Template 1: Budget Initiative template

There are five sections of this template agencies need to fill out:

- Overview and context
- Detail on the investment proposal
- Wellbeing impacts and analysis
- Cost understanding and options
- Collaboration

Overview and context

Key Question/area	Comment/answer
Agency to complete	
Portfolio of lead Minister	Hon Dr. David Clark
Portfolio(s) of other Ministers involved (if this is a joint initiative)	
Votes impacted	Health
Initiative title	Intensive parenting support
Initiative description	This bid seeks to expand Pregnancy and Parenting Services (PPS) to [redacted] new sites. PPS is an intensive outreach service that provides case co-ordination and services for pregnant women and parents with children under 3 years of age who are experiencing problems with alcohol and other drugs and are poorly connected to health and social services. It aims to reduce harm and improve wellbeing of children by addressing the needs of parents whilst working to strengthen the family environment.
Type of initiative	**Priority aligning initiative**
If this initiative relates to a priority, please outline the specific priority/ies it contributes to	4. Reducing child poverty and improving child wellbeing, including addressing family violence. Also Child Wellbeing Budget priority: Investment in preventative and early interventions to support children in early years (0-6) and their parents, families and whānau [Cab 18 Min 0449.01 refers].
Does this initiative relate to a commitment in the Coalition Agreement, Confidence and Supply Agreement, or the Speech from the Throne?	**N**
Agency contact	Ruth Wiltshire, Ministry of Health, Ruth_Wiltshire@moh.govt.nz s 9(2)(a) [redacted]
Responsible Vote Analyst	Please provide the name of your Vote Analyst

Funding

Funding Sought ($m)	2018/19[1]	2019/20	2020/21	2021/22	2022/23 & outyears[2]	TOTAL
Operating	s 9(2)(f)(iv)					

Funding Sought ($m)	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	TOTAL
Capital[3]	-	-	-	-	-	-	-	-	-	-	-

1. Executive Summary

1.1 EXECUTIVE SUMMARY	
A. Short summary of the proposed initiative and expected outcomes.	This bid seeks to expand services at the intensive end of parenting support services by building on successful prototypes operating in four sites across the country. The Pregnancy and Parenting Service (PPS) is an intensive assertive outreach case coordination service for pregnant women and parents of children aged under three who are experiencing problems with alcohol and other drugs and are poorly connected to health and social services. PPS is proven to reduce harm (including mortality) and improve the wellbeing of current and future children by addressing the needs of parents and working to strengthen the family environment. It is targeted at families experiencing multiple and complex issues related to, for example, alcohol and other drugs, stigma, mental and physical health, pregnancy, poverty, parenting, family violence, child neglect and abuse, custody issues, fear of involvement with child welfare agencies and criminal involvement. Despite a high degree of mistrust of services among this population, this service consistently has a high level of self-referral. It is also a key referral service for a wide range of health, social and justice sector services; including the Police, Oranga Tamariki and Corrections. This bid would fund would use the same successful mentoring model to further roll out the service into [redacted] new regions (identified through data analysis based on highest need). The bid has links to mental health, maternity services, Well Child Tamariki Ora, family violence, criminal justice reform and Oranga Tamariki's new intensive services for children at risk of entering or re-entering state care.

2. The Investment Proposal

2.1 Description of the initiative and problem definition	
What is this initiative seeking funding for?	To extend a successful substance abuse harm reduction and minimisation programme that works with pregnant women and families with children under three. It has already been successfully implemented in four sites; Waitematā, Northland, and Tairāwhiti and Hawke's Bay. The programme will be expanded to a further [redacted] sites; based on an analysis of the next highest areas of

[1] If there is no funding required in 2018/19, then please delete this column

[2] If funding is time-limited and does not carry on into out-years please delete the reference to "& out-years"

[3] The first 10 years of capital investment is counted against the multi-year capital allowance. Please reflect the full 10 year profile in the table.

