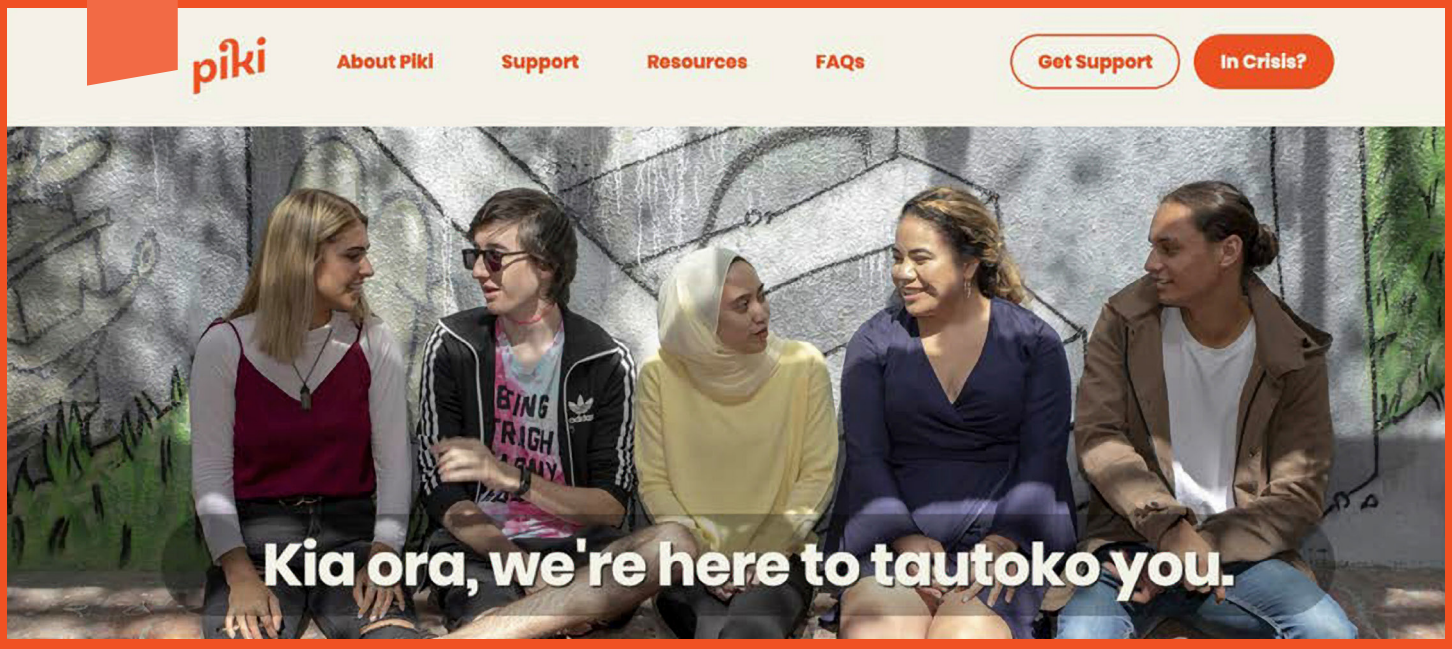
Evaluation of the Piki Pilot Project
(January 2019 – December 2020)

INTEGRATED THERAPIES FOR 18-25 YEAR OLDS

Final Report

May 2021



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We would like to thank the entire Piki team at Tū Ora Compass Health, Te Awakairangi Health Network, Victoria University of Wellington, Massey University Wellington, Ora Toa, PeerZone (now a part of *Mind & Body*), HomeCare Medical (now *Whakarongorau Aotearoa*), and Melon Health, as well as the members of the Youth Reference Group, the Service User Reference Group, the Steering Group, Practitioner Advisory Group and Operations Group for their willing contributions of time and energy to support the evaluation. We also thank James Stanley (University of Otago Wellington) for biostatistical support.

We particularly wish to acknowledge how hard everyone involved in this pilot service has worked to successfully pull this complex project together in a short timeframe, including therapists, managers, supervisors, peer supporters, CBT trainers, data analysts, and Melon app developers. We also thank the service users who gave feedback through the surveys and particularly those who agreed to be interviewed in more depth for this evaluation.

NOTES ON TERMINOLOGY

The terminology used within this report is consistent with current academic publications; however, language in this area can change quickly and is constantly evolving.

A range of terms is used to describe people who experience mental distress and are engaged with services, and there is a range of views on what these terms mean.

Throughout the report, we use the terms ***service user*** and ***client*** interchangeably to refer to those receiving support from the Piki service. The Māori word ***rangatahi*** is used by Tū Ora to refer to young people in the Piki age group and is also sometimes used in this report. It should be noted that PeerZone (the peer support organisation within Piki) use the terms ***peer*** or ***participant*** to refer to those they support, but the use of these words in many other contexts could cause confusion so has not been used here.

We use the terms ***therapy/therapists*** and ***counselling/counsellor*** interchangeably, as some Piki therapists are located within counselling services and the term 'therapy' encompasses counselling. (In fact, Piki therapists come from a range of professional backgrounds as described in Section 5.1 of this report). The phrase ***psychological therapies*** is also used in this report (as per the original RFP) and reflects the fact that more than one type of therapy may be offered. A more general term used to reflect the range of mental health services being offered is ***support***.

A range of terms is also used in the report to refer to interactions between service users and providers that are conducted remotely. These include ***telehealth***, ***virtual*** and ***remote*** which usually refer to telephone or video-conferencing where participants are literally talking to each other, but also include ***digital*** and ***online*** where support is offered through electronic communication such as email, messaging, an online community forum, or provision of online resources. ***Digital app*** refers to the use of a purpose-built app or platform where users can access a range of digital features, such as the Melon app used within this pilot. The term ***digital*** is also sometimes used as an umbrella term to encompass telehealth interactions as well as purely digital experiences.

While the term ***face-to-face*** is often used to refer to interactions where both participants are physically present in the same space, in this report we prefer to use the phrase ***in-person*** for this to acknowledge the fact that remote interactions using video technology are also face-to-face in the sense that the participants can see each other via the video. Where interviewees or documents use the term face-to-face, this usage has been retained, and is likely to mean in-person.

piki

KEY POINTS, SUMMARY AND RECOMMENDATIONS

KEY POINTS

What is Piki?

- Piki is an innovative free primary mental health service for youth that has been piloted successfully across the Greater Wellington region.

Why was Piki established?

- The report of the 2018 Government Inquiry into Mental Health and Addiction identified that children and young people in Aotearoa New Zealand are exhibiting high levels of distress leading to deliberate self-harm, risk-taking, anxiety disorders and other concerning behaviours. The Inquiry noted extensive unmet need, delayed and inappropriate interventions, and high rates of youth suicide.
- Some sectors of society face disproportionately high levels of mental distress, with Māori, Pasifika, and Rainbow youth all experiencing higher levels of depression than Pākehā. Pasifika and Māori youth, and young males, access mental health services at particularly low rates.
- The Piki youth mental health pilot initiative was instigated to address the needs (and particularly unmet needs) of the 18-25-year-old population who experience mild to moderate mental health and substance use-related distress.

What did Piki aim to achieve?

The overall aims for the pilot service were:

- to improve access to mental health and wellbeing support for all young people aged 18-25 years with mild to moderate mental and/or substance misuse-related distress.
- to increase equity via a strategic focus on priority ('under-served') groups.
- to trial an integrated psychological therapies model for youth in Aotearoa New Zealand, adapted from the *Improving Access to Psychological Therapies (IAPT)* model in the UK.

How did we do the evaluation?

- The embedded evaluation team used mixed methods within a modified action research framework to encourage ongoing review and adaptation. This was informed by principles of co-design combined with tools from complexity and implementation science.
- This approach is underpinned by a philosophy of 'appreciative inquiry' which seeks to identify opportunities, strengths, and the positive and aspirational features of innovation, whilst commenting constructively on emerging challenges and problems.

What innovations did Piki test?

Key innovations included in the pilot were:

- co-design and co-evaluation with young people, including service users.
- a free open access service with online self-referral ('any door is the right door').
- enhanced training and professional development for therapists/peer supporters.
- an integrated 'stepped care' model building on existing services:
  - evidence-based psychological therapies.
  - structured peer support (individual or group).
  - online peer community and emotional wellness tools.
  - free phone/text counselling and mental health support .
  - a local website to help connect young people to services.

Elements of success

Overall success of a complex and innovative mental health service for young people:

- reduced barriers to access (5307 clients had 21,015 free sessions over the first 24 months).
- delivering a range of therapy and wellbeing support.
- a comprehensive workforce training and development programme.
- integrated 'brand' and provision across Wellington, Hutt, Kāpiti, Wairarapa.
- constructive collaboration between multiple partners.
- ongoing engagement with youth and service user reference groups.
- positive feedback from service users (75% would recommend Piki to others).
- growth of peer-to-peer support programme (tailored approach received praise).
- rapid adaptation to COVID19 and pivot to virtual delivery.
- national and international recognition.

Challenges

Piki was designed as a pilot and testbed for new ideas. As such, it was expected that some aspects may not work as intended, and that ongoing review and refinement would be needed.

Challenges included:

- defining and operationalising co-design principles.
- establishing robust governance and operational structures.
- improving equity of access for priority groups.
- integrating new and existing service components.
- information management and communication.
- managing workforce capacity and workload.
- achieving consensus on models of care and outcome measures.

These challenges were influenced by a range of inter-related factors:

- complexity of the programme (many 'moving parts' and stakeholders).
- compressed timeframe.
- need to build on existing platforms.
- higher than anticipated levels of demand.
- effects of COVID19.
- emergent changes in the wider health sector/policy environment.

Key recommendations

- Continue the Piki service locally.
- Roll out similar free or low-cost initiatives more widely.
- Retain successful innovations (e.g., peer support, self-referral, integration).
- Strengthen focus on equity and targeting to priority groups.
- Commit to genuine co-design and engagement with tangata whenua, local communities.
- Offer a range of evidence-based talk therapy and digital options.
- Consider widening the age range (especially 16–18-year-olds).
- Systematically address workforce capacity and training issues.
- Routinely embed formative evaluation/CQI into new initiatives.

FULL EXECUTIVE SUMMARY

1. Introduction

The Piki programme is an innovative free primary mental health service for youth that has been piloted successfully across the Greater Wellington region. The overall aim was to improve access to mental health and wellbeing support for young people aged 18-25 years with mild to moderate mental and/or substance misuse-related distress. Piki was designed to enable multiple partners to provide psychological therapies and other mental wellbeing supports within an integrated stepped care service.

After 24 months of ongoing development and operation (2019-2020), Piki had delivered over 21,000 therapy or peer support sessions to 5307 young adults in the Wellington, Porirua, Hutt, Kāpiti and Wairarapa areas.

Service users gave very positive feedback about the support they received through Piki. Many identified the existing youth mental health system outside of Piki as underfunded and overstretched, making access to support extremely difficult. They affirmed the value of the original intention of Piki as a free, easily accessible service, and that it was highly desirable to extend Piki beyond its pilot stage.

The pilot has shown that it is feasible to transition from an existing platform of primary mental health service delivery involving multiple partners to an integrated service model, and to progressively introduce and sustain significant innovations.

This final evaluation report covers the piloting of the service during 2019 and 2020 and builds on previous interim reports (June 2019, June 2020) from the University of Otago evaluation team. It presents conclusions as assessed against the original aims and objectives of the Piki programme. We summarise the successes of the pilot programme, provide commentary on the main complexities and challenges encountered, and make recommendations about the key issues that are relevant to continuation and/or wider rollout of Piki or similar models in 2021 and beyond.

The executive summary is presented in the same sequence as the main report: 1) introduction; 2) methodology; 3) programme description and development; 4) outcomes and effectiveness – Piki overall; 5) outcomes and effectiveness – Piki components and integration; and 6) discussion, conclusions. The evaluation recommendations follow the executive summary.

Our brief review of background literature focuses on lessons learnt from the development, adaptation, and implementation of the UK-based *Improving Access to Psychological Therapies (IAPT)* initiative and concludes that, despite some criticisms and concerns, an integrated psychological therapies model for youth remains worth considering in the Aotearoa New Zealand context.

This is followed by a high-level overview of the pilot initiation, existing service delivery and the broader primary mental health environment within which Piki was conceived:

- In July 2018, the Ministry of Health called for tenders to develop, implement, and evaluate a pilot primary mental health service based on the IAPT model. This was to be free to all youth (aged 18-25) experiencing mild to moderate mental health and substance use related distress. Tū Ora Compass Health PHO (Tū Ora) and the University of Otago were awarded the contract in partnership with Te Awakairangi PHO (TeAHN) and Explore. The pilot commenced in January 2019.
- Evaluation was embedded into the design and implementation of the pilot and was integral to its development. Its scope included the programme's structure and implementation processes, outcomes and effectiveness, and lessons learned for future scale up of this or similar services.
- The establishment of the Piki service involved a transition from existing platforms of primary mental health activity within the Wellington region to a new integrated service delivery model with multiple possible entry points, where 'any door is the right door'.
- Key innovations included co-design with young people including service users, and integration of psychological therapies with peer support services and digital (online) wellbeing support. Improved equity of access for young people from underserved groups (including but not limited to Māori, Pacific, and the Rainbow community) across the primary and community healthcare sector was an important focus.
- Following the award of the contract, the Ministry of Health reduced the pilot timeframe from 3 to 2.5 years. This necessitated a reduction in the target number of young people to receive services during the pilot, and a conflation of the design and service roll-out phases. The compressed timeframe meant individual elements were introduced in a staged fashion as they were ready to deploy, rather than a complete integrated service being offered from the point of launch. This added complexity to an already ambitious pilot programme and had an impact on the ability for true co-design to occur.
- Tū Ora, as the main contractor, employed a dedicated Piki project lead and had contracts with a range of partner organisations to deliver the integrated service across the region.
    - Clinical providers (therapy) were Te Awakairangi Health Network (Te AHN), Ora Toa PHO, Victoria University of Wellington, Massey University (Wellington), Evolve Youth Health, and Explore.
    - Digital and telehealth services were provided by Melon Health and HomeCare Medical[a] (website development, social media marketing campaign, 1737 National Telehealth Service and Puāwaitanga telephone counselling).
    - Intentional Peer Support (IPS) services were provided by PeerZone.

a Now *Whakarongorau* Aotearoa

2. Methodology

The embedded evaluation was co-produced by a diverse team of ten researchers, four of whom identified as service user academics. A service user reference group (SURG) of young people with lived experience of mental distress was also involved in the evaluation throughout. Co-production within the evaluation team (with this combination of service users and non-service users) was an innovative and ground-breaking aspect of the pilot.

The evaluation used mixed methods within a modified action research framework, informed by principles of co-design combined with tools from complexity and implementation science. It was underpinned by a philosophy of 'appreciative inquiry' which seeks to identify opportunities, strengths, and the positive and aspirational features of innovation, whilst commenting constructively on emerging challenges and problems.

QUANTITATIVE METHODOLOGY

This involved collation and analysis of service utilisation and outcome measurement data routinely collected by Tū Ora and other providers, using a cohort design to analyse individual service user data. Workforce data were also collected and analysed.

- It was complicated for Tū Ora to collect and combine quantitative data, both in terms of extracting data from their own Patient Management System and in terms of completeness from external organisations. Some data issues remained unresolved.
- Four surveys were conducted during the pilot: two surveys of therapists and two surveys of service users (one of users of the peer support service, and one of all Piki service users).

QUALITATIVE METHODOLOGY

Three main categories of data were gathered for the qualitative part of the evaluation: direct participant observation, document review, and interviews or focus groups. All qualitative information was systematically collated and incorporated into an integrated coding framework.

- Evaluation team members undertook participant observation and critical reflection on all steering, advisory, operations and reference group meetings throughout the pilot in addition to key workshops and public events. These observations were supplemented by systematic review of correspondence, official minutes, planning documents, media and communications, and input from the youth and service user reference groups.
- In-depth qualitative information was collected from key service design and delivery stakeholders at two points via interviews and focus groups.
- Input from a selected subset of service providers from all partner organisations was collected via interview, firstly to explore experiences of using telehealth options during the COVID-19 lockdown period. Later, more general feedback on Piki was collected from providers via focus groups and individual interviews with therapists, peer supporters and Melon community moderators.
- A diverse sample of clients was interviewed by a service user academic on the evaluation team who was in her late twenties and identifies as a member of the Rainbow community.

3. Programme description and development over time

This section describes the governance and co-design structures of the pilot, and outlines the development of key aspects of Piki operations and processes that defined services and supported their delivery.

GOVERNANCE AND OPERATIONAL GROUPS

Piki is a complex pilot service with a similarly complex structure of five groups to guide its development:

- **Steering Group (SG)** or Governance Group
- **Practitioner Advisory Group (PAG)** (renamed from Clinical Advisory Group to reflect inclusion of peer support)
- **Project Operational Group (POG)** of Piki service providers
- **Youth Reference Group (YRG)** made up of 15-23 young people
- **Service User Reference Group (SURG)** made up of 6-11 young people with lived experience of mental distress

Group names and membership evolved over the course of the project, with attempts to be inclusive of people from youth, service user, Māori, and Pacific perspectives, as well as the appropriate service providers and organisational stakeholders.

KEY FEATURES OF THE PROGRAMME

- **Evidence-based psychological intervention:** Therapists are expected to hold a recognised Post Graduate Certificate (PGC) or equivalent in Cognitive Behavioural Therapy (CBT) or be working towards this and have knowledge of Acceptance Commitment Therapy (ACT) and Motivational Interviewing.
- **Intentional Peer Support (IPS):** IPS is a system of providing peer relationships or peer to peer support services to service users.
- **Free access and self-referral options to reduce barriers:** Services are free; a website provides for self-referral; an increased workforce facilitates accessibility.
- **Focus on improving equity of access and outcomes:** Services are available in a range of locations and are being promoted to Māori and Pacific young people; providers have received Māori and Pacific cultural training and Rainbow training.
- **Co-design with rangatahi:** The youth reference group and youth service user reference group were operational from the beginning of the project.
- **Integrated services delivered across the region:** A digital wellness app was provided by Melon Health. Integrated services are being provided by multiple general practice and community organisations.

WORKFORCE COMPOSITION AND TRAINING

- The core Piki workforce consists of in-person therapists/counsellors and peer supporters, supplemented by Puāwaitanga phone counsellors.
- CBT training and CBT fidelity courses were offered by the University of Otago Wellington to Piki therapists/counsellors.
- Specific training in target areas (e.g., Rainbow, Pasifika, and Māori cultural competency) were provided for Piki practitioners.
- Melon provided repeated training sessions in how to use the Melon app for therapists from the partner organisations, plus some online training.
- In-person therapists and peer supporters also received some training in telehealth in response to the sudden need for widespread use of this during the COVID-19 lockdown.
- Regular supervision for providers is part of the Piki model. Explore recruited two clinical supervisors (registered psychologists with formal training in CBT) to provide this service, and PeerZone have their own 'co-reflection' process.

CLIENT JOURNEYS AND CLINICAL PATHWAYS

- Reducing barriers to access and ensuring rapid response to referrals were key elements of the Piki design from the outset. Usual pathways into mental health support through GPs were supplemented by the addition of self-referral through a website to address this.
- The goal of enabling multiple entry points through which clients received rapid responses and initiation into services was logistically very challenging.
- The initial aim was to 'deliver low intensity interventions with a wait time of less than 5 days for 90% of clients' but actual wait times have been much longer.
- The introduction of a centralised intake co-ordinator based at Tū Ora was designed to streamline the referral pathway, manage clinical risk, and reduce wait times. However, this process created a new set of operational issues and was later disestablished.
- The new intake process involved administrators sending self-referrals directly to partner organisations. This reduced therapeutic and administrative duplication, but meeting the goals for minimal wait times remained a challenge.
- Referrals and wait times reduced during the initial lockdown at alert levels 3 and 4 of Aotearoa's four-level alert system in response to the COVID-19 pandemic, but then rebounded.

BRANDING, PROMOTION & MARKETING

- The compressed project timeframe necessitated an unusually rapid development of branding, and resulted in progressive rollout of social marketing and engagement activities as each new service component or provider came on-stream.
- Social media marketing to Māori and Pacific was delayed in part by unexpected spikes in demand in the second half of 2019. Plans for improving access for Māori and Pacific were further developed in early 2020. Despite delays due to the COVID-19 lockdown, Piki was successfully promoted to these groups in a range of ways from the second quarter of 2020.

DEVELOPMENT BEYOND THE EVALUATION TIMEFRAME

Further development of the service is ongoing and, as of May 2021, Tū Ora and the Ministry of Health were in discussions regarding renewal of the contract for a further 18 months with a particular focus around improving equity, reviewing digital app options, and refreshing the co-design and governance structures.

4. Outcomes & Effectiveness – Piki Service Overall

This section describes the outcomes and effectiveness of Piki as a whole: the design process, overall service utilisation, the psychological measures used to assess outcomes, issues around equity and improving access for target populations, and service accessibility and flexibility.

- The number of young people seen by the service is a measure of its success.
- Service users, in general, gave very positive feedback about the support they received, with some identifying the existing youth mental health system outside of Piki as underfunded and overstretched, making access to support extremely difficult. They were strongly in favour of keeping Piki going beyond its pilot stage.
- Service users also had constructive feedback and suggested areas for improvement and enhancements. Their interest in providing feedback, and thus directly influencing their own mental health care, indicates that involvement of young people is a principle that the Piki project should continue to uphold through an ongoing process of co-production as this service continues, or as similar services are rolled out in future.

DESIGN AND MANAGEMENT PROCESSES

Two major factors impacted the design processes and how changes were introduced: (1) the design constraints inherent in the RFP and in the proposal from Tū Ora and the University of Otago, and (2) time constraints resulting from the compression of the pilot timeframe.

- There was general agreement that in an ideal world, true co-design means starting from scratch. This ideal conflicts with the pragmatic imperatives of a need to build on existing services, efficiency, and inherent constraints in funding models.
- Many of those involved in the development of Piki accepted there were limitations on the extent of 'true' co-design due to these constraints.
- However, there was a lack of transparency about the limitations that led to dissatisfaction amongst the youth and service user groups in particular about the nature of their contribution to Piki.
- While Tū Ora positioned the co-design element of Piki as being co-design with young people (rangatahi), it is important to consider whether other relevant community groups (particularly target groups such as Māori and Pacific) should also have been involved.

OVERALL SERVICE UTILISATION

- 5307 individuals (excluding Melon only enrolees) accessed the Piki service in the two years up until the end of December 2020 (2090 in 2019; 3217 in 2020).
- The majority of Piki clients were female (65.3%) and European (69.9%).
- Māori comprised 13.7% of clients, while Pacific youth comprised 3.5%; these two priority groups thus accessed the service at levels below their population share (17.4% and 8.0% respectively based on 2018 census data).
- The majority of Piki clients had between one and three sessions, with 33% having only one session. A substantial minority of service users (4.6%) had 13 or more sessions.

PSYCHOLOGICAL MEASURES

The original intention was to collect psychological measures at several points in the Piki client journey, with all clients offered the opportunity to complete all measures. In response to strong feedback from SURG and wider discussion with partner organisations, it was decided that completing outcome measures would not be compulsory.

There was debate around which measures were most appropriate. Completion rates were not high: baseline PHQ-9 and GAD-7 measures (intended as screening tools) had a 42% completion rate; WHOQOL-bref (a quality-of-life measure) had 11% completion; Session Rating Scales (SRS) had 10% completion; Outcome Rating Scales (ORS) had 20% completion. Factors affecting (lack of) completion included the choice of measures, practical/workload considerations, impact on the therapeutic relationship and a lack of clarity about the purpose of measures collection.

EQUITY AND TARGET POPULATIONS

Addressing equity issues was a challenge from the beginning and was one of the two most pressing issues or challenges identified by key informants, together with managing demand. Strategies for increasing equity included:

- (Co-)Design processes to ensure that services were appropriate: concerns about engagement were expressed by several Māori members of governance and advisory groups, as well as the youth reference groups YRG and SURG. It was generally acknowledged by key informants that the Māori/Pacific voice needed to be heard more.
- Actual provision of appropriate services: in addition to increasing availability, providing services that are appealing and appropriate for priority groups is key to engaging these populations in services. This aspect of Piki is still a work in progress.
- Effective marketing to increase awareness: a key theme from the key informant interviews was the importance of in-person communication and using existing networks. These include existing Māori, Pacific, refugee groups and youth organisations, as well as links through GP clinics and talking directly to the target groups.

However, it is extremely challenging to undertake effective consultation or co-design with target groups without well-planned strategies and relationships being established from the outset, and allowing the necessary time to enable the outcomes of these processes to inform service design.

PIKI AS A SERVICE FOR YOUTH WITH MILD-TO-MODERATE MENTAL HEALTH NEEDS

The classification of mental health problems in terms of severity has been the subject of ongoing debate within Piki, with a range of views about the appropriateness of diagnostic 'cut offs' based on scoring or clinical assessment. Many presentations in primary care settings, particularly when associated with significant socio-economic deprivation and other factors, may not fit neatly into a 'psychiatric' classification of severity.

There was a greater likelihood of service users presenting to Piki at the more severe end of the distress spectrum. Over a third of GAD-7 scores were in the severe category and over half recorded moderately severe or severe scores on the PHQ-9. Just 13% of the surveyed clinicians described their client group as 'only mild/moderate'. Many clients would have benefited from access to intensive therapy input beyond the scope of the Piki objectives and resourcing.

Therapist surveys indicated a perception that workload and demand were producing an emphasis on providing shorter duration and intensity of intervention. Given the pressures on both Piki and on secondary care services, a degree of risk holding was regarded as inevitable. It is difficult to manage 'clinical safety' or 'risk management', and prioritisation of clients with more acute presentations within an 'open access' service with online self-referral. How to design optimal processes to manage intake and triage without creating barriers to access has not yet been fully resolved.

SERVICE ACCESSIBILITY AND FLEXIBILITY

The provision of free services and self-referral options improved access to mental health support and were highly valued by rangatahi. These features were also probable drivers of the ongoing high demand for the service. The introduction of additional options for support was seen as valuable, but there are further ways that flexibility and integration of service offerings can be enhanced in the future, such as increasing the range of locations of services and introducing ways for clients to have choice of service provider.

5. Outcomes & Effectiveness – Piki Components

This section reports on the outcomes and effectiveness of the individual components of Piki. Each sub-section describes the utilisation of that element by young people, workforce development, and the experience and perspectives of service users, service providers and key informants.

THERAPY

Issues with collecting an adequate set of outcome data meant that it was not possible for the evaluation to comment directly on the effectiveness of the psychological therapies offered through Piki in terms of psychological measures. However, the majority of Piki clients accessed in-person therapy, and the feedback collected via service user interviews and survey responses indicates that therapy was beneficial overall.

There has been ongoing discussion from the outset about CBT-based therapy content and style and to what degree there would be variation of both content, duration, and intensity of psychological intervention.

It is appropriate to review both present and planned therapy content and style when incorporating Piki type programmes into the primary mental health platform mix. There should also be national and local discussion about the overall aim of therapy for this age group. In Piki there was a trend towards shorter duration therapy inputs for various reasons. It is important that therapy is evidence based and tailored to need and is not driven by workload pressures.

PEER SUPPORT

Introducing and fully integrating the peer support service with more commonly used and understood service options required considerable attention and resourcing. As a new type of service, it took time to inform clients (and other providers) about what peer support could offer, and PeerZone had to develop a version of their existing service into one that was tailored for youth (which launched in July 2019). They now provide a very diverse peer support workforce and were able to rapidly increase cultural diversity to address the equity aims of the project, partly due to the lower demands of training compared to therapists.

While only a small percentage of total Piki users (2.9%) used the peer support service (reflecting its smaller share of resourcing), the feedback collected from service users was very positive. Having someone who had experienced similar struggles to talk to in a safe space where they felt validated and understood in a non-judgemental way was highly valued. Clients enjoyed the more equal relationship (less power imbalance compared to therapy) and a less clinical experience.

Suggestions for improvement from interviews and the surveys included:

- clearly communicating the definition of peer support to manage expectations
- having a dedicated focus for sessions
- the addition of an option to meet in a private location
- more peer supporter availability in general.

DIGITAL MENTAL HEALTH APP (MELON)

Enrolments in Melon were significantly lower than expected. Early in the pilot, 50% of all Piki clients registered, but the cumulative enrolments had declined to 30% by the end of 2020.

Contrary to what may be assumed, digital support does not appeal to all young people. Both the quantitative data and qualitative feedback from the evaluation indicated that while some young people value having access to a range of digital options to support their mental health and wellbeing, a significant proportion have little or no interest in this kind of support.

Nevertheless, the Melon platform successfully provided a range of useful inputs to a significant subset of Piki clients and providers, and progressively expanded its range of resources, activities, and operational features over the duration of the pilot.

As such, Melon was a useful testbed for the utility and acceptability of various components of a digital platform and possible resources, and how these can most usefully be integrated into a youth-oriented service.

PUĀWAITANGA / 1737

Two phone counselling services provided by HomeCare Medical were available: Puāwaitanga (a referral only service that provides counselling sessions), and 1737 (a phone/text service that provides open access to a counsellor 24/7).

Overall, the option of having telephone counselling services as part of the integrated services offered by Piki was well-received, particularly the Puāwaitanga service which aims to replicate in-person counselling via remote delivery. This service was not utilised to its full extent as originally envisaged (i.e., as an option for those clients who faced barriers to access or preferred a remote mode). It was instead used mainly as a response to excess demand for services, especially after the COVID-19 lockdown in 2020.

The 1737 service fulfilled an important need for immediate support at any time of the day or night. Both these services have a place within an integrated service.

WEBSITE/ SELF-REFERRAL

The Piki website, delivered by HomeCare Medical and launched in May 2019, included information on Piki and a self-referral pathway with the aim of reducing barriers to access.

The number of Piki self-referrals received between October 2019 and December 2020 was 2,254 (out of 5307 Piki service users), indicating that this feature is working well to increase accessibility of services; this conclusion is supported by positive qualitative feedback. However, the ability to provide services to meet the demand generated by self-referral needs to be carefully planned for when introducing such an innovation.

There is further room for development of the website overall which could not be prioritised within the timeframe and other constraints of the pilot.

TELEHEALTH DELIVERY BY IN-PERSON SERVICE PROVIDERS

The natural experiment afforded by the unexpected widespread use of telehealth options during the COVID-19 lockdown resulted in a clearer picture of service user and provider experiences of this mode of delivery than would otherwise have been available.

While both users and providers were often pleasantly surprised at how effective phone or video sessions could be (and there were some service users for whom the remote mode was preferable), in-person therapy or other support remained the preferred modality in most cases. It is heartening to see indications here that if required, telehealth service delivery is a viable option that means support can be offered when circumstances demand.

INTEGRATION OF PIKI SERVICE COMPONENTS AND INFRASTRUCTURE

Piki has demonstrated that it is possible for multiple partners within a region to work together to deliver comprehensive mental health and wellbeing support for young adults, encompassing the integration of psychological therapies with innovative services like peer support and digital wellness apps.

Ongoing attention does need to be paid to the balance of different components and levels of support, and how these can best be integrated across multiple providers. Consideration of the relative resourcing and accessibility of each component, the maintenance of client choice, strategies for enhancing client and provider awareness of all components, and the development of robust information and management systems are all important factors supporting success.

While there are additional compliance costs involved in developing and operating an integrated primary mental health programme such as Piki, overall, the value of combining these different elements is likely to outweigh the cost and additional effort required.

6. Discussion and conclusions

DISCUSSION

Overall, the Piki pilot represents the ongoing success of a complex and innovative mental health programme. It continues to enable multiple partners to work together to deliver comprehensive and integrated support to young adults in the Wellington, Porirua, Hutt, Kāpiti and Wairarapa regions.

Service user feedback has been largely positive. Challenges faced by the pilot were driven by a range of factors including: the complexity of the programme design, the effects of the compressed timeframe, the number of different organisations and stakeholders involved, the ability to be responsive to differing expectations of co-design, and new pressures created by emergent changes in the wider policy, health sector and political landscapes.

Addressing equity issues has been a challenge within Piki in respect to fulfilling the original target aims of prioritising specific groups and in particular fulfilling obligations to Te Tiriti o Waitangi and ensuring appropriate engagement with Māori.

The evaluation team has identified several aspects of service design and delivery where trade-offs and tensions must be considered, and where the optimal solutions will differ for different settings. These include:

- development from existing services vs a 'blank slate'
- provider-led service development vs a service user/community-led approach
- response to priority groups vs ever-increasing demand
- tailored services vs 'one size fits all'
- place of national services within a locally delivered service
- acknowledgment of the complexity within project innovation.

We believe it is important that service planners and co-design partners take the time to consider these issues within their own contexts and in the light of an increasing evidence base of which this report is a part.

CONCLUSIONS

Overall

- Piki represents successful development of a complex and innovative free youth mental health pilot programme. The pilot has shown that it is feasible to transition from an existing platform of primary mental health service delivery, and to introduce and sustain innovations.
- The engagement of multiple partners and the incorporation of an embedded evaluation stream has enabled the programme to deliver services and adapt to a range of challenges and unexpected events.
- It has been possible to accommodate local variations, while maintaining an adequate degree of programme cohesion.
- Clients have been able to access a range of services including the innovative elements, despite challenges to delivery at different times of the pilot.
- Barriers to access have been reduced by good uptake of the website self-referral, although wait times for services remain an issue. This may be due in part to high demand as result of the increased ease of access offered by the self-referral pathway and may also reflect the extent of distress that youth are experiencing and ongoing unmet need for support.
- The original service delivery target in the Piki Charter has not been reached. Realistic strategies for reaching such targets in future will need to take account of workforce development and capacity, the likelihood of unexpected fluctuations in demand, and other systems constraints.
- While an integrated primary mental health programme may be more resource-intensive initially, with appropriate strategic planning the benefits add up to more than the cost of individual parts.

- As Piki matured, it was able to offer a more 'seamless' interface and better integrated service. However, clients (and therapists) often lacked clarity about the full range of component services Piki offered in addition to or instead of traditional forms of therapy and counselling which have remained the primary focus for most.
- Piki had a complex management and operations structure in order to provide an integrated comprehensive service across different organisations, geographical areas, and settings. This provided cohesion and inclusivity, but also created operational challenges and significant systems complexity.
- We recognise the considerable challenge in introducing the very significant innovations developed in Piki to service platforms of business as usual which vary widely across the primary care sector in NZ.

Equity and priority populations

- There were delays in operationalising the focus on improving equity of access and outcomes to priority groups. Piki has faced challenges in fulfilling obligations to Te Tiriti o Waitangi, and in providing sufficient culturally responsive services.
- More recently, targeted marketing to Māori and Pacific youth using brief social media marketing and local community promoters had started to show promising results. It is too soon to say how successful this will be in terms of improving access by these groups.
- Earlier engagement with target groups and local communities in a co-design or tikanga process may lead to a better outcome than the provision of largely pre-designed services.

'Co-design'

- The use of co-design with youth/service users within the project has been a mix of successes and challenges. We applaud the fact that co-design was recognised as important and that efforts were made to seek the input of service users and youth. However, for various reasons the ideal of co-design was compromised.
- Co-design needs to be fully understood by all parties involved, have transparent parameters, and have sufficient time and resources to be well carried-out.

Therapy models, duration, and intensity

- Debate continues within Piki around the most appropriate therapy models for this context, the optimal duration and intensity of talk therapy, and issues with measuring outcomes.
- Although Piki was aimed at those with mild-to-moderate mental distress, there must be systems in place to provide or arrange appropriate care for those presenting with any level of distress. A service like Piki thus needs to have well-developed stepped care pathways.
- The implications for training and supervision of new and existing staff in evidence-based therapies, and for the apportioning of the workforce to achieve optimal effectiveness and equity, are significant. This is particularly pertinent given the multiple new roles currently evolving in the primary mental health care sector.

Peer support

- The intentional peer support service has shown great promise, and the evaluation evidence supports its continued development as a component of youth mental health services.

Telehealth and digital options

- The Piki pilot displayed commendable agility and flexibility in adapting quickly to the unexpected demands of the COVID-19 pandemic by continuing to provide services using telehealth.
- Delivering mental health support through telehealth can be effective and acceptable to service users and providers, when required in some situations and at some times.
- Telehealth should be offered as an option for mental health support, but in-person delivery remains the overwhelmingly preferred mode of delivery and should be prioritised.
- While telehealth, and digital mental health support options are now an integral part of primary mental health support, there was limited evidence of support for a dedicated and fully integrated digital app component to the service.
- The Melon Health Piki digital app was a valuable additional support option for some young people but did not appeal to all, and not all enrolees actively engaged with the app. Those who did found the community forum and some other features useful.
- The original aim of the Melon platform being an integrated digital hub (a conduit for information, referrals, and evaluation data, and for client-therapist communication and peer community engagement), was not fully realised.

Impact of COVID-19

- Negative impacts of the COVID-19 pandemic included delays to work in some areas (particularly equity targets, rollout of staff training development for DBT/group therapy, and the development of MDTs).
- The psychological impacts of the pandemic and the lockdown are also likely to have increased demand for the service.

Evaluation

- The collection and interpretation of quantitative data on service utilisation and outcomes has been challenging. This aspect will require a great deal of careful planning in future, especially when working across multiple organisations.
- Clear consensus and communication is required on the use, utility, and selection of outcome measures for both therapeutic and evaluation purposes.
- Embedding a formative evaluation into Piki from the outset allowed ongoing feedback to all parties and provided opportunity for immediate response to suggested course corrections as the pilot progressed. The experience from this pilot supports including continuous evaluation as an integral part of all new mental health initiatives.

RECOMMENDATIONS

Key messages

- Given the overall success of the Piki pilot, we recommend the continuation and ongoing evolution of this youth mental health initiative with its integrated suite of services in its present location.
- The development of similar initiatives around the country should build on the lessons learned in this pilot but will need to follow the needs of local communities.
- All youth mental health projects should align with the principles of Te Tiriti o Waitangi and involve tangata whenua in co-design from the outset.

Recommendations for the current Piki service in the Wellington region

Continuation

- Retain a modified platform of primary mental health service delivery for 18-25 year olds in the Wellington region beyond the pilot period.
- Maintain innovative elements from the Piki pilot such as peer support, self-referral, multiple modes of therapy delivery, and provision of a free service.
- Consider the needs of immediately adjacent age groups, including making Piki available to the 16-18 year age group as well.

Implementation of equity & targeting focus

Increase efforts to reduce inequities for mental health support to underserved groups (especially Māori and Pacific, the Rainbow community, and others such as those not in employment or training, refugees, young males, and people with disabilities):

- Continue to expand the existing promotion and engagement programme with Māori and Pacific communities to other areas (Hutt, Kāpiti, Wairarapa, Wellington);
- Develop strategies to tailor services and promote access for other groups identified as being at higher risk of mental distress, but (actually or possibly) underrepresented currently within the Piki client group (e.g., young males, Rainbow, homeless);
- Boost engagement with current and other Māori/Pacific providers, Youth One Stop Shops, and non-university tertiary and training providers to enhance access for target/priority groups (including High Deprivation and NEET - Not in Employment, Education or Training).

