SYNERGIA

Evaluation of the Tōku Oranga (Access and Choice) programme

A REPORT FOR WELLSOUTH

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MARCH 2023

Acknowledgements

Synergia would like to thank everyone who supported the evaluation by supporting its implementation or participating in interviews. We would especially like to acknowledge the consumers who gave their time and shared some personal and thoughtful reflections on their experience with Tōku Oranga.

Synergia has worked with the team at WellSouth to support the delivery of this evaluation. We acknowledge your engagement, expertise and guidance which has contributed to this evaluation.

Contents

1. EXECUTIVE SUMMARY

Tōku Oranga integrates the roles of Health Improvement Practitioners (HIPs), Health Coaches (HCs) and Support Workers (SWs) with general practice teams to create better integrated support for those with mild to moderate mental health and addiction needs as part of the Access & Choice programme. At the time of the evaluation, 27 of WellSouth's 81 general practices were providing the programme.

WellSouth has commissioned this formative evaluation to help understand the aspects of delivery that are effective for consumers and inform implementation through exploring programme delivery data. We used evidence from interviews with 12 consumers, 12 months of programme data from a sample of 13 practices (total of 8511 introductions), and primary health network (PHN) referral data to brief intervention services (BIS) and secondary mental health services.

To what extent is the programme valuable to consumers?

Consumers told us they valued the programme to a great extent, with one saying they were 'screaming from the balconies' in support of it - a sentiment others shared. Consumers described a range of separate interconnecting experiences to us, and themes form these experiences relate to the effectiveness of the model itself and the high quality of delivery. Consumers experienced no barriers to access, and they went on to have caring and safe interactions that were very personalised. Enhanced self-efficacy and activation was supported by the practical, strengths-based approach of workers, evidence of client progress and a sense of accountability to someone who understood and cared. Consumers liked the flexibility of the support and the degree of agency they had, including when to stop using support. Knowing they could go back provided a reassuring safety net.

What patterns of service delivery are emerging? Are they equitable for Māori?

Collectively, the 13 sample practices reached 8% of their enrolled population in the 12-month period, however this varied considerably between practices (range of 4%-23%). Introductions to Tōku Oranga are primarily to the HIP role. Three in four Tōku Oranga consumers (75%) were introduced to a HIP, usually because of anxiety and depression. Consumers who were introduced to a HC (29%), mostly had long term conditions and physical health needs. SWs received only 8% of programme introductions and the presenting needs of those consumers were most likely to be related to whānau, social and community wellbeing. DUKE wellbeing scores on entry and the classification of presenting needs are reassuring evidence that consumers were introduced to the right roles to support them.

Across the programme, 8% of the enrolled population had one or more contacts with a HIP, HC, or SW in the 12-month period. This represented 11% of enrolled

Māori and 7% of non-Māori. This result suggests equitable access from a proportional population perspective, though individual practice results varied. The equity analysis completed on the available data, suggested experiences were equitable for Māori compared with non-Māori.

We identified 6912 consumers who could be considered exited. Almost three in four of those exited consumers only saw a HIP and just over one in twenty saw staff in two or more roles. This exited cohort also showed a predominant theme of single consult only and those having more than three contacts were the minority. This pattern varied a little between roles, with HCs and HIPs seeing 70% and 58% of their consumers once, and SWs most likely to see their consumers more than three times (15%).

How does Tōku Oranga compare with the traditional counselling model?

Tōku Oranga responds to a much broader range of biopsychosocial needs than counselling and offers consumers faster access to support and an approach that is more flexible and practical than counselling. Consumers with previous experience of counselling told us that because of this, Tōku Oranga felt to be a better fit for them, and the benefits were more immediate and impactful.

What outcome patterns are emerging? Are these equitable for Māori?

There are meaningful and measurable benefits as result of Tōku Oranga; evidence of the programme effectiveness. The change in Duke Heath Profile (DUKE) ratings between the first and last consultation shows statistically significant improvements in the domains of mental, physical, and social health, giving a mean total health change of 8.32 points from 100. This improvement in wellbeing was equitable for Māori compared with non-Māori. Consumers described positive impacts of the programme on their self-efficacy, wellbeing, and their lives overall as a result of the support they received.

What changes are emerging at the system level?

BIS is delivered by an allied health workforce trained in brief counselling models. We standardised and compared changes in referrals to BIS and secondary services with the same period the year before implementation began. The mean number of referrals to BIS dropped in the 13 sample practices by 39% (a significant decrease) and increased by 7% for practices without Tōku Oranga. Historically, sample practices had higher referral rates, so this magnitude of change may not be an accurate predictor for all PHN practices once they have the programme in place; it is more likely to be a reduction of around one third of the 2019-20 volumes.

Referral rates to secondary mental health services between these two time points showed a small (insignificant) reduction in mean referrals for sample practices and practices without Tōku Oranga. This indicates that current implementation has not affected the demand for secondary services, and is not expected to with the broader roll out of the programme.

Reflections and considerations

The achievements of this programme are to be celebrated. The impact this programme is having on the lives of consumers is huge, and one that cannot be communicated by routinely generated programme data alone. Consumers want more people to be aware of the programme and be able to self-refer. While Tōku Oranga is well established, we have raised a small number of considerations that may enhance the understanding of current implementation.

2. BACKGROUND AND CONTEXT

Tōku Oranga is the name gifted to WellSouth PHN for the Access & Choice programme that integrates the roles of Health Improvement Practitioners (HIPs), Health Coaches (HCs) and Support Workers (SWs) with its general practices (GPs). Part of the national Access & Choice initiative, Tōku Oranga places behaviour change practitioners in general practices, making it faster and easier for consumers to access care. Tōku Oranga practitioners provide free and timely support for consumers needing to improve self-management; they provide guidance with behaviour change - including addressing stress, addictions, social issues, or long-term physical health struggles.

WellSouth has the largest geographic area of all primary care networks in Aotearoa. Tōku Oranga was available in 27 of WellSouth's 81 practices at the time of the evaluation, with provision in all regions.

Tōku Oranga began implementation in August 2020. COVID-19 and its risks and restrictions have been part of this early experience. The programme is delivered by WellSouth in partnership with seven health and wellbeing providers in the region. These providers employ HC and SW and are: Active Southland, Corstophine Baptist Community Trust, Nga Kete Matauranga Pounamu Charitable Trust, PACT Group, Sport Otago, Te Kaika and Te Hau o Te Ora.

Other psychological support is available from WellSouth's brief intervention service (BIS). This is a referral based programme of five sessions, available to practices with and without Tōku Oranga. It is delivered by an allied health workforce employed by WellSouth and trained in brief counselling models.

Identifying the need for evaluation

In May 2022, WellSouth commissioned Synergia to complete a formative process evaluation of the programme, with emphasis on the perspective of consumers and the impact of Tōku Oranga on other psychological support available.

Following a summary of the evaluation approach, the findings are presented in three key sections:

- Section A, from page 9, provides is programme perspective – drawing on programme data and consumer experiences.
- Section B, from page 26, provides a population perspective – looking at the reach of the programme, applying an equity lens to the data and exploring emerging influence referrals to BIS and secondary mental health services.
- Section C, from page 36, addresses the evaluation questions and summarises the insights and learnings from the evaluation.

3.EVALUATION IMPLEMENTATION

The evaluation will contribute to the evidence base for Tōku Oranga and what works for consumers. It will also identify adjustments, improvements and support future planning. We worked collaboratively with WellSouth for the evaluation.

3.1. Key evaluation questions

- To what extent is the programme valuable to consumers?
- What patterns of service delivery are emerging? Are these equitable for Māori?
- What outcome patterns are emerging? Are these equitable for Māori?
- How does Tōku Oranga compare with the traditional counselling model?
- What changes are emerging at the system level?*

*Evaluation scope was extended to explore referrals to counselling and secondary services.

3.2. Data collection and analysis

Programme data

Identified extracts of service data (client profile information, activity, and outcomes) from September 2021 to August 2022. We refer to this as our 12-month period in the report. WellSouth identified 13 practices consistently delivering Access & Choice. These are referred to as the sample practices.

PHN level data

Aggregated referral counts and ethnicity breakdown of practice referrals to BIS and secondary mental health services for the previous five years.

Consumer interviews

We interviewed 12 consumers (September to November 2022). We planned to interview 27 but received insufficient introductions, despite extending the timeframe. Interviews were conducted over Zoom or by phone. People were introduced to us by the HIP, HC or SW familiar to them. We had representation from across the region except central Otago. Consumers received koha for their participation.

Inferential and descriptive statistics were completed for the quantitative data, and thematic analyses for the qualitative data. Additional information is included in the relevant sections. All data sources were interpreted and synthesised to establish the evidence to answer the evaluation questions.

Limitations of this report

The 13 sample practices have high needs populations (higher percent of Māori, Pacific peoples and those living in lower socioeconomic areas)[1]. and/or higher referral rates to BIS and secondary services) and this limits the applicability of results to other practices with lower levels of need. This is discussed in relevant sections of the report. Consumers interviewed do not represent those with single consults only; this would require a specifically designed evaluation to understand.

[1] https://bpac.org.nz/BPJ/2010/June/highneeds.aspx

SECTION A: PROGRAMME DELIVERY

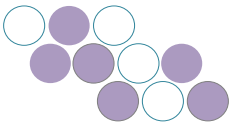
4. WHO IS SUPPORTED AND BY WHOM?

The 13 sample practices received a total of 8511 introductions in the 12-month period, July 2021 and September 2022. The demographic profile of consumers introduced is predominantly female, non- Māori and mostly of working age. Over a third of consumers presented with anxiety and depression but a whole range of biopsychosocial needs were responded to. Along with DUKE wellbeing profiles from first encounters, the severity and nature of presenting needs is well matched with the three different roles.

4.1. A demographic profile of consumers

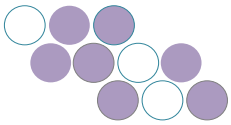
This demographic profile is based on the 8511 consumers introduced to the programme in the 13 sample practices in between July 2021 and September 2022.

Six in ten consumers are female, seven in ten are non-Māori



There were more female (61%) than male (39%) consumers

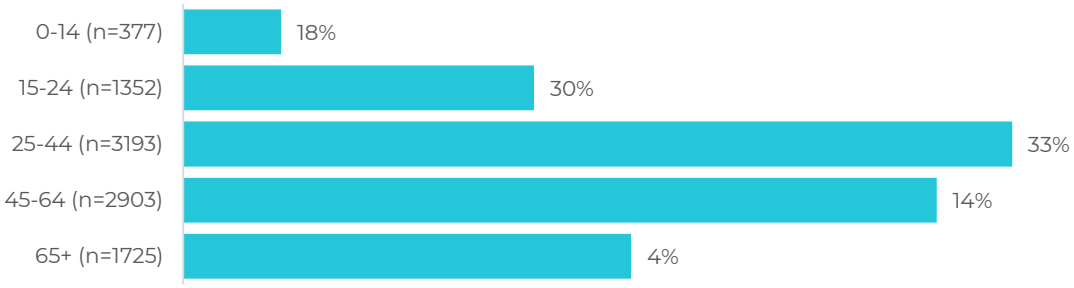
There were more non-Māori (66%) than Māori



Reaching consumers across the entire life course

As **Figure 1** shows, the majority of consumers were working age; those aged 25-44 (33%) and 45-64 (30%). The oldest person was 102.

Figure 1 Age distribution of consumers from the 13 sample practices (n=8511).

