which kept Mataora and whānau safe and acted as a triage for whānau. Through wānanga, whānau were part of te ao Māori and learned about their strengths and identities. They shared kai and spent time with other whānau who were ready to make a positive change in their lives. Outside wānanga, whānau were supported by ūe, Mataora who would lead caseloads and support decision-making. Whānau were connected with their whānau, hapū, iwi. They were assisted to identify and apply for training and study. They were accompanied to their appointments at government agencies. Parents were able to have supervised visits at Te Hiringa Matua whare instead of Oranga Tamariki. At the beginning of the service, Te Hiringa Matua would notice their whānau names on morning Police lists. By the end of the evaluation, few names on the Police list were Te Hiringa Matua whānau.

Te Hiringa Matua lost their beloved and knowledgeable kaiārahi in 2019. His leadership was instrumental in developing the service. Our last engagement with Te Hiringa Matua was during the COVID-19 lockdown. The team was dynamic in reaching out to whānau by delivering kai and providing online rewana bread baking, maara kai, and facilitating online waiata and pūrākau. Mataora reflected that the success in Te Hiringa Matua was the whānau being able to help develop the service.

Moving forward, Te Hiringa Matua support new kaupapa Māori PPS, and encourage them to use their own tikanga and kawa, involving their kaumātua and kuia in their own journey.

[3] Mahi a Atua is one approach developed by Māori practitioners to respond more appropriately to their own people. It is part of a much wider movement to nurture a specifically Māori approach to philosophy, research, social science, psychology and community development. This development, called Kaupapa Māori, is intrinsically critical of dominant traditions of knowledge making and research and seeks to deconstruct the ways in which Māori people and their culture, their history and spirituality have been represented in the various Western discourses that have encountered them.

2. The evaluation

The Ministry of Health commissioned a multi-year evaluation of PPS. The overall evaluation approach was collaborative to provide information to support the DHB teams as they developed and strengthened their PPS as well as providing information about service outcomes for MOH.

A logic model was developed to provide a foundation for the evaluation while recognising differences between the pilot sites. Information for the evaluation was sourced from PRIMHD[4], provider and DHB administrative data, new data collected for the evaluation, and interviews with PPS teams, referrers, other community organisations, and PPS clients and whānau.

The Ministry of Health commissioned evaluation of PPS began in late 2016 and ended in June 2020. The aims of the evaluation were to:

- Support the expansion of the programme by contributing to the Programme's development by acting as a quality improvement tool.
- Assess whether the programme achieved its desired outcomes of reducing harm for vulnerable children whose parents were impacted by alcohol and drugs.

The evaluation had three phases:

- **Formative evaluation (designing the service)**: described the locality context, how the services developed, and the pathways into the service for women and their families.
- **Process evaluation (developing the service)**: tracked the progress of the PPS and provided feedback to the Ministry of Health and local teams to learn from the different approaches and ways to mitigate challenges in implementing the services.
- **Evaluating outcomes for children:** to examine what had been achieved in the three localities within the timeframe of the evaluation.

2.1. A logic model and evaluation framework provided the theoretical foundation

A logic model provided a conceptual framework for discussing how the PPS was designed to function and effect change. The logic model summarised the activities and outputs for the development of PPS and linked them to the intended outcomes.

[4] Programme for the Integration of Mental Health Data. https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data

A separate logic model was developed for Te Hiringa Matua to reflect the Mātauranga Māori approach.

An evaluation framework was developed based on the logic model to define the evaluation questions and specify key indicators for each question. The detailed evaluation plans specify the information sources for each indicator. The logic model is appended (Appendix One).

2.2. Information for the evaluation was triangulated from different sources

Information for the formative evaluation was sourced from:

- Document and literature reviews: Project plans provided by each site and focussed review of the literature about specific topics that arose during the evaluation.
- Quantitative data:
    - PRIMHD extracts provided by MOH each quarter.
    - Client outcomes information: ADOM[5] and Hua Oranga[6] were completed by Northland and Hawke's Bay teams. Tairāwhiti PPS used Feedback Informed Treatment (Outcomes and Session Rating scales) to collect information from clients.
    - New primary data collected by the PPS teams for the evaluation that included client goal setting, changes in child exposure to risk factors and services received by clients and their whānau.
- Site visits approximately six-monthly to:
    - Interview the PPS project managers (in the formative phase), PPS team leaders and team members and other stakeholders including referrers.
    - Interview PPS teams – individual and group interviews
    - Observe and take part in PPS activities such as MDT meetings and wānanga.
    - Interview clients and whānau.
- Telephone interviews – three to six monthly with PPS team leaders, interviews with new PPS staff between site visits and debriefing meetings with exiting staff and to fill in gaps with other stakeholders not interviewed during site visits.

[5] Alcohol and Drug Outcome Measure (ADOM). https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data/alcohol-and-drug-outcome-measure-adom

[6] Hua Oranga – was developed by Te Kani Kingi and Mason Durie as a Māori measure of holistic mental health outcomes based on Te Whare Tapa Whā.

- Individual and group interviews with 48 clients (including some whānau interviews) completed at the PPS sites, in clients' homes and/or by telephone. Those interviewed in person were given $20 supermarket vouchers as koha for their time. In Tairāwhiti clients and whānau were frequently interviewed in group settings which limited the numbers of direct quotes recorded.
- Discussions at workshops and meetings.

Details of the site visits and interviews are appended (Appendix 1).

2.3. Ethics and consent

The evaluation approach was reviewed by the National Health and Disability Ethics Committee who confirmed the work as an evaluation and out of scope for their review. They requested local ethics processes be followed. Approval was provided by the CEO of Northland and Tairāwhiti DHBs and the Hawke's Bay DHB Research Ethics committee. Ethics approval was also provided by the Ngāti Porou Hauora Ethics advisor.

PPS clients were required to provide consent to be part of the PPS. In consenting they were alerted to the use of their data for research and statistical purposes. Three levels of consent were developed with the Ministry of Health and PPS team members for this evaluation:

- **Data routinely collected for service delivery and reporting** e.g. PRIMHD. Use of routinely collected data is part of the consent processes for service users – brochures provided by the Ministry or the PPS site specify the use of heath information. No additional consent was sought.
- **New data collected to deliver the programme and track programme activities and client progress**. Routinely collected new data associated with PPS was de-identified before being shared with the evaluators.
- **Narratives from PPS providers, stakeholders and clients and whānau**. Specific verbal consent was sought from each person to be interviewed. Clients and whānau were given an information sheet inviting them to hear more about sharing their experiences of the programme. Those who gave permission to be contacted were either approached directly by the evaluators or by the PPS team.

2.4. Analysis

Quantitative PRIMHD data, provider and DHB data, and new data collected by the PPS teams were linked using a file number and encrypted NHI. This enabled longitudinal analyses and comparisons between services provided and outcomes. An

exception was the ORS and SRS data from Tairāwhiti which it was not feasible to link with PRIMHD data. Data were analysed in SPSS (the Statistical Package for the Social Sciences).

Longitudinal analyses compared either the first recorded data with exit data or the most negative assessment with exit data. This approach was taken as we frequently heard from providers that clients often disclosed more about themselves as they built trust with the provider. Therefore, baseline data from first assessments could be artificially positive.

Qualitative data were analysed thematically to identify common points of agreement and difference related to the evaluation measures. Case studies of individuals and were developed to illustrate the quantitative evaluation findings. Fictitious names were used for clients throughout.

2.5. Reporting

Quotes from PPS team members, other local stakeholders and PPS clients and whānau are included in the report. They have been de-identified and are reported as:

- PPS managers and team members in black italic font: location–PPS–year.
- Clients in brown italic font: location–client ID–first, second or third interview.

The acronyms used for the teams in quotes are N - Northland/He Tupua Waiora; T – Tairāwhiti/Te Hiringa Matua; HB – Hawke's Bay/Te Ara Manapou.

Te Hiringa Matua team members are referred to as Mataora and the team leader as Kaiārahi.

2.6. Strengths and limitations of the evaluation

As the evaluators, we were involved in the design and development of the PPS. Early involvement was important to bring a collaborative approach to the evaluation, and in discussing access to data and setting up new data collection methods. In Tairāwhiti early involvement was essential in learning from the team about the Mahi a Atua, other aspects of the service model and how a Western approach to evaluation could be adapted to sit alongside a kaupapa Māori service.

The PPS teams linked us with clients and whānau, many of whom wanted to share their experiences. We heard from one client that sharing her story near the end of the evaluation had reminded her of how much she had achieved. However, despite talking with many over the course of the evaluation, it was often difficult to recontact clients and whānau for follow-up interviews. Clients and whānau changed phone numbers frequently, they were busy with young families, some spent time in rehabilitation or other health facilities and all faced day to day challenges. While we

were able to follow up with clients and whānau who remained engaged with PPS or had exited the service, we did not manage to re-connect with those who had become lost to contact with the PPS.

The evaluation provided learnings to inform longitudinal evaluation of similar services

Systemic challenges with DHB IT systems:

PPS aimed to support children in the context of their whānau. DHB case management systems focus on individual patients. Whānau information included in case notes does not routinely include children's NHI number or the information required to look up NHI numbers (full names, dates of birth and addresses) making it difficult to track outcomes for children.

Implementing IT changes for specific projects is difficult. Changes tend to be made by adding more 'electronic forms' of various types. DHBs have different systems requiring forms to be constructed in different ways, leading to variation in the data collected. That means although the information required can be collected in case notes it is not as readily available for analytical purposes.

Simple online data collection tools are available that meet privacy requirements. These can be easily customised for individual projects. However, the tools cannot be linked with DHB systems and if used as external systems the information they contain cannot be easily viewed by the clinical team members.

Limitations to generic datasets such as PRIMHD and data collected by providers as part of their delivery of a service:

These are a rich source of information for evaluation and have the advantages of minimising the information evaluators need to collect from providers and clients. However, there are challenges:

- Clinical focus – information collected in PRIMHD is not tailored to the unique interventions used by PPS, particularly to the Tairāwhiti model.
- Systemic challenges with PRIMDH – The DHB coding frameworks do not provide the codes that would be most useful for new initiatives.

Challenges arose in matching Ministry of Health PRIMHD data to data from other sources, which did not use NHI/encrypted NHI for privacy and accessibility reasons. Clinicians had access to referral ID numbers or local identifiers which had to be matched to the PRIMHD datasets. Clients often had multiple referral IDs for PPS (sometimes as many as ten) and not all referral IDs were included in the subset of the PRIMHD data linked to PPS.

Quantitative measurement of wellbeing outcomes:

Measuring wellbeing outcomes is an integral component of tracking the progress of whānau in services such as PPS. Sustainable change requires improved wairua and whānau health as well as changes in addiction. There is no consistent way to measure holistic wellbeing. PRIMHD includes ADOM which provides clinical outcomes but does not include any assessment of wairua. Hua Oranga provided a holistic measure of wellbeing but was collected in an external system not linked to case management systems. Feedback informed treatment assessed outcomes and was routinely used by Te Hiringa Matua to inform the support they provided to clients and whānau.

3. Outcomes for clients and whānau

Key findings:

Over the three years of the evaluation, PPS reached 446 clients and whānau. The PPS took time to establish and support provided to clients and whānau was long-term. The evaluation to the end of March 2020 provides a snap-shot in time of services that were still developing. At the end of the evaluation, 202 (45%) of clients were still being actively supported by PPS and we heard that some clients who disengaged were returning. The support provided to whānau were not recorded. The evaluation findings therefore under-estimate the impact of the support PPS provided to clients and whānau.

PPS made a positive difference for many clients and whānau, including those who exited the services before treatment was complete. Clients and whānau described the changes they had made. Their descriptions were supported by quantitative data from Hua Oranga, ADOM (He Tupua Waiora and Te Ara Manapou) and Feedback Informed Treatment (FIT) (Te Hiringa Matua). It was important to compare changes on exit with the most negative client assessment as on entry to PPS clients may not disclose the full extent of their addiction or child exposure to risk.

The positive changes to wellbeing underpinned reductions in addiction, reductions in risk for children and re-engagement with whānau.

Outcomes for clients were considered holistically. Improvements in client/whānau wellbeing, reduction or abstinence in alcohol and drug use, and positive parenting were outcomes that flowed through to improved child outcomes.

3.1. The total clients reached

Over the three years of the evaluation, PPS reached 446 clients and whānau. The PPS took time to establish and support provided to clients and whānau was long-term. The PPS service specifications estimated 100 clients would be supported per annum by each PPS. The numbers of clients increased each year. In the year 1 April 19 – 31 March 20, He Tupua Waiora supported 83 clients, Te Ara Manapou supported 97 clients and Te Hiringa Matua supported 122 clients (Table 1).

Table 1. Summary of new clients and referrals per annum (Source: PRIMHD data, with client status from provider notes)

PPS	Northland He Tupua Waiora	Hawke's Bay Te Ara Manapou	Tairāwhiti Te Hiringa Matua	Total
Quarter first referrals were received	Apr-Jun 17	Jul-Sept 17	Oct-Dec 17	
Year 1: April 17-March 18				
All referrals (includes incomplete)	61	75	32	168
New clients (accepted referrals)	53	45	26	**124**
Clients (anyone with an activity in PRIMHD during the year)	45	42	24	111
Exits	13	15	0	28
Year 2: April 18-March 19				
All referrals (includes incomplete)	55	75	93	223
New clients (accepted referrals)	47	40	76	**163**
Clients (anyone with an activity in PRIMHD during the year)	79	73	99	251
Exits	45	41	44	130
Year 3: April 19-March 20				
All referrals (includes incomplete)	47	72	68	187
New clients (accepted referrals)	34	57	68	**159**
Clients (anyone with an activity in PRIMHD during the year)	83	97	122	302
Exits	34	32	36	102
Total all accepted referrals with activities recorded (all years)[7]	**134**	**142**	**170**	**446**
Status for all PPS clients at the end of March 2020 (Year 3)				
Active	45	42	115	202 (45%)
All exited clients				244 (55%)
Exit: Treatment complete	20	17	30	67 (28%)
Exit: Declined or disengaged	34	53	20	107 (44%)
Exit: for another reason e.g. moved away	35	30	5	70 (29%)
Incomplete referrals	29	80	23	

[7] Note: All accepted referrals is a total of all new clients from April 2017 to end March 2020.

PPS also supported whānau as well as clients but whānau were not likely to be recorded in PRIMHD.

> *We might have 80 on our books but you have the whānau in for all those 80 people. Most of our mothers up the coast have five kids and a partner and cousins staying at the same house and they've got four kids. For us it's not really about the numbers we have on the seats, (it's) how many whānau we are influencing to returning back to how things should be. (T-Kaiārahi-2019)*

The evaluation to the end of March 2020 provides a snap-shot in time of services that were still developing:

- 202 (45%) of clients were still being actively supported by PPS
- 67 (15%) clients had achieved their goals and were providing a safe environment for their children:
    - Some clients got to a place where they were managing their addiction. They had community support in place, their child was safe and they declined further support.
    - Some had returned to work or were taking part in education or training.
- 107 (24%) clients declined or disengaged from PPS but we heard some were returning:
    - Some were not ready to change their addiction whereas others engaged for a short time.
    - Some engaged for considerable time and then relapsed. Some clients who relapsed and disengaged were returning to the services. They had seen what they could achieve and were ready to try again.
    - Systemic factors such as lack of access to appropriate rehabilitation services contributed to some clients leaving.
- 70 (16%) clients left for a variety of other reasons such as moving away.

3.2. Changes in holistic wellbeing underpinned other changes for PPS clients

PPS clients provided many examples of positive changes they had made across the four domains of Te Whare Tapa Whā.

PPS client/whānau descriptions of changes they had made
Taha wairua (spiritual health): *They heal the broken hearted. They helped me find my self-belief because they didn't pressure me. (T-C17-1)* *Because now I'm cleaner I feel like I can do stuff and think for myself again, and the head is clearing. Way more possible now whereas everything was so hard. (HB-C44-1)*

My house feels a lot brighter, no more darkness, I get to see the sun. My life was dark. Now I'm starting to love life. A bit better than last year. (HB-C35-1)

I'm just discovering, rediscovering myself and the talents that I did have as a child. It's quite good, because I'm actually starting to see what I can do. (HB-C14-2)

Yeah, and I'm starting to feel like a better person, happier in my life and stuff. I'm so grateful for all the help she has given and I definitely wish to continue our relationship over because I'm not where I want to be yet, but I really appreciate the help along the way to get there. (N-C2-1)

Taha hinengaro (mental health):

Changes in mental health included addressing trauma, anxiety and depression and reducing addiction.

I went to the GP and got me some counselling for the really deep stuff. (T-C30-1)

I have given up drugs for good in the last four to six months. She helped me to get into the appropriate rehabilitation. Which didn't work out for me, but I still was able to keep off drugs once I came out of there. (N-C24-1)

This has been life changing. I've had lots of counselling in the past, but this is the first one that has given me a proper diagnosis of PTSD. And that's got me on the proper medication and allowed me to have proper … counselling. … So it's made a massive difference really. (N-C22-1)

[PPS] is different and it's like I can't really explain it. I just loved the vibe when I came here, the positive feeling like we could come here and have a real stink morning but get picked up and have a really good time here. I know this for myself over the months I have been coming. Like I came in here depressed, like sad as, could barely talk or look at anybody and now three or four months later I feel like yeah, way better. (T-C11-1)

Taha tinana (physical health):

When I was on drugs I would never eat. I felt dead. My family is seeing a lot of change in me which is good. My hygiene is better too, I never noticed when I was on meth, didn't worry about being clean when all you think about is your next hit. (HB-C35-1)

I have a [physical problem], … I haven't been able to be very consistent with going to the gym as I haven't found a day care yet. As soon as I get the day care in place there will be able to be some consistency and lessening pain hopefully. (N-C2-1)

Taha whānau (family and community health):

Regaining custody or access to children was a major aspect of whānau health and clients also valued connection with whānau, hapū, iwi and community.

Things seem to be going forward in the life department. The last time I saw you, we'd been having supervised access with baby. (T-C10-2)

Spending time with my kids is everything I've ever asked for and I've worked so hard to get to where I am today and I love it. It self-centres me into being mum. Whereas if I was on drugs, I wouldn't even do the things that I've done. (HB-C14-2)

This is about the most change we've seen in him looking good and speaking better to us, having a better dialogue to business people or even shopkeepers. Many times, previously going into shops, his attitude had not been helpful for him, so we have noticed changes. (HB-C35-Whānau-1)

We haven't hit one another for a long time. We are just doing a lot more active things together like going to spend a lot of time with her family. Back in the day if she said we were off to our in-laws it would be like "see ya later" and now we both go see them. … Big changes in our lives. We both wanted to change. (HB-C35-1)

Yeah, I was feeling really isolated for a while there. … I hermited myself a bit. It was difficult for me in social situations. It still is but at least she helps lessen that and helps guide me along and ease me into it because I used to get a little bit anxious around other people. (N-C2-1)

Some clients also described education and training or getting jobs:

Just came back from a web seminar. It's just seasonal work but something good for me for now. Better than what I was doing before. (HB-C35-1)

…I'm doing the computer course that gets you up to date with all the Microsoft office stuff, emailing. I thought with all this time off work, I still want to be able to use all those functions, upgrading. (HB-C13-4)

The changes described by clients were supported by changes in assessments by He Tupua Waiora and Te Ara Manapou using Hua Oranga[8]. Hua Oranga was completed by keyworkers, peer supporters and clients themselves. Comparison with the lowest assessments demonstrated positive changes for all client/whānau exit categories across all four domains of wellbeing. Of exited clients, the most substantial changes were for clients who remained with PPS until they and the PPS team agreed PPS support was no longer required.

[8] Hua Oranga – was developed by Te Kani Kingi and Mason Durie as a Māori measure of holistic mental health outcomes. Since its development it has been used by other researchers in different settings. Hua Oranga was developed based on Te Whare Tapa Whā and includes four questions in each of four domains: taha tinana or physical health; taha wairua or spiritual health; taha whānau or family health; and taha hinengaro or mental health. Five-point rating scales for each question provide scores out of 20 for each domain. Higher scores are most positive.

Northland: He Tupua Waiora

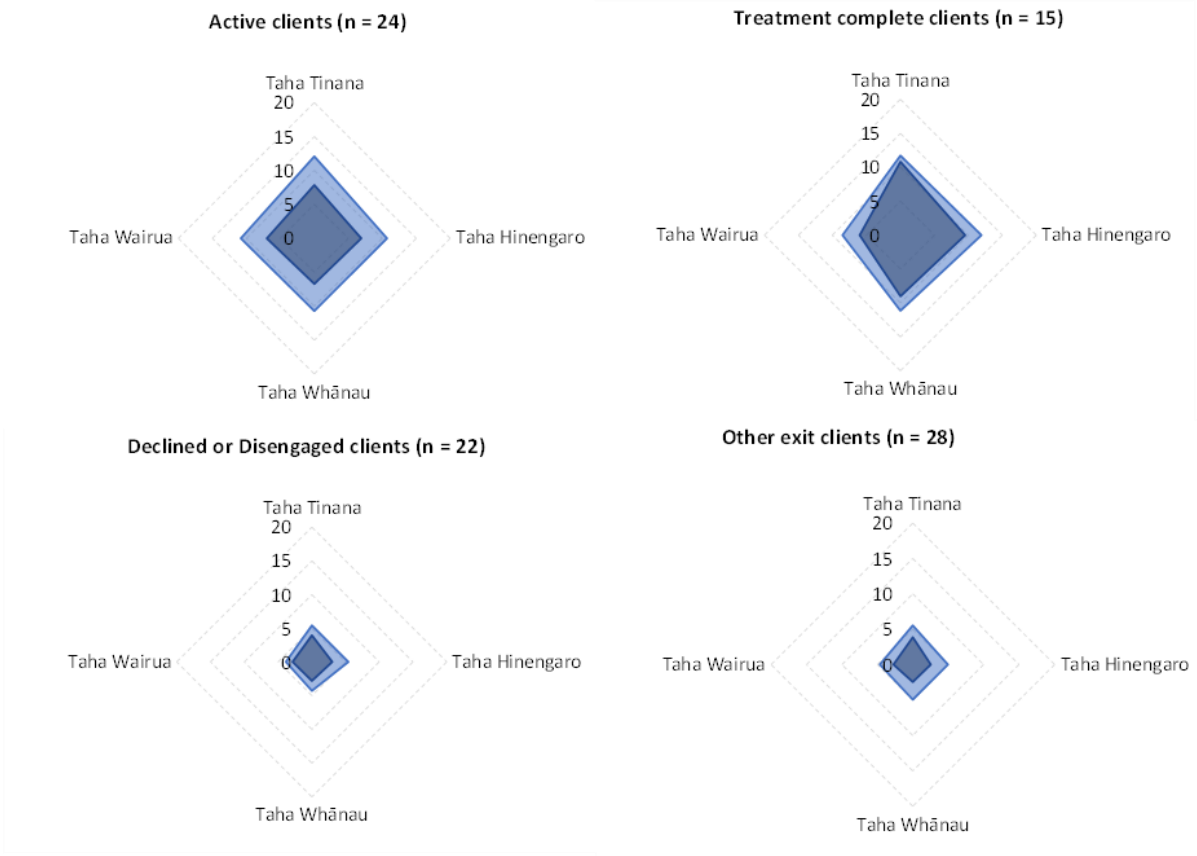


Figure 1. Changes in overall Hua Oranga scores for Northland clients comparing minimum scores recorded (dark) and most recent scores (pale colour). (Source: New data collected by PPS team)

Hawke's Bay: Te Ara Manapou

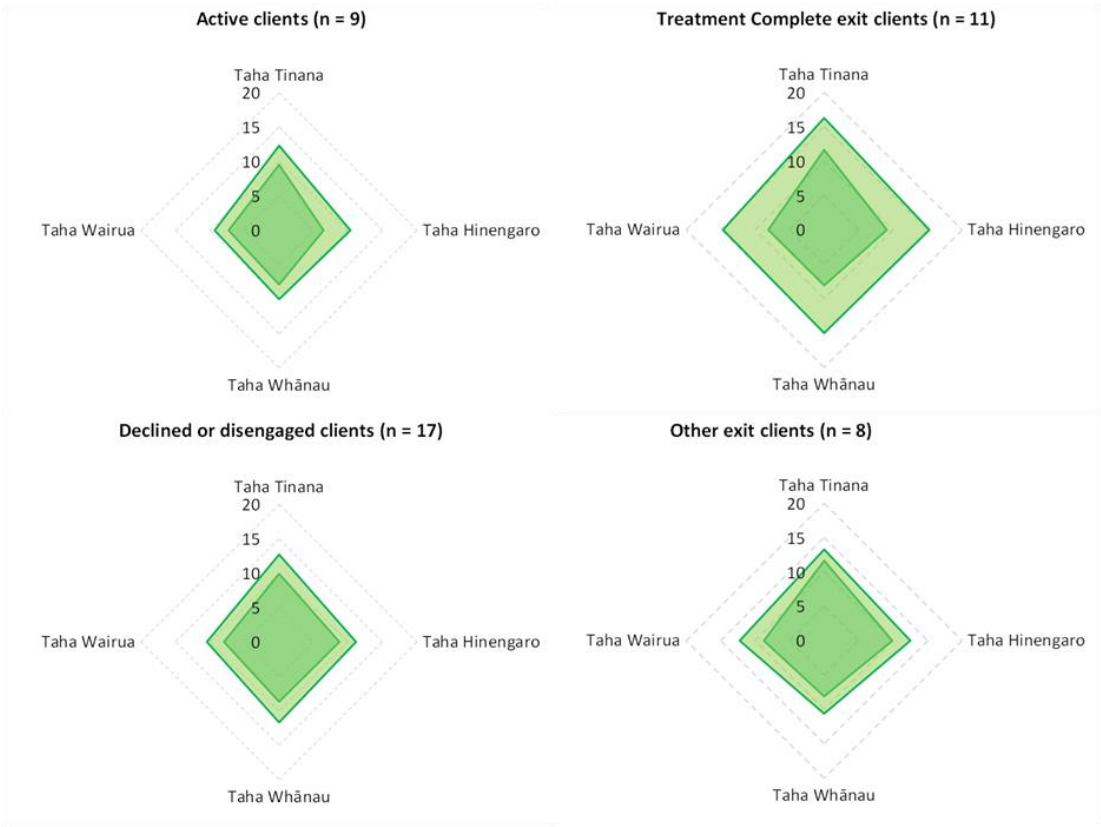


Figure 2. Changes in overall Hua Oranga scores for Hawke's Bay clients comparing minimum scores recorded (dark) and most recent scores (pale colour). (Source: New data collected by PPS team)

3.3. Changes in ADOM supported client descriptions of the changes they had made

Two or more ADOM assessments were completed by He Tupua Waiora and Te Ara Manapou for a small sample of clients. ADOM complements Hua Oranga and provides more information about changes in addiction. In contrast to Hua Oranga, lower ADOM scores are more positive.

In Northland (Figure 3) the dark blue shape demonstrates the positive changes made by He Tupua Waiora clients. Results also clearly demonstrate that the first assessment was more positive than the most negative assessment.

Rating scales of satisfaction with progress and whether clients are close to where they want to be also demonstrated positive changes (largest numbers are most positive).

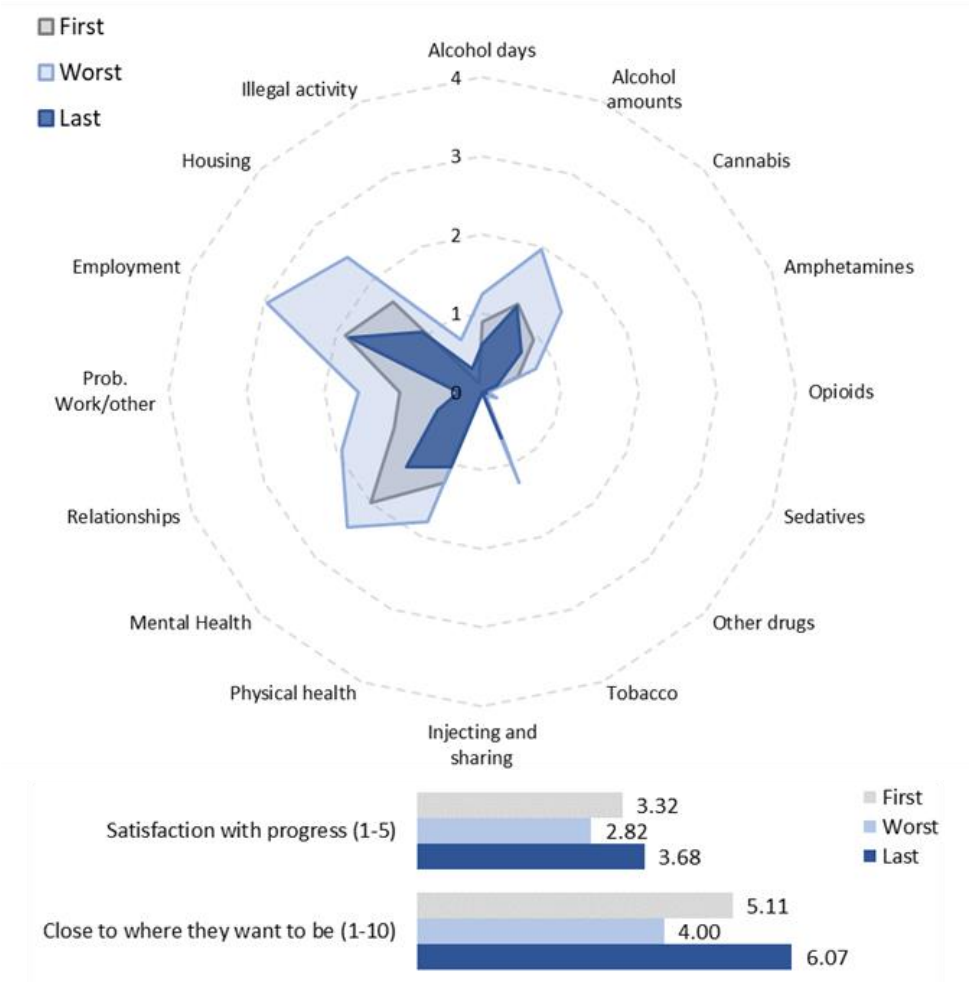


Figure 3. ADOM progress for all whānau with two or more completed assessments (including active clients) from He Tupua Waiora (n = 28). All measures in the radar chart are coded from 0 (best) to 4 (worst). In the rating scales scores of 1 are the lowest (Source: PRIMHD)

He Tupua Waiora clients also described the changes they had made. One interviewed client commented about how discussing her journey with the interviewer had reminded her of how much she had achieved.

The importance of trust: Cassie's story (*real name not used):

Cassie has been part of He Tupua Waiora for over two years and has been in rehabilitation over this period.

> *Her whole life revolved around meth, drugs, gangs. Twenty-five years of using. She had been in rehab for over two years, to different rehabs… she is in (name of rehabilitation facility) now. (N-PPS-2020)*

When Cassie connected with PPS, whānau had taken her older children and Oranga Tamariki had uplifted her younger babies.

There was no hope, the Oranga Tamariki social worker wiped her hands on this mum and said she will never get her kids back. (N-PPS-2020)

PPS were consistent in their engagement with Cassie. The caseworkers listened to what Cassie wanted. They helped her make a plan and did not judge her.

[We are able to be] the social workers that we want to be and be those role models. So they can see what consistency looks like. And heaps of them get to trust us … (N-PPS-2020)

A lot of it is the little stuff, when they get to the point where they can trust you. They make comments like well I can just be myself with you and you're not going to judge. (N-PPS-2020)

With the support of PPS and a lot of hard work in rehabilitation, Cassie has remained free of drugs. PPS also worked with Cassie's whānau and Cassie now has a relationship with her sisters and her children.

With our engagement with the whānau if you are consistent and keep going, they realise that you're going to be there. (N-PPS-2020)

Now she is at the stage where she is having fortnightly contact. They take the kids to Auckland and in April she will be having weekend days with the kids. (N-PPS-2020)

Achieving goals: Moana's story (*real name not used)

Moana had been a client of many services during her life. She could never settle at one service and kept running away from agencies. Just coping to get through the day. One of Moana's whānau knew about He Tupua Waiora and referred her.