Model of care and workforce capability

- Undertake further work to clarify roles and to determine an optimal model of care.
- Integrate existing therapy modes with newer options such as support from Health Improvement Practitioners, Health Coaches, and peer supporters.
- Provide clear and consistent communication (possibly in simple graphic form) for clients and providers to show the full range of options that Piki provides.
- Ensure greater coherence and consistency in content and expected duration and intensity of therapy, dependent on service user preference and workforce capability.

Digital elements

- Identify and provide access to a quality-assured selection of digital wellbeing apps that meet identified client preferences (including those already used/recommended by Piki service providers).
- Retain some elements of the current Melon platform or provide equivalent alternatives for those clients and providers currently using components of the Melon app (e.g., a moderated community forum, wellbeing resources like personal diaries, mood tracking).
- Ensure access to telehealth is available for mental health support as an option where needed and appropriate and strengthen training and technical support to facilitate this.
- Provide training to all Piki therapists and peer supporters, and information for clients, on what digital resources are available and recommended, and how they might be integrated into a package of care and/or ongoing mental health and wellbeing support.

Lessons for wider scale up and roll out

General recommendations

- Prioritise the development of mental health support for this age group in other regions.
- Build on the lessons learned in the Piki pilot to develop similar initiatives, with careful attention to co-design processes to ensure new initiatives address local needs.
- Carefully consider the relative resourcing and accessibility of each element of the service to facilitate client choice.
- Develop a clear plan as to how existing successful and new services will be integrated and/or become complementary.
- Avoid overly complex structures and operational processes.
- Acknowledge system complexity and encourage formal implementation planning, expectation management and evaluation as part of broader scale up and roll out.
- Retain mental health service COVID preparedness in telehealth and other organisational areas for the foreseeable future.

Innovation transfer from the Piki pilot

- Provide free or low cost access to services
- Include a self-referral pathway and telehealth options to reduce barriers to access.
- Create a single portal for all clients (self-referring or other) to simplify management processes and data gathering.
- Continue the development and evolution of peer support services as a component of youth mental health services nationally and consider increasing investment.
- Include carefully selected digital apps as a support option for young people to complement in-person interactions with support people.
- Develop a coherent national strategy for digital mental health provision with regard for the preferences of different population groups and the specific requirements of different service delivery contexts.

Equity, 'co-design' and engagement

- Encourage co-design early in the rollout and scale up process, with particular focus on engaging with stakeholder groups that face the greatest inequities.
- Give due attention and commitment to the time, resources and transparency required for meaningful co-design, community engagement and inter-provider relationships.
- Identify clear equity strategies at the outset that are appropriately tailored to different localities and contexts and that recognise the importance of intersectionality.
- Do contingency planning for the 'predictably unpredictable' events that are likely to impact on equity.

Workforce

- Provide more personnel and funding to support the mental health needs of young people in line with the evident demand.
- Develop clear workforce plans and appropriately allocate different workforce personnel to support mental health needs to young people to suit local needs.
- Increase numbers being trained/upskilled in evidence-based therapy approaches, using in-depth training courses to ensure competence.
- Match growth of (new) services to the available workforce.

Therapy

- Offer a range of evidence-based talk therapy options tailored to need and context.
- Ensure that appropriate referral pathways are readily available and adequately resourced where a higher level of care is required.
- Communicate clear and realistic expectations to both therapists and clients on the number of sessions to be provided and the factors that may affect this.

Outcome and utilisation measures and evaluation

- Encourage the use of robust, formal Continued Quality Improvements (CQI) for all youth mental health services, especially integrated, multi-provider services (as for Piki).
- Incorporate some means of outcome evaluation, at a minimum, into all new youth mental health initiatives in primary and community care settings.
- Make collection methods for psychological outcome measurements and utilisation data as simple, complete, and systematic as possible from the outset.
- Establish a consensus on the use and therapeutic value of outcome measurements as well as for the purposes of monitoring and quality improvement.

PART 1:
INTRODUCTION

Part 1: Introduction

The Piki programme is an innovative free primary mental health service for youth that has been piloted successfully in the Greater Wellington region. The overall aim was to improve access to mental health and wellbeing support for young people aged 18-25 years with mild to moderate mental and/or substance misuse-related distress. Piki was designed specifically to provide psychological therapies and other mental wellbeing supports within an integrated stepped care service.

After 24 months of ongoing development and operation Piki was delivering comprehensive and integrated support to young adults in the Wellington, Porirua, Hutt, Kāpiti and Wairarapa regions, and had provided over 21,000 therapy or peer support sessions to 5307 young adults in the target age group.

Service users gave very positive feedback about the support they received through Piki. Many identified the existing youth mental health system outside of Piki as underfunded and overstretched, making access to support extremely difficult. They affirmed the value of the original intention of Piki as a free, easily accessible service, and that it was highly desirable to extend Piki or a similar service beyond its pilot stage.

The pilot has shown that it is feasible to transition from an existing platform of primary mental health service delivery involving multiple partners to an integrated service model, and to progressively introduce and sustain significant innovations.

This report incorporates outcome and utilisation data and summaries of information, key themes and recommendations reported progressively to the Piki Steering Group by the evaluation team as part of the embedded process evaluation and iterative quality improvement cycles for the pilot over the past 27 months (see 1.5, 2.1). Section 1.1 provides background information on youth mental health in Aotearoa New Zealand, including a brief review of literature on lessons learnt from the development, adaptation, and implementation of the UK-based Improving Access to Psychological Therapies (IAPT) initiative. The original aims and initiation of the Piki pilot are briefly reviewed next. The following sections describe the service delivery context and flag significant emergent events in the wider health sector since early 2019 (relevant to but external to Piki), up to and including the COVID-19 pandemic response.

1.1 BACKGROUND

The report of the 2018 Government Inquiry into Mental Health and Addiction[1] identified that children and young people in Aotearoa New Zealand are exhibiting high levels of distress leading to deliberate self-harm, risk-taking, anxiety disorders and other concerning behaviours. It noted extensive unmet need, delayed and inappropriate interventions, and high rates of youth suicide. Feeling isolated from others is strongly associated with symptoms of depression, anxiety, and other forms of mental distress, and with lower levels of life satisfaction. 15 to 24-year-olds report high levels of isolation and mental distress.[2] Exclusion is typically a feeling of acute alienation, and for youth in particular, social exclusion (along with discrimination) is experienced as pervasive.[3]

Some sectors of society face disproportionately high levels or mental distress, with Māori, Pasifika and Rainbow youth all experiencing higher levels of depression than Pākehā, particularly Rainbow youth (57%).[4-6] Māori youth also experience higher rates of suicide.[7] Health seeking behaviour also varies, with Pasifika youth reporting lower rates than other ethnicities for seeing a health professional for anxiety or depression.[8] While young women report higher rates of depression and suicidality than young males (almost double).[5] they are more likely to report seeking help than males.[9] Young males have particularly low rates of accessing mental health services, with an Australian study finding that only 13.2% of males experiencing mental distress aged 16 to 24 had accessed services in the previous 12 months.[10] Males aged 15-24 have significantly higher suicide rates than females.[11]

The Piki youth mental health pilot initiative was instigated to address the needs (and particularly unmet needs) of the 18-25 year old population who experience mild to moderate mental health and substance use-related distress.[12]

The intended service was based in part on the Improving Access to Psychological Therapies (IAPT) model introduced in England in 2008[13] and the Children and Young People's CYP-IAPT in 2011[14] (see below). Psychological therapies (or talking therapies) have been shown to improve mental health outcomes,[15,16] and the UK-based National Institute for Health and Care Excellence (NICE) guidelines recommend Cognitive Behaviour Therapy (CBT) as an effective therapy for most psychological conditions.[17] Furthermore, according to a meta-analysis on patient preference, service users show a threefold preference for psychological therapy over medication[18], and clinical trials show that psychological and pharmacological treatments achieve similar outcomes in the treatment of anxiety and depression.[19,20]

The aim of IAPT therefore, was to provide more evidence-based psychological therapies to the general population for common mental health conditions such as anxiety and depression.[21] Based on a 'stepped care' model of 'low intensity' interventions (e.g. guided self-help) and high intensity interventions (e.g. psychotherapy) for people with more severe or complex conditions,[22] IAPT has reportedly transformed the treatment of anxiety and depression in England and is recognised by many as one of the most ambitious programmes of talking therapies worldwide.[13]

Evaluation of IAPT has shown a number of positive outcomes,[23-25] with some claiming it has helped make the UK-based National Health Service 'accountable to scientific evidence and human need' (p. 642).[23] Clinical outcomes have been measured for 98.5% of the 560,000 people treated through IAPT each year, and based on results from those, around half have deemed to have recovered and two thirds to have shown reliable improvement.[21] International services based on the IAPT model (e.g. in Norway, Sweden, Australia) also report positive results with services described as appropriate and effective in their local mental health service delivery environment,[26 27] and the Australian version NewAccess reporting an overall recovery rate of 68% in persons experiencing depression and/or anxiety symptoms.[27]

However, IAPT is not without its critics. In a 2017 paper on what can be learnt from IAPT in Aotearoa, Haarhoff and Williams cite concerns of industrialised talking therapy, audit culture and competency frameworks that straightjacket clinical practice.[28] A paper by Timimi published in 2015 is critical of both IAPT and CYP-IAPT, noting no recognisable change in the underlying (problematic) paradigm of. traditional, medical/ technical models of therapy that assume mental health problems arise from faulty or abnormal mechanisms or processes within the individual; are not context-dependent; and can be treated independently of relationships, contexts and values).[29] He also notes that within treatment, the therapeutic alliance (as rated by the client) has the biggest impact on mental health outcomes, 'with matching treatment model to diagnosis having a small to insignificant impact' (p.57).[29]

Other concerns include the privileging of so-called objective, empirical data underpinning evidence-based therapy over other forms of social, cultural and political knowledge that also inform a wide range of therapeutic approaches to mental health.[23 28-32] Criticism is directed at quantitative methodologies used to measure recovery, and CBT in particular which has 'enjoyed political and cultural dominance within mental healthcare' (p. 344) [28] using numerical outcome data as its evidence base. Several researchers mention the importance of an interpretative perspective (as opposed to a positivist position) using qualitative methodologies to include service user narratives and subjective individual experiences.[23 28 30-34] In terms of mental health services specifically targeting youth, it has also been reported that young people do not rate symptom reduction as highly as health professionals and consider social relationships and physical health as more important for quality of life.[35]

Evaluation of CYP-IAPT also highlights the importance of preparation for implementation at the national level, having a clearly defined and understood programme and investment from practitioners, having explicit guidance on how to operationalise key programme principles, and good collaborative relationships between different organisations – which requires time and effort – in order for transformational changes to be sustained.[36]

The overall conclusion from the literature examined is that, based on lessons learnt from the development, adaptation and implementation of the IAPT initiative in various contexts, an integrated psychological therapies model for youth was and remains worth considering in the Aotearoa New Zealand context.[5 28]

1.2 PROGRAMME INITIATION

In July 2018, the Ministry of Health called for tenders to develop, implement and evaluate an Improving Access to Psychological Therapies (IAPT)-based pilot primary mental health service, free to all youth (aged 18-25) experiencing mild to moderate mental health and substance use related distress. Particular aims were increasing equity of access and addressing unmet needs. Tū Ora Compass Health PHO (Tū Ora) and the University of Otago were the successful applicants in response to the request for proposals, in partnership with Te Awakairangi PHO (Te AHN) and Explore.

The design of the pilot programme and the evaluation framework submitted by Tū Ora Compass Health (Tū Ora) and the University of Otago incorporated a number of additional key features and innovations to enhance and adapt the IAPT model the Aotearoa New Zealand context.

These included: co-design with youth (rangatahi), including young service users, integration of psychological therapy with intentional peer support services and digital and telehealth services, along with improved access from across the primary and community health care sector. (See Section 3.2, Table 9 below for further detail).[12] Another innovative aspect of the pilot was inclusion of an integrated evaluation workstream to facilitate evidence-based review, refinements and 'course corrections' at multiple time points throughout the programme timeframe (see Section 1.5). These features have become more significant in the light of recent Government announcements of significantly increased spending on enhancing access to primary care psychological services.

The initial proposal was for a 3 year project, including a 6 month service development phase before commencement of new and integrated service delivery. Following awarding of the contract, the Ministry of Health reduced the time frame to 2.5 years.[b] The reduced time frame required some changes to the original plan. Principally these were: (1) a reduction in the target number of young people to receive services during the pilot from an estimated >10,000 over 3 years to >8,000 over a 2 year period; and (2) a conflation of the design and service roll-out phases, whereby elements of the initiative involving the scale-up of existing services were initiated earlier in the pilot period, while the full service, including innovative components, was still in the design and development phase. Individual elements of the service were thus introduced in a staged fashion as they were ready to deploy, rather than a complete integrated service being offered from the point of launch. As reported previously, this created additional complexity for both service delivery and the evaluation, and impacted the ability for true co-design to occur.

1.3 EXISTING SERVICE DELIVERY PLATFORMS PRIOR TO PIKI PILOT

In the pilot area, primary care mental health services for this age group are provided through the local Primary Health Organisations (PHOs), and other charitable and government funded organisations such as Explore Psychology NZ.

Tū Ora Compass Health PHO covers 61 GP practices in Wellington, Porirua, Kāpiti and Wairarapa, and also incorporates Evolve Youth Health and Social Support Service, Massey University Student Health (Wellington) and Victoria University of Wellington Mauri Ora (Student Health and Counselling). Te Awakairangi Health Network PHO (Te AHN) covers 23 practices in the Hutt Valley. Ora Toa PHO is the only iwi-led PHO in the Wellington region, providing a range of primary care services to Māori and non-Māori in the Porirua and wider Wellington areas.

Prior to 2019, Tū Ora's *Primary Solutions/To Be Heard* initiative delivered free counselling services within a stepped care model to eligible enrolled patients, (with priority given to youth (aged 12-25 in Wellington and 10-24 in Wairarapa), Māori/Pacific or Community Services Card holders). Te AHN's Wellbeing Service provided a free primary care mental health service for anybody enrolled with Te AHN, Vibe Youth Health and Ropata practices (with priority given to youth aged 12-19, Māori /Pacific, or people living in a low income area). *Mauriora* is a kaupapa Māori Primary Mental Health and Addictions service, incorporating Tū Te Wehi Primary Mental Health, that provides free services to rangatahi registered with the Ora Toa PHO. (See section 3.3 for further details).

The Piki pilot was designed to build on these existing platforms of primary mental health service delivery in order to enhance access to, and integration of, services; and increase the range of options available for young people in the 18-25 year old age group experiencing mild to moderate mental distress. Innovative elements of the Piki service were also developed out of existing services: the Melon Wellness App and PeerZone both of which modified services specifically for Piki. Existing phone-based counselling services were provided to Piki clients via Home Care Medical's existing national 1737 direct phone line and Puāwaitanga (telephone counselling by referral)

1.4 PIKI WITHIN A BROADER PRIMARY MENTAL HEALTH ENVIRONMENT

The Piki pilot has been unfolding within the national context of *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*[1] released in late 2018, announcements in the May 2019 *Wellbeing Budget* of additional funding for front-line mental health services including the *Access and Choice* initiative, and most recently the progress report of the Initial Mental Health and Wellbeing Commission *Mā te rongo ake: Through listening and hearing*.[37] A key focus is on ensuring that existing barriers to accessing mental health and addiction services are dramatically reduced.

There are currently numerous initiatives underway throughout Aotearoa New Zealand that focus on improving mental health services, encompassing in-person and telehealth delivery as well as support options in the digital space. An example of one such initiative being implemented within the Wellington region from 2019, is the recruitment of *Health Improvement Practitioners* and *Health Coaches* into the wider primary mental health team working within Tū Ora Compass Health practices, along with NGO support workers being linked to individual practices. These practitioners can engage directly with young people and/or support them in accessing Piki services where appropriate. By the end of 2020 this model had been extended to 30 practices across the Greater Wellington region, all within the Piki catchment area, including 17 practices in the Ora Toa and Te Awakairangi PHOs. The Ministry of Health began procurement of additional mental health services in other parts of Aotearoa New Zealand from late 2019, and this work programme is still underway. Also at a national level, there is a growing number of digital wellbeing platforms and self-help tools available (e.g. *Just a Thought, Clearhead, The Lowdown, Mentemia* and *SPARX*, to name just a few), some of which were funded and promoted as part of the government's response to the COVID-19 pandemic (see below).

b Note: at the time of writing, Tū Ora and the Ministry of Health were in discussions regarding renewal of the contract for a further 18 months to allow time for Tū Ora to consider and address findings of the evaluation report with a particular focus on improving equity.

The coronavirus pandemic is potentially the most significant event to affect health care services within recent times. Primary care was required to undergo very rapid transformation of service delivery in the light of potential significant community transmission, and this affected Piki alongside other activities of the PHO partners. During the 2020 lockdown, the required transformation of Piki involved a shift from delivering services to most client through in-person consultations to delivering these remotely through telephone and video consultations, alongside other forms of digital support.

As noted above, the Ministry of Health funded and/or promoted a suite of online mental health and wellbeing resources and self-help tools as part of the COVID-19 response, including several targeted at young people.[38] The Melon Wellbeing app, a tailored version of which is part of Piki, was one of the tools selected for public rollout by the Ministry of Health as part of the pandemic response. As the COVID-19 pandemic and its implications continue to unfold, it is clear that mental health initiatives will be a significant part of the response.

In early July 2020, the government announced $25 million of new contestable funding to help tertiary students manage ongoing stresses related to COVID-19 by expanding and accelerating free frontline mental health and wellbeing services at tertiary education institutes. This increased support for students is to be modelled on existing pilot programmes, including Piki and services based at Auckland and Canterbury universities, and was to be rolled out nationally from early 2021 (Beehive media release, 11 July 2020).[39]

It is not clear at this point precisely how the recent initiatives described above, or those still in the pipeline, will interface with the current Piki service, or any wider rollout going forward. It also remains to be seen whether it will be possible, in such a rapidly evolving environment, to retain distinctive features of the Piki model that have been positively evaluated, including the integration of evidence-based therapies with innovative components such as prioritising ease of access and choice for youth service-users, and the focus on co-design and equity.

1.5. SUMMARY OF EVALUATION REPORTING

The first interim report on the Piki pilot from the University of Otago evaluation team (June 2019) described the formation and early development of the Piki pilot in detail, focusing on the co-design process and developing model of care in the period from the request for proposals by the Ministry of Health (mid-2018) through the first 6 months of service design and development (late December 2018 – June 2019). The evaluation team identified key process themes based mainly on qualitative analyses of early observational data and documents, supported by baseline quantitative information on existing service provision, upon which the Piki service was being built, as well as initial therapy workforce and client utilisation data.

Other ad hoc reports submitted during the pilot were a framework analysis of key informant interviews (February 2020) and the analysis of results from a survey of Piki therapists (March 2020).

A second interim evaluation report in June 2020 provided a more comprehensive assessment of the design of the Piki service model and its implementation, and the maturing of the service to June 2020, incorporating additional data from qualitative interviews with a wide (but not full) range of key informants, service users and service providers, updated workforce data and provisional utilisation data. It also provided an initial (partial) assessment of outcomes and effectiveness of the service since staged rollout began in early 2019.

This final evaluation report builds on previous interim reports and incorporates more recent analyses of data gathered up to the end of the planned intensive evaluation period for the pilot in December 2020, with selected further commentary and final conclusions up to 31 March 2021, as assessed against the original aims and objectives of the Piki programme.

The report is presented in 6 parts. This Introduction is followed by details of the evaluation methodology (Part 2), and a description of the programme and its development (Part 3). Next we present the evaluation findings on outcomes and effectiveness, firstly considering Piki as a whole (Part 4), and then assessing each component individually and in terms of their integration (Part 5). The final part of the report provides a brief summative discussion and then presents our conclusions and recommendations (Part 6). Additional information on the qualitative and survey data collected can be found in the Appendices.

PART 2:
METHODOLOGY

Part 2: Methodology

Evaluation was embedded into the design and implementation of the Piki pilot programme, and has been integral to its development. It was co-produced by a diverse team of ten researchers from Otago University Wellington, four of whom identified as service user academics. The team also included researchers and clinicians including included a general practitioner with a specific interest in primary mental health, a psychologist involved in CBT training, and other qualitative and quantitatively trained health researchers (one of whom is of Pacific background).

The team was supported by a youth service user reference group (which included Māori, Pacific and Rainbow representation) and a biostatistician. The Service User Reference Group's involvement in the evaluation included input on the question schedule for interviews with service users, the client survey, and the analysis of the service user interviews. This kind of co-production within an evaluation team – involving service user academics as equal partners with non-service user academics and clinicians, supported by a youth service user reference group as co-evaluators, is in itself an innovative and ground-breaking aspect of the pilot.

2.1 EVALUATION FRAMEWORK

The evaluation scope included the pilot programme's structure and development processes, its outcomes and effectiveness, and lessons learned for future scale up or rollout of this or similar services. These objectives are summarised in Table 1.

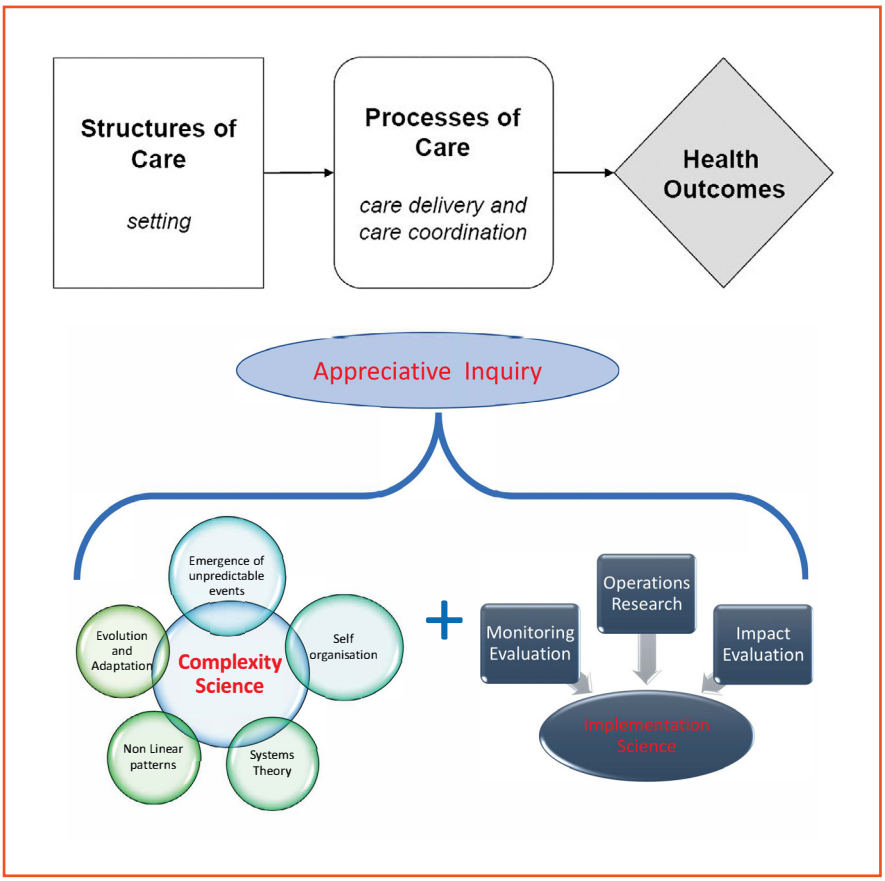
Table 1: Evaluation objectives

Process evaluation: has the pilot service been implemented as designed/intended? Analyse pilot development and implementation processes and assess the extent to which elements significant to service users and other stakeholders were incorporated and operationalised through co-design.
Outcomes/effectiveness evaluation: how effective has it been in meeting its objectives? Assess how well the pilot has achieved its aim of providing an effective integrated service that improves access, equity, and outcomes for the client group of youth from 18-25 years old who experience mild to moderate psychological distress.
Conclusions/recommendations: What are the 'key lessons' from the pilot? Provide an integrated evaluation of the overall strengths and weaknesses of the pilot service model and assess questions of future scalability and effect of delivery across multiple PHO services/NGOs.

The evaluation was conducted within a modified action research framework informed by principles of co-design, combined with tools from complexity and implementation science.[40 41] This approach was underpinned by a philosophy of 'appreciative inquiry' which seeks to identify opportunities, strengths and the positive and aspirational features of innovation, whilst commenting constructively on emerging challenges and problems.[42] It also drew upon Donabedian's framework for Health Services Evaluation: Structure Process Outcome.[43] Ethical approval for the evaluation research was given by the University of Otago Human Ethics Committee (Health) on 14 April 2019 (Reference number H19/044). (See June 2019 interim report for a full description of the evaluation framework and protocol).

Findings from the iterative collection and analysis of quantitative and qualitative evaluation data were incorporated into the regular programme implementation review cycles built in to the Piki pilot, and also informed the independent process and outcome evaluations. The evaluation focus and methods used continued to evolve during the development of Piki, in response to input and questions from project partners and the Steering Committee, as well as emergent events such as the COVID-19 pandemic.

Figure 1: Evaluation Framework



Note: Diagrams from McDonald et al (2007). Closing the quality gap: a critical analysis of quality improvement strategies (Vol. 7: Care Coordination) Figure 4. Donabedian's Quality Framework. (Available from: https://www.ncbi.nlm.nih.gov/books/NBK44008/figure/A25995/) and Dowell et al (2019). An evolution in thinking to support the post 2020 global vaccine strategy: The application of Complexity and Implementation Science. Vaccine. 37:4236-40.

2.2 QUANTITATIVE METHODOLOGY

The quantitative component of the evaluation involved ongoing collation and analysis of service utilisation and outcome measurement data routinely collected by Tū Ora and other providers, analysed using a cohort design to analyse individual service user data. Workforce data was also collected and analysed.

a. Service utilisation & measures

Contracted data collection for evaluation

Data collection and delivery was included in each service provider's contract for Piki. Prior to the start of Piki, and in consultation with the Evaluation team, Tū Ora created a data specification which included detailing the information to be collected by each of the service providers. Service Providers (Te Awakairangi PHO, Ora Toa, Victoria University Counselling, Melon, Puāwaitanga, PeerZone, Explore and Homecare Medical) were to deliver the data monthly to Tū Ora, all linked by encrypted National Health Index number (NHI) as a unique personal-level identifier.

Table 2: Data files for evaluation

FILE	DATA
Referral file	NHI, referral source, referral date, gender, date of birth, ethnicity, NZDep[1], GP provider, practice
Service Provision file	NHI, contracted service type (e.g., in-person counselling), name of organisation providing service, name, or counsellor/peer supporter
Non-attendance (DNA) file	NHI, date of appointment not attended, name of organisation providing service
Melon only files	NHI, date enrolled in Melon, reason for attending Piki, psychological measure scores (e.g., GAD-7, PHQ9, SRS, ORS, WHOQOL-bref)

1 NZDep2013 provides a deprivation score for each meshblock in NZ, based on a person's address

Data covering Tū Ora practices (including Victoria University) and Massey University Counselling is collected directly by Tū Ora through their patient management system.

Data was supplied directly to the evaluation team from Tū Ora. Several issues concerning accuracy and interpretation of the data were identified by the evaluation team over the course of the project. Through meetings and emails, Tū Ora were able to rectify many of these issues. It was a complicated dataset for Tū Ora to combine, both in terms of extracting data from their own Patient Management System and in terms of data delivery from external organisations. Some data issues remained unresolved. The number of data issues presenting is standard for a project of this size where data streams are being integrated from several different sources. Remaining data issues are as follows:

Referral file:

This file was intended to collect NHI, referral mechanism (GP or self), referral date to the service, and GP/general practice details if referred through that mechanism. Difficulties with this file included identifying accurate service entry and exit dates. For example, some service users had re-entry dates prior to their exit dates, or duplicate exit dates. As there was no formal consistent administrative method for exiting people from the service this date often had to be inferred from an agreed rule of 3 months since date of last contact with the service. Some service users appeared in this file when they should not have (e.g., they had used mental health services prior to the Piki time frame) and conversely others should have appeared in this file and did not (e.g., some Victoria University students). In some situations, service users were referred to the service by their GP and then subsequently self-referred, prior to their first engagement with the service; for others, initial self-referrals were followed by GP referrals. For these reasons this referral file was not used for tracking entry into the service and instead session data was used as a proxy marker of enrolment.

PHQ9 file:

Service users were initially only able to complete the PHQ9 on the Melon app and these measures were forwarded to the evaluation team. From the beginning of January 2020, they were also able to complete the measure on the Piki website. Some Piki website entries were unable to have the date recorded against their measure collection and this had to be added subsequently. For those who completed more than one measure on the website, we were unable to tell which date belonged to which PHQ9 response, and hence these people's measures were removed (n =47 responses).

b. Other quantitative data

Melon

Data appearing in Section 5.3 (the Melon Service Component section) was supplied directly to the evaluation team by Melon following negotiation over what was required (Evaluation team) and what could be supplied (Melon).

Website

Data appearing in Section 5.5 (the Website Service Component section) was taken from Homecare Medical Reports to Tū Ora.

c. Client and therapist surveys

Four surveys were conducted at different points during the course of the pilot: two surveys of therapists, one designed by Tū Ora (mid 2019) and one designed by the evaluation team (early 2020); and two surveys of service users, one of users of the peer support service, designed by PeerZone and the evaluation team and administered by PeerZone (January 2020 and still running) and one of all Piki service users (January to September 2020) designed by the evaluation team and distributed by Tū Ora (November 2020 – January 2021).

Tū Ora survey of Piki therapists

A Tū Ora based psychologist designed and sent out a survey to Piki therapists in July-August 2019 asking questions related to their experience and practice with regards to therapy. Surveys were sent to all Piki therapists employed at the time (n=33) and twenty-seven therapists responded (response rate = 82%). See Appendix 1 for the list of survey questions.

University of Otago Wellington survey of Piki therapists

Survey Design

Some of the survey questions were modified from a previous 2007 survey of primary mental health clinicians completed as part of an evaluation of Primary Mental Health Services.[44] Specific questions around standard CBT skill use based on dimensions of the Cognitive Therapy-Scale-Revised[45] and integration into practice were added, as well as questions about role title, hours per week in the Piki role, number of clients being seen, and administrative parts of the work. Demographic data including age, ethnicity and gender were also included. (See Appendix 2 for the list of survey questions).

Participants and recruitment

The evaluation team surveyed Piki therapists on their experience of working within Piki, with a particular emphasis on the use of CBT within therapy. For this reason, invitations were only sent to those who were: i. enrolled on the 2019 or 2020 CBT course, or ii. had completed the Fidelity course, or iii. were known by the evaluation team to be highly trained and experienced in the use of CBT. The psychologist and evaluation team member who runs the CBT courses sent an email link inviting 41 therapists (who met the above criteria) to complete the survey, with a follow up reminder email a month later. This recruitment method was used as the psychologist is known to participants and it was anticipated that response to the survey would be improved by the personal invitation. Thirty-seven therapists responded to the survey, providing a response rate of 91%.

PeerZone exit survey

Survey Design

During late 2019 Peer Zone contacted the evaluation team to see if it was possible to design a survey for those who had used Peer Support. A member of the evaluation team in conjunction with a peer support staff member designed a short survey, which was reviewed and finalised with input from the evaluation team.

Participants and Recruitment

Peer Zone was supplied with the survey link and initially emailed the survey to exiting service users. Response rates for emailed surveys were low and so Peer Zone moved to texting surveys on exit. This method appeared to work better, and Peer Zone have continued to text survey links out to service users since January 2020. Results for this report include responses received up until the end of December 2020. (See Appendix 4 for details of demographic characteristics of respondents and a summary of results).

Piki service user survey

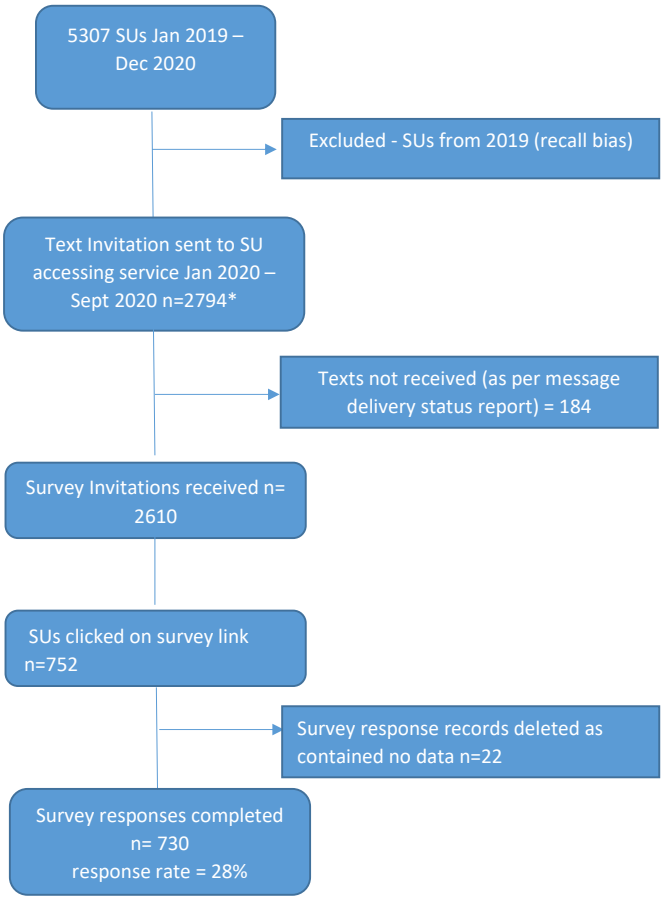
Survey design

There was concern from both Tū Ora and the evaluation team about the lack of psychological measure completion, and it was felt that, in the absence of this, assessing service user satisfaction via survey would give some meaningful information on service effectiveness. A draft survey (using similar questions to the Peer Zone survey and a recent survey with young people[46]) was designed, and feedback was obtained on survey questions and design from the entire evaluation team, four young people in the target age range, and the Service User Reference Group. Questions were asked about each of the four components of Piki (in-person counselling, Puāwaitanga phone counselling, Peer Support, Melon) and how helpful people found these. Additional questions covered wait times and gave an opportunity for free text comments on the Piki service. Demographic data included, gender, ethnicity, work or study status, and where services were accessed. The survey was deployed using the Qualtrics online survey platform.

Participants and recruitment

The link to the Service User survey was sent via text message (or email where no mobile number was recorded) to all Piki service users who had attended a Piki session or enrolled with the Melon App between 1 January 2020 and 30 September 2020 (n=3278). The initial text was sent on 1 December 2020, followed by two reminder texts (22 December and 21 January). Respondents were invited to complete a short survey about their experience of using Piki services and offered the opportunity to enter a draw for three $100 vouchers. This survey focused on 2020 Piki service users to maximise information from those who had experienced the fully established service (for future relevance) and to avoid recall issues that may have arisen if surveying service users from 2019. See Figure 2 below for survey respondent inclusion and response rates. (See below for details of demographic characteristics of respondents compared to the Piki cohort. See Appendix 3 for a summary of results.)

Figure 2: Piki Service user (SU) Survey Participants



*165 had no cell phone so were sent an email invitation

Interpretation of Piki Service User Survey results

Survey results appear throughout the report but should be interpreted with caution. Only a subset of the total Piki cohort were invited to take the survey (2610/5307, 49%) and only 28% of those invited, responded to the survey. Response rates by ethnicity and gender are shown below (Table 3) and are compared with the total Piki cohort. Response rates by ethnicity were similar to the overall Piki cohort, although rates for Māori were higher and European rates lower, than for the total cohort Response rates by gender were significantly more skewed towards females than that of the overall cohort, but comparisons are difficult for the gender diverse sub-group as data on gender diversity was poorly collected for the overall Piki cohort (due to Patient Management System limitations), but was explicitly asked about in the survey. Approximately 33% of the total Piki cohort had one session, while only 10% of survey respondents had one session. It is likely that those who used the service more extensively responded to the survey.

Table 3: Demographics of survey respondents compared with the total Piki cohort

DEMOGRAPHIC CHARACTERISTICS OF SURVEY RESPONDENTS (N=730)	COUNT	%	TOTAL PIKI COHORT %
Ethnicity			
Māori[1]	133	18.2	13.7
Pacific	25	3.4	3.5
Asian	41	5.6	6.4
European	483	66.2	69.9
MELAA/Not Stated	48	6.6	6.5[2]
Gender			
Female/Wahine	516	70.7	65.3
Male/Tane	133	18.2	29.9
Trans Man	15	2.1	
Trans Woman	8	1.1	0.2[4]
Other[3]	31[2]	4.2	
Not stated	27	3.7	4.6[5]

1 Ten of these are Māori/Pacific
2 MEELA/unknown
3 Non-binary = 8, Takatāpui = 1, Agender = 1, Genderfluid = 4, Transmasculine = 1, other = 1
4 Gender diverse
5 unknown

2.3 QUALITATIVE METHODOLOGY

Three main categories of data were gathered for the qualitative part of the evaluation: direct participant-observation, document review, and interviews or focus groups. All qualitative information has been systematically collated and incorporated into an integrated coding framework using the QSR-NVivo platform.

a. Participant-observation and document review

Evaluation team members attended and undertook participant observation of, and critical reflection on, all steering, advisory, operations and reference group meetings throughout the pilot in addition to key workshops and public events. These observations were supplemented by review of correspondence, official minutes and other planning documents, media and communications material, and input from the youth and service user reference groups, to inform a robust analysis of process themes.

b. Interviews and focus groups

Interviews and focus groups were conducted with 119 individuals in total from three categories: those we have called 'key informants' who included those involved at the design and management level and members of the governance and operational groups; service providers (therapists/counsellors, peer supporters and Melon community moderators); and service users. Participant codes to identify quotes from these participants use the following codes: KI (Key informant), SP (Service Provider), SU (Service User).

Key informants (Service designers and management etc)

In-depth qualitative information was collected via interviews and focus groups with key stakeholders involved in the service design and delivery at two points over the course of the pilot: Sep-Dec 2019 (n=46) and Oct-Dec 2020 (n=25). In addition, three key personnel at Tū Ora were interviewed in June 2020 (all of whom were also interviewed at other points).

The first round of interviews included questions about what had worked well or had been challenging during the previous 3 months; challenges and priorities for the upcoming 3 months; and barriers to/suggestions for improving access for priority groups (especially Pacific youth).