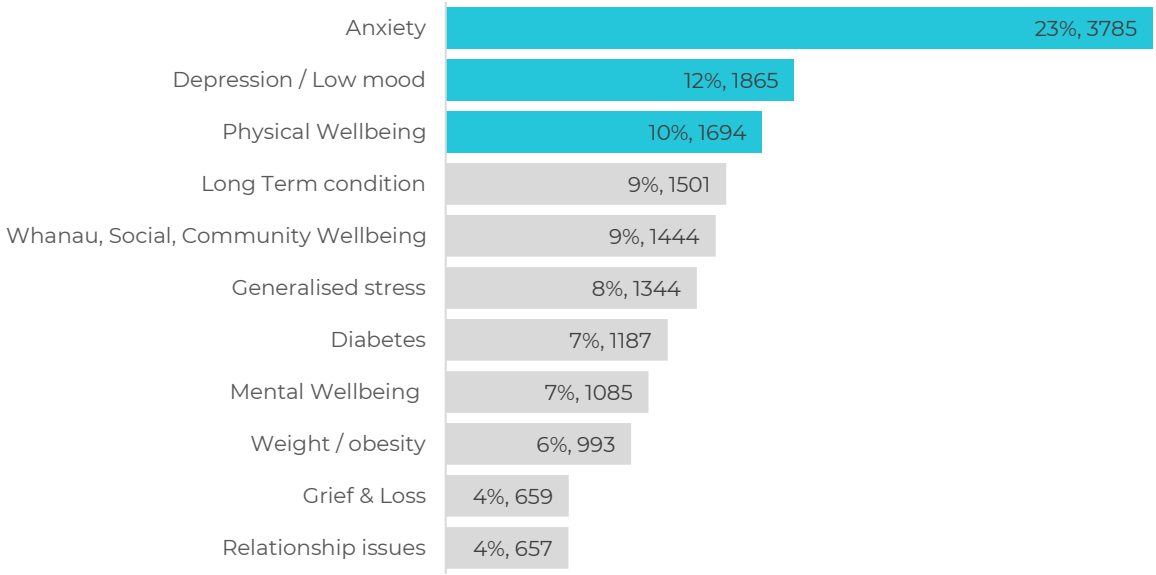


Presenting with a range of needs; anxiety and depression the tip of the iceberg

Access and Choice is designed to reach people with mild to moderate mental health and addiction who would benefit from support. **Figure 2** shows the range and frequency of wellbeing needs people from the 13 sample practices have presented with over our 12-month period. Multiple issues can be recorded for each consumer and these can be added as they emerge. The most frequently presented issues are anxiety (23%), depression (12%) and physical wellbeing (10%).

Presenting with poor mental health

Figure 2 All presenting issues.

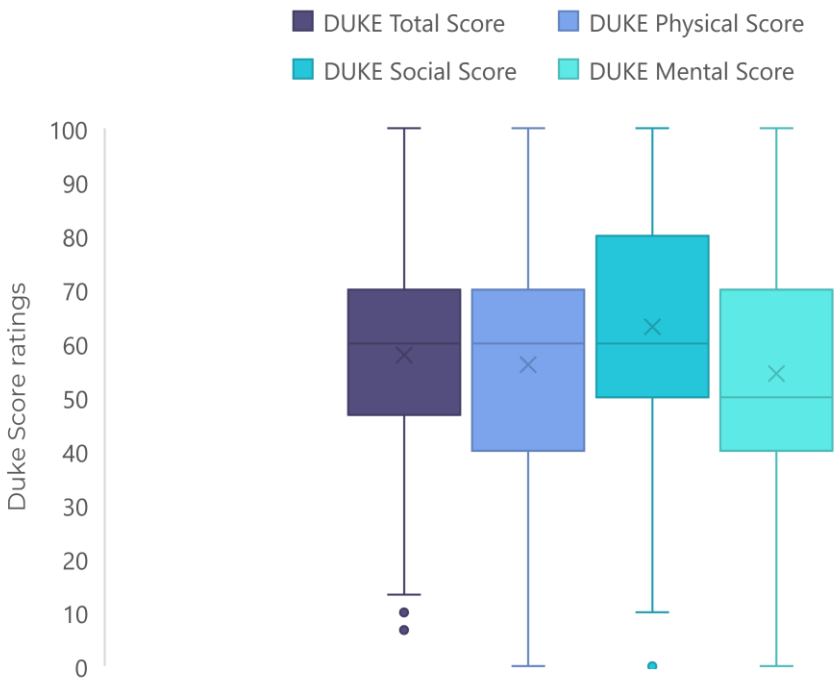


The Duke Health Profile (DUKE) contains six health measures which are physical, mental, social, general, perceived health, and self-esteem. Anxiety, depression,

pain, and disability make up the four dysfunction measurements.[2] The DUKE is self-administered and provides scores for physical health, mental health, and social health and a total score derived from those three domains. Each domain score is on a scale of 0-100, with 100 representing optimal wellbeing.

Of the 8511 introductions, there were 2566 completed DUKE ratings (30% of first encounters). **Figure 3** shows the mean overall score to be 57.8 out of 100. Of the three health domains, the lowest mean score is for mental health (54.7 out of 100), indicating the programme is reaching those with poor mental wellbeing. The mean score for physical and social health is 56.1 and 6.1 from 100, respectively.

Figure 3 DUKE scores completed at first encounter (n=2566).

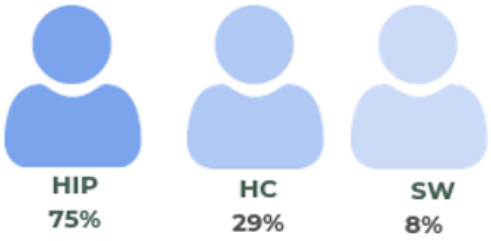


[2] https://www.statisticssolutions.com/free-resources/directory-of-survey-instruments/duke-health-profile-the-duke/#:~:text=The%20Duke%20Health%20Profile%20(The%20Duke)%20is%20used%20as%20a,High%20scores%20indicate%20good%20health.

4.2. Matching the support needs with the right role

Greatest demand is for HIPs

Figure 4 Percentage of all introductions by role



The adjacent figure shows that three in four introductions were to HIPs (75%, n=8511).

The presenting needs of consumers are well matched to the different roles. The majority of consumers introduced to the three roles presented needs as follows:

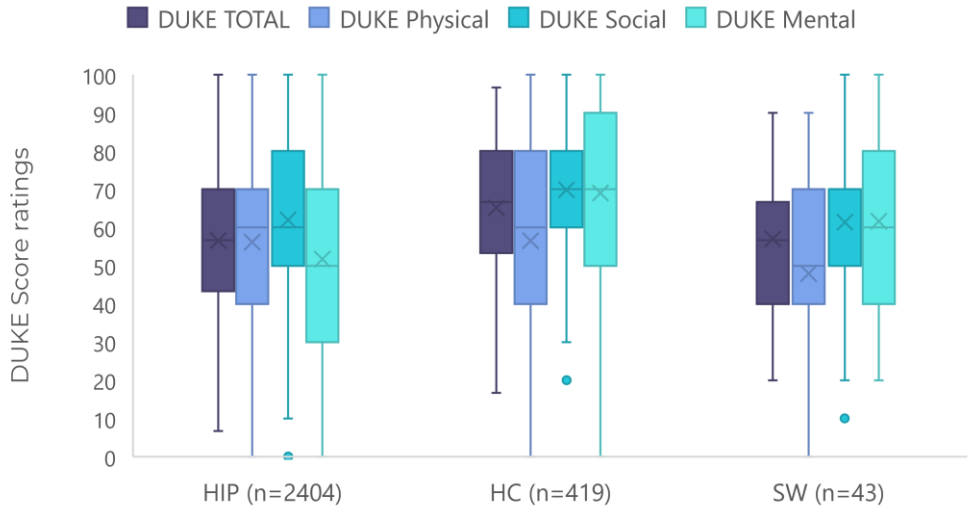
- HIP consumers most likely to present with anxiety, depression, and generalised stress.
- HC consumers most likely to present with long term conditions and physical health needs.
- SW consumers most likely to present with whānau/social/community wellbeing, anxiety, and physical health needs.

This shows the range of needs being met and that introduction to the appropriate roles is happing. Consumers described holistic support provided by the roles, with HCs for example, supporting mental health needs as well as physical health and lifestyle behaviours .

DUKE wellbeing profile shows level of need is well matched to roles

Figure 5 shows the 2566 DUKE scores completed by consumers on their first encounter with the programme. Along with the description of presenting needs, it confirms the appropriate matching of consumer need to roles. The chart identifies that consumers introduced to HIPs have the poorest mental health, those introduced to HCs the poorest physical health and those introduced to SWs the poorest social health, as measured by DUKE.

Figure 5 DUKE scores from the first encounter by role (n=2566)



5. CONSUMER REFLECTIONS

Consumers experience no barriers to access and go on to have caring and safe interactions that are very personalised. This supports self-efficacy with progress and consumer activation supported by the practical, strengths-based approach of workers, evidence of their progress and a sense of accountability to someone who understood and cared. Consumers like the flexibility of the support and the degree of agency over how they use it, including when to stop using it. Knowing they can go back if required provides a reassuring safety net. The existing connection with a GP or medical centre plays a critical role in linking consumers to Tōku Oranga. The only improvement consumers identified was to promote the availability of this support more widely.

5.1. The consumers we spoke with

Most of the consumers we interviewed reported a minimum of four sessions and some of them had contact with two or more roles. This means the experiences of consumers with only one contact (the majority of consumers) is not represented by those we interviewed.

Consumers we spoke with were seeking support for a range of reasons: Several described managing long-term conditions, mental health challenges, and/or medication management. Other needs included weight management, physical activity, mobility, and changes to nutrition. Some consumers identified social and financial needs such as isolation, accommodation and financial issues.

Previous support seeking varied from those with extensive use of GP support and/or psychosocial support services (such as private psychologists and counselling services) to those who were first time support seekers. Some of these first time support seekers had never thought of asking for help before and weren't sure they were 'bad enough' to warrant support.

Support came at different times in these consumers' lives as these examples illustrate:

- Support from a HIP as part of their discharge process from surgery.
- Managing a long-term condition and developed severe depression which prompted a referral to a HIP and then a HC.
- GP follow-up support after ACC-related surgery where the consumers described issues with mood and anxiety which led to support from a HIP.

Key themes of their experiences

Figure 6 summarises the key themes of consumers' experience of Tōku Oranga. It is the combination and interplay of these themes that have resulted in positive and effective experiences for those we spoke with. These key themes are discussed in more detail in the following sub-sections.

Figure 6 Key themes of consumer experience

5.2. No barriers to access

General practice provides an easy and natural setting for any member of the practice team to recognise consumer needs and respond with the suggestion of an introduction to a Tōku Oranga worker. Many consumers described this as an almost casual process of meeting another person "down the hall" or agreeing to a phone call from someone else based at the practice. Consumers were quickly seen by the person they were referred to.

Consumers felt they could gain, or that they had nothing to lose, by agreeing to a referral. Some consumers expressed pleasant surprise that support was free with one consumer commenting on how expensive this kind of support usually was.

The introduction could include a sense of uncertainty and even apprehension, and none of the interviewed consumers were aware of Tōku Oranga prior to the introduction. The way the support was described to the consumer seemed to help with a successful connection, with one consumer enjoying how the GP included phrasing he would use by saying there was support available which would be "up his alley." On the first contact, many interviewees described an instant sense of comfort and of having found a person they could connect with who offered the right kind of support.

"He made it so easy to walk in there on the first day. He could see me at the door, and he walked up to me. I don't like being around a lot of people." – HC consumer

"She's a very, she's a really lovely lady" - HC consumer

It was evident that consumers needed additional support which went beyond what would usually be provided by a GP or nurse. In some cases, the consumer-initiated conversation about mental health, social, or financial needs with practice staff. The combination of factors described above made for a smooth and warm handover process.