	material deprivation. s 9(2)(f)(iv) [redacted] The new sites are expected to operate at the same level of caseload, each supporting a caseload of approximately 100 women and their families per annum [redacted].
Why is it required?	Parental use of alcohol and other drugs harms children and is having significant impacts on our health and education systems and communities. It has dynamic, far reaching and inter-generational effects. Working with parents can mitigate harm both to themselves and their existing and future children. For example our analysis suggests that this proposal could avert or mitigate approximately 30 cases of FASD per 100 mothers in the programme. Young children of people with significant issues with alcohol or other drugs, and children who are alcohol- or drug-affected as a result of exposure in utero, are a priority population because they are more likely to lack a stable or nurturing home, live in a home environment with someone who is abusing alcohol and/or other drugs, and be a victim of family violence. For such children, there can be life-long disparities that inevitably impact on them, the community, and Government, and their future children. This situation can be at least partially prevented, and/or effectively mitigated. It is important that PPS takes a holistic approach to managing pregnant women and parents of children under three to ensure the drivers of behaviour are also mitigated; for example poverty, lack of stable and safe housing, family or intimate partner violence, or mental health issues. Poly-drug use is common and PPS addresses all of them. There is often other older children in the household who also benefit from improved parenting and better coping skills. Although this is a treatment service it can help prevent further pregnancies where the foetus is exposed to alcohol and other drugs. ***There are a range of different ways and points in time when harm can be done and there are multiple intervention points…*** The risks of exposure during pregnancy are different for different drugs, and risks increase if more than one drug is used. Of all the drugs of abuse, including cocaine, heroin and marijuana, alcohol is the most harmful to the developing fetus. While Ministry of Health advice has consistently been that women who are pregnant or contemplating pregnancy should not drink alcohol, the evidence suggests that about one in two pregnancies in New Zealand are alcohol exposed[4], and that one in ten pregnant women drink alcohol at levels which place their fetuses at a high risk of damage[5]. Fetal exposure to alcohol can lead to permanent damage to the brain and other critical organs, functions and structures. Fetal Alcohol Spectrum Disorders (FASDs) is a non-diagnostic umbrella term describing the range of different effects that can result from fetal alcohol exposure. FASD is conservatively estimated to cost the state $17,000 per year per individual for every year of life, due to increased health costs, impaired educational outcomes, increased justice system costs, increased benefit dependency and reduced employment prospects. People with FASDs are also more likely to have children who are exposed to alcohol and other drugs in utero, putting them at risk of FASDs. It is conservatively estimated that about 1% of New Zealanders have FASDs. While as noted above alcohol is more significantly toxic for developing fetuses than other drugs, pregnant women who have problems with any type of drug may have difficulty taking care of themselves physically and mentally. This in turn impacts on the safety, development and growth of their fetus. ***Supporting parents and parenting is an important way of supporting at-risk children and keeping them safe…***

[4] This is the (rough) average of the findings of three pieces of recent local research: 19 per cent (Ministry of Health 2015), 56 per cent (O'Keefe et al 2015) and 71 per cent (Superu 2015).

[5] O'Keefe et al (2015). This is based on any episode of binge drinking (four or more standard drinks) at any stage in pregnancy.

	The impacts of drug and alcohol abuse continue ex utero. Growing up being exposed to alcohol abuse is highly correlated with experiencing adverse childhood events[6]. Children whose parents' ability to parent is compromised due to problems with alcohol or other drugs are at risk of a range of negative outcomes. Substances impact on a caregiver's ability to be emotionally responsive to their infant, which is the mechanism through which both attachment and brain development occurs[7]. There is also a link between drug and alcohol misuse in parents and child abuse It is also difficult for parents to parent well when they themselves are either physically or mentally unhealthy[8 9 10 11] The IDI analysis undertaken for this cost benefit case found that children with FASD and/or whose mothers had indicators of drug or alcohol abuse at birth or post-partum were 9-12 times more likely to have an Oranga Tamariki (OT) finding of abuse and neglect than other children. Improving parental mental health and treating alcohol and substance dependency may therefore reduce the number of children going into OT care. Having problems with alcohol and other drugs is also harmful for the person who abuses them[12]. Have these problems is not incompatible with being a good parent, but it is likely to affect parenting ability. Adults who have problems with alcohol and other drugs often require significant support and extensive engagement to access relevant services, and may themselves have FASDs (as there is a known intergenerational link) or cognitive impairment. With support they can be effective parents, but they may not seek services for fear of having their children removed. Therefore services, in addition to being highly effective clinically, need to be tailored in a way that makes them accessible and reduce barriers to their use by this population (for example cultural barriers and social judgements).
2.2 Options analysis and fit with existing activity	
What other options were considered in addressing the problem or opportunity?	The Child Wellbeing Strategy work programme for the first 1000 days has medium term policy work scheduled through the Well Child Tamariki Ora review to look at how best to deliver parenting support services and provide advice to Government on options and funding going forward. This initiative is an opportunity to gain quick wins for the Government through expanding this successful programme targeting highly vulnerable populations. s 9(2)(f)(iv) [redacted]

[6] Dube, S. R., Anda, R. F., Felitti, V. J., Croft, J. B., Edwards, V. J., & Giles, W. H. (2001). Growing up with parental alcohol abuse: exposure to childhood abuse, neglect, and household dysfunction. *Child abuse & neglect*, *25*(12), 1627-1640.