Most of the first round of interviewees were with key stakeholders involved in the oversight, design and implementation of the pilot service (rather than actual service delivery) and were members of one of the Piki governance or operational groups. They were from the following organisations: Tū Ora, Te Awakairangi Health Network, Victoria University of Wellington, Massey University, PeerZone, Melon Health, Inside Out, Evolve, Explore, Maraeroa, Ministry of Social Development, Porirua Union Community Health Service. In addition, group interviews were conducted with 14 Youth Reference Group members (two of whom were also interviewed separately due to their additional roles).

All members of the Steering Group, Practitioner Advisory Group and Operations Group were approached for interviews, but the two Pacific reps from the Steering Group were unable to be contacted. In light of this, a Pacific youth primary care nurse who made referrals to Piki was interviewed to obtain some Pacific input.

In late 2020, a further round of 25 interviews was conducted, with stakeholders from the following organisations: Tū Ora, Ministry of Health, Ora Toa, HomeCare Medical (including Puāwaitanga), Te Awakairangi Health Network, Massey University, Victoria University of Wellington, as well as from 3 organisations who had referred young people to Piki: Weltec/Whitireia Polytechnic, Partners Porirua, and Maraeroa Marae Health Clinic, as well as members of the Youth Reference Group. Seven of the interviewees had been interviewed previously, and in some cases, interviews were with people who had taken over roles from people who had been previously interviewed.

Table 4: Demographics of key informants interviewed

	2019 INFORMANTS		2020 INFORMANTS	
	KIS (NOT VRG)	VRG MEMBERS	KIS (NOT REFERRERS)	REFERRERS
Non – European Ethnicity*				
Māori	3	4	4	2
Pacific	1	4	2	3
Asian	1	1	0	
African			1	
Age				
18-25	0	13	3	0
26-35	7	1	2	0
36-45	6	0	3	2
46-65	17	0	8	3
66+	1	0	0	0
unspecified	0	0	1	1
Gender				
Female	25	5	15	5
Male	7	4	4	1
Non-binary	0	3	0	0
Gender queer	0	1	0	0
Not specified	0	2	0	0
Identify as LGBTQIA	Not asked	7	Not asked	Not asked
Identify as having a disability	Not asked	5	Not asked	Not asked

* Note: ethnicity is only reported for those who identify as non-Pākēhā; may be one of multiple ethnicities

Service Providers

Service providers from all partner organisations (8 therapists and 3 peer supporters) were individually interviewed via Zoom in June 2020 specifically for the purpose of exploring their experience of using telehealth options during the Covid-19 lockdown period.

Table 5: Demographic characteristics of Piki service providers interviewed in June 2020 (n=11)

	N		N		
Gender		**Ethnicity**		**Age**	
Female	7	NZ Māori	3	20-29	3
Male	4	Other	1	30-39	4
		European (including NZE)	7	40-49	1
				50+	3
Organisation		**Profession**			
Tū Ora Wgtn	1	Counsellor	3		
Tū Ora Wairarapa	1	Mental Health Nurse	1		
VUW	1	Psychologist	1		
Massey University	1	Social Worker	2		
Explore	1	AOD clinician	1		
Te AHN (inc Vibe)	2	Peer Supporter	3		
Ora Toa	1				
PeerZone	3				

In late 2020, more general feedback on Piki was sought from providers. Two focus groups were conducted, one with 7 therapists and one with 7 peer supporters. Due to difficulty with the logistics of the therapist focus groups, which meant that only 3 organisations were represented at the focus group, individual interviews were conducted with a further 5 therapists and 3 Melon community moderators (one of whom was also in the peer supporter focus group).

Table 6: Demographic characteristics of Piki service providers participating in focus groups or interviews in November 2020 (n=20)

	N		N		
Gender		**Ethnicity**		**Age**	
Female	15	NZ Māori	4	20-29	8
Male	4	Other	1	30-39	5
Non-binary	1	Asian	1	40-49	2
		European (including NZE)	14	50+	5
Organisation		**Profession**			
Tū Ora Wgtn	1	Counsellor	1		
Tū Ora Wairarapa	3	Therapist	1		
VUW	3	Nurse (Mental Health Nurse)	3		
Explore	2	Clinical Psychologist	2		
Te AHN (inc Vibe)	1	Educational psychologist	1		
Puāwaitanga	1	Social Worker	4		
Melon (inc 1 also PZ)	3	Administrator	1		
PeerZone (PZ)	7	Peer Supporter	7		

Service Users

A total of 26 one-to-one interviews were conducted with a diverse sample of service users by a member of the evaluation team who was in her late twenties and identifies as a service user and a member of the Rainbow community. Most of the interviews (22) were with clients who were enrolled in Piki between June 2019 to April 2020 (these interviews were conducted between February and May 2020). A further four interviews were conducted between September and December 2020, with specific efforts made to ensure a maximally diverse sample overall. However, further attempts to recruit additional interviewees, particularly young males and service users from the geographical areas that were under-represented, were unsuccessful.

As detailed in the table below, the service users interviewed were predominantly female (17/26) and included three identifying as non-binary. Six identified as part of the Rainbow community. Participants came from a range of ethnic backgrounds including 9 Māori and 7 Pacific or Asian. All had completed at least NCEA Level 2 or 3 with 11 having completed a diploma or bachelor's degree. Half were students, and most from the central Wellington area, with small numbers from Lower and Upper Hutt, Porirua, and the Kāpiti Coast (none from Wairarapa). Most (17/26) had accessed only therapy, with 9 having also accessed peer support (or used peer support alone).

Table 7: Description of Interviewed Client Demographic Characteristics (Total n = 26)

	N		N		N
Gender		**Occupation**		**Rainbow**	
Female	17	In employment	8	Yes	6
Male	5	Unemployed	4	No	19
Non-binary	3	Student	13	Unanswered	1
Unanswered	1	Stay at home parent	1		
Ethnicity		**Geographical Area**		**Support Type**	
NZ Māori	9	Wellington	16	Therapy only	17
Pacific	4	Lower Hutt	5	Peer Support only	2
Asian	3	Upper Hutt	1	Both	7
European (including NZE)	10	Porirua	3		
		Kāpiti Coast	1		
Highest education		**Substance misuse**		**Referral**	
NCEA 2 or 3	11	Yes	6	GP	13
Diploma	2	No	18	Self	9
Bachelors	9	Unanswered	2	Both	2
				Unsure	5

Analysis of all qualitative data

All interviews and focus groups were transcribed by an independent transcriber. These transcripts, and all documents collated and created as part of the process evaluation, were imported into an NVivo file and coded using a content framework as well as more inductive thematic codes that were developed by the evaluation team. In addition to content coding, relevant sections were coded for ''sentiment'' i.e., as either positive or negative.

A separate additional process was followed for the analysis of the service user interviews. The analysis of this data was conducted primarily by the researcher who interviewed the participants, but also included direct involvement from the Service User Reference Group (SURG), for the purpose of validating the analysis from a service user perspective. More specifically, SURG was involved in two data analysis phases: searching for and reviewing themes. The group met in four weekly meetings and followed the steps below.

- Initial PowerPoint presentation introducing the concept of thematic analysis, the interview question zones and the initial collation of codes into three loose themes.
- Analytic group work on printed excerpts from these themes following the format below.
  - Presentation of each theme and a transcript excerpt using power point.
  - Description of thinking process out loud, to demonstrate the level of analysis required.
  - Group discussion about the researcher's thinking and whether this was consistent with the rest of the group.
  - Distribution of hard copies of random anonymised transcript excerpts to each member for individual analysis using colour coded pens and sticky notes (three or four excerpts per person).
  - Each person wrote down their initial thoughts, and swapped transcripts with another member when they were finished, who then ticked what was written down if they agreed or added their own thoughts.
  - Structured discussion with each member being given the opportunity to provide their reflections on the transcripts they worked on. Members collaborated by either supporting or challenging these ideas.
  - Final more reflexive group discussion.
  - Researcher collation of the hard copies of data and writing up of further notes on the group discussion.

PART 3:
PROGRAMME DESCRIPTION AND DEVELOPMENT OVER TIME

Part 3: Programme Description and Development over time

The original proposal for the pilot was for a three year project that allowed for a six month initial planning and development phase. Subsequently, the timeframe was compressed to two and a half years which necessitated a faster set-up and effectively eliminated the dedicated planning phase.

Tū Ora Compass Health was the main contractor and thus the central organisation in Piki. As such, they employed a dedicated Piki project lead from February 2019, and a Piki administrator from May 2019. Changes in staffing have meant that the project lead role was filled by three individuals over the course of the pilot (including a Tū Ora staff member acting as interim project manager in the initial project set-up).

Tū Ora had contracts with a range of other organisations in order to deliver an integrated service for the pilot period. These included:

Clinical providers (therapy):

- Te Awakairangi Health Network (Te AHN)
- Victoria University of Wellington
- Massey University (Wellington)
- Evolve Youth Health (initially)
- Explore
- Ora Toa PHO

Intentional Peer Support (IPS) services:

- PeerZone[c]

Digital and telehealth services:

- Melon Health
- HomeCare Medical[d]
- Website development
- 1737 National Telehealth Service
- Puāwaitanga (telephone counselling by referral)

c Now a part of Mind & Body Consultants
d Now *Whakarongorau* Aotearoa

3.1 GOVERNANCE AND CO-DESIGN STRUCTURES

Piki is a complex pilot service with a similarly complex structure of five groups (two at governance level, one operational and two reference groups) to guide its development. This chapter outlines the aims, functioning and evolution of these groups. At least one member of the evaluation team attended the meetings of all groups as a participant or observer (or both) to feed into the process evaluation.

Governance and Operational groups

The governance structure was set up in January 2019, with two groups, a Steering Group (SG) and a Clinical Advisory Group (CAG), initially meeting monthly. A Project Operational Group (POG) of Piki service providers was also set up to meet weekly or fortnightly.

All the groups initially had relevant representatives from Tū Ora and some organisational partners (VUW, Te AHN, and Explore). Other partners were represented on some but not all groups. Group membership has evolved since the beginning of the project, with attempts to ensure appropriate representation of youth, service user, Māori, and Pasifika, as well as all participating service providers and organisational stakeholders.

There has been some variability over time in the naming of the various groups, both informally and in documents (e.g., 'governance' vs. 'steering' vs 'advisory'; 'reference' vs. 'advisory'; clinical vs. 'practitioner').

Steering Group (Governance Group)

The purpose of the Steering Group (according to the Terms of Reference) was to provide overall strategic guidance and direction of the project to ensure it was able to achieve its objectives. The group initially met monthly, then bi-monthly after the first year, and could delegate decisions to the Practitioner or the Youth advisory groups. The group was chaired by the CEO of Tū Ora Compass Health and included representatives from the partner service organisations (Tū Ora, Te Awakairangi Health Network, VUW, Evolve, and Explore), Capital & Coast and Hutt Valley DHBs, the Ministry of Health, youth representation (including the 2019 President of Victoria University of Wellington Students Union), the University of Otago, and the Ministry of Social Development.

Māori representation was reasonably strong, with a representative from Maraeroa Marae in Porirua East part of the group until June 2020. Other Māori members have included staff from Evolve Youth Health and the YRG representative. A Pacific representative was appointed to the SG at the outset, and another attended from April until July 2019, but this initial Pacific representation was not maintained. A Representative from HomeCare Medical joined in June 2019, and a representative from the Health Promotion Agency (HPA) joined in February 2020.

The group reviewed and revised their terms of reference and membership in February 2020.

Clinical Advisory Group (CAG); Practitioner Advisory Group (PAG)

Initially, the purpose of the original Clinical Advisory Group (according to the Terms of Reference) was to provide clinical advice to help inform the model of service, operational policies and procedures, clinical risk management and the evaluation of the initiative. These terms of reference were amended in September 2019 to extend the advice from clinical to also include the peer support perspective after the inclusion of two peer support representatives from PeerZone, and the group was renamed the Practitioner Advisory Group (PAG) to reflect this change. Its terms of reference state that it also contributes to co-design processes, supporting youth and consumer interests, and aims to ensure that the model of service and operational procedures are suitable from clinical and peer support perspectives, in terms of facilitating the support of improving in health outcomes as well as equity of access and other key objectives of the project.

The group met monthly for the first year with one remote meeting during the lockdown in 2020, and bi-monthly meetings thereafter.

The members initially included representatives from key partner organisations (Tū Ora, Te AHN, Melon Health, Victoria University of Wellington, Explore, HomeCare Medical, the University of Otago Wellington, Capital & Coast DHB, and the Ministry of Health. A representative from a Māori health provider (Maraeroa Marae) was a member of the group from May 2019 to August 2020. A Rainbow community representative joined in April 2019. An additional Māori representative (from Te Rau Ora) joined in July 2019 and a Pacific representative in January 2020, although they were not present at many meetings.

The chair of the group in 2019 was a GP from Victoria University of Wellington contracted to Tū Ora, followed in 2020 by the Clinical Director of *Freshminds NZ* (an Auckland mental health initiative) who had joined the group in late 2019 and who coincidentally further strengthened the Māori representation on the group. The diversity of membership and the terms of reference were reviewed following the change in chair, but no changes were made.

Piki Project Operational Group (POG)

Originally set up as the Project Establishment Group in late 2018, the focus of this group was on day to day operations, workflows, and processes, waiting lists and so forth, but with any decision making required elevated to Practitioner Advisory or Steering Group level. The group generally met weekly, although less frequently at times, and these meetings were maintained remotely over the lockdown subsequently reducing to fortnightly. This group is made up of team leaders and managers of the partner organisations.

Important areas of focus for this group included intake and referral processes, strategies for prioritising Māori and Pacific, the development of a multidisciplinary team for higher needs clients, training needs identification and planning, and logistics relating to the Melon app. There were discussions (e.g., in late 2019) to clarify the main purpose of the group which at times seemed to overlap with the Practitioner Advisory Group.

Regular data reports were reviewed at each meeting (including Melon registrations and completion rates for client psychological measures as well as productivity and wait times) with a view to using metrics (e.g., Melon registration rates) to encourage therapists to increase their rates of registration.

Remote communication between the partner organisations improved over the period of the pilot as enhancements to IT systems at Tū Ora facilitated document sharing via Sharepoint and remote attendance at meetings using Microsoft Teams (with smoother operation than the prior use of Skype).

Youth and Service User Groups

Two reference groups were established in January 2019: a Youth Reference Group (YRG) set up by Tū Ora to help with co-design of the project, and a Service User Reference Group (SURG) set up by the University of Otago Wellington (UOW) evaluation team to support both the co-design and evaluation processes. Both groups meet bi-monthly and there is some overlap of membership.

Youth Reference Group (YRG)

YRG is a large group of 15-23 young people, intended to be representative of the general youth population (i.e., not necessarily past, or present users of primary mental health services). The purpose of the group (according to the Terms of Reference) was to provide a youth perspective to help inform various components of the model of care and its evaluation, to contribute to co-design processes and to ensure that the model of care and operational procedures benefit from the inclusion of a range of youth perspectives/interests covering gender, ethnicity, rural and urban.

The YRG transitioned in the first 6 months from being facilitated by Tū Ora to having a youth member as Chair. Tū Ora staff, including the Project Lead, routinely attend YRG meetings.

The original brief for the YRG was to provide advice on youth culture, environment, communication, accessibility, and marketing. At an initial workshop in early 2019, the group contributed to the branding (name and logo) and website design for Piki, including selection of videos from Depression.org to add to the website and Melon resource pages. Since then, the YRG has been requested to provide input on the following matters via meetings, email and/or surveys:

- selection of outcome measures/clinical scales used within Piki (i.e., PHQ9, GAD, ORS, SRS, WHOQOL)
- consideration of additional optional scales and measures for clinicians to use with clients experiencing particular types of distress (e.g., ADOM to assess substance use and recovery; others considered included OCD, Panic, Agoraphobia, Internet/gaming addiction etc)
- Melon (including the online community, Melon resources, and framing and visibility of clinical measures and resultant scores)
- PeerZone feedback
- first contact questions
- Wellness/Hauora Plan (for use with exiting clients)
- improvement of Māori and Pacific access plan
- the social media marketing strategy
- development of the DBT group and MDT approach.

The group also completed a 20-point survey in June 2019 for Tū Ora about what they value in a mental health service and participated in Key Informant focus groups with the evaluation team in November 2019. The Chair of the group was also interviewed in November 2020.

Issues with the diversity of the group, participation (dropping attendance rates) and how the group was operating were identified by YRG members and Tū Ora (see section 4.1 for further detail). In response to this, in the first half of 2020, the Chair (Māori) and another co-opted member (Pacific) reviewed the structure and operations of the group and put a proposal for revision to Tū Ora. In mid-2020, the membership changed with some choosing to leave and others joining. Specific strategies were put in place to ensure representation from all the geographical areas in which Piki is offered as well as by young people with disabilities, those from Māori and Pacific backgrounds, and from a greater range of occupations to reduce the bias towards students. A virtual whakawhanaungatanga meeting was held for the new membership to get to know each other in late May 2020 (during lockdown).

A revised way of operating was also established in which monthly meetings were to be held, mostly via Zoom with every third meeting (i.e., a quarterly meeting) to be in-person with the location rotating around different geographical areas. There was a plan for additional sessions with the co-ordinators (no longer referred to as the chair) to be held one week before each meeting to allow members to better prepare for the meetings. The first meeting of the revised group occurred via Zoom on 29 June; 22 members attended as well as the CEO of Tū Ora, the project lead of Piki, the Tū Ora Piki Māori/Pacific promoter and a servicer user member of the evaluation team. Two further meetings were held in 2020, the last of which was in person. See Table 8 for YRG demographic characteristics of the membership at different points in time.

Service User Reference Group (SURG)

SURG was a small group of 6-11 members with lived experience of mental distress who had used primary care mental health services. This group had a high proportion of gender diverse individuals and included members from different ethnic and socio-economic backgrounds, the disability community, and those with drug and alcohol use-related distress. Members came from across the Wellington region, and encompassed the full 18-25 year old age range. SURG was facilitated by a younger service user member of the evaluation team who collated the feedback and presented this in de-identified form to the relevant Piki group(s). Tū Ora staff attended some of the meetings for a portion of the time. The demographic characteristics of the group (which varied with changes in membership) are shown in Table 8 below.

The group met bi-monthly during 2019 and provided input on similar matters to the YRG from an evaluation perspective. In addition, they co-designed the semi-structured interview and focus group schedules for the evaluation team's qualitative work with Key Informants and clients and participated in a focus group with the evaluation team in November 2019.

In the first half of 2020, the group was inactive while the facilitator was deployed to interview service users, and during the COVID-19 lockdown. In the second half of 2020, they contributed to the evaluation process by participating in the analysis of service user interviews, as detailed in the Methodology section.

Table 8: Demographics of members of the youth and service user reference groups

	VRG			SURG	
	OCT 2019	JUNE 2020	SEP 2020	2019	2020
Gender					
Male	4			1	1
Female	5			1	3
Non-binary	3	Not collected	Not collected	3	2
Gender diverse	0			1	
Genderqueer	1			1	
Not reported	2				
Non-Pākehā Ethnicities					
Māori	4	7	6	3	2
Pacific	5	3	4	2	1
Asian		2	2		
Other		2	2		
Rainbow community	6	7	6	6	5
Disabilities (inc learning impairment)	5	2	2	3	3
Total members	15	22	23	7	6

Notes: 1. ethnicity is only reported for those who identify as non-Pākēhā
2. YRG also included representation from the refugee community by the end of the pilot period

3.2 DEVELOPMENT OF THE SERVICE

Co-design processes were built into the project from the initial proposal in which work with a service user group was proposed to review and revise 'the proposed model of care, strategies to support optimisation of the service, and evaluation'. The project design evolved to include co-design with a youth reference group at the start of the funding period.

Piki was an intentionally evolving service with continuous improvement 90-day review cycles, supported by input from the external evaluation team throughout the development and rollout process.

By June 2020, the main features of the Piki service were articulated in the Standard Operations Manual as shown in the left column of Table 9 below. Details of the implementation of each aspect have been added by the evaluation team in the right hand column.

Table 9: Key features of the Piki service and implementation

KEY FEATURE	IMPLEMENTATION
1. Evidence-based psychological interventions	Therapist training programmes in Cognitive Behavioural Therapy (CBT) were delivered by the University of Otago. Therapists were expected to hold a recognised Post Graduate Certificate (PGC) or equivalent in CBT or be working towards this and have knowledge of Acceptance Commitment Therapy (ACT), and Motivational Interviewing.
2. Intentional Peer Support	PeerZone recruited and trained peer supporters to deliver this service
3. Free access and self-referral options to reduce barriers	Piki services are free and the Piki website provides the facility for self-referral. An increased workforce facilitates accessibility.
4. Focus on improving equity of access and outcomes	Piki service providers are available in a range of locations; promotion to Māori and Pacific occurred in 2020; service providers received Māori and Pacific cultural training, and Rainbow training, PeerZone hired more Māori and Pacific peer supporters in 2020.
5. Co-design with rangatahi	A youth reference group and youth service user reference group were set up and operational from the beginning of the project.
6. Integration of therapy services with general practice, community organisations, a digital wellness app and peer support	Melon Health provided a digital wellness app. A Standard Operating Procedures manual outlines how the services are integrated and details referral pathways.

The timeline below (Table 10) summarises key events in the process of development of Piki up until the end of 2020, including unexpected external events and the evaluation component. Note that the pilot continued beyond the evaluation period and events in 2021 included the Te Rau Ora (Māori) training for service providers, and further promotional activities to Māori and Pacific by the Piki promoter.

Table 10: Timeline of the development of the Piki pilot Jan 2019-Dec 2020

		JAN-MAR 2019	APR-JUN 2019	JUL-SEP 2019	OCT-DEC 2019
SERVICE DEVELOPMENT	**Governance**	• Steering Group (SG), Clinical Advisory Group (CAG) and Operational groups established • MSD rep joins SG • New (#2) project lead hired	• Māori representation from Maraeroa on CAG	• New project lead (#3) • Ora Toa invited to SG and PAG • 2 peer supporters join CAG, becomes Practitioner Advisory Group (PAG) • Search for Pacific rep for PAG	
	Codesign	• Youth Reference Group (YRG) established • Service User Reference Group (SURG) established	• YRG & SURG meetings • Youth member becomes Chair of YRG	• YRG & SURG meetings • YRG surveyed to check diversity	• YRG & SURG meetings
IMPLEMENTATION	**Operational**	• CAG confirms outcome measures	• Melon app live • Website self-referral live	• Peer support Live (no formal launch) • Puāwaitanga receives 1st Piki referrals • Ora Toa becomes partner organisation	• Risk management and reportable event management guideline drafted (Oct)
	Workforce	• 17 new therapists hired • CBT training commenced – 19 Piki therapists • Therapists orientated to Melon app	• Fidelity training completed • InsideOut (Rainbow) training • 3 clinicians hired @ Massey, Te AHN • 12 peer supporters recruited and trained by PeerZone	• Intake coordinator appointed based at Tū Ora (0.6FTE, Jul; to 1.0FTE, Sep) • Therapist survey of training gaps • Le Va (Pacific) training & InsideOut (Rainbow) training • Clinician PD hui	
	Promotion	• Porirua Launch • Initial website design and content completed	• VUW Launch • Website live	• Hutt & Wairarapa Launches • Draft social media marketing plan put on hold till 2020	• Plan for improving access for Māori/Pacific drawn up
OTHER	**Unexpected or other related events**		• Wellbeing Budget announces additional funding for front-line mental health services	• Sudden death Postvention meeting (Aug) • Unexpected surge in demand	
	Evaluation	• Protocol finalised/ ethics approval	• First evaluation report	• Key Informant (KI) interviews begin	• KI Interviews completed; Pasifika youth lit review • Summary for 90-day review inc Pasifika youth focus

	JAN-MAR 2020	APR-JUN 2020	JUL-SEP 2020	OCT-DEC 2020
SERVICE DEVELOPMENT	• SG and PAG become bi-monthly • New chair for PAG • Pacific rep joins PAG • HPA rep joins SG	• All committees meeting virtually • POG meetings reduce to fortnightly	• SG meetings continue virtually • PAG & POG in person and virtually • POG meetings reduce to monthly Sep	• All committees meeting in person
	• YRG meeting	• YRG membership refresh to improve geographical spread and target group representation • YRG become monthly by Zoom; quarterly in person • YRG pre-meetings with 2 co-ordinators (instead of a Chair)	• YRG meeting via Zoom due to Level 2 Covid restrictions with refreshed membership	• 4 SURG meetings on evaluation analysis • YRG meeting in person (1st since Jan)
IMPLEMENTATION	• PHQ9 & GAD7 made part of website self-referral (optional)	• WHOQOL integrated into Melon App • 1st Multidisciplinary Team (MDT) meeting • Standard Operating Procedures (SOPs) manual finalised with new intake process • Remote service provision due to COVID19	• Tū Ora Wellington pauses enrolments and refers clients to Puāwaitanga for phone therapy due to demand for services	• Peer Supporters begin accessing the Melon app in client view
	• 2nd CBT course - 6 Piki therapists • Intake Coordinator role disestablished and intake moved to each service • Te Rau Ora (Māori) training postponed • Uni therapist survey of training gaps	• 4 Māori and 1 Pacific peer supporters in Porirua and Hutt Valley recruited	• Le Va (Pacific) training • InsideOut (Rainbow) training • Te Rau Ora (Māori) training postponed	• Sexual Harm Training • Trauma training in planning stage • DBT training in planning stage
	• Community promotion to Māori and Pacific • Māori and Pacific (M/P) promotion temporarily paused	• Tū Ora youth M/P promoter appointed (initially redeployed to Covid role) • meetings with Porirua/Hutt Pacific groups • Māori & Pacific direct text trialled at 10 Tū Ora practices • FB/Instagram campaign launched 5 June	• Social media campaign stopped • Tū Ora youth M/P promoter continues work with Porirua groups (inc sports) and Weltec/Whitireia students etc	• Tū Ora youth M/P promoter continues work with Porirua church and education groups; planning for work in Hutt Valley
OTHER	• COVID-19 Level 4 lockdown (Mar) • immediate transition to telehealth	• Tū Ora IT transformation • Launch of COVID19 Digital Wellbeing apps		
	• Full summary of KI interview themes • Service User interviews commence • Therapist and Peer supporter surveys	• Service Provider interviews re telehealth/COVID19 • Interim evaluation report		• Service Provider focus groups & interviews • Further KI & SU interviews • SU survey sent out

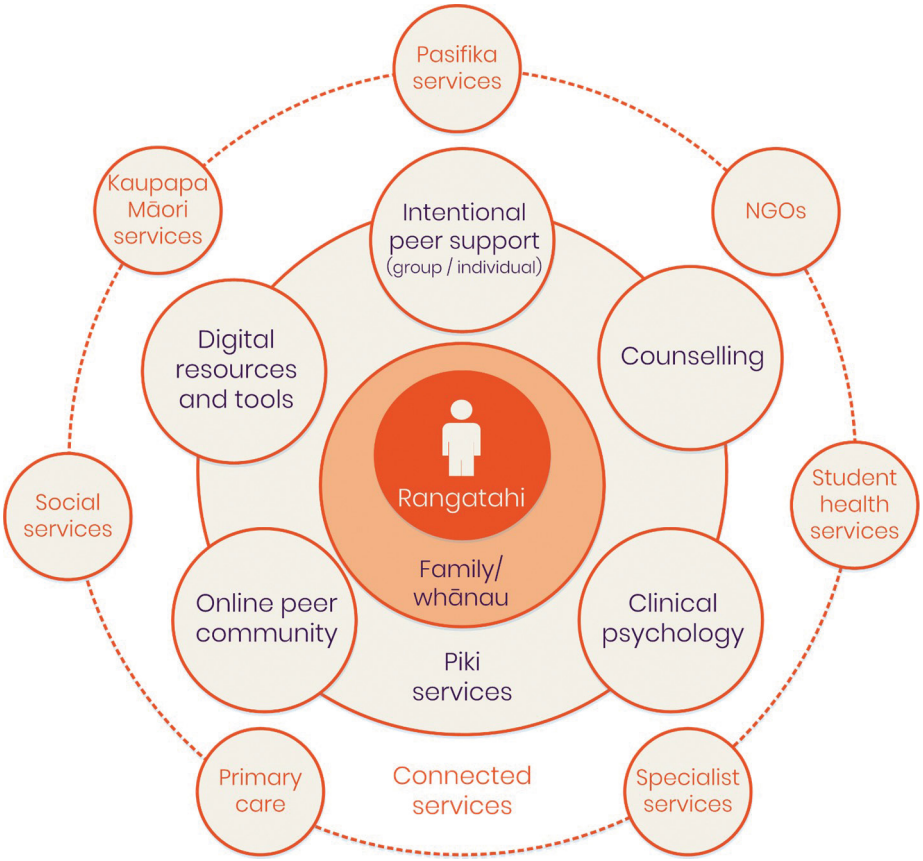
3.3 SERVICE COMPONENTS

The full range of Piki services has been operational since mid-2019; namely, the three fundamental parts of Piki: psychological therapies, peer support, and the Melon Wellness app, as well as telephone services provided by Puāwaitanga, 1737 if required.

The components were rolled out in a phased progression, with an increase in the qualified/trained therapist workforce being the first stage, followed by the launch of the digital Wellness app by Melon in April 2019, and of the Piki website that enabled self-referral in May 2019. The peer support element, provided by PeerZone, was under development during the first half of 2019 and launched in late July 2019.

The Standard Operations Manual provides the following visualisation of how the partners in the Piki programme work together to provide integrated mental health support for rangatahi:

Figure 3: Piki integrated therapies diagram



The full range of components was available from late July 2019. This section describes the way in which each of the components of the Piki service was implemented: the Website with its self-referral function (as a pathway into the service), Psychological Therapies (as the largest component of the service), Peer Support (as an innovative support model), and the Digital Mental Health app (Melon).

Website and Self-referral

With the aim of reducing barriers to accessing services, the Piki website (provided through HomeCare Medical) was designed to appeal to youth and to represent the target groups (Māori, Pacific, other ethnic groups, Rainbow community) through imagery. Input was incorporated from a workshop held with the YRG in January 2019, and feedback from the Piki Operational group. YRG promoted the idea that the website be 'positive, uplifting, bright and simple'. A photo shoot with a diverse group of youth produced the imagery for the website. YRG also tested the website prior to it going live in early May 2020. While the website imagery was culturally diverse, including Māori and Pacific, the website did not originally include any Māori language, aside from the name.

The website was initially conceived as a basic starting point, providing information on the Piki service as well as a form for self-referral, that could be up and running quickly, given the compressed development timeframe. The website was further updated and developed over the period of the pilot with additions to the information about the services offered and changes to the self-referral form. Initial issues with the site not appearing in google searches were also addressed. One component of the service that has not been visible on the website has been the option of phone-counselling through Puāwaitanga. The website also has a page of resources which contains links to online resources on a range of topics, including healthnavigator.org.nz topics, selected videos of young service users' stories from lowdown.org.nz and depression.org.nz, and a list of helplines on the Mental Health Foundation website.

In the second year of the pilot, changes to the self-referral form included the addition of an ethnicity question, and a free text box for gender. Two psychological measures (PHQ9 and GAD7) were also added for optional completion. Results enabled prioritisation of contact with clients where scores reflected high levels of distress. Other changes included the incorporation of Māori words. Consideration has been given to the more complex task of incorporating Pacific languages.

Plans to develop the website beyond this (such as a webchat feature) had not been fully pursued as of December 2020, due to a range of competing commitments, including attending to the impact of COVID-19.

Psychological Therapies

The psychological therapy component of Piki is provided by a range of provider organisations and is intended to be CBT-informed, although the training backgrounds of individual providers varies (see Section 5.1, Table 40). Individual in-person therapy is the core offering, with telephone or other remote modes of delivery built into the Piki model in order to reduce barriers to access. The provision of group therapy is also part of the model although this has not been implemented during the evaluation period, having been delayed by the COVID-19 lockdown. Stepped care is provided through the inclusion of Explore psychological services as part of the Piki service for clients to be referred to when they need more specialised and/or more intensive therapy.

In-person Service Providers

The following organisations provide the in-person therapy component of Piki, as well as providing remote options via phone or video-conferencing where desired or needed. (See section 5.1 for further discussion).

- Tū Ora Compass Health Primary Health Organisation

As noted above, Tū Ora Compass Health is a PHO with 61 General Practice Teams and a number of other health care providers throughout the Wellington, Porirua, Kāpiti and Wairarapa regions, including health services on two Wellington tertiary campuses, although these services are described in a separate section below as they are distinct.

Building on the existing all-ages *Primary Solutions/To Be Heard* services described above, additional funding of 7.0FTE was allocated for Piki therapists at Tū Ora in Wellington, Porirua & Kāpiti, and 1.0FTE for Wairarapa from the commencement of the pilot in January 2019. All Tū Ora therapists and their 18-25 year old clients are considered to be part of Piki.

As at 30 December 2020, Tū Ora Piki therapists were available in 26 medical centres across Wellington, Porirua, Kāpiti and Wairarapa (including a kaupapa Māori health service on the Kāpiti coast), and in 12 other locations, seven of which were in Porirua, Kāpiti and Wairarapa (as shown in Table 11).

Table 11: Location of Tū Ora Piki therapists as of 30 December 2020

REGION	LOCATIONS OF MEDICAL CENTRES	TŪ ORA LOCATIONS	OTHER
Wellington	• Central city • Island Bay • Johnsonville • Kelburn • Khandallah • Miramar (2) • Newlands • Newtown (2) • Kilbirnie	CBD (3) Newtown	• Wellington Kahungungu Whanau Services (CBD) *Earlier in the pilot period:* • Whitireia • He Huarahi Tamariki Teen Parent School (Tawa) • Evolve (Wellington Youth Service)
Porirua & Kāpiti	• Porirua (2) • Paraparaumu (3) • Raumati • Tawa/Linden • Whitby	Porirua Kāpiti	• Coastlands Shopping Centre (Paraparaumu) • Maraeroa Marae Medical Centre
Wairarapa	• Masterton (1) • Carterton • Greytown • Featherston	Masterton	• Featherston Community Centre • Te Rangimarie Marae (Masterton) • Youth Kinex (Masterton) *Earlier in the pilot period:* • Makoura & Kuranui Colleges

- Te Awakairangi Health Network (Te AHN)

As noted above, Te AHN is a PHO with 22 practices and the After Hours Medical Centre in the Hutt Valley. Building on their *Well-being* service described above (with youth aged 12-19 as one priority group), the Piki pilot provided for additional funding of 4.6FTE therapists at Te AHN from the commencement of the pilot.

As at 30 June 2020, Te AHN Piki therapists were available in 6 medical centres and in 4 other locations.

Table 12: Location of Te AHN Piki therapists as of 30 December 2020

LOCATIONS OF MEDICAL CENTRES	TE AWAKAIRANGI OFFICES	OTHER
Upper Hutt Lower Hutt Wainuiomata (2) Pomare Petone	Lower Hutt	Orongomai Marae (Upper Hutt) Stokes Valley/Koraunui Marae Vibe Youth Centre (Upper Hutt and Lower Hutt)

- Ora Toa Mauriora

Ora Toa Mauriora is a kaupapa Māori Primary Mental Health and Addictions service based in Porirua/Kāpiti, providing free services to assist and support rangatahi and their whānau. They aim to provide culturally appropriate, quality care services for all people.

Ora Toa became a partner organisation for delivery of Piki in August 2019, as planned from the outset. A Porirua-based therapist (0.7 FTE) was recruited in December 2019 and began seeing Piki clients in February 2020.

- Evolve Youth Health Service

Evolve (an independent youth 'one-stop shop' in central Wellington) had a Tū Ora Piki therapist (0.2 FTE/ one day a week) based within their service from July 2019 to March 2020. Evolve expressed an interest in employing a Piki practitioner directly to be a member of their clinical team and organisation rather than being part of Tū Ora. Tū Ora offered funding to employ their own therapist but Evolve decided not to take up this offer, and are therefore no longer a partner organisation.

- University Services

The place of Piki within the existing counselling services at the two partner universities, and referral pathways for students, evolved over the course of the pilot.

Massey University Wellington: The Massey University counselling service is relatively small (3.8 FTE), including the additional 1.0 FTE that is directly funded by the Piki pilot. All Massey counsellors have been considered by Tū Ora to be Piki providers, and reported as such, from the start of the pilot in Jan 2019.

Victoria University of Wellington: Student Health and Counselling service (Mauri Ora) is a much larger service commensurate with their student population. Introducing the Piki service within this large and busy service was complex and it was introduced progressively to minimise disruption to existing services. Within the counselling service, Piki provided funding for an additional 3.7 FTE of therapist time above the usual staffing which averaged 10.5 FTE over the whole year in 2018. Until the introduction of Piki, all clinicians worked under the same service model and structure, with students seeing a clinician based on availability rather than clinical presentation. When the Piki service commenced, only the Piki funded counsellors were initially regarded as Piki providers (in contrast to Massey University) and able to offer access to Piki services other than therapy. As discussed below (section 3.5), this arrangement created operational complexities in terms of referral pathways and wait times for VUW students during 2019, and led to a somewhat unwieldy 'two tier system', whereby only those students who self-referred via the website became Piki clients. A decision was made in early 2020 to expand Piki (in terms of access to the Melon app and PeerZone) to all VUW students who seek counselling, and to begin the process of better integrating Piki and the existing service. By mid 2020, all VUW counsellors were considered Piki providers and were able to offer their clients access to the full range of Piki services, although the Piki funded positions remained at the same level.

- Explore

Explore is a specialist psychological service with offices based in central Wellington and Petone, as well as in the Wairarapa and Porirua. Explore clinical psychologists provided more intensive therapy to Piki clients where required as part of the stepped care model. They also provided supervision to other Piki therapists and received Piki funding for 2.1FTE. During the course of the pilot, they expanded their therapy provision locations to include the Wellington office of Ngāti Kahungunu Whānau Services.

Other referral options

While the aim was for Piki therapists to provide care within their own organisations, they did sometimes refer to private providers (psychologists or other more specialised therapists) when it seemed a better solution for the client, either due to excessive waiting lists for Explore or for a better match for some types of care (e.g. eating disorders where another private provider may have particular expertise).

Phone counselling services

Puāwaitangi telephone counselling is by referral only and is an option that was included within Piki, ostensibly for clients in certain circumstances: preference for phone counselling, desire for some level of counselling while waiting for in-person counselling on a waiting list, inability to access counselling during business hours or to physically access in-person counselling due to, for example, disability or transport issues. They received their first referrals from Piki in July 2019, but initially only from Tū Ora clients. Other Piki providers were not initially referring to Puāwaitanga until late 2020 when demand for services had increased to a such a high level that the decision was made to refer to this service as a way to manage wait times.

Clients referred to Puāwaitanga used their Patient Management System (Input Health) which allowed them to choose a counsellor and schedule their phone appointments. Counsellors were either part of a small core team or contractors from around the country, who provide services for a range of referring organisations. For this reason, although their system indicated that a person was a Piki client, they were not primed to talk to clients about Piki as an integrated service with a range of offerings, but just to deliver phone counselling. They also routinely use a different outcome measure (the Duke instrument) and did not use the Piki outcome measures.