There was no constant person in my life and then one day I said help me.

Although her initial engagement with the PPS service was positive, Moana had been deceived by agencies in the past, so she was apprehensive in the beginning. Moana and her PPS worker built a strong foundation and cultivated trust. Moana connected with her PPS worker and said she felt safe and genuinely supported by the service.

I came into the PPS office. Just even the intake was safe for me. There was no judgement. She was offering help. Sincere about my concerns…. Trust is a big thing for me. But a lot of agencies broke my trust. [My PPS workers] role is professional, but there is a relationship and trust.

Moana has kicked her addictions and moved into her own whare. She is attending couples counselling, individual counselling and has graduated from My Circle of Security Parenting Programme. She continues to improve her life with the end goal in mind - to have her tamariki back in her care. Moana continues to meet with different agencies who are supporting her. She worked closely with her social worker to have unsupervised visits with her son.

[I worked with my social worker to get] support in moving on to unsupervised visits with my son, so I'm now there… I am… achieving my goals. I am sober. Just got my own home. On the way to getting my kids back. Our [PPS] engagement has continued. My interaction [with other agencies] has improved.

In Hawke's Bay, ADOM completions demonstrated the same positive changes (Figure 4) but information was available for only 11 clients.

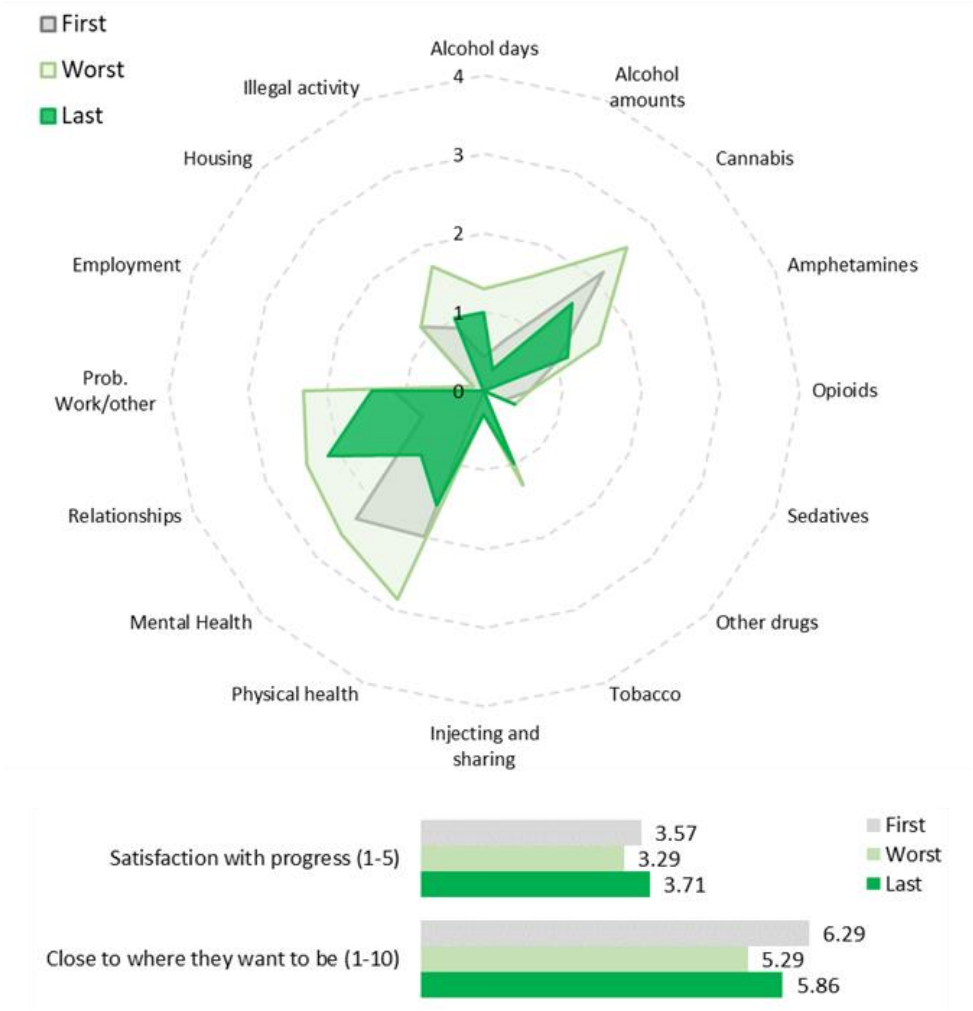


Figure 4. ADOM progress for all whānau with two or more completed assessments (including active clients) from Te Ara Manapou (n = 11). All measures in the radar chart are coded from 0 (best) to 4 (worst). In the rating scales scores of 1 are the lowest (Source: PRIMHD)

Returning to work: Sofia's* story (*real name not used)

Sofia was a young pregnant woman who had experienced some issues with alcohol and smoking. Her midwife told her a little bit about the PPS service and Sofia decided to try it. A PPS team member visited Sofia at home and told her more about the service and made sure that she felt comfortable before they started working together.

I found it better to start off with it in my house… it was easier for me to talk to them in my own environment. How they introduced themselves made me feel comfortable. I didn't feel pressured or anything like that, so it was an easier way to just get to know them first and gain that trust.

Sofia had experienced problems with services in the past, which contributed to her losing trust in the system. She had felt judged and marginalised by other services. Her key worker listened to her and focused on building their relationship. As a result, Sofia felt respected by the service. The trust and relationship-building helped Sofia engage with the service.

The PPS team key worked with Sofia and her family to address her social and health needs. Sofia was also connected to the wider team of key workers, who were available for her if her main key worker was absent. Sofia got support for drinking, mental health, socialising with others and progressing towards a greater sense of independence. The key worker also attended appointments at other services with her and built up her confidence.

> *I went with [key worker] to [service]. That was good because just even walking into that place, and I think I was overthinking things… I said to her, 'If I give you the look, you take over'. But it went really smoothly.*

Overall, Sofia made a lot of progress in a short amount of time. She stopped drinking and started seeing a counsellor and taking medication for her mental health needs. Her doctor also cleared her for driving again. These achievements helped Sofia gain more confidence in herself and made her feel like she was capable of being independent.

> *Every week I do better… I'm doing these big achievements but it's good because every time I meet [key worker], it's like same old, same old. There's always something different to accomplish and deal with… The doctor gave me the OK to start driving short distances. That lifted my confidence so much and kind of gave me my independence back as well.*

Sofia exited the service a few months after her baby was born. She was determined to become totally independent but knew she was still welcome to access support whenever she felt she needed it.

> *[Key worker] did let me know that I was welcome to still ring them if something went wrong.*

Sofia experienced a minor relapse after exiting the service. She decided to stop taking her medication because she felt like she was in a good place. She called her key worker again when she realised she was still unwell. Her key worker helped her get back on track.

> *[Key worker] also made sure, 'how is your support group going, anyone you can call now?' And I said, 'yeah I'm going to stay with my auntie for a bit until I can get back on top of things'.*

Sofia continues to make progress. She felt ready to return to work but recognised that she should take more time to ensure she was well. In the meantime, she focused on her development and looking after her baby. She enrolled in a course to help her upskill and become work ready and subsequently returned to work.

> *I'm doing the [course] that gets you up to date with [skills]. I thought with all this time off work, I still want to be upgrading… [and I] thought if I go for a job interview, at least they can see in my time out that I'm keeping my skills up.*

Maya's* story (*real name not used)

Maya had not been getting the support she needed as a pregnant woman. Because she had stopped using drugs, she was no longer categorised as having a high level of needs. However, she still needed support to help her stay on track. She found out about the PPS service through a friend and was connected to the support team.

> *I was slipping through the cracks of the other services because I had a long history. But I had stopped using and… I didn't qualify for DHB stuff… I still needed to have that support to stay on the right track but they said the only thing they could offer me was [support group] and I was not ready for that. I did need that support then and I wasn't going to get it, but then this service came along, which was perfect.*

Maya found it easy to engage with the service. The team was supportive. She trusted them and felt comfortable contacting them at any time.

> *They've been awesome, like constantly in contact with me. I can text them or ring them whenever.*

The main supports Maya got from the team involved helping her access and engage with other services. The team advocated for her and helped translate some of the jargon that she encountered when engaging with other services.

> *They were very helpful with liaising between them and myself and helping me to understand the jargon and what was happening with another service.*

The team provided her with emotional support throughout her pregnancy and after her baby's birth. This was really important to Maya because her pregnancy had been a challenging time for her and she had felt isolated.

> *One time when I was very pregnant and very upset, they just came around with chocolate one day out of the blue just to cheer me up.*

Maya particularly valued the help from the peer supporter. She found it helpful to have someone who could relate to the struggles she had been through, and who she could look at as a symbol of the hopeful life she could one day live.

> *One of them [the team] was really open about her past as well… she'd been through a lot of similar stuff herself and it was really cool seeing someone who had their head screwed on, who came out the other side, who could empathise with you but also show you, you can get back on track and do something really awesome with your life.*

Maya exited the service and continued to attend the coffee group and was grateful that this follow-up peer support group was available. It was a social outlet for her and a place where she could talk about things that were important to her.

> *I still attend the coffee group each week… It's a great excuse to get out of the house and it's kid-friendly… it really is the only place I can sort of talk about something really important so it's not swept under the mat.*

3.4. FIT assessments used by Te Hiringa Matua describe whānau journeys of change

Te Hiringa Matua used Feedback Informed Treatment (FIT)[9] both to assess whānau support needs and to monitor changes.

Changes for whānau were not linear. The line on the chart shows assessments at different times. Things are going well when the line is in the green area. When it is not in the green area, the team discuss with the client what support is needed. FIT charts demonstrate how events in whānau lives can influence their progress but by responding to the feedback the team can support whānau to continue to progress. This client had the courage and confidence to share her Te Hiringa Matua journey with an interagency team.

> *She shared her struggles ending in her elation and happiness to getting custody of her children. (T- Kaiārahi – 2020)*

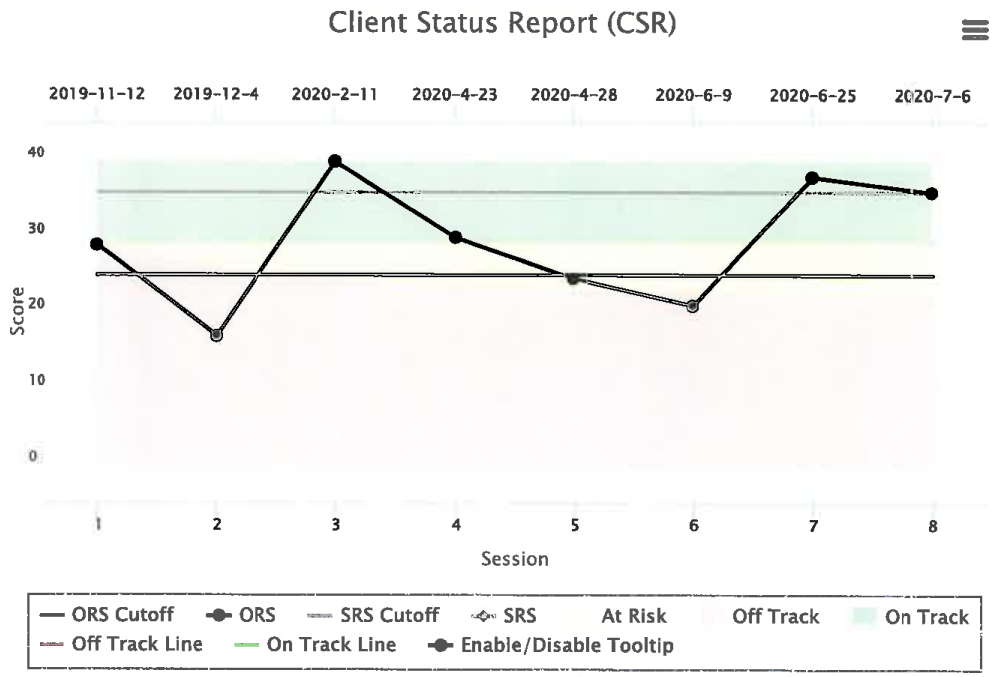


Figure 5. Client status report from My Outcomes (Source: Te Hiringa Matua)

[9] Feedback informed treatment (developed for use in secondary care settings but being used more widely) including outcomes (ORS) and session rating scales SRS). ORS are designed to be administered at the beginning of treatment as well as throughout to determine progress. The SRS is designed to be administered at the end of each session to measure the alliance. The client/whānau perspective of the alliance and their perspective of their progress are two of the greatest predictors of outcomes.

Positive changes in FIT scores were seen when comparing the most negative assessment with the latest assessment across each of the measures (Figure 6).

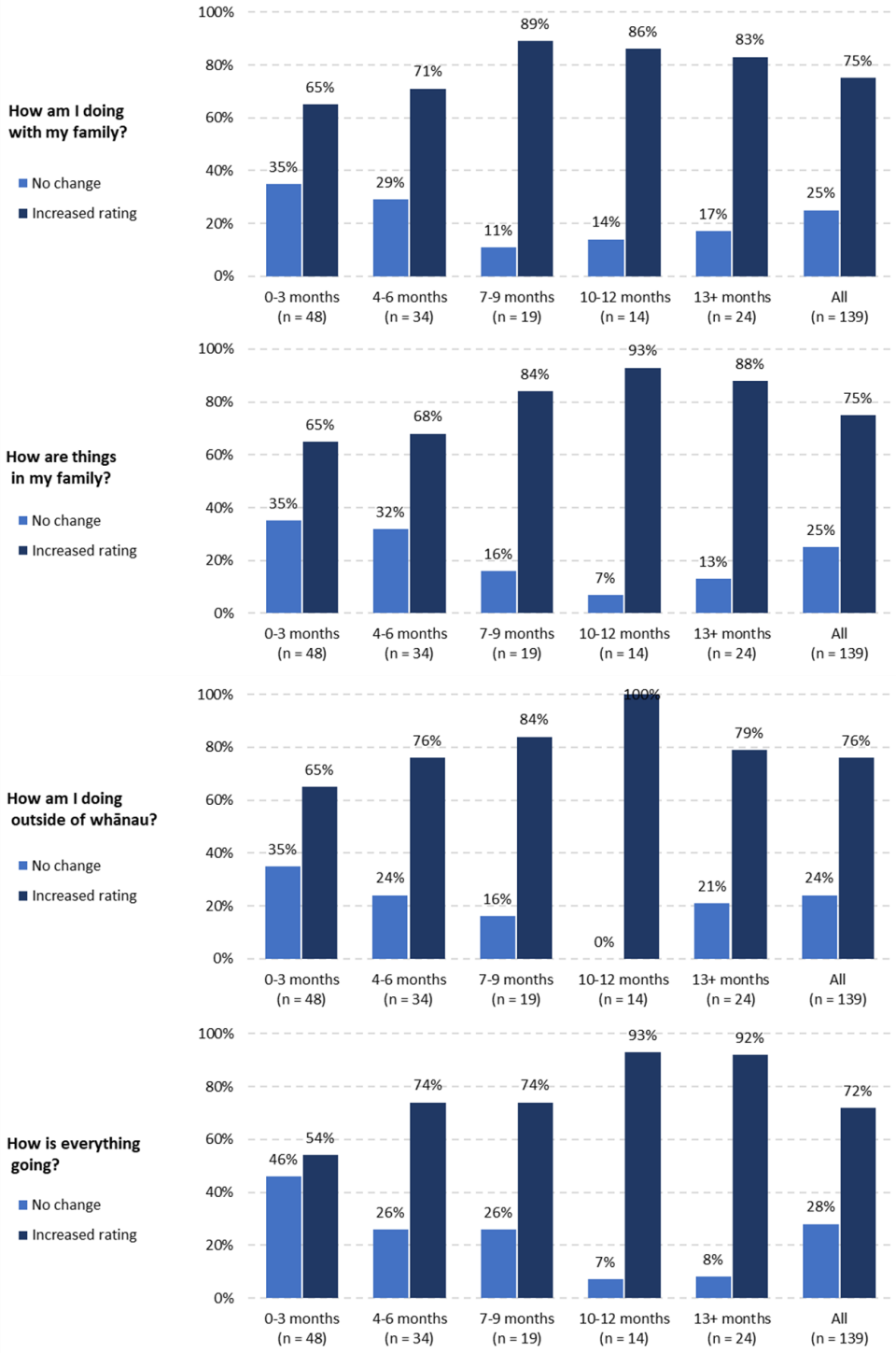


Figure 6. Proportions of Te Hiringa Matua clients who increased or had no change comparing their lowest ratings and most recent ratings recorded by the duration of engagement (Source: Tairāwhiti ORS)

Examples of client/whānau journeys are illustrated in the case stories below. Some case stories reflect multiple interviews with individual clients and others are composites of client and whānau interviews to preserve confidentiality. All names and personal details have been changed.

Connection and identity: Wiki's story (*real name not used)

Wiki had very bad meth and alcohol use and was almost homeless. Her whānau had tried to support her but had cut ties with her. She had a baby prior to coming to PPS and baby had been living with whānau for some time.

> *Wiki's journey with us started shaky … Wiki was the lead in her journey. It was more around trying to connect herself to herself, reconnecting with her whakapapa and being able to understand what that means and how some of her trauma is not built from what she is going through at that time, it may be historic trauma. (Mataora 2020)*

To help Wiki understand her trauma and connect with herself and her whānau, Te Hiringa Matua Mataora helped to ground Wiki to her whenua.

> *Taking her to her papa kainga, marae, we were able to support her to meet with her uncles, koro, and she was able to take her baby to connect to all of that. (Mataora 2020)*
>
> *That reconnecting with whānau and hapū, which was a process that didn't used to be foreign to our people, now it is. You have got to come to a service to get reconnected with your hapū, and if we can offer that and we can make it a natural experience, it's got to be better for her, when she takes her baby back home. And actually her baby went with her, even though he can't articulate that he was there, yes you were there. You were with your koroua, your tipuna. (Kaiārahi 2018)*

Connecting with her whānau and hapū was a turning point for Wiki. There were setbacks along Wiki's journey but she began identifying goals and reaching out for support instead of relying on Te Hiringa Matua.

Change and development: Roimata's story (*real name not used)

Roimata was a māmā of three tamariki who had been uplifted by Oranga Tamariki. Her two eldest were returned but her pēpi remained in Oranga Tamariki care. Roimata struggled with substance abuse and needed intense support to overcome her addictions.

Roimata was welcomed into the Te Hiringa Matua whare and service with a pōwhiri. The cultural inclusiveness of the service made her feel comfortable enough to come again. She was supported by Mataora to navigate Oranga Tamariki systems and to visit her pēpi. The Te Hiringa Matua space was warm and inviting and Roimata felt empowered and in control of the time she had with her pēpi.

> *[They had a pōwhiri process when I first arrived]. I liked it. I actually went again after that.*
>
> *...[Mataora] come with me to Oranga Tamariki meetings. I have all of them behind me. Before, I was picked on. They can't pick on me when I have all those people behind me.*

[Mataora] pick up my kids and they organised for this space and a supervisor for my Oranga Tamariki visits. Before I couldn't see my baby. Then it was in this horrible room but here it is good. It is always clean and inviting. There are toys and they don't mind if baby is drops banana everywhere.

Roimata attended wānanga and learnt about who she was as a wahine Māori. She used the pūrākau, and resources from the wānanga in her everyday life. The service support extended beyond Roimata to her partner. Through Mātauranga Māori and wānanga with men and fathers, her partner was able to address his behaviours and continuously work on who he was as a person.

I can relate to the stories. I think about the pūrākau throughout my day... in different situations I think about what happened. How they would deal with it. It makes sense to me. It's helped me a lot with confidence, learning about my roots, who I am.

At the end of the evaluation, Roimata was working towards sitting her restricted driving test and moved into a new home.

They helped me get a house, supported me in getting that.

4. Outcomes for children

Key findings:

A substantial number of children were directly involved with PPS teams: 181 children by He Tupua Waiora and 103 children by Te Ara Manapou including pregnancies and 182 by Te Hiringa Matua. Many clients also had older children with the potential to benefit from PPS.

PPS aimed to break intergenerational cycles of disadvantage. Improved parenting and positive outcomes for parents will flow through to positive home environments for children.

Qualitative information from interviews with providers and clients provided examples of reduced risk, increased safety and more positive home environments for children. Interview findings were supported by data demonstrating decreased risks for children.

Although PPS was for whānau with children younger than three, PPS teams provided examples of benefits for older children as their parent(s) changed and became addiction free.

PPS aimed to break intergenerational cycles of disadvantage for children by providing them with a safe and stable physical and psycho-social environment with their birth parents or if that was not feasible, with another family.

Improved client/whānau outcomes were the most important factor improving outcomes for children. Clients and whānau described the differences they had made for their children.

> *My progress is at [top assessment] through just being clean and having a clear head, it makes the world to me and that things are going to be okay rather than everything is [sh*t]. My main goal is to [also] have a happy family. Me and my partner are trying to get clean and our relationship is one of the short-term goals, have a happy family for baby. … (HB-C41-1)*
>
> *I'm so lucky for this place, I know baby's going to be healthy when he comes out. And his health has been really good. If I was still drinking, who would've known. (HB-C13-2)*
>
> *The wānanga help me with understanding about who I am. Those fairy tales about princesses (that you hear growing up) they are not ours. …. (T-C31-1)*

4.1. Children reached by the PPS

A substantial number of children were directly involved with PPS teams: To the end of March 2020, He Tupua Waiora supported approximately 181 children and Te Ara Manapou supported 103 children under three including pregnancies[10]. To July 17 2020, Te Hiringa Matua had supported 182 children under three and 238 children aged three to 18 (Table 2).

Although the PPS focus is on the under three age group, many whānau also had older children who potentially benefit. The average number of children per PPS client was substantially more than the average number of children for Aotearoa New Zealand.

Table 2. Recorded involvement of PPS clients with children (Source: New primary data. The n values in brackets reflect the number of clients with information recorded in their first assessment)

	Northland: He Tupua Waiora (to 31 March 20)	Hawke's Bay: Te Ara Manapou (to 31 March 20)	Tairāwhiti: Te Hiringa Matua (to 17 July 20)
Pregnancies	29 (n = 100)	24 (n = 87)	
Number of children involved with PPS	152 (n = 114)	79 (n = 97)	182 (n=211)
Children under 18 living with clients	157 (n = 114)	117 (n = 85)	238 (n=211)

4.2. PPS support improved parenting and attachment

Positive parenting has demonstrated positive impacts on child outcomes. Better parenting practices and reduced AOD use during pregnancy lead to reduced engagement with Oranga Tamariki (e.g. reduced abuse and neglect), a reduction in Adverse Childhood Experiences (ACEs) and improvement in the child's health (e.g. reduced likelihood of infectious diseases and serious illnesses requiring hospitalisation)[11]. Qualitative evidence from interviews with the PPS teams and clients described improvements in parenting for children. Parenting education is discussed in detail in Section 5.10.

[10] Limitations of recording systems made it difficult to accurately estimate the number of children reached by PPS.

[11] Morton, S. M. B., Atatoa Carr, P. E., Grant, C. C., Berry, S. D., Marks, E. J., Chen, X. M-H., & Lee, A. C. (2014). *Growing Up in New Zealand: A longitudinal study of New Zealand children and their families. Vulnerability Report 1: Exploring the Definition of Vulnerability for Children in their First 1000 Days*. Auckland: Growing Up in New Zealand.

Just at the moment with [client], just the change with her with this baby and this pregnancy, it's huge. And that's going to have a huge positive outcome on that baby now. Great attachment and she is loving the whole process of that baby and it's going to have a whole different experience of parenting than what all of her other children had. So yeah, I think it is achieving that outcome really well. (HB-PPS-2019)

I learnt some skills that I still use to this day. I've never had to be the authority person over any child, like I have but it was well I'll call your mother and tell your mother what you've done but with me, being the mother. So being able to learn things. I'm trying to put one thing into action at the moment... it's been really good being able to learn little things that I never had growing up myself. (HB-C43-1)

Children of parents with addictions are at increased risk of FASD. Positive parenting is the most effective way of improving outcomes for children with FASD. The PPS teams observed children and linked them with specialist support for their disability or to improve speech or other developmental delays.

I have loved the guest speakers at the wānanga. I have a son who is [disabled] and we have had an expert …. They have helped me get the support I need. Sometimes I don't have the energy to grab for support. (T-C31-1)

Although PPS supported clients with children under three, many clients also had older children. We heard from PPS teams that there were benefits to older children of improved client wellbeing.

I can think of two examples. One is [client name] daughter, who is 14. And the only times when I saw her was FGCs or at the house. She was always really angry and oppositional. And you could see it in her body language. And she was really horrible. And she came in here about three weeks ago with her mum for [groups support] and she was smiling, and she was happy. And I had a wonderful conversation with her. She was talking about what she was doing, and she really connected to the new-born baby. She was a different person. And if you speak to her mother, her mother has noticed the difference too. And even with another mum who went to rehab, her children said, "Mum's not the same mum. She is different. She takes time to talk to us". It's huge. (HB-PPS-2019)

4.3. Children were connected with other services

All PPS services connected children with other services with the potential to improve their outcomes. He Tupua Waiora and Te Ara Manapou recorded connection with services (Figure 7).

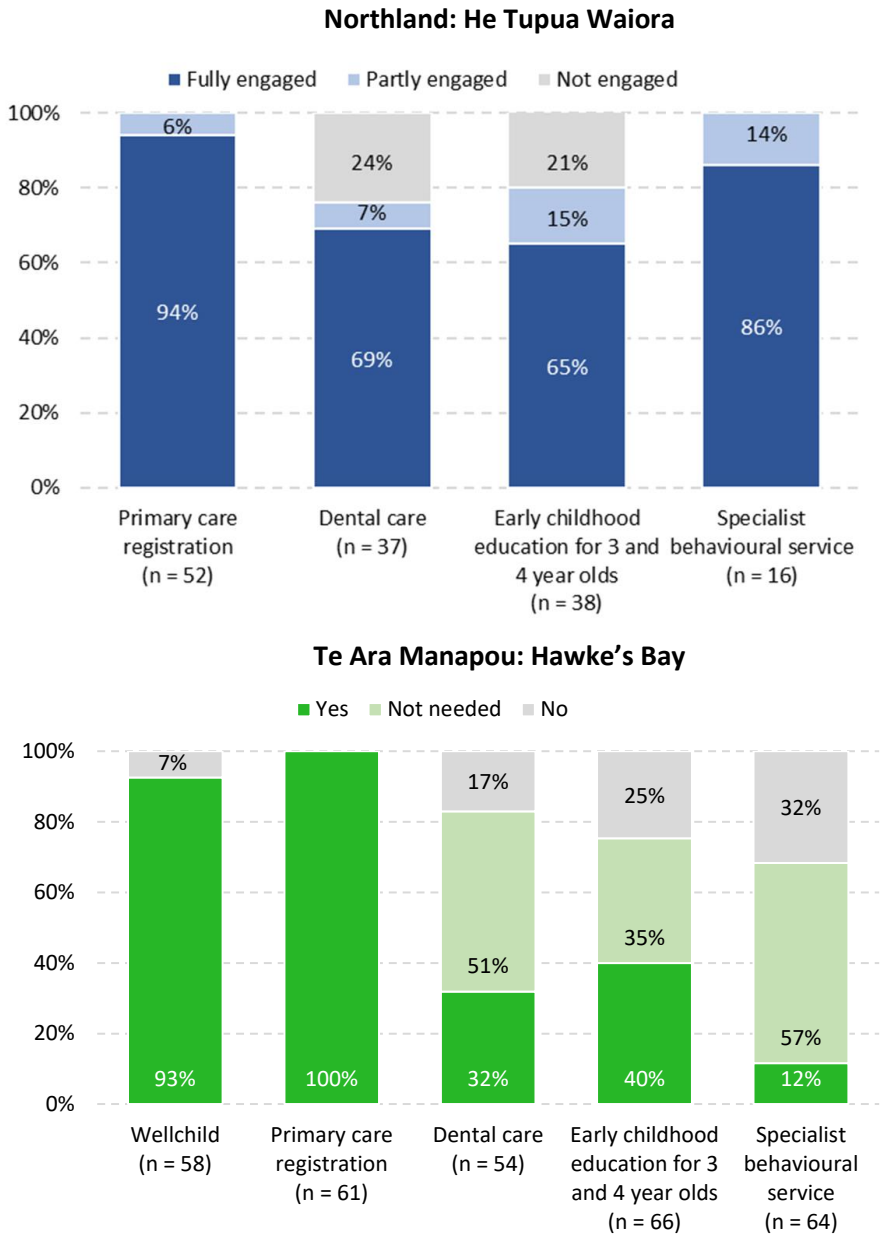


Figure 7. Connection of children with services with the potential to improve their outcomes (Source: New data collected by PPS teams based on connection to services for the proportion of children requiring services – information was not recorded for all children)

4.4. Exposure to risk was reduced for many children

Team members were aware the focus of PPS was improving outcomes for children and understood that in some cases this might only be achieved by the child living with someone else. The PPS teams managed the tension between building trust and confidence with whānau and being perceived by clients as working with Oranga Tamariki.

> *Sometimes the kids not being in the home for a period of time, that can sometimes be the catalyst for change. And maybe for some of these mums, as hard as it is to say yeah it is not ideal that the kids are with them for a period of time, and obviously [kids staying with whānau] is what we try to work towards, but I think they're looking at success in terms of the kids as well because that is our focus is better outcomes for the kids. (N-PPS-2020)*

Risk assessment and risk management with a clear child focus were foundational components of the PPS. Risk reduction was achieved by PPS and other services actively managing the child's exposure to risk. On engagement with PPS, clients may not recognise or reveal the extent of a child's exposure to risk.

> *The risk may not have gone down due to the client now trusting the practitioner and was now being honest about the drug use of family violence. (HB-PPS-2019)*

He Tupua Waiora and Te Ara Manapou teams recorded risk assessments at three monthly intervals (Figures 8 and 9).

> *If you've something like [PPS] you've eyes, support, somebody keeping an eye. They're pretty good at referring to Oranga Tamariki, they don't put children at risk but they're also acting as a pair of eyes which is huge because it gives women the opportunity to parent. (HB-stakeholder-2020)*

Figure 8. Changes in risks to children of He Tupua Waiora: Northland clients/whānau, comparing first to last assessments for treatment complete clients with at least two assessments recorded. Note results are reported for each child. (Source: New data)

Figure 9. Changes in risks to children of Te Ara Manapou: Hawke's Bay clients/whānau, comparing first to last assessments for treatment complete clients with at least two assessments recorded. Note results are reported for each child. (Source: New data)

5. Client journeys with PPS

Key messages:

Pregnancy and children were a strong motivation for change and the reason many clients engaged with PPS. Many PPS clients were also Oranga Tamariki clients and were working to retain or regain custody of their children.

After referral, the PPS teams built engagement and trust with clients and whānau to enable them to assess and respond to each client's needs. Clients and whānau described that the way the PPS team treated them, listened to them and moved at their pace were different to what they had experienced before and were key to them staying with the service and sharing their stories. Clients understood that in trusting PPS and disclosing their situation they risked Oranga Tamariki involvement with their children.

Support for clients included in-house support from the PPS teams, and treatment and co-ordination of services. Making sure clients had safe places to stay and money for food were often first steps. PPS supported clients to engage in a breadth of services including health and social services and education support. Often clients needed PPS advocacy with police, justice and Oranga Tamariki.

Parenting education and child safety were service priorities. Child risk reduction was addressed through assessment and monitoring, reduction in substance abuse and parents' participation in education to reduce family violence.

Including whānau in PPS support contributed to sustainable recovery. Other whānau had addiction issues and including them in support contributed to recovery. Some clients separated themselves from whānau they considered a negative influence.

Client journeys through the services were complex and not linear. Support was long-term and often lasted more than a year. Client relapses were not uncommon but clients who had relapsed and left PPS were starting to return. All PPS kept their doors open for returning clients who needed additional support.

Clients who exited because they had achieved their goals were not always free of addiction but positive influences in their lives and other strategies ensured their children were safe.