5.3. Experience is positive and safe

Consumers were consistently provided with support that they found to be relevant. Relationships inspired a sense of trust and safety. Tōku Oranga staff took a practical and solutions-focused approach which met consumers "where they were at." Valuing oneself and being conscious of self-care was a focus for some consumers. One consumer describing working on a few goals and the encouragement they received to do positive things for himself. This prompted him

to “go to a nice viewing spot on my way home from work.” He came to realise “I just need to stop and do some positive things to actually reward me.”

> ***“She’s like a sounding board. When I sit down and have a kōrero with [name] she doesn’t say much. She listens to me… she doesn’t lead me, she doesn’t push, she walks alongside.” – HIP consumer***

Some consumers experienced stigma and challenges with self-worth, and the positive and affirming approach of these workers put them at ease and made it easier to open up. Their experience with Tōku Oranga felt much less judgmental than some of their other health care encounters.

> ***“It wasn’t an interrogation. I felt very comfortable and I felt I could trust her. Yeah, I think that’s really important. And we just clicked, we clicked personality-wise. I just can’t say enough about her to be honest. She’s amazing.” - SW consumer***

> ***“To know that all I had to do was send a text if an issues came up and know that she was there to answer it without judgment. Yeah, that’s a very comforting thing yeah. She’s a really lovely lady too.” – HC consumer***

5.4. Personalised response is highly valued

As described earlier, these workers tailored their support to what the person wanted and needed. The intensity of contact was often adjusted to what the person needed at the time, with one consumer describing having two contacts a week for a time and then spacing out the support. Workers were sources of encouragement, and consumers felt praised for their efforts particularly in the management of long-term conditions.

> ***“[HC said] I don’t need to tell you about your food. You have it down to a fine art… Job well done.” – HC consumer***

Support was provided flexibly to consumers, and it could include face-to-face visits,

phone calls, text messaging, and remote meetings (e.g. through Zoom), as well as community visits for roles that had that flexibility.

> ***"It's super flexible. I love the fact that if I can't physically make it in, I can make an online appointment or a phone call appointment. I kind of really enjoy how informal it is. It's a really nice environment, particularly in my practice. She's got her own cosy little office and it's set up really nicely… I can either email her or book through the front desk… yeah, it's really easy." - HIP consumer***

The individual and personalised nature of the contact felt meaningful and valuable to consumers, and this made them receptive to the guidance and advice of the workers.

> ***"While I enjoy things like the diabetes group talk, I've never ever felt that you could sit one-on-one and really talk about your problems not listening to everyone else in the group. Sometimes the same things affect you and a lot of times they don't." – HC consumer***

> ***"….they don't actually teach you, they guide you… You can actually empower yourself. And it's important to empower yourself to actually become a healthier and better person… I took everything they could offer me. I soaked it up like a sponge." – HC consumer***

It was evident that the consultations and support sessions helped the change process and activated greater self-management. Several consumers felt that this created a sense of accountability also, and that even with ups and downs, they were still valued and affirmed.

> ***"I think we were both really wanting to maintain that kind of accountability on the things that I was working on in the meantime because it really did make a difference to me. Like, the weeks where I wouldn't have appointments, my sleep schedule would go out the window and things would just fall apart a little bit." – HIP consumer***

Multiple sessions of support also helped consumers and workers to adjust goals, and track and appreciate change. Comparing DUKE scores and looking back over notes helped to highlight even small signs of progress.

> ***"Having that appointment to appointment comparison of how things were going was really good… it made identifying the really bad weeks easy. And then we could kind of hone in on the more simple stuff that works and just focus on maintaining a good baseline instead of pushing for something more." – HIP consumer***

Ratings concur, support is helpful and people are confident

Consumers are asked to rate the helpfulness of each contact and how confident they feel about carrying out the plan they have created in the session. This information is available for around one in six contacts: Of the 21,191 contacts in this 12-month period, 57% had a completed helpfulness rating (n= 12,102) and 56% had a confidence rating (n= 11,868). These ratings were very positive.

- 93% of contacts were rated as very helpful (rating 8 or more on a 10-point scale).
- 86% of consumers who made rating at the end of their s contact were very confident in carrying out their plan (rating 8 or more on a 10-point scale).

> ***"I got 100% service and I'm more than 100% satisfied. And I'm lucky to have the support ··· I just felt there was no judgement, no judgement whatsoever ··· and it may my life so much easier. It really did. " - SW consumer***

5.5. Consumers make the exit call

Some consumers we spoke with no longer used the programme, though they were very aware that they could get in touch with their worker if needed. It was clear from the interviews that consumers have control over when they feel ready to stop using the support.

> ***"We'd dragged everything out… It was only last week, I actually said to [my HC], 'I don't need you anymore. I feel strong.' She's taught me new skills and I do journals now. I do meditation…. I'm a different person than I used to be. I like myself now. Honestly, she saved my life." – HC consumer***

Workers may bring up the subject of exiting the service but ultimately the decision is left with the consumer. One consumer recalled that after a few visits they exited the service and that if they experienced any more difficulties that they would reach out for support again.

> ***"I said I don't think I need to book in again. I felt like I was just at a place where, you know, things are good. And I've now got the toolkit to sort of respond to myself… She sort of said, 'I'm getting the feeling that you're on your feet', or something like that… But if I start feeling in a bad way, I would certainly reach out and try and catch myself before I get into a terrible place." – HIP consumer***

Exit and potential re-entry to the service was described as a somewhat fluid process. As consumers had their sessions, these could become shorter and/or further apart. Consumers felt that "I have a safety net" and that there would be no problem making contact if they needed some more support down the track.

6. PATTERNS OF USE

We identified 6912 consumers who could be considered as exited to explore emerging patterns of use. This showed almost three in four consumers only saw a HIP. Just over one in twenty consumers see two or more roles. This exited cohort also showed a predominant theme of single consult only and a minority of consumers having more than three contacts. This pattern varied a little between roles, with HCs most likely to see consumers once, and SWs most likely to see consumers for more than three contacts.

The ability to see some of the people the same day they are introduced to the service is a key feature of the Access and Choice model. WellSouth made adjustments to the way this information is captured during the 12 month sample period. This means we do not have accurate data to include in this report for this aspect of programme use. WellSouth and its practices can monitor who is seen

the same day, wait times and other aspects of service delivery, from its live dashboard.

6.1. Emerging patterns of use

We have defined exit as occurring when a consumer did not have any recorded contact with the programme for at least 90 days. This working rule is necessary to be able to analyse the data; in practice there is no formal exit status. Out of the 8511 consumers that used the programme, 6919 met that working criteria so were classified as having exited the programme. This enabled us to differentiate between consumers who have a 'completed' episode of support, and those that are still effectively 'current'.

Most delivery provided by HIPs

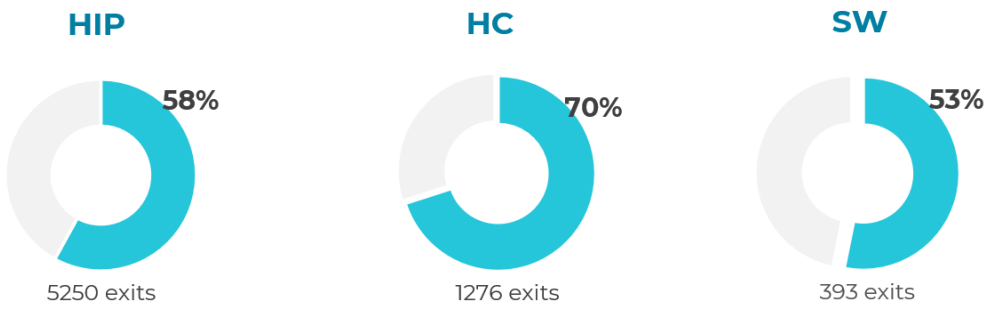
We analysed contact data of those consumers classed as exited, to see which roles they had worked with following their initial introduction. As **Figure 7** shows, the majority (74%), of consumers were supported exclusively by a HIP. Almost 5% of the exited consumers were supported by two or more of the team.

Figure 7 Percentage of consumers seeing different combinations of roles

Predominant pattern is of a single contact for all roles

Access and Choice is a flexible support model so people can use it as much or little as they need. Of the 6919 exited consumers, between five and seven in ten consumers had contact with their HIP, HC or SW only once. The variations by role are shown in **Figure 8.**

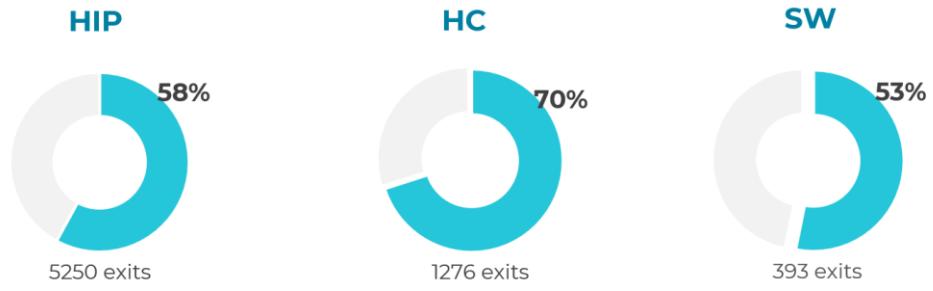
Figure 8 Proportion of exited consumers that had a single contact.



Minority of consumers have more than three contacts with any role

A minority of exited consumers had more than three contacts with any of the roles. As **Figure 9** shows, this was more likely to be with a SW than a HIP or HC.

Figure 9 Proportion of consumers that had more than three contacts



The mean number of contacts for these exited consumers was similar for those seeing a HIP (1.84) or a HC (1.73). Exited consumers that saw a SW had a mean of 2.67 contacts.

7.MEASURABLE MEANINGFUL BENEFITS

There are meaningful and measurable benefits as result of Tōku Oranga; evidence of the programme effectiveness. The change in DUKE ratings between the first and last consultation shows statistically significant improvements in all three domains of mental, physical, and social health. This concurs with the experience of consumers who describe the impact on their

self-efficacy, wellbeing, and their lives, as a result of the support they have received.

7.1. Statistically significant improvement in DUKE scores

The DUKE is designed to be used at each contact and results used to identify areas consumers would like to work on, progress, change and challenges. Consumers who spoke to us about this about this said they had found using DUKE interesting and useful. Of the 21,191 contacts that occurred in our 12-month period, only 6411 had an associated DUKE completion (30%).

A matched pair includes DUKE scores from a consumers first encounter and matches it with the DUKE scores from their last encounter on record. We identified a set of matched pairs that represented the consumers who had exited the service (no contact for more than 90 days). This resulted in 765 matched pairs.

Pre and post measures are typically used as evidence of a programme's effectiveness. We have analysed Tōku Oranga data to do just this. However, this analysis must be understood in context and interpreted with caution. There are no entry criteria for Tōku Oranga, consumers can be introduced to the programme for a broad range of needs, have very different experiences and expectations of distress and wellbeing, and decide they may no longer need support after a number of days, weeks, or months.

Mental health domain shows greatest increase

Figure 10 shows the changes in DUKE scores across the domains between the entry and proxy exit score. **Table 1,** which follows, lists the mean changes for this data and shows the mental health score domain increased the most. The changes for each domain were statistically significant ($p<0.01$).