The 1737 phone line is a pre-existing free phone or text service that is listed on the Piki website as a service that Piki clients can call if they need to talk urgently at any time of the day or night.

Group therapy (Dialectical Behaviour Therapy)

Group therapy was intentionally developed later after other components of Piki had been established. Dialectical Behaviour Therapy is a form of cognitive behaviour therapy that builds emotion regulation skills. A sub-group of the Clinical Advisory Group began work on the development of this in the 3rd quarter of 2019 but this was paused due to the impact of the COVID-19 lockdown. A plan was developed to prioritise participation of Māori and Pacific by trialling these groups in areas where there are higher numbers of Māori and Pacific (e.g. Hutt Valley and Porirua). This aspect of Piki had not been implemented by the time of this report, although plans were in place to commence in early 2021.

Peer Support

PeerZone were contracted to Piki to provide peer support at a late stage in the project initiation phase after planned engagement with another peer organisation did not go ahead. Their contract was to provide Intentional Peer Support for Piki clients through peer supporters who have personal experience of mental distress and have received training in utilising this experience to support others within a structured peer support framework. This is qualitatively different to the informal support offered by anonymous peers through the Melon online community.

In PeerZone's words, 'Peer support is unique because it enables people to:

- Build trust quickly through shared experience.
- Be exposed to role models for hope and wellbeing.
- Share knowledge and solutions based on lived experience.

Everyone is offered both one-to-one and group peer support. In most cases participants only access one form of peer support at one time. A common pattern may be that participants start with one-to-one peer support and then move on to group peer support.'[47]

Having not offered a peer support service tailored for youth before, PeerZone worked with SURG and YRG and Māori and Pacific groups between March to May 2019 to develop this. They initially recruited and trained 12 peer supporters in preparation for their launch in July 2019. The peer supporter workforce initially totalled 2.4FTE, made up of part-time staff, and was based in Wellington. The initial lack of peer supporters based in the Hutt, Kāpiti or Wairarapa regions, was addressed by the recruitment of 2 in Wairarapa in early 2020. In 2020, funding from the disestablishment of the intake co-ordinator role was redirected to Peer Zone to allow the recruitment of new Māori and Pacific peer supporters, some based in the Kāpiti region (five began their training on 18 June 2020).

PeerZone offered clients up to ten one-to-one or structured group sessions with a peer supporter. They also ran informal group social get-togethers.

While the centralised intake coordinator role was in operation (see 3.5; 5.2), their brief was to offer all Piki services to clients, and those who expressed interest in peer support were referred through to PeerZone. Service provider and user interviews indicated that not all Piki service users were aware of the peer support option, however. This lack of awareness may have increased following the devolution of intake processes to the partner organisations in early 2020, with the potential for greater variability in communication. From June 2020, a web-based referral form to PeerZone was made available. This could be used by the Piki administrator (using a link in the SOP manual) to directly refer clients who expressed a preference for peer support on their self-referral form, or by therapists, or by non-therapist Melon coaches if clients were using Melon but not accessing therapy.

Peer supporters conducted their sessions online during the Covid-19 lockdown, with PeerZone paying for data packages for the supporters and upgrading their Zoom to facilitate this.

A brief online exit survey for peer support clients was developed with the assistance of the evaluation team.

We note that PeerZone is now part of Mind and Body Consultants Ltd within the Emerge Aotearoa group (a national charitable trust that provides a wide range of social services) and continues to provide the same services.

Digital Mental Health app (Melon)

Melon Health provided a digital app with a range of support functions for clients and service providers to access and use. The development phase of the app included an online survey with 18-25 year olds in the greater Wellington area (receiving 250 responses), interviews with mental health therapists providing services to this demographic, and 'user testing' focus groups with youth (e.g. trades students at WelTec, construction crew in Petone, hospitality workers) as well as feedback from SURG and YRG. The app was launched in April 2019.

For clients, Melon provided a range of wellbeing resources, an online community for anonymous chat with peers , tracking tools (e.g. for mood, sleep, exercise), a health journal, and the ability to communicate with a 'coach' (a Piki therapist or Melon clinician) through messaging, or to have virtual appointments via video conferencing. The term 'coach' was part of the pre-existing infrastructure of Melon.

The wellbeing resources were a part of the general Melon Wellness app and by the end of the pilot were available in the following categories: webinars, Te Ao Māori, Sleep, Sexuality & Gender Diversity, Recipes, Physical Activity, Pasifika Wellbeing, Pain Management, Nutrition, Emotional Wellness, Creating Habit, Communication and Anxiety & Depression. More recently, Melon also added webinars on a range of topics to their offering for clients, including one by a peer supporter.

For clinicians, it provided a dashboard listing all their Piki clients which enabled them to invite clients to join Melon, to ask clients to complete 'surveys' (i.e., psychological measures GAD-7, PHQ-9 and WHOQOL-Bref as well as Session and Outcome Rating Scales), and to schedule remote sessions over a video platform. Messaging clients was also possible. An appointments feature was removed in October 2019 due to minimal use. Therapists were able to view clients' health journal entries but following feedback from therapists, a message was added to advise that they did not do this.

Clients needed to be invited to register in order to access the Melon app. Initially they were only able to be invited to register with Melon by their 'coach' (normally their therapist). This has evolved over the course of Piki: during the period when there was an intake co-ordinator (see below), inviting clients to register with Melon became part of that role. Since the devolution of an overarching intake co-ordinator to administrators in each service organisation (including PeerZone), the invitation to register with Melon can be made through the client's therapist or by these administrators. (See section 5.2.2 below for details of the evolving intake process).

While the intake co-ordinator role existed, the Melon Clinical Lead was assigned as 'coach' when clients did not have an assigned therapist (i.e., in the interim while they were waiting for their first therapist appointment, or if they were only accessing peer support or Melon, though there was no way for the Melon staff to distinguish between these categories of clients).

By the end of the evaluation period, the process of registering new clients onto Melon and assigning a coach was varied. The Tū Ora Piki administrator could book a first appointment with a therapist for the client and assign that therapist as coach unless the client did not want therapy (in which case they could assign the Melon Clinical Lead as 'coach'). Alternatively, the therapist could invite the client to register with Melon at the first appointment and assign themselves as 'coach'. Processes in the different provider organisations were variable. At Victoria University, the App was initially only available to those who saw one of the subset of therapists in the service who were Piki-funded and trained, but it was later extended to all students within the Piki age range.

PeerZone was initially not integrated with Melon and could not register clients. They expressed a desire for integration and as a consequence, from May 2020, operated a single account through which they could invite clients (assigning the Melon Clinical Lead as coach). Later in the year, the peer supporters themselves were given access to the App in the same way as service users, enabling them to interact with the App as users would, but not to access the functions of a 'coach'. Through their current single account, peer supporters could access the direct messaging and video calling one at a time.

Integration with the Puāwaitanga phone counselling service was explored but did not eventuate.

Registering with the Piki Melon app was voluntary. Not all Piki clients received an invitation to join as this depended on Piki staff. There were efforts to increase invitation rates. Once invited, not all Piki clients accepted the invitation. Those who accepted did not necessarily engage actively with the app, although they received notifications of survey prompts. Piki clients could continue to access the Melon app after they had completed their therapy or peer support sessions, either remaining with the therapist listed as their coach or being re-assigned to the Melon Clinical Lead as coach at that point. The gender options for clients to select during the 'onboarding' process were expanded to include a non-binary option in February 2020.

The community forum was moderated by rostered 'community support', with a community code that informed clients of their obligations around risk. The community was originally intended to be monitored 9am-8pm on weekdays and 12 noon-8pm on weekends. Before the app went live, this was increased to 24-hour monitoring with funding by Tū Ora after the Ministry of Health identified the lack of such full-time monitoring as a risk in early 2019. This overnight monitoring was discontinued in July 2020 after low levels of client posts and/or risk had been observed, and a Melonbot provided a message noting this.

Melon continued to actively develop the app throughout the course of the pilot, adding resources, and beginning a trial coaching community for therapists in June 2020. The WHOQOL survey was made available to Piki clients directly on the Melon app (rather than through a link to an outside location) in April 2020. Other changes (notified to 'coaches' in June 2020) increased the options for survey completion and prompting through the app, and made the Hauora Wellness Plan available for use when clients were exiting the service (originally circulated in November 2019). They also reported ongoing work to improve the user interface in many aspects of the app.

3.4 WORKFORCE COMPOSITION, TRAINING AND SUPERVISION

The core workforce for Piki consisted of in-person therapists/counsellors and peer supporters, supplemented by counsellors at the HomeCare Medical services (Puāwaitanga and 1737) when these were accessed.

The in-person therapist workforce of existing staff in the partner organisations was supplemented with an additional 20 FTEs from the beginning of 2019. A CBT training course and a CBT fidelity course were offered by the University of Otago Wellington to Piki therapists/counsellors, as detailed in section 5.1.

Peer supporters were recruited and trained specifically for Piki by PeerZone. In 2019, 12 peer supporters were recruited and trained. By 2020, several had left and been replaced, and the geographical locations had been increased to include Wairarapa and Kāpiti. Māori and Pacific peer supporters were explicitly recruited in 2020 in a strategy to provide peers from the ethnic backgrounds that Piki was targeting. This drew on a redistribution of funding from 1 FTE of therapist salary that had previously been used to fund a dedicated intake co-ordinator. More detail is provided in section 5.2.

Other training in specific target areas was provided for Piki practitioners:

- Rainbow competency training provided by InsideOut (3 sessions in 2019; one session in 2020)
- Pasifika cultural competency training provided by Le Va (one session in 2019 and one in 2020)
- Māori cultural competency provided by Te Rau Ora (twice postponed in 2020 due to Covid-19 lockdowns and alert levels; rescheduled for 2021)
- Sexual Harm training in November 2020 (rescheduled due to Covid-19 lockdown)

In addition, trauma training is in development.

Peer supporters were not initially included in the Pasifika cultural competency training but were included in the Rainbow training and subsequent Pasifika and Māori cultural competency trainings.

A hui for therapists was held in August 2019 and a survey run by the organisers of this (with a 30% response rate) found that clinicians identified the following as training priorities, some of which were addressed in the training programme provided (or planned):

Most frequently mentioned:

- risk assessment and management
- trauma
- bi-cultural/Māori mental health models, cultural & clinical approaches, working with Māori (supported by cultural supervision).

Less frequently mentioned:

- clinical skills e.g., Treatment planning and motivational interviewing
- pathways for rape crisis, sexual harm
- refugee services.

A second hui planned for 2020 to include therapists and peer supporters was cancelled in view of the need for other targeted sessions (Pasifika, Māori, Rainbow, and sexual harm).

Melon also provided repeated training sessions in how to use the Melon app with therapists from the partner organisations, plus some online training. VUW *Mauri Ora* staff also received training on Melon and Peer Support in the first months of 2020, after the decision that all would become Piki therapists.

In-person therapists and peer supporters also received some training in telehealth to prepare them for the sudden need for widespread use of this during the COVID-19 lockdown. See section 5.6 below.

Regular supervision for therapists was part of the Piki model. Supervision for therapists who completed the CBT training with Otago University was provided by psychologists from an external organisation: Explore. Explore recruited two clinical supervisors (registered psychologists with formal training in Cognitive Behavioural Therapy) to provide this service to Piki. (see section 5.1 for more detail).

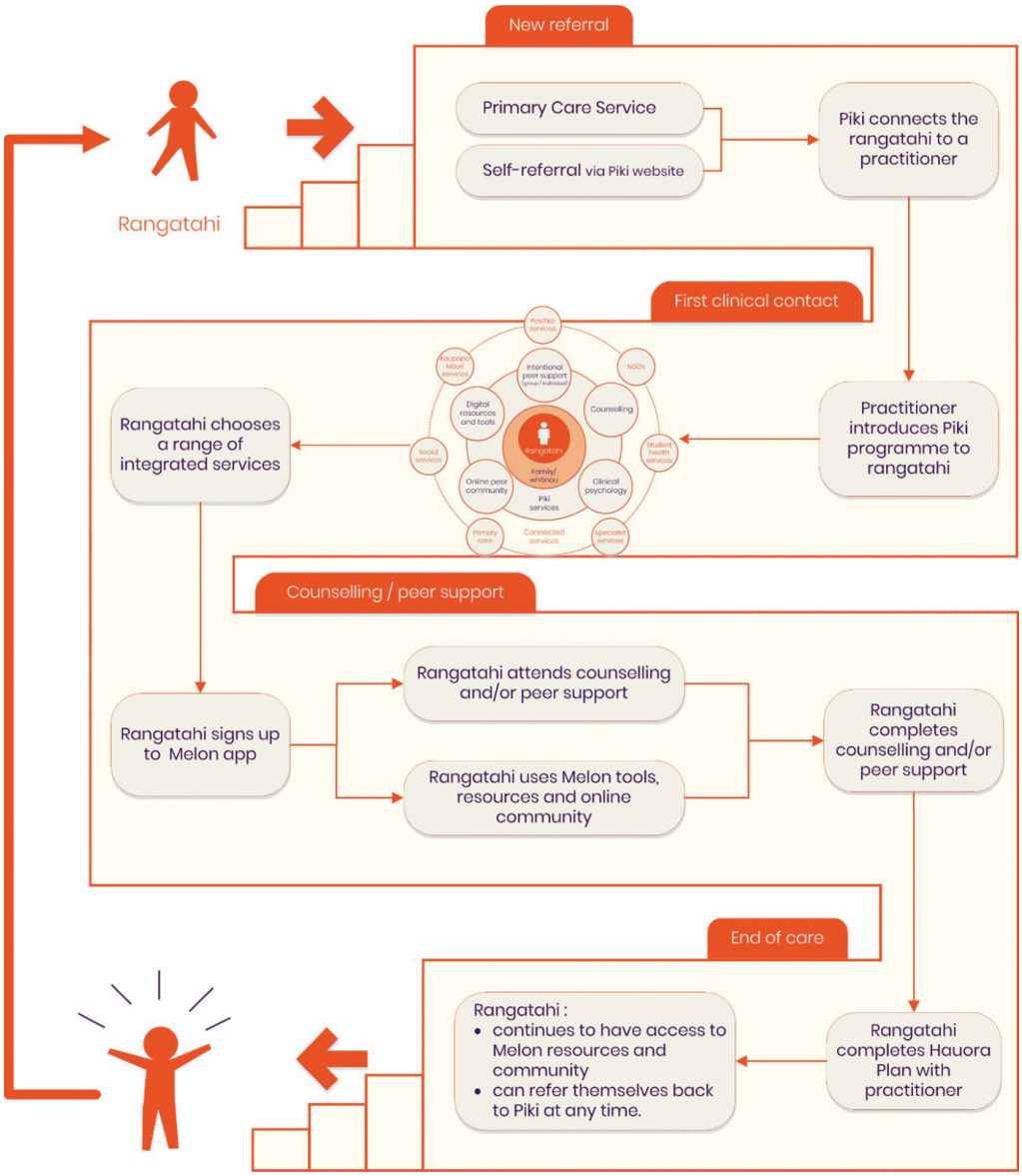
PeerZone had their own systems for supervision. Peer supporters were expected to attend a 1.5 to 2-hour monthly group supervision or co-reflection with their fellow peer supporters. This group supervision was for support and professional development.

3.5 CLIENT JOURNEYS AND CLINICAL PATHWAYS

Reducing barriers to access and ensuring rapid response to referrals were key elements of the Piki design from the outset. While usual pathways into mental health support through GPs were an important part of the Piki service, the addition of self-referral through a website was a key innovative feature that aimed to reduce barriers to access. The goal of enabling multiple entry points through which clients receive rapid responses and initiation into services (i.e., with short wait times – within a matter of days) was logistically very challenging. A sub-group of the Piki Project Operational Group met for a period in 2019 to focus exclusively on the issue of clinical pathways but managing the high level of demand remained an issue.

As at 28 May 2020, a concept of the journey of a young person into and through Piki services was diagrammed by Tū Ora as follows:

Figure 4: Diagram of client pathways from Piki Operations Manual (2020)



Wait times

The initial plans for the service included stated aims to 'deliver low intensity interventions with a wait time of less than 5 days for 90% of clients'[12] with 'onsite service delivery, immediate booking and warm handover, with waiting times of hours and days not weeks'.[48]

However, by late May 2019 wait times for a first appointment, especially at Victoria University of Wellington, were as long as 5 weeks after a surge in demand for services following the public launch on the VUW campus in early May. Wait times at the university services are also affected by study and exam cycles and related stress points for students.

A centralised intake co-ordinator (IC) role was created in July 2019, based at the lead service provider organisation (Tū Ora Compass Health), and operated until March 2020. The role was established at 0.6FTE, mainly to respond to self-referrals, but also to manage GP referrals. The idea of such a role had been mooted since the beginning of Piki but was not implemented until the website and self-referral became fully operational.

The reasons for establishing this role were that this would provide:

(i) an initial contact within 3 days of self-referral 'to bridge the wait time gap before seeing a therapist.' (Minutes of CAG meeting 3 July 2019)

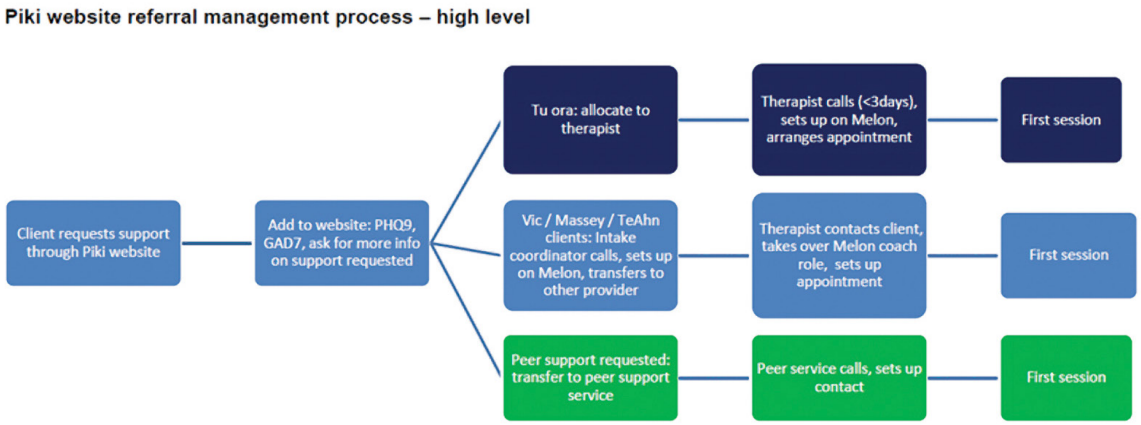
(ii) triage and risk assessment - adding an ultra-brief scale to measure 'distress levels' to the website self-referral form to assist in prioritising contact (Minutes of CAG meeting 3 July 2019)

(iii) 'enabling' peer support access (this was prior to an on-line referral form to peer support)

(iv) smoothing out service delivery across the region.

Given the triage aspect to the role, there was a need for those in the role to be clinically trained. The intake co-ordinator's role was to have an initial discussion with the client, to explain the services available within Piki and to refer them to the appropriate organisation. The communication of client information to organisations outside Tū Ora was initially delayed by the need to set up secure file transfer systems. Figure 5 below illustrates the self-referral process at this time, as shown in the Clinical Advisory Group Agenda papers for meeting 3 July 2019.

Figure 5: Diagram of Piki self-referral process in July 2019



An additional task for the IC (from late August 2019) was to invite clients to register with the Melon app (see above for details). This meant that the client would be able to register and access the self-management resources on the Melon app and direct message the Melon coach while waiting for their first appointment. Occasionally clients did so, primarily to enquire about wait times they were experiencing (such messages were passed on to the relevant organisation).

In response to a peak of self-referrals from VUW students in September 2019, the IC role was increased to 1.0FTE and rotated through 10 Tū Ora therapists as a temporary measure, with the intention being for the role to be shared among 3-4 therapists in the future. Massey and Te AHN retained responsibility for their own intake assessments for a period at this time. In October 2019, an online triage tool was discussed.

The purpose of the introduction of the intake co-ordinator was partly to ensure a rapid initial response to clients in terms of first contact although this could not reduce wait times for an actual first appointment. However, in the initial stages, the wait time even for the intake call could at times be up to 5 days when the goal was to be within 3 days. This increased to as much as 2 weeks to book an intake call, and then a further wait of weeks before an initial therapy session.

Issues with the centralised intake co-ordinator (IC) role and process were identified from the beginning, particularly around the need for an initial intake conversation leading to the potential for the young person having to tell their story a second time once being assigned a therapist and having to begin two therapeutic relationships. By January 2020, it was agreed that the IC role would be dis-established and new intake processes would quickly pass self-referrals on to the partner organisations using Sharepoint. This change was effective from April 2020. Additional reasons for the disestablishment of the IC role included freeing up 1.0FTE of resources for other service provision (additional peer support in Porirua and the Hutt Valley), avoiding issues with peaks in self-referrals which were largely from the student population and were seen as best managed by those organisations, and to remove the necessity for Melon staff to be interim 'coaches' (as therapists could more quickly be allocated to clients).

The intake process continued to require a Tū Ora administrator to process each self-referral and to allocate them to the appropriate organisation, but no longer required clinical input at this stage. Each partner organisation received spreadsheets of new self-referrals via Sharepoint for follow-up.

Each provider then carried out their own intake process. For example, at Tū Ora, the administrator allocated clients to the first available therapist who then made initial contact with the client, while at Te Awakairangi Health Network there continued to be a centralised intake process through which first contact was made before allocation to a practitioner. These processes also involved facilitating registration with Melon and referring clients for peer support (as detailed above).

Due to the nature of the existing service, the process for VUW students has been somewhat different from the beginning (as detailed above). From 1 July 2020, when all VUW *Mauri Ora* counsellors were designated as Piki therapists, their self-referral pathway differed slightly from that for the other partner organisations. VUW students self-referring via the Piki website received an email from Tū Ora advising them to contact *Mauri Ora* directly to book an appointment with the first available therapist within the service, at which point they entered the standard intake process for VUW, unless they completed online GAD-7 or PHQ-9 tests during their self-referral process and their scores were high. VUW also received lists of self-referrals for follow-up if students did not present.

Meeting the goals for minimal wait times continued to be monitored by the Piki Operational Group and remained a challenge, which was exacerbated by natural staffing fluctuations.

The initial lockdown at alert levels 3 and 4 of Aotearoa's 4-level alert system in response to the COVID-19 pandemic (April-June 2020) resulted in a reduction in referrals and wait times during that period. However, during late 2020, the Wellington office of Tū Ora had such a high level of demand, and consequent wait times, that they temporarily closed their books to new clients for a period (referring clients had the option of Puāwaitanga phone counselling or a lengthy wait).

Triage

Piki aimed to provide support for rangatahi with mild to moderate mental distress. Whether or not it was intended that those with more severe distress should therefore be excluded from the service has been debated in relation to issues of risk management as well as accessibility and inclusiveness (See Section 4.5).

Given the range of severity of distress among presenting clients, and in view of high demand creating long wait times, one strategy to manage wait times proposed in June 2019 (paper to address wait times to CAG) was to enrol clients onto the Melon app prior to seeing a therapist to collect PHQ-9 and GAD-7 scores. This allowed prioritisation if scores reflected high levels of distress, or possible diversion if scores were very low. Early enrolment to Melon was not able to be implemented until the establishment of the IC role in July 2019 at which point conversation with the IC was the initial informal means of triage.

As mentioned above, the GAD-7 and PHQ-9 have since been incorporated into the self-referral form to allow prioritisation at point of intake if scores reflect high levels of distress. Administrators who process self-referrals have guidelines for when to contact team leaders by phone regarding new clients who potentially need priority based on their scores.

Prioritisation strategies

In May 2020, the Practitioner Advisory Group (PAG) agreed to support the prioritisation of Māori and Pacific rangatahi for available therapy appointments. (This was informed by a similar approach operating at Victoria University of Wellington). We do not have detail on the implementation of this other than the agreement at a later PAG meeting that each provider would implement this in a way that worked best for their service delivery model.

Links to other services

Progress was made in forging links with other social sector agencies to enable greater support to Piki clients where social factors are a concern (e.g., MSD, Probation services and youth champions, WINZ, Bail Support Service and Plunket). As part of a focus on improving access for Pacific youth, links were made with groups such as the Kapi Mana Pacific Network, Pacific Youth Ambassadors, and others through the Porirua City Council Pacific Advisor. Links were also made with Community Networks Wellington (a network of social services sector organisations and community groups).

Multidisciplinary Team (MDT)

In October 2019, discussions were initiated with the Mental Health, Addictions, and Intellectual Disability Service (MHAIDS) to develop referral pathways to specialist services and to consider the establishment of a Piki MDT for clients with more complex needs. This development process was paused during the COVID-19 lockdown but was quickly re-activated with an initial meeting held in late June 2020 (without referrals). The purpose of the team was to assist practitioners with advice regarding medication, social support, and other services for Piki clients who require extra support. Partner organisations were invited to refer clients. VUW also have their pre-existing own MDT team with a visiting psychiatrist once a month and a monthly meeting with the Community Mental Health Team and were thus less likely to use the Piki MDT.

Hauora (Wellness) Plan

A Hauora (previously known as 'Wellness') plan was developed by Tū Ora in late 2019 with input from the youth reference group and team leaders from partner organisations. This was intended for use by therapists (and possibly peer supporters) in a final session with clients, although it was noted that it may also be of use during a course of therapy or other support. It was described by Tū Ora as 'a strengths-based tool that is designed to help people understand what is important to their wellbeing and identify what wellbeing looks like for them and what will help when times are tough'.[e] It was developed within in the framework of *Te Whare Tapa Whā*. A plan to add it to the Piki website did not eventuate but it was made available through the Melon app from June 2020. Given that many clients do not have a clearly identified final session, therapists were encouraged (in the Operations Manual) to email the plan to exiting clients or to point them to the plan on Melon. The plan also gives a list of other support services (including Melon and 1737) at the end, as well as noting that rangatahi can return to Piki at any time by self-referring through the website or asking a GP for referral.

e Minutes of Youth Reference Group Meeting 2 October 2019

3.6 BRANDING, PROMOTION AND MARKETING

The compressed project timeframe for Piki necessitated both an unusually rapid development of branding, and a progressive rollout of social marketing and engagement activities as each new service component or provider came on-stream rather than a single official launch preceded by comprehensive consultation.

In January 2019, after consultation with youth, the project was named 'Piki'. The te reo Māori meanings of *piki* are (Verb): 1. 'to come to the rescue or support of another'; 2. 'To ascend'; Noun: 1. 'To be a supporter, helper'; 2. 'success'. An advertising/PR company, Befly.co.nz, were contracted to develop branding documents, within which the purpose of the project was articulated as follows:

Figure 6: Excerpt from Branding Document (BeFly.co.nz)

Our Purpose

To empower and support young adults in improving their mental wellness by removing barriers, providing guidance and tools to assist them to define self selected pathways, support networks and to navigate through challenges.

The official launch of Piki was held in Porirua in February 2019, followed by another launch at Victoria University of Wellington in May 2019, coinciding with the launch of the Piki website. Following these more high profile launches, there were more low-key launches of Piki in the Hutt Valley and in the Wairarapa in August 2019. A 'celebration' was held at Tū Ora offices to launch the PeerZone component of Piki in July 2019, but there was no public launch in order to avoid overwhelming the new service in its early stages.

The development of the website for the purpose of promoting and enabling self-referral is detailed above (under 3.3).

Promotional strategies targeting Māori and Pacific

Social media marketing targeted to Māori and Pacific was initially planned for July to September 2019, once the waiting list had stabilised after the initial website launch. Due to a large spike in demand that created long waiting lists around September/October (largely driven by the student population stress levels at this time of year), this plan was put on hold.

Work was put into further developing plans for improving access for Māori and Pacific in early 2020, and while there were some delays due to the COVID-19 lockdown, Piki was promoted to these groups in a range of ways (both in-person and digital) from the second quarter of 2020.

Early in 2020, a Piki t-shirt was produced to give away at various Māori/Pacific community events. The Mental Health Service Lead for Porirua/Kāpiti at Tū Ora worked on in-person strategies for improving Pacific access, specifically in Porirua, by developing community relationships, running meetings, giving presentations at training institutions, and attending events and festivals such as Creekfest.

A youth promoter for Māori and Pacific was employed in March 2020 and (after initial redeployment to assist with COVID-19) engaged in various activities in the Porirua area including in-person promotion of Piki in churches and at a health promotion stand, as well as providing written materials with care packages for whānau sent out by Hora Te Pai and Te Rūnanga o Ngati Kahungunu iwi, and in the *Shift* newsletter to empower young women. There were plans to expand this activity to the Hutt. Digital initiatives include promotion on a Te Roopu Tiaki Rangatahi live Facebook event, and the creation of a short video to advertise Piki on the Ora Toa Mauriora Facebook. Videos were also created for students of Whitireia/Weltec in Porirua, Wellington and Petone, which included material relating to self-care for students and information about Piki, Melon and PeerZone.

As a trial, direct marketing texts were sent out in May 2020 to approximately 3000 young Māori and Pacific clients of Tū Ora in May 2020.

A digital marketing plan targeting Māori and Pacific was developed jointly by Tū Ora and HomeCare Medical, with input from the YRG in terms of content, imagery, and languages, and launched on 8 June 2020. The plan consisted of a year-long dissemination of Facebook posts (linked to Instagram) which had been written in consultation with YRG (via surveys) and translated into four Pacific languages. This was delayed by the COVID-19 lockdown. Due to problems with meeting overall demand for Piki, the sponsored Facebook campaign was paused on 8 July 2020, instead of running for a year as planned. The Facebook page remained live (although without additional posts) and community promotion and promotion of peer support continued.

3.7 DEVELOPMENT AFTER THE EVALUATION TIME FRAME

The timeframe for the evaluation of the Piki pilot encompassed the two year period from January 2019 to December 2020. We briefly note here anticipated continued developments and refinements to particular aspects of the service. These include an extension of the existing outreach and promotion programme to Māori/Pacific communities beyond the Porirua area, further rollout of DBT group therapy and changes to the website. These were already in the pipeline for the final 6 months of the pilot (as per its original timeframe).

As of May 2021, Tū Ora and the Ministry of Health were in discussions regarding renewal of the contract for a further 18 months from 1 July 2021 to December 2022. This would allow time for Tū Ora and its partners to: address key recommendations from the evaluation report, particularly around improving equity and access for Māori and Pacific rangatahi; refresh Piki's co-design and governance structures; explore alternative/additional digital resources and tools to improve access to online wellbeing support; and work on a transition plan with Melon Health.

PART 4:
OUTCOMES & EFFECTIVENESS – PIKI SERVICE OVERALL

Part 4: Outcomes & Effectiveness – Piki Service Overall

Overall, the Piki pilot represents the ongoing success of a complex and innovative mental health programme. After 24 months of operation Piki continues to deliver comprehensive and integrated support to young adults in the Wellington, Porirua, Hutt, Kāpiti and Wairarapa regions.

The pilot has shown that it is feasible to transition from an existing platform of primary mental health service delivery involving multiple partners to an integrated service model, and to progressively introduce and sustain significant innovations.

Service users gave very positive feedback about the support they received through Piki, both in interviews and survey responses. A number identified the existing youth mental health system outside of Piki as underfunded and overstretched, making access to support extremely difficult. They affirmed the value of the original intention of Piki as a free, easily accessible service, and that it was highly desirable to keep Piki going beyond its pilot stage.

Many stressed the importance of having services such as Piki widely available and were grateful for any and all support they were able to receive. Some clients identified the presence of mental health professionals and/or peer supporters in their lives as being instrumental to positive mental health outcomes and recovery from mental distress.

All clients had constructive feedback and suggested areas for improvement and enhancements. Clients also expressed that they welcomed the opportunity to give feedback for the purpose of evaluation. This suggests that young people have an interest in directly influencing their own mental health care – a principle the Piki project should continue to uphold through the ongoing process of co-production, as this service continues, or as similar services are rolled out in future.

Although there were inevitably some clients with negative experiences, the client survey results showed that overall Piki was seen as useful for young people, as assessed by the numbers who would recommend it to others. In terms of overall client satisfaction with the service, from the survey 75% were quite or very likely to recommend Piki to a friend, as shown in Table 13.

Table 13: Likelihood of recommending Piki to a friend

HOW LIKELY ARE YOU TO RECOMMEND PIKI TO A FRIEND? (N=631)	N	%
Very likely	290	46.0%
Quite likely	182	28.8%
Somewhat	56	8.9%
Neutral	69	10.9%
Not at all	34	5.4%

4.1 DESIGN AND MANAGEMENT PROCESSES

The design of the service was determined to a large extent by the parameters set out in the original Request for Proposals from the Ministry of Health, and secondly by the proposal put forward by Tū Ora and the University of Otago. Significant elements introduced to the pilot service by the team awarded the contract were the peer support offering and co-design processes with service users and youth. Through a process of continuous improvement, 90-day reviews and input from the evaluation, the service has developed throughout the pilot period.

Two major factors impacted the design processes and how changes were able to be introduced: the design constraints mentioned above and time constraints that resulted from the compression of the timeframe.

The design constraints were mentioned by some as limiting the potential for true innovation:

> *it might be useful to look at how useful was it to have those very set requirements and did they benefit the development of Piki and the innovation and the codesign aspect or did they hinder it.* (PK06)

> *I sometimes worry that when the Government talks about investing more in mental health, I worry that its investing more in the same systems that don't work and I think we need to have more like different services and diversity of services, that's important to me, whether that's peer support or Kaupapa Māori or stuff like that, that it's not just putting more money into the same things.* (Peer supporter focus group)

The tight timeframe was mentioned by many informants, and that the required fast pace that this involves runs the risk of not being able to achieve all the aims of the project:

> *I've worked on a lot of projects and that one has been quite fast.... the risk from that is maybe missing out some key things when you go too fast, some key parts of that project.* (PK14)

> *Take it a bit slower, take the formative stages a bit slower. It was described as a plane taking off before it was actually properly built. (PK87)*

One key focus of the project, the focus on equity, was delayed in implementation. (See 4.4).

One way in which the design constraints and timeframe intersected was the use of existing platforms as the basis for the service. This approach has benefits in terms of enabling rapid implementation but can be challenging and limit innovation, especially when working with a service that is continuously operating:

> *changing a service and how it works is a process – and it does require flexibility from people working in those roles and it can be difficult when there's already clients in the mix.* (PK41)

The on-going design and management processes to implement and further develop the pilot service were always going to be complex given the number of partner organisations involved. In addition to the partner organisations, there were five committees or groups set up to contribute to the design, management, and oversight of the service (see 3.1). There was some feeling that this may have been an overly complicated structure in which the roles of each group were not always clear and appeared to overlap. This was reflected in the shifting terminology for naming the various groups, though this did become more consistent over time, as the terms of reference and relationships between the groups were reviewed and refined.

> *an operations meeting ... discusses the same things as ... the clinical meeting and the same things that the governance meeting discuss – but with different people around the table with slightly different takes on what's going on.* (PK01)

Over time, lines of communication and clarity of roles of the groups improved, but some may still question whether the complexity of the structure is optimal.

Communication between multiple organisations and multiple governance, operational and reference groups is also inherently challenging. However, the overlapping membership of some groups, while potentially confusing, also had the advantage of supporting communication between the groups.

Co-design

These issues of timeframe and design constraints also impacted on the implementation of the intended element of co-design.

Whether or not the processes followed within Piki constituted true co-design was questioned by many involved, and the time constraints were a large part, but not the only aspect, of this:

> *this project has moved under immense time pressure and I think proper codesign needs potentially a larger timeframe to really expand and kind of get the most out of it.* (PK13)

> *if you want to travel fast, travel alone.* (PK14)

There was general agreement that in an ideal world, true co-design means starting from scratch. This ideal conflicts with the pragmatic imperatives of efficiencies to be gained by building on existing services and the inherent constraints in the funding models. Many of those involved in the development of Piki also accepted the inherent limitations on the extent to which 'true' co-design could be enacted because of these constraints.

That said, there was a lack of transparency with the youth and service user groups about the nature and extent of their contribution to Piki. It was noted that the constraints on the degree to which co-design could occur were not well communicated, at least at first, despite acknowledgement of these in some Tū Ora documents from the outset.[49]

> *we probably weren't getting the message across clearly enough that we're codesigning within these parameters.* (PK38)

> *the amount of codesign, that's not the issue, it's just about being up front and really clear about what the expectations and limits were from the different parties involved.* (PK33)

This led to some discontent among both youth reference groups who commented on feeling that they were not heard when it became clear to them that fundamental aspects of the proposed model of care had already been decided. On other occasions, there may have been other reasons for the lack of responsiveness to input, but these were not communicated well.

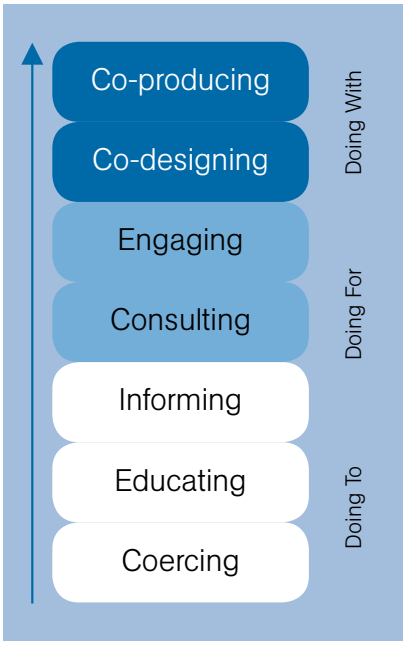
> *sometimes people get really frustrated in this group because they feel like their stuff is not quite being used but there's a reason for it. But they don't quite get told that stuff.* (PK40)

Another limitation was the degree to which the youth/service user group members could usefully provide input about innovative elements of the service of which they had no direct experience (e.g., the Melon app, peer support, telehealth). For example, views on and expectations of telehealth were changed to some degree during the COVID-19 lockdown when many service users and providers used this medium out of necessity and were pleasantly surprised in many cases.

YRG members expressed frustration that they were being consulted on what they considered minor points or on decisions that had already been made, and a concomitant desire for more workshop-style sessions where they could work in partnership on substantive issues. The YRG were frequently consulted on the Melon app, despite having expressed a view in focus groups that they considered this a relatively low priority element of the service and this also led to some frustration, especially when changes to the app that they favoured were reportedly unable to be implemented by the provider.

There were different understandings of the nature of co-design and co-production from the outset, reflected in the different terms used at times. The terms 'co-design' and 'co-production' were initially most prominent in the evaluation plan of the Proposal Response Form, and were then picked up by the service providers (e.g. in a newsletter to providers)[50] but the terms 'feedback' and 'input' were also often used elsewhere, implying more of a consultation framework.[51] The conflation of these terms conflicts with the definition of co-design as qualitatively different from consultation, as shown in Figure 7 which shows a model by Slay & Stephens (2013), (p.4, Figure 1).[52]

Figure 7: "An alternative 'ladder of participation'" (Slay & Stephens (2013), p.4)



Who should be involved in co-design or consultation?