5.1. Pregnancy and children were a strong motivation to make changes.

Clients and whānau who needed PPS support were often motivated by their pregnancy or children and recognition they needed help.

> *The babies are valued, they love their babies. I've never met a mother who didn't want to do a good job or care for their child. Regardless of everything else they love their children. They just don't know what to do or how to care for them in a way that is going to be positive. (HB-stakeholder-2020)*

Many of the PPS clients were also Oranga Tamariki clients[12]:

- Oranga Tamariki were involved with at least one child for 60% of Te Ara Manapou clients at some point in their engagement with PPS.
- In Northland, at first assessment, 25 (23%) were partially engaged, 24 (22%) fully engaged and 4 (4%) not engaged with Oranga Tamariki. The team were not sure for 25 (23%) and the service was not needed for 33 (30%).

Motivation to retain care of their children or to regain custody was the reason many clients connected with PPS. Some of these clients had been referred or encouraged to self-refer by Oranga Tamariki. Some were referred by Police or other agencies. After referral, clients had to provide consent to be supported by PPS. The team relied on referrers to seek that consent because whānau knew them.

Reasons for client referral to PPS

I first heard about it from my social worker at Youth Services. … Motherhood is pretty hard at my age, so I just thought I'd give it a go to see what's out there. (N-C23-1)

I heard about it from my drug and alcohol counsellor. The first time I came she came with me and my partner. (T-C17-1)

I decided because I needed help. For myself and for my family, I want my family and kids and I seen that I need help for my addiction that I had. (HB-C35-1)

I said yes because I needed as much support as I could get. I was not in a good place then. I had lost my kids and I had no hopes of getting them back. (HB-C6-1)

I first heard about Te Hiringa Matua from [Mataora] … He said we have this group … It might be good for you. I was hapū and my youngest was taken at birth. (T-C10-1)

We got in the shit with the police, me and my partner had been fighting and we had an incident in the car … we had the baby with us, so it went to family harm. They recommended this place (HB-C20-1)

[12] The information was collected differently in Hawke's Bay and Northland and not collected in Tairāwhiti.

[Neighbour] told me like if your kids are in CYFS they help you get them back. They help you with everything, support and talk and transport. I was like mean because I need that in my life. So, she ended up contacting one of the ladies and then I got a hold of them. (N-C4-1)

…because I have two other kids that are with their grandparents …But [PPS key worker] will be like, "think about it, 18 months from now, you will be a great, an awesome parent, the best parent they could ever have"… (N-C5-1)

5.2. Clients and whānau were at different stages of readiness to change

Clients were at different stages of readiness to change when they engaged with PPS (Figure 10). The largest group of Te Ara Manapou clients was in the pre-contemplation stage of the Prochaska and DiClemente stages of change cycle. Clients in the pre-contemplation stage may take longer to engage with and support to change, however when we examined outcomes by the stage of change at entry there was no obvious difference, possibly due to loss to follow-up and/or limited follow-up data recording for some clients.

Typical clients starting in the pre-contemplation phase would be those who were referred by Oranga Tamariki and came along to try and retain or regain custody of their child. Some clients did not fully engage but others engaged more as they build understanding of PPS and how it was different from other services.

[Caseworker] rang me the first time and I turned them down because I didn't think we were in dire straits, that there was other families out there that need protecting not just mine… I turned them away the first time and when she came back to me I had a black eye, she was like you got to ring these people and I did, and I've never looked back. It's been the best thing ever. (HB-C44-1)

Some clients referred by Oranga Tamariki were contemplating or preparing for change. Some had already started to manage their addiction and a smaller group had given up and needed support to maintain change.

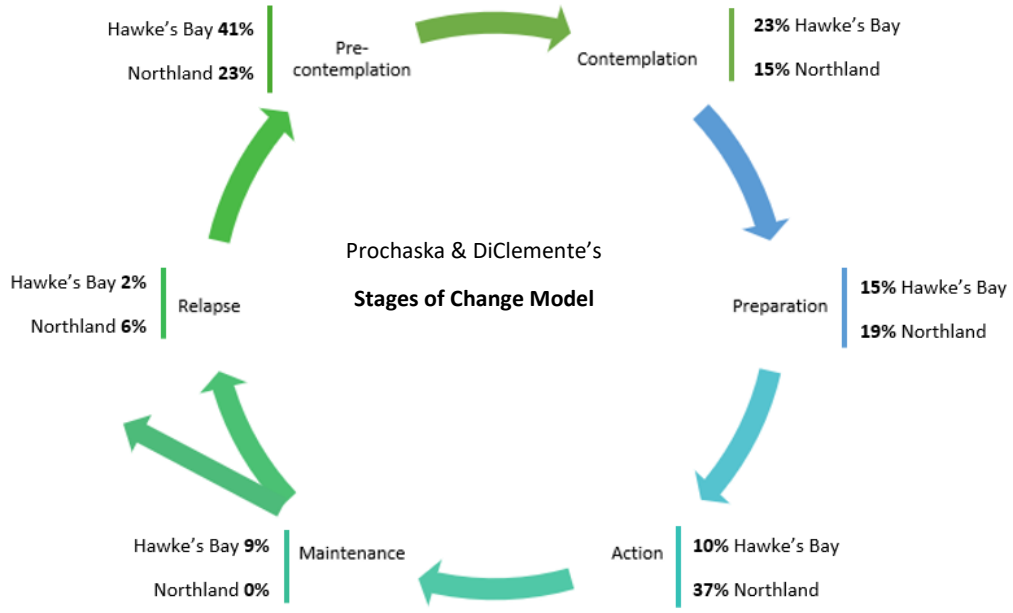


Figure 10. Clients were at different stages of readiness to change on enrolment with PPS based on Prochaska and DiClemente's stages of change model (New primary data: Te Ara Manapou: Hawke's Bay (n=105) and He Tupua Waiora: Northland (n=79))

Stages of change
Pre-contemplation: *They'll say yes and agree to that first visit because Oranga Tamariki is with them. So, we sign them up and they do everything, and they don't want to be there in the first place. (HB-PPS-2019)* *They came to wānanga once but they came on their own agenda because if they wanted their kids back they had to attend these courses. They started to come along and they started to realise this is more than that, this is around me working on myself, me connecting me back to my whānau, hapū, marae, iwi. (T-Mataora-2020)* *The first time I came here and saw the wānanga I said no, this is too much for me. The space I was in at the time. (T-C30-1)* **Contemplating change:** *I was really messed up. In the beginning I didn't find [PPS] helpful because I didn't even know I needed help. I felt like I was in control. … I was open to it but I didn't think much of it at the time. She gave me a run down about who she was as a nurse and that she could help me, I didn't know what I needed. (HB-C47-1)* **Action and maintenance:** *My therapist referred me through because I was a little bit nervous about maybe, once baby was born, maybe I would fall back into my old habits again and it was just*

basically to ensure that I had a support network there to keep me on track so she just referred me through. (N-C9-1)

I was only a couple of months of stopping using, it was still a very risky time I think. I was doing well, but I still needed to have that support to stay on the right track... (HB-C21-2)

5.3. Early engagement focussed on building trust

Engagement was the first step in supporting clients. Building trust took time because the previous experiences of many clients meant they did not trust services. Those who referred themselves or were ready to change were easier to engage with to build trust and for the teams to assess their needs.

They've actually come forward and done something. The other services I've asked for help, they say write your name here and there and they'll get back to me. But [PPS] comes straight to your door. (HB-C35-1)

The PPS team recognised the complexity of clients' lives and the barriers to keeping appointments. The PPS model meant that the team were able to spend the time needed to slowly build trust with the clients. They also had the flexibility to meet with clients and whānau in different settings.

I think it makes the client feel that they are not being given up on because life does get in the way. So, they can be doing their life and we are not going to give up because life got in the way of an appointment. (HB-PPS-2019)

We've actually built it in that we don't talk any shit. It starts right at the start when we're… You know? And they always say, 'Do you do any drugs? Do you do any alcohol?' And they go, 'I just have one or two. I might have a cone every month.' Come on! But after that, once they get used to us... (T-Mataora-2019)

Two PPS sites accessed cell phones from the DHB after an upgrade and provided these to clients with data so they had a way of contacting PPS and other services if they could not make appointments. An unanticipated benefit of providing phones was the ability of clients to connect with their whānau.

Once trust was established, clients would gradually reveal information that would allow the key worker/Mataora to assess their needs. Some clients were more comfortable disclosing things about their lives to the peer support worker.

We actually have the time to be able to sit there and listen and do things with people. It means that they don't have to think about what they want to talk about and cram it into this small space of time. (HB-PPS-2019)

… for them to trust us enough in disclosing some stuff has been a surprise, I think more than anything, knowing there will be implications. But I think some mums are in a position where they are disclosing because they actually want something to be done, they know they need to be stopped. We can't stop them but they know that something has got to happen but trusting us, that we can be part of that change process and that is something that is happening without us actually just throwing them away but actually sticking with them when all the stuff starts to happen. (HB-PPS-2017)

What success is to me is when the mothers are honest with their use. We can support our whānau when they're honest, to me they want to support, and they want out of that lifestyle. (N-PPS-2020)

Matua always used to say koha atu, koha mai, when you're giving you will receive back, that is the whole reciprocal thing happening. (T-Mataora-2020)

The ōkawa pōwhiri process was the first step for whānau entering Te Hiringa Matua

Ōkawa pōwhiri was important in establishing relationships between whānau and Mataora, but also in keeping everyone safe.

It's a technology…ōkawa is technical too, it's not just spiritual, it opens doorways to esoteric spiritual…but it's really technical and physical. The technology of it is it slows us down in our meeting process, we don't just meet. That's too messy. Our ancestors knew, bit by bit broke it down, so we could have a more meaningful engagement. (T-Kaiārahi-2018)

Te Hiringa Matua, Mataora placed emphasis on making sure that the ōkawa process was done properly and that every person who came to the service was treated the same way. The kaiārahi described how ōkawa was grounded in a very long history of successful encounter.

What we started from the very beginning is our ōkawa process… the reason we brought that in is ōkawa is a process of engagement that's worked for our people for over a thousand years. (T-Kaiārahi-2018)

So, we create a consistency, a consistency of delivery, and hopefully a consistency in the way that we address people and their katoatoa and everything that they bring. It doesn't matter whether they are a member of parliament or a member of the Mongrel Mob, they get adjudicated with the same ōkawa process, which is something that I am adamant is going to stay with Te Hiringa Matua. I think we are one of the very few services that use it in this way. (T-Kaiārahi-2018)

The ōkawa process set the scene for whānau to feel safe, valued and part of the service. This process was also a risk assessment tool for Mataora in observing and assessing whānau as they entered the service.

For me it's our ōkawa, because that's almost like our valued thing that we have to hold to and we have to make happen so that the sequence of our ōkawa allows for a group to meet properly… ōkawa doesn't allow people to bleed over emotional, it doesn't allow other people to bleed out so therefore you have to bring who you are but not all of what is inside, you don't over expose yourself. (T-Mataora-2018)

5.4. Effective ways to support Māori was a priority for all PPS teams

Doing things differently for whānau Māori to achieve different results was one of the core components of PPS. The teams recognised the impact of colonisation on trauma and addiction for whānau Māori.

We move forward by doing things better for Māori. (HB-PPS-2019)

A PPS team member described concepts of past and future to illustrate fundamental differences between Māori and Western worldviews that are important in supporting whānau.

Just by way of example of fundamental world view differences held by pre-colonised Māori and mainstream Western man are the words used for past and future. In Māori past is represented by the word- mua. This means 'in front of'. So, for old school Māori your past was directly in front of you, and you were literally walking in the footsteps of your tupuna- ancestor, those who have gone before, you were following them.

The Māori word for future is 'muri ' – behind. So, the future was unseen and coming up behind one. In fact the future could cast its shadow forward onto oneself.

And discussed the power imbalance confronted by Māori in clinical care engagement:

There's the fundamental power imbalance between Māori client and clinician practising with 'mainstream' paradigms/theories.

…The discourse is in English, and this is not by choice. Not being able to speak one's mother tongue is laden with the history of this country and carries a huge sense of loss of identity and loss of our own original teachings/philosophies… Because the discourse is not in our own language, the concepts, paradigms, idiomatic speech and so on is weighted towards the clinician's world view - hence an overwhelming power imbalance.

Meeting the needs of Māori and eliminating institutional racism were inherent in the Tairāwhiti kaupapa Māori design. Te Hiringa Matua described systemic change by *indigenising the space*[13] and in showing whānau the wider systems that influenced their day to day struggles instead of self-blame.

And that is that whole whakapapa aspect of the wānanga is that you go "oh I am not just a crazy person, this way of being actually stems from mai rānō so not just I am depressed.

[13] One of the three principles of Mahi a Atua

This sack of thing happened because it is my fault". Actually, that has a whakapapa to it and when they start going...and it makes it okay. It also shows that there is room for movement. (T-Mataora-2017)

The kaupapa of Te Hiringa Matua to value and respect whānau contributed to whānau willingness to engage with the service. Tikanga including pūrākau, ōkawa and wānanga was the essence of Te Hiringa Matua and helped whānau feel cared for and connected.

Even if its baking rewana, or [Mataora] has put up [online] pūrākau that he has talked through and done demonstrations on. One of his talents is maara kai, kumara harvest. They're quite beautiful and very humbling to watch and see so you can imagine if that was in front of people, wāhine can feel good about that where they may never get that anywhere else. (T-Mataora-2020)

All Tairāwhiti participants interviewed for this evaluation described the empowerment whānau gained and continued to learn through Mātauranga in an indigenised space. Strengthening their identity, and the identity of their whānau was providing a foundation for unlimited potential as parents and as whānau, hapū, iwi community members.

Today we talked about what pēpeha means to you. Many (whānau) didn't grow up learning it. Not until they came here and began to grasp where they are from. Their babies will know where they are from and be grounded. (T-Mataora-2020)

Although He Tupua Waiora and Te Ara Manapou were not kaupapa Māori services, te ao Māori was inherent in the way Māori team members worked. All team members recognised the importance of integrating tikanga into their work.

… how could we take some of the principles and build it into te ao Māori world view…. Building on pūrākau, using tikanga process and using some of the more clinically based elements but expressing it in different ways. To use some of that mindfulness stuff but use it in conjunction with stories about our whenua. Let's go and do it and talk about the story of the land. (HB-PPS-2020)

He Tupua Waiora and Te Ara Manapou have built networks with iwi services and kaupapa Māori providers and with local marae. They continue to nurture those relationships.

We've got a hapū wānanga which is a service here that has started doing a Māori cultural antenatal class. Like wānanga which runs for a whole two days…they learn a lot about their identity, where they are from, weaving, all sorts of stuff about how precious a baby is to the cultural world (N-PPS-2019)

To create partnerships between clinical and cultural partnerships. Acknowledging that the cultural is not just an add-on. The clinical part needs to be nested in it." (HB-Psychologist-2019)

When we discussed the importance of Māori keyworkers with clients, some considered that a non-judgemental attitude and the type of support provided were

more important than ethnicity. However, other clients talked about how important it was to be supported by Māori and not have *yet another Pakeha telling them what to do (HB–C14-1).*

> *My sister, she told me the service was really great and had a Māori outlook … (HB-C20-1)*

For some Māori, reconnection with te ao Māori was life changing. For others the impacts of colonisation have resulted in them not wanting to reconnect.

> *[Client] has done so well; She had connected to faith and te ao Māori that was really big for her. (HB-PPS-2020)*
>
> *They have like a Māori process and a Māori tikanga and I think what a lot of us need being Māori but not really knowing or being brought up around anything like this. (T-C11-1)*
>
> *[Tikanga is] really, really, really important. … I've been brought up Pākehā but I'm finding for who I am I need my culture, and with [PPS] they're mainly Pākehā workers … but with [Māori key worker] she's working with me which is the Whare Tapa Whā and she does a bit of te reo and she encourages it for me.(HB-C47-1)*
>
> *But then you've got to understand that there's some Māori that don't know the Māori language and stuff like that, so not all of us are into that. (HB-C13-1)*
>
> *I wasn't expecting a powhiri. I was like, what? Do we have to do this? But it was really good. (T-C10-1)*
>
> *It's helped me a lot with confidence, learning about my roots, who I am. (T-C12-1)*
>
> *I've never actually thought it was important growing up but I've realised now it really is important to me now. Like I'm questioning, not who am I, like I say I'm Māori but I can't speak Māori. I don't know anything about it. I'm Māori but I'm not. It was like identity issues, especially being here by myself while my family is living [overseas]. (T-C11-1)*

5.5. Inclusion of whānau was integral to PPS support

Sustainable pathways to improving outcomes for children addressed challenges in the context of whānau. Not involving whānau or inability to engage with them could be a barrier to sustainable progress for clients. Some clients were supported by their partner or whānau to come to PPS. Whānau could be involved in developing safety plans for the clients and children and positive whānau support could be a deciding factor in whether children remained with the client.

The importance of a whānau/family focus

The more they got to understand that [the importance of connection to whānau, hapū, marae, iwi]. the more they started to ground and reconnect to their kids again, understand their parenting responsibilities, having to give up the drugs and alcohol, having to do that to be able to provide for their kids. (T-Mataora-2020)

I guess for me that's one of the things that I was missing when I was in my time of drug use, I forgot my identity, forgot where I came from, I forgot who my grandparents were, I forgot who my kids were, I forgot who my parents and siblings were. (HB-C14-2)

She always involved my parents because I was okay with that, because they were my support and she did it where she explained things to Mum and Dad to make it clearer for them, because they had to learn what it was like to look after someone like me. (HB-C13-1)

Yeah, because the best resource for a person when they're unwell or they're struggling is their family. I know that sounds really stupid, especially when you've got really dysfunctional families, but actually they're the ones that know them the best, … some of our clients, they've got some amazing families, but their addiction is so strong that they've destroyed some of those supports. If you can strengthen the family, the family's going to do the most healing. Not us. We're not there 24 hours a day, the families are. (HB-PPS-2018)

We've had one where one of the parents have gone and used again but the whānau went full in and maintained that the father or partner needs to move out and sort himself out so they don't have Oranga Tamariki step in and uplift the kids again. The positive thing out of it is whānau are talking about it much more to agencies, with ourselves. (T-Kaiārahi-2020)

Connecting with positive family support: Bridget's story (*real name not used):

Bridget is 21 and pregnant with her second child. She has had a lot of traumatic experiences in her life and has been transient for 20 years. Bridget's older child was taken from her at birth.

She had been in a violent relationship. That is why her son got removed and they are still together, and they are working really hard to make that relationship strong. (HB-PPS-2019)

Being pregnant has been a turning point for Bridget in addressing her addictions. She is determined to keep her new baby. With the help of PPS Bridget has given up all substances and alcohol. She has recently given up cannabis.

I think she is 19 days clean of cannabis. She is making appointments, meeting her midwife appointments. (HB-PPS-2019)

Every week Bridget travels from Napier to Hastings to see her son on home visits. Because she is making positive changes, friends and family who had given up on Bridget are coming back into her life.

> *That is her mum as well. All of a sudden her mum has seen change and wants to be part of this new girl in her life. So, she's done it on her own, really. There are good supports in place. She is going to keep this baby and she is working towards getting her other baby. (HB-PPS-2019)*

Other PPS clients discussed how their whānau also needed support. Family violence was prevalent amongst the PPS whānau and partners were included in PPS support.

> *They have helped my partner get someone he can talk to and they can support him. (N-C3-2)*

> *Yeoh because you can't make change with just the one person. If they are going back into an environment where their whole whānau is going to impede their change or whatever. So we try to work with their partners and the people who live in the house with them, all to the benefit of the children really, and mum. (T-Mataora-2020)*

> *It is counselling as a whole whānau. A lot of them have moved back in with parents and it has had to be a re-education for our parents. Some of it has been really hard and sad, a lot of it is. It has been great for the kids. The kids love having their parents back. (T-Kaiārahi-2020)*

> *My family aren't so pushy now. There are quite a lot of good differences now. They have let me grow. (T-C16-1)*

Some whānau were dysfunctional and we heard from some clients that to progress they needed to distance themselves from whānau. Some moved away and did not share their new contact details with whānau.

> *There are not integration services that are safe for people to go to when they are the only people in their whānau that has stopped using. It's hard for them to go back and have to live in this home while the rest of their whānau is still using and they are trying to maintain sobriety. (HB-PPS-2019)*

> *I have removed myself from whānau. I don't give them the address to protect my recovery. (HB-C32-1)*

> *In my whānau I am really close to my brother and sister. My mother, well that is another long story. (T-C10-1)*

5.6. Assessing client/whānau needs and managing risk

Multi-disciplinary team (MDT) meetings were a key part of the PPS model. In the MDT meetings, the different perspectives of team members provided a breadth of views that contributed to client interventions and to risk assessments. PPS policies

required every client to be reviewed in an MDT at least every three months. However, the frequency of client review was linked to client need and could be daily.

> *…MDTs, I think, are really important for ensuring that we have that fidelity in our practice, and that we have to be quite robust, and that we have to be robust enough to be challenged and think about things a different way, because we don't have all the answers. (HB-Psychologist-2018)*

In Tairāwhiti, the team met every Friday for wawata. Wawata were hui to discuss the work Mataora did in ūe, within the wider group. Mataora highlighted that in a clinical DHB context, wawata would be called an MDT meeting. However, the language was very different, as wawata means aspirations and wawata discussion focussed on safety rather than risk. One Mataora described wawata as MDT meetings *with a twist*.

> *We want to know their pepehā. Not, "This is [mother] and she is 22." Blah blah blah. That's important too, but where she comes from, her whakapapa, her lineage, that's what we want to know. (T-Kaiārahi-2019)*

> *Her mountain, her connection to her land, to her waters. (T-Mataora-2019)*

Risk assessment was a priority for PPS and included assessing the risks for the mother and the risks to the children. The teams wanted to make clear they had the wellbeing of babies and mothers at the forefront of their practice, but transparency and trust were important to the way they worked with whānau.

> *The qualitative, and so for me, risk needs to be assessed within the context of a good formulation, so having a formalised process around assessing risk in every single case is important, but you can't say, "If this is present, we will report," because the context might be completely different. … And I do think it is really important for us to manage the risk, rather than outsourcing it. (HB-PPS-2018)*

For Te Hiringa Matua, the ōkawa process was also part of risk assessment. The case management system My Outcomes[14] informed the kōrero.

> *[The ōkawa process] It is safety. A risk assessment tool. Making things easier. Much more open and people can talk the hard talk. It has helped us to help whānau - helped them move forward. (T-Kaiārahi-2018)*

Whānau scales and accompanying narratives could be seen by the team on a graph. The graph was the foundation for structured conversations about whānau. Whānau progress is discussed and responses worked through as a team. If whānau were not making progress, response might include considering whether another Mataora might be a better fit for whānau needs.

> *[Mataora] and [Mataora] they did a really good one last week. They had their case and you could see the graphs, and then they talked to it and they talked about the whānau and it matched up with the outcomes and where it was moving to. We've started doing that*

[14] The team use Feedback Informed Treatment which includes an Outcomes Rating Scale (ORS) and a Sessions Rating Scale (SRS)

too, instead of focusing on the risk, and usually the risk comes out anyway in that kōrero... (T-Mataora-2019)

Te Hiringa Matua used records of whānau journeys to inform their support. They used a system called Feedback Informed Treatment (FIT).

The Colour Status give a Mataora from just glance to remind oneself to stay on track and which whanau need direct attention. (T-Kaiārahi – 2020)

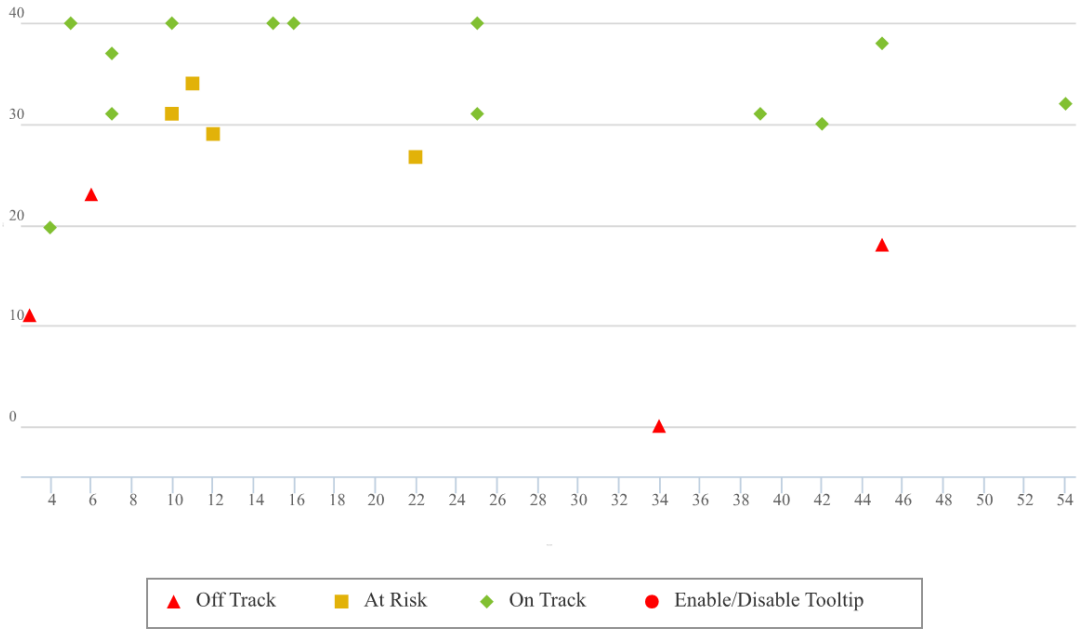


Figure 11. An example of whānau progress mapped using My Outcomes (Source: Te Hiringa Matua)

5.7. PPS support was client centred and moved at the client's pace

Once trust and engagement were established the key workers assessed the clients' needs and developed goals and strategies with the clients. Client/whānau needs varied. PPS support moved at the client's pace and progressing goal by goal. A frequent comment from clients was that they were not pushed to do things they were not ready to do.

When you come in here and sit down with them, they ask you what your goals are. Then they make pathways to help you reach them. (T-C11-1)

We write down goals and stuff like that, and it's like, little steps, but it's been working for me. (HB-C13-1)

The space was comfortable. [they said] 'help there if you want to take it'. I felt like 'thank you'. (N-C28-1)

Providing PPS support through Mātauranga Māori

The main engagement for whānau with Te Hiringa Matua was wānanga, held every Tuesday in Gisborne, and on other days up the coast. Wānanga brought whānau together to share Mātauranga Māori, connection, activities and awhi. Whānau were invited to wānanga when they are referred to the service and participating in wānanga enabled a triage process where Mataora could start having honest conversations with whānau.

> *The wānanga draws out the kōrero, and then you can feel when a whānau is in distress but they are trying to hide it, you can feel it. We are able to pick up on certain little cues from all of our experiences. And it's about being honest and upfront and actually talking about those things with the whānau. (T-Mataora-2018)*

Wānanga provided the opportunity for whānau to connect with each other and Mataora. Whānau were nurtured and knowledge shared through wānanga. Wānanga content evolved with the service. Mataora described in 2019 how the structure of teaching pūrākau was changing to allow whānau consistency in learning and sharing their knowledge. Linking pūrākau to everyday experiences was also an important aspect of support and healing.

> *They're hungry and thirsty for something, but they don't know what it is. We teach them their pepehā. They're like, "Far, I didn't even know I was from there. I'm related to all these famous weavers! I've always wanted to weave. I just didn't know how to get it, or I didn't know how to do it, and my great-grandmother, she made all these whāriki for my whare! I didn't know that." (T-Mataora-2019)*

As whānau began to gain knowledge at wānanga they shared it with others.

> *Yeah, and they take ownership of this space, so when new people are coming in, not only us are telling them about the tikanga, but also the whānau that are already here. (T-Mataora-2019)*

5.8. Clients and whānau set goals to work towards

Client and whānau descriptions of their goals

Children were at the centre for many:

> *To get kids back, and to look after them the way my Aunty and Uncle do. They have the kids at the moment and they are doing an awesome job. I want to stick with that. (HB-C6-1)*

> *So, we've set a few other goals, around my use of drugs, and having my kids in my life, working towards a healthy relationship with my partner. Then if that's not in my future then having a relationship where we can still be there for all our kids. (HB-C25-1)*

> *My goals are to become a better father, … to become a father that everyone wants. I want to own my own house before I pass. (HB-C35-1)*

Another goal I worked on with my social worker was to get her support in moving on to unsupervised visits with my son, so I'm now there. (N-C28-2)

Goals for children were linked with improving mental health:

He helped me to set goals. When I was in that space I couldn't think. Everything was going around in my head and I couldn't see that there were steps I could take and they were easy. My goal is to get through my depression. (T-C30-1)

Improving living conditions, employment and training:

Just getting my licence, my CV done. (N-C23-1)

I'm on my way to getting my restricted [driver licence] (T-C10-2)

Get my kids back, that's my main goal. Getting my kids back and getting a place to stay, a house, she helped me out with that, we went to do, to sign up for some emergency housing and I already signed up with social housing way back. (N-C4-1)

Becoming a peer supporter:

I want to help other women now. I have made just leaps and bounds ... It's been really, really good. The fact that I'm at refuge at the moment just proves that, that was scary in itself. (N-C9-1)

What I'm hoping to do when I have good sobriety time I'm going to study social sciences and I want to do my te reo and I want to work in the community and give back to crackhead mums and prostitutes and homeless and I want to be able to help as well. (HB-C47-1)

Te Ara Manapou and He Tupua Waiora recorded client engagement with their goals approximately three-monthly. Waitematā had suggested that as clients progressed they became more engaged in setting and achieving goals. The figures below illustrate Te Ara Manapou and He Tupua Waiora clients' progress towards achieving goals from the first assessment to the latest recorded assessment for active clients and those who had exited PPS for (Figure 12). Clients who left PPS as 'treatment complete' had progressed further towards achieving their goals than clients who left for other reasons. A similar pattern was seen for client/whānau engagement with goal setting.

Te Hiringa Matua whānau described how they identified with pūrākau and how different pūrākau helped them manage their challenges and progress towards their goals.