[7] The Science of Early Childhood Development. (2007) National Scientific Council on the Developing Child. http://www.developingchild.net

[8] Streissguth, A. P., Bookstein, F. L., Barr, H. M., Sampson, P. D., O'Malley, Kieran A. N., & Young, J. K. (2004). Risk factors for adverse life outcomes in fetal alcohol syndrome and fetal alcohol effects. *Journal of Developmental & Behavioral Pediatrics*, *25*(4), 228-238.

[9] Ibid

[10] Astley, S. J. (2010). Profile of the first 1,400 patients receiving diagnostic evaluations for fetal alcohol spectrum disorder at the Washington State Fetal Alcohol Syndrome Diagnostic & Prevention Network. *Can J Clin Pharmacol*, *17*(1), e132-e164.

[11] Ospina, M., & Dennett, L. (2013). Systematic Review on the Prevalence of Fetal Alcohol Spectrum Disorders. *Institute of Health Economics, Edmonton, Canada*.

[12] Degenhardt, L., & Hall, W. (2012). Extent of illicit drug use and dependence, and their contribution to the global burden of disease. *The Lancet*, *379*(9810), 55-70; New Zealand Law Commission report "Alcohol in our Lives"

	Senior Ministry clinicians advise that home-grown approaches developed in partnership with the sector, Māori, Iwi and Pacific people are most likely to be attractive to highly vulnerable populations and therefore have the best chance of succeeding.
What other similar initiatives or services are currently being delivered?	There is an initiative still in its first year of delivery that looks very promising. It is part of the South Auckland Place Based Initiative and is called Start Well. It is also an intensive home visiting service for vulnerable, young pregnant mothers and also uses a multi-disciplinary team. Clients do not necessarily have addiction issues. It is likely that there are other similar initiatives underway across District Health Boards that will be captured through the first 1000 days work programme.
What other, non-spending arrangements in pursuit of the same objective are also in place, or have been proposed?	As mentioned above the social sector agencies involved in the Child Wellbeing Strategy have prioritised policy work to ensure agencies work effectively together to deliver the most cost effective suite of services that can be tailored by localities to best meet the needs of their populations. However, this is a medium term policy deliverable.
Strategic alignment and Government's priorities/direction	This initiative is strongly aligned to the first 1000 days, reducing child poverty, and child mental wellbeing priority areas under the Child Wellbeing work programme being led by the Department of Prime Minister and Cabinet (DPMC). It is also aligned to work underway to reduce family violence and is strongly linked to achieving equity for Māori, Pacific and other disadvantaged populations.
2.3 Outcomes	
Overall outcomes expected from this initiative	A key rationale for providing this service is the accumulating evidence that early intervention delivers the best outcomes over the long term for the children, whānau and society. Programmes such as PPS can shift focus from the mother's drug using to a positive focus on her children's future. Such programmes aims to move mothers from feelings of shame and guilt about their drug taking, to being motivated to give their children a better chance, which requires addressing their drug issues. The PPS model has been refined over time and has been informed by some key reports and examples of similar services (overseas). The latest outcome evaluation report from Waitemata DHB (Nov 2017) show positive outcomes in relation to providing a safe protective environment of children. Critically the number of children exposed to violence is reduced. Data indicates that there is a reduction in AOD use and AOD-related harm for PPS clients. There is also evidence that clients develop positive parenting skills which enable them to better support the health and wellbeing of their children. Many clients highlight this as a key outcome which has a range of impacts, for example enabling them to manage stress, bond with their children, focus and be settled with their children, understand child development and respond appropriately to the needs of their children, have custody of their children and ensure the safety of their children.
2.4 Implementation, Monitoring and Evaluation[13]	
How will the initiative be delivered?	***Approach to implementation*** PPS is a mobile service that provides case consultation, coordination, and case management services. PPS is delivered by a skilled multi-disciplinary team of nurses, psychiatrists, psychologists, and peer workers. Knowledge of how best to implement this service is developing with each expansion wave. Waitematā mentored the other three sites and they are now, in turn, ready to mentor new sites.

[13] This doesn't necessarily have to include a full implementation and evaluation plan, however the information provided must provide confidence that the proposal will be successfully delivered and there is a plan to ensure that the outcomes described are actually achieved.