Whatever the degree of participation, it is crucial to consider who exactly should be engaged with, when designing and moulding a service, an issue which was raised explicitly or implicitly in various ways.

Both youth and other key informants acknowledged the importance of youth involvement in this youth-focused service. One service provider noted:

> *it's incredibly important that we design this in a way that works for young people, and the only way really we're going to do that is by really really hearing that voice.* (KI-PK07)

This also has implications for the effective use of resources, as noted by a YRG member:

> *a lot of campaigns launched on mental health are so well meaning and [have] so much resources poured into them but just miss the mark entirely because they're just ... tweaked.* (KI-KI03c – focus group)

However, age is only one dimension of the people for whom the service was intended to provide an improved and more accessible service. Piki's intended focus on improving access for various under-served populations, including Māori and Pacific, also implies that co-design with iwi and other groupings would have been appropriate. The approach taken within Piki was to seek representation of these groups (particularly Māori, Pacific, and Rainbow) on the various governance and reference groups (see 4.4 below on Equity) but this meant that input was at a high level from a limited number of individuals, rather than involving more grassroots input. Some therapists also expressed dissatisfaction with the timing and level of their input.

Logistics of implementation

Even when there is transparency around the level of input, and the appropriate groups are engaged with, there are many practical considerations regarding how this kind of co-design process is carried out. The experience within Piki has highlighted the following issues:

- **The size and representativeness of the group membership**

  It was noted that the smaller SURG group made it more conducive to active participation, whereas the larger YRG was able to have a wider range of youth represented, although there was initial criticism that the membership was skewed towards students and those in the Wellington central area

- **Meetings with service providers and users together versus separate meetings**

  While some saw the latter as working in silos (making it difficult to come to a consensus between the different parties), others noted the danger that power dynamics may result in youth/service users having less influence if they work directly with providers. However, from a service user point of view, these systematic inequalities are something to be aware of and worked against by consciously giving opportunities for those in less powerful positions to be actively and meaningfully engaged and involved.

  Inclusion of service users (peer supporters) in the clinical/practitioner advisory group also met initial resistance from some members (although others were very supportive) based on a perception that 'clinical experience' was required without acknowledging that service users do have relevant experience, albeit from a different angle.

- **The location of meetings**

  Choice of venue for co-design meetings is more consequential than may at first be thought. Initial meetings held at the Tū Ora offices were felt by some YRG members as denoting more of a sense of partnership:

  > *you were actually in the same room with the officers all the time, ... at Tū Ora.* (KI-KI03a – focus group)

  Others felt that relaxed settings such as the rooms at Evolve were more conducive to people feeling comfortable to contribute:

  > *less formal clinical settings...[created]...a more collaborative creative style of ... environment.* (KI-KI03a – focus group)

  Meeting locations can also affect inclusiveness. After the first few YRG meetings, most were held at Victoria University of Wellington, effectively favouring VUW students. SURG members also noted that more disability representation was required, and more attention to the needs of marginalised groups (e.g., gender neutral toilets, wheelchair access, parking etc).

Efforts were made to accommodate the expressed, sometimes divergent, preferences of different group members, and a revised strategy for YRG meetings from the second half of 2020 was adopted to address barriers to attendance through use of Zoom for some meetings and rotating locations for others. One drawback of the remote meeting option is the limitations on what can be achieved in such a forum with a relatively large group and the issue of 'Zoom fatigue'.

- **The length and frequency of YRG meetings was initially perceived as problematic**

  The relatively short length of meetings was felt to compromise in-depth discussion, and the two month interval between meetings was felt to be too long. It is unclear whether the changes to the running of this group have overcome this issue.

- **Communication modes and processes**

  There was a perceived lack of feedback from Piki management on input from the YRG to explain the degree to which that input had been implemented and why (although part of the problem may have been how feedback was delivered). This led to a feeling that the same YRG feedback was being given repeatedly.

  Communication about how the pilot was operating was also perceived as lacking. These concerns were exacerbated by the initial high turnover of project leadership at Tū Ora resulting in the need for repeated relationship building.

  Reaction to electronic communication between Piki leadership and YRG was mixed. While emails were acknowledged as a useful way to receive resources and to provide extra feedback, the use of surveys and emails in between meetings to mitigate their relative infrequency received some negative reactions about feedback through these modes being more limited.

  Nevertheless, communication was felt to have improved over time, including the creation of a Facebook group to facilitate communication and the circulation of a paper outlining the impact of the YRG on Piki developments.

- **Confusion about the roles of the two groups (YRG and SURG)**

  The existence of two groups (YRG run by Tū Ora, and SURG run by the University of Otago) was confusing for many involved with Piki, including the group members themselves, especially given overlapping membership.

Summary

While Tū Ora positioned the co-design element of Piki as being with young people (rangatahi), it is important to consider whether other relevant community groups (particularly Māori and Pacific where these are target groups) should also be involved in this process, notwithstanding recent efforts to ensure that the youth reference groups have appropriately diverse membership.

Clear communication about the parameters of any co-design is essential, as well as ongoing feedback loops that inform partners about the reasons underlying how suggestions are or are not responded to.

A further challenge for co-design within Piki related to innovative components. It can be difficult for all those involved (funders, managers, providers, users, reference groups) to contribute to effective design and determine appropriate resource allocation when they have limited experience or pre-knowledge of what these innovative elements might entail; a natural inclination to make assumptions needs to be avoided.

Finally, co-design needs to be given sufficient time and resources to be carried out, and the logistical details of how processes are implemented need to be carefully thought through to avoid unintentional consequences.

Co-design is increasingly recognised as a very potent source of innovation and empowerment across many areas of health care, and particularly in mental health. Efforts in this direction have been a significant and commendable feature of Piki in project development and ongoing evolution of both service delivery and project evaluation. This has highlighted both the feasibility of incorporating elements of co-design, and the challenges of achieving this in a meaningful and sustained way.

We recognise that there can be inherent tensions between the advantages of centrally designed projects and transition from existing services, compared with a more grassroots co-design and community engagement model with its attendant unknowns in terms of cost and time needed for development. Meaningful and transparent co-design or collaborative design with service users and communities from different stakeholder groups will be important as part of rollout and scale up. This should involve those that face most disparities and inequities and have due regard to local contexts. This is in keeping with findings of the 2021 report of the Initial Mental Health and Wellbeing Commission.[37]

4.2 OVERALL SERVICE UTILISATION

This section presents quantitative data on Piki service users extracted by Tū Ora Compass Health (Tū Ora) from their IT system as collected directly by, or supplied to, Tū Ora from each of the organisations involved in the Piki Service (Te Awakairangi PHO, Victoria University Counselling, Ora Toa Melon, Puāwaitanga, PeerZone, Explore and Homecare Medical).

This section includes Piki enrolments, service utilisation, non-attendance rates, and a description of the psychological measures completed by Piki clients. It covers the period 1 January 2019 through to 22 December 2020 (two calendar years). The close of this evaluation period was chosen to allow time for data analysis prior to the reporting deadline of 31 March 2021. Note that December 2020 data only covers up until 22 December as most services do not see service users beyond this time due to the Christmas/New Year shut down period.

There were 5307 individuals (excluding Melon only enrolees) who accessed the Piki service for the two years up until the end of December 2020 (2090 in 2019 and 3217 in 2020). The aspirational objective of the Pilot was to see 4,500 young people per year (as per the Charter).

Piki Enrolments (first session)

The most consistent data point to use for entry into the service is the date of each individual's first therapeutic session (e.g., counselling, phone counselling, peer support etc). This use of 'first session' data has implications for interpreting the enrolment tables and figures below as they are currently not based on the very first contact (sign up) with the Piki service. The term 'enrolment' will be used however, to mean first therapeutic session.

As the Piki service was developed on the back of existing primary mental health services, the initial figures for 'enrolment' are based on business as usual with additional funding, prior to the establishment of the new components being added to the service, such as the digital app, peer support and phone counselling. (See the timeline in section 3.2 for when these components were added).

Table 14 shows the Piki enrolments over time from January 2019 (start of service) until December 2020; these are shown graphically in Figure 8. It is impossible to know from the data we have received how many clients were discharged and then re-entered the service during the period, so each Piki client only appears once in Figure 8 and Table 14, even if they re-entered the service. (There may therefore be a small undercount of total client enrolments).

Figure 8 generally shows a steady increase in new Piki clients each month. There is a sharp increase in the second half of 2020, most likely due to a change in data collection methods where from June 2020 all Victoria University Counselling service users were included as 'Piki clients' (previously this had not been the case). It may also reflect an increase in referrals due to Covid-related issues.

Table 14: Piki Enrolments from start of service to Dec 2020

MONTH	COUNT OF NEW ENROLMENTS IN MONTH	QUARTERLY TOTAL OF ENROLMENTS
Jan -19	142	
Feb-19	102	
Mar-19	182	426
Apr-19	162	
May-19	240	
Jun-19	201	603
Jul-19	192	
Aug-19	200	
Sep-19	185	577
Oct-19	211	
Nov-19	166	
Dec-19	107	484
Jan-20	109	
Feb-20	171	
Mar-20	211	491
Apr-20	179	
May-20	163	
Jun-20	229	571
Jul-20	577	
Aug-20	427	
Sep -20	456	1460
Oct-20	327	
Nov-20	239	
Dec-20[3]	129	695
Total		**5307**

[3]Data for this month up until 22 Dec 2020 only

Figure 8: Cumulative Piki enrolments over time

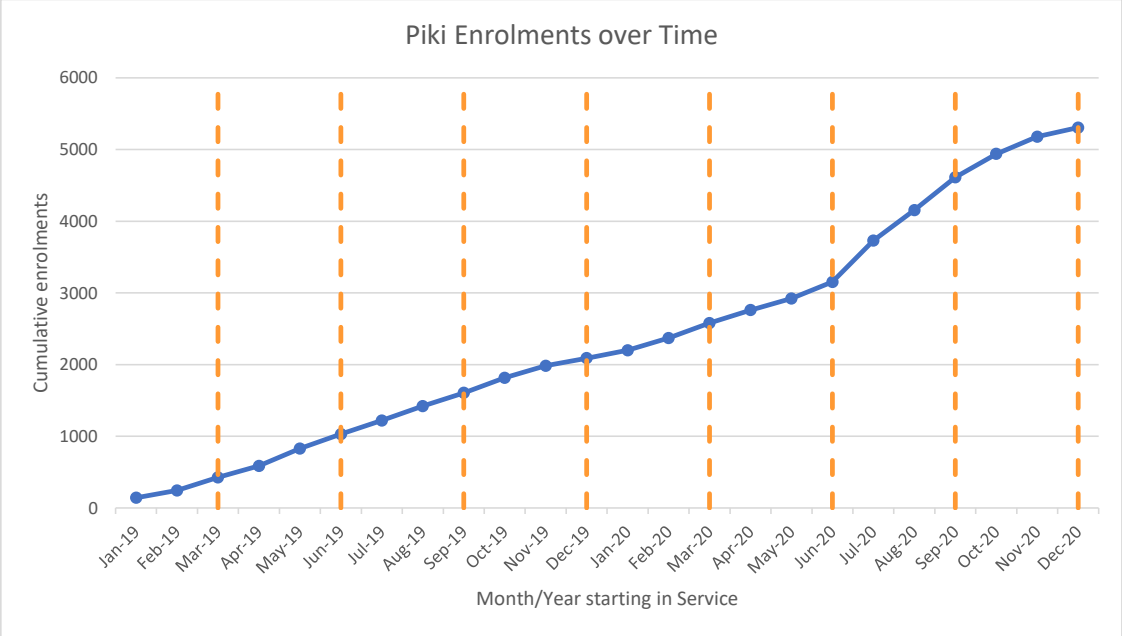
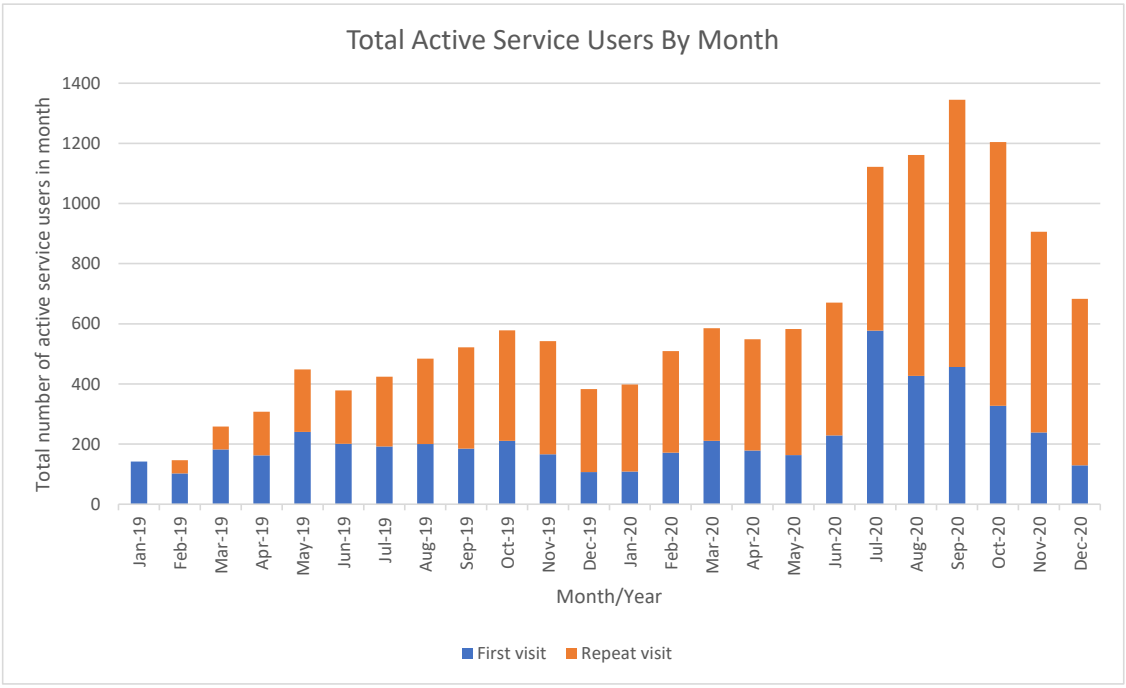


Figure 9 shows the total number of 'active' service users engaged with Piki per month from January 2019 to December 2020. (Active users = current users minus those who have been discharged from the service or who have not used any services for 3 months). There appears to be a peak in May 2019 (possibly coinciding with the Website launch which allowed people to self-refer for the first time and also the Victoria University launch). This is followed by a steady increase then a marked drop off coinciding with tertiary education summer holidays. Numbers start to increase again in February 2020 and then there appears to be a slight drop off around the time of the COVID lockdown. Service use increases again over April, May, June with a sharp rise in July, again possibly due to the change in data counting for Victoria students.

Figure 9: Active service users by month January 2019- December 2020



Service utilisation – January 2019-December 2020

The following tables and figures report on unique individual service users who used the Piki Service.

Table 15 describes the characteristics of service users and compares them with those resident in the area based on 2018 Census data. The majority were female (65.3%) and European (69.9%). Priority populations for Piki (i.e., Māori 13.7% of service users; and Pacific 3.5% of service users) were engaged at levels below the population share of these ethnicities (17.4% and 8.0% respectively based on Wellington region 2018 census data for this age group). The deprivation levels (based on NZ Deprivation quintiles) of service users show a fairly even spread across levels 1-4 with deprivation level 5 (the most deprived), being seen the least, although this is consistent with population levels.

Table 15: Demographic characteristics of Piki clients (Unique Individuals n= 5307)

DEMOGRAPHIC CHARACTERISTICS	COUNT	%	DEMOGRAPHIC CHARACTERISTICS OF YOUNG PEOPLE IN THE REGION[1] N (%) TOTAL N = 58,956[2]
Gender			
Male	1589	29.9	28,981 (49.2)
Female	3468	65.3	29,975 (50.8)
Gender Diverse	8	0.2	N/A
Unknown	242	4.6	N/A
Ethnicity[2]			
European	3710	69.9	35,254 (59.8)[3]
Māori	725	13.7	10,261 (17.4)
Pacific	184	3.5	4,734 (8.0)
Asian	342	6.4	7,664 (13.0)
MELAA[3]/Unknown	346	6.5	1,043 (1.8)
Quintile[4]			
1 least deprived	994	18.7	11,664 (19.8)
2	936	17.6	11,613 (19.7)
3	1014	19.1	13,839 (23.5)
4	1104	20.8	12,665 (21.5)
5 most deprived	769	14.5	9,148 (15.5)
Not known	490	9.2	N/A

1 Based on Statistics New Zealand 2018 census data by Wairarapa, Capital and Coast and Hutt Valley DHB area
2 Total for NZ Dep quintiles is lower (n=58,929) due to random rounding
3 Includes MELAA (Middle Eastern, Latin American, African)

Table 16 describes how many individual service users accessed each Piki service. As Melon is a self-access adjunct to the therapy and peer support services offered by other Piki providers the total number of enrolled service users for Melon has been listed separately and is not included in the total count. Melon enrolment numbers will include people who only enrolled and did not visit the app again, through to those who used the app on a regular basis (we have no individual level data on the extent of Melon use).

Table 16: Unique Individuals accessing each type of Piki service (n=5307)

SESSIONS BY PROVIDER	COUNT	% DENOMINATOR = 5307
Tū Ora	2400	45.2
Te Awakairangi	548	10.3
VUW	1561	29.4
Massey	760	14.3
Ora Toa	38	0.7
Explore (Clinical psychology)	172	3.2
Puāwaitanga (Telephone counselling)	185	3.5
PeerZone (Intentional Peer Support, group and 1 to 1)	155	2.9
Melon Enrolment[1]	1669	31.4

Note: some people had more than one service so count column equals 5819
1 Not included in total count

Piki Service Use Combinations

Table 17 shows the combination of service use. The total number of individuals accessing only one service was 4970 (93.6%), with 319 people (6%) accessing two services and 18 people (0.3%) accessing three services (these figures do not include the Melon app). Although most service users accessed one service, we do not know how many service users wanted to use a combination of services, or to what extent (if at all) every service user knew about every service available.

Table 17: Piki Service Use Combination

SERVICE USE COMBINATION	N
One Service only	**Total = 4970[1]**
Melon Only	*207*
Explore Only	34
Peer Zone Only	31
Puāwaitanga only	86
In-person counselling only	4819
Two Services	**Total = 319**
In-person counselling + Peer Zone	104
In-person counselling + Explore	126
In-person counselling + Puāwaitanga	83
Puāwaitanga + Peer Zone	5
Explore + Peer Zone	1
Three or More	**Total = 18**
Explore/Peer Zone / In-person counselling	7
Explore/Puāwaitanga/ In-person counselling	4
Peer Zone/Puāwaitanga/ In-person counselling	7

1 Total does not include people accessing Melon

Service Use 2018 (Pre-Piki) compared with 2019-2020 (Piki)

Prior to the introduction of Piki, partner organisations Tū Ora, Te Awakairangi, Massey, Ora Toa and VUW were already providing primary mental health services to young people in this age group. To illustrate the change in services provided during the Piki pilot, the figures and tables below compare pre-Piki service delivery (2018) with Piki service delivery (2019-2020). Unfortunately, Ora Toa were not able to provide us with pre-Piki service delivery data so we have been unable to include this comparison in the figures below. In order to make accurate comparisons for VUW we have used data for all 18–25-year-olds for 2018-2020 (not just Piki service users) as the majority of 18–25-year-olds were not counted in VUW Piki data during the period Jan 2019 through to June 2020.

Figure 10 shows the number of individual service users seen by therapy providers across the three years. Tū Ora showed the biggest increase in number of service users seen, with VUW appearing to see fewer 18–25-year-olds in 2020 than in 2019.

Figure 10: Service user count pre-Piki period compared with Piki period

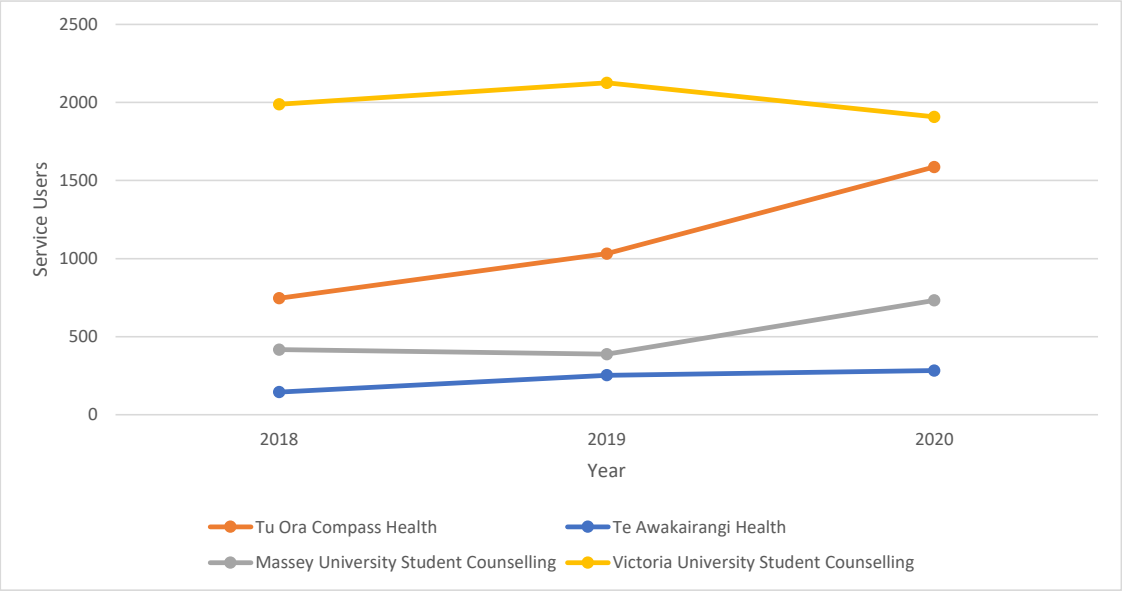
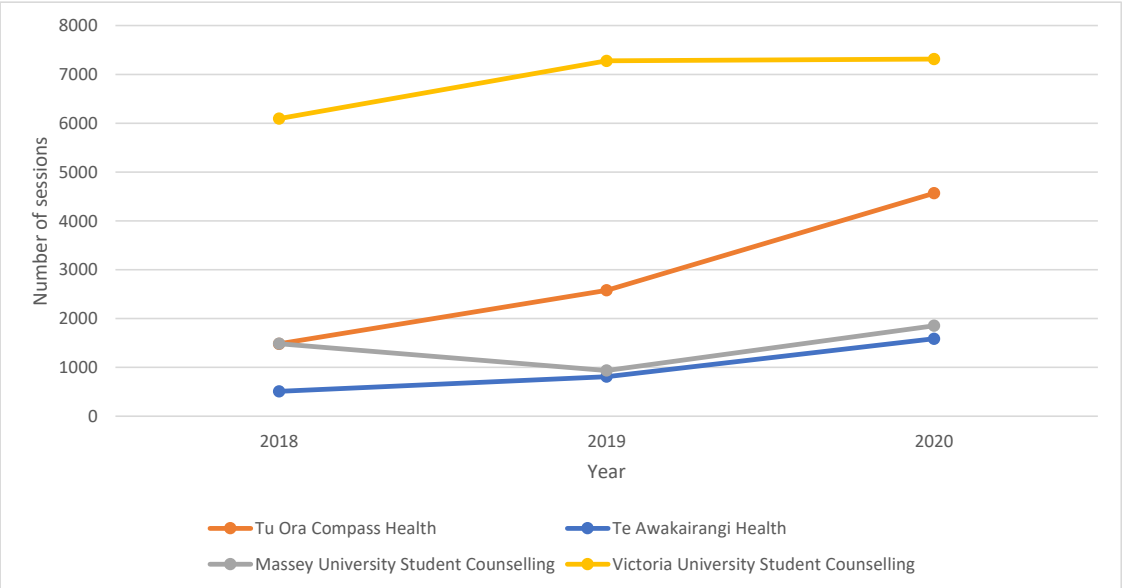


Figure 11 shows the number of sessions delivered by each therapy service provider across the three-year period. Massey appeared to be delivering less sessions in 2019 (though this is likely to be an issue with data recording), with all services delivering more sessions by the end of 2020.

Figure 11: Session count pre-Piki period compared with Piki period



Figures 12 and 13 focus on two sub-populations: Māori and males. Figure 12 shows the number of individual service users identifying as Māori who accessed therapy services across the period. Except for Te Awakairangi and Massey who both experienced a slight dip in 2019, all services show a slight upward trend in the number of Māori seen.

Figure 13 shows the number of individual males accessing Piki therapy services. For most services there was only a very slight increase in the numbers of males seen, except for Massey where numbers remained static. Piki did not appear to significantly increase the numbers of young men engaged with these services.

Figure 12: Number of Service users identifying as Māori pre-Piki period compared with Piki period

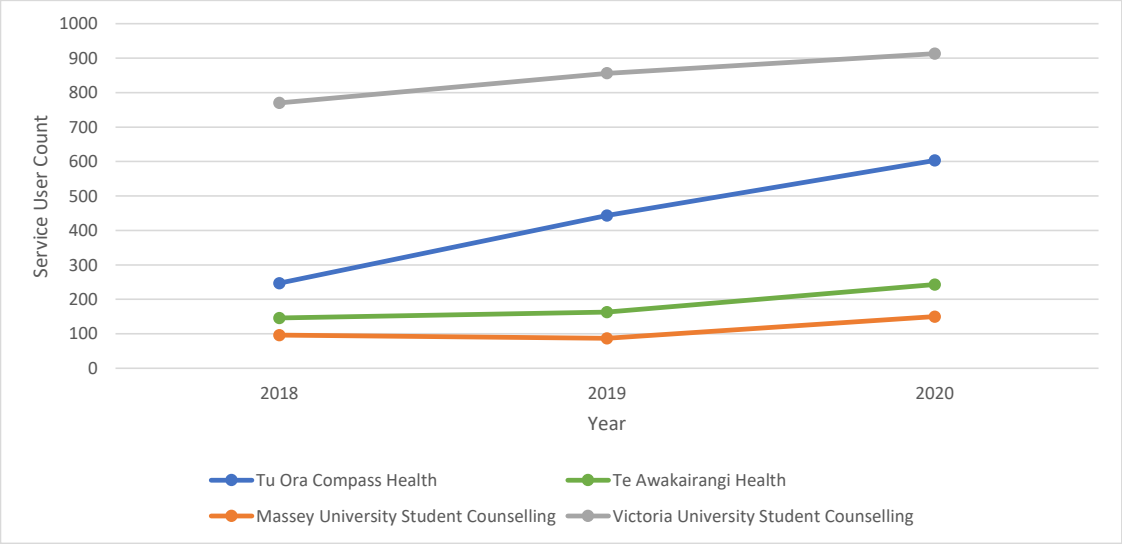
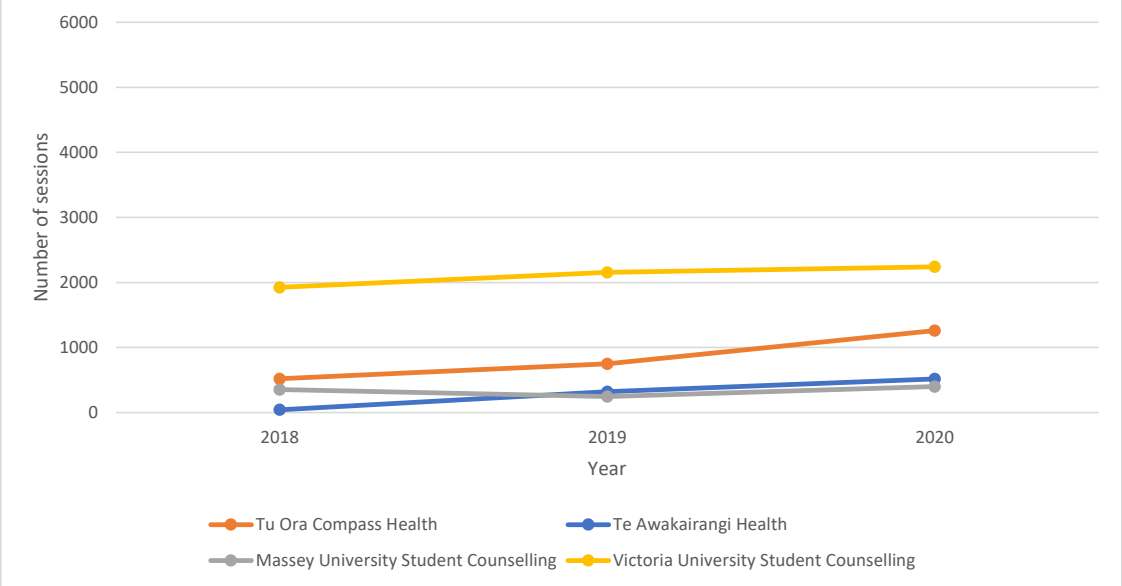


Figure 13: Number of Service users identifying as male pre-Piki period compared with Piki period



The following tables (18-21) give more detailed data for each of the four organisations providing therapy services prior to and during the Piki period. (Note that in each of these tables, the category of Gender Diverse was only collected for self-referrals via the website and was introduced only in 2020).[f]

Table 18: Tū Ora: Total visit count for psychological services provided to 18-25 year olds 2018 - 2020

TŪ ORA COMPASS HEALTH	TOTAL 2018 (PRE-PIKI)	TOTAL 2019 (FIRST YEAR OF PIKI)	TOTAL 2020 (SECOND YEAR OF PIKI)
Unique Individuals	746	1032	1587
Total Sessions	1483	2579	4566
Gender			
Male	520	748	1260
Female	960	1776	3233
Gender Diverse	-	-	16
Unknown	3	55	57
Ethnicity			
NZ Māori	247	443	603
Pacific	83	76	122
Asian	98	133	277
MELAA	10	14	48
European	1018	1852	3398
Not known	27	59	115
Deprivation Quintiles			
1 Least deprived	360	607	1004
2	350	547	924
3	283	529	927
4	270	439	819
5 Most deprived	191	336	430
Not known	29	121	560

f Note also most GP patient management systems only have binary gender fields although this will be changing in the future in line with Ministry of Health guidelines from June 2020.

Table 19: Te AHN: Total visit count for psychological services provided to 18-25 year olds 2018 - 2020

TE AWAKAIRANGI HEALTH	TOTAL 2018 (PRE-PIKI)	TOTAL 2019 (FIRST YEAR OF PIKI)	TOTAL 2020 (SECOND YEAR OF PIKI)
Unique Individuals	145	253	380
Total Sessions	509	811	1587
Gender			
Male	42	320	517
Female	375	473	1032
Gender Diverse	-	5	6
Unknown	-	13	32
Ethnicity			
NZ Māori	146	163	243
Pacific	45	29	66
Asian	16	47	60
MELAA	13	5	15
European	280	557	1195
Not known	9	10	8
Deprivation Quintiles			
1 Least deprived	87	175	256
2	69	127	291
3	132	148	255
4	101	161	459
5 Most deprived	118	171	248
Not known	0	29	78

Table 20:Massey University: Total visit count for counselling services provided to 18-25 year olds 2018 - 2020

MASSEY UNIVERSITY STUDENT COUNSELLING	TOTAL 2018 (PRE-PIKI)	TOTAL 2019 (FIRST YEAR OF PIKI)	TOTAL 2020 (SECOND YEAR OF PIKI)
Unique Individuals	417	388	732
Total visits	1,486	935	1852
Gender			
Male	355	246	400
Female	1131	767	1278
Gender Diverse	-	-	-
Unknown	0	98	186
Ethnicity			
NZ Māori	96	87	150
Pacific	22	20	38
Asian	89	66	146
MELAA	13	15	36
European	1230	828	1297
Not known	36	93	197

Note: Massey does not record deprivation scores for students, so this is unable to be reported.

Table 21: Victoria University: Total visit count for counselling services provided to 18-25 year olds 2018 - 2020

VICTORIA UNIVERSITY STUDENT COUNSELLING	TOTAL 2018 (PRE-PIKI)	TOTAL 2019 (FIRST YEAR OF PIKI)	TOTAL 2020 (SECOND YEAR OF PIKI)
Unique Individuals	1988	2126	1908
Total Visits	6094	7278	7313
Gender			
Male	1925	2154	2240
Female	4169	4942	4941
Gender Diverse	-	-	-
Unknown	0	182	132
Ethnicity			
NZ Māori	770	856	913
Pacific	234	311	234
Asian	759	884	935
MELAA	102	107	170
European	4158	4974	5019
Not known	71	146	42

Note: Victoria does not record deprivation scores for students, so this is unable to be reported

Table 22 below shows a breakdown of service use by ethnicity with confidence intervals. In-person counselling was accessed most often (by 97% of service users) compared to the other services. Other services were relatively rarely used (e.g. Peer Zone service use was <3% overall), though for Peer Zone there was some evidence that Asian (5.6%) and Pacific (4.9%) service users had higher rates of access to Peer Zone than the service user group as a whole (2.9% access).

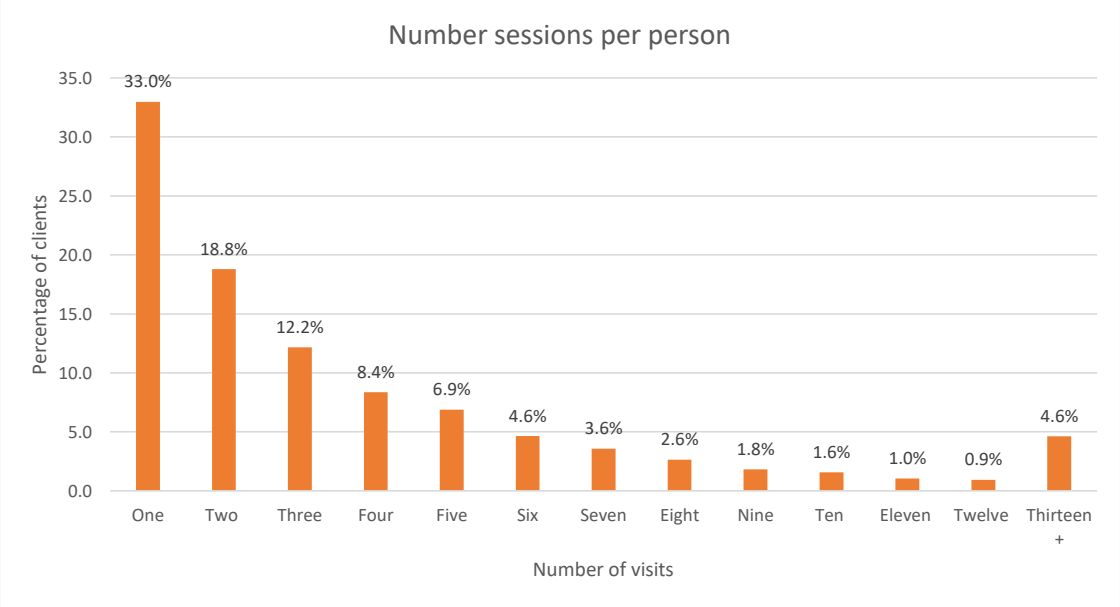
Table 22: Proportion of each ethnicity using a particular service

SERVICE USE BY ETHNICITY		MĀORI	PACIFIC	ASIAN	EUROPEAN	OTHER (MELAA, UNKNOWN)	TOTAL USE (ALL ETHNICITIES. PER SERVICE)
Total N		**725**	**184**	**342**	**3710**	**346**	**5307**
In-person counselling	N (%)[1]	709 (97.8)	178 (96.7)	332 (97.1)	3694 (99.6)	337 (97.4)	5150 (97.0)
	CI	96.4-98.7	93.0-98.8	94.7-98.6	99.3-99.8	95.1-98.8	96.6-97.5
Explore	N (%)	25 (3.4)	1 (0.5)	9 (2.6)	133 (3.6)	3 (0.9)	172 (3.2)
	CI	2.2-5.1	0.01-3.0	1.2-4.9	3.0-4.2	0.2-2.5	2.8-3.8
Puāwaitanga	N (%)	22 (3.0)	7 (3.8)	14 (4.1)	139 (3.7)	3 (0.9)	185 (3.5)
	CI	1.9-4.6	1.5-7.7	2.3-6.8	3.2-4.4	0.2-2.5	3.0-4.0
Peer Zone	N (%)	16 (2.2)	9 (4.9)	19 (5.6)	108 (2.9)	3 (0.9)	155 (2.9)
	CI	1.3-3.6	2.3-9.1	3.4-8.5	2.4-3.5	0.2-2.5	2.5-3.4

1 Denominator for % is total count of each ethnicity

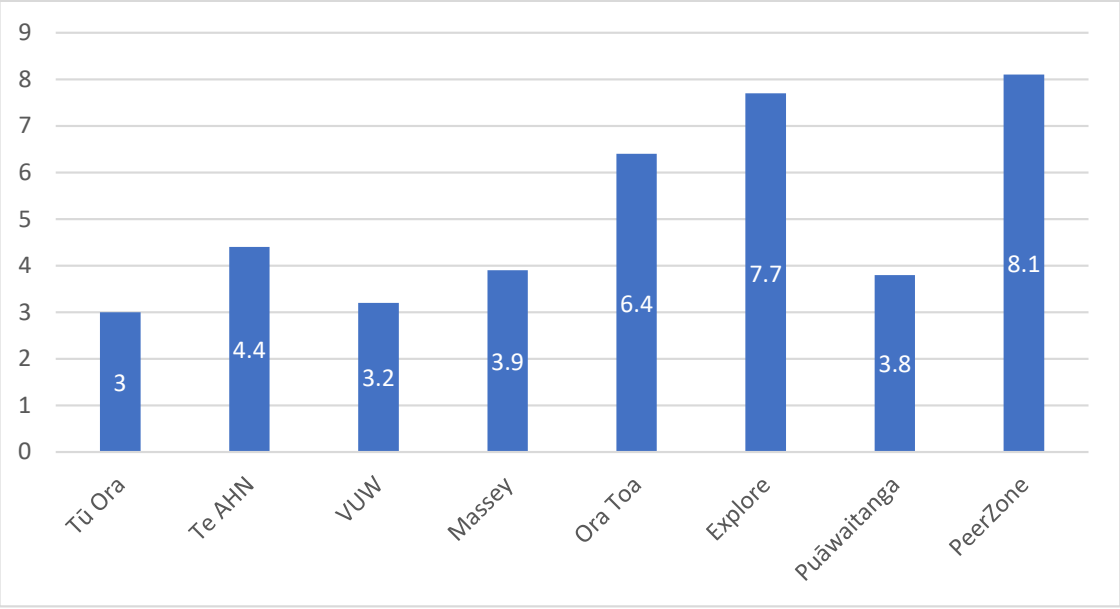
Figure 14 shows the number of sessions per person. The majority of Piki clients had between one and three sessions, with 33% having only one session. A substantial minority of service users (4.6%) had 13 or more sessions. This figure should be interpreted with caution. As the Piki service is ongoing (i.e., people were still entering the service up to time of the data capture period 'closing'), there will be an overcount of those having small numbers of sessions because those who first entered the service recently would not have had time to have more than one session.