I have a book to share the pūrākau with my whānau. With my partner it was good to share the story of Niwareka, the domestic violence one … I love hearing stories from our own ancestors. They have helped me to find out who I am. (T-C31-1)

It's funny as, because we'll learn a pūrākau, and then we'll go home and everyday things just happen, like what we had learn about. Like Ruaumoko being angry and shaking and things like that, and then Tangaroa washing away that burning feeling. Things like that. (T-C10-2)

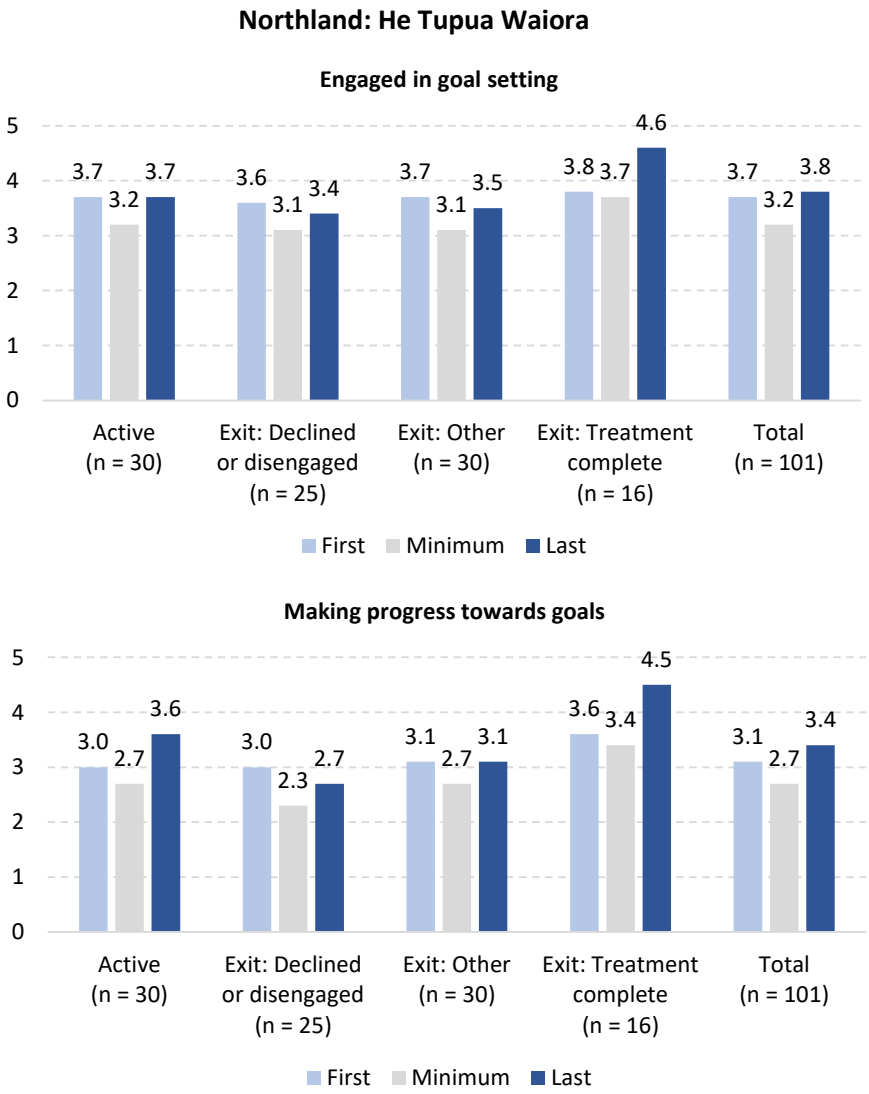


Figure 12. He Tupua Waiora clients' mean scores (where 1 is worst and 5 is best) for engagement with goal setting and making progress (Source: New data collected by PPS teams)

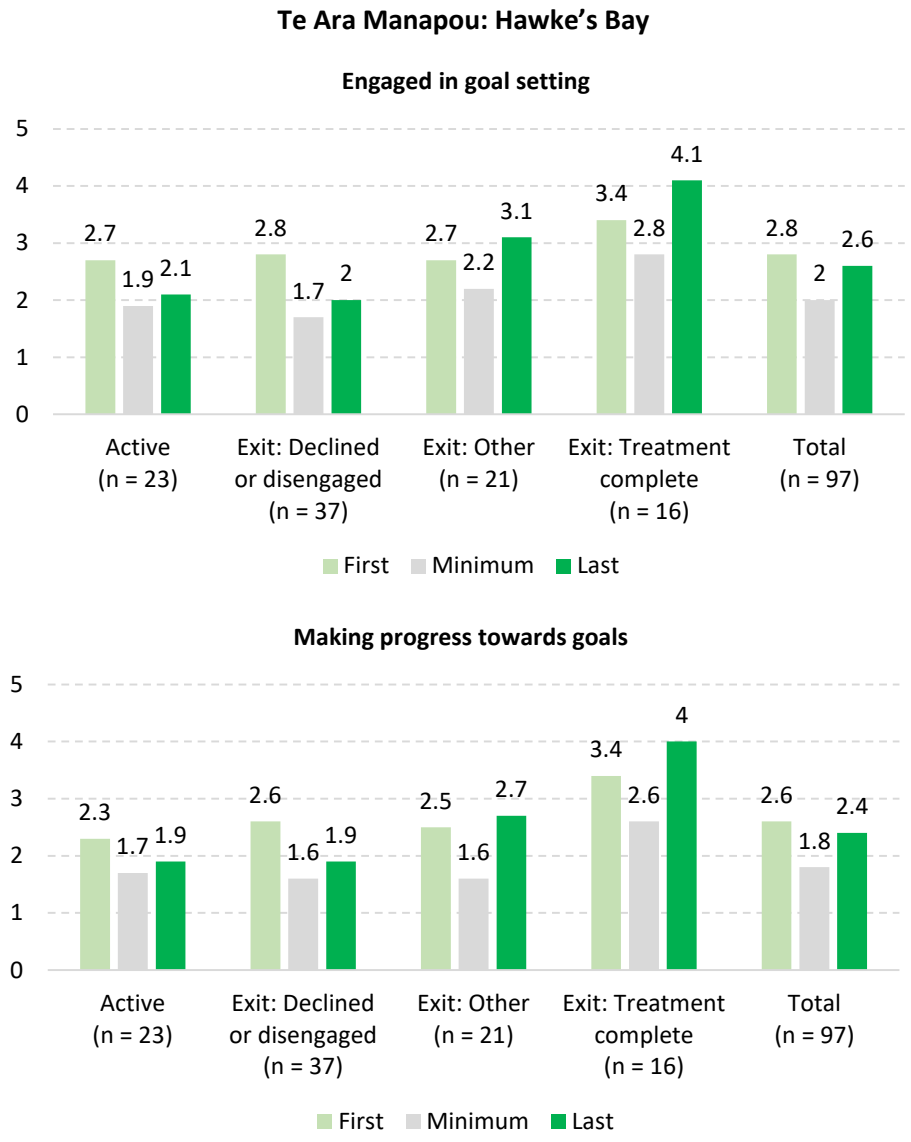


Figure 13. Te Ara Manapou clients' mean scores (where 1 is worst and 5 is best) for engagement with goal setting and making progress (Source: New data collected by PPS teams)

5.9. PPS teams co-ordinated services for clients

Helping clients to engage with other services was an important part of helping them to achieve their goals and work towards independence.

> *With [PPS] there is potential for every domain and issue of need to be addressed so that they are not having multiple contacts with lots of different services. Hopefully, there is one clear pathway and one clear support person. (HB-Stakeholder-2017)*

Social support provided the foundation for either working directly with clients to address issues or to link them with other services they need. Social support included ensuring clients had food and somewhere safe to live.

Sustainability: Taro and kumara provide more than nutrition

Mataora and kaiārahi shared a story with us about sustainability of the tools and knowledge whānau were learning through wānanga. Whānau were able to participate in planting and harvesting healthy kai that would continue to nourish their whānau and wider community in the future.

> *We have a taro that has come off Tākitimu waka, and it has been growing in Aotearoa for 400 years. So it's quite different, the taste and the growth patterns, because they've become acclimatised, so that brings back in the whakapapa to the food. With the kumara, we're bringing that whakapapa back in... Karakia, whakapapa, even for some of our whānau who have never dug the soil… (T-Kaiārahi-2019)*

> *You just saw me bring all those seedlings in. So, we had today set aside which we're going to try do tomorrow, to go and share those seedlings and help the whānau plant those seedlings behind their house. … they've got seven children between them, and no one works. And so in their case he said by planting this taro, he's going to be able to fundraise and make money for his children. And so that was a goal we set with them and with ourselves as an ūe. (T-Mataora-2019)*

Connecting whānau with te ao Māori included infant nutrition. In our last focus group Mataora outlined traditional, sustainable kai that whānau were growing which provided rich nutrients and could replace the cheap foods that whānau could afford from the supermarket.

> *Things like with that whakatō kai and growing kai, … it's re-instating the Mātauranga Māori and it's reinstating food sources. We've got one kumara there that was the kai that our infants ate until they were three years old. They ate nothing else. Just this kumara. And we've got the opportunity to give it to the mums. 'Grow it. Feed your kids it.' Never mind feeding them bread, milk, and sugar, because that's the reality of this place, you know? (T-Kaiārahi-2019)*

The charts below illustrate the breadth of support provided to clients (Figure 14). Work and Income support was required by 81% of Northland clients and 90% of Hawke's Bay clients. These proportions reflected need for benefit support and accommodation assistance but also challenges PPS clients had in engaging with services on their own.

> *I didn't know how to go into WINZ and ask for any of that. She came into WINZ with me, and I think, if I hadn't gone in with her, they wouldn't have even given it to me… She pretty much coached me through everything, and if you're not able to do it yourself, she'll do it on your behalf, so it's made things a lot easier for me because I was in a bit of a state when I first met her. Everything was pretty overwhelming, I suppose. (HB-C20-1)*

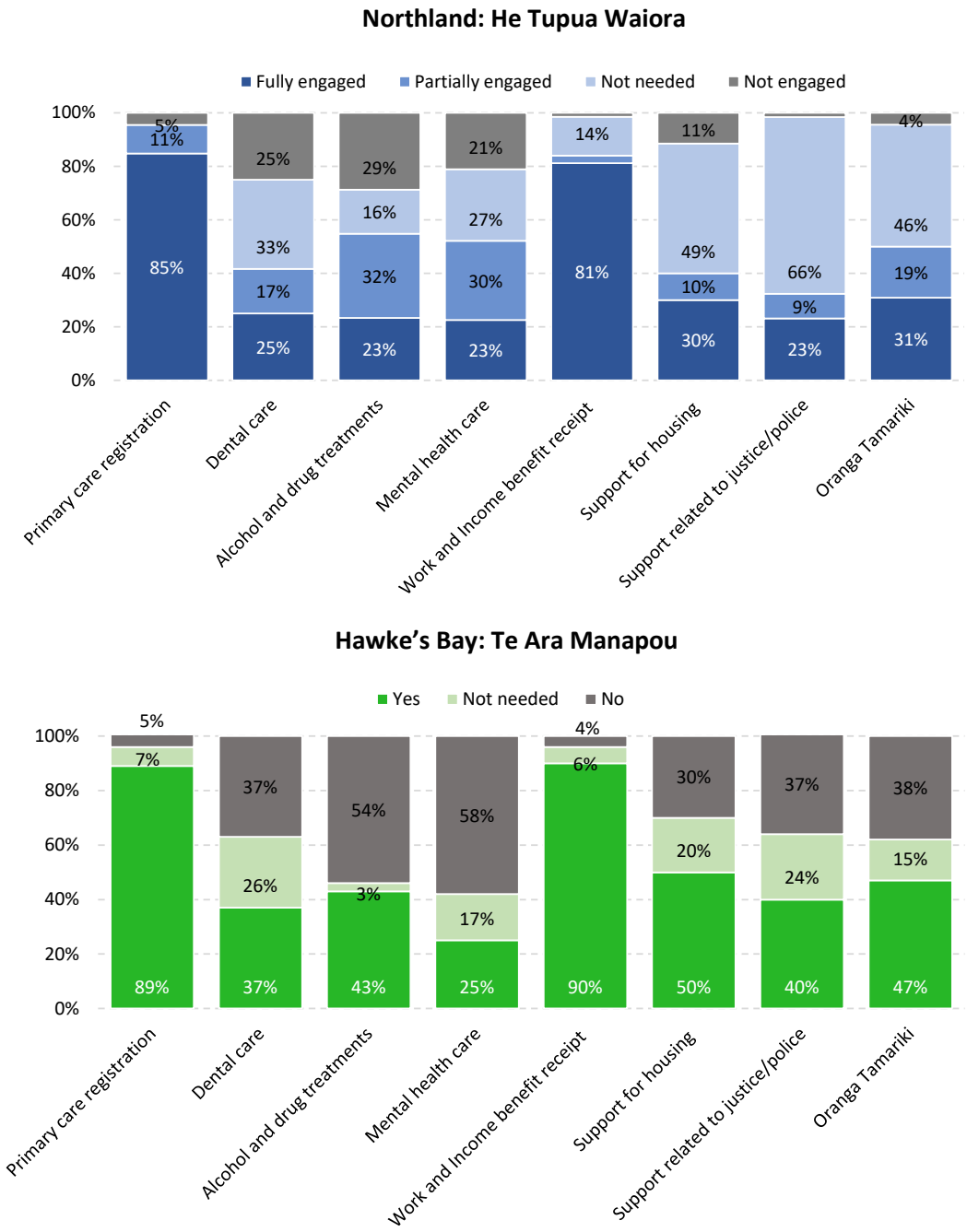


Figure 14. Proportion of all He Tupua Waiora and Te Ara Manapou clients who were engaged with or did not need different services (Source: New data collected by PPS teams)

Support for health-related issues included primary care registration, dental care through to specialist counselling for trauma underlying addictions.

> *Yes. AA. She's come with me to a few meetings when I've been too nervous to go. She's also come with me to a personal doctor's appointment, which involved me having to talk about childhood trauma. She actually came with me to those because she knew it would bring up things from the past. (N-C22-1)*

Clients also needed advocacy and support to engage with Police, Courts and Oranga Tamariki. Some clients were also supported in Police and Justice settings and in Family Courts.

> *CYFS. At the birth of my baby they told me about ten minutes after she was born that CYFS were coming. I was all sleepy and I didn't understand what was happening. I phoned (my Mataora) and she was there within oh five or eight minutes I reckon. She was there and she has watched me from the beginning. (T-C17-1)*
>
> *I've got [PPS] and CYFS said that's great, you've reached out, you're doing something about your problem. (HB- C20-1)*

Some of the teams had access to a flexifund/pūtea they could use if other sources of funding were not available. The main ways Te Ara Manapou had used the flexi-fund were to pay for prescriptions, GP visits and food (if Foodbank was not an option).

> *We have a lady at the moment that we've got to try and advertise for a free double pram or something because she has a pram but one of the wheel is about to fall of her own, and it's her only mode of transport and she has a two year old and a new born baby and the pram isn't even safe. (HB-PPS-2017)*
>
> *Well she supported me through everything, as much as she could. She gave me some baby clothes as well. (N-C3-1)*

Clients' examples of the breadth of support they have received

Helping clients get to appointments:

> *One time I missed my appointment. I think I slept in. I did want to go but I didn't get there. They knew the people and they came with me. (T-C16-1)*
>
> *I didn't have a car at that point in time either, and she said she'd help pick me up and take me to my appointments … otherwise I probably would've gone to them, and she would write down all of the days and times of my appointments, I can't even forget about them because she'll be messaging me or calling me or turning up at my house ... (HB-C20-1)*

Social support and connection:

> *It is helpful when they bring food parcels. And learning about healthy food. (T-C31-1)*
>
> *She has given my kids shoes, brought milk around. Just being there, somebody being there that you feel like you can trust, that actually does care about how you are doing and where you are going, from being isolated to having someone like that, its huge. (N-C2-1)*
>
> *It [wānanga] is the only social thing I do. Otherwise I would just stay at home. Baby loves coming here. (T-C31-1)*
>
> *They helped me get a house… so Housing New Zealand knew that I was with safe people. (T-C10-2)*

Practical support to learn life skills:

> *… We've done painting, crafts, weaving. Gardening, sometimes we will just come in and eat. Also taught us how to make some crafty things for kids like playdough. (HB-C46-1)*

Connection with health services:

She gave me a midwife as well, so I called up a few of them and they were all fully booked, … so she set me up with a midwife. (HB-C20-1)

She would take me there but with my doctors and that, yup she will come in for my doctors, come and sit with me and sometimes I know what to say so I will ask her if she can speak for me. She helped me with everything, she travels me everywhere, come and chat with me in my placements. (N-C4-1)

I am going to other things once I have finished my rehab. She points me in the direction of other services, I didn't need help with accommodation or WINZ but she helped me with the doctor and ACC counselling. (HB-C6-1)

One time in a supervised visit baby had skin peeling off her fingers and I panicked. I didn't know what it was. None of my other kids had eczema or anything like that. I freaked out. But then (Mataora -a nurse) came in and said it is just a fungal infection. You can get cream from the pharmacy to put on that. It is no cost for under 5's. (T-C10-1)

[Mataora] picked us up and took us to the doctors cause baby had sores on her legs. Little things like that I'm real appreciative for. (T-C11-1)

Advocacy:

She took me to my family planning appointment and stuff. Probation, doctors as well. And WINZ appointments. (N-C3-2)

She's helped me with getting a new lawyer. (HB-C39-1)

WINZ and housing. They know how to do that stuff. (T-C16-1)

Referral to specialist services:

We are looking into an AOD counsellor. And possible rehab. We haven't set that up yet but we are working towards something like that. Yeah and my GP, we've made an appointment today, … she was worried about my health with the stress and the sleeping in my car so I'm going to the doctor and there was one other with [provider], that's like a community support worker for people with mental health. (HB-C25-1)

She has just been so helpful, she has helped me get my green card for exercising, to help that physical welling, mental wellbeing. She helped me connect with ACC counsellor and she has helped me meet up with a psychologist, (probably a psychiatrist) she helped me with that, also benefit budgeters and day-cares, she helped me with that also. (N-C2-1)

Addiction services: Rehab was very important to some clients

I felt like I had to yell it out, send me to rehab. But then I started Connections group and that's where I started talking with the other mums, and that's when [keyworker] suggested we have an AOD counsellor. (HB-C47-1)

Part of that was going to rehab and get her away from that space of drugs and alcohol and be able to give her tools to manage outside of rehab. (T-Mataora-2020)

Parenting:

I am connected with a service… They visit me every month and bring educational books and toys. And they take a photo every month too. We can use that in any point in time to show this is what is happening. (N- C1-3)

5.10. Parenting education was very important in improving child outcomes

PPS was a service for clients who were parents or expecting a child. There were different scenarios:

- Children were in the parent(s) custody but Oranga Tamariki were involved and were monitoring risk to the child. Involvement of PPS in supporting the client and whānau provided Oranga Tamariki with a more accurate picture of the risk and protective factors in the child's life. Good communication between Oranga Tamariki and PPS meant both teams were aware of what was happening.

  We listen if they say they are worried – they are with the family more than we are (PPS-stakeholder-Oranga Tamariki-2019)

- Children were in the care of someone else but working to regain the custody of their child. The relationships between the PPS teams and Oranga Tamariki teams led to improved communication between whānau and Oranga Tamariki and supervised visits at PPS.

  The supervision doesn't feel so forced and unnatural [at PPS]. Clients and whānau accept guidance from PPS. (PPS-stakeholder-Oranga Tamariki-2019)

- Clients were pregnant or had a young child in their care but had lost the custody of older children or an older child had died. We heard that these clients were grieving for the children they had lost and that trauma and grief underpinned their addiction. PPS support helped them to grieve for the loss of their children.

  A really good example would be [service] who withdraw their service if the child is removed from the woman's care. And then they come up again in 18 months because they are pregnant again and there has been no input for grieving the loss of the child. And they do what they do best which is having another child. [PPS] is going to be an eye opener for other services about the success you can have if you just stick with that woman. (HB-Stakeholder-2017)

- PPS clients lost custody of their children after engaging with PPS. PPS continued to support clients when children were not in their care but there was hope to the children being returned if the parent made changes. By '*sticking with'* the mother, even if children or babies were uplifted, continuity of care was maintained and women could have support throughout a difficult grieving period. This ongoing contact differed to other services who discharged women after an uplift.

  A lot of the really vulnerable women end up with the children not in their care and then services drop. (HB-Stakeholder-2017)

  If baby is uplifted and the mother then does not meet [PPS] criteria, that is an issue. They link women to another service. Improved child outcomes require a positive

relationship with mother. From a te ao Māori view, this doesn't fit. Mother's wellness is still important, and mother should get services. (HB-PPS-2019)

Parenting support was inherent in the support PPS provided for clients. Parenting education was provided by the PPS through the Circle of Security programme in Northland and Hawke's Bay, either individually or in group settings (Figure 15).

Clients and whānau who participated were very positive about the parenting education including those who already had children. Although some clients had supportive whānau, others had not experienced positive parenting when they were children.

[Parenting class] was excellent and helped me even though I have lots of children. I learnt that crying means they need something. (HB-C44-1)

Parenting support became very important for clients who regained the custody of their children.

She's got children coming back into her care because she's done so well. But she needs some help and some knowledge around what the issues are going to be for those children and what she is likely to encounter in order to be successful. Otherwise she is going to fall over. (HB-PPS-2019)

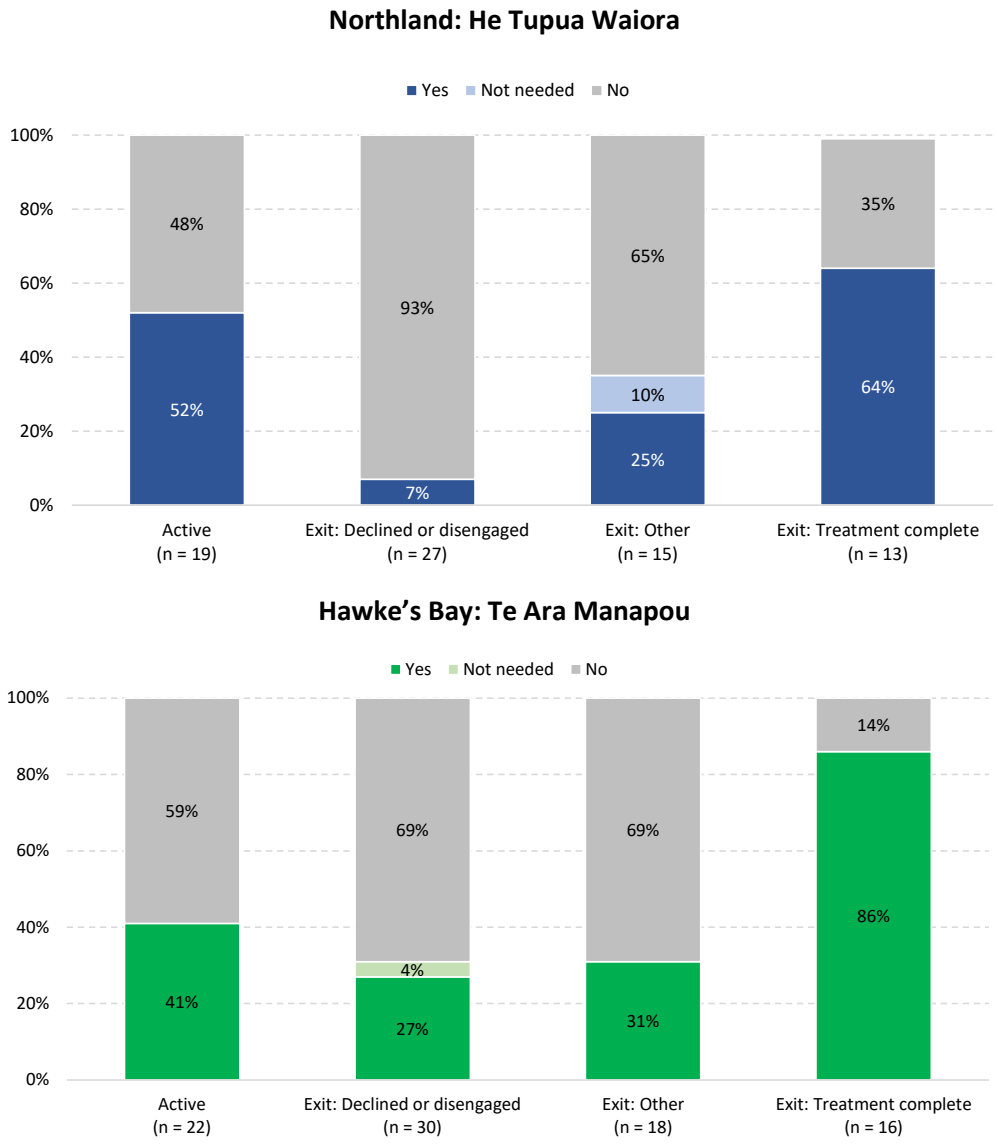
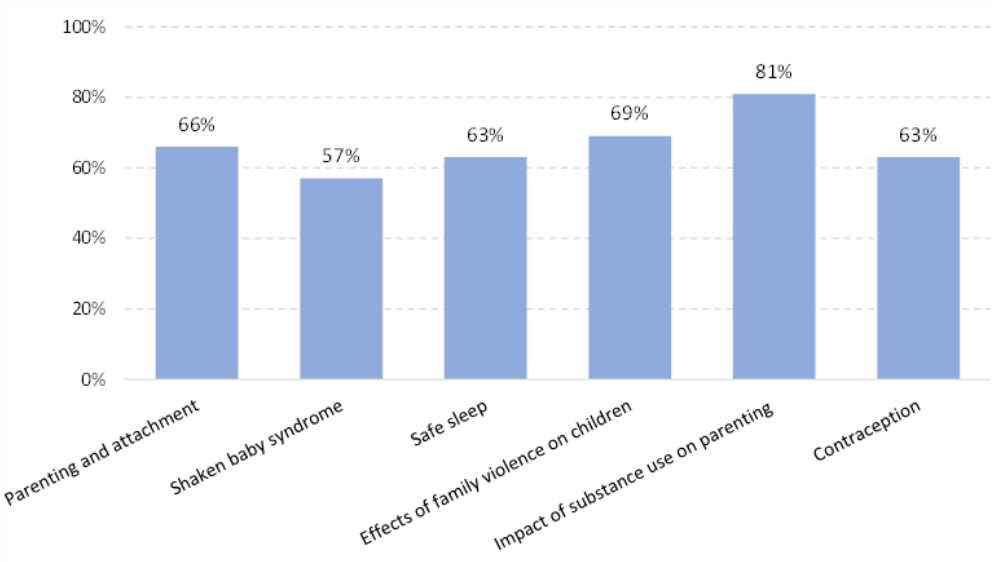


Figure 15. Parenting support provided to all PPS clients (Source: New data collected by PPS teams)

Other support for child safety included education and resources about shaken baby syndrome, safe sleep and education or resources for parents about the effects of family violence and substance use on parenting (Figure 16).

He Tupua Waiora: Northland



Te Ara Manapou: Hawke's Bay

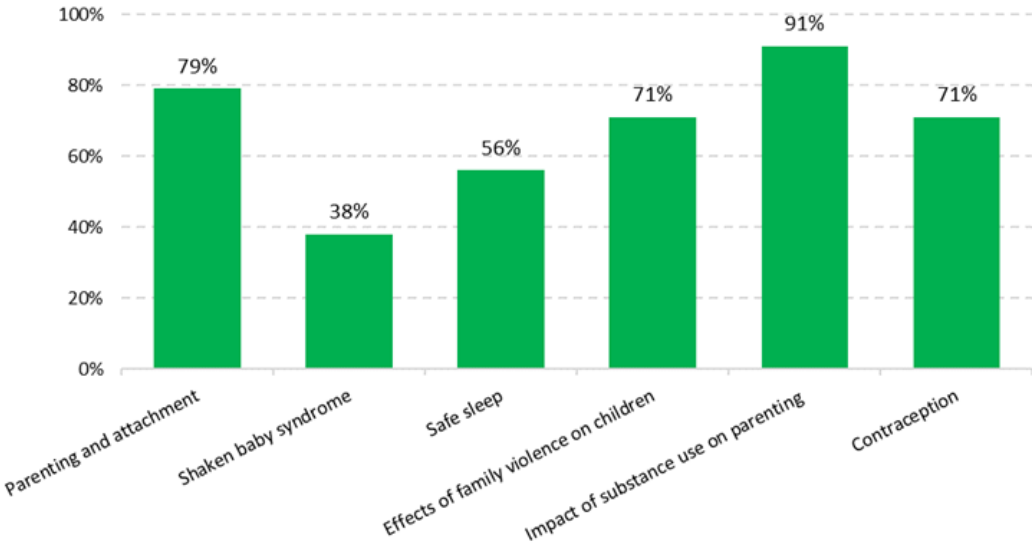


Figure 16. Proportions of He Tupua Waiora and Te Ara Manapou clients where a clinician recorded delivering education on different topics at any time during their engagement with the service (Source: New data)

5.11. Support for clients was long-term and the intensity of support varied

Online resources indicate that recovery is a lifelong process[15]. One source argues that it may not be possible to tell whether someone has achieved stable recovery until five years after achieving remission[16]. PPS teams described the ability to engage with clients for as long as they needed as a strength of the service. The non-linear recovery journey meant that some clients who had been drug or alcohol free for some time could relapse. Where other alcohol and drug services may discharge clients as soon as they became addiction free, the PPS teams continued to provide ongoing support for clients for the other changes they needed to make in their lives.

> *With the relapse, they think that we won't hear about it because we are two hours away. There is a real 'they can't find out' mentality. They get a big shock when we do find out. All the agencies talk to each other. We see the police list. We find out. (T-Mataora-2019)*

> *We're just closing her soon, she's 18 months, there was a couple months of non-engagements, but she came really ready, so it's still taken 18 months for someone who has come in really ready. Best case scenario, working, baby back in her care, clean. (HB-PPS-2020)*

The duration of support chart below describes the length of client engagement with the PPS teams (Figure 17). For some clients, engagement has been for 25+ months. A few clients have been supported by PPS since the start of the service.

[15] Addiction Resource (2016). How long does rehab take for drug and alcohol addiction? Retrieved from https://addictionresource.com/rehab-answers/rehab-duration/

[16] Advisory Council on the Misuse of Drugs (2013). What recovery outcomes does the evidence tell us we can expect? Second report of the Recovery Committee. Retrieved from http://www.williamwhitepapers.com/pr/UK%20ACMD%20Second%20Report%20of%20the%20Recovery%20Committee%202013.pdf

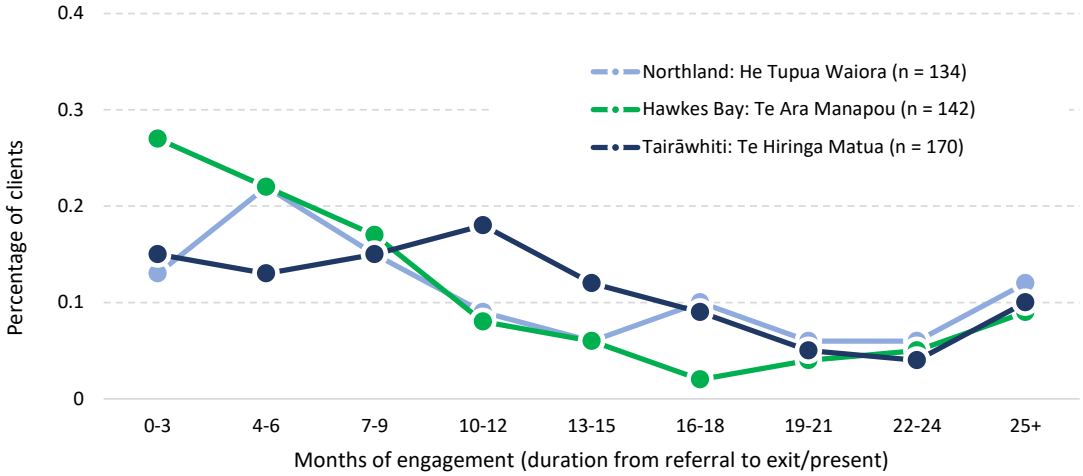


Figure 17. The duration of support with PPS (excludes incomplete referrals and clients with no activities recorded) (Source: PRIMHD)

The number of hours of support recorded also varied by quarter and by PPS site (Figure 18). A proportion of Te Hiringa Matua support was provided in group settings contributing to a higher number of hours per clients and whānau.

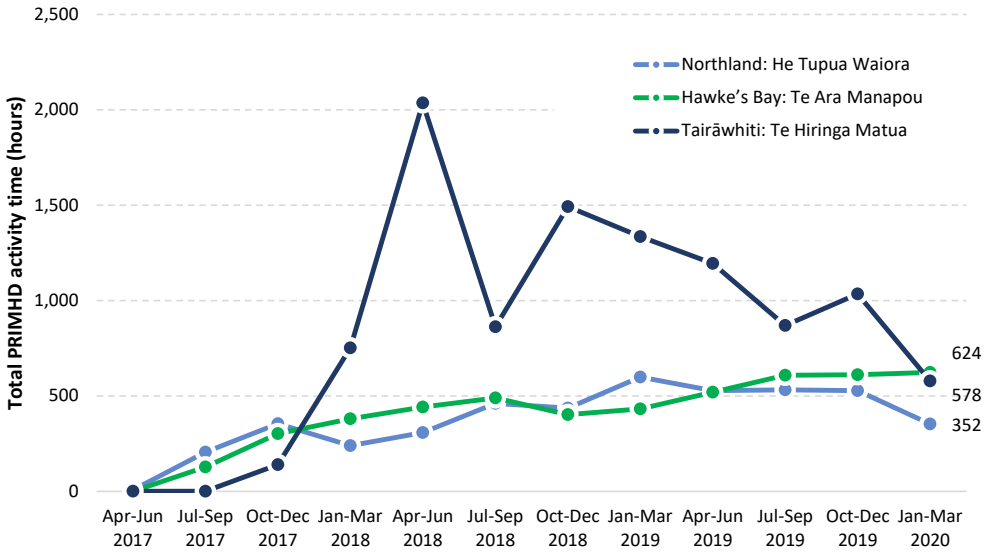


Figure 18. Total hours recorded on client activities per quarter for PPS clients (PRIMHD)

The duration of activities was shortest in the early engagement phase likely reflecting time spent on phone calls and trying to establish engagement. As expected, the longer clients engaged, the greater the duration of activity. The following charts are examples of individual clients selected randomly to demonstrate variation in the intensity of support needed.