	The Tairāwhiti site uses a Tikanga Māori approach and is run by three NGOs. The other two sites are run by DHBs and each was developed to meet the needs of their population. We expect the new sites to continue to mature health's partnership approach with our Treaty partners and the local community to ensure services best meet local needs. PPS is delivered by a skilled multi-disciplinary team of nurses, psychiatrists, psychologists, and peer workers. It engages 80% of its clients for more than six months, with 50% engaged for more than twelve months. 64% of clients complete treatment. It is likely that a significant proportion of the cohort (Ministry of Health estimates 30-50%) will give birth to at least one child with a FASD unless intervention occurs. Ministry of Health analysis suggests that PPS is currently averting about twenty cases of FASDs per site, per annum, and mitigating the impact of a further ten. We expect other children are receiving increased development, health and learning benefits as a result of the parenting support and education their parents have received. PPS also makes referrals to other services. For example in 2014/15 50% of clients were referred to family violence services. All clients with children in their care were referred to parenting programmes. In 2015 PPS was documented and evaluated by the Health Promotion Agency[14]. As a result the elements that must be replicated for similar success have been captured and this information used in contract development, as well as being disseminated across the sector more broadly. In terms of outreach, a significant finding is that 39% of women self-refer to the service, which is important considering the weak connection, or active distrust, this cohort often has with health and social services. In Tairāwhiti self-referral is as high as 80%.
How will the implementation of the initiative be monitored?	The services will be required to fill out PRIMHD data like all addiction services. Quarterly reporting could be included in the contract and follow the same format of the information collected by the evaluators of the current pilot. Both quantitation and qualitative measures would be captured. Including soft measures.
Describe how the initiative will be evaluated	The current three pilot sites are under evaluation with some promising results. These [redacted] new sites will allow us to keep momentum going on what is shaping up to be a very successful service. The new sites can be included to a certain degree in the current evaluation, but would not have the same amount of running time. Once the evaluation of the pilot is complete, we can consider if any further evaluation of the new sites is required

3. Wellbeing Impacts and Analysis

3.1 Wellbeing domains – People's experience of wellbeing over time	
Identify and quantify how the initiative impacts on wellbeing domains	Please refer to Table 3.1 below.

[14] Parsonage, ibid.

3.1 Wellbeing domains – People's experience of wellbeing over time

Domains List domains, using the key above, where there is an impact. Order domains by magnitude of impact, i.e. largest impact domain first[15].	**Impact(s) description** Identify the impacts, with a separate line for each impact relating to a specific domain *Note you can identify multiple impacts for a particular domain. Delete/add rows as needed.*	**Who are affected?** Individuals/families/government/etc? Be as specific as possible. Are there distributional differences?	**Magnitude of impact** Relative to the counterfactual key assumptions, quantified to extent possible, and where possible monetised	**How big?** High/ Moderate/ Low, or where possible present value	**Realised** in <5 / 5-10 / 10+ years	**Evidence base** Nature of evidence and key references	**Evidence quality** High/ Medium/ Low
Health ✚ Primary	QALY gains	Foetus Infant Child Mothers Parents/caregivers families	Less in-utero exposure to toxins such as alcohol and other drugs leading to healthier infants at birth and less risk of serious neurodevelopmental issues such as FASD. Healthier pregnant mums and parents; both physically and mentally. Support to pregnant mothers and parents to learn new coping behaviours, parenting skills and experience less stress. This increases their ability to improve their own health and wellbeing. Support to enable good attachment between mum/dad and baby ensures baby has a good chance of achieving all the vital neurodevelopmental goals in the first 1000 days. Supporting mums and whānau to parent well and build their own resilience will improve the overall resilience of the whānau; including older children.	Evidence not available but likely to be large over 50 years	<5 years ongoing		low
	Fewer hospital visits	Government – District Health Boards	Reduce visits for pregnant mums, infants, children and wider whānau	Evidence not available yet	<5 years ongoing		Low
	Less demand for services	Government – District Health Boards, DSS services	Reduce use of FASD and other child development services	Evidence not available yet	<5 years ongoing		Low
Jobs and earnings ✂ Secondary	Increased capability for work and productivity	Parents	Improved capability to earn income	Evidence not available yet	<5 years ongoing		Low
Knowledge and skills 📖 Secondary	School attendance and learning	Government – schools	Less disruption of schooling leading to less truancy and higher levels of engagement at school. This is expected to result in higher levels of achievement in NCEA levels 1 & 2.	Evidence not available yet	10+ years ongoing		Low

[15] *Please note that in CFISnet, you will need to include the primary domain impacted, and up to two secondary domains impacted by the initiative. You can include as many domains as relevant in this table.*

3.2 Wellbeing capitals – Sustainability for future wellbeing	
Wellbeing capitals	Please fill out the table below to demonstrate how your initiative may contribute positively, negatively or neutrally to the four capitals.