Figure 14: Number of sessions received by each Piki client



As shown in Figure 15, most therapy providers (including Puāwaitanga phone counselling) had similar mean numbers of sessions per Piki client (around 3-4), with Explore expectedly having a higher mean (being a stepped-up level of care) and Ora Toa having a high number based on a very small total number of clients. PeerZone had a higher mean number of sessions (offering peer support) per client compared to therapy.

Figure 15: Mean number of sessions per client by service



Based on Piki service user survey data various reasons were noted for people only accessing one session. (See section 5.1 for more information).

Further investigation of those who had only one visit is shown in Table 23 (using 22 November 2020 as a cut-off point to allow clients to have had an opportunity to present for a second visit). Tū Ora and Victoria University appeared to have the highest proportion of clients who only had one visit, with Peer Zone having a relatively small proportion with only one visit (16%).

Table 23: Number of Piki clients with one visit by Service

SERVICE	N	TOTAL CLIENTS[1]	% OF TOTAL CLIENTS
Tū Ora	871	2283	38.2%
Te AHN	181	538	33.6%
VUW	584	1486	39.3%
Massey	224	747	30.0%
Ora Toa	7	34	20.6%
Explore	36	164	22.0%
Puāwaitanga (Telephone counselling)	37	183	20.2%
PeerZone	24	149	16.1%

1 Up to 22 November 2020

Table 24 shows the total number of sessions delivered as part of the Piki service. A 'session' is defined as a therapeutic interaction with another person (in-person therapist, phone therapist or peer supporter). Enrolment on the Melon app does not appear in this table as there are no 'sessions' to be counted, rather just enrolment or non-enrolment by individual. Detailed information on Melon use appears further on in this report (See 5.3).

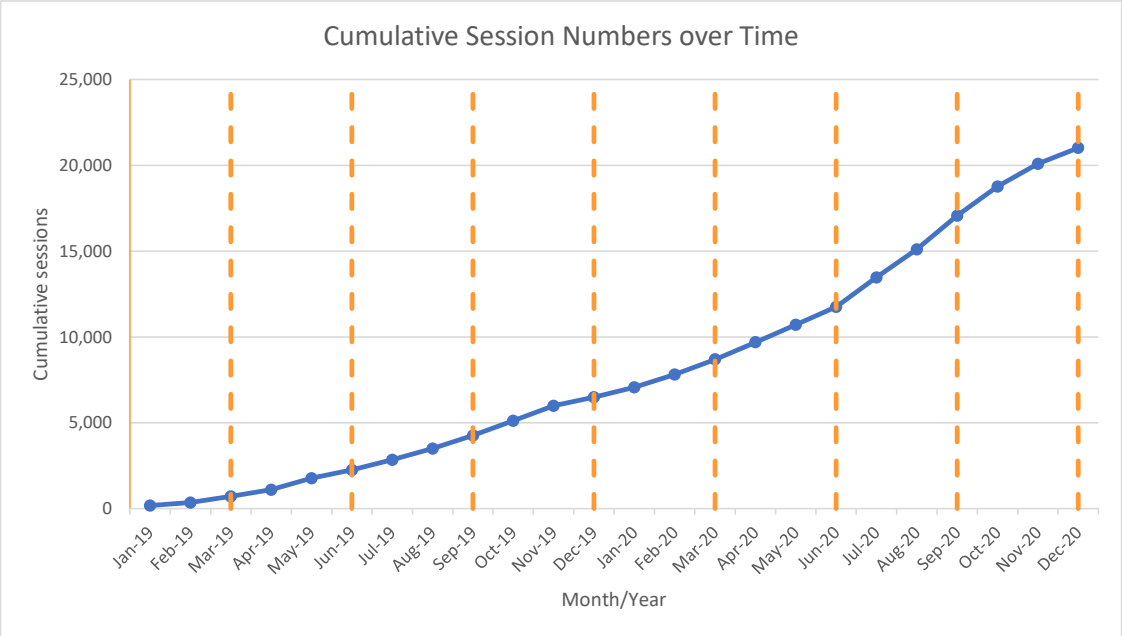
The bulk of therapy was delivered by Tū Ora counsellors as they make up approximately half of the Piki therapy workforce. Explore is a specialist service and by nature should only see a subsection of Piki clients whose needs cannot be met by standard therapy or counselling. Puāwaitanga and PeerZone services were only introduced into Piki in July 2019. Ora Toa started delivering Piki in February 2020. Sessions for all Massey counsellors have been included in this data (although there may have been some issues with Patient Management System coding in 2019). Sessions for Victoria counsellors only include Piki funded counsellors up until June 2020 and from then all Victoria counselling sessions are included.

Table 24: Total Session Count (n=21015 sessions)

SESSIONS BY PROVIDER	COUNT	% OF TOTAL SESSIONS
Tū Ora	7145	34.0
Te AHN	2398	11.4
VUW	4937	23.5
Massey	2974	14.2
Ora Toa	242	1.2
Explore (Clinical psychology)	1320	6.3
Puāwaitanga (Telephone counselling)	704	3.3
PeerZone (Intentional Peer Support, group and 1 to 1)	1252	5.6

Figure 16 shows the cumulative count of session numbers over time. Session numbers rose gradually over 2019, with a small peak in May 2019 (likely due to the website launch which enabled self-referral for the first time, and the Piki launch at VUW) and with some flattening of the curve in November 2019 – January 2020, likely accounted for by University holidays. Sessions rose steadily over the first half of 2020 with a sharper increase in the second half, again likely due to the different method of counting Victoria University students.

Figure 16: Cumulative count of session numbers over time



The following tables describe non-attendance rates by organisation and by Piki client characteristics.

Table 25 describes the total number and proportion of non-attendance rates by organisation type. Puāwaitanga appear to have proportionately the most non-attendance per total amount of appointments at 27.9%, with VUW and PeerZone having very few (8.1% and 3.0% respectively).

Table 25: Non-attendance rates 1 January 2019 – December 2020 by Service Type

SERVICE	NUMBER OF NON-ATTENDED SESSIONS	NON-ATTENDED SESSIONS AS A PERCENT OF TOTAL SESSIONS	TOTAL SESSIONS IN SERVICE INCLUDING DNAS
Tū Ora Counselling[1]	1797	20.0%	8942
Te AHN	884	26.9%	3282
VUW	436	8.1%	5373
Explore	377	22.2%	1697
Ora Toa	48	16.5%	290
Puāwaitanga	273	27.9%	977
PeerZone	40	3.0%	1292

1 This number includes Massey Student Counselling as we are unable to identify in DNA data which belongs to Newtown Union Health Service and which belongs to Massey

Table 26 describes the demographic characteristics of those individuals who had at least one non-attended session. Due to the large numbers of people with unknown demographic data it is difficult to draw any firm conclusions about which Piki clients are more likely to not attend.

Table 26: Individuals with at least one non-attended session by demographic characteristics

DESCRIPTOR	NUMBER OF INDIVIDUALS WITH > 1 NON-ATTENDED SESSION	PERCENT OF ALL USERS WITH AT LEAST ONE NON-ATTENDED SESSION	TOTAL INDIVIDUALS IN SERVICE INCLUDING INDIVIDUALS WITH A NON-ATTENDED SESSION
Total	**2173**	**37.6**	**5875**
Gender			
Female	1323	36.3	3640
Male	615	35.8	1719
Gender Diverse	6	66.7	9
Not known	229	45.2	507
Ethnicity			
European	1352	34.8	3889
Māori	350	43.3	809
Pacific	94	47.7	197
Asian	105	29.2	359
MELAA[1]	33	38.8	85
unknown	239	44.6	536
Deprivation Quintile			
1	349	33.5	1043
2	386	38.6	1000
3	394	37.0	1065
4	428	36.6	1169
5	303	36.6	829
unknown	313	40.7	769

1 Middle Eastern, Latin American, African

4.3 PSYCHOLOGICAL MEASURES

A traditional marker of mental health research and evaluation, and of service delivery has been the collection of measures of mental health and wellbeing. These measures include both baseline and ongoing measures of clinical status and 'severity', and measures to assess session effectiveness.

The collection of completed outcome measures was planned as an integral part of the Piki pilot and was important in terms of evaluation, but for a range of reasons became problematic.

A plan was developed as part of the co-design nature of Piki and from the outset involved active discussion with organisational partners and service user representation about the appropriateness and nature of proposed outcome measures.

The following measures were selected and included in the data collected for evaluation:

- PHQ-9: a nine-item self-administered scale to measure depression
- GAD-7: a seven-item self-administered scale to measure anxiety
- WHOQOL-Bref: a 26-item self-administered measure assessing overall health and functioning
- ORS (Outcome Rating Scale): a four-item self-administered scale assessing areas of life functioning over time
- SRS (Session Rating Scale): a brief self-administered scale using visual sliding scales

The GAD-7, PHQ-9, ORS and the WHOQOL-bref were chosen to be used as clinical and quality of life outcome measures and the SRS as a session effectiveness measure. The GAD-7 and PHQ-9 are also used as screening tools. They were intended to be collected as part of the Piki client journey at several points in time, with all clients being offered the opportunity to complete all measures.

Baseline PHQ-9 and GAD-7 measures were requested when clients enrolled on Melon (clients could complete via the Melon app, although therapists may have also used the measures in paper form or clients may have completed them with their GP prior to referral to Piki). During the second year of the pilot, these were also offered to new clients on the website during the self-referral process but were not required to complete that self-referral.

The baseline WHOQOL was initially only provided to clients through a link emailed separately to the client once they enrolled on Melon, but from May 2020 it was loaded directly onto the Melon platform.

Follow up measurements for the above three were intended to have been completed at discharge, but the timing of measure completion was inconsistent, based on the data received.

The ORS and SRS were intended to be completed at the end of each therapy session, with completion initiated by the therapist.

Factors Affecting Outcome Measure Completion

Choice of measure

The decisions about which outcome measures to include were based on a number of different, and at times competing, perceptions of usefulness and feasibility.

In response to strong feedback from the Piki youth service user reference group (SURG), and wider discussion with partner organisations, it was decided that outcome measures would not be compulsory.

At the start of Piki, discussion highlighted tensions between the previously accepted utility of commonly used measures such as the PHQ-9 and other measures such as the WHOQOL which is less routinely used in clinical practice. The WHOQOL was perceived as being of more value by the service user representation, but was not initially incorporated into the Melon platform.

> *I was concerned that if you didn't have the measures you can't do the analysis. I honestly believe that the sort of biomedical sort of standard kind of measures aren't helpful and people just don't want to do it. So, I can't do anything about that ... but the WHOQOL, because ...it kind of can make sense to people and for relating to people.* (KI-PK31- PeerZone)

While some service providers were concerned that the length of the WHOQOL would be reduce the likelihood of completion, completion rates for this measure were higher than expected.

There was also repeated discussion of the use of other potential outcome measures, for example tools to assess OCD or ADHD. The overall conclusion was that these should not be part of routine data collection, but could instead be used where indicated by therapists.

There was also discussion about data collection relating to alcohol and other drug use, although an initial decision to use the Alcohol and Drug Outcome Measure (ADOM) for this did not translate into long term data collection. While it was listed as a measure for use within Piki, feedback from four service provider organisations suggested it was not used or used only occasionally with Piki clients. Reasons given for not using it were lack of training, seeing it as a secondary care mental health tool, not having been advised to use it by their service, or believing that sufficient information can be gathered through kōrero to diagnose substance use problems. One person noted that they found it helpful as a motivational interviewing tool.

Practical measures and workload

At the practical level, there was a perception that there was additional work involved in trying to facilitate completion of measures, and that completion was not seen as a high priority by service users:

> *Pretty hard to get them to do it even if they're part of Piki in my experience. They just ignore the prompts and don't fill in the forms.* (Therapist focus group)

Throughout the Piki pilot, outcome measure use has been dependent on alignment with the capability of the Melon digital app. Issues that were raised included the inclusion of outcome measures within the platform (PHQ-9, GAD-7) and those that were initially only accessible by an additional link (WHOQOL), and the need for the evaluation team and service providers to review and access a 'dummy shell' of the programme. (See section 5.3)

Impact on the therapeutic relationship

A further issue which may have compromised outcome measure collection was concern over confidentiality and the need to provide assurance that the evaluation team would not receive any identifiable information about individuals.

The service user group also expressed concerns about the use of session rating scale measures potentially jeopardising the relationship with a therapist if they were negative.

One issue for future development is the time frame over which outcome measures should be agreed and implemented. In Piki it took over 6 months for the final measures to be in place, due to the need for co-design.

Further debate concerned the degree to which clinical measures might give an indication of mental health status and thus be part of risk assessment.

This was particularly drawn into focus as volumes of referrals created pressure on access to services.

> *the other part of that was building in some quick measures up front so that you can say well what's their score so that when you're doing the call you've got some information already around how they answered various questions. And that can give you the basis of risk assessment as well.* (KI-PK44 – manager)

Purpose of measures collection

There was also some resistance from therapists and clinicians to the collection of outcome measures based on a perception that it was 'for the sake of the evaluation':

> *I don't think they got on board with it in the first place and I know that the practitioners often just completely forget to allow the person to go in and do it, cos that's another ... I think that's some of it cos it's just another thing that they need to do and ... I don't think it was sold very well to the practitioners cos I think ... they take it really personally if they're not gonna get a good score, instead of it being about the session, they take it like it's about them.* (KI-KI05 – team leads)

> *also, if we have to sit down and do it with someone, it takes away time from what people want. They want counselling, they don't want to be doing these rating things.* (KI-KI05)

Some of the service delivery teams felt that collecting clinical measures did not fit their paradigm of care:

> *it's a Counselling Centre. So we don't tend to do assessments in that way on people. We don't make diagnoses. That's not what we do. We don't even have a formal assessment process with people. We assess on first sessions based on presentation.* (KI-PK84)

There were also some perceptions that users might be 'gaming' the scores in order to get more immediate access to therapy:

> *it seems people are just increasing their own scores so that they can get immediate response. So I get people scored a total PHQ9 twenty-seven and you call them and then it's like, 'I just want to ...* (KI-KI05)

Throughout the pilot there was discussion about whether other more generic measures should be used (e.g. Penn State Worry Questionnaire), and also the degree to which there should be alignment with measures that are used with more enthusiasm as part of other service delivery (e.g. the Duke questionnaire used for 'Access and Choice' settings and at Puāwaitanga).

> *Duke for everyone. It's a way more holistic, cos it kind of fits with the model. I mean GAD7, PHQ and so on are all predicated on diagnosis, whereas this model and this instrument are transdiagnostic. So the Duke is about wellbeing.* (KI-PK105)

Given the pilot nature of Piki, the project continued with the original measures. For future projects, it would be helpful to have consistency and more collective endorsement of measures to be used in particular clinical contexts and settings. It would also be helpful to have more time to communicate the benefits of using measures to therapists, along with resources allowing easier administration of measures, such as ipads.

Descriptive data for outcome measures used in the Piki pilot

Due to the limitations of the data collection, the following section presents only descriptive data for outcomes measured. Tables presenting score completion for each measure include **all** scores recorded for an individual, while only the first score for each service user for each measure is presented in the distribution figures. This is because only a small proportion of service users completed a measure more than once. It should also be noted that **first** scores were not necessarily completed at entry to the service and could occur at any point during the episode of care. The denominator for the outcome measures section is based on 5116 individuals, representing Piki clients who had first sessions on or after 1 May 2019. Melon enrolment only started on 26 April 2019, so prior to this it was impossible for clients to complete any outcome measures. GAD7 and PHQ9 were able to be completed via the Piki website as of January 2020.

GAD-7

The General Anxiety Disorder 7-item scale (GAD-7) is a tool used to screen for anxiety or to measure its severity. Scoring indications: Scores of 5, 10, and 15 represent cutoff-points for mild, moderate, and severe anxiety, respectively.[53]

Table 27 shows a summary of GAD-7 scores completed by Piki service users. Approximately 42% of Piki service users completed a GAD-7, with only a small proportion of these people completing it more than once (17.7%). The mean score was 12.4 which is above the recommended score (10) for further evaluation.

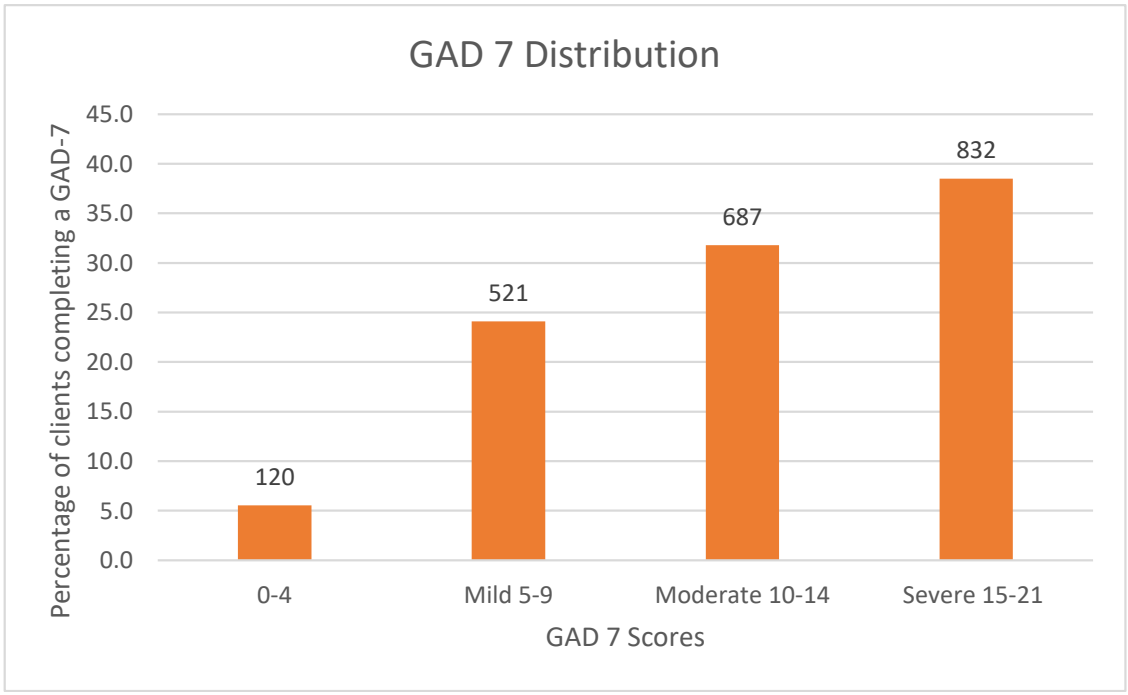
Table 27: Summary of GAD-7 score completion

GAD-7	NUMBER	PERCENTAGE
Total Scores completed	2925	-
Unique Individuals with scores[1]	2168	42.3
Completing One score[2]	1631	75.2
Completing Two scores[2]	385	17.7
Completing Three or more scores[2]	152	7.0
Mean Score	12.4	5.0 SD

1 denominator based on Piki clients from 1 May 2019 (n=5116)
2 denominator based on unique individuals completing a GAD7 (n=2168)
Note: measures not always completed at first presentation

Figure 17 shows the distribution of GAD-7 scores. For those clients who completed more than one GAD-7, only their first score appears in this figure in order to highlight distress at presentation. The majority of scores sit within the moderate and severe category, with a small number of people (n=120, 5%) presenting with relatively mild anxiety. Piki is targeted at those in the mild to moderate categories and 1208 people (55.9%) scored in this category on the GAD-7.

Figure 17: GAD-7 Score distribution



Patient Health Questionnaire (PHQ-9)

The Patient Health Questionnaire (PHQ-9) is one of the tools used to screen for the presence and severity of depression.[54] Scoring indications: score of 0-4 (minimal or no depression), score of 5-9 (mild depression), score of 10-14 (moderate depression), score of 15-19 (moderately severe depression) and score of 20-27 (severe depression).

Table 28 shows a summary of PHQ-9 scores completed by Piki clients. Approximately 42% of Piki clients completed a PHQ-9, with only a small number completing it more than one time. The mean score was 14.7 which sits in the moderate depression category.

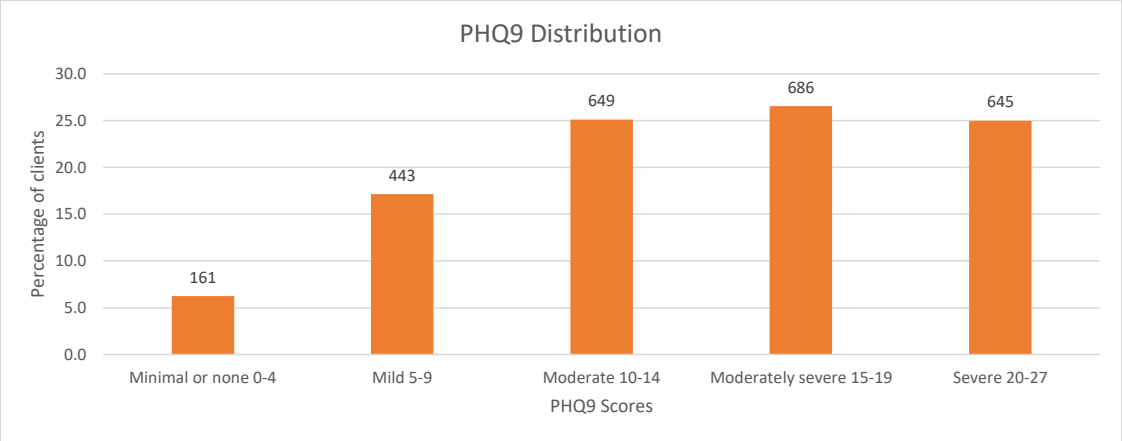
Table 28: Summary of PHQ-9 score completion

PHQ-9	NUMBER	PERCENTAGE
Total Scores	2901	-
Unique Individuals with scores[1]	2162	42.3
Completing One score[2]	1639	75.8
Completing Two scores[2]	372	17.2
Completing Three or more scores[2]	151	7.0
Mean	14.7	SD 6.2

1 denominator based on number of Piki service users from 1 May 2019 (n=5116)
2 denominator based unique individuals completing a PHQ9 (n=2162)

Figure 18 shows the distribution of PHQ-9 scores. For those service users who completed more than one PHQ-9, only their first score appears in this figure, in order to highlight symptoms at presentation. Due to data issues 47 records had to be removed as score completion dates could not be determined. The large majority of scores fell within the moderate, moderately severe, and severe categories (approximately 25% in each). The final 25% were spread across the minimal/none and mild categories.

Figure 18: PHQ-9 Score distribution



World Health Organisation Quality of Life (WHOQOL-bref) Questionnaire

The WHOQOL-bref used in Piki is a combination of two scales: 31 items from the New Zealand version of the WHOQOL-bref[55] in addition to 7 items focusing on recovery[56], making a total of 38 items. The WHOQOL-bref is intended as a quality of life measure covering four domains: physical health, psychological health, social relationships, and the environment.

Table 29 shows a summary of WHOQOL-bref scores completed by Piki clients. Approximately 11% of Piki clients completed a WHOQOL-bref, with only a small number (18.3%) completing it more than one time.

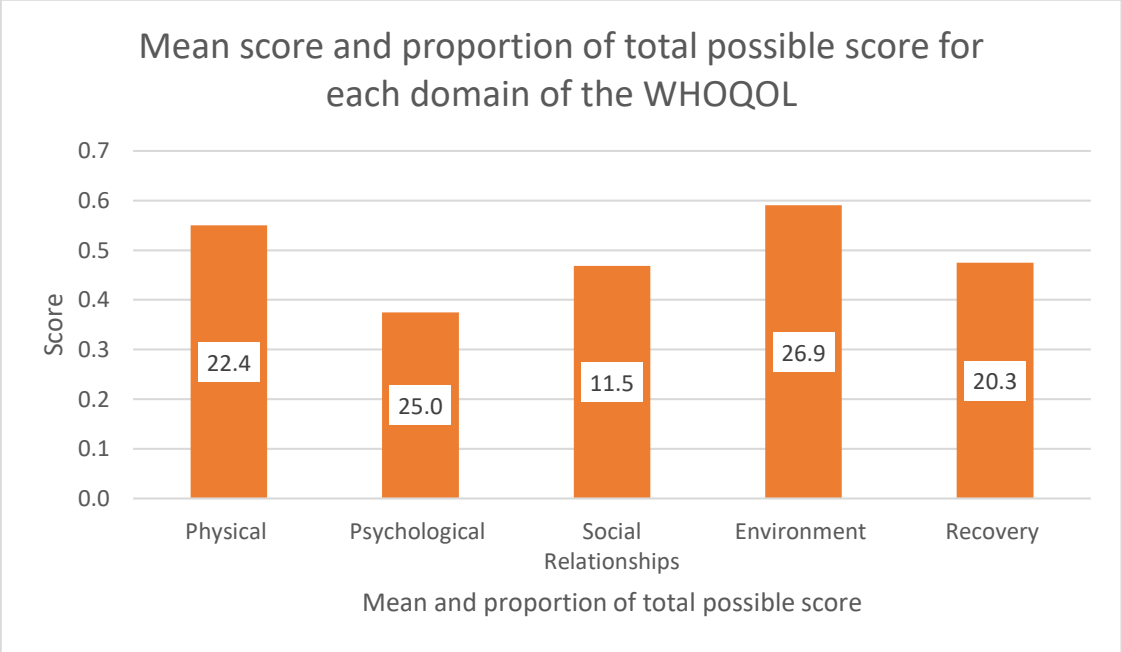
Table 29: Summary of WHOQOL-bref score completion

WHOQOL-BREF	NUMBER	PERCENTAGE
Total Scores	719	-
Unique Individuals with scores	546	10.7[1]
Completing one score	415	76.0[2]
Completing Two scores	100	18.3[2]
Completing Three or more scores	31	5.7[2]
Mean	112.5	21.9 (SD)

1 Denominator based on Piki clients from 1 May 2019 (n=5116)
2 denominator based on unique individuals completing a WHOQOL- bref (n=546)

Figure 19 shows the proportion of the total possible score of the WHOQOL-bref for each of the four domains of physical, psychological, social relationships and environment with the addition of the recovery questions. The number on each bar shows the mean for each domain with the possible range of scores for each domain as follows: Physical 7 to 35, Psychological 10 to 50, Social 4 to 20, Environment 8 to 40 and Recovery 7 to 35. A lower score indicates a poorer outcome. For those clients who completed more than one WHOQOL-bref, only their first score appears in this figure.

Figure 19: WHOQOL-bref score distribution



Outcome Rating Scale (ORS)

The Outcome Rating Scale (ORS) is a simple, four-item session-by-session measure designed to assess areas of life functioning known to change as a result of therapeutic intervention.[57] The four items cover: symptom distress, interpersonal wellbeing, social role and overall well-being. Four visual analogue scales are presented to the client with the instruction to place a mark on each line indicating low to the left and high to the right. The highest possible score is 40, with ten being the highest score for each of the four scales. The clinical cutoff is 0-25 indicating clinical distress and 26-40 indicating normal distress.[57]

Table 30 shows a summary of ORS scores completed by Piki clients. Approximately 20% of Piki clients completed an ORS, with the majority completing two or more times (57%). The mean score was 17.0 which sits in the 'clinical distress' range. When looking at first score completed by an individual, the majority of scores sit within the 'clinical distress' range (87.7%).

Table 30: Summary of Outcome Rating Scale Scores Completion

ORS	NUMBER	PERCENTAGE
Total Scores	2392	-
Unique Individuals with scores[1]	1059	20.7
Completing One score[2]	450	42.5
Completing Two scores[2]	243	22.9
Completing Three or more scores[2]	366	34.5
Mean	17.0	7.8 SD
Clinical distress range (0-25)[2]	930	87.7
Normal distress range (26-40)[2]	130	12.3[2]

1 denominator based on Piki service users from 1 May 2019 (n=5116)
2 denominator based unique individuals completing an ORS (n=1060)
Note: measures not always completed at first presentation

Session Rating Scale (SRS)

The Session Rating Scale or (SRS) is a simple, four item visual analogue scale designed to assess the service user's view of the quality of the therapeutic relationship ('alliance'). The SRS is administered, scored and discussed at the end of each session to get real time alliance feedback from young people and carers so that alliance problems can be identified and addressed.[58] The SRS translates the assessment of the alliance using four visual analogue scales, each 10cm long based on the service user's perceptions of: respect and understanding, relevance of the goals and topics covered, service user-practitioner fit and overall alliance. The highest possible score is 40, with ten being the highest score for each of the four scales. Any score less than 36 should involve the therapist having a discussion with the client about how the alliance can be improved.

Table 31 shows a summary of SRS scores completed by Piki clients. Approximately 10% of Piki clients completed an SRS, with smaller numbers completing it more than one time. The mean score was 34 which sits in the range requiring discussion between the therapist and client. When looking at the first score completed for each individual, nearly 50% of scores sit below the score of 36 and would require further conversations between therapist and client.

Table 31: Summary of Session Rating Scale Scores completion

SRS	NUMBER	PERCENTAGE
Total Scores	844	-
Unique Individuals	544	10.6[1]
One score	371	68.2[2]
Two scores	98	18.0[2]
Three or more scores	75	13.8[2]
Mean	34.4	5.6 SD
Acceptable score (36-40)	277	50.9[2]
Score needs further checking with client (<36)	267	49.1[2]

1 denominator based on Piki clients from 1 May 2019 (n=5116)
2 denominator based unique individuals completing an SRS (n=544)

4.4 EQUITY AND TARGET POPULATIONS

Improving equity was a key focus of the pilot service as required by the original tender which aimed to 'provide free evidence-informed psychological therapies for 18 to 25 year olds with mild to moderate mental health needs within the pilot location and with a focus on increasing equity'.[59] This equity focus is underpinned by the Treaty of Waitangi principles of partnership, participation and protection which mandate Māori receiving equal benefits and rights as non-Māori. This section evaluates to what degree the Piki pilot has met its objectives with respect to addressing inequities for Māori and for other target populations and the issues related to this.

The proposal for the pilot included an explicit focus on improving service access for Māori and Pacific young people. Other groups were also listed as target populations: Asian, those with alcohol or drug misuse problems, those with gender identity related distress and LBGTQIA. These other groups have received less explicit attention, while detailed plans were made and implemented to improve access for Māori and Pacific.

Addressing equity issues has been a challenge within Piki from the beginning and was one of the two most pressing issues or challenges identified by key informants in late 2019, together with managing demand.

The pilot proposal noted that reasons underlying the low rates of service access by Māori and Pacific are primarily 'a lack of service availability, ... lack of awareness of services and a lack of culturally attractive options for Māori and Pacific young people'. The strategies for increasing equity thus naturally fall into three main categories: (co-)design processes to ensure that services are appropriate; actual provision of services (both increased services and more appropriate services); and effective marketing to increase awareness.

This section first addresses each of these three areas, with reference primarily to Māori and Pacific as a combined group (as they often were grouped together), although they apply equally to other priority populations. This is followed by sections with more detail on specific target populations: Māori, Pacific, Rainbow communities and other target populations.

Co-design / engagement processes

Despite acknowledgement from the beginning that there needed to be strong and early engagement with iwi and other grassroots organisations, there were issues and challenges with this. Concerns about engagement were expressed by several Māori members of governance and advisory groups, as well as the youth reference groups YRG and SURG. It was generally acknowledged by key informants in interviews that the Māori and Pacific voice needed to be heard more.

There was also a clear identification of the need to include Māori and Pacific representatives at the higher level of working and policy groups and this led to improvement for Māori, but Pacific representation proved more difficult to establish and retain.

YRG membership was also felt to lack sufficient diversity from the beginning:

> *We are missing and the voices from young men, early school leavers, men in trades, teenage mums, Pacific early school leavers in employment who need to contribute financially to their families.* (Notes from YRG meeting)

Changes to the group membership resulted in substantial improvement in diversity, although Pacific representation remained low compared to Māori.

SURG were also aware of an even greater lack of diversity in their membership in terms of ethnicity. This group had a large representation of those from the Rainbow community. While this was a welcome contrast to the more common under-representation of this population group, ironically it meant that a fuller range of voices was not heard. However, this strength was capitalised on by the YRG which was able to increase their diversity in this repect by including members of SURG in their own membership.

The Piki evaluation team at the University of Otago Wellington also identified a need for Māori and Pacific representatives on the team. At the end of 2019 an emerging Pacific researcher was employed but, despite several attempts, the team was unsuccessful in engaging a suitable Māori representative due to lack of availability or research capacity.

The student sector had strong and consistent representation on all the advisory groups with either staff and/or students from VUW and/or Massey on each, but other tertiary providers were not involved. There was a feeling from some at polytechnics that their student body was demographically more akin to the target population for Piki's equity goals, and yet they were not included in the pilot, thus resulting in the perpetuation of inequalities:

> *what about the ITPs [Institutes of Technology and Polytechnics], what about us? The University has already got [Piki on] ... all their campuses on site ... we're like the poor version of those ... and yet we weren't included – it was put into Universities first. We've a different demographic and we've been trying for two years now to get Piki on campus.* (PK113)

Partner organisations Melon and PeerZone also used co-design processes in developing their services for Piki. Melon convened groups of potential users (e.g., 'tradies') to advise on usability of their app (a common strategy of digital developers), while PeerZone consulted with members of the Piki YRG and SURG as well as with Māori and Pacific groups. There were, however, some critiques from the YRG and SURG as to how effectively these processes were carried out.

Overall, co-design is even more difficult and requires more time, effort and thought when attempting to engage and involve those population groups that face the most inequities and disparities. It requires the establishment of well-planned and designed strategies from the outset and sufficient time to enable the outcomes of these processes to inform the service design.

Service provision and design

Given the continued low rates of Māori and Pacific accessing Piki relative to need, attention was directed to strategies to combat this. One approach was to develop a strategy for prioritisation of Māori and Pacific clients for initial intake contact and/or therapy appointments when service capacity is stretched. This was implemented by the various partner organisations in ways that worked best with their individual service delivery models, rather than as a uniform approach across Piki services.

In addition to increasing general availability, providing services that are appealing and appropriate for marginalised groups is key to engaging these populations in services. Specific strategies identified in the RFP included using peer support workers and therapists that identify as Māori or Pacific and providing group therapy options. This aspect of Piki is still very much a work in progress; both these strategies have been challenging to implement with resulting delays.

Increasing representation of Māori and Pacific in the workforce inevitably takes time to address, although progress was made through the employment of several Māori and Pacific peer supporters (facilitated by a purposive redistribution of funding from therapy). The addition of Ora Toa as a Piki service provider in late 2019 has also increased therapy provision by Māori, but numbers of Māori and Pacific therapists overall remain low.

At a more fundamental level, some question the model of 'talking therapy' itself as one that is based on a Western tradition and thus may intrinsically favour Pākehā (see section 5.1).

Getting the nature and location of services right was also frequently mentioned by key informants. This means having services where the priority populations are or in places they frequent and with the right staff (i.e., who reflect clients' identities), while providing choice of whether to access ethnic specific services. As mentioned above, there was some movement in this direction in the second year of the pilot with increased services available in Porirua particularly. Services also need to take account of the needs of young people in different situations so that they are convenient for those who work or have children. The nature of services offered is also important and we acknowledge that Piki allows for the use of other approaches such as those based on Kaupapa Māori within the CBT-informed therapy approach of Piki, with many therapists reporting using such approaches.[60] The Wellness/Hauora Plan developed for Piki clients as an exit document also utilises the model of Te Whare Tapa Whā.

A need for diversity training was strongly expressed by the SURG early in the project and such training has been delivered both within the CBT training course and within services. Sessions in Māori and Pacific cultural and Rainbow competency training provided opportunities for current Piki practitioners to increase their skills in these areas, but this is not a substitute for an appropriately diverse workforce. Some key informants felt there was more that could be done in terms of training, and one therapist felt a need for more culturally appropriate resources.

Therapist feedback from surveys in 2019 and 2020 aligned with these ideas.[60 61] Table 32 summarises free text responses from the first survey into themes with illustrative quotes.

Table 32: Therapist views of what is needed to meet the needs of cultural & ethnic groups

THEME	ILLUSTRATIVE QUOTES
Workforce and workforce diversity	• I think we need to employ more Māori and Pasifika people. We will need to also focus on needs of Asians. • More representative population of clinicians. • Cultural advisors that spend time across the teams, so they are visible, accessible, and modelling behaviour.
Training	• Training in Pacific peoples' ways of thinking and approaching therapy, Māori tikanga and protocols incorporated into service and specific Māori models of therapy taught and practised with supervision. • The cultural trainings on offer are fantastic, however they should be made compulsory to ensure all staff are familiar with multicultural services.
Supervision	• More established pathways/relationships to seek cultural supervision and input. • Access to cultural advice/supervisory services for Piki clinicians on a regular/as needed basis. • Access to cultural supervision which is formal and provided by the employer.
Service Delivery	• Inclusion of a support person in therapy if possible. • Creating new ways of delivering services (groups, peer support, etc.) • Home visits for some.

Ways of changing how services are offered to make them more inviting for priority populations were an aspect of Piki, with peer support a good example. However, further development in this aspect was noted as being an ongoing aspiration, with group therapy, for example, still under development at the time of writing. Based as it was on existing services, the overall model of care of Piki was not substantially altered to allow for other approaches to providing support, as commented on by members of YRG:

> *when we first started on this, we thought it would be like community and whānau focused care for people that don't fit into the normal individualised like western therapy model and I haven't really seen that model change at all.* (KI-KI03a – focus group)

In-person referral processes were also mentioned as important by both youth and university providers, both for self-referral in person or by handing in a slip (rather than digital) and through warm handovers when changing providers.

Service user views also aligned with these comments and augmented the points made here. When asked how Piki and mental health services in general can be improved for Māori, Pasifika and other cultural groups, clients had a range of suggestions for improvement.

- Changes to the workforce such as employing more people of colour for therapist and peer supporter roles; this is because having support people of the same cultural identity can help clients to build trust and rapport.
- The importance of support people recognising and embracing the intersectionality of clients and encouraging clients to embrace their cultures. Avoiding assumptions by asking clients if they want whānau involvement was mentioned as important since responses to this question can vary from person to person and across situations.
- Making services known and accessible. Suggestions included making sure that advertising to specific underserved groups is done in a way that reaches the potential clients, having therapists and peer supporters on marae to make seeking support more easily accessible, and building relationships with adults in the community as recommendations for support often come from whānau.