Figure 10 Change in distribution of entry and exit DUKE ratings

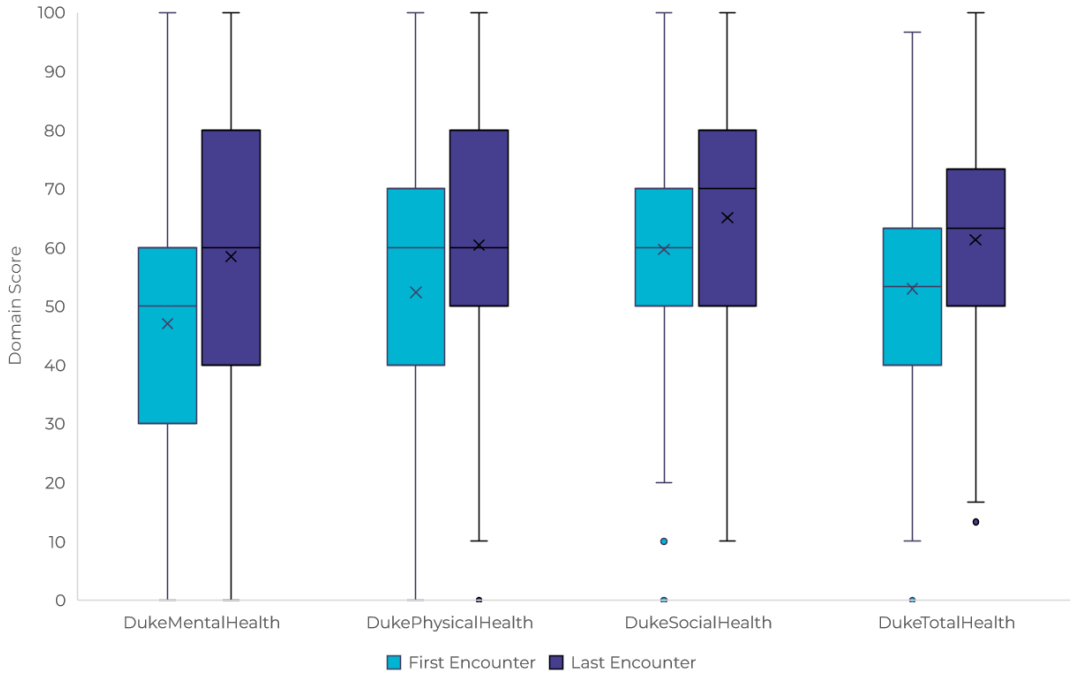


Table 1 Mean entry and exit DUKE ratings from 100

DUKE DOMAIN	MEAN OF FIRST ENCOUNTER	MEAN OF LAST ENCOUNTER	CHANGE
Mental Health	47.02	58.5	11.48
Physical Health	52.38	60.46	8.08
Social Health	59.65	65.06	5.41
Total Health	53.02	61.34	8.32

Mean increase in DUKE scores applies to all three roles

When the DUKE total score at entry and exit for this group of 765 exits are broken down by the role seen we can see that the mean and median increase in consumers' DUKE total score has increased for those working with HIPs, HCs and SWs. The mean increases in consumer scores by role are as follows

- HIP: DUKE total score mean change is 8.39 ($p < 0.01$)
- HC: DUKE total score mean change is 8.21 ($p < 0.01$)

- SW: DUKE total score mean change is 6.22 (not significant p> 0.05)

Seven in ten people experience an increase in total health

The percentage of individuals who rated an improvement in their DUKE total score between entry and exit is another way of looking for patterns from these 765 matched pairs. The data shows that:

- 62% had an improved mental health score
- 50% had an improved physical health score
- 44% had an improved social health score
- 68% had an improved total health score.

The entry and proxy exit ratings represent two timepoints in a person's wellbeing trajectory, and this can have ups and downs. This is evidenced by the percentage of individuals whose DUKE total scores (and associated wellbeing) decreased between entry and exit (16%), and those whose score remained unchanged (16%). A table in **section 13.1** in the Appendix shows all DUKE changes at an individual level.

"It was great, because I was able to be like, 'We've been chatting for a year and I feel really good this week because everything's finally clicking into place. Yeah, so I think my experience has been quite life changing from that perspective." – HIP consumer

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7.2. Giving the measures meaning – the benefits consumers experienced

Consumers identified several benefits and impacts from Tōku Oranga and a few described the support as critical or life changing.

"[It] was a godsend as she got me into transitional housing when I had nowhere to live." – SW consumer

"Things moved very quickly from that first phone call and it was awesome. It was probably within ten days [that I experienced significant change]. I got my benefit changed. I got my disability card sorted out. It was just awesome. I keep saying to her, 'You changed my life.' And she did, she changed my life." – SW consumer

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The support was available at a critical time or when consumers were ready to try new approaches, and for some, this resulted in the disruption of patterns or circumstances that detracted from health/wellbeing. Several consumers described increases in knowledge, skills, and self-efficacy. Greater attention to self-care and management of the condition or medication was also a focus for some consumers.

> ***"If it wasn't for him, there is no way I would have gone into the gym… I feel great. I miss the gym!" – HC consumer***

In some instances, consumers described gaining even more than they imagined and significantly expanding their knowledge, and toolbox of psychological and behavioural tools.

> ***"[Me and my partner] we're learning a lot. I never went into real depth before, but because I was able to have this one-on-one conversation it was making me aware to get out and Google it and have a look and see what it was all about. So yeah, I have learned quite a bit." – HC consumer***

The flexible and integrated nature of the support was helpful to consumers engaging in change, and for some it improved their perception of primary care and support services available.

> ***"She's very much there on both sides [referring to communication with the GP]. She's certainly doing her work." – HC consumer***

The broad nature of support and inclusion of people's social contexts also had positive impacts on people's self-esteem, and sense of meaning and purpose. The following quote is from a consumer who engaged in voluntary work.

> ***"I've now got friends, good friends, lifetime friends…. [At the centre] they've sort of attached themselves to me as a role model I guess you might say… It's built my confidence and it's nice to give back just for the sake of helping." – HC consumer***

Tōku Oranga provided a safe space where people could share, feel listened to, heard, normalise distressing feelings and disrupt downward spirals. The following quote illustrates how significant this was for one male consumer.

> ***"As a Kiwi male, you're not gonna sort of sit your mates down and say, hey, I'm really struggling or whatever. And, don't get me wrong, I've got support networks around me. But the meeting [with the worker] itself wasn't daunting. It's kind of a weird feeling, but maybe it's okay to feel like this. It was kind of an objective perspective that pulled me out of a downward spiral. It kind of just pulled me up a little bit and that was enough for me." – HIP consumer***

The goal focus also helped with tracking and seeing signs of change, factors expected to boost self-efficacy and decrease use of some services.

Three of the 12 consumers we spoke with told us they had visited their GP or practice nurse less frequently because they were able to get the support they needed from a Tōku Oranga worker instead. For these consumers, HIPs and HCs became the first person to contact at the practice when they needed support.

7.3. It's great as it is - just tell people it's available

Consumers that took part in interviews did so with the intention of giving back – both in gratitude to those who had supported them, and to those in their communities that could benefit from this support.

Those interviewed could not identify improvements to the support or the model itself and most talked in glowing terms about the support they received. The only enhancement mentioned by most of those we spoke with, was simply to let people know this support was available. Tōku Oranga was seen as a novel and highly useful model which the enrolled population, or wider community, is unlikely to be aware of. This was seen to benefit those who may not usually access such services. Men were noted as less comfortable with seeking support than women so would benefit from this normalising of mental health support.

> ***I think as a Kiwi bloke, we tend to close up a bit and not talk about our personal issues. So it's been nice to give my perspective and know that others could be looking at that and saying, well, maybe if I ask for help, I can have something better. Yeah." – HC consumer***

Interviewees said they would recommend the support to friends and family, several had already, and one described themselves as "screaming from the balconies in support of your service."

One consumer felt there were still challenges with males mentioning useful services such as Tōku Oranga to male friends. Shining a light on mental health was seen as a delicate process.

> ***"When your mates are sort of off colour or they're quiet, quiet and withdrawn, you never see them. Then if you came out of the blue and said, 'I think you need to see this person to try and help yourself….' There's no easy way to get that across without either coming across or being perceived as put down or a bit critical of someone… if they're already in a really bad place, and then you're shining a light on it, that could potentially be quite confronting to people." – HIP consumer***

Of note

It was unclear how many consumers fully grasped the information-sharing part of an integrated practice team approach. One consumer felt this may need to be made explicit to all consumers. Another consideration raised related to the patient portal and ways it can be used to increase self-management as well as promotion of Tōku Oranga.

7.4. Different to previous support experiences

A few consumers we spoke with had received psychological support previously and commented on the differences they saw with the Tōku Oranga model and its workforce. The consumers we interviewed had a positive experience of Tōku Oranga, and this wasn't always their experience with other support.

People working in a strengths-based way

Consumers recognised the interpersonal skills of Tōku Oranga workers and said

they were easy to build rapport with and trust was established quickly. Consumers also spoke about feeling accepted and encouraged from the place they were at rather than feeling judged. This contrasted with previous experiences with other services. Of course, this may reflect personal qualities of those delivering previous and current support. It does highlight that the other ways of working did not meet their needs as well as Tōku Oranga and tended to focus on the problem rather than the whole person.

> ***"[Another service] suggested I go to the hospital to be weighed once a week … I did not find that helpful. I found that very discouraging."*** – ***HC consumer***

A consumer who had used counselling services in the past reflected that the 'fit' between them the counsellor could have been better, and this limited the value of their work together.

Another consumer preferred the one-to-one contact and very personalised approach of working with a HC to their previous experience of group health education because they got much more out of each interaction.

> ***The one-on-one is very special because you're dealing with what's happening with you … that one-on-one is a big factor because you're not wasting any time – you're talking about the subjects [that matter to you] and getting information. And it's just been so helpful."*** – ***HC consumer***

It's more practical than counselling

The approaches in Tōku Oranga often centred around goals and action, while also in the context of a warm working relationship. The focus on goals and progress was very heartening for this consumer who was not critical of counselling but realised she needed something more practical to make progress.

> ***"But towards the end [of counselling], I was kind of just raring for some more direction. And it got to the point where rehashing my problems for the week wasn't enough for me to be doing anything about it. So yeah, I think the swap [to a HIP] came at a really good time for me… it's still got similar undertones of like, 'çome in, tell me how your week has been, tell me what you want to do.' But then [with the HIP] there's a bit at the end where it's like, okay, so how are we doing with that?' " – HIP consumer***

The repeated use of DUKE wellbeing measures was also highlighted as a very practical way to see change between contacts and understand the overall direction of progress without the distraction of ups and downs. This consumer's DUKE scores provided tangible evidence of improving wellbeing that was reassuring and supported self-efficacy. It was not something they had experienced during counselling.

> ***"Acknowledging those goals and sharing with her was quite cool to be able to do. It also helped quite a lot because sometimes when you're working on yourself, you don't really know what progress you've made because you're always in the driver's seat. But in our third and fourth session, she sort of looked back over other notes of session one and two and said, 'Well, look here in session one and two. We touched on this and this, but you know now that's not an issue at all'… And that was quite positive to be presented with evidence that what I'm doing is effective." – HIP consumer***

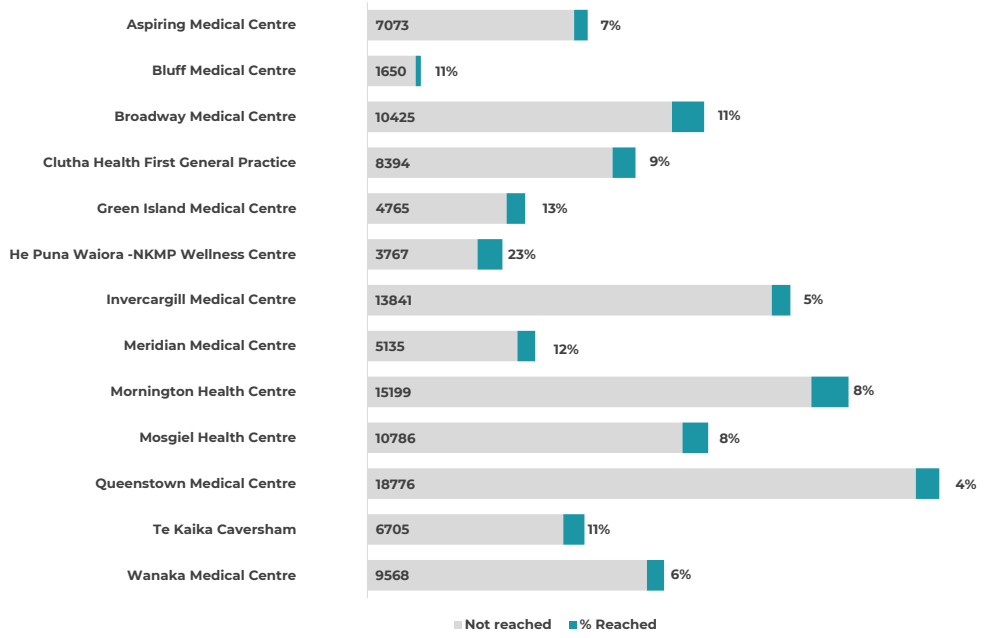
SECTION B: POPULATION PERSPECTIVE

8. REACH INTO THE ENROLLED POPULATION

Collectively, the 13 sample practices reached 8% of their enrolled population, this varied considerably between practices, from 4% to 23%.