Capitals	**Describe the impact and its magnitude**	**Realised in** <5 / 5-10 / 10+ years
Financial/Physical	**Increase** Although there is an initial cost outlay for Government there is a net decrease in costs for Health, Police, Organa Tamariki and MSD downstream. There is also an increase in people's capacity to earn income and possibly to support the educational achievements of their children.	<5 years through the impact on health and social services
Human	**Increase** This initiative improves health, wellbeing, and resilience for children and parents and also builds life skills for parents. This improves life choices, increases the quality of life for an individual, reducing hospital visits and sickness, and promoting productivity.	<1 year through the impact of children experiencing less violence, neglect, and exposure to environmental toxins (particularly in utero)
Natural	**Maintain** This initiative has no impact on natural capital.	N/A, as no impact
Social	**Increase** There could be some increase in social capital through addressing the stigma of alcohol and addiction issues and supporting healthy reconnection with whānau and community	5-10 years

3.3 Risk and resilience narrative	
Does the initiative respond to or build resilience?	Yes – significantly. These families require a holistic approach to help alleviate the stressors operating on the family (such as poverty and housing) as well as provide the necessary clinical care, and social supports to protect and grow the family's ability to raise healthy and resilient children.

4. Costing understanding and options

This section will provide further information on the costs of delivering the initiative and options for scaling and phasing to support assessment, prioritisation and decision-making.

4.1 Detailed funding breakdown

Please provide a breakdown of the costs of this initiative

These costings align with previous costing for the 2016 initiative and are based the costs of the Waitematā service.

($m)	2018/19	2019/20	2020/21	2021/22	2022/23
Setup costs	s 9(2)(f)(iv)				
Service Delivery					
Total					

4.2 Options for scaling and phasing

Scaling, phasing or deferring - including 75% and 50% scenarios

This initiative could be either phased to later budgets or scaled to [redacted].

Option 1: Delaying funding for [redacted] one year. The key impact would be no reduction in the service gap for these highly vulnerable pregnant women and parents with children under three.

Option 1	2018/19	2019/20	2020/21	2021/22	2022/23
Delay one year		[redacted]	[redacted]	[redacted]	[redacted]

Option 2: Reduce funding to [redacted] This would ensure there is a further expansion in services available for this vulnerable population.

Option 2: fund 2 sites	2018/19	2019/20	2020/21	2021/22	2022/23
Setup costs	[redacted]				
Service Delivery	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Option 3: Reduce funding to [redacted] This would allow for a minimal expansion in services available for this vulnerable population.

Option 3: fund 1 sites	2018/19	2019/20	2020/21	2021/22	2022/23
Setup costs	[redacted]				
Service Delivery	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

5. Collaboration

5.1 Collaboration and evidence	
What type of cross-agency and/or cross-portfolio initiative is this?	This initiative is part of a wider cross social agency work programme for 0-6 year olds for the Child Wellbeing Strategy being led by DPMC. This work programme includes reviewing parenting support services across the social sector. It is also linked to Ministry of Health's maternity service improvement programme and the review of the Well Child Tamariki Ora programme.
Agencies and Ministers that have been engaged in initiative development	The original initiative around piloting for intensive home visiting services has been discussed with DPMC, Education, Oranga Tamariki, MSD and the Family Violence Unit. It has since evolved and this iteration is yet to be shared in its current form.
Impact of cross-agency collaboration	The Ministry of Health continues to work with the Department for Prime Minister and Cabinet, Ministry of Education, Oranga Tamariki, Ministry for Social Development and the Family Violence/Sexual Violence joint venture to develop an integrated wellbeing package for Budget 2019. Although there is a significant policy programme to complete for the first 1000 days and child mental wellbeing priority areas under the Child Wellbeing work programme this initiative is investment ready and can deliver quick wins while a more comprehensive view of what funding and policy changes are required in Budget 2020.
Risks and challenges	This is one of a number of successful initiatives we will be collectively studying through the Well Child Tamariki Ora review. This will enable us to better understand how agencies can most effectively deliver services to vulnerable populations as well as identifying workforce needs going forward.