Marketing/outreach

The initial launch in Porirua publicly emphasised targeting services to Māori and Pacific, while the subsequent launch at Victoria University of Wellington inevitably shifted the focus to some degree onto the student population.

There was some feeling that Piki was not reaching the target populations:

> *More outreach to populations who have had difficulty accessing mental health support. Currently, I believe Piki mainly increases access to counselling for those who already had little difficulty accessing counselling (e.g., white cisgender straight Pakeha who are predominantly middle class).* (Therapist survey comment, 2020)

The original plan for the pilot included promotion through linking with Māori social service and community providers and with churches and sports clubs as well as through targeted campaigns and social media.

Piki promotion to Māori and Pacific young people was deliberately delayed initially (in June 2019) due to concerns about whether there was capacity to manage any surge in demand that resulted, in the context of the demand generated by the VUW launch of Piki. As reported above, a direct text messaging campaign and a targeted social media (Facebook) campaign were subsequently carried out in May and June 2020 with some success.

The text campaign led to 25 Māori and 8 Pacific rangatahi accessing Piki services as a direct result of the text promotion. Tū Ora calculated that this equated to a cost of $32 per new client and saw this as an extremely cost-effective and targeted strategy for increasing Māori and Pacific access. This makes such a strategy a promising one to use in the future, although it was short-lived with the Piki pilot due to high demand for services.

Tū Ora reported that the social media campaign resulted in an increase in self-referrals over the first week, with 44% of self-referrals for that week being from social media (n=100). Prior to the social media campaign, an average of 1 Māori and 0.2 Pacific referrals were received per week, in comparison to the average of 13.5 Māori and 3 Pacific referrals per week during the month that the campaign was running. This indicates that a targeted social media campaign can increase referral rates for these groups. Since the campaign paused, average referral numbers for Māori and Pacific have returned to a little above previous rates (3 Māori and 0.3 Pacific referrals per week).

Although these campaigns to increase Māori and Pacific access to the service were trialled in a very limited way, there was a small overall increase in Māori self-referrals over the course of the pilot, from a baseline of 16% of total referrals (February 2019 to May 2020) to 18% in June. Pacific self-referrals also increased from 5% (February 2019 to May 2020) to 6% in June 2020.

Aside from digital campaigns, a significant theme from the key informant interviews in 2019 (from both youth and most partner organisations) was the importance of in-person communication and using existing networks. These include existing Māori, Pacific, and refugee groups and youth organisations, including sports groups, trade schools and libraries (YRG), as well as links through GP clinics and by talking directly to people in the target groups. Young people particularly (but not exclusively) noted the importance of trust, i.e., promotion through trusted people, whether that be peers via word of mouth, or community leaders (e.g., church leaders) that young people know and trust. These views were echoed by therapists (Tū Ora survey, July 2019).

In line with this view, several informants noted the limitations of digital strategies. They suggested placing physical posters in a range of locations where young people might see them to reach those that might not see online publicity. Where social media was mentioned by key informants, they had suggestions for improving online design, including use of clear language, videos, good design and visuals, and provision in various priority languages, although some noted that these were costly to provide.

While emphasis within Piki appeared to focus initially (during 2019) on social media, work did begin on in-person work in early 2020 in tandem with the development of the social media campaign. The employment of a dedicated youth promoter to work with Māori and Pacific has enabled a balance of in-person work and digital strategies to be implemented. As shown below, while these efforts are valuable, it is not possible to see tangible results in terms of client numbers in such a short term.

The website, a key strategy for making Piki easily accessible in general through the self-referral feature, was initially designed with input from the YRG and with imagery intended to show a range of youth including Māori, Pacific, Asian and Rainbow youth. The need for further cultural content has been acknowledged throughout and while some amendments have been made, by incorporating a number of Māori words into the text, this aspect was still being critiqued in February 2020 by members of the YRG. The branding exercise and website design was conducted in a much shorter time than usual, although youth involvement in these processes did occur. The initial restriction of communication to digital modes may also have impacted on market segmentation in terms of which sectors were being reached through these channels.

Another reason mentioned for low rates of engagement with Māori and Pacific youth is that *'they aren't traditionally the ones that put their hand up for help'* until they are beyond mild to moderate and need more intensive support. (KI-PK09_PK10)

(a) Māori

This report covers a full two years of Piki service delivery and by the end of 2020 the total number of Māori who had accessed services was 725 individuals, accounting for approximately 14% of the entire Piki cohort. Numbers of Māori resident in the Piki catchment area based on census data would indicate that Māori aged 18–25 years make up 17.4% of the total population. Given that rangatahi Māori are known to have higher needs than other population groups we would have expected more than 14% of Piki clients to be Māori.

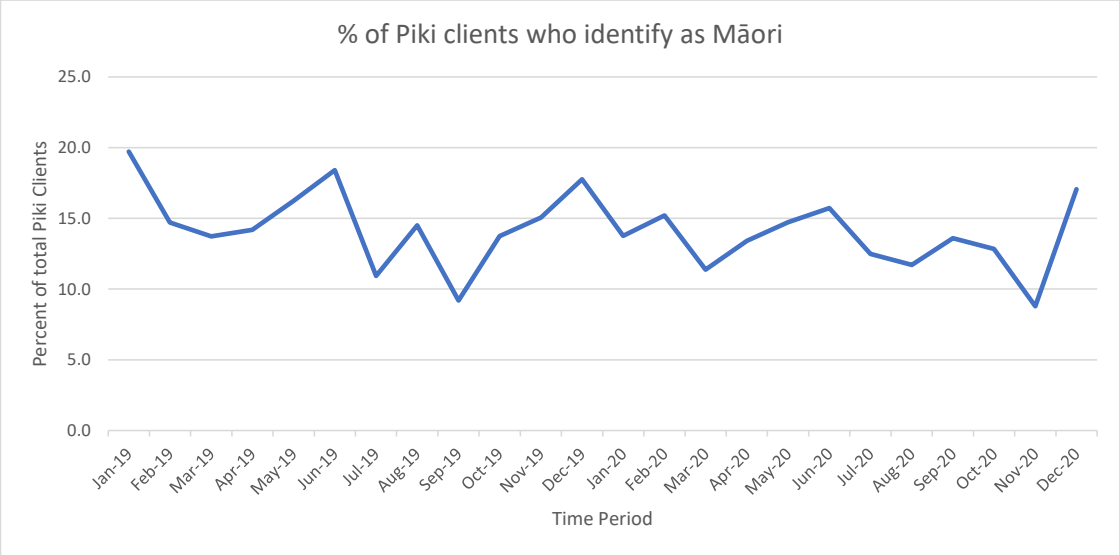
The numbers of Māori in the Piki therapist workforce remained low (5 out of 39 therapists in early 2021, based in Porirua, the Hutt Valley and at VUW, with none in central Wellington or in the Wairarapa). Puāwaitanga reported only 2 of their workforce of 36 as Māori. Explore had a Māori psychologist for a short period from April to August 2019.

The number of peer supporters identifying as Māori increased in 2019 after increased funding was provided in mid-2020, and by the beginning of 2021 was around 33% of their workforce.

Client survey respondents and interviewees who identified as Māori had a range of experiences with many giving very positive feedback.

The percentage of Piki clients who identified as Māori varied over the course of the pilot period but did not show any strong overall trend, as shown in Figure 20.

Figure 20: Percentage of Piki clients identifying as Māori by month



As noted above, there are three main areas in which equity can be addressed: (co-)design processes, service provision and promotion.

(Co)-design processes

There had been plans to engage with local iwi and there was an awareness of the importance of being proactive in this area (e.g., in Governance group discussion at the beginning of the pilot), but this does not appear to have occurred.

Characteristics of service provision

Strategies to ensure that Piki provided appropriate services for Māori included plans for Māori cultural competence training for service providers. Unfortunately, this was delayed in implementation mainly for Covid related reasons and did not occur within the two year span of the evaluation, though it was scheduled for 2021 (see 3.4).

Some therapists noted that their training did not generally prepare them well for working with Māori, although one with social work training reported the opposite:

> *in our Universities through lots of our training, there isn't too many Māori or Pasifika models taught as therapeutic models and we, certainly we incorporate elements of language and other cultural ideas from other cultures but I'm not sure that they're as inclusive as they could be.* (SP-PK108)

> *with my undergrad being social work, Te whare tapa whā and Fonofale is kind of embedded within all of our practice, within all of our, everything we do is every year, every paper you've got to incorporate what you study, within that.* (SP-PK73)

Tū Ora did develop partnerships with some Māori-focused organisations included Kahungunu Whānau Services, Maraeroa Marae Health Clinic and Ora Toa which meant that some Piki services were offered in some of these locations.

There was an awareness that the lack of Māori among the workforce impacts on the appeal of the service to Māori, with both service providers and clients noting that often Māori do prefer or even need to receive support from Māori:

> *I would say that our Māori clients definitely gravitate towards Māori counsellors.* (SP-PK106 – Puāwaitanga)

> *I definitely have people see me and kind of go, 'Do you have any Māori colleagues?'.* (SP-PK103)

> *some rangatahi may be more connected to their whakapapa than others and we find usually that whānau that come through for Social Services, the ultimate thing is connection to their whakapapa, wanting to know who they are and that's the first thing that we have to do before we can do any other mahi with them. But in saying that you'd have to have the clinicians able to work in that space.* (SP-PK116 – Māori)

> *Also, she was Māori which helped so much - I've found, in the past, when I've had non-Māori counsellors I've spent a lot of time explaining cultural matters and family dynamics etc. This was not necessary with my counsellor this round, she understood everything already.* (SU-Client survey respondent)

> *Wish there were Māori counsellors available near me.* (SU-Client survey respondent)

> *I was looking for ... a Māori counsellor because I was also kind of dealing with some stuff related to that identity and, well I didn't get a Māori counsellor and I think that he sort of struggled a bit to kind of grasp a lot of what I was saying... I feel like ... more Māori male representation would be a big deal for me as a Māori male and I feel like a lot of other Māori males probably feel the same way ... because that specific kind of counselling would be a bit more casual... I think that's the biggest thing that I struggle with Pākehā counsellors in general, is that its way more formal usually.* (SU-PK85)

The decision to redirect funding freed up by the disestablishment of the intake coordinator role towards the recruitment of additional Māori (and Pacific) peer supporters went some way towards increasing level the Māori (and Pacific) in the workforce but the recruitment and retention of Māori in the counselling/therapist workforce remained a challenge.

The fact that Piki was not generally set up to cater well for Māori was reflected in several comments from clients and other informants:

> *right now it's very kind of monocultural right this second - like even though it's called Piki and ...there's some Māori words and stuff but there's not quite enough.* (KI-PK40)

> *It made me realise the NZ health system is systematically racist, not just my old GP, and it's all designed specifically to oppress my identity and take away from my reality because it isn't white.* (SU – client survey respondent (Māori))

There were conflicting opinions as to whether the digital app was a desirable and useful addition for Māori, with one Wairarapa provider expressing the view that *'the Māori population are not interested at all'* whereas Melon staff reported anecdotally observing activity in the online community from Māori/Pacific, with many posts from the latter being quite 'heavy' and indicating issues that were beyond the mild to moderate category.

The prioritisation strategies employed by some partner organisations were seen as effective in improving the experiences for Māori clients:

> *We've changed our process so we prioritise, the Māori float immediately to the top of our list so they get seen more quickly and I think that's probably helped with dropout that we might have had in the past.* (PK109 – Explore)

Some providers are keenly aware of the need to improve the way they work with Māori but feel constrained by existing systems:

> *I own that that I probably need to learn more ... we're not really very well set up for, even physically set up, I mean it's a tiny cupboard of a room I'm in, set up for whānau meetings or ... going out into the community to meet with people which might be more appropriate - so it does feel quite constrained ... We might have to be a bit more flexible but just the mechanics behind ... anything that I might want to do to mix up how I work with Māori clients – I have to work that out.* (PK109 – Explore)

The fit of the service for the higher needs of some Māori was also questioned:

> *I think some of the challenges I can see ... we come up with this brevity, you're looking at intergenerational trauma and really, really complex family histories and in the back of my mind I'm thinking – I've got twelve sessions and that even opening that box may not be the most appropriate thing.* (PK109 – Explore)

Promotion and marketing

As previously noted, the trial of digital marketing (Facebook and direct texting to Māori youth) showed promising results. Unfortunately, in the context of overall high demand for Piki services, the campaign was not sustained, and thus overall numbers of Māori have not increased as much as they might have.

In-person outreach and communication could be developed further, with one provider noting that:

> *services are kind of still siloed with a kind of white mainstream culture, like our service was doing some outreach at a couple of maraes based in the region. ... but I don't think it's really targeted Māori and Pasifika like maybe it was hoping to.* (SP-PK108)

Encouraging Māori to access mental health programmes is a challenge that even Māori organisations struggle with:

> *it's a bit of a mission ... the Māori organisations supporting whānau – they're still struggling to get clients to come in to see me under the Piki programme.* (SP-PK89 – therapist team lead)

One peer supporter emphasised the crucial importance of word of mouth among clients and potential clients in spreading the word about services:

> *the Māori community – but also, I know the Pasifika community – everything is word of mouth, so if you have a shit experience, you're going to tell all your mates, all your family, the church ... if someone from that community has a bad experience, you've lost multiple families from using that service – so you have to give a good experience when someone comes in and then its good word of mouth.* (Peer supporter focus group)

(b) Pacific

By the end of 2020, 184 Pacific young people had accessed Piki, accounting for 3.5% of the Piki population. Pacific young people living in the pilot region make up 8% of the total population of those aged 18-25 years. It should be noted that when using prioritised ethnicity for data collection, young people who identify as both Pacific and Māori will be only be counted as Māori, as Māori ethnicity comes first in the prioritisation process. Therefore, there will be an undercount of Pacific service users. Nevertheless, it appears that Piki did not reach Pacific youth at the level expected for their percentage of the population.

The numbers of Pacific in the Piki therapist workforce remained low (3 within the in-person Piki workforce of 38 and another 3 within the Puāwaitanga workforce of 39 in early 2021). The number of peer supporters identifying as Pacific increased in 2019 after a funding increase in mid-2020, and by the beginning of 2021 there were 3 Pacific peer supporters among their workforce of 18.

(Co)-design processes

As for Māori, Pacific service users mentioned the importance of engaging with a wide range Pacific youth in the early stages or implementing and evaluating services:

> *I think a lot of the ideas that would help Pacific young people would probably come from Pacific young people, so I feel like in this process of like I guess the sort of review that you're doing with Piki, I think it would help to have some sort of like engagement with Pacific young people... because I mean young people of course are very different from each other and so you're not gonna kind of get like this one fits all.* (SU-PK86)

Barriers to accessing mental health services

Various barriers to accessing mental health services were identified by Pasifika service users, some being culturally specific. Some youth identified an existing stigma and negative perceptions from their families towards mental health which led to a reluctance to seek help from these services. There was also the cultural belief (and sometimes a financial imperative) that mental health issues should be dealt with inside the family unit (aiga) or community, rather than through external agencies:

> *I don't think many Māori Pasifika would go to a counsellor unless a family member or someone really close told them. I think that would be the case cos it's so taboo and you just talk to people instead.* (SU-PK55)

> *I think for me being a young Pacific woman, mental health isn't really championed in the communities that I exist in... so I think a lot of the misconceptions that there are about mental health in the community are solely based on like religious beliefs or cultural values which don't necessarily take into account that mental health is a real thing, essentially. And then also growing up, my parents kind of worked low level jobs, so even if we had an understanding of mental wellbeing or mental health, it wasn't like there was available funds within my family to be able to support any sort of Mental Health Service.* (SU-PK86)

The Pacific promoter and other key informants for Piki also mentioned the reluctance of Pacific youth to ask for help outside of their community as a cultural issue. They indicated that there would need to be a cultural shift in this way of thinking, through promotion of services like Piki, however, this would likely take some time:

> *I've gone out to various groups within ... the Porirua community and just spoke about what Piki offers but also with that I have tried to normalise as such - just reaching out for help when needed because ... that's the barrier. Not the services as such but just asking for help in general, especially from a PI and Māori background. We are taught to like toughen up or just carry on and like or just either compress those feelings.* (KI-PK94)

> *...research tells us that Pacific have highest stigma around mental illness and help seeking but knowing that they also are more likely to ask friends and family where to go.* (KI-PK-01)

In addition, one service user noted a general lack of knowledge in their community about mental health services:

> *I think especially with my background, both my ethnicity but also my socioeconomic background, no one really knows about Mental Health Services or how much it costs or what types there are and so Piki was an easy way for me to find the, kind of figure out what I needed and made it easy for me to make that decision on my own.* (SU-PK86)

Facilitators of access to mental health services

Pacific youth identified Piki being a free service and providing easier access to mental health services as being important features of the Piki service that facilitated access for them.

> *But I do feel that Piki is an awesome service especially that its free for our people, it is crazy, I know like, actually I don't know but I'm assuming one session is very expensive, so that's an awesome thing and I know ears prick up when I'm like, 'Yeah it's a free service,' and they're like, 'What?' So that's an awesome thing.* (KI-PK94)

> *I think yes it is an improvement cos there's been very little to be honest, been very little available for rangatahi, of this nature, at this level. Any additional stuff is an improvement, particularly for our community.* (KI-PK14_PK114)

Service Provision

Pacific service users noted that greater accessibility of services was needed through more staff to provide services in general, and through access at school level:

> *There's not enough people who are on the service side to kinda help ease the amount of people that want to access it.* (SU-PK54)

> *If there was more access in schools that would be better, cos then they'd get in early.* (SU-PK55)

They also identified the importance of increasing the number of Pacific therapists. Youth found it easier to relate to service providers that shared their culture:

> *I think like for a lot of people, they often find it easier to talk to people that are also Māori and Pacifica, so I feel like if there were more people available that they could talk to, that would be great.* (SU-PK53)

> *Would also have loved the option to have a Pasifika counsellor for comfort.* (SU – Piki Client Survey)

Pacific youth also felt that there should be more awareness among Piki service providers of Pacific models of health. These models incorporate a more holistic viewpoint, similar to Te whare tapa whā; emphasising the role of family as integral and influencing every area of health and wellbeing:

> *I think it would be really helpful for Mental Health Services to kind of have a look at young people, firstly in the communities they exist in and to kind of look at a more holistic viewpoint on young people and understand that young people don't come on their own... in order to address the mental health or the mental wellbeing of a Pacific young person, you kind of have to have those intergenerational conversations and you have to bring their families into it.* (SU-PK86)

> *particularly with those cultures because they are so collective based and family orientated, there is a whole breadth of issues that connect to an individual's personal issues cos they aren't able to separate themselves as an individual as easily as somebody from a western standpoint.* (SU-PK64)

Key informants perceived that it was important for Pacific youth to know in advance who their therapist was going to be and what they looked like. This often related to their preference for seeing a therapist who matched their ethnicity:

> *...with young people, they like to see who it is they're going to meet so they've got a better knowledge and understanding and if it is of the same culture and ethnicity, yeah, it's gonna be much better but I also do feel regardless of whether it is or not, knowing who that person's going to be prior to... can help.* (KI-PK112_PK113)

However, there was also some apprehensiveness about breaches of confidentiality in the relatively close-knit Pacific community in Porirua, which could lead some to opt for a therapist from a different ethnic group:

> *they go with that idea of: I just want to kind of be out of anyone who might know someone from my family or community or friend group and the safest way to do that is to pick someone completely outside of my ethnicity.* (KI-PK106)

PeerZone was mentioned by key informants as being well-tailored and acceptable to Pacific youth and a good entry option into mental health services:

> *our Pacific students are less likely to ask for help but that's a cultural thing. So, having something like peer support on campus where they don't feel that they're going to ask for help but they have peer support is probably a better fit.* (KI-PK112_PK113)

> *So I got to speak to each team and basically talk about our service, what we provide and what I told them was that we also, yeah we provide the counselling as well but we do do the peer support, which they found, they were like, 'Wow, what's peer support?' and all that kind of stuff. So I explained that and they were like, 'That kind of sounds more like us...'* (KI-PK94)

Promotion and marketing

Engagement with Piki among Pacific youth was low in comparison to other ethnic groups. As noted previously, the employment of a Pacific promoter provided a targeted approach through social media and community meetings (fono) to increase participation. As a result, there was a small, but noticeable increase in self-referrals from Pacific youth. However, it would have been more effective for this promotion to have been implemented earlier on in the pilot. The Pacific promoter accessed sports and church groups in the Porirua community to spread awareness of the Piki service, and was beginning to engage with groups in the Hutt Valley at the time of their interview:

> *I go out and do community functions, so for example I've promoted at Creek Fest, Waitangi Day, also with like the Massey ... orientation days, cos we also have counsellors within Vic and that. So that's pretty much it but like I think for me, one of the highlights was, from my promoting, was being able to promote with my rugby club.* (KI-PK94)

(c) Rainbow communities

Data on only male-female binary gender identification of clients was collected until a free-text box was added to the self-referral form in 2020. Data was not collected regarding sexual orientation of Piki clients (nor was it appropriate to collect this). As such, it is unknown how many young LGBTQIA+ people were seen through Piki.

Gender data for therapists identified only male and female. At PeerZone, there was a deliberate strategy to ensure diversity in this respect and by early 2021 their workforce included one transgender and five gender diverse peer supporters. In February 2020 the Melon wellbeing app added a non-binary option for clients to select during the onboarding process (enrolment with Melon).

Rainbow competency training sessions were provided by InsideOut to both therapists and peer supporters. All counsellors who underwent CBT training also received gender and sexual diversity training as a module of the CBT course, which was added to the training after feedback from the service user reference group. The vital importance of therapist awareness of the language of Rainbow communities was emphasised by SURG early on, pointing out that incorrect pronouns and assumptions about gender and sexuality can be detrimental to both therapeutic relationships and to clients' wellbeing.

There was no specific marketing targeted towards young LGBTQIA+ people. A number of service providers who were interviewed identified that they had *'a few'* Rainbow people as clients. Interviewees from University based health providers noted that the University environment might have a large number of Rainbow students as compared to community settings:

> *I saw a large number of that sort of population within a University environment and I think Universities are probably quite good at including that population, in a community setting not so much.* (SP-PK108)

> *I think working within the University environment, that access is already pretty well served I think compared to the general population but I think Piki's another avenue I think particularly for the Rainbow community. I've been seeing a lot, a lot of Rainbow community this year and Piki has made that, has been part of making that possible.* (SP-PK02)

Client survey respondents and interviewees who identified as LGBTQIA+ gave a range of responses about their experience of the service, which were largely in line with responses from service users who did not specifically identify as such.

Of particular note, responses from the client survey and from interviewees identify that there can be a lack of trust in the ability of healthcare providers to cater adequately and respectfully to the Rainbow population, in particular with regard to language and understanding around gender:

> *Over a few years have noticed that mental health staff generally don't have a good understanding of transgender identities or how to use gender neutral pronouns and/ or appropriately gendered language.* (SU – Client survey response)

> *With LGBT people, I think, so I identify as polyamorous and I am leaning towards nonbinary as well but I don't bother with that whole thing because so many people just can't cater to that.* (SU-PK57)

> *There's been a lot of feedback from our Rainbow community that they won't touch certain elements with a barge pole because they have no confidence in the fact that people are well trained and culturally sensitive to the needs of the groups that they're working with.* (KI_PK09 & PK10)

Some service providers also identified the need for more training in this area:

> *I have a client at the moment who's transgender, I've had another young person who was wanting to transition. I think there is definitely being welcoming and accepting [...] I almost wonder if we need specific, different training.* (SP-PK108)

LGBTQIA+ interviewees identified that in order for Rainbow people to feel welcome there needs to be specific indications that a provider is supportive and inclusive:

> *Even on the intake form at Vic where it asks your gender, having like another option that's not just male or female. It's all the small things that make you feel welcome and accepted rather than like you don't fit in, like [...] you have gender issues and you're going in and you see on the form male/female, you're going to be like oh well they don't want to, they don't care, you know, if they're not even willing to put that on a form.* (SU-PK56)

> *I think that goes with the same for like Rainbow spaces as well. Like most of the time you'll find out about Rainbow friendly services through other Rainbow people because like yep nobody else bothers to say they're Rainbow friendly or they have the Rainbow take.* (KI-KI03b YRG focus group)

> *I guess making it or like, not advertising but for lack of a better word, showing their support somehow so that when the person in that community then goes to get that help, they don't have to sit there and like wonder if they're going to be accepted by that person. There can be some kind of display like oh yeah like it's okay for me to come out to this person or something.* (SU-PK62)

Some respondents also identified that it is helpful to be able to talk to someone who is also from the Rainbow community themselves:

> *It was good because I felt like I didn't have to preface half of the things I was saying with a little bit of historical back story... I was talking to someone that was just a little bit older than me, like a few years older than me but also part of the Rainbow community and so I didn't have to, I feel like I didn't have to justify why I felt that way.* (SU-PK67)

It must also be considered that intersections of identity mean that there is no one size fits all approach to serving the needs of the Rainbow community:

> *I think what would really help me is to have someone who's Rainbow friendly and who understands from a person of colour's point of view... even if there are psychologists who specialises on Rainbow issues, a lot of the time they're talking about western Rainbow issues and not a lot of people from other ethnic minorities.* (SU-PK60)

(d) Other target populations

While the target populations for Piki initially specified Asian, male, rural and high deprivation populations as well as those with alcohol and/or other drug use-related distress, there has been little specific attention to these groups over the course of the pilot. Given the large number of other priorities, this is not surprising. Nevertheless, the accessibility and appropriateness of mental health services for these populations needs to be considered.

Males accessing the Piki services made up 30% of the total number of service users, compared to 65% identifying as female. This is similar to the rates reported for primary mental health use in 2008.[44] As shown in Figure 13 (section 4.2), rates of males accessing the service have not substantially increased over the pilot period.

Qualitative data from the five service user interviews conducted for this evaluation which were with young males, give some indications as to why more males do not use services such as this. Two young males reflected upon the societal basis for this whereby males are enculturated into certain ways of thinking and behaving that make them less likely to access such services, and how campaigns to counter this might be helpful:

> *most men ... they've grown up having toxic masculinity kind of injected into their head and it sort of makes them think about things in a certain way which I definitely did and sort of still do with some things – kind of why I'm always a bit hesitant to actually go to counselling. So, for men I don't know how you'd even fix that other than slowly eradicating that out of society.* (SU-PK85)

> *I really enjoy seeing like campaigns... just sort of like poking at the fact like 'hey, like it's okay to be emotional as a man', like 'it's okay if you need help, you don't have to feel bad about these things'... I think just sort of promoting it and making this information readily available and not just like 'hey there's counselling services available to you' but also information that might help them understand that they have something wrong so that they can go and see someone in the first place - cos a lot of men don't know that there's something wrong with them.* (SU-PK115)

The way in which services are delivered may also be important. The suggestion by the young Māori man quoted above regarding a more informal, casual approach than the perceived formality of counselling might apply to males of other backgrounds as well.

Young people experiencing alcohol and other drug use-related distress, while listed among the stated target populations for Piki, also did not appear to be an explicit area of focus for the service. As mentioned above in section 4.3, the ADOM measure was approved for use within Piki but appears to have been used very rarely, with therapists noting that they were not trained in its use, were not aware of it being promoted or found other ways of assessing this issue with clients.

It is unclear how many young people using the Piki services experience alcohol or drug use-related distress, although 10% of those self-referring into the service ticked this as at least one of their reasons for seeking support. Service providers informally reported mixed levels of this as a primary reported problem. Peer supporters were not aware of this as an issue within their clientele, which may indicate that this is an area that young people are less inclined to talk about in this type of service. Therapists varied between reporting no clients to up to 20% of their clients needing support with this.

Some partner organisations have their own AOD counsellors offering a more specialised service for rangatahi experiencing alcohol and other drug use-related distress, reducing the number within Piki. It was not always clear to Piki therapists how AOD related distress should be dealt with within Piki. Some therapists were of the view that this type of distress should be dealt with by more specialist services, while others approached it within their sessions using the tools of CBT, ACT and/or Motivational Interviewing. Often alcohol and drug use-related distress co-exist with other mental distress and are inter-related and evidence suggests that mental distress and AOD-related distress need to be dealt with together in a holistic way.[62] It was also noted that the relatively brief duration of therapy within Piki may not be conducive to supporting youth experiencing alcohol or drug use-related distress.

People in rural and high deprivation populations may experience barriers to accessing mental health services (such as restrictions on availability for therapy sessions, need for childcare and physical distance from services) that may make access to a remote service such as Puāwaitanga more necessary. This service could probably be more clearly offered to encourage access by these target populations.

The rate of service delivery to Asian youth is also below the expected level for the population, being 6.4% of the Piki service users, compared to making up 13% of the population in the age group.

Finally, the parameters of targeted age group for the Piki service was questioned by some informants. It was acknowledged that Piki had been specifically designed for the 18-25 year old group to address the gap in services seen for that group, in the context of other initiatives which target the 12-19 year old group:

> *we fought for a long time to get recognition for the under twenty fives ... for eighteen to twenty five. They are still in a completely developmental transition mode and we know globally that age group has huge unmet health needs. They're not help seeking, they're not engaged, they're not enrolled.* (KI-PK95)

That said, several informants saw a need for this kind of service to be offered to a younger age group:

> *what's the difference between a sixteen and seventeen and then eighteen year old, that's because we get a lot of enquiries from sixteen, seventeen year olds asking about Piki.* (SP-PK89)
>
> *I think it would be really ideal if the age was brought down to sixteen. Just like I said, we have young mums that are sixteen years old that could really do with that support.* (PK118 – Referrer)
>
> *I'd love to see a younger version. I would love, love, love, love to see a younger version.* (SP-PK73)

Final comments on equity

To inform our evaluation of this aspect of the pilot, we have also made use of a selection of questions from the HEAT (Health Equity Assessment Tool),[63] as a way to rate the pilot overall. This tool is typically used to assess equity with respect to Māori and some questions have been rephrased below to suit the wider focus of equity concerns within Piki and the retrospective nature of this process, where ideally the tool would be used prospectively.

What were predicted outcomes of this intervention for health inequalities?

The intention of Piki was to reduce health inequalities in terms of reducing the disparity between Māori and non-Māori youth accessing mental health services, as well as increasing access to services for other priority groups. If access to service was the measure for assessing this, then Piki to date has not succeeded in this respect given the lower than population rates of access by rangatahi Māori and Pasifika. Difficulties in measuring access rates for the Rainbow community mean we are unable to assess this for this group. Rates of access for young men remain relatively low.

Who stands to benefit most from this intervention?

Under current service delivery mechanisms, it appears that NZ European females appear to benefit most from this intervention.

Are there unintended consequences that can be foreseen?

If service delivery continues using the same model, then an even larger number of European females will be seen and groups who tend to have poorer mental health outcomes (such as males, Māori, and Pacific) will continue to access services at the current low rates.

Risk Mitigation – What needs to be done to ensure that the benefits accrue to the intended populations?

Overall, the design of Piki (being largely based on existing services) appears to have perpetuated the status quo. We observe that the pilot recognised major equity themes at the outset and acknowledge that with the complexity of the Piki design and process, and the impact of COVID-19, there would be substantial challenges in achieving major transformative change in this area. To make a real difference in terms of equity, there needs to true co-design with people in the low access groups from the outset, and for Māori and Pacific communities, there is a need for more services based within Māori and Pacific health providers and in other locations. There were some promising changes to the workforce profile with the greater diversity that was able to be quickly enacted with the peer support service but clearly more work needs to be done in this area which will take time. Promotional campaigns are another strategy for raising awareness of the usefulness and acceptability of accessing mental health support, particularly among males and within Pacific communities. Prioritising these at the beginning of any service that aims to reduce inequities is important.

When working to reduce inequities it is important to remain conscious of intersectionality in that individuals often identify with more than one group simultaneously and maintaining options for clients to choose from themselves is necessary to avoid stereotyping or pre-judging what people want or need.

4.5 AS A SERVICE FOR YOUTH WITH MILD-TO-MODERATE MENTAL HEALTH NEEDS

Throughout this section we address questions of effectiveness in terms of various measures of outcome, and in line with the stated purpose and aim of the Piki pilot.

This section highlights themes from the quantitative and qualitative data in relation to whether there has been appropriate targeting towards the mild/ moderate end of the 'severity' spectrum and the relationship to appropriate management response and referral.

Background

The original RFP request based on the IAPT programme in the UK, was clear in terms of the intended level of 'severity' the pilot programme should address:

> *The Pilot seeks to address the needs and probable unmet needs of the 18-25 year old population with mild to moderate mental health problems and who are not accessing existing services and further develop this for a New Zealand context.*[59]

The classification of mental health problems in terms of severity has been the subject of ongoing debate, with a range of views about the appropriateness of diagnostic 'cut offs' based on scoring or clinical assessment.[64] Moreover, presentations in primary care settings, particularly when associated with significant socio-economic and other factors, may not fit neatly into a 'psychiatric' classification of severity.

The Tū Ora/University of Otago response to the RFP was clear that Piki should address presentations of mild to moderate distress which were amenable to management primarily in community settings, and that therapy intervention should be tailored to that end.

Inherent in this focus on mild to moderate presentation is the implication that those who do not fully recover at this level should be stepped up to a course of high intensity treatment in line with a stepped care approach.[65]

In addition, service users in primary care have tended to present at the more acute end of the mild to moderate spectrum, according to previous evaluation of existing primary mental initiatives.[44] It would therefore be expected that existing service platforms contributing to Piki were likely to have a case mix which tended towards that end of the presentation spectrum.

Counter to this apparent need for support for more severe distress were recurring debates from the outset relating to the other end of the spectrum: could or should there be greater variation of style, duration, and intensity of psychological intervention to suit a range of client need, especially at the mild end of the continuum? This is also linked to the degree to which a focus on providing positive support to enhance resilience and mental wellness in this population should be emphasised.

Adding to the challenge was recognition that assessment in this group could be challenging and that there was potential volatility in scoring assessments over a short period of time.

> *Yes. I think it's an unhelpful continuum anyway actually, I mean it's so difficult with young adults to work out what mild to moderate actually means.* (KI-PK10)

> *You can go potentially from mild to something quite complex very quickly.* (KI-PK09)

The appropriate positioning of Piki within the mild to moderate spectrum of severity then raised the question of how clinical safety needs could be managed. The availability of 'open access' through the website, along with other external drivers of demand, meant that in the early stages of the pilot there could be significant waiting times where a service user could present without any triage or clinical contact. This prompted concern of whether there were significant risks to young people who had more severe presentations.

Did Piki address primarily problems of mild/ moderate severity?

Reference to section 4.3 shows that overall, there was a greater likelihood of service users presenting to Piki at the more moderately severe end of the distress spectrum with over a third of GAD-7 scores in the severe category and over a half of PHQ-9 scores at moderately severe or severe.

In January 2020, most clinicians surveyed by the evaluation team (88%) reported seeing at least some clients who were experiencing more severe distress than the mild/moderate group that Piki was designed for, which accords with anecdotal reports by providers. Just 13% of the surveyed clinicians described their client group as 'only mild/moderate'.

The Piki case mix was expectedly broad, with therapists, and particularly the intake coordinator, having to manage cases across a wide range of presentations and severity:

> *now after some of the promotions we're getting a broader range of clients, so with sort of complex trauma histories, I'm not sure that this model fits that group as well.* (SP-PK109)

> *there's definitely people who I have talked to more in the intake role than as a counsellor but there's been a few as a counsellor who have kind of said, 'I just thought that everyone should have counselling and I saw it was free so here I am,' and you kind of say, 'What do you want to work on,' and they say, 'I don't know.' So there's been a few like that but then there's also been some incredibly complex people come through who definitely should be under secondary services.* (SP-PK03)

The challenges in gauging severity are illustrated in an example of a reported interaction with a client apparently at risk where one therapist described saying:

> *this is what you present to us and we can't get hold of you, then we have a duty of care to find out what's happening with you and if that means the police turning up to your home so be it. We make no apologies. So it's like 'oh but I didn't really mean it'.* (KI-PK16)

It was clear that many presentations would also have benefited from access to intensive therapy input beyond the scope of the Piki objectives.

> *you're looking at intergenerational trauma and really, really complex family histories and in the back of my mind I'm thinking I've got twelve sessions and that even opening that box may not be the most appropriate thing.* (SP-PK109)

How did therapy intensity match a mild to moderate presentation?

Despite the data and narratives indicating presentations at the more severe end of the mild/ moderate severity spectrum, there is a potential paradox in the match to intensity and duration of therapy offered within Piki. As indicated in Figure 14 above, there was often a relatively low level of engagement with individual clients, with the majority of Piki clients having between one and three sessions, although these numbers should be considered with some caution.

Although in many instances the 'brief' input may be appropriate for perceived straightforward presentations, there are clearly cases where the intensity matching does not seem to have been optimal:

> *I don't know if we've actually looked at the other end of the mild mild mild actually just normal anxiety or normal everyday stresses that don't require CBT and the whole six sessions. Maybe they might require a single session.* (KI-KI01)

> *I was offered 4 free sessions at my initial appt, though was recommended that I seek longer term counselling first as that is what I really needed. When I couldn't find anyone, I came back to Piki and was told that the parameters had changed, and I was no longer eligible for a package of care.* (Client survey response)

> *Because I was initially rejected from the service when it was very busy (in September I think), there's been a real sense that my use of Piki is a) on borrowed time i.e. I only get a few sessions to fix myself when I actually need ongoing support.* (Client survey response)

> *when you've got someone coming in with multi layered trauma or multi, not just, we've got comorbid, heaps of comorbid, drug and alcohol alongside mental health, alongside eating disorders.* (SP-PK73b)

It is also unclear to what extent service users were aware of the service dimensions, and felt a need to 'game' their symptoms towards the mild end of the spectrum.

> *Like I need to keep it sort of like on the milder side when we talk about like the very surface level issues otherwise they're going to kick me out because they're not going to be able to handle it or something like that.* (KI-KI04)

Therapists also had a range of views about the appropriate match of therapy intensity to problem severity. In some of the services there was a strongly held view that existing patterns of care matched assessed severity appropriately; this seemed particularly the case with the university student health services.

In other cases, it was clear that the perception overall of great acuity and severity meant that more prolonged treatment was warranted:

> *Since the launch of Piki, my clients who have achieved the best outcomes are the ones who I have worked with by going against the service model (i.e., booked in weekly for 12-20 sessions), whereas making any progress is difficult for clients who can only be seen once a month.* (Therapist survey)

There was significant perception from a survey of therapists that workload numbers were resulting in pressure to provide interventions of shorter duration and intensity.

> *Encouraged to see clients for 1-4 sessions maximum. Told clients often only need 1, told average from British Pilot was three session or so. No taking into account there may have been a lot of dropouts or other reasons for the average.* (Therapist survey)

> *Encouraged to do very brief interventions and as a therapist had to push back for ethical, and good practice standards.* (Therapist survey)

How was 'risk' managed given the spectrum of presentations?