Across the 13 sample practices, 116,084 individuals had at least one contact with the programme in the 12-month period, this equates to 8% of all those enrolled. This varied across the practices from 4% to 23%, a considerable range that suggests the model has been operationalised differently in these practices. He Puna Wairoa – NKMP Wellness Centre achieved the greatest reach and 23% of their enrolled population had contact with the programme. **Figure 11** illustrates the percentage reach for each of the 13 sample practices. The number of people enrolled in each practice is at the base of each bar.

Figure 11 Sample practices reach into enrolled populations



9. APPLYING AN EQUITY LENS

The available programme data shows that 11% of enrolled Māori and 7% non-Māori have accessed the programme. Proportionally, this can be considered equitable. Māori have poorer wellbeing on introduction to the programme, but once introduced, their experiences (role access, patterns of use, experience of helpfulness) are equitable with non-Māori. Both Māori and non- Māori make statistically significant improvements in wellbeing between their DUKE entry rating and the one prior to exit.

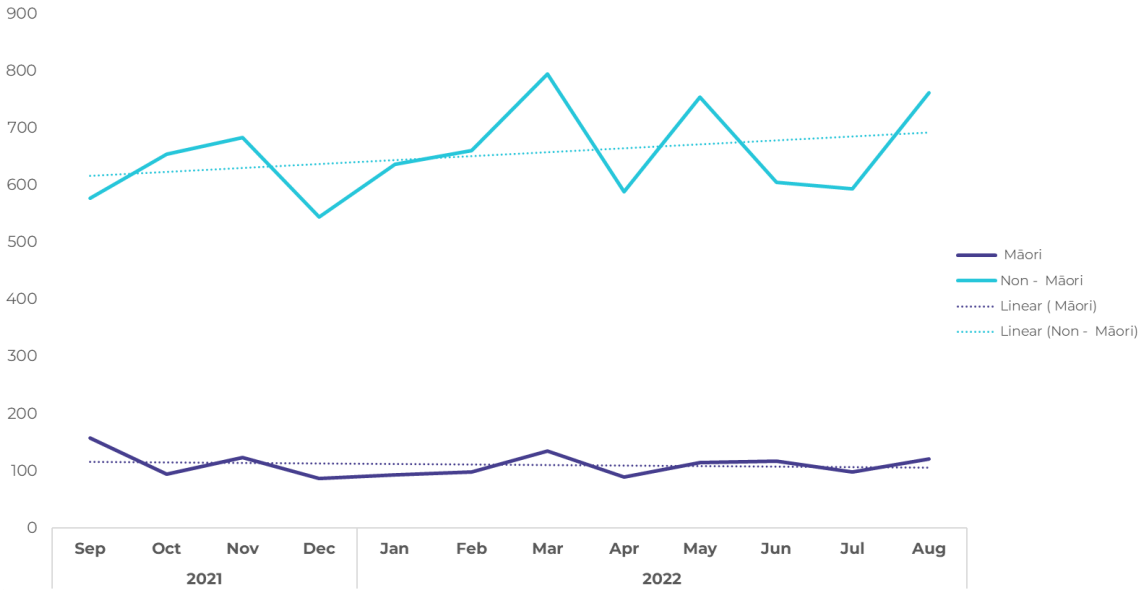
Data presented so far demonstrates a programme that is working well for consumers; access is easy, the experience is positive and improvement in wellbeing are evident. This section brings an equity lens to the available data. An equitable service should not be extending those benefits to one group more than another, in this case to non-Māori more than Māori.

9.1. Is access equitable? Yes, but

Steady pattern of Māori and non- Māori introductions is emerging

When the number of unique individuals introduced to the programme on a monthly basis is split by Māori and non-Māori, the counts for the 12-month period are distinctly different but the overall pattern of introductions is similar. This is illustrated by the trend lines on **Figure 12.**

Figure 12 Introductions by ethnicity



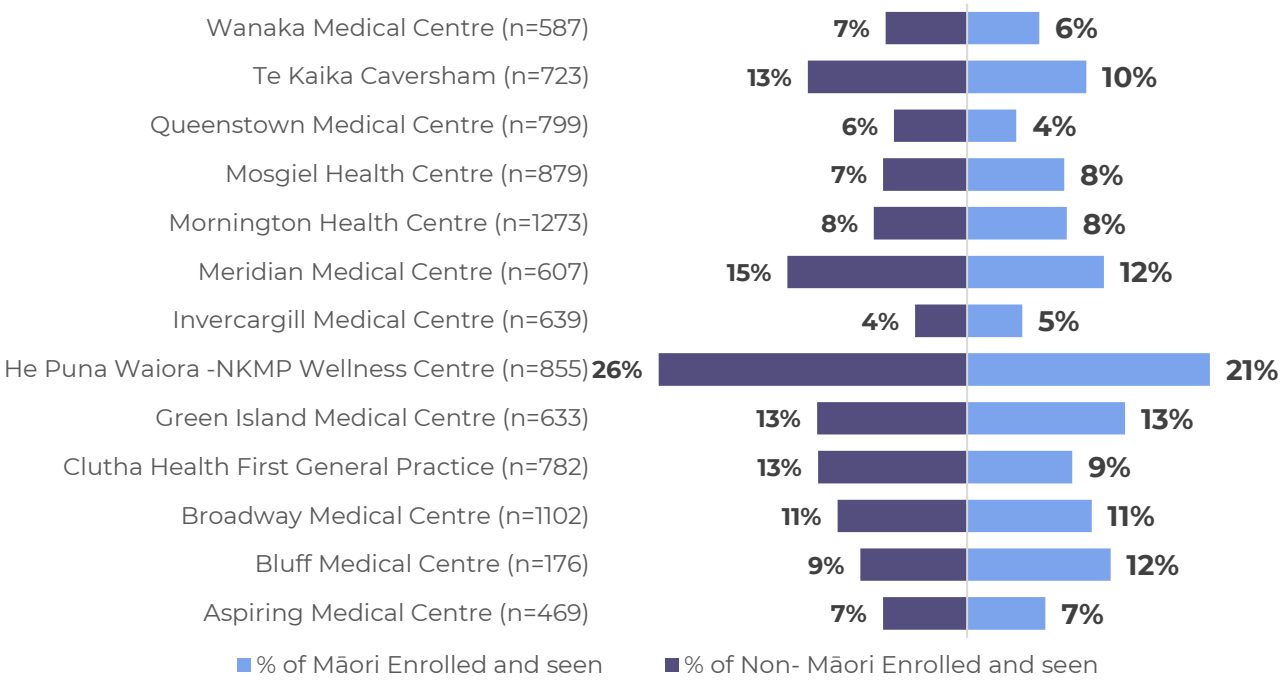
Of those enrolled, 11% Māori and 7% non-Māori were reached

Across the 13 sample practices, 12,145 Māori (11% of those enrolled) had at least one contact with the programme. Of the 103,939 non-Māori enrolled in these practices, 7% had at least one contact with the programme.

Equity of reach varies at practice level

Equity of reach throughout the sample practices is not consistent. The percentage of reach in Māori, is heavily skewed by three practices that have 13%, 15% and 26% of their Māori enrolled population using the programme. The percentage reach by Māori compared with non-Māori is shown in **Figure 13** by practice, where the 'n' after the practice name refers to the total enrolled population.

Figure 13 Overall reach for Māori and Non-Māori



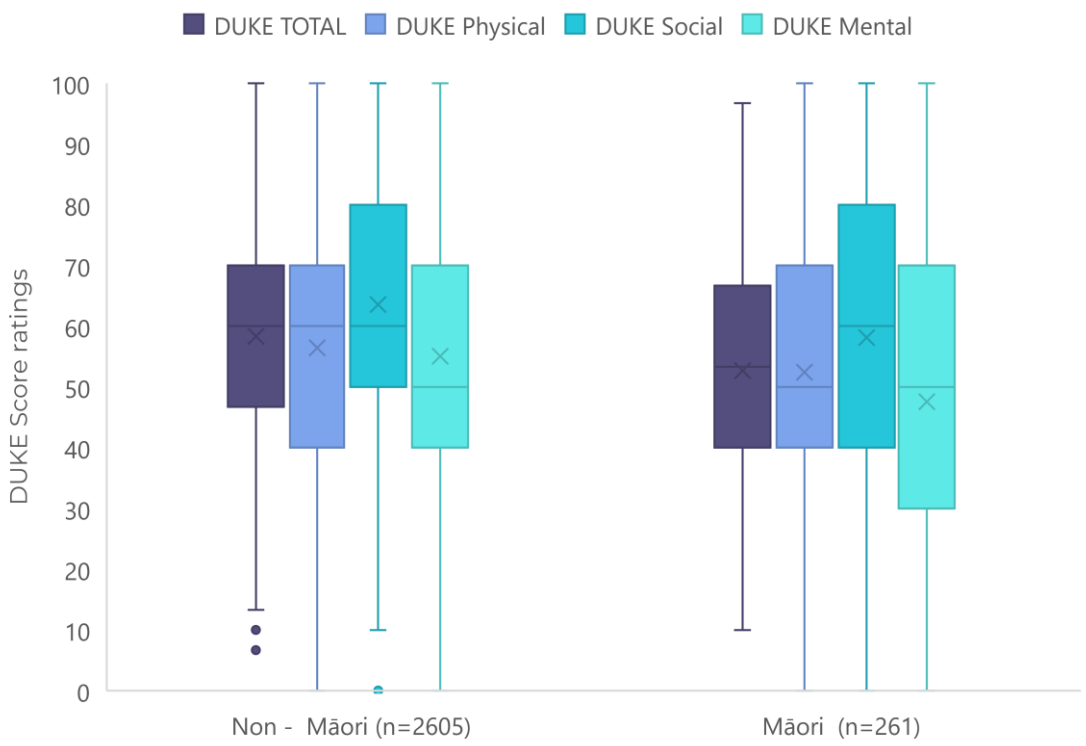
Enrolled population denominator gives a partial picture

Consumers need to be enrolled and also to attend a consultation, or have some contact with the practice team, to be able to access this programme via an introduction. Generally, Māori are less likely to be enrolled in primary care, or to attend than non-Māori. In addition, Māori experience higher burden of morbidity across a range of biopsychosocial health indicators. This greater need would be represented in higher access rates from Māori than non-Māori in an equitable programme; Tōku Oranga has higher access rates for enrolled Māori.

Presenting needs

The first DUKE score on record for all consumers, shows the mean scores are lower for Māori than non-Māori. The mean total health scores are 58.4 and 53.2 for Māori and non-Māori respectively. Māori have poorer wellbeing than non-Māori on entry. This could be an indicator that access is delayed (therefore inequitable) for Māori.