> *I was seeing her quite regularly, maybe every other week or so. I think it really just depends on how I'm going. Sometimes I'll be going really well and we won't speak for a while… She checks up on me and sort of gauges how I am at each visit, I suppose. If I'm probably not*

doing as well, she'll message me sooner, but if she thinks that I'm doing fine she'll just send me a text instead, "How are you doing?" or whatever. (HB-C20-1)

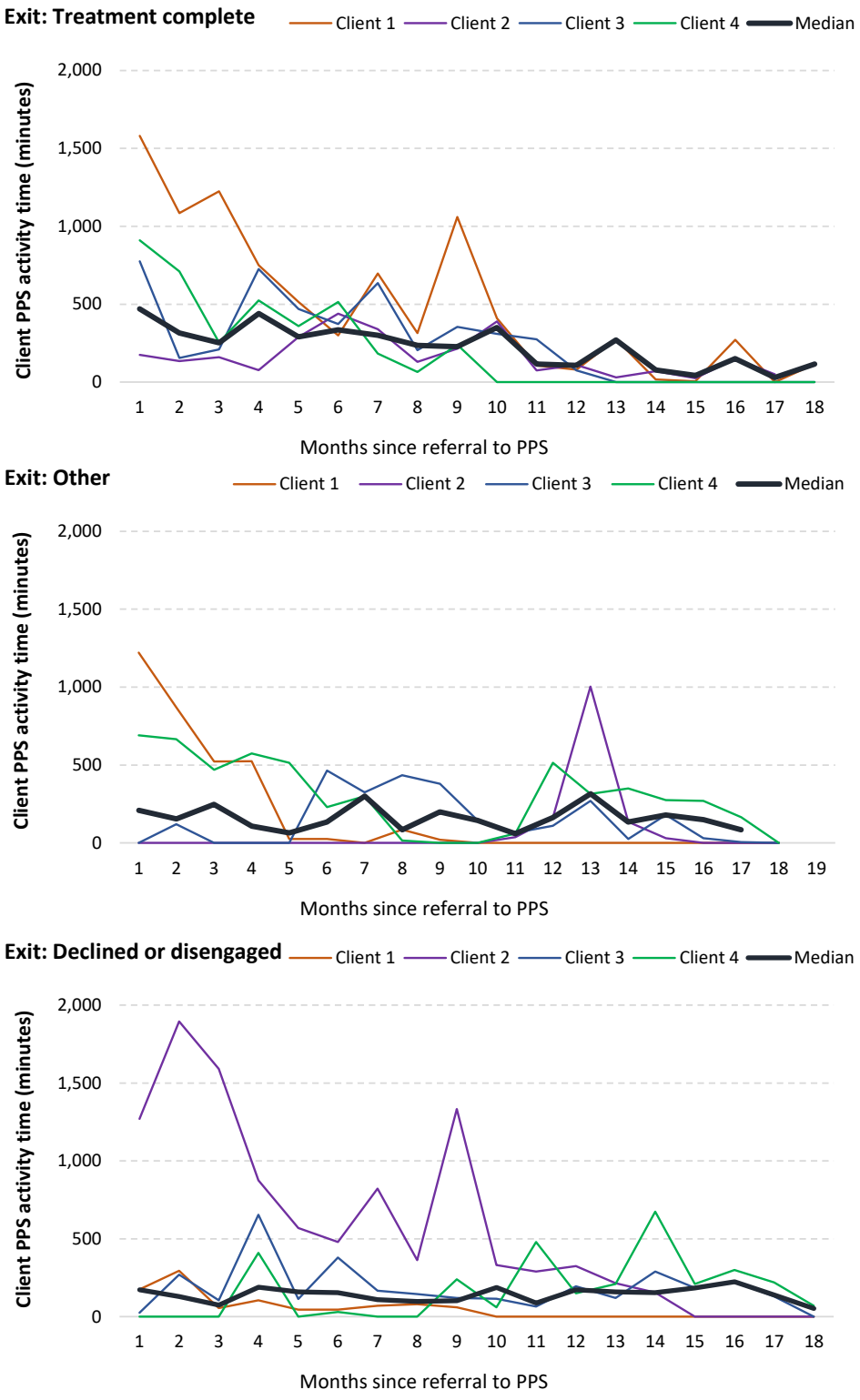


Figure 19. Examples of duration of activities (minutes) by length of client engagement with PPS for clients of different types with the median for those types (Source: PRIMHD and provider feedback)

5.12. Relapse

Relapse ether short or long-term is a recognised step on Prochaska and DiClemente's cycle of change.

> *We need to be realistic about the client base. Even the ones who relapse remember you and remember something. None of our work is a waste of time. That is the resilience you need to have to do this work. (HB-PPS-2019)*

The PPS teams remained supportive of clients who relapsed and did not give up. Their non-judgemental approach helped clients to re-engage. Other strategies included approaches by another key worker.

> *She came around and she was really comforting and non-judgemental, she just made me feel comfy. She's really lovely… I talk to her about everything, every time we slip up, and she has not judged me for it, frowned at me. All she's said is how can I help you for next time. She's had really good suggestions for me too and given me ideas. I tell her all the time she's an angel on earth, the service is amazing, I cry to her out of gratitude. She walked into my life at such the right time. (HB-C44-1)*

Long-term support and relapse: Emma's* story (*real name not used)

Emma experienced substance abuse issues. When her youngest child was born, Oranga Tamariki got involved in her case and removed her children from her custody. This prompted Emma to step back and re-evaluate the priorities in her life, and she decided to make some big changes.

> *I guess I never wanted help at the start of the year. I actually didn't want the help, but because I lost my custody battle, it made me step back and think about what I truly wanted.*

Emma found it easy to engage with the service and her key worker. She said she felt valued and respected by her key worker and had gained complete trust in her. It helped that her key worker was Māori like Emma. She felt she could trust her key worker more to understand who she was as a person and to meet her cultural needs. This was important for Emma, who said she had experienced a lack of trust in other services before, which had made her reluctant to reach out for help.

> *I think trust is the biggest issue… when I first came here, it took me a bit just actually to meet the standards and everything that comes with the service… It made me feel a bit more closure [that key worker is also Māori]. It's actually finding comfort within the service.*

Support

The biggest support that Emma got from the service was help with her drug and alcohol use. She had suffered from addiction for a long time and no longer wanted to rely on substances to get her through life. The service helped her get into rehab and become sober. Her key worker also helped her attend peer support groups for substance abuse,

which Emma found isolated her less. Emma had been 10 months sober at the time of final contact.

> *Since I'm drug-free I can do a whole lot more with my kids… [key worker] takes me to the alcohol and drug groups at [facility] and it gives me a good perspective, leaving my house, because I'm always isolated in the house.*

Working with her key worker helped improve Emma's self-esteem and her sense of self-worth. They had worked together to set goals for Emma and identified ways to achieve those goals.

> *I've been pretty hard on myself and I don't think, nothing I do is ever good enough, because I've always been told that as a kid. [Key worker] has helped me come to understand a lot of things about myself… She gives me the best advice I need… Being here I've met so many goals that I thought I'd never fulfil.*

Becoming sober helped Emma in many other ways. She reconnected with her family and confided in them more, which helped her fix relationships with close whānau members that had deteriorated. She had also developed a strong support network of friends.

> *[I] just slowly decided to open up to my family too, never really did. My life was more or less private due to the circumstances… it was a long journey that I had to face on my own… [but now I'm] starting to mend my relationship with my daughter and my dad… I have a few solid friends that still come and see me now and again just to check up and ask me how I am and how the kids are.*

One of the most important outcomes for Emma was that she was able to set clear boundaries with people. She no longer wanted to be around drugs and alcohol and made that clear to her whānau and family.

> *I don't smoke, I don't drink, if friends and family come over, don't bring that into my home. I'm trying to put a message across for my family and friends so they can respect me for who I am.*

When we tried to contact Emma to ask her to review her case study we found that she had relapsed and had disengaged from PPS. However, the PPS team were confident she would reengage at a later date and that the progress she had made would enable her to make further changes.

5.13. Exits

Exits from PPS reflected the complexity of client journeys. The higher proportion of clients who left Te Hiringa Matua having completed treatment may reflect the higher proportion of self-referrals and whānau referrals suggesting increased readiness to change.

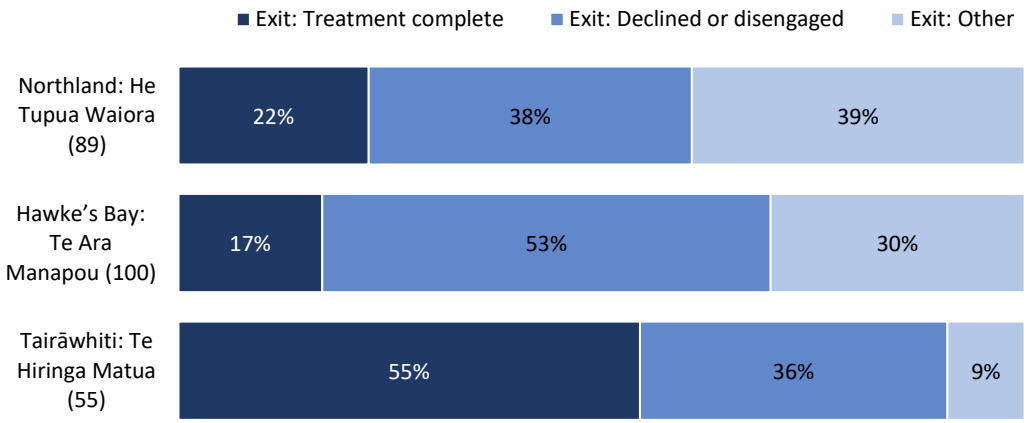


Figure 20. The proportion of clients exiting PPS for different reasons (Source: New data collected by the PPS teams)

Te Hiringa Matua do not use the terms 'exit' or 'discharge'. Whakawātea is a celebration when whānau are ready to leave the service.

> *A good end point varies. There is a remarkable improvement in some people. Some learn to manage their habit rather than kicking it (HB-stakeholder-2020)*

> *I think successes for our clients is measures differently than other people's because in an addiction service, a lot of people look at success as abstinence. And I think that it's people getting their kids to school when they haven't before, and people going to the doctors. (HB-PPS-2019)*

> *Normally they decide themselves…the whakawātea process comes in as they are ready to go. (T-Kaiārahi-2019)*

Once a client had relapsed the PPS team needed to complete a final risk assessment. When there were concerns that disengaged mums had children in their care and exposed to risk, PPS contacted the referrer and lodged a report of concern to Oranga Tamariki.

> *If there are concerns, Oranga Tamariki. You let them know that they've disengaged, as well as the referrer... If you do have concerns where they do disengage and do have their kids in their care, we let the appropriate services know and maybe do a report of concern. (N-PPS-2019)*

Client exit profiles

Clients are addiction-free and no longer need PPS support (treatment complete):

PPS teams described awareness by themselves and the client when it was time to leave the service. Clients were confident and able to manage their lives without the support of PPS.

> *When they feel like they no longer need our support, it's probably the right time to close it. When they can't see any value of us being there anymore. (HB-PPS-2019)*

> *And you both come to that conclusion… because you suddenly kind of run out of reasons to meet other than building a connection with each other. And saying goodbye is never easy. Just being discharged, she knows where I am and she can tell me about things in her life. and that's fine. (N-PPS-2019)*

> *You've got those clients that aren't in that pre contemplative/ contemplative and they don't shift from there. One of our mums, her mother has the children, our work was done, and the kids were safe and treatment is complete for that time…. (HB-PPS-2020)*

Some clients who are addiction free may not be ready to exit because of other challenges in their lives.

> *It was hard to let her go the first time because she wanted to go, and we weren't really ready for her to go. We thought we were worried about her. She had made huge gains, but we thought there was more that we could do. She wanted to go, so we let her go. Then she came back. (HB-PPS-2018)*

Clients progress and manage their addiction, risks to children have been minimised or removed but PPS may consider that clients are not quite ready to exit:

> *I just wanted to see if things would truck along for myself without the help, but still knowing in the back of my head, that they're still there for me, [key worker] did let me know that I was welcome to still ring them if something went wrong, I just wanted to see how things have progressed. (HB-C13-4)*

> *She [client] had made huge gains, but we thought there was more that we could do. She wanted to go, so we let her go. Then she came back. (HB-PPS-2019)*

Client disengages:

Some clients who disengaged may have been with the PPS teams for considerable time. All the PPS teams went to extensive lengths to try to re-engage with clients before considering them as an exited client. The PPS teams were positive that the clients who disengaged would return, and that had already been the case for a few clients.

> *They have seen what they can achieve and how it feels. (HB-PPS-2019)*

> *She came back herself. She rang me and wanted help again. (HB-PPS-2019)*

> *I lost touch with this place about April, I guess. And then I came back about June. … But I've still been clean since, going on four months. (HB-C32-1)*

Clients leave for a variety of other reasons:

Moving away: The PPS client group are quite mobile and clients who had engaged moved away from the service locations. In a few cases clients moved to another PPS.

Incarceration: For a few clients, exiting for other reasons can include going to prison suggesting the potential benefits of discussion with Corrections about ongoing support related to the clients underlying trauma and addiction.

Death: A few clients have died through injury (car accidents) or overdose.

Clients become ineligible for PPS:

Clients may have their children permanently uplifted. PPS tried to support clients after children were uplifted, but sometimes the women disengaged.

5.14. Support after exit from PPS

It can be hard for the PPS teams to let people go after supporting them for many months and all teams offered ongoing support to clients and whānau who had left the service and needed it.

> *We closed off a couple weeks ago…There will still be a chance where I can call someone and have a yack with them, I don't think she'll completely shut me out even though we've closed off. I think there is still that opportunity there. (HB-C15-2)*

An aim of PPS was to connect clients to natural supports in their community. However, we heard from PPS staff and clients that they felt out of place in community groups or support groups and felt that people looked down on them.

> *You know when you think of young mums…You go to coffee and you build friendships [but]... you want to meet and talk about motherhood. Not having that educational side of it, this is how you should bring up your kids, shouldn't do this…feeling like you're being looked at. A lot of mums and dads up here feel very suspicious, it's not about support it's about you want to keep an eye on them. (N-PPS-2019)*

> *They don't feel comfortable going to peer support groups and things while they're pregnant, saying that they're using substances, because they feel judged. (HB-PPS-2018)*

> *I used to do a Plunket group but I dropped it to come to this, not because I wasn't getting on, but because it was very full there were 20 mums and they were lovely people don't get me wrong, but they were not in the same place in their lives as I am. (HB-C21-1)*

The PPS groups filled the gap of community supports.

> *When they turn up to wānanga they make new networks and friends. They start to look at opportunities together - why don't' we look at this mum's group, or this school. (T-Mataora-2019)*

In Tairāwhiti, the door was always open for whānau to continue attending wānanga or stay in touch with Mataora and Te Hiringa Matua whānau.

There is no closed door, the only time there would be a closed door is when there is a breach of confidentiality or conflict of interest but we have a really broad look on that side of things. It has to be really bad for us turn away a māmā. (T-Kaiārahi-2020)

Once you become part of a whānau like ours it really is a lifetime experience. (T-Kaiārahi 2020)

Teams all developed approaches to bring clients together so they could share experiences learn from each other and have social engagement. Te Ara Manapou had a Connections group that provides ongoing contact. The group was also attended by current clients.

It's great excuse to get out of the house and it's kid friendly, so he's going to run around and he's not going to get into mischief, but also it's nice for a change to just be yourself. Not that I can't do that and the playcentre we go to, but everyone else at the coffee group is there for similar reasons, you talk about what you're going through and know that there is no judgement and just really cool. (HB-C21-2)

I have met a lot of people who have been through the same things as me and we are doing really well. We can see how much has changed. We are sticking together and staying away from all the druggies and alcohol friends that we made. Just keeping in our own little circle. (N-C48-1)

Being able to hear it from other parents that have children that are way older than my children because I've got two now, just hearing it from other parents. Through the groups here and meeting new mums that are on their first child or expecting their first. (HB-C43-1)

Te Ara Manapou were entering a partnership with a local marae to provide ongoing support for their Māori clients.

What I noticed when we created that space [marae partnership] is that women came along and connected in there in a very different way to connecting with a service and we need to create more spaces for that. (HB-PPS-2020)

He Tupua Waiora held coffee groups but when a key staff member left these stopped.

Yeah and plus I was new to Whangarei so I got told they help with women's groups, coffee groups and all that and you get to meet new people so I thought that would be a good idea too. It was actually quite cool, I met to other women there and we did Christmas cards for our kids. And it actually quite cool, meeting new faces and becoming friends with women that are women. (N-C4-1)

6. Client and whānau profiles aligned with the intention of PPS

Key messages:

The numbers of PPS clients increased each year as the services became established and awareness of PPS and the whānau they could support increased amongst communities and local services. After the first quarter the average number of referrals per quarter has been 11.7 for He Tupua Waiora, 12.9 for Te Ara Manapou and 15.5 for Te Hiringa Matua. As referral numbers were relatively constant, increases in the numbers of clients for each year were primarily driven by the duration of support provided to clients and whānau which often exceeded one year.

The average age of clients ranged from 26 for Te Hiringa Matua to 28 for Te Ara Manapou. Approximately one-quarter of Te Hiringa Matua clients were younger than 20. At all three PPS, most clients (87%) were female but increasingly men and other whānau were being reached.

Māori were over-represented amongst PPS clients (81% of clients were Māori) highlighting that supporting whānau Māori was a priority, as was evaluating how well whānau Māori were supported by PPS.

6.1. The numbers of referrals have been relatively constant after the first quarter

First to open was He Tupua Waiora. The 'slow start' worked for introducing the new services. It enabled the teams to develop and embed processes like the MDT meetings and risk assessments. A potential risk of acceptance of clients with lower acuity in the early months of the services was not realised.

After the first quarter the average number of referrals per quarter has been 11.7 for He Tupua Waiora, 12.9 for Te Ara Manapou and 15.5 for Te Hiringa Matua[17] (Figure 21). Fluctuations in referrals per quarter reflect fluctuations in demand but also timing of data entry into PRIMHD and periods when there were staff shortages.

[17] The averages exclude incomplete referrals that may be entered in PRIMHD but were later found to be not eligible or included insufficient information to assess eligibility and were not able to be contacted.

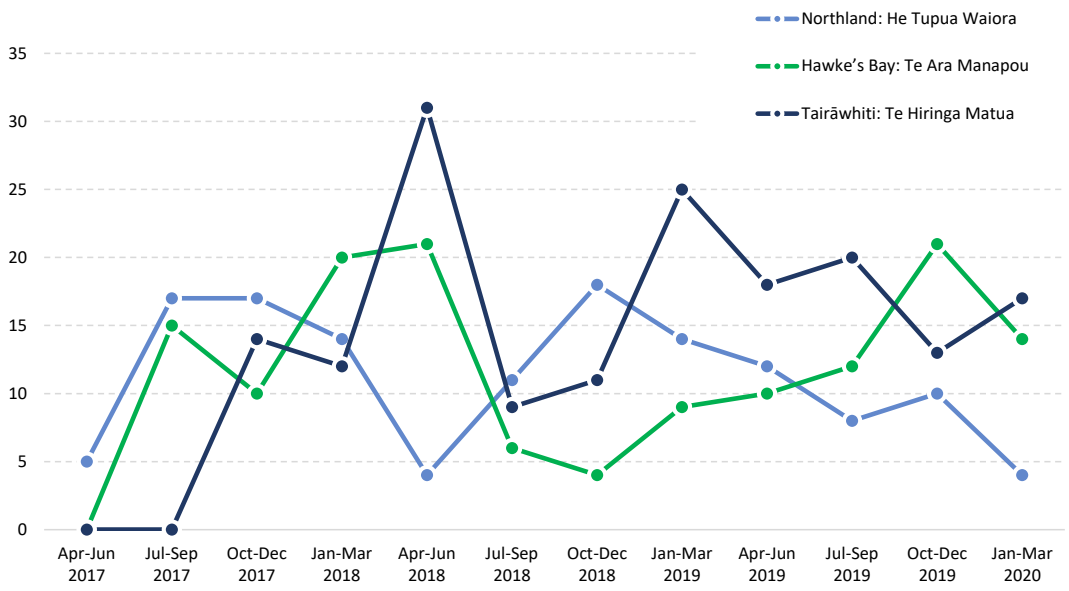


Figure 21. The number of new referrals per quarter (Source: PRIMHD)

6.2. There were multiple entry points to PPS

As for any new service, the PPS providers needed to promote the service and the service model to their communities and to organisations that might refer clients. PPS built awareness by meeting with local organisations and explaining their services.

> *There is a lot of passion and willingness. I'm hearing people have been crying out for this type of service to be available. The risk is we don't disappoint... It's that relationship building and having key people inside those organisations that are passionate and willing to engage. (HB-PPS-2017)*

> *We are a new service and a lot of it is them having the trust in us as well. Being a new service can they trust us? (N-PPS-2017)*

He Tupua Waiora and Te Ara Manapou had established links with their DHB services and in the first months after the service started these were the main source of referrals (Figure 22). Te Hiringa Matua were based in one of Gisborne's main streets and most of their referrals were self or whānau referrals. It has taken them longer to build awareness of what they offer amongst local providers.

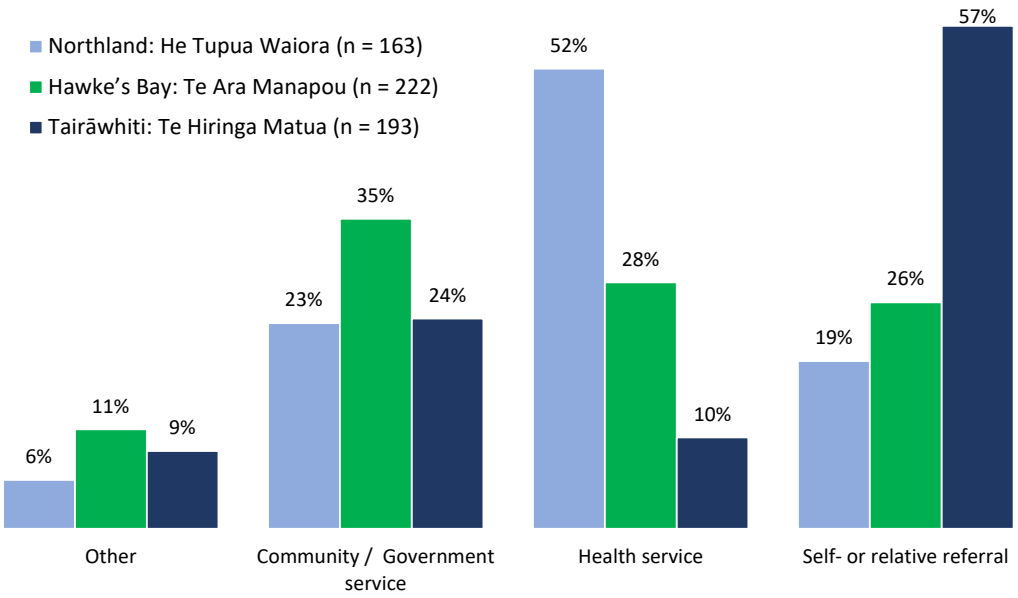


Figure 22. The main sources of referral for clients (Source: PRIMHD). Note: Referral source data are coded by DHBs according to a standard list. It is not possible to re-code the 'other' category)

The PRIMHD coding system does not capture the breadth of community organisations who referred clients to PPS including Women's Refuge, Plunket, NGO providers such as youth services, lawyers and government agencies including Police and Oranga Tamariki. These agencies and organisations often referred to PPS because they understood the need for the intensive outreach and long-term support and there were few other options for the clients PPS aimed to reach.

> *…You are almost hoping for disclosure of that drug seeking behaviour so we can refer to the service. It is something that is really lacking. You are almost wishing that they will admit to using so that you can get them in. because you just know that with that level of input they will thrive. (HB-PPS-2017)*

> *The values of service sit well with maternal wellbeing. Care. Care for the client that comes across their desk. Irrespective of their issues they are still a vulnerable woman and a person that needs support and care to remain on the better track. And the belief that mistakes don't define them. (HB-Stakeholder-2017)*

The teams also spent time on incomplete referrals and finding alternative support for people referred who did not engage or who did not meet the PPS criteria. People were not turned away without other support being provided. Clients who declined or disengaged were also often supported for considerable lengths of time (Figure 23).

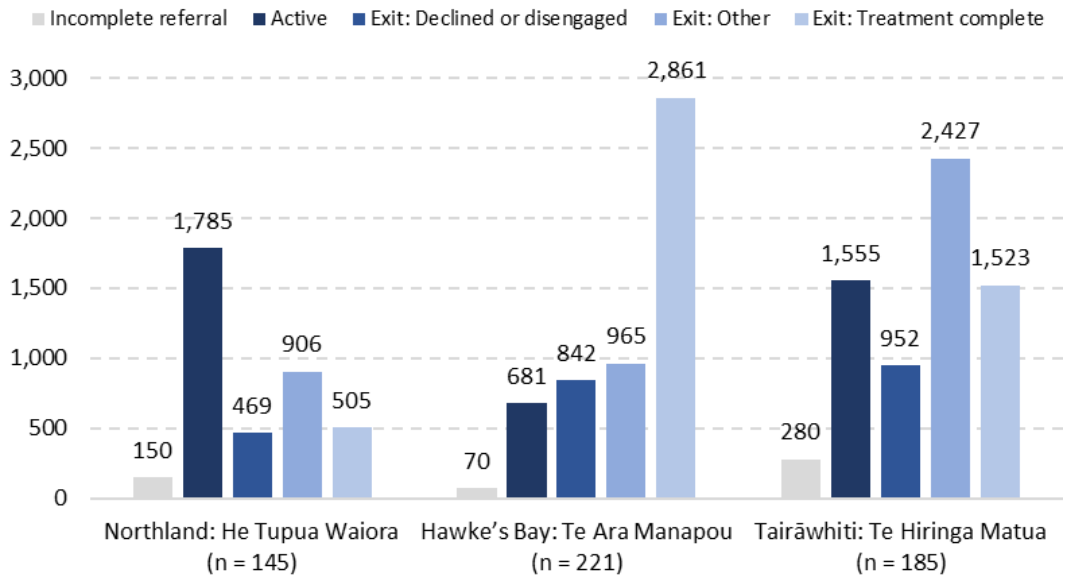


Figure 23. The hours spent supporting clients of different types (Source: PRIMHD. Note, incomplete referrals with no activities recorded are excluded from the n-values)

As the PPS became more established, community awareness increased and clients heard about it from friends and self-referred or were referred by whānau. Te Hiringa Matua has had a higher proportion of self-referred or whānau referred clients. As awareness of their service has increased the proportion of referrals from community services and agencies is increasing (Figure 24). All PPS were part of local cross-agency meetings where complex whānau and potential ways to support them were discussed. Being part of these meetings maintained awareness of PPS and local networks.

> *A friend of mine works for the hospital, and she found about the service when it started and referred me on. I'm so grateful that she did because I was slipping through the cracks of the other services because I had a long history. (HB-C21-1)*

> *My dad told me about Te Hiringa Matua. I was having lots of problems with my partner and pregnant with my baby. The police kept getting called and my mum called my dad. He came and talked to my aunty. Her friend is a is a nurse and she had had people ask about the programme. She said call Te Hiringa Matua. (T-C31-1)*

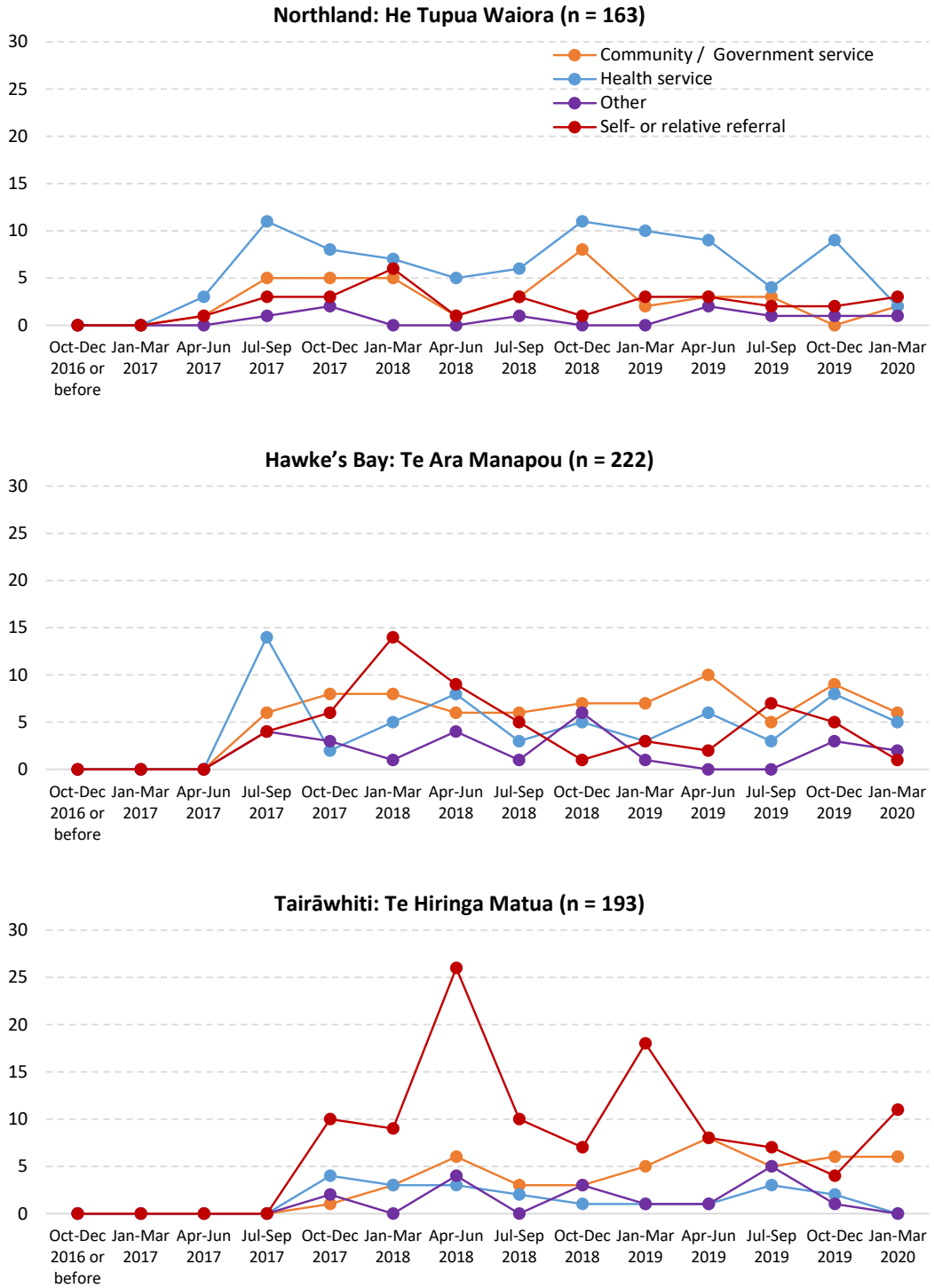


Figure 24. Number of referrals received from different sources in each quarter (Source: PRIMHD data for all referrals)

6.3. Most clients were female, young and Māori were the largest ethnic group

Most clients (87%) were female although there was some variation between sites: Northland 96% female, Tairāwhiti 82% and Hawke's Bay 87%.

The average age of clients ranged from 26 in Tairāwhiti to 28 in Hawke's Bay (Figure 25). Approximately one-quarter of Tairāwhiti clients were younger than 20.