As noted above, Piki was accessed by youth with a wider spectrum of mental distress than initially envisaged, raising the issue early on of how clinical risk would be managed, and how service users and health providers perceived severity. Added complexity was due to the multiple referral pathways into Piki, and the degree of oversight across different parts of Piki. Assessment and triage might be different if the client self-referred through the website compared to referral from general practice. Questions about spectrum severity and risk management were posed from different perspectives, including the service user perspective (which was seen as essential in the context of co-design):

> *While we know Piki is for mild to mod distress, SURG want to know what is the safety plan set-up in place if someone does become suicidal?* (email from coordinator of Service User Reference Group)

Risk discussions were particularly significant where peer support was part of the package of care, given the peer support philosophy of 'walking alongside', no matter how complex the problems.

> *there may be times when a peer supporter is concerned about a person and feels they need a bigger team around them.... In these kinds of situations, the peer supporter needs to follow the advice set out in 'Responding to crises' and 'Responding to serious risk of harm' in this manual and use the outlined shared risk-taking approach with the participants.* (Piki peer support pilot manual)

> *a huge number ... probably majority of the people who are calling wanting support are who I consider to be not mild in terms of their needs... the majority of them seem to have some kind of trauma .... a large portion of people we are asking those questions and we are getting quite high scores which indicates that there's not just suicidal thoughts or ideation but there's actually additional behaviours that indicate the level of suicidality that's kind of beyond the mild kind of presentation.* (KI-KI01)

The challenge of managing a spectrum of severity was recognised by Piki and the various management groups. Given the pressure on the service and the challenges faced by secondary care services in terms of workload, a degree of risk holding was regarded as inevitable.

The risk-holding was made more complex by some of the difficulties faced by primary care providers such as GPs feeling that Piki may represent the most accessible source of care for the young person, and at times having clients referred from secondary care with a request to refer on to Piki.

> *you'll be well aware of some of the tension between secondary care and primary care anyway around the Piki staff and being able to actually clearly clarify which point the client's in and that information sharing thing has not gone well, with hidden information and trying to sneak clients in here and they're really acutely unwell and that has created a lot of issues...we've had multiples who have said, 'Well I was told by Te Haika Crisis Response just go and get your GP, just refer yourself to Piki and they will definitely take you.* (KI-PK90)

As a recognition of the challenges of accommodating service users who might either develop more severe presentations after initially being assessed as mild/ moderate, or who from the outset had strong secondary care affiliation, various strategies were employed to try and manage the risk.

When there were increased referral rates and increased waiting times, the use of an intake coordinator was employed to 'triage' according to severity, with the aim of finding those who required more immediate help. (See section 3.5).

> *Action – this will be discussed as part of the intake process conversation at Tū Ora, and the proposed Intake Coordinator role would enable assessment in a timely manner, and referral to more appropriate services for those presenting with higher levels of distress.* (Practitioner Advisory Group minutes)

While self-referral was a key pathway into Piki as a way to improve access, pathways also existed to refer up to more intensive psychological care from Explore, to other private providers with more specialist expertise, or to secondary services, as part of the stepped care model.

A multi-disciplinary team (MDT) was another strategy to provide additional support for complex cases which took some time to establish (becoming operational late in the pilot period, in July 2020). The operation of the MDT faced several challenges including lack of clarity over referral processes; by the end of 2020, one MDT meeting had occurred with 6 referrals.

Suicidality and severe risk

Given the challenges of managing the tension between 'open access' and the focus on 'mild to moderate 'presentations, there has been consistent thought given to managing severe risk and suicidality in Piki. This was the subject of discussion at Steering Group and Practitioner Advisory Group level. Asking about self-harm and suicide was included in training and assessment procedures and there was a particular focus on support for peer supporters in sharing suicidal concerns.

> *And so you know how we look at that from here on is going to be really challenging and is going to require steering and governance, clinical advisory, probably some budget from somewhere because there's risk, ... I think the providers feel there's risk holding that level of severity when often it's actually not in their scope.* (KI-PK07 – Clinical advisory group)

> *I think there are probably young people accessing the service who are also part of secondary services as well but you know when you're in need, you're in need right and you will try any door regardless of what it is.* (KI-PK15)

During the Piki pilot there was, sadly, a completed suicide; a young person who had a significant history of secondary services involvement, and Piki engagement was seen as additional support with knowledge of very clear risks.

In the extensive postvention activity that occurred, there was particular discussion around the place and timing of psychological screening, and the role of the community notice board, and the degree to which monitoring is employed.

Summary

The issues of 'clinical safety' or 'risk management', and prioritisation of clients with more acute presentations are difficult ones to manage within an 'open access' service (with online self-referral). This has raised the problem of how to design optimal processes to manage intake and any need for triage without creating barriers to access. A key question here is: How can clinical needs be safely managed in the context of a service designed to mainly address 'mild to moderate mental distress?' and this is one for which the answer has not been fully resolved.

4.6 SERVICE ACCESSIBILITY AND FLEXIBILITY

Another important goal of the Piki pilot service was to reduce barriers to access and to increase flexibility of the service with more options for support for clients.

Service users noted in interviews that lack of accessibility remains one of the biggest barriers to support-seeking. The fact that the pilot was free was an important advantage to this age group. However, those in full-time employment found it difficult to schedule appointments and it was suggested that more flexible hours of appointments should be provided to address this. The inclusion of telehealth and a digital app were intended to improve accessibility for young people living outside main centres and in rural areas, or others who found it difficult to attend in-person services for various reasons. The potential of the included telehealth services and digital app did not fully realise their potential in this regard (see sections 5.3 and 5.4).

Barriers to access more generally were reduced by making the service free to clients and making it possible to self-refer to the service through the website. Both of these were felt by service providers to be valuable and successful ways of improving access:

> *Most of the young people that I see of those that very few are employed fully, they're employed part time, they're studying part time, they're working part time, they're not working and so I think the fact that it's free is great.* (SP-PK108)

> *the ease of access, the fact that people can self-refer, certainly has encouraged people to use it.* (SP-PK109)

> *I think ease of access has … made it more appealing, like being able to self-refer, not having to jump through too many hoops to get some counselling.* (SP-therapist focus group)

This open access can, however, lead to issues with processing referrals where some form of triage and intake co-ordination becomes required and sudden surges in demand can lead to problems with excessive wait times. These problems have all been encountered within Piki as detailed elsewhere.

Another aspect of improving accessibility is providing a rapid response to referrals and this was a goal that was also challenged at times by heavy demand in some geographical areas, though not all:

> *in the Wairarapa we've been quite lucky that we've been able to respond quite quickly. We don't have huge waiting lists and so people do get quite a quick response.* (SP-therapist focus group)

The suite of options available in the service, in addition to the usual default of therapy, was another innovation that was valued as being appropriate to the age group, and empowering for clients:

> *really liked that it was offering options, cos again my experience with working with this age group, you don't necessarily need talking therapies, you just need someone to walk alongside with you for a time.* (KI-PK95)

> *the great thing with Piki is that there's lots of different options for people … that's something that hasn't been offered previously in mental health programmes…. rather than us being the experts saying, 'No you're going to do this cos that's what you need,' it's actually saying, 'These are the things that we can offer you, you're the expert, what do you think is gonna help?' … I think that's one of the most important things for people is them feeling empowered.* (SP-PK106)

Additional ways of giving service flexibility and choice were on the radar but were not able to be incorporated within the pilot timeframe. These included having on-line profiles of service providers (therapists/peer supporters) so that clients could see who they would be working with and potentially be able to choose their therapist/peer supporter. This kind of choice is available at the Puāwaitanga phone counselling service and potentially improves the likelihood of a good fit. It is notable that a small number of client survey respondents (n=11) commented that they had only attended a single session of therapy because they felt that the therapist was not a good fit for them. While such flexibility is desirable, there are logistical issues in implementation especially when the service is experiencing high demand and consequently lengthened wait times.

For example, at one stage when this was the case, Tū Ora was assigning therapists to clients based on the day of referral which worked in the opposite direction with regard to choice and matching service provider and client:

> *They don't get any choice. So if they referred on a Friday they get me and if they're referred on a Monday they get one of our colleagues and at the moment we're being told that we shouldn't be swapping clients around.* (SP-PK03 – Tū Ora therapist)

The importance of finding a service provider that suits individual clients was acknowledged as well as finding ways to make it easier and more comfortable to change service providers, which could be achieved by having an intake co-ordinator as the contact or through an app. More work needs to be done to normalise such a process and reassure clients that this is acceptable.

> *the likelihood of you picking the person that, the best person right off the bat is probably pretty slim... I always say to them you're gonna get more out of this when you're talking to that person who you think gets you ... they're kind of apprehensive about saying this isn't working because then they've got to wait again... It would just be so great to be able to create an environment within the service where people feel very comfortable.* (SP-PK106)

> *I guess that would be a perk of having an intake person would be that that would be someone you could go back to and say, 'Actually we didn't really click.'* (SP-PK03)

> *Maybe have a way of making sure the counsellor fits the person seeking help.* (SU – Client survey response)

> *I think maybe I could've asked if there was anyone else.... Maybe if it was on the app or something but I didn't want to let her know.... I didn't want to hurt her feelings.* (SU-PK55)

> *maybe through someone else, like through the organiser or something and maybe being reassured ... Maybe just saying like its emphasising that its normal to switch people, like it's a common thing and sort of establishing that.* (SU-PK61)

Other flexible elements mentioned as desirable were locating therapists on a rotating basis in existing services, for example at polytechnics, and having sessions available outside the normal business hours of 9 to 5 for those who are unable to take time off work to attend.

> *I think also the counsellors actually sitting in services one day a week or whatever that accessibility is just way more efficient.* (KI-PK119 – referrer)

> *It can be quite hard to find a time for a session as someone who is working full time during the day. If there were options outside of 9-5 that could be helpful.* (SU – Client survey response)

Overall, the improved access to mental health support through the service being free and available for self-referral were highly valued and probable drivers of the high demand for the service. The implications of this need to be carefully prepared for. The introduction of additional options for support was also valuable, but there are further ways that flexibility in service offerings can be enhanced in the future.

PART 5:
OUTCOMES & EFFECTIVENESS – PIKI COMPONENTS

Part 5: Outcomes & Effectiveness - Piki Components

5.1 THERAPY

This section reports on the outcomes and effectiveness of the individual talk therapy component of Piki. It describes the utilisation by young people, the workforce development (including CBT training outcomes) and includes the experience and perspectives of service users, service providers and key informants.

Therapy utilisation – Jan 2019- December 2020

Table 33 describes how many individual service users accessed therapy through each Piki provider of this service (excluding the dedicated telephone counselling services). The vast majority of Piki clients accessed the therapy component of the service.

Table 33: Unique Individuals accessing each Piki service for individual therapy (n= 5307)

UNIQUE INDIVIDUALS BY PROVIDER	COUNT	% DENOMINATOR = 5307
Tū Ora	2400	45.2
VUW	1561	29.4
Massey	760	14.3
Te Awakairangi	548	10.3
Ora Toa	38	0.7
Explore (Clinical psychology)	172	3.2

Note: some people accessed more than one service

Table 34 shows the total number of therapy sessions delivered as part of the Piki service.

It should be noted that Tū Ora, as the provider with the most Piki therapists, provided the bulk of therapy, while Explore is a specialist service which by its nature should only see a subsection of Piki clients. Sessions at the university services represent those for all Massey counsellors (whether funded by Piki or not), while only sessions with Piki funded counsellors at VUW were counted until June 2020, and from then on, all counselling sessions were counted.

Table 34: Total Session Count (n= 21015 sessions)

SESSIONS BY PROVIDER	COUNT	% OF TOTAL SESSIONS
Tū Ora	7145	34.0
VUW	4937	23.5
Massey	2974	14.2
Te Awakairangi	2398	11.4
Ora Toa	242	1.2
Explore (Clinical psychology)	1320	6.3

Non-attendance rates

Table 35 describes the total number and proportion of non-attendance rates by organisation type. Puāwaitanga appear to have the most non-attendance per total amount of appointments at 27.9%.

Table 35: Non-attendance rates 1 January 2019 – 31 December 2020 by Service Type

SERVICE	NUMBER OF NON-ATTENDED SESSIONS	NON-ATTENDED SESSIONS AS A PERCENT OF TOTAL SESSIONS	TOTAL SESSIONS IN SERVICE INCLUDING DNAS
Te Awakairangi	884	26.9%	3282
Tū Ora Counselling[1]	1797	20.0%	8942
VUW	436	8.1%	5373
Explore	377	22.2%	1697
Ora Toa	48	16.5%	290

1 This number includes Massey Student Counselling too, unable to identify in DNA data, which belong to Newtown Union Health Service and which belongs to Massey

Therapist Workforce composition

The Piki pilot funded additional therapists to increase the capacity of existing services. To provide context for these numbers, the populations the providers were serving in 2018, prior to commencement of the pilot were as follows:

- Tū Ora: approximately 38,500 enrolled 18-25 year olds in the Wairarapa and Capital Coast DHB regions (July 2018)
- Te AHN: approximately 12,000 enrolled 18-25 year olds (July 2018)
- Victoria University of Wellington: approximately 22,500 enrolled students (2018)
- Massey University (Wellington): approximately 3000 enrolled students (2018); now about 4000.

Table 36 shows the number of full-time equivalent therapist positions funded by Piki for the pilot period. The position at Ora Toa was not allocated until late 2019, after agreements between the service providers were finalised. The actual FTEs at other organisations varied over the course of the pilot according to staff turnover and vacancies.

Table 36: Piki Funded Workforce FTEs

ORGANISATION	FTE
Tū Ora Wellington (inc Porirua/Kāpiti)	7.0
Tū Ora Wairarapa	1.0
Te AHN	4.6
Explore	2.0
VUW	3.7
Massey University	1.0
Ora Toa	0.7
Total (therapists)	20.0

Notes:

1 The FTE for Tū Ora Wellington includes 1.0 FTE dedicated to Intake Coordination, but with the dis-establishment of this position in April 2020, this FTE resourcing has been reallocated to 5 additional peer supporters in Porirua and the Hutt Valley.

2 The place of Piki is somewhat complex within the two university services. While Massey has funding for 1.0FTE therapist, sessions with the total therapist work-force of 3.8FTE were counted as Piki sessions. At VUW, only those sessions with the 3.7FTE therapists who are Piki funded were counted up to June 2020. The VUW counselling service as a whole has fluctuating staff numbers according to yearly study cycles of term and holiday periods and in 2018 averaged 10.5FTE across the year spread across five psychologists, 13 counsellors, two social workers and one occupational therapist. From 1 July 2020 onwards, all VUW student counselling sessions for 18-25-year-olds were counted as part of Piki, with all counsellors able to sign people up to Melon and refer to Peer Support services. A training programme for these VUW therapists is being developed (as described above).

As of December 2019, there were 41 individual therapists employed within the in-person Piki services (including Explore) of whom 31 were CBT trained, according to data provided by the organisations (i.e., this includes all counsellors at Massey but only the Piki funded ones at VUW). The following tables (Tables 37-39) show the demographic and employment/training characteristics of the Piki workforce at Tū Ora and other partner organisations as at July 2020 and February 2021, as reported by each organisation to Tū Ora.

Table 37: Gender and ethnicity of therapist workforce as at July 2020 and Feb 2021

	TŪ ORA						UNIVERSITIES									
	WGTN		POR/ KAP		WRPA		VUW		MASSEY		ORA TOA		TE AHN		TOTAL	
	'20	'21	'20	'21	'20	'21	'20	'21	'20	'21	'20	'21	'20	'21	'20	'21
Gender																
Male	4	2	3	1	0	0	2	2	2	2	0	0	3	2	**14**	**9**
Female	5	9	6	7	3	3	1	2	3	2	1	1	9	6	**27**	**30**
Ethnicity																
European*	9	9	5	5	3	3	2	3	4	3	0	0	10	5	**33**	**28**
Māori	0	0	2	2	0	0	1	1	0	0	1	1	1	1	**4**	**5**
Pacific	0	1	2	1	0	0	0	0	0	0	0	0	1	1	**3**	**3**
Other	0	1	0	0	0	0	0	0	1	1	0	0	0	0	**1**	**2**
Unknown														1		**1**
Total	**9**	**11**	**9**	**8**	**3**	**3**	**3**	**4**	**5**	**4**	**1**	**1**	**12**	**8**	**41**	**39**

* includes NZ European and Other European

In addition, Piki uses the services of four psychologists (2 male and 2 female) at Explore, all of whom are of European/NZE backgrounds.

This table shows the variation in staffing in some organisations over time, with concomitant variability in demographics. Two-thirds of the therapist workforce were female in mid-2020 and the imbalance towards females had increased by 2021. While most therapists were of European background, there has been some improvement in ethnic diversity although there are still only 5 Māori and 3 Pacific therapists. Explore also had a Māori psychologist for a short period from April to August 2019 which is not reflected in this table.

Data on age of therapists is only available from survey responses from 37 of 41 therapists surveyed by the evaluation team in February 2020. This indicated that most therapists over all organisations (except Massey University) were aged 40 and above.

Table 38: Age of 37 of 41 Piki therapists surveyed as of February 2020[60]

	N	%
Age		
20-29	3	8.1
30-39	10	27.0
40-49	12	32.4
50+	12	32.0

According to data reported by the partner organisations Piki therapists came from a range of professional backgrounds and that there was just over 20% who did not have CBT training (see Table 39). In addition, the four psychologists working as part of Piki at Explore were all CBT-trained.

Table 39: Employment/training characteristics of therapist workforce

	TŪ ORA			UNIVERSITIES			TOTAL CORE
	WGTN	POR/ KAP	WRPA	VUW	MASSEY	TE AHN	PIKI
Qualification							
Counsellor	2	4		1	2	1	**10**
Mental health nurse	2	1	1			4	**8**
Social Worker	2	3	2	1	1	3	**12**
Psychologist (inc intern)	2	1		1		2	**6**
Occupational Therapist	1						**1**
Psychotherapist					2		**2**
Other						2	**2**
CBT-trained							
Yes	6	8	2	2	3	11	**32**
No	3	1	1	1	2	1	**9**
FTE per week on Piki							
0.2 – 0.4 FTE	1	1	0				
0.41 – 0.6 FTE	1	6	0	N/P	N/P	N/P	
0.61 – 0.8 FTE	4	0	1				
0.81 – 1.0 FTE	3	2	2				

Note: N/P = Not Provided

The data on FTE spent with Piki clients in Table 39 above is shown only for Tū Ora as the partner organisations do not report this to Tū Ora. As noted above, all Tū Ora therapists share their time between Piki clients and other clients (*Primary Solutions* or *To Be Heard* in the Wairarapa). A broader picture of data on FTE per week spent on Piki is shown in Table 40 below from the February survey of therapists and includes all Piki service provider organisations except Massey University and Puāwaitanga.

Table 40: FTE per week spent on Piki as of February 2020[60]

FTE	N	%
0.2 – 0.4 FTE	6	16.2
0.4 – 0.6 FTE	9	24.3
0.6 – 0.8 FTE	6	16.2
0.8 – 1.0 FTE	10	27.0

Note: for 37 out of 41 Piki therapists (including partner organisations)

Therapist Training

Baseline training, expertise, and needs

Prior to the Piki pilot, existing services included therapists with training in a range of modalities and evidence-based therapies and with varying levels of qualification and experience in Cognitive Behavioural Therapy (CBT) which was a key element of the pilot. Therapists working in those existing services were all qualified professionals, with professional memberships and registrations. Many had training in and used therapy styles which were aligned with CBT-informed training.

A survey by Tū Ora of all Piki therapists as at July 2019 (n=33) found that clinician expertise was reported mostly in Motivational Interviewing, Brief Intervention, Cognitive Behaviour Therapy and Supportive Counselling, and least experience with Dialectical Behaviour Therapy, Eye Movement Desensitisation and Reprocessing (EMDR) and Cognitive Processing Therapy/Trauma-Focused CBT. In terms of assessment competency, Mental Health Assessment and Risk Assessment were most often reported, in contrast to Neuropsychological assessment and Formal Assessment of Psychological conditions, for which no competency was reported by many. There was broad interest in further CBT-informed therapy training including advanced CBT (including for trauma), third wave CBT therapies such as EMDR, ACT and DBT, Māori and Pasifika cultural training and group facilitation skills.

CBT Training

The University of Otago provided post-graduate CBT training courses for Piki therapists. In 2019, 19 therapists enrolled and completed the course. Six more completed the course in 2020 and three enrolled in the course in 2021, with two of the 2019-2020 Piki certificate level students undertaking advanced CBT training in 2021, which includes working with trauma (an identified training need by Piki therapists).

The 2019 cohort was approximately two thirds female, ranging in age from 26 to 66 years old, with three of non-European background. They were mostly social workers and counsellors, and most were employed by Tū Ora. The 2020 cohort of consisted of 5 female and one male, aged between 33 and 55, with one student identifying as Māori. The 2021 cohort consists of 3 female European therapists from Tū Ora. Table 41 below summarises the demographic and professional backgrounds of the students.

Table 41: Description of the Piki Therapist Training cohorts

CHARACTERISTICS	2019 N	2020 N	2021 N
Gender			
Male	6	1	0
Female	13	5	3
Ethnicity			
European	16	5	3
Māori	2	1	
Pacific	1	0	
Profession			
Nurse	3	0	
AOD Clinician	0	1	
Psychologist	1	1	1
Social Worker	7	2	2
Counsellor	6	1	
Mental health nurse	1	1	
Occupational therapist	1	0	
Organisation			
Tū Ora Compass Health	15	2	3
Explore	1	0	
Victoria University Counselling Service	1	0	
Vibe	1	0	
Massey University	1	0	
Ora Toa Mauriora	0	2	
Te Awakairangi Health Network	0	2	

The CBT post-graduate certificate course covers the basic concepts and techniques of CBT as applied to depression, anxiety, substance use and psychosis. The course materials were adapted for the Piki students to have a strong focus on working with young people. The course has a particular emphasis on working in a culturally appropriate way, including a half-day bicultural workshop and a workshop on working with gender and sexual minorities. Due to COVID-19 the 2020 blocks were delivered largely online. The students meet with their CBT supervisors regularly and submit three graded assignments before sitting a final exam. The university worked hard to support the students to continue with the course during COVID-19 lockdowns. The first and second 2020 block courses had to be delivered online due to covid restrictions. The students were surveyed in April 2020 as to their situations in order to ensure that the course assessments were feasible for students working from home.

The three assignments involved written case histories with conceptualisations and treatment plans accompanied by a recorded session with the client the written assignment was based on. There was a final (oral) exam at the end of the course. All assignments were worth 25 marks including the exam.

Table 42: Piki CBT Training grades

	2019	2020
Assignment 1	17.4	14.1
Assignment 2	18.6	20.8
Assignment 3	17.4	20.3
Final exam	15.7	16.7
Overall mark	68.8	74.8

These grades suggest an improvement in competence across the training.

All Piki students passed the course in 2019 and 2020, gaining a post-graduate certificate in Health Sciences (endorsed for CBT).

Therapist CBT Fidelity training

The University of Otago Wellington also ran a two-day CBT fidelity training course in April 2019 which was attended by 11 therapists. The aim of this course was to ensure that previously CBT trained therapists were adhering competently to the CBT approach.

Approximately 2/3 of the fidelity course trainees were female and all identified as European. Over half were nurses by background and the largest number were employed by Te AHN. Table 43 summarises the demographic and professional backgrounds of the therapists in this course.

Table 43: Description of the Fidelity Training cohort

THERAPIST CHARACTERISTICS	N
Gender	
Female	7
Male	4
Profession	
Nurse	6
Clinical Psychologist	4
Social Worker	1
Organisation	
Te Awakairangi Health Network	5
Victoria University Counselling Service	3
Tū Ora Compass Health	3
Self-ratings of extent of CBT use in practice	
Not reported	1
40 – 60%	2
60 – 80%	4
80 – 90%	1
90 – 100%	3

The content of this course was standard CBT as it was not possible to cover all the possible kinds of therapy under the broad 'CBT-informed' umbrella of Piki in a two-day course. All clinicians submitted a video of themselves conducting CBT. Two clinicians were asked to submit a second video as they did not meet a minimum pass mark (36/72) on the Cognitive Therapy Scale-Revised.[45] Their second video passed in each case.

No additional CBT fidelity training courses have been offered since the April 2019 course.

Participants were asked to complete an evaluation at the end of the 2019 two-day fidelity course. Table 44 shows the summarised results of the evaluation. This suggests that the fidelity training was generally well received.

Table 44: Summary of Participant Evaluations for Fidelity Training

ITEM	RANGE	MEAN
(Rating Scale: 0: Not at all 1: Somewhat 2: Moderately 3: Very much 4: Extremely)		
Stimulate my interest in using CBT	2 - 4	3.3
Use appropriate teaching methods	2 - 4	3.4
Provide content was relevant to my clinical work	1 - 4	3.6
Provide useful additional readings and handouts	1 - 4	3.5
Balance theoretical and applied learning	1 - 4	3.0
Provide content that was at an appropriate level of difficulty	2 - 4	3.4
Cover a manageable amount of material	2 - 4	3.4
Pace the content appropriately	0 - 4	2.8
Provide enough opportunity to practice clinical skills	1 - 4	3.0
How likely would you be to recommend this training to a colleague who has existing CBT training?	0 - 4	3.3

Other training plans

In the first half of 2020, Tū Ora conducted a further workforce survey of Victoria and Massey University student health counsellors to ascertain the CBT and related qualifications and experience of this segment of the workforce. This was in the light of the decision to include all VUW counsellors as Piki therapists from 1 July 2020. Results from this survey were used to inform the development of workforce training plans to ensure that this expanded workforce has, or are working towards, evidence based, youth-focused and CBT-based skills and competency requirements, as laid out in the Piki SOP Manual[66] (2.2 Therapy Model, p3). Following the CBT fidelity training for three VUW therapists and the formal CBT training of one VUW therapist through UOW in 2019, no further training in VUW enrolments occurred in 2020, largely due to difficulties with meeting the timelines for enrolment when the service was still recruiting staff. The training plan that was agreed on for VUW noted that instead three Piki-funded clinicians were being supported in 2020 to complete the online CBT training through the Oxford Cognitive Therapy Centre and that other clinicians were required to complete at least one training option in 2020 from a range that included Piki training in Culture & Diversity, online CBT training through Pyschwire.com, and various online ACT, FACT, Co-existing Problems (CEP) Trauma, Child & Youth, and Motivational Interviewing courses (through goodfellow.org, werryworkforce.org and matuaraki.org.nz).

Supervision for therapists

As noted in section 3.4, regular supervision for therapists was part of the Piki model and was provided by psychologists from an external organisation, Explore, for therapists who completed the CBT training with Otago University. Explore recruited two clinical supervisors (registered psychologists with formal training in Cognitive Behavioural Therapy) to provide this service to Piki.

Therapists were allocated a supervisor, rather than being able to choose. There were some initial delays at the start of 2019 in getting supervision set up. There was variability in how supervision was provided at each provider organisation: Tū Ora therapists received fortnightly supervision, while Te AHN had their own monthly external supervision systems, including cultural supervision. The Tū Ora therapist based at Evolve Youth Health centre for part of the pilot period had Tū Ora supervision and peer supervision within Evolve. There were also informal opportunities for therapists to share experiences in organisations such as VUW where there were a number working in the same location (not all Piki therapists were in a location with other therapists). Additional ways to facilitate more informal communication between therapists were Piki clinician hui (as mentioned above) plus the trial of a community forum for service providers on the Melon app (from June 2020). This had not been used extensively by December 2020.

The Tū Ora survey in July 2019 found that about half of the therapists felt they did not require any additional supervision, while others suggested a need for the following: more frequent or longer sessions of supervision, discipline specific supervision to maintain registration, and supervision regarding case management (especially in relation to case numbers), culture and gender identity, and risk management.

Initially there was a lack of formal supervision for therapists in the intake coordination role. There was feedback from some students around June 2019 that CBT supervision time was being spent dealing with therapist stress about changes to the system rather than discussing CBT. It was also noted that supervision time needs to be built into the workload model to keep workloads realistic. Some therapists who are newly provisionally registered with their professional body, also need to have monthly supervision with their professional body.

A possible gap in the supervision provided at some of the partner organisations is cultural supervision. In addition, Explore felt they needed more resources put into supervision. Tū Ora acknowledged a lack of awareness regarding the level of supervision required to support the CBT training, which had led to the under-resourcing.[67] There were also concerns that some clinicians were not organising sufficient supervision sessions for themselves, despite this being available.

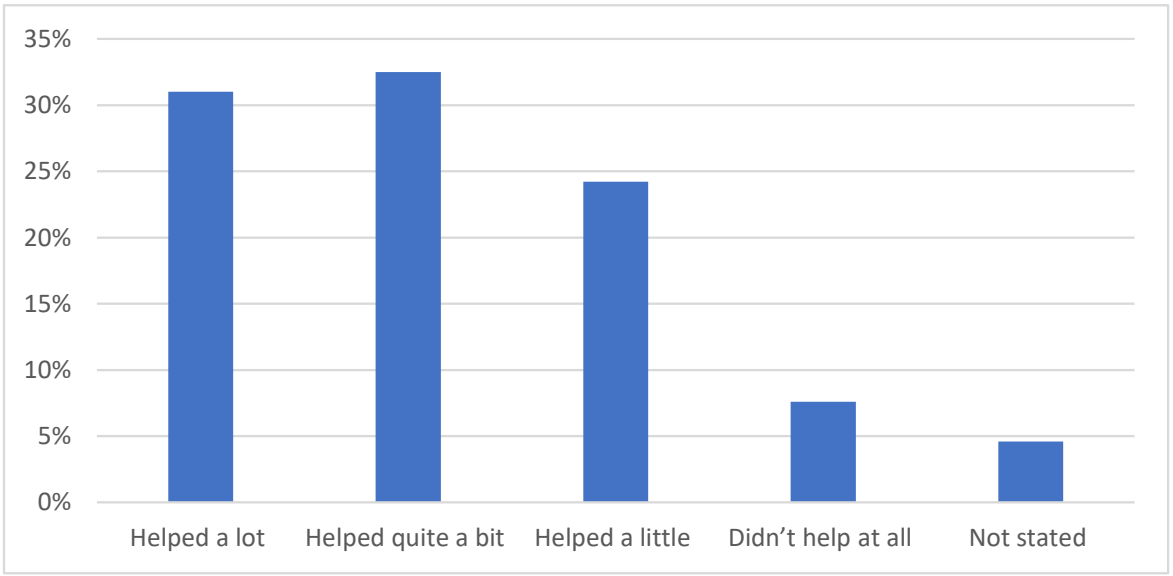
Perspectives on therapy delivery

Overall feedback

Issues with collecting an adequate set of outcome data mean that it is not possible to comment directly on the effectiveness of the psychological therapies offered through Piki in terms of psychological measures. However, the majority of Piki clients accessed in-person therapy and the feedback collected from service user interviews and survey responses indicates that therapy was generally seen as beneficial overall.

The client survey provided feedback on therapy from 582 service users (out of the 730 who completed the survey) and the majority were positive about their experience, 64%) indicating that it had helped them a lot or quite a bit, as shown in Figure 21:

Figure 21: Client responses to the survey question: Please tell us how well face to face counselling/therapy (incl video or phone during or after Lockdown) helped you with the issue that you were struggling with?



An important theme of the service user interviews was 'therapist fit'. Clients who built rapport with their clinicians saw more effectiveness in relation to their recovery outcomes than those who did not have a strong connection or found their therapist not quite the 'right fit'. All reported feeling heard and respected and felt like the sessions had a clear focus. Many praised their therapists, going as far as stating that their Piki therapist was the best they had ever had. However, some clients felt their therapists were out of touch with youth-related activities and wished for a smaller age gap between therapist and client in order to build better rapport. From the client survey, the minority with negative experiences of therapy mentioned therapists seeming scripted, repetitive, or 'dismissive':

> *Counsellor just read off a website/referred me to the same website for homework, didn't know how to help with issues other than mild depression and anxiety, often felt like it was a waste of both of our time.*
>
> *I had a lot of trouble with therapists not getting back to me, no communication, etc and a lot of the things I went over in sessions were repeated and were not helpful.*
>
> *Was a mixed bag. I'm a difficult patient with some difficult problems, but I feel my therapist got target fixation on things that weren't relevant to my care and wasted unnecessary time going through them, being dismissive towards things I care about.*

Suggestions for improvement included having therapist photos and profiles available for a more tailored approach (this was consistent with YRG group feedback at co-design stages of Piki), training for therapists in youth lifestyle, more comfortable offices (a few stated feeling anxious due to the office being in what seemed an abandoned, dark building), and being able to see their therapist's notes between sessions.

Model of therapy delivery

The original RFP from the MOH indicated that the pilot service should conform to the IAPT model of therapy delivery with a focus on fidelity to CBT as the treatment modality. The rationale for this was evidence from IAPT evaluations that treatment fidelity was an important factor in successful outcomes.

However, there were recurring debates from the early stages of the pilot as to whether there could or should be greater variation of style, duration, and intensity of psychological intervention to suit a range of client need, especially at the mild end of the continuum. These discussions can be seen as an active part of the co-design process with respect to perspectives on appropriateness and flexibility of approach for the client population and bearing in mind previous session averages and clinician qualifications and training in other modalities. There may also have been an understandable element of resistance to change or innovation.

Therapy style

The initial focus on standard CBT-based therapy was reflected in the workforce development programme set up at the start of the pilot (See Therapist training section above), and remains embedded as a key feature of the Piki service, as articulated in the Piki Standard Operating Procedure Manual in June 2020:

> *Piki clinicians will provide youth focussed and cognitive-behavioural based* counselling and therapy. Piki clinicians will ensure that all services will be delivered in an inclusive, culturally safe, and sensitive manner with the young person's needs and wishes given utmost importance.*
>
> **Cognitive Behavioural based therapy can include ACT, Focused ACT, DBT, Behavioural Activation Therapy, Problem-Solving Therapy, Standard CBT, Compassion-Focussed therapy, and Motivational Interviewing.*

The transition from an existing platform of service delivery created complexities around alignment of existing work practices with the Piki focus on CBT-based therapy models. Piki inherited several different styles of therapy delivery by the existing workforce, from supportive counselling and brief interventions through to several labelled styles of therapy, including Kaupapa Māori models. A significant number of new therapists were recruited, and different therapist groups (Tū Ora, VUW, Massey, Te AHN) had to work together more closely than previously. This range and diversity of therapy options and teams was a potential strength but was also a challenge to manage in the context of the pilot service.

Whilst there was certainly a strong core of CBT-informed provision within Piki therapy services, it is fair to say that there was considerable variation between services and clinicians in the extent to which CBT-informed therapies were delivered. While Piki included a training programme in CBT for therapists, thus increasing the skill-base of the workforce in this area, the evaluation team had no way to directly assess the extent of adherence to evidence based modes of practice within sessions, and reflections on this rely mainly on therapist self-report data.

A survey of CBT-trained therapists by the evaluation team in January 2020 found that a high proportion of Piki clinicians reported using specific CBT strategies (i.e., setting agendas, using behavioural experiments, homework-setting) with some or all clients. A few reported not using CBT at all or only with some clients. Where Kaupapa Māori therapy models were used, 'Te Whare Tapa Whā' was the most commonly used model, followed by 'tikanga', and then 'Te Wheke', 'Tika, Pono, Aroha' and 'Dynamic of whanaungatanga'. In the July 2019 Tū Ora survey, most therapists reported considering the inclusion of cultural practices, individual and spiritual preferences, family/whanau involvement, though to varying degrees.

Interviews conducted with Piki therapists suggested that of those who used standard CBT, many were very positive about it. They liked the focus and structure and found the worksheets helpful. Interviews with service users suggested that there were some who explicitly appreciated the benefits of CBT, with five interviewees explicitly referencing the therapy style:

> *probably ...the most beneficial thing cos that's mainly what we've just been doing is CBT in all of the sessions and by introducing me to it then I can sort of go home and do the homework and stuff and that's had real benefits.* (SU-PK61)

There was an intersection between the style of therapy advocated and the number of sessions available to clients. Several therapists expressed frustration that service pressures and expectations did not 'fit' well with standard CBT, which tends to involve at least four sessions.

On the other hand, some therapists and key informants, particularly in university services, held the view that youth did not want or need more than 1-3 sessions. Several expressed the view that ACT and other brief approaches, including strengths-based CBT,[68] fitted better with their service and/or 18-25 year old service user needs. Many therapists reported using ACT as well as (or instead of) standard CBT, while others appeared to be using a range of other therapies.

Other therapists reported that they were able to deliver more extensive standard CBT interventions and that this was resulting in good outcomes for young people. There was also some concern expressed that within some services existing or prior therapy philosophy could put some pressure on therapists to 'scale back' on a CBT informed approach to conform to previous working practice.

The difficulties of delivering a consistent approach through several existing organisations was acknowledged by Tū Ora management, particularly when there was a mixed funding model, as at the student health services: *'they self-fund counselling services and when people are self-funding something you've got limited kind of leverage on them to change the way they do it'*.

It was noted by a few that the model of 'talking therapy' and the CBT model favoured Pākehā, coming as it does from a Western tradition:

> *therapy by its nature is quite western.* (SP-PK108)

> *I think it's great if you're white Europeans. I don't think it's great for Māori and Pacific and other, so much.* (SP-PK87)

> *a lot of it is to do with like talking therapies but not everyone wants to talk and that is like you see with the Pacific boys they don't always want to talk.* (KI-PK43)

> *I felt like the structure just wasn't flowing as well with the Pasifika and Māori clients... that model just didn't fit with some of my clients coming through within Piki...I'd pull certain parts of CBT, but I couldn't follow the structured model of the CBT with some of the clients, it just didn't match.* (SP-PK73)

The CBT model was mentioned as perhaps less suitable for those with lower levels of education:

> *[for] my ones that weren't at University – were working, things like that – I found it was a bit harder for them to mould ...* (SP-PK73)

Interviews with service management and therapists suggested that some felt the CBT emphasis was imposed by the Ministry of Health: *'it's the prescriptive nature of having to use it that was the issue'* (KI-PK41b). However, many liked that there was training available, and that standard CBT is structured, practical and evidence-based. Several commented on the centrality of the therapeutic relationship (which is fundamental in standard CBT as in other therapies). Some negative comments about standard CBT by service management and therapists reflected misconceptions about what CBT is. For example, some thought standard CBT cannot address psychosocial problems – *'You can't CBT poverty. You can't CBT homelessness'* (KI-PK36) – when in fact empathising, normalising emotional responses, helping clients learn structured problem-solving skills and referral to community support agencies are all part of CBT.

There was continued discussion within Piki about the appropriateness of the CBT focus, with a shift over time from standard CBT, to 'CBT-Based' to 'CBT-informed therapy', including discussion of the possible benefits of offering a more varied menu of therapy options, and building evidence-based brief interventions into the overall therapy