



Evaluation of the Tōku Oranga (Access and Choice) programme

**A SUMMARY REPORT FOR WELLSOUTH**

Sarah Andrews

Dr Stella vickers

Sanjana vyavaharkar

Eli kliejunas

March 2023



Tōku Oranga

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 commissioned a 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. This data was used to answer the following evaluation questions:

**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.

*“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.”*

*“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.”*

**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 were predominantly 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.

We have raised a small number of considerations that may enhance the understanding of current implementation. These include understanding more about the dominant pattern of single consults and the relatively low rates of DUKE completion (30% of consults). We have explored programme data through an equity lens and qualitative enquiry using a kaupapa Māori paradigm would be required to fully understand the experiences of Māori.