Figure 14 DUKE scores on entry by ethnicity



9.2. Experience equitable? Yes

Analysis of programme data enables us to consider equity of experience from several perspectives.

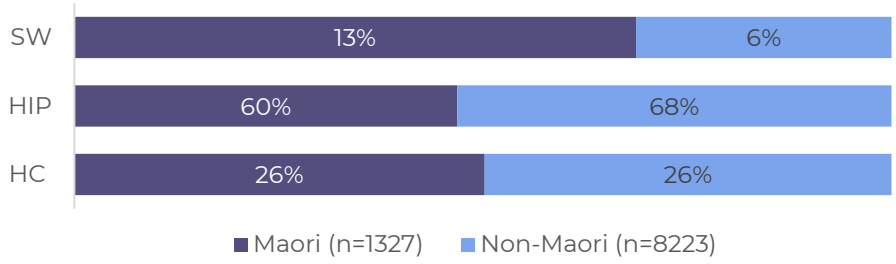
Māori access to HIP and HC similar, greater SW access

We looked at the introductions to the three roles in section 4.2 and have reanalysed that data to see if there were any obviously different patterns emerging for Māori. As **Figure 15** shows,

- Māori are slightly less likely to have contact with a HIP than Non- Māori (60% compared to 68%).
- Māori are as likely to have contact with a HC than non-Māori (26%)

- Māori are more than twice as likely to have contact with a SW than non-Māori (13% compared with 6% respectively).

Figure 15 Proportion of consumers seeing roles by ethnicity



We must remember that the approach of all Tōku Oranga workers is holistic; SWs and HCs can support mental health, HIPs can support physical health needs etc. The consumers we spoke with confirmed this experience. The results of this analysis show that Māori were accessing all roles.

Māori were as likely as non- Māori to see a HC. Further exploration would be required to understand what this represents. The poorer presenting physical health of these Māori consumers suggests they would be more likely to see a HC than non- Māori.. This result could mean that the mental health needs of Māori are recognised and practices are not substituting HCs for the physical heath care provided by GPs and nurses.

Māori were much more likely to see a HC/SW hybrid role than non- Māori, but those numbers are small as few of those roles exist.

Equitable experiences of helpfulness and confidence

Session related ratings are indicator of experience. Analysis of this data shows that experiences were equitable:

- Māori (96%) were more likely than non-Māori (93%) to rate contacts as very* helpful.
- Māori (90%) were more likely than non-Māori (85%) to report a high* level of confidence in carrying out plans created in collaboration with their support person.

*'very' and 'high confidence' classed as ratings of 8 or more on a 10-point scale

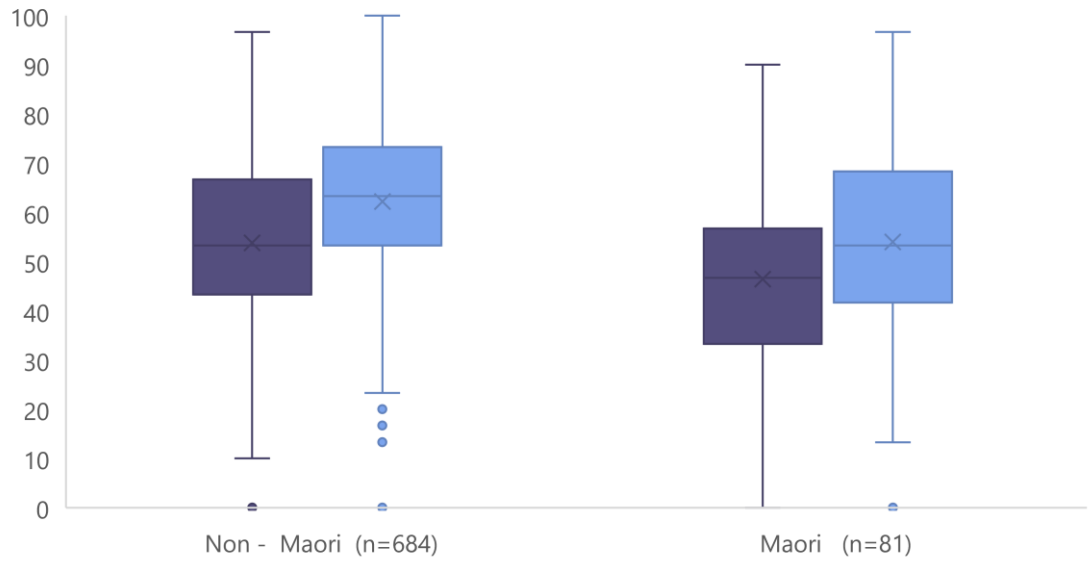
9.3. Measurable outcomes equitable? Yes

We analysed the matched pairs of DUKE scores looking at mean change between

entry and exit from **Section 7.1** by ethnicity. The changing distribution of these scores is shown in **Figure 16**. The mean improvement in total health scores for both Māori and non-Māori was statistically significant (p< 0.01) and of a similar magnitude.

- The mean difference for non-Māori is 8.41 out of 100 points
- The mean difference for Māori is 7.56 out of 100 points

Figure 16 Change in DUKE total score on entry and exit by ethnicity



10. FIT WITH THE BROADER SUPPORT SYSTEM

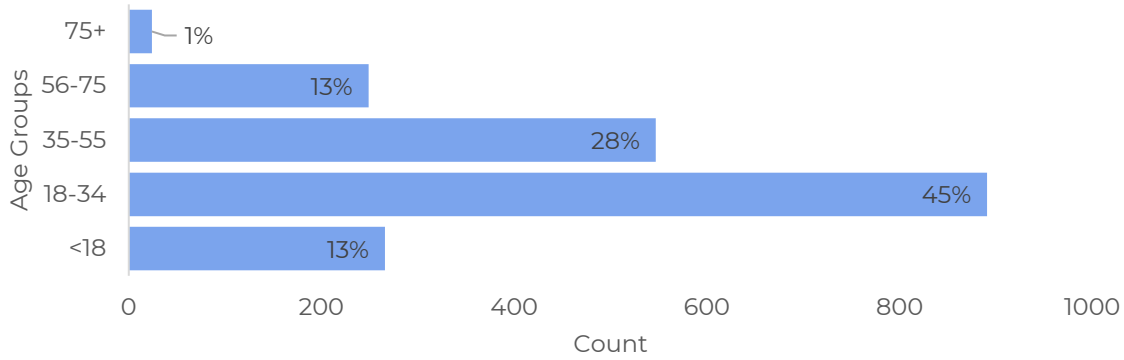
When standardised per 1,000 enrolled population, we can see that referrals from sample practices to BIS have dropped by 38% compared with the year before implementation, a statistically significant decrease. This decrease occurred when referrals from practices without Tōku Oranga were increasing. The sample practices are high needs practices so this magnitude of change will not be expected from all PHN practices. In terms of referrals to secondary mental health services, there is nothing significantly different to report.

This section uses Tōku Oranga programme data, PRIMHD data and WellSouth BIS referral data to look at emerging evidence of the fit and effect of Tōku Oranga with, and on, the broader mental health support system.

10.1. One in four consumers known to secondary services

Matching the available data sets showed that 1977 of 8511 Tōku Oranga consumers (23%) were known to secondary services. 'Known' is defined as having at least one contact with PRIMHD reporting services in the July 21 to September 22 period. This means almost one in four consumers has some contact with secondary mental health services, and half of these are young adults, as shown on **Figure 17.**

Figure 17 Age distribution of consumers known to secondary services



This degree of overlap is an indicator of the scope for collaborative working between primary and secondary care so a seamless wrap around support to consumers, especially young adults. This scope may be wider as these figures do not include those enrolled who have not been introduced to Tōku Oranga.

10.2. One in a hundred referred to secondary services

Of the 8511 Tōku Oranga consumers, 122 (1.4%) have been referred to secondary services by their worker or a member of the practice team. While a range of services were referred to, the majority of referrals were to:

- Adult mental health services (55, 45% of all referrals)
- Child mental health services (55, 45% of all referrals)

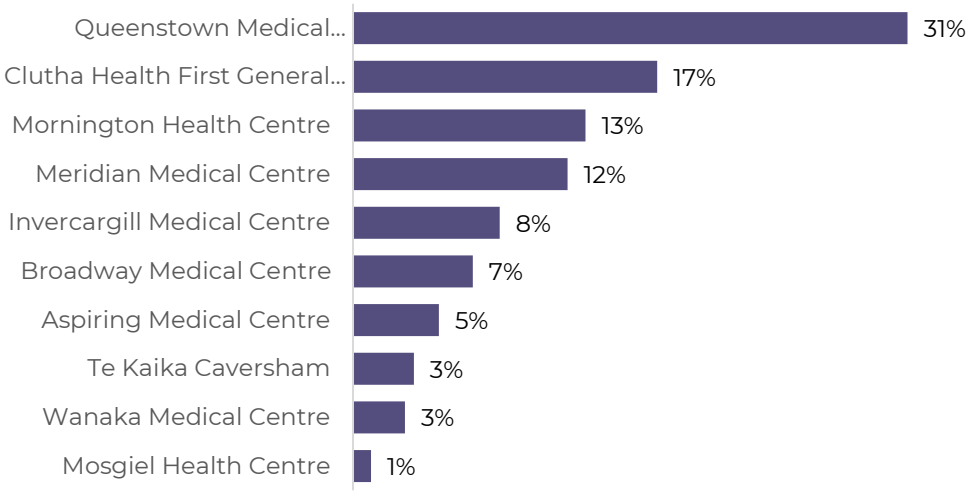
10.3. Two in a hundred referred to BIS

Brief intervention services (BIS, also referred to as the brief intervention counselling or BIC) is available to WellSouth enrolled populations aged over 20 for

up to 5 free sessions of counselling. We understand there is usually a wait list, and this is typically between six to eight weeks.

In the 12-month period September 21 to August 22, the 13 sample practices made 208 referrals to BIS. As **Figure 18** shows, 31% of these originated from a single practice and three of the sample practices did not make any referrals at all. This suggests very different population needs or operational protocols used by the sample practices.

Figure 18 Percent of referrals made to BIS by sample practices Sept 21 to Aug 22



11. EXPLORING CHANGES IN REFERRAL PATTERNS SINCE IMPLEMENTATION

We standardised and compared changes in referrals to BIS and secondary services with the same period the year before implementation began. The mean number of referrals to BIS dropped in the 13 sample practices by 39% (a significant decrease) and increased by 7% for practices without Tōku Oranga. Referral rates to secondary mental health services between these two time points showed a small (insignificant) reduction in mean referrals for sample practices and practices without Tōku Oranga.