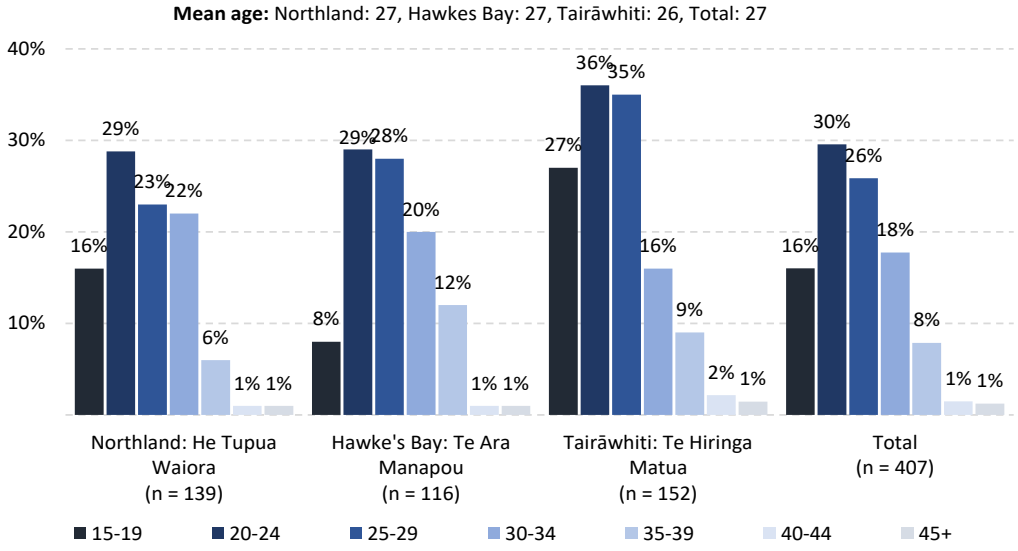


Figure 25. The age distribution of PPS whānau (Source: PRIMHD. Note: One Hawke's Bay client had no age recorded)

Māori made up the largest group of clients at all sites, but particularly in Tairāwhiti where 95% of whānau were Māori (Figure 26). The over-representation of Māori amongst PPS clients highlights the importance of effective engagement with Māori.

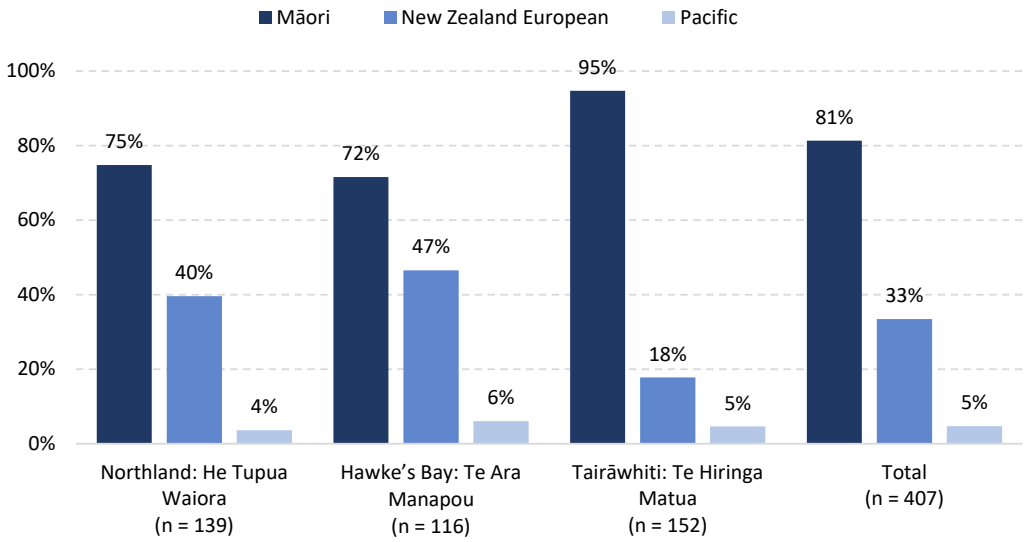


Figure 26. Ethnic groups the PPS clients identified (PRIMHD). Note: Ethnicity percentages may exceed 100% as people were counted in each ethnic group they identified.

Typical client/ whānau profiles included histories of disadvantage, poor parenting, state care, trauma contributing to addiction, pregnancy at a young age, exposure to family violence and disengagement from whānau.

> *The client base is very different from maternal mental health. The clients there have minor issues compared with what we are dealing with (HB-PPS-2020)*

Clients and whānau were disengaged from other services often because of the way other services treated them and systemic issues that made it difficult for them to engage with services. For example:

- Did not attend (DNA) criteria. Clients had complicated lives and lack of transport, changes of address, no money on cell phones meant that they were unable to attend appointments or to advise they were not available.

  Because the AOD service works very differently from PPS. So you can refer to them but the clients have to show up for their appointments. So if they DNA three times it's just a closed case discharge ... (N-PPS-2020)

- Lack of respect:

  … there's a huge judgment, and our clients have got anxiety just walking into the building because of how they're going to get treated, and the fact that with the WINZ offices here, you're not allowed in the building unless you've got an appointment, and you need to show photo ID, and then you've still got to stand in a line for half an hour to 45 minutes before you can even take a seat and then sit there for another four hours. (HB-PPS-2018)

- Lack of fit with the service:

  She's been using for 12 years and she has been abstinent for three months. But she's seen her AOD worker four times and the AOD worker thinks she is stable. But this is a woman who has had 12 years of addiction. There is no way she is stable. … So we are told [by AOD services] that they are too unwell and can't get there or they are too well and don't meet the criteria for the [AOD] service. (HB-PPS-2019)

PPS client/whānau profiles

When I first came here I was hooked on drugs and alcohol. They provided encouragement. They didn't pressure me. Now I have been clean for five months. (T-C17-1)

Getting my kids back was my main goal and for me to do that I had to get off my drugs and alcohol and all that stuff and learn to be not so nasty to people. I think a lot of that was due to the lifestyle I had growing up and the mob with my father and living on the streets and my mother putting me out on the streets when I was 11. Just growing up with all that in my life I just didn't want to change. I thought alcohol was the way to live. (N-C48-1)

We don't speak out and don't ask for help because we don't really know and plus, we feel scared as well. When I was in a domestic violence relationship, I didn't ring the cops ever because I was scared of the repercussions, the CYFS. … I am really open and I really love my kids and it's been so hard, I only get one hour a fortnight with my two babies …. (HB-C47-1)

I was a bit worried how I was going to cope with baby now being here …. And I was relieved when [Name] said they don't leave when baby comes out, cause I thought the services would stop then. Cause I was thinking, "shall I just make up that I'm relapsing so I can still stay here?" 'Cause you know, I'm going to be taking a different path once baby's here. So, I will need that support just to see how I am, not that I want to sabotage myself and make it seem like I'm going to go. (HB-C13-2)

7. The core elements of PPS

Key messages:

All three teams were clear about the core components of the Waitematā model but operationalised it differently to meet the needs of local communities. The core components of PPS were:

- A multi-disciplinary team (MDT): The three PPS developed multi-disciplinary teams that worked closely together. Working together as a team was important in support for clients and risk management as different perspectives provided different insights.
- Effective leadership to form and maintain the teams and support the team members in working with clients. Support in developing their roles as leaders of MDTs was important, especially for team leaders new to leadership roles.
- The team compositions varied between locations with Te Hiringa Matua and Te Ara Manapou including non-clinical team members. All teams emphasised the importance of Māori team members and men. Te Hiringa Matua included male and female staff. A lack of male staff in the other teams was identified as a gap by clients and team members.
- PPS team members committed to their roles. Although the work could be very rewarding it could also be very difficult. Team members needed access to good professional development and supervision to manage the personal challenges of their roles.
- A strengths-based treatment model. The way PPS were delivered was important to clients. Clients consistently described the importance of trust. Once they had engaged with clients, the teams provided holistic and whānau focused support.
- Intensive outreach to engage with clients and whānau in different settings including in their homes. PPS were described by referrers, clients, whānau and the teams as *not giving up.*
- Smaller PPS caseloads that allowed PPS teams to work more effectively with whānau. More time with each client aimed to contribute to sustainable change and avoid the *'churn'* of clients coming in and out of the same services.
- Active risk assessment through MDT meetings for each client/whānau as frequently as needed, but at least three-monthly.
- Long-term support to develop sustainable change. For Te Hiringa Matua, priorities included connecting or re-connecting whānau with te ao Māori.

7.1. Service design was supported by MOH and Waitematā

The first half of year one was focussed on service design and development. Funded development time included in the service agreements was important as it enabled the three sites to hire project managers to manage the design and setting up of the services including consultation within the DHBs and with locality stakeholders such as NGOs. As well as input into the service design, consultation meetings and workshops raised awareness of PPS and how it differed from other services. Governance groups, either new or existing DHB groups provided oversight of the service development.

MOH funded the Waitematā PPS team to support the development of the pilots. The support included workshops about the services, use of Waitematā resources such as job descriptions, descriptions of pathways through the service and internships. The opportunity to learn from Waitematā was valued by the teams in providing a foundation of experience that they could adapt to fit their local service delivery models.

> *They have been generous and that needs to be acknowledged. They have been generous with their experience, they haven't held back in many ways. (HB-PPS-2017)*

> *I think the support they gave through training, the sharing of documentation of the model that they had created, their learnings, the internships, the monthly supervision, those are all things that definitely added value to our experience. It felt like you had a big brother or big sister over there. (T-Project manager-2020)*

There was mixed feedback on the internships. They provided a way for new team members to learn about the PPS model. However, more experienced team members wanted more specific learning objectives and more client contact from the internships. Their suggestions included having a suite of topics to choose from and, later, focussed support with 'difficult' cases. Waitematā responded and built in client contact to later internships.

> *Training has been a learning curve. We are used to having students in an observational setting. We have now figured out how to do it and taken on board that they are not students. (Waitematā)*

Waitematā and MOH facilitated six-monthly workshops as opportunities for teams to share experiences, provide updates and for Waitematā to present on specific topics including client case studies. Workshops were mainly attended by team leaders and occasionally one other team member. Waitematā also offered monthly teleconference discussion sessions for the team leaders and site visits to provide feedback on local processes.

As the PPS teams became established, they found Waitematā mentorship less useful and increasingly valued their own knowledge and experiences developed in their locality contexts. For example, risk thresholds might differ in a smaller locality where the NGOs were all aware of a whānau and jointly monitoring risk. In interviews, team

leaders and team members requested opportunities for wider groups to get together to share and learn but funding was not available.

We have all these systems and processes from Auckland that have been transported up here. We have shaped and shifted them to try and fit with our team. Trying to make sense of all these systems and processes and make them work the Northland way. (N-PPS-2017)

7.2. PPS teams were committed to their roles

The PPS team members were committed to their work and had different reasons for wanting to be part of the PPS.

- **The need in their communities**

  There is a need... I have seen it personally and I have seen it in my role as a … social worker. (N-PPS-2017)

- **The advantages of early intervention** in improving outcomes for children and creating intergenerational change.

  Co-ordinating everyone into appropriate care and trying to make a generational difference I suppose. A generation that will help more generations to come. I guess that is our ultimate goal. (N-PPS-2017)

- **Belief in the service model.** The team members' past experiences in working with whānau in the target group contributed to their belief in the potential of the service model to make a difference.

  I believe your outcomes are better when you take that bigger picture, Holistic, is your ability to form a rapport with your client is going to be a whole lot different 'cause they are actually interested in [the client] as a whole. Not what drugs I've done. (HB-PPS-2017)

  Having a relatively smaller caseload, more manageable. Gives us time to meet them where they are at. More time to build a relationship and I think that will be the difference that will produce some good outcomes. (N-PPS-2017)

  The great thing is not discharging after a certain number of DNAs – having the freedom to not discharge because they are not engaging. (N-PPS-2017)

- **The potential to effectively engage with Māori and Pacific clients.** By doing things differently the teams hoped to support mothers to access appropriate services and gain skills so the next generation would be better positioned for their futures.

  I think also too acknowledging that the majority of our clients are Māori so a strong bicultural focus in our practice. Acknowledging the systemic injustices and oppression that Māori face that lead them to the place in their lives when they are needing services like ours. (N-PPS-2017)

For Te Hiringa Matua Mataora, commitment to PPS was part of positive Māori development. They emphasised the power of the kaupapa and the opportunity to share te reo Māori me ōnā tikanga with whānau.

Being paid to be you, to be us, and to be able to share our knowledge with our whānau which unfortunately haven't been immersed or haven't had the teachings that we know… We are here because we want to be here. (T-Mataora-2018)

- **A shared sense of equity and social justice.** The team agreed that the women and babies they would be working with were often portrayed and perceived very negatively by wider society.

  What encouraged me was that it was going to be non-judgmental, we would use good language around woman. I've spent many years hearing professionals run down young woman with language. My interest was we were coming from a place of support, strength based … I was excited about the role of doing things differently and having better outcomes for our babies. (HB-PPS-2017)

7.3. A multi-disciplinary focus

A collaborative MDT was one of the core components of PPS. MDTs are an integrated approach to healthcare that combines the skills and perspectives of health professionals from different disciplines and others from non-clinical backgrounds such as peer supporters, kaiāwhina and cultural advisors. Effective MDTs respect the different skills and experiences individuals bring to the team and do not prioritise specialist skills over generalist skills. The intention is that by working collaboratively, an MDT improves the quality and safety of care for clients[18] [19] through:

- Incorporating different perspectives to support client care and risk assessments. The range of expertise within the PPS teams contributed to ensuring service needs were met for vulnerable groups[20].
- Encouraging and benefiting clients by[21]:
  - making it easier for them to get to the right service the first time
  - avoiding people having to tell their stories multiple times
  - ensuring that everyone in the health care team is working together.

[18] Byrne, M. (2006). A response to the Mental Health Commission's discussion paper 'Multidisciplinary team working: from theory to practice'.

[19] Moore, D., Love, T., & Ehrenberg, N. (2013). Review of health services on the East Coast-Public Report. *Wellington: Sapere Research Group*.

[20] Ministry of Health. 2018. Mental Health and Addiction Workforce Action Plan 2017–2021 (2nd edn). Wellington: Ministry of Health.

[21] Moore, D., Love, T., & Ehrenberg, N. (2013). Review of health services on the East Coast-Public Report. *Wellington: Sapere Research Group*.

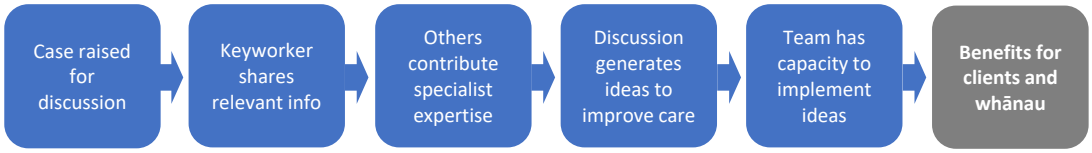


Figure 27. An overview of an MDT approach[22]

All three PPS had built collegial team approaches and emphasised the importance of working as a team to avoid dependence on one key worker, to allow cover if people left or were absent and for clients to have some choice in key workers.

The team composition varied between the three pilot sites (Table 3). At all sites, team members were very committed to the need for PPS and the expectation that the services would improve outcomes for whānau.

Table 3. PPS team composition based on service specifications

PPS	Service specifications
Northland – He Tupua Waiora	Team leader: 1 FTE based in Whangarei Psychiatry: 0.4 FTE Social Work: 5 FTE RN (Far North): 1 FTE (access to psychology and occupational therapy through Manaaki Kakano service)
Hawke's Bay – Te Ara Manapou	Clinical co-ordinator (nursing, social work, psychology or other mental health qualification): 1 FTE Key workers – registered health practitioners: 5 x 1 FTE Peer supporter: up to 1 FTE Team administrator: 1 FTE Clinical psychologist: 0.2 FTE Psychiatrist: 0.2 FTE
Tairāwhiti – Te Hiringa Matua	Emphasis on all team members as Mataora, rather than division between *clinical* and *artist* roles Kaiārahi: 1 FTE Mataora: 9 FTE (includes 3 clinicians, 5 non-clinical team members with Mātauranga Māori skills and experience, 1 administrator) Tohunga expertise included in the kete of support: 0.2 FTE Hauora Tairāwhiti intended to provide: Psychologist 0.5 FTE and Psychiatrist 0.2 FTE but this support was intermittent.

[22] a Bháird, C. N., Xanthopoulou, P., Black, G., Michie, S., Pashayan, N., & Raine, R. (2016). Multidisciplinary team meetings in community mental health: a systematic review of their functions.https://discovery.ucl.ac.uk/id/eprint/1471491/10/Caoimhe%20Nic%20a%20Bhaird%20Thesis%2030.9.15.pdf.%20REDACTED.pdf

7.3.1. The team administrators

Te Ara Manapou and Te Hiringa Matua had administrators who were integral members of the team. The team administrator role was broader than administration. The administrator was often the first voice heard by whānau when they called the services. They also monitored staff whereabouts when they were with clients, providing an important layer of safety.

> *I like to think that I can do as much admin as I can, so they can spend more time with their clients. That's what it's about I think. (HB-PPS-2018)*

The administrator for Te Hiringa Matua was considered by herself, the kaiārahi and the team to be a Mataora. She was an active wānanga participant and a contact and support to whānau.

> *I don't see myself as just the administrator, I feel very much a part [of the team]. I feel very level with these guys because I have an input into the whānau lives as well. It may not be as in-depth, but it's a speckle, which can help. It's like a seed, you just plant it and it grows, that whānau. (T-Mataora-2018)*

He Tupua Waiora received administrative support from Te Roopu Kimiora, the Child and Adolescent Service but for the most part, PPS team members did their own administrative tasks.

7.3.2. Psychologist and psychiatrists

The psychologists and psychiatrists were the latest appointments to the Northland and Hawke's Bay teams, due to difficulty recruiting people into the roles. The teams and the clients valued the clinical leadership and expertise brought by the psychiatrists and psychologists and the chance to ask for advice. In-house access to psychologists and psychiatrists contributed to a seamless referral and communication process when clients needed these supports, in contrast to long waiting lists to access other services.

> *Having the psychologist's and the psychiatrist's view, which can be quite different, and the different conversation that they're coming out with, and the amazing help … It just made all the difference… (HB–PPS-2018)*
>
> *I'm glad they have a psychologist as well. She digs right into those things you wouldn't normally think about. (HB-C46-1)*
>
> *[the psychiatrist] is great, really hands on... He is really excited about the team. He loves it eh. That makes a big difference. He does clinics up north too … the girls up there really appreciate that. … He will go into the homes. He does it more than the other doctors. Driving in the car [is also a chance for] supervision! (N-PPS-2017)*
>
> *So I had a meeting with the psychologist I think it was, and he was amazing as well, just super non-judgemental and again supportive and just wonderful, absolutely wonderful …. (N-C9-1)*

In Tairāwhiti, the Māori psychiatrist who lead the operationalising of Mahi a Atua, the framework she designed, provided support to the team at the start of the service. Te Hiringa Matua was not allocated a psychiatrist resource when she left. Te Hiringa Matua consider that psychologist/psychiatrist expertise would be helpful for an estimated 20% of whānau who need specialist support. As for the other PPS, the psychologist/psychiatrist needs to be part of the team and understand the PPS service model.

7.3.3. Peer support workers

Te Ara Manapou included a peer support worker who added personal insights and encouraged clients by demonstrating what they could achieve.

> *To me, peer support is someone that's walking alongside you in your journey and kind of, listening to what you want and guiding you in that direction until you're ready to take the leap yourself. (HB-PPS-2018)*
>
> *… the clients know that I can't judge, so they feel more comfortable, and then on the flipside, there are clients that see that I can see through things and I ask the hard questions, so then they shut off because they're like, "Oh, actually, I can't pull the wool over her eyes." … (HB-PPS-2018)*
>
> *[Peer support worker] makes a real difference in engaging with clients and giving them hope…. Goal planning on a different level to their assessment. (HB-PPS-2018)*

Interviewed PPS clients highlighted the importance of the peer support worker as a role model.

> *I was glad I met [peer supporter] and [key worker] at the same time, I have the best of both worlds, one that was on one side of the track and one that was on the other. … I found working with [peer supporter] really helpful, to be able to hear her story of where she used to be, it was like this chick has actually been there before. (HB-C43-1)*
>
> *She has life experiences that are similar to what I am going through. She lifts me up when I'm down and reminds me of things that I'm good at or that I'm achieving. (HB-C42-1)*
>
> *… As a parent I'd love to be where she is. As someone coming from a drug background, I empathise with her, you can get out of it. She does an awesome job and I'm in awe of her, because I want to work towards that as well. (HB-C21-1)*

The peer support worker was the first employed in that role in the DHB and a salary scale and job description had to be developed. Carving out a new role in a DHB context was not easy and it took time for the team and others in the DHB to understand the role.

> *When I started in this role and I saw we had a peer support role, I was like – big-headed ego me – "What would that person know? They're not a professional." I spent a week here*

and I realised within that week how valuable that role is. It's like gold, if you have the right person. (HB-PPS-2018)

The key themes from the PPS evaluation were consistent with the findings from an AOD Collaborative report.

Peer support workers – A synthesis report for the AOD Collaborative[23]

Findings suggested that peer support is effective and delivers good value for money. Service users typically:

- Valued the peer support
- Found it met their expectations and consistently supported their recovery
- Had a beneficial connection with their peer support worker, founded on trust, rapport, mutuality and respect
- Felt understood and supported, that peers heard and respected their world views and circumstances
- Experienced positive impacts in their recovery and felt their lives were improved through the peer support provided
- Believed themselves to be better resourced to manage their AOD addiction.

The synthesis highlighted the importance of well-defined and supported roles that are understood by managers and colleagues. Defining the roles includes considering workloads, activities, confidentiality requirements and expectations of how to engage with health professionals.

The report also highlighted a major difference for peer support workers as an expectation they would bring elements of their personal life into their professional life in a way that may seem unprofessional to clinical team members. Supervision and mentoring for peer support workers are important to enable them to develop their roles.

7.3.4. Male and female team members

Te Hiringa Matua were deliberate in including males in the team as wāhine and tāne carried the mana of Mataora. Mataora observed that the presence of men had been questioned by some in the community, who did not understand the male role in a pregnancy and parenting service.

And the biggest thing in this industry, we get posed this question weekly, especially from a whole lot of clinicians. "But you're a man!" You know? "Are you dealing with pregnancy and parenting? But you're a man! Half of your team are men! Is that appropriate?" Yeah, it's appropriate in my world. Mummy and Daddy. (T-Kaiārahi-2019)

[23] King J, Panther G (2014). Synthesis report: Peer support themes. AOD provider collaborative.

Reinstating fatherhood in pregnancy, birth and parenting

Te Hiringa Matua supported whānau, which included mothers, fathers, siblings, cousins, grandparents, aunties, uncles, cousins and more. The kaupapa included supporting dads as parents and partners and having tāne in the team helped whānau to feel comfortable and welcomed.

> *I think it's made it better, from my point of view anyway. Having a tāne in the mix, because they come from a totally different angle from all of the discussions. Especially that male person over there. He gets on well with everyone, and all of the babies too, and especially when other tāne come in, he's like, "Hey bro, what you up to?" (T-Mataora-2019)*

> *I told [Name] earlier around [Name's] experience of leading the haka and being able to do that with another dad who came in and he was affiliated with the Mongrel Mob. So being able to work together on that is not something you'd see in common unless you're given the space to do that. (T-Mataora-2019)*

Te Hiringa Matua kaiārahi described how the role of men throughout pregnancy, birth and parenting had been undermined by colonising practices. Reinstating these by including tāne in romiromi and in the birth helped to strengthen the bonds of the parents.

> *There's about four of them that actually do romiromi, which is the old form of manipulation that was in pregnancy, manipulating and massaging the baby. And that's another thing we want to bring into our wānanga, and that for me is one of the things that helps build firm relationships between the parents. Otherwise you get the father just being the dumb-dumb nowadays, and then Mum goes in to have the baby and he's there for a while, and then he disappears and goes down to the pub and shouts the boys, and that's probably the reality of what happens, and we want to change it to have that connection from the birth… And I've seen it working in PPS. (T-Kaiārahi-2017)*

In Northland and Hawke's Bay there were no male key workers and this was identified as a gap by team members, clients and stakeholders. He Tupua Waiora planned a secondment to add a male clinician to the team but COVID-19 restrictions had put this plan on hold.

> *… I really think it would be a good mix having a male in the team and especially the person they're looking at, he would bring real calmness to the fathers the males of the partners. (N-PPS-2020)*

> *Having a man on board to be a case worker to work with dads and the relationships with their children and whānau and what they need to do that can just hang in there with them and keep them out of jail. (HB-PPS-2019)*

> *Reasons being, because our Māori people, it's a cultural element where the house needs to be cleansed and so forth, we've got our Māori services over there that are able to do that. But if you keep it in the service itself holds that mana as one. (HB-PPS-2018)*

> *Someone that has worked in Corrections, because those are the type of men that we get through, so someone that can be firm but actually is used to people that have been*

through the system and has gone from Corrections and wants to do something like that. (HB-PPS-2018)

Interviewed male and female clients also described the advantages of a male key worker.

Yeah, like a few male workers would make this a bit easier to come to, … I think a male worker who works in addiction would be much easier to talk to. And really more addiction workers where they can relate to what we're saying. (HB-C32-1) – male client

They're awesome and friendly, only thing I'm a little sad about is there are no male workers so I guess that would be awkward for dads. (HB-C45-1) – female client

7.4. Effective leadership

As the PPS were new services, the team leaders had to build their staff into effective and collaborative teams. Including and valuing the expertise of people with non-clinical skills and balancing the approaches of different disciplines such as nursing, psychology and social work added an additional layer of complication. For Te Hiringa Matua, the kaiārahi also had to manage the interface between Western clinical training and Mātauranga Māori. In Northland, the team leader managed team members located in Kaitaia and had to develop effective MDT meetings at a distance.

All the PPS team leaders experienced the challenges identified in the literature about managing MDTs to varying degrees. Acknowledging the need for general management skills and to develop multi-disciplinary teams is important in establishing effective PPS leadership.

…letting everyone have their voice and also keeping the boundary around everything too, to make everything safe by the boundary at the same time. It's something you don't teach in management training or whatever. (HB-DHB-2018)

You need a team culture where it is okay to be able to share stuff or when you're not sure about something, I guess that is where that trust comes in. It is huge within our team not just our clients. I think it is really important to have a team leader that fosters that culture and a team leader that is passionate about and understands the work. (N-PPS-2020)

The teams we met with in 2020 were very different to the new PPS teams being set up in 2017. All teams saw changes over the evaluation period in team leaders and team members that required ongoing rebuilding of team dynamics. In Northland and Hawke's Bay, the foundation team leaders moved to other geographical locations or to new positions.

Effective leadership is highlighted in the literature as essential in building functioning teams and ensuring a functioning MDT meeting[24].

The challenges of building effective MDTs from people with different health backgrounds is described in the literature.

Bringing diverse professionals together and calling them a team does not guarantee productive collaboration[25].

- There are situations reported in the literature where there is lack of mutual respect, poor leadership and power struggles, blurred role definitions and descriptions, and professional bullying or feelings of being undervalued and/or misused[26].
- Tensions between practitioners own traditional practice and the overall team goal potentially contributing to conflicts over treatment approaches[27].
- Challenges that arose while working in a multidisciplinary team environment included unstructured and unfocussed meetings. Lack of seriousness around content and unprofessionalism during meetings (i.e. answering phones, range of conversations happening at once, dominant team members and confusion around topic of discussion)[28].
- Employment status, cultural differences, and lack of collaboration between teams[29].

[24] a Bháird, C. N., Xanthopoulou, P., Black, G., Michie, S., Pashayan, N., & Raine, R. (2016). Multidisciplinary team meetings in community mental health: a systematic review of their functions. *Mental Health Review Journal*. https://discovery.ucl.ac.uk/id/eprint/1471491/10/Caoimhe%20Nic%20a%20Bhaird%20Thesis%2030.9.15.pdf.%20REDACTED.pdf

[25] a Bháird, C. N., Xanthopoulou, P., Black, G., Michie, S., Pashayan, N., & Raine, R. (2016). Multidisciplinary team meetings in community mental health: a systematic review of their functions. *Mental Health Review Journal*. https://discovery.ucl.ac.uk/id/eprint/1471491/10/Caoimhe%20Nic%20a%20Bhaird%20Thesis%2030.9.15.pdf.%20REDACTED.pdf

[26] Orovwuje, P. R. (2008). Contemporary challenges in forensic mental health: the ingenuity of the multidisciplinary team. *The Mental Health Review*, *13*(2), 24.

[27] Mental Health Commission. (2006). Multidisciplinary team working: from theory to practice. *Dublin: Mental Health Commission*.

[28] Giles, R. (2016). Social workers' perceptions of multi-disciplinary team work: A case study of health social workers at a major regional hospital in New Zealand. *Aotearoa New Zealand Social Work*, *28*(1), 25.

[29] Iliffe, S. (2008). Myths and realities in multidisciplinary team-working. *London journal of primary care*, *1*(2), 100-102.

7.4.1. Supporting the health and safety of the PPS staff

The team leaders also had to support their teams from a health and safety perspective. The nature of the support provided to clients by PPS was complex. Team members engaged with and entered homes of whānau with addiction issues and where family violence was a risk. Teams supported each other. Visits to client/whānau homes were always completed in pairs until the team had assessed the clients and understood safety issues for that client and their whānau. Working in remote rural locations, often outside of mobile coverage had potential risks to staff safety.

> *How do I take care of a team? Going out on visits is important. It's gotten harder and more complex in my 15 years. How do you support the staff? [PPS team] managers need to recognize this. (HB-PPS-2019)*

> *…and the risks. I hate to say that but there will be some risks in terms of mobile coverage, and you know [name of team member] and I are going to have to work quite closely together in terms of travelling. Until we get to know the whānau, to know the community basically. (N-PPS-2017)*

Te Hiringa Matua whānau and Mataora were kept safe in wānanga by tikanga and each participant agreeing to shared expectations.

> *As we developed wānanga, we needed a tikanga and kawa in that space, from their experience we were able to draw from that and put some tikanga and kawa in that space so that everyone was safe in that space and it was a space for learning. (T-Mataora-2020)*

Mataora worked in ūe to connect with whānau safely in their homes. The use of 'ūe' where Te Hiringa Matua team members work in pairs originates from a Mahi a Atua principle to remain an active learner and highlights the need to have a critical lens over practice. Te Hiringa Matua found that when other services focussed on their own safety, vulnerable whānau could miss out on support.

> *It depends on the definition of risk…because if they go to her house, every single member of our Mataora, go in pairs and drop her off at her house and then go in and have a cup of tea with them, it really is the definition of risk. A lot of the other services for these particular whānau, they won't go to the gate. [Why won't they go to the gate?] because there is dogs, and gang members…People can see the person and the whānau as too risky, and worrying about their own safety so to speak. That becomes more paramount than considering the person and the whānau and what their needs may be… (T-Kaiārahi 2019)*

Although client/whānau successes made the work very rewarding, some clients the team had worked closely with relapsed and some children were uplifted. Some staff noted that working part-time was feasible and would be a way of managing the pressure.

> *…there have been one or two times where I didn't think I could take the sadness of what the people are going through, it threatens to overwhelm me. (HB-PPS-2018)*

7.4.2. Supervision

The teams supported each other and received professional supervision through their DHB. A senior DHB manager or NGO manager also supported the teams and team leaders. The unique aspects of the PPS and the roles made professional supervision challenging as there were often limited people in the DHB who could provide supervision.

> *I kept on my supervisor that I had originally for three months because she was really schooled up on mental health and addictions. So I kept her on and I paid for her myself so I would have that good solid supervision. (N-PPS-2019)*

The teams also needed confidence they could confidentially share information about aspects of the team that were not working well. Team members felt this could be difficult to achieve when one supervisor supported multiple team members.

In Tairāwhiti, Mahi a Atua wānanga promoted hongi te wheiwheiā, reflection and constructive communication amongst the team, promoting an environment of embracing feedback and talking honestly and openly with each other.

> *Constructive criticism and that sort of stuff and that is what hongi te wheiwheiā is. So it is embracing that feedback. And not just holding on to it, doing something about it. So when you go out, you change something. (T-Mataora-2017)*

> *I think another thing that sort of helps us too is our own honesty with each other. It helps some of us grow. Being able to just sit at the table, let out whatever it is, and then leave it at the table and be able to move forward from that… (T-Mataora-2019)*

The kaiārahi was integral to keeping Mataora safe across all domains of wellbeing.

> *There's a sense of spiritual safety as well, with [kaiārahi]… So the taha tinana and taha wairua is protected, and he's taught us the ōkawa's going to protect us in that space, and when you think of it as an ao Māori, spiritually and physically, when we clear the space through the pōwhiri, through the ōkawa, we're making sure we're safe, so that's another thing that I feel is very important within an organisation like this. (T-Mataora-2019)*

Professional supervision is also essential for the team administrators and for the peer support worker but not necessarily routinely provided by DHBs.

> *…It's sad stuff sometimes… Admin don't get supervision… in this service, it's very personal, and that's the way it is. It's also really rewarding when you have successes. (HB-PPS-2018)*

He Tupua Waiora was led by a Māori project manager and team leader. Staff were grounded by their own whānau, hapū, iwi and community links and had access to cultural supports. In Hawke's Bay, cultural supervision was raised as a need.

> *From my perspective, I think a kaumatua role would be really good, having some cultural supervision or cultural aspect for our clients as well. … (HB-PPS-2019)*

7.5. A strengths-based approach

PPS aimed to reach clients by taking a strengths-based approach and treating them with respect. Clients and whānau descriptions of what was different about PPS echoed the service objectives.

Client and whānau descriptions of what was different about PPS

Building rapport:

I don't know what it is, but they seem to touch me, I don't really open up to people. All the things I've gone through in my life I've kept to myself. I met these people, I've opened up and let them know all about my life. It's like I've released a monster in me that I've kept held up for years and life's been great, better than what it was since I met them. (HB-C35-1)

She is lovely. She has a really good personality. She's just really smiley. She's happy. People like that we need in our life – happy people. (N-C23-1)

I have made this place my home. [I am] making connections with others at wānanga, stand up, share, listen to others pēpeha. (T-Client wānanga)

Having someone in their lives to support them:

She helped me, checked up on me. She would ring two to three times per week or text. I liked that. I felt like she cared. (N-C19-1)

A lot of mums have broken hearts. We support each other [at wānanga]. And new people. We are curious to learn about them. (T-C16-1)

It kind of took a while to feel I could trust them but I can, but they are actually all really cool people, all of them that work here. (T-C11-1)

Being treated with respect:

I remember one day … I thought stuff was going on and I was in in a really bad place and one of them just came down with some chocolate just out of the blue. Always making sure you're okay. I never felt that they were up here and I was down there. (HB-C21-1)

Not giving up:

Even when I didn't want him to come he would knock on the door. I know I'm supposed to listen to you and you said don't come, but here is some kai. How are you? (T-C30-1)

Non-judgemental:

It's like, for me I needed people to help me to get on, neutral people I didn't know and didn't know anything about me. (T-C11-1)

She made me feel comfortable straight away. Not judged. You really need that. When you are going through all of that you need someone that you can talk to. I felt like I could talk to her. (HB-C6-1)

if I've got a relapse or something. … She was really positive, and just the vibe you get off her too. It was good. It wasn't like a real negative vibe and she wasn't judgmental or anything like that. (N-C8-2)

She makes me feel comfortable, I don't feel like she is judging, I feel like she genuinely cares and has a quite a realistic expectation of progress and people and their natures. (N-C2-1)

I think of them as my extended family, because they saw me at my worst and helped me through it and believed in me the whole time which is really what you need at the time, you don't need judgement. (HB-C21-2)

Effective and clear communication:

…Because she has a good way of making you understand exactly what it is that is needed, what it is that someone else has said. She has got a very good way of explaining all of that …(N-C1-1)

I like the way that she is real straight up with me, she knows that is how I respond (N-C5-1)

Just them being themselves, when they explain something to me. They break it down, so I understand. It's like I'm talking to my family. Whereas other people I'm talking to it feels like I'm talking to a cop or something. I feel at home and welcome with them. (HB-C35-1)

Listening:

They actually listen, they don't just try and shove you into whatever holes you think would do it. (N-C5-3)

They're just real supportive, and the person's needs. Whoever goes to them they're real supportive and try to hook you up with what you want. They listen. (HB-C37-1)

Understanding:

She was just understanding, nice, was always there if I needed as well, on many levels. That's how I would explain it, really. Just everything. (N-C29-1)

I am supported by the team. Heard. They give me choices. Support me in my choices. (T C10-1)

Being honest:

It was pretty scary, but she reassured me that she was here for me and not to take my baby away from me but it was to help me get better. Just over time talking with her I trust her heaps and she's helped me so much. ... (HB-C41-1)

7.6. Intensive outreach

PPS teams supported whānau in different settings to provide flexibility and different strategies to engage with clients (Figure 28). Te Hiringa Matua whānau were supported in wānanga held in the Gisborne whare and at different venues up the coast. Whānau were also supported outside wānanga in their homes and at appointments. Warm and welcoming buildings encouraged people to be there.

I love it. It's just like, family-oriented, welcoming. It just feels like family when you go there. (T-C12-1)

In Northland and Hawke's Bay clients were visited at home, met in cafes or taken to appointments.

You are trying to earn their trust and sometimes a coffee is all that is needed. (HB-PPS-2017)

Because these people are struggling with transportation and things, [the PPS team] do use them as a way of engaging them. They'll often say I can take you to PAK'n SAVE or I can take you to that appointment and a lot of the talking happens then. … A lot of that therapeutic conversations a lot of exploring their ambivalence around their situation and wanting to make changes or not make change. All of that stuff happens in the car rides and waiting at appointments. (N-PPS-2020)

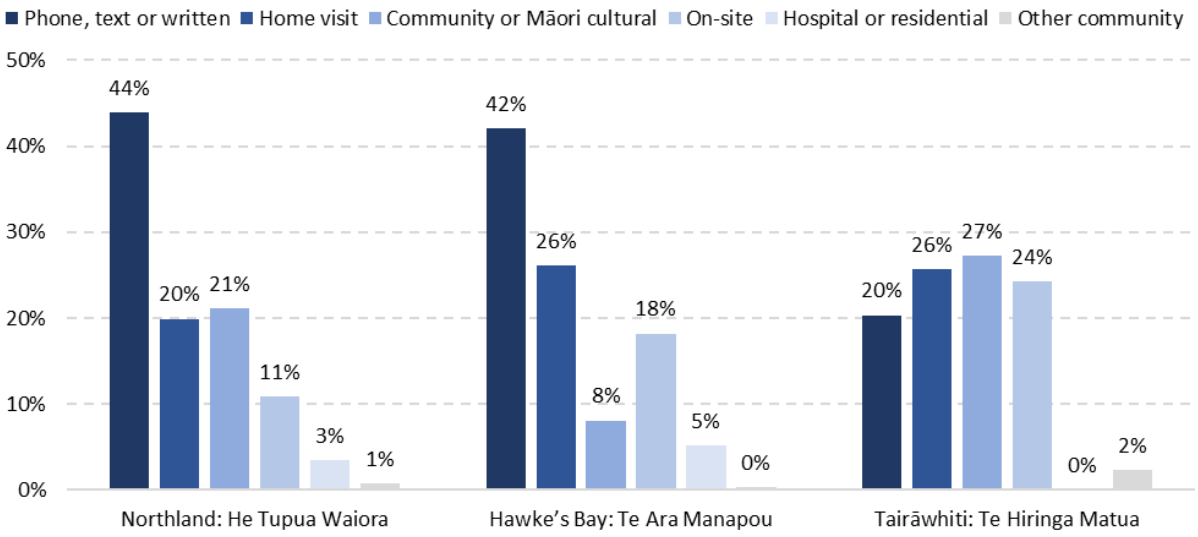


Figure 28. Proportion of the total number of contacts with all clients made in different settings (Source: PRIMHD)[30]

7.7. Lower client caseloads for PPS enabled intensive outreach

The time and flexibility of the smaller caseloads in PPS was a core service component and allowed PPS teams to work more effectively with whānau. More time with each client aimed to contribute to sustainable change and avoid the *'churn'* of clients coming in and out of the same services.

The time factor – that's huge (HB-Stakeholder-2020)

They spend a lot of hours with each person. So they can spend a whole day with one person, going to lawyers, WINZ. Doing all that sort of stuff takes up a whole day. (N-PPS-2019)

The PPS specification capped caseloads at 12 per key worker. The PPS teams described 10 to 12 clients as about the right number, although the mix of acuity influenced the number of clients one key worker could support. At the start of the

[30] PRIMHD code for home visit: Domiciliary; PRIMHD code for Hospital or residential includes Emergency Department, Inpatient, Non-psychiatric and Residential; PRIMHD code for onsite: Day tāngata Whaiora/ consumer setting, Onsite; PRIMHD code for other community: Court, education sector, other social media/e-therapy, primary care, police, prison, youth justice.

services, most clients were at the same stage and required intensive support to build up trust and engagement. As the services established there was more of a mix of clients. The intensity of support for clients who had been with the services longer varied as progress was not linear.

> *I think at 10 you are just slightly pushing it. It depends on where the clients are. If you had 12 and they are all chaotic or you had 13 and they are all chaotic, then you really are in trouble. (HB-PPS-2019)*

The caseloads (the number of clients who had received support during the quarter January-March 2020) at the end of the March 2020 (Figure 29) were[31]:

- 47 clients for He Tupua Waiora – six key workers with average caseloads of 8.
- 73 clients for Te Ara Manapou - six key workers with average caseloads of 12.
- 85 clients for Te Hiringa Matua - nine key workers with average caseloads of 9

The caseloads are an estimate and do not consider quarterly fluctuations. The average caseloads at the end of March 2020 aligned with the service expectations of caseloads capped at 12. The manageable level of caseloads per key worker depended on the intensity of support each client required.

> *Once they have been in our service for a bit, then it starts to wean off the support because we've supported them to the point where they can manage most of their appointments or other services. (N-PPS-2019)*

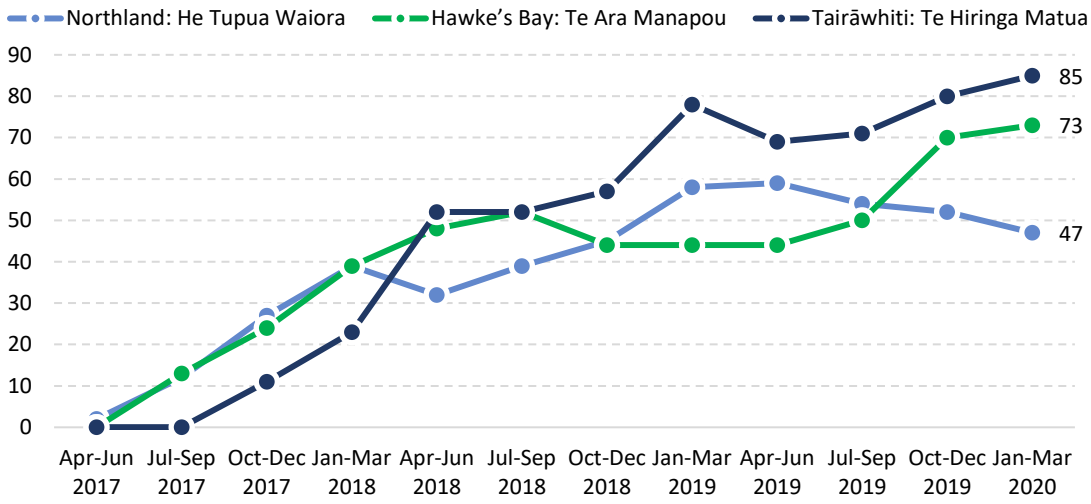


Figure 29. Total clients with any activities per quarter (Source: PRIMHD)

[31] Caseload calculations included key workers and peer support workers. Administrators and team leaders were excluded.

Te Hiringa Matua were able to support more clients in a wānanga setting than could be supported 1:1 but this had to be balanced against outreach support they provided to whānau in Gisborne and remote East Coast Bays. For Te Hiringa Matua, supporting a 'client' did not mean an individual but a kaupapa Māori approach to healing as a people as opposed to individually.

Whānau were also supported and nobody was turned away.

> *Yeah, one of the things of doing the wānanga, it's like doing group work, you can get a lot achieved in a session, and this team is doing more than one wānanga a week. (T-Kaiārahi-2019)*

8. Influencing other services and reducing institutional racism

Key findings:

One of the aims of PPS was to connect clients to specialist services and to change the ways other agencies and organisations engaged with PPS clients.

The Waitangi Tribunal report Hauora[32] noted that all parties to that inquiry, including the Crown, were aware of the impact of the social determinants of health and the ongoing impact of colonisation and institutional racism. One way institutional racism is expressed is through barriers to access services to support health and wellbeing. PPS clients described attitudinal barriers to accessing services because they felt were *'looked down'* on and did not engage. Waiting lists and not following up with people who did not attend appointments were also examples of barriers to access.

Offering specialised support within the PPS teams, as well as supporting clients to engage with other services helped to address institutional racism.

One of the aims of PPS was to change the ways other agencies and organisations engaged with the client/whānau. PPS clients felt they were not respected by other services and the 'traditional' service models had the potential to create barriers to engagement. Clients and whānau engaged with PPS all described what was better and different about PPS compared with other services. We also heard from clients about examples of discrimination and judgemental attitudes of some services towards them, including attitudes of other health providers and lack of respect from social services.

> *I was on this high thinking I'm doing really well, and then you get sent back like that, and I was like, "Is this always going to be slammed in my face every time?" It might not be the hospital but something else. "Is this always going to be a reminder?" because we come here to get better and get well but if we're going to be constantly reminded … you might as well just go back to your addiction or whatever because you're going to get judged anyway because it's already on your file, so you might as well just go, "F*** it!" (HB-C13-3)*

All three PPS engaged with local services in their communities. Examples included inviting services to PPS, being part of local groups that identified and responded to vulnerable families and inviting agencies to MDTs to discuss shared clients. They worked closely with government agencies including Police. They have worked to break down barriers with Oranga Tamariki and other key stakeholders, and these

32 https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf

relationships have grown. Te Hiringa Matua Mataora continue to invite all community stakeholders to wānanga, and to visit the premises.

> *We've set up recently a little bit of a liaison meeting where we all met to get to know each others faces. They feel like it is really helpful to have a team that is working alongside them that are out there supporting these mums. But, we had to also remind them that just because we are here and we are eyes on baby when we can that we are not the safe team, where you should close cases because we are involved because that is what we found was happening a wee bit where they there quickly closing cases and the clinicians felt that they shouldn't be closed. We were feeling it was because they thought oh well PPS is involved now, they go and visit regularly they will be able to keep eyes on baby, so probably more so from them. Most of our positive feedback is coming from definitely Oranga Tamariki and Women's refuge. (N-PPS-2020)*

Qualitative information from the evaluation demonstrated some changes in:

- Understanding of the PPS client group
- The ways local services engaged with clients
- Benefits for local services of being able to refer clients to PPS.

For agencies involved in care and protection such as Oranga Tamariki and the Police, sharing the responsibility for clients with PPS enabled more clients to retain custody of their children because of more certainty about level of risk for the child(ren). Collaborative approaches have been developed with Oranga Tamariki and this has resulted in better engagement for whānau. Visits with their children in the PPS premises allowed them to be in a less stressful environment to bond with their child(ren).

> *Te Hiringa Matua understands our role and have become mediators between us and the families. (PPS-stakeholder-2018)*

In time, the availability of PPS may improve the interface between the PPS clients with other services by providing pathways to appropriate care and making it easier for people to seek help from services without fear or without stereotyping and judgement. Comments from some clients demonstrated that by building trust, PPS was normalising client/whānau engagement with other services.

> *I feel like I am not judged, I feel like, they are more realistic about people's habits and stuff and more realistic about the process of recovery which takes a lot of pressure off, the fear of losing your children, for me is huge, so to feel like I can trust someone in this position to help me through that sort of thing without a fear of having to lie about things because I am scared of losing my kids, I'm able to be truthful to receive the help that is necessary. It is really huge because I have never felt that trust with any other government facilitators of anything. (N-C2-1)*

> *I went to Oranga Tamariki for help. I said I am 15, I have a baby. I have to shoplift to get him kai. They took advantage. They have been in my life ever since, telling me they will take my children… (N-C40-1)*

8.1. Systemic barriers limited outcomes for some clients

The PPS teams and clients discussed barriers that limited the outcomes clients could achieve:

- Housing shortages, especially social housing, made it difficult for clients to move into safe and stable housing situations including moving away from partners and whānau who were a risk for them and their child(ren).

  I am trying to get my baby [back from Oranga Tamariki care] but the problem is always housing. … It is a real problem here finding a place. (T -C10-1)

  Housing is one thing that has been impacted, most of them will have somewhere to stay but it is that fact that they have to keep moving around they don't know week to week where they're going to be. (HB-Stakeholder-2020)

  For one of our clients, everything has moved beautifully. Her addiction – she is clean, she had her children removed – they are now back in her care, … We should be closing her by now, whereas now she is about to lose her house. (HB-PPS-2019)

  An example of one of my mums, she is thirteen weeks clean tomorrow so we have been working with her for sixteen weeks and just took her to WINZ appointment and she just got looked up and down, and the WINZ lady said I can't do anything to help you. So we are currently sitting her in a refuge and she has got no family support, nobody will take her because of her history and we have just managed to get her into a special housing unit for mums in her situation… (HB-PPS-2017)

  At the start of their engagement with PPS some women were able to go to Women's Refuge but it was difficult to find places to stay for some because of safety considerations for others.

  There's no way I could put her up in a hotel, because she'd be putting the rest of my clients in that hotel at risk, so you are just kind of left in a little bit of a…(HB-PPS-2018)

- Co-existing problems and gaps in service availability for clients. Residential rehabilitation services, especially services that would take children, were frequently mentioned in Hawke's Bay and Northland.

  What I found challenging was the rehab and not being able to get our whānau into rehab, that is a big struggle and they really wanted the help. You know they're just going back to their old ways. They can't go anywhere so they fall back into the same cycle. For our māmas not to be able to have somewhere to stay, you know housing. (N-PPS-2020)

- Community organisations with limited capacity to take on PPS clients.

  What I have been told is that we are supposed to try and get this client with another service and linking in. However, the capacity that other community organisations have – there is none… And what that might mean for, this particular mum anyway, is that she might have her children removed again because that support wasn't there when she needs it. (HB-PPS-2019)

9. The financial benefits of pregnancy and parenting services

Key messages:

PPS were funded in recognition of the social and economic benefits of investing in early intervention for children at risk of poorer health and social outcomes because of exposure to addiction, family violence and poor parenting.

Although PPS are resource intensive, there is substantial evidence from the literature of the financial benefits of achieving the outcomes PPS are achieving for clients and whānau. There is also strong evidence it is more cost effective to spend money on early intervention to improve long-term outcomes for children than on remedial programmes[33] [34]. Pregnancy is an opportunity for early identification and response to family and whānau needs, as almost all women will engage with maternity services at some point during their pregnancy, even if for some it is only during delivery.

The benefits of PPS are difficult to monetise as many are indirect and long-term. However, the target group has been reached and the evaluation demonstrates improved outcomes for PPS clients and whānau.

9.1. PPS is resource intensive

PPS service delivery is resource intensive. The budget to deliver PPS was $1 million per year per site to support 100 clients and whānau. The costs of PPS delivery also included additional costs of social and health services clients.

The evaluation confirmed low client caseloads are an essential component of the PPS model and are required to enable intensive outreach and to build trust and engagement. Becoming and remaining addiction free also requires long-term support.

[33] Fox, S., Southwell, A., Stafford, N., Goodhue, R., Jackson, D. and Smith, C. (2015). *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention*. Canberra: Australian Research Alliance for Children and Youth (ARACY).

[34] Ministry of Health. (2011). *Report on the Youth Health Workforce Service Review – April 2011*. https://www.health.govt.nz/system/files/documents/pages/youth-health-workforce-service-review.pdf

9.2. There are far reaching and intergenerational benefits of PPS

A reduction in the adverse outcomes of addiction therefore have far reaching and intergenerational benefits (Figure 30).

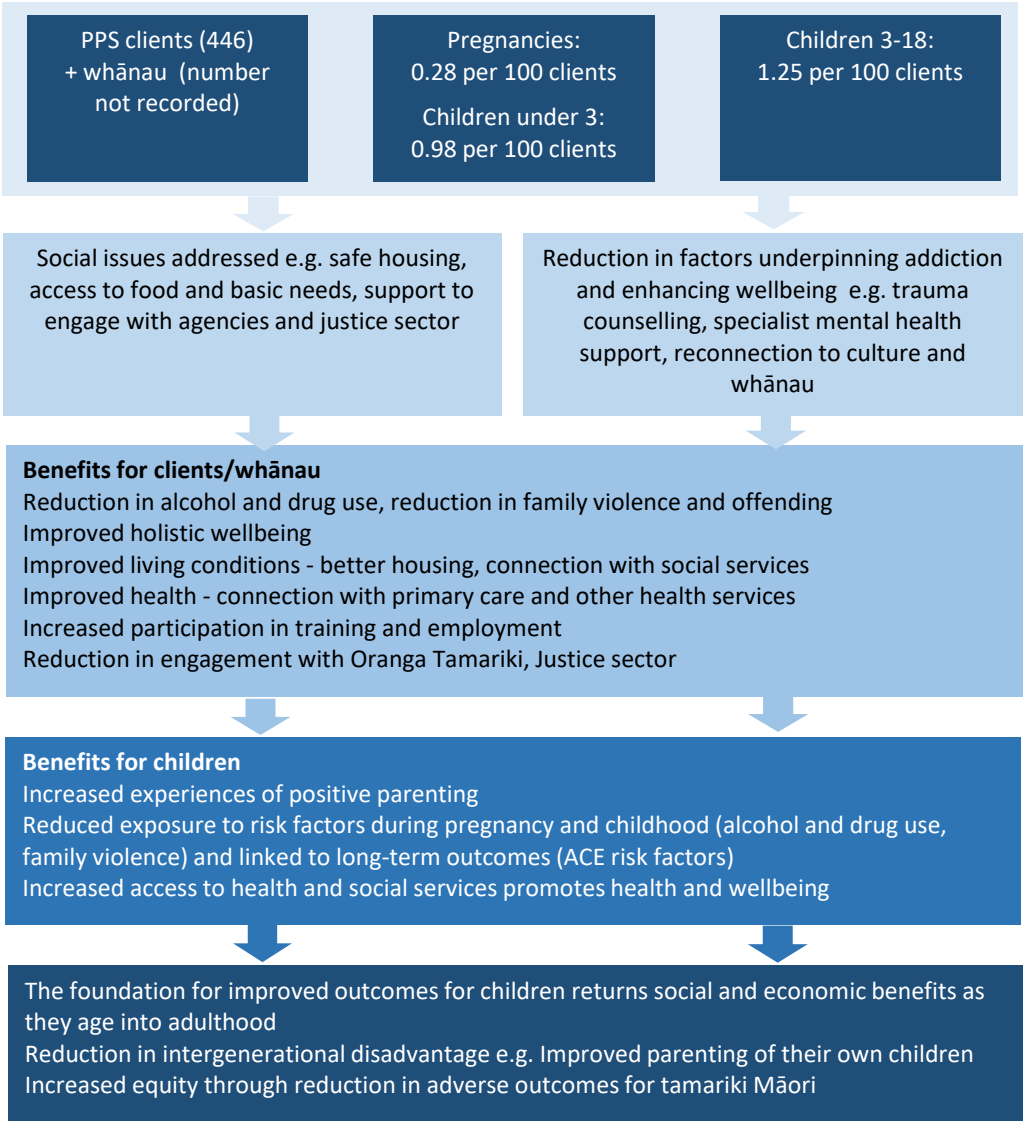


Figure 30. An overview of the benefits of PPS for clients and their children.

9.3. The financial benefits of improving outcomes for children are well established

Alcohol and other drug problems have a significant impact on people's health and wellbeing in the immediate, short, medium and long terms. These problems have wide impacts on individuals and families, communities, and government (through

both incurred costs and lost benefits[35]. Direct impacts on children include disability arising from in-utero exposure to alcohol and/or drugs, poor parenting and a higher risk of experiencing adverse events during childhood.

Adverse Childhood Experiences (ACE) of childhood abuse and neglect and household challenges impact on later-life health and well-being[36]. The number of ACEs children are exposed to increases their risk of health, social and emotional problems. ACEs include exposure to emotional, physical and sexual violence, not feeling loved, poverty, parents who were drunk or addicted or had mental illness, incarceration of a household member, parental separation or divorce and mother's exposure to domestic violence.

Longitudinal data sets consistently show a positive return on investment for effective and well-implemented prevention and early intervention programmes. Examples from the literature of the financial benefits of interventions improving outcomes for children and whānau are provided below (Table 4).

Table 4. Examples of the benefits of interventions to improve child outcomes

Benefits for clients	Evidence of financial benefits from the literature
Reduction in alcohol and drug use: The social and economic costs of alcohol and drug misuse are well established in New Zealand and internationally.	
Reduction in violence: A causal relationship has been established between alcohol and violence from both individual and population-level studies. The relationship between alcohol and injury can be an indirect one – the person who has consumed alcohol may injure someone else (and possibly themselves as well)[37].	
Improved holistic wellbeing: The PPS evaluation demonstrated improvement in holistic wellbeing, including improvements for clients who left PPS early.	
Improved living conditions – better housing and access to social services[38]: Improved housing has benefits ranging from improved health, reduced costs of health services. When health and energy results were combined with an analysis of industry impacts and employment changes a final cost benefit analysis estimated that the Warm-up New Zealand initiative would have a net benefit of $951 million dollars, and a benefit cost ratio of 3.9:1.	
Improved health and connection with health services: There is well established evidence across the health sector demonstrating the social and financial benefits of prevention and	

[35] PPS cost benefit analysis template

[36] Felitti VJ, Anda RF, Nordenberg D, Edwards V, Koss MP, Marks JS. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. AJPM 14 (4), p 245-258.

[37] Research New Zealand (2012). Alcohol-related injury: An evidence-based literature review. https://www.hpa.org.nz/sites/default/files/imported/field_research_publication_file/alcohol-related%20injury%20lit%20review%20FEB2012_0.pdf

[38] Evaluation of warm up New Zealand. https://www.healthyhousing.org.nz/research/past-research/evaluation-of-warm-up-new-zealand-heat-smart/

early intervention. For example, Treasury CBAx[39] estimates savings from avoided diabetes at $4,705 per annum and of avoided cardiovascular disease as $7,932 per annum.	
Increased participation in training and employment: There is a clearly established link between a mental health condition and both reduced participation in the labour force (6% for women, 13% for men) as well as the number of hours worked[40]. Suffering from poor mental health is also associated with an increased likelihood of benefit receipt[41].	
Reduction in engagement with Oranga Tamariki, Justice sector: Reduction in the costs of care placements: The United Kingdom Family Drug and Alcohol Court (FDAC) is an innovative approach to care proceedings where parental drug or alcohol misuse is a key feature of the case. An evaluation demonstrated the effectiveness of the court which included judicial continuity, a problem-solving therapeutic approach and a specialist multi-disciplinary team. The Court demonstrated savings though more children staying with their families and shorted placements for those who did not[42].	
Benefits for children	**Evidence of financial benefits from the literature**
Reduction in the prevalence of FASD: Estimates of the annual cost to the NZ Government per person with FASD vary, but a very conservative estimate would be $15,000. As well as direct costs, estimates of productivity loss to NZ due to morbidity and premature mortality from FASD range from $49 million to $200 million per year[43]. Reduced likelihood of ill health including FASD and Sudden Unexplained Death in Infancy[44], improved birthweight, reduced likelihood of a preterm birth, and reduced neonatal intensive care utilisation.	
Increased experience of positive parenting: Better parenting skills by the client learned through the service lead to a safe and enhanced psychosocial environment for their infant and an increased likelihood for the	

[39] https://treasury.govt.nz/information-and-services/state-sector-leadership/investment-management/plan-investment-choices/cost-benefit-analysis-including-public-sector-discount-rates/treasurys-cbax-tool

[40] Holt, H. (2010). *Working paper 10/03 – Health and Labour Force Participation*. The Treasury. http://www.treasury.govt.nz/publications/research-policy/wp/2010/10-03

[41] Fergusson, D. M., J. M. Boden & L. J. Horwood. Recurrence of major depression in adolescence and early adulthood, and later mental health, educational and economic outcomes. *British Journal of Psychiatry, 191*, 335-342. http://www.ncbi.nlm.nih.gov/pubmed/17906244

[42] Harwin J, Alrouh B, Ryan M and Tunnard J (May 2014) *Changing Lifestyles, Keeping Children Safe: an evaluation of the first Family Drug and Alcohol Court (FDAC) in care proceedings.* Brunel University. **ISBN** 978-1-908549-13-6

[43] https://www.health.govt.nz/our-work/diseases-and-conditions/fetal-alcohol-spectrum-disorder

[44] O'Leary, C. M., Jacoby, P. J., Bartu, A., D'Antoine, H., & Bower, C. (2013). Maternal alcohol use and sudden infant death syndrome and infant mortality excluding SIDS. *Pediatrics*, *131*(3), 770-778.

child developing 'secure attachment' which is necessary for emotional development[45] as well as for reduced antisocial behaviour late in life[46].

Parenting is a strong protective factor limiting adverse outcomes for children with FASD. PPS contributes by improving the postnatal environment[47]. The extent programmes work for children with FASD is not known. The review concludes that effective parenting interventions for this population group are part of an integrated support system for children with FASD and their families.

Reduction in child maltreatment: Each new substantiation of child maltreatment is conservatively estimated to cost $255,000[48].

Improved labour market participation/increased earnings and reduced dependence on the social welfare benefit system:

Increased educational attainment[49] and better social and academic competence[49] are potential outcomes for children supported by PPS.

Leaving school could cost between $3,500 and $15,000 per year in lower median earnings, compared to graduating or obtaining a tertiary degree[50] [51].

A young person entering the social welfare benefit system has an average lifetime liability of $250,000.[52] Those who leave school early are twice as likely to receive a benefit within

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[45] Honig, A. S. (2002). *Secure relationships: Nurturing infant/toddler attachment in early care settings*. Washington, DC: National Association for the Education of Young Children.

[46] Waller, R., Hyde, L. W., Klump, K. L., & Burt, S. A. (2018). Parenting is an environmental predictor of callous-unemotional traits and aggression: A monozygotic twin differences study. *Journal of the American Academy of Child & Adolescent Psychiatry*, *57*(12), 955-963.

[47] Sharman K. Literature review: Effects of parenting interventions on externalising behaviours of young children with fetal alcohol spectrum disorders.

[48] Segal, L., Dalziel, K., & Papandrea, K. (2013). Where to invest to reduce child maltreatment – A decision framework and evidence from the international literature. Brisbane: Queensland Child Protection Commission of Inquiry. Reported in Fox, S., Southwell, A., Stafford, N., Goodhue, R., Jackson, D. & Smith, C. (2015). *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention*. Australian Research Alliance for Children and Youth (ARACY), Canberra, Australia. https://www.aracy.org.au/publications-resources/command/download_file/id/274/filename/Better-systems-better-chances.pdf

[49] Crocker, N., Vaurio, L., Riley, E. P., & Mattson, S. N. (2011). Comparison of verbal learning and memory in children with heavy prenatal alcohol exposure or attention-deficit/hyperactivity disorder. *Alcoholism: Clinical and Experimental Research*, *35*, 1114–1121.