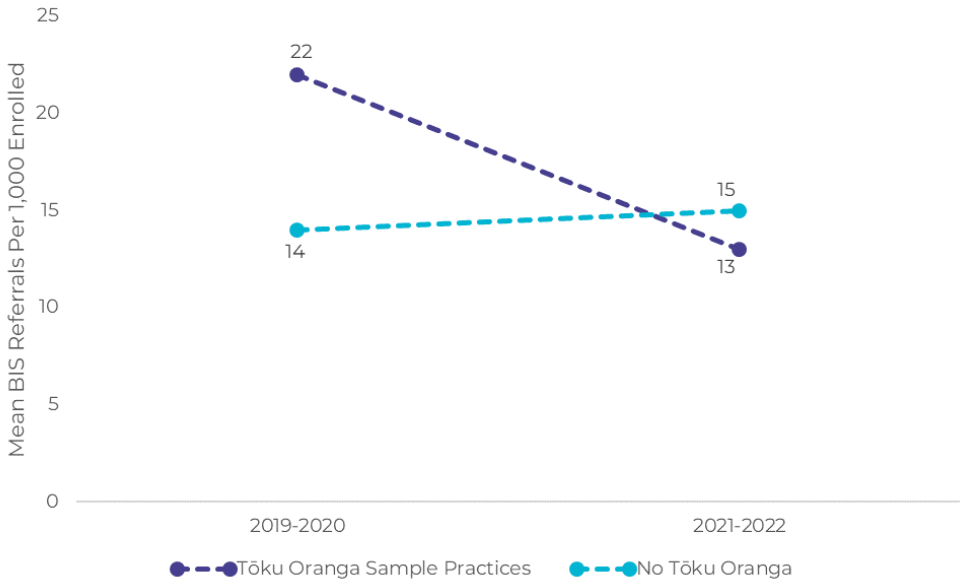
To examine the possible effect of Tōku Oranga implementation on BIS, data from the last year before its rollout (1 September 2019 - 31 August 2020) was compared to the second year of its rollout (1 September 2021 - 31 August 2022) for sample practices without any Tōku Oranga implementation at all. While this is not

comparing like with like, it provides some comparison between periods and practices when there has been much change, not least following the response to and recovery from COVID-19. For more details on the methods of this analysis, please see **Section 13.4** of the Appendix.

11.1. Significant reduction in referrals to BIS

When standardised to referrals per 1,000 enrolled population, the sample practices reduced referrals to BIS from 22 to 13 between these two time periods. This equates to a 39% mean decrease (95% confidence interval: 29% to 48%) which is statistically significant ($p<0.01$). Practices without Tōku Oranga marginally increased their referral rates from 14 to 15 per 1,000 enrolled population. This equates to a mean change of 7% that is not statistically significant ($p>0.05$).

Figure 9 Change in volume of referrals to BIS per 1000 enrolled



What does this mean for other practices? Realistically, expect around a third fewer referrals to BIS

In summary, if other WellSouth practices with comparable levels of need within their enrolled populations were to implement Tōku Oranga, a decrease of 29% to 48% reduction in BIS referrals per 1,000 enrolled could be expected by the second year of implementation.

An important caveat to this analysis is that the 13 sample practices are qualitatively different from the non-sample practices. Sample practices were among those selected to implement the Access and Choice programme because their enrolled populations are considered high need. This was also borne out by the data, which showed that sample practices had significantly higher BIS referrals per 1,000 enrolled than the non-sample practices before Tōku Oranga was implemented.

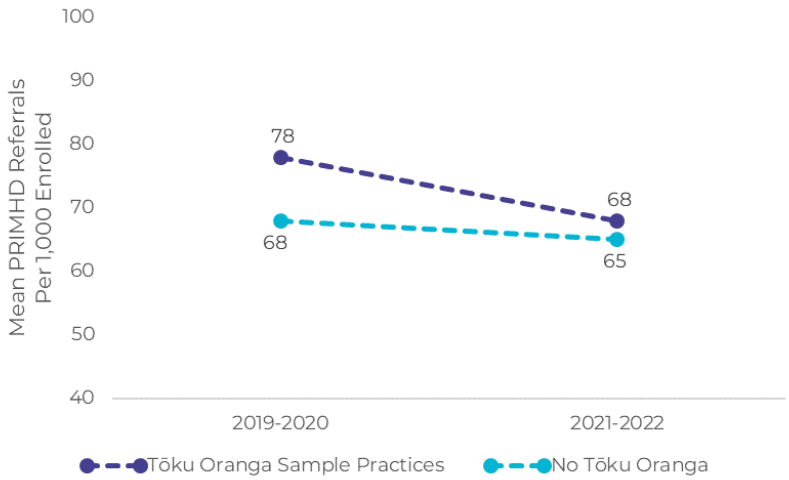
This means other practices may not see such a significant reduction in referrals to BIS, and it would be prudent to consider this occurring at the lower end of the confidence level of this analysis (i.e. around a third fewer referrals). This provides some guidance for future planning, but also highlights the need to understand the impact on practices that are not defined as high need as programme roll-out broadens.

11.2. Reduction in referrals to secondary services is not significant

We used the same methodology used to analyse the change in BIS referrals over time to explore changes in referrals to secondary mental health services. Sample practices reduced referrals to secondary services from 78 to 68 referrals per 1,000 enrolled. This equates to a 13% mean reduction, a change that is not statistically significant. Similarly, other practices' referral rates did not change significantly between 2019-2020 and 2021-2022.

Overall, there was no statistical evidence to suggest the change in referrals to secondary services (PRIMHD referrals) was different for the sample practices with Tōku Oranga and those without.

Figure 20 Change in volume of referrals to secondary mental health



What does this mean for other practices? Realistically, expect little change in the volume of referrals to secondary services.

The difference in the change in referral volumes to secondary services is not significantly different between the sample practices and practices without the programme. It would be wise to assume that implementing Tōku Oranga in other practices would not impact the volume of referrals to secondary services in any meaningful way.

The model underpinning Tōku Oranga would suggest that consumers referred to secondary services are more likely to be appropriate for referral, and that referral information is of good quality.

Programme management consider the overall pattern of declining referrals to reflect the sectors' awareness that secondary mental health services are at capacity, rather than lack of need for their services.

11.3. Bringing back the equity lens

We applied our equity lens to the changes in referral trends to BIS and secondary services to see if, within those patterns, changes we saw were statistically different for Māori compared to non-Māori. Though nuanced, the analysis does not identify patterns within these overall trends that are different for Māori compared to non-Māori. The outputs from that analysis are included in the Appendix, **section 13.4.**

SECTION C: LEARNING

12. ANSWERS AND INSIGHTS

12.1. To what extent is the programme valuable to consumers?

The short answer to this question is to a great extent. Consumers identify success as being influenced by the **effectiveness of the model itself and the high quality of delivery**. **Consumers valued easy access support and go on to have caring and safe interactions that are very personalised**. This supports self-efficacy with progress and consumer activation supported by the practical, strengths-based approach of workers, evidence of their progress and a sense of accountability to someone who understood and cared. Consumers liked the **flexibility of the support** and the degree of agency over they use it, including when to stop using it. Knowing they can go back if required provides a reassuring safety net.

Consumers we spoke with included those with low and high levels of health literacy, with extensive, little, or no previous experience of support seeking. All these **consumers achieved benefits that impacted on their lives**. We have noted the importance of consumer engagement in their wellbeing, and that sense of activation and agency to helps support success.

12.2. What patterns of service delivery are emerging? Are they equitable for Māori?

Across the programme, 8% of the enrolled population was reached and had one or more contacts with a HIP, HC or SW. This represents 11% of enrolled Māori and 7% of non-Māori. Such a result **shows equitable access from a proportional population perspective**; it is a positive achievement when we consider Māori are less likely to attend primary care than non-Māori, and this is a pre-requisite of an introduction. However, **access rates could be even higher for Māori than non-Māori as the health burden is greater for Māori.**

Tōku Oranga delivery is dominated by demand for the HIP role. Three in four introductions (75%) are made to the HIP with anxiety and depression the most frequently presenting issues. Three in ten consumers are first introduced to a HC (29%) and these are mostly likely to be consumers with long term conditions and physical health needs. SWs receive only 8% of initial introductions and presenting needs are mostly likely to relate to whānau, social and community wellbeing. **DUKE scores and presenting needs are reassuring evidence that consumers are introduced to the right roles to support them**.

A pattern of single consultation is emerging for over half of all consumers we considered as exited. Those seeing a HC were most likely to have a single consult (70%) followed by HIP (58%) and SW (53%). While a single consult is an expected aspect of the HIP model, it is beyond the scope of this evaluation to interpret this finding further. Consumers' helpfulness ratings of each consult show 93% of consults were rated as very helpful (8 or more on a 10-point scale).

We have seen that a fifth of all consumers have had contact with two or more of the HIP, HC, and SW roles. This **indicates integrated practice and wrap around support;** an experience that was confirmed during our interviews with consumers.

The equity analysis completed on the available data, shows **experiences are equitable** and Māori do not have notably different patterns of use, role associations or helpfulness, compared to non-Māori.

12.3. What outcome patterns are emerging? Are these equitable for Māori?

The immediate outcomes of the service experience could be the degree of confidence consumers have with carrying out their plan. Such confidence was highly rated by consumers with **85% of consumers very confident in carrying out their plan from their consultation** (by rating 8 or more on a 10-point scale). The high degree of confidence is an indicator of self-efficacy, an essential component of self-management which is the underlying premise of the programme. Tōku Oranga is not a passive service experience and consumers need to be activated and engaged in their own well-being. **Māori and non-Māori were equally confident** in their ability to follow through with their plans.

We used a working rule to classify consumers who hadn't had any contact with the programme for more than 90 days as exited and analysed the change between matched pairs of DUKE entry and exit scores available from 765 consumers. **Statistically significant increases were evident across the domains of mental, physical, social, and total health.** The mean increase in total health score (an aggregate of the three domains) was 8.32 points from a 100 point scale. Results showed an **increase in wellbeing for consumers working with HIPs, HCs and SWs**. These increases may not seem huge and are best thought of as an indicator for a trajectory of change rather than and end point achieved. **Improvements in wellbeing, measured by DUKE, were equitable.**

Consumers we spoke with emphasized how meaningful the changes they experienced had been, with some describing them as life changing or lifesaving. These included **improvements in consumers ability to self-manage as well as changes in their health and wellbeing that had occurred directly as a result of Tōku Oranga**.

12.4. How does Tōku Oranga compare with the traditional counselling model?

Tōku Oranga **responds to a much broader range of needs than counselling**, so the two are not directly comparable. Consumers told us the **flexibility and action orientation** of Tōku Oranga is valued, and that fast, easy access is a key enabler of engaging in support. These are not features of counselling.

Access for both types of support is through practice team member, but the **waiting time is very different**. Those referred to BIS usually wait weeks, while Tōku Oranga is designed to have minimum wait times for those who can't be seen the same day they are introduced.

Counselling is offered for a set number of sessions (usually five) whereas Tōku Oranga is flexible around the needs of the consumer, with the **majority of**

consumers having a single consultation, others using it flexibly over weeks and months, and only a minority having more than three consultations.

Consumers we spoke with who had previous experience of counselling said they preferred the practical goal focused nature of the support and felt the benefits were more immediate.

Ten of the 13 sample practices were still referring to BIS, although at a much lower rate than prior to implementing Tōku Oranga.

12.5. What changes are emerging at the system level?

Tōku Oranga is providing fast access to effective support, and it appears to have reduced the demand for referral to BIS services. Our comparison showed a **39% statistically significant decline in referrals from sample practices (per 1,000 enrolled)** while those without Tōku Oranga increased their referrals to BIS in this period by 7% .

The analysis showed that a reduction between 29% and 48% could be expected of similar practices in the future. However, sample practices have high needs populations, and the WellSouth practices without Tōku Oranga do not. This projection needs interpreting with care, and it would be more **realistic to assume other practices would reduce referrals to BIS by around a third.**

There was **little change in the referrals to secondary services by practices with or without Tōku Oranga,** between the two time periods. This suggests that future planning should not expect to be able to direct resources from secondary mental health services to primary care. It may also **indicate that the programme is reaching the missing middle and not simply substituting primary care for secondary mental health support**.

Three of the 12 consumers we spoke with said they had visited their GP or practice nurse much less frequently because of Tōku Oranga. This system impact is an intention of the model and an indicator that consumers are receiving timely and appropriate support for their mental health and addiction needs. The prevalence of this impact was beyond the scope of this evaluation, but is something for WellSouth to explore further as implementation matures.

12.6. Reflections and considerations

The achievements of this programme are to be celebrated. The impact this programme is having on the lives of consumers is huge, and one that cannot be communicated by routinely generated programme data alone.

Learning from consumers

- What was most important to consumers was **the promotion of the programme within the practice and potentially beyond**, so people who may not directly present for support know it is available and are encouraged to engage.
- **Consumers we spoke with had a high degree of activation** and most began their journey with an attitude of being willing to do and try anything. The **sense of accountability** consumers had towards their worker played a key role in maintaining this activation.

Insights and blind spots from programme data

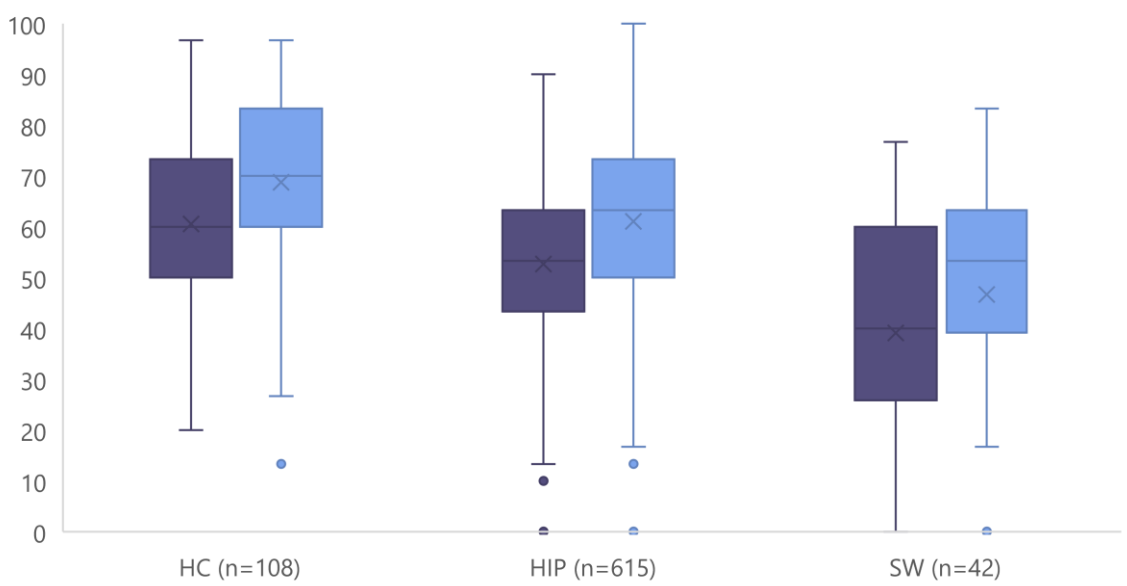
- Implementation may not yet be optimal, even in the 13 sample practices. Understanding if introductions are made from a small number of 'champions' in each practice or made widely from the entire team is a key piece of information required. .
- To truly understand how, where, and why, Tōku Oranga is or isn't experienced as equitable by Māori would require **additional qualitative enquiry be completed, using a kaupapa Māori paradigm**.
- The predominance of single consult may be an indicator of poor fit, or an indicator of immediate, effective support. WellSouth may want to explore this further.
- The **low percentage of consultations with a DUKE score** (30%) is something for WellSouth to follow up on.

13. APPENDIX

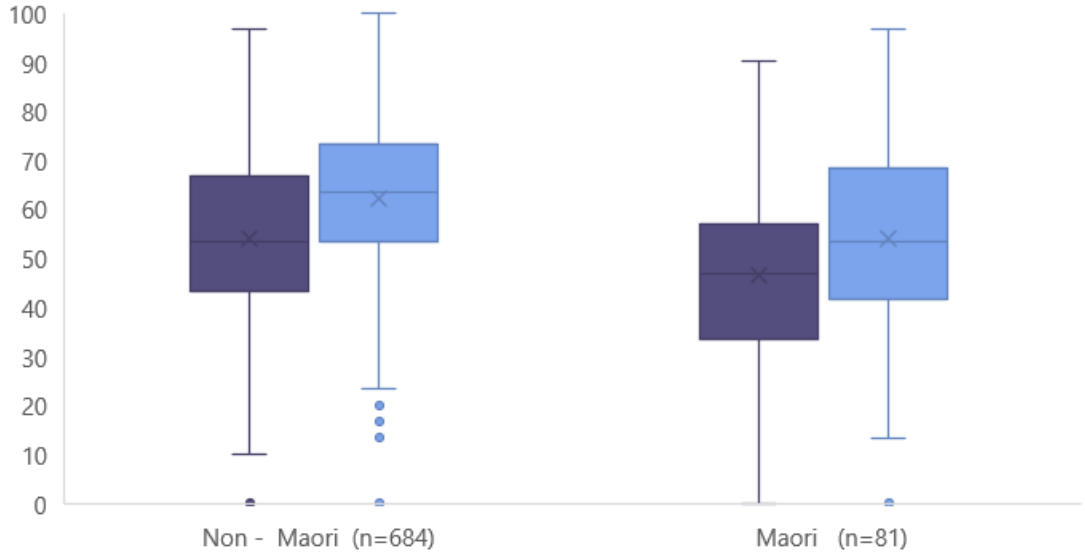
13.1. Individual increases in DUKE scores between entry and exit

Row Labels	Percent of exits	Count of exits
Duke Mental Health		
Decrease	13%	103
Increase	62%	462
Same	25%	200
Duke Physical Health		
Decrease	15%	116
Increase	50%	383
Same	35%	266
Duke Social Health		
Decrease	19%	149
Increase	44%	341
Same	36%	275
Duke Total Health		
Decrease	16%	126
Increase	68%	521
Same	16%	118
Grand Total	100%	765

13.2. Change in mean DUKE total score at exit, by role seen (n=765)



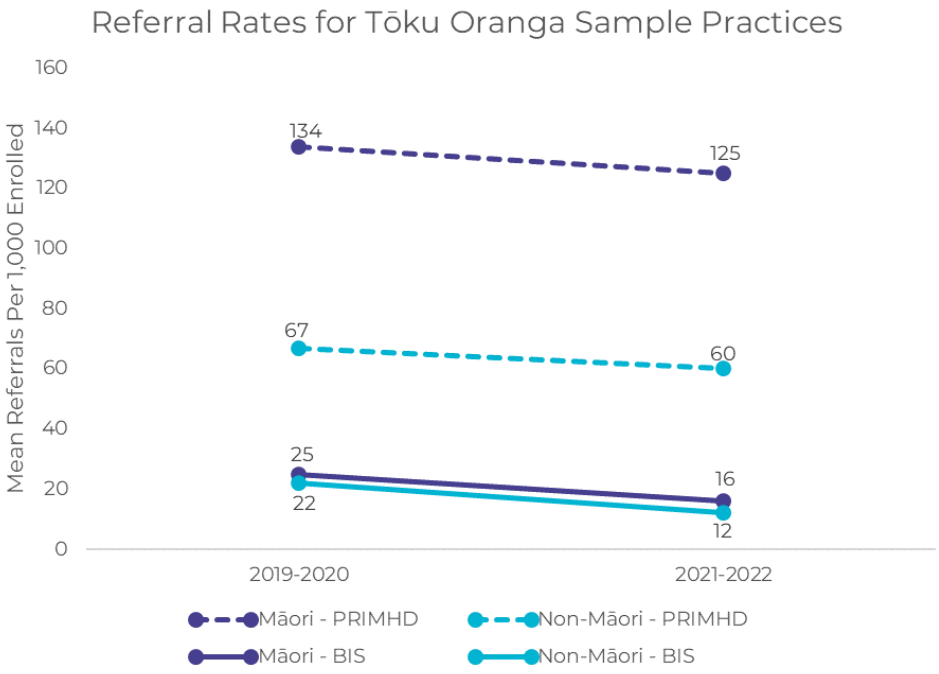
13.3. Entry and exit change in total DUKE score by ethnicity

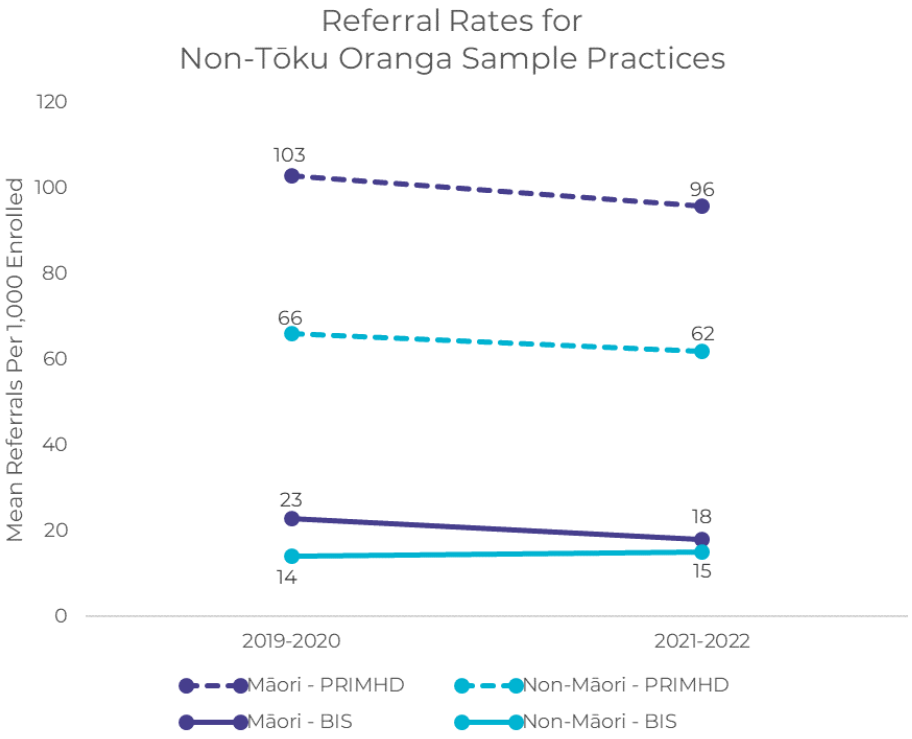


13.4. BIS and PRIMHD referrals analysis

To examine the possible effect of Tōku Oranga implementation on BIS and PRIMHD referrals, the last year before its rollout (1 September 2019 - 31 August 2020) was examined as well as the second year of its rollout (1 September 2021 - 31 August 2022). The first year of the Tōku Oranga rollout was excluded because, presumably, optimal implementation of the programme could not be achieved in its first year.

- The 17 practices that were labelled as "Tōku Oranga Practices", but were not part of the 13 practice sample of interest, were excluded from the analyses. This was because, though they had implemented Tōku Oranga at various points after August 2020, the programme was not as well established in those practices.
- To examine the possible effect of Tōku Oranga implementation on practices' BIS and PRIMHD referrals, Two-Factor Mixed Measure ANOVAs were carried out. Subsequently, differences in BIS and PRIMHD referral rates were examined for Māori compared with non-Māori using Three-Factor Mixed Measure ANOVAs.
- Māori and non-Māori followed the same overall referral trends between 2019-2020 and 2021-2022, for sample and non-sample practices. with the only notable difference being the reduction in referrals to secondary services.
- From this we can only conclude that there are no significantly different patterns to suggest Māori and non-Māori have been affected differently when we explore these high-level referral trends.


Referral Rates for Tōku Oranga Sample Practices
Mean Referrals Per 1,000 Enrolled
160
140
120
100
80
60
40
20
0
134
125
67
60
25
16
22
12
2019-2020
2021-2022
Māori - PRIMHD
Non-Māori - PRIMHD
Māori - BIS
Non-Māori - BIS


Referral Rates for
Non-Tōku Oranga Sample Practices
Mean Referrals Per 1,000 Enrolled
120
100
80
60
40
20
0
103
96
66
62
23
18
14
15
2019-2020
2021-2022
Māori - PRIMHD
Non-Māori - PRIMHD
Māori - BIS
Non-Māori - BIS