[50] Education Counts. (2015) *Impact of education on outcome.* https://www.educationcounts.govt.nz/indicators/main/education-and-learning-outcomes/1919

[51] Education Counts. (2013). *Tertiary education occasional paper 2013/02. Looking at the employment outcomes of tertiary education: New data on the earnings of young graduates.* https://www.educationcounts.govt.nz/__data/assets/pdf_file/0020/143561/Looking-at-the-employment-outcomes-of-tertiary-education-ii.pdf

[52] Ministry of Social Development. (2012). *Investment approach refocuses entire welfare system*. http://www.msd.govt.nz/about-msd-and-our-work/newsroom/media-releases/2012/valuation-report.html

five years (13%) compared to those with qualifications (6%), and more than six times as likely compared to those with a tertiary degree (2%).[53]	
Reduced exposure to risk factors for long-term outcomes (ACE risk factors): Evidence from the evaluation confirmed reduced exposure to family violence, poor parenting, parental mental illness, parent incarceration and experiences of state care. Improved resilience[54]	
Benefits for government and society	**Evidence of financial benefits from the literature**
Increased participation in society: Reducing early childhood vulnerability (as measured by the Australian Early Development Index) by 9% by 2020 was estimated to result in an increase in GDP of more than 20% over the life course of those children. The total long-term human and social costs of child abuse and neglect were estimated as $2,025 billion. There was limited qualitative evidence from the evaluation of clients moving back into employment. The number of clients moving into employment and training would be expected to increase as at the time of the evaluation clients had young children.	
Increased equity through reduction in adverse outcomes for tamariki Māori: Māori were over-represented in the PPS client/whānau group. Positive benefits for clients therefore contribute to a reduction in adverse outcomes and reduction in inequitable outcomes.	

9.4. Monetising the benefits of PPS is difficult

There are challenges in an economic analysis of the costs and benefits of the PPS. As for the Waitematā model on which the PPS were based, the costs of setting-up the pilot PPS services were not disaggregated from the total PPS funding. Lack of disaggregation, the number of active clients at the end of the evaluation and variation in the intensity and length of support provided varied per client limiting any analysis of the costs and benefits of PPS.

In addition, many of the benefits of PPS are indirect and longer-term benefits. There are also wide-reaching benefits from improved wellbeing. It is not feasible to estimate the proportion of the PPS cohort incurring these benefits and there is limited information available to monetise these benefits.

Treasury recommends reverse analysis where the impacts of an intervention are known but hard to monetise[55]. Table 5 provides examples of a limited list of potential

[53] Education Counts. (2013). *Tertiary education occasional paper 2013/02. Looking at the employment outcomes of tertiary education: New data on the earnings of young graduates.* https://www.educationcounts.govt.nz/__data/assets/pdf_file/0020/143561/Looking-at-the-employment-outcomes-of-tertiary-education-ii.pdf

[54] https://www.budget.govt.nz/budget/2019/wellbeing/child-wellbeing/index.htm

[55] https://treasury.govt.nz/sites/default/files/2019-09/cbax-guide-sep19.pdf

benefits of PPS. The list is based on evidence from the evaluation and is limited by the absence of a comparison cohort and any information about the cumulative impact of benefits.

The cohort size is an annual conservative estimate based on:

- Sixty-seven clients who routinely exited PPS (15% of all accepted referrals) – assuming benefits are experienced by all clients completing PPS.
- Benefits for pregnancies and to children estimated on the rates per 100 clients available from PPS data:
    - 0.28 pregnancies per 100 clients
    - 0.98 children under three per 100 clients
    - 1.25 children aged three to 18 per 100 clients.

Table 5. Annual estimates of the potential financial benefits of PPS – assuming benefits are experienced by clients who routinely exited PPS and their children

	CBAx value (2020)	Clients (n=67)[56]	Children (n=149)[57]	Aversion of FASD (n=6)
Improved wellbeing - Quality-adjusted life year (QALY) gained	$33,306	Estimates not available		
Physical health for every 1 point change (improvement) (0-100 scale)	$1,205	$80,735	$179,545	
Mental health for every 1 point change (improvement) (0-100 scale)	$4,795	$321,265	$714,455	
Being able to express cultural identity for every 1 point change (0-4 scale)	$9,951	$666,717	$1,482,699	
Reduction in FASD costs (for 30% of children)	$15,000		$670,500	$90,000
Productivity costs related to FASD per child per year	$1,633			$9,800

[56] Routine exits from PPS with treatment complete

[57] The number of children is calculated at 0.98 under the age of three and 1.25 aged three to 18 per client routinely exiting PPS with treatment complete.

However, additional benefits can be expected for:

- Clients and whānau (45%) who remained active at the end of the evaluation: 15% of these clients could be expected to exit routinely. The time over which further support is required is unknown.
- Clients and whānau who disengaged or exited early. There is qualitative evidence of benefits and some are returning.
- The wider reach of PPS to whānau including partners. Qualitative evidence supports the wider benefits.
- Benefits to subsequent pregnancies.

Over time, the Integrated Data Infrastructure has the potential to provide information about the long-term financial benefits of PPS. However, its use is limited by the lack of association of child and parent NHIs in DHB data collection tools.

10. Overview

Three PPS have been established based on the Waitematā model. Providing the Waitematā service as a foundation for extension to other localities has been effective in facilitating service development.

The three PPS have delivered an intensive outreach programme for pregnant women, and parents with children under three years of age, who experience problems with alcohol and drugs. The services have improved outcomes for many of the clients they have supported to mitigate the harm to both themselves, their children and their future children. Clients who have achieved their goals and exited the services have achieved more positive changes than other groups. However, many clients who have exited the services early have still achieved positive changes and some have re-engaged.

Delivering support through PPS is resource intensive but has direct and indirect financial benefits for clients, children, whānau and communities. Intergenerational benefits have the potential to result in substantial long-term savings for government. PPS services target the segment of the population that account for disproportionate economic costs in later life[58].

> *We're talking about a small percentage of the population that required a lot of resources to change and there is no reason why it can't be changed but it does require very intense resources and its having places and people that are able to do that. (HB-Stakeholder-2020)*

10.1. The core components of the PPS model were reflected in each service

The diagram below summarises the core components of PPS delivery developed by Waitematā. The three PPS pilots drew from the Waitematā experience to set up service models that were adapted to their locality contexts.

[58] Caspari A, Houts RM, Belsky DW, Harrington H, Hogan S, Ramrakha S, Poulton R, Moffit T. (2016). Childhood forecasting of a small segment of the population with large economic burden. Nature Human Behaviour (1). Article number 0005.

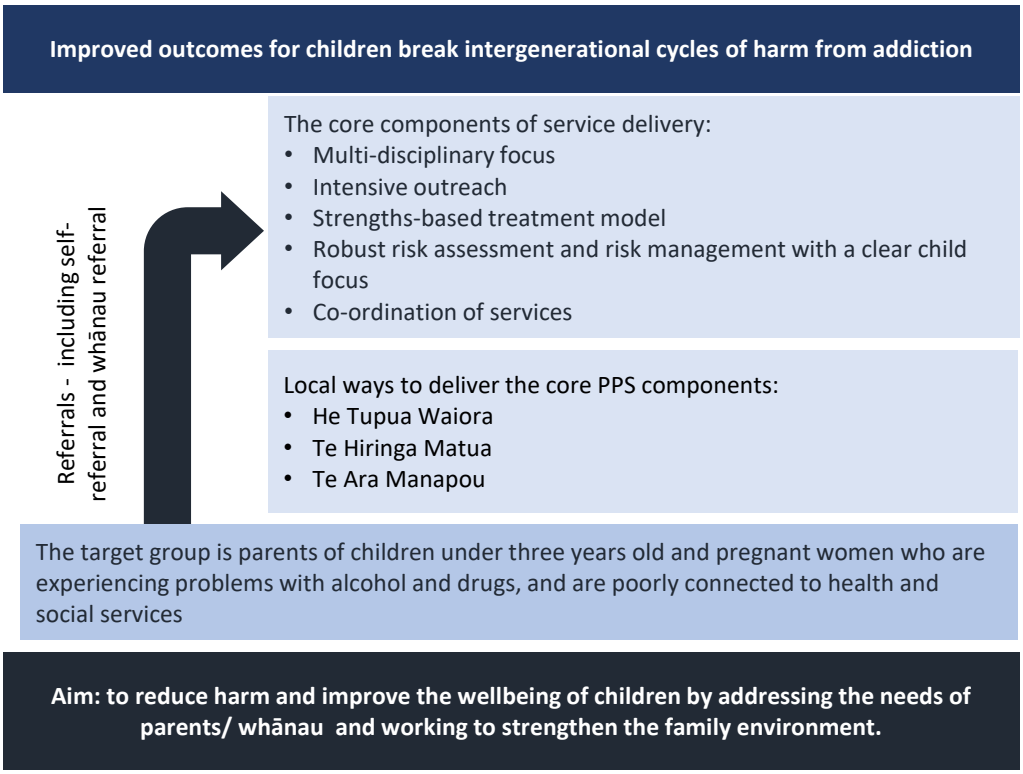


Figure 31. The core components of PPS

Interviews with PPS teams and clients demonstrated that the core components underpinned the effectiveness of PPS in reaching clients in the target group and supporting them to achieve changes for themselves and their children.

- A multi-disciplinary focus was achieved through committed teams that were built within each service to support clients. Different skills were valued and teams included registered health professionals, peer supporters, and practitioners with skills and knowledge of Mātauranga Māori. The PPS workforce was supported by leadership and robust management structures.
- Intensive outreach was enabled by low caseloads. The teams could go to clients and spend time engaging with them and '*stick with them through the ups and downs'* but there were challenges in consistently reaching clients in remote and isolated communities.
- Strengths-based treatment model. The way PPS were delivered was important to clients. Clients consistently described the importance of trust. Once they had engaged with clients, the teams provided holistic and whānau focused support. The teams did not lose sight of the aim of improving outcomes for children but focussed on the child in the context of whānau.
- Meaningful risk assessment and risk management with a clear child focus were achieved through regular risk assessments and meaningful engagement of the MDT.

- Co-ordination of services. PPS supported clients by co-ordinating a wide range of services and delivering support and education. Support was provided to clients and whānau and the importance of whānau in sustainable recovery was highlighted by the teams. Support for housing and food provided the foundation to responding to other needs (Figure 32).

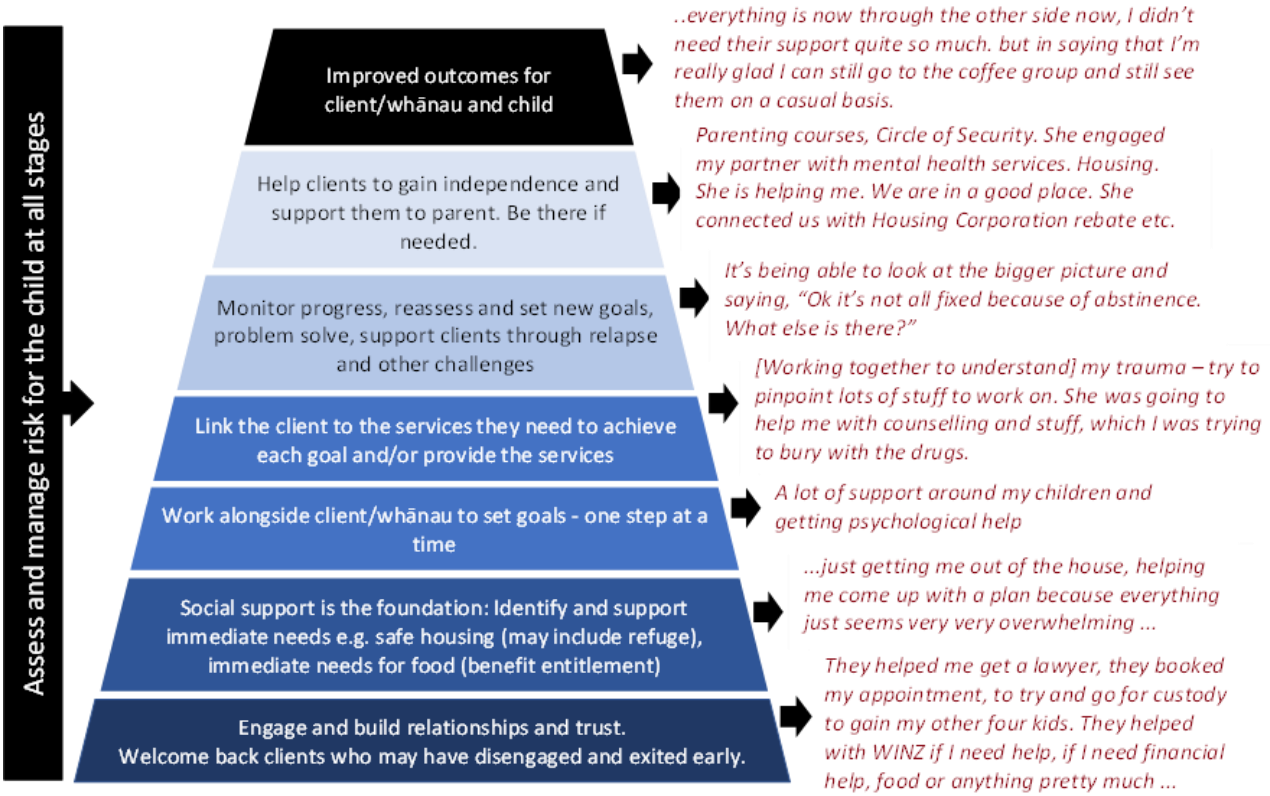


Figure 32. Examples of the breadth of support PPS provide for clients

10.2. Differences in the way the core components were operationalised influence reach and service delivery

The evaluation of the three PPS provided insights into the implications of different approaches to be considered when establishing new PPS.

- Funded service development time was important to provide a firm foundation. Funded development time enabled employment of project managers and the time to build a solid service foundation.
- Mentorship from an established service helps with development of new PPS but it is important for the mentors to recognise the need for local adaptation of the core elements.
- Teamwork is at the heart of PPS. MDT enable a breadth of support and working as pairs reduces risk for the PPS teams. There are advantages of

including in the PPS teams an administrator, male and female case workers and non-clinical team members. Consistent support from a psychiatrist and psychologist was important for the PPS team members and clients and whānau.

- Appointing the full team at the start of developing a new service allows more time for preparation and starting the service with lower caseloads. Staggered recruitment provides flexibility to see what other experiences and/or roles were required as the service developed.
- Promoting the PPS to local communities and services communicates the profile of whānau the PPS support. Community based services help promote self-referrals. Self-referred clients and whānau may be more likely to be ready to make changes and less likely to disengage.
- The PPS whare are important. Welcoming environments and whānau rooms enable on-site work, group work and provide sites for visits with children who may be in Oranga Tamariki care.
- Whānau focussed support: PPS funded client numbers will be expanded by support provided to whānau.
- Group settings are important in providing peer support and connections. Te Hiringa Matua were able to support more clients in a wānanga setting than could be supported 1:1 but this had to be balanced against outreach support they provided to whānau in Gisborne and remote East Coast Bays.

10.3. Not all clients who were referred met PPS criteria

Entry criteria were tightly defined as part of the PPS design. However, an ongoing challenge for PPS was receiving referrals for people who were not eligible for their support. They spent considerable time trying to contact people to engage and confirm eligibility and if they were not eligible to link then with some other form of support.

> *And especially for those who we get referred, and they don't meet our criteria, but we can't just drop them, so we do refer them on to other services and do quite a bit of work to engage with them with somebody who is going to help them, so they don't end up in our service. (HB-PPS-2018)*

Referrers and the PPS teams frequently commented that they wished PPS had slightly wider criteria and could take women before they became pregnant or whānau with children outside the eligible age range who met all other criteria.

> *I will say it has been quite difficult seeing people come in with three year olds, that we can't do anything with because it's under three and there has been quite a few and the youngest child is three and we do we send them and there is nowhere for them to go, … that's been difficult for me just sitting and just thinking about …. (HB-PPS-2017)*

Recognizing the traumatized children younger than five that walk in the door that you can't save. And being able to work with them, and maybe get them an appointment with a psychiatrist or paediatrician that comes up this way. Being able to say to OT can you do some sensory stuff…we've got a couple of children that slipped under my caseload, over the age of three but part of that whānau that would otherwise go without anything until they reached the criteria somewhere else. (N-PPS-2019)

In Northland, PPS criteria excluded whānau in the mid-North region.

Yeah. And they're still asking us, "Can you just come over here and see these people?" And it's just not really possible. (N-PPS-2019)

Te Hiringa Matua were able to support whānau who did not fit the PPS criteria through wānanga.

That is part of our kaupapa as well, if they don't fit our criteria but they want to be part of, we still have that open forum for wānanga, its open to all people, being able to provide that for them but also support them to find a space that would be more suited to them. (T-Mataora-2020)

10.4. Outcomes for clients

PPS support has achieved a range of sustainable outcomes for clients and whānau who are at highest risk of relapse by strengthening whānau connections and developing a support network that maintains their sobriety[59].

10.5. Outcomes for children

The focus of PPS was on improving outcomes for children and reducing the intergeneration transfer of disadvantage. The Child and Youth Wellbeing strategy sets out six interconnected wellbeing outcomes that provide an overarching framework for the work of government in improving outcomes for children in Aotearoa New Zealand. The indicators in the Child and Youth Wellbeing strategy provide a framework for summarising the benefits of PPS for children.

Although rates were not able to be accurately calculated improved outcomes for children were demonstrated through qualitative and quantitative evidence.

[59] da Silva, M. L., Guimarães, C. F., & Salles, D. B. (2014). Risk and protective factors to prevent relapses of psychoactive substances users. *Revista da Rede de Enfermagem do Nordeste*, *15*(6), 1007-1015.

Table 6. The benefits of the three pilot PPS

Child and youth wellbeing strategy[60]	PPS service outcomes
Are loved, safe and nurtured	Feeling loved: Increases in positive parenting Feeling safe: Reduction in risk factors through parents' reduction in alcohol and drug use; increased rates of safe parenting Family/whānau wellbeing: Holistic wellbeing increased across the four domains of Te Whare Tapa Whā Harm against children: Reduction in risk factors (whānau and others' AOD use; exposure to family violence) Quality time with parents: Increases in positive parenting
Have what they need	Material wellbeing: Some parents returning to work or training Food security: Connection with full and correct benefit entitlements Housing quality: Improved housing quality flows through to reduced needs for health care
Happy and healthy	Prenatal care: Connection of pregnant women with prenatal services Prenatal reduced exposure to toxins: Reduced exposure during pregnancy; Reduction in AOD use will lead to reduced exposure for subsequent children Subjective health status: Increased access to Well Child Tamariki Ora services; primary care registration, dental care
Learning and developing	Early childhood learning attendance: Increased connection with ECE for older children Social skills: Referral to specialist behavioural services
Accepted, respected and connected	Sense of belonging: Increases in positive parenting; reconnection with whānau Experience of discrimination: Changes to the way other services engage with PPS whānau Social support: Parents have improved taha wairua and taha whānau Support for cultural identity: Reconnection with culture, especially through Mātauranga Māori embedded in Te Hiringa Matua
Involved and empowered	Involvement in community: Parents reconnection with whānau and culture.

[60] https://childyouthwellbeing.govt.nz/sites/default/files/2019-08/strategy-on-a-page-child-youth-wellbeing-Sept-2019.pdf

10.6. Risks

PPS is effective because it supports clients differently to other services. The core components of the PPS model – the multi-disciplinary focus, the intensive outreach, the strengths-based treatment model that respects clients and moves at their pace and risk assessment processes – are all essential in reaching and supporting the target group. Delivering the core components of PPS requires low caseloads and experienced and well-resourced and supported teams. The high demand for support for the PPS client/whānau group and the high upfront cost poses a risk as PPS becomes business as usual. The risk of pressure to increase caseloads must be resisted.

> *I would say PPS is such a unique service and a unique way of working with its assertive outreach that there is risk that it gets gobbled up with all of the mental health services and treated the same. It needs to be a little bit different. Those capped caseloads do make a difference they work more effective but there is the risk like you say the 'Northland way' it can become like any other mental health service as long as the mum had used substances it should be with PSS. (N-PPS-2020)*

10.7. Opportunities

The evaluation has demonstrated the positive outcomes of PPS for clients and children and supports the extension of the services at the current sites and to additional locations.

In addition to extending and expanding PPS sites, there is an opportunity to include clients with addiction issues and who poorly connected to services who are likely to become pregnant. This could include first and subsequent pregnancies and increases the potential of PPS to limit the adverse effects or drug and alcohol use on the foetus.

We heard about the positive difference PPS made for other local services, in particular Oranga Tamariki, with whom many clients were shared. There is the potential to formalise the links between PPS and Oranga Tamariki as part of an increasing focus by Oranga Tamariki on early and intensive intervention with at risk families.

> *I think Oranga Tamariki could actually rework their system. And I think we are in the perfect opportunity to work alongside one of the branches to actually show what that could look like. (HB-PPS-2019)*

At a system-level, Oranga Tamariki and Well Child Tamariki Ora services have a focus on the child and the whānau context is often not included. The PPS focus on whānau as a pathway to improve child outcomes has demonstrated positive outcomes for clients and children. Extension of holistic support for the whānau is an important system-level change.

Their focus is on the child and the safety of the child which is good. But we've really seen, if children are uplifted from the parents, the parent gets left with nothing. All of the focus stays with that child, services, everybody is focussing on the child and the parent is just left. (HB-Stakeholder-2020)

I had to go to Women's Refuge because I was in a violent relationship and then I went out into my own in the community and it was all about baby because of Plunket and there was nothing for me, for my mental health. (N-C5-1)

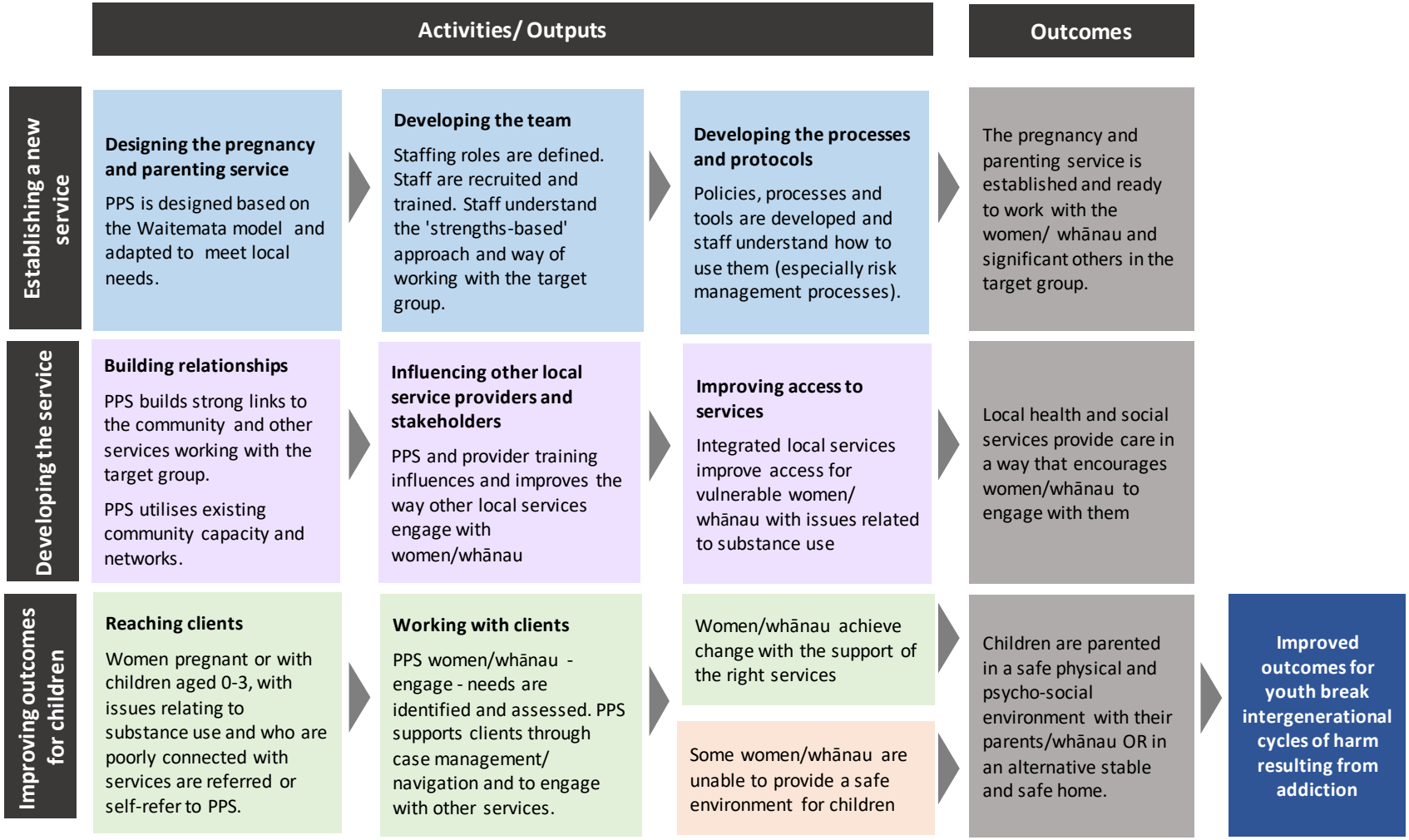
Te Hiringa Matua operationalised Mahi a Atua and demonstrated the effectiveness of kaupapa Māori services to reinstate Mātauranga Māori and reduce the impacts of colonisation on whānau Māori. Learning from the Te Hiringa Matua service model and expanding it to increase access for whānau Māori provides an opportunity to meet Tiriti o Waitangi[61] obligations to provide equity for Māori.

A last word from one of the PPS team leaders is about the importance of services continuing to grow and develop to respond to the needs of their communities and the clients and whānau they support.

61 https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf

11. Appendix 1: Evaluation details

Evaluation Logic model



The logic model for Te Hiringa Matua

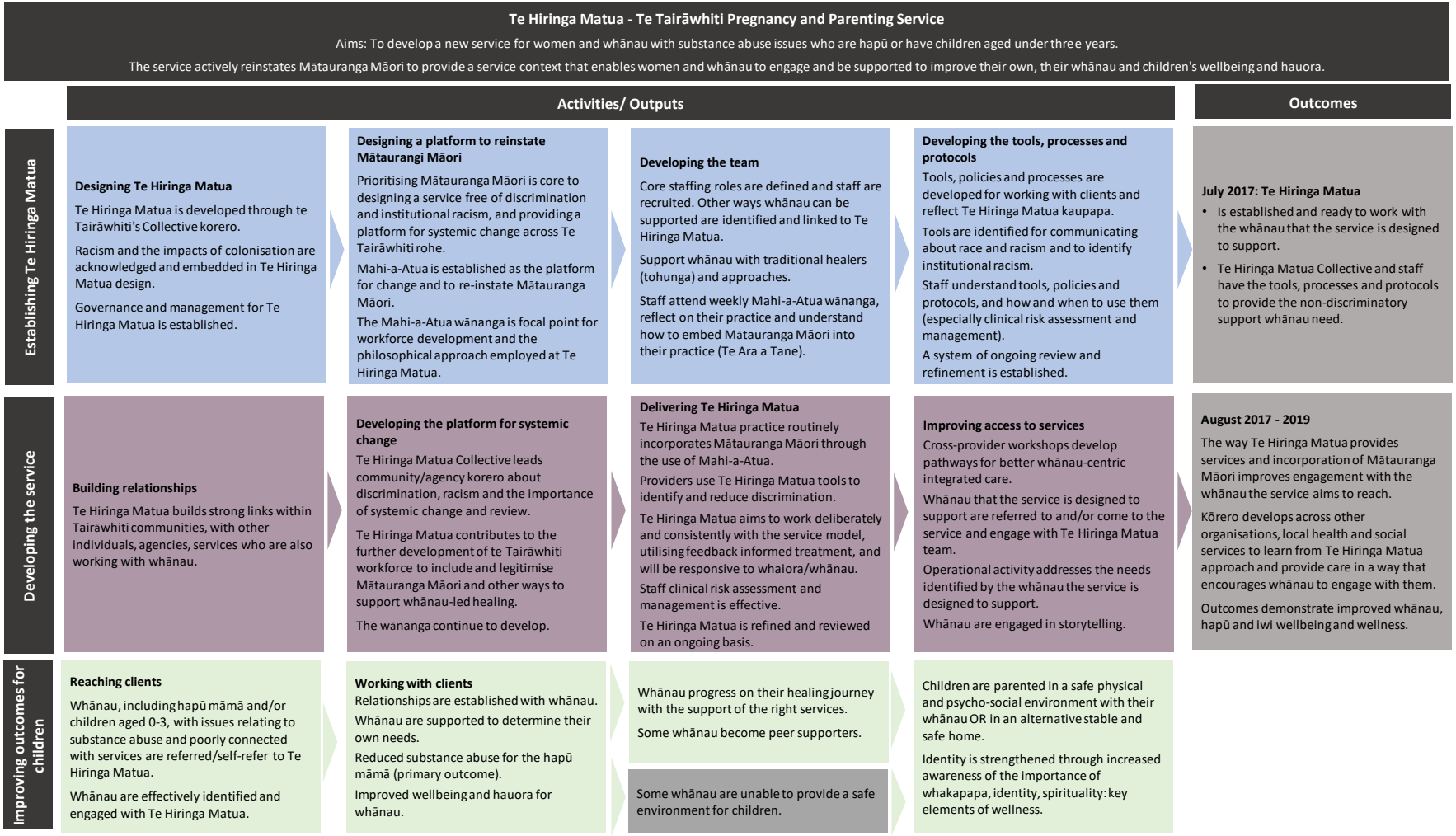


Table A1. In-person and telephone interviews

Information sources	Number of interviews
Northland – He Tupua Waiora	
Site visits[62]	December 2016, Jan 2017, April 2017, July 2017, December 2017, February 2018, August 2018, October 2018, January 2019, July 2019, March 2020 Interviews included: • Project manager • Team leader • Team members, including psychologist and psychiatrist – individual interviews and focus groups Telephone interviews were completed with the team leader between site visits.
Client interviews	Total clients interviewed: 19 19 first interviews 8 second interviews 2 third interviews
Other stakeholders	Midwife -July 2017 Placed Based Initiative (2 representatives) -July 2017 Oranga Tamariki (2 representatives) -February 2018, August 2019 Women's Refuge -July 2017, February 2019 Maternal Mental Health Service-January 2019
Tairāwhiti – Te Hiringa Matua	
Site visits	January 2017, Mar 17, April 17, June 17, Oct 17 August 2018, October 2018, January 2019, July 2019, January 2020, March 2020[63]
Te Kurahuna wānanga attended	2
Te Hiringa Mātua wānanga attended	4
Whānau interviews	Wānanga attended with whānau discussions Total whānau interviewed: 7 7 first interviews 2 second interviews 1 third interviews

[62] Site visits were completed in person but when flights were cancelled on two occasions these took place by phone or Zoom instead. One site visit was to the 'spoke' in Kaitaia (January 2019)

[63] Site visits included attending wānanga, whānau, mataora, kaiārahi and project manager interviews. Most project manager and kaiārahi interviews were conducted over the telephone separate to the site visit days and the March 2020 interviews were undertaken by phone and Zoom.

Other stakeholders	MSD -August 2019 50 Families- August 2019 Oranga Tamariki -September 2019 Te Kurahuna- March 2020 Midwife- March 2020
Hawke's Bay – Te Ara Manapou	
Site visits	Dec 16, Feb 17, Dec 17, June 18, Dec 18, Aug 19, March 20 Site visits included interviews with: • The DHB manager (Mar 17, August 18, July 19) • Interviews with the team leader at each site visit • Interviews with the team members – individual interviews and focus groups Site visits also included interviews with the psychologist (June 18, July 19, March 20) and psychiatrist (July 19). Telephone interviews were completed with the team leader between site visits.
Whānau interviews	Total whānau interviewed: 22 22 first interviews (21 clients and one whānau member) 4 second interviews 3 third interviews
Other stakeholders	DHB stakeholders and referrers (x 2 in Aug 17, March 2020) Oranga Tamariki (August 2017, March 2019, June 2020) Te Poutouma Tautoko (2018) Community (2018) Police (March 2020)
Other information sources	
Workshop attendance	Nov 16, Feb 17, June 17, Oct 17, May 18, Mar 19, Oct 19
Interviews with Waitematā	Feb 17, Oct 17, Jan 19 MDT meeting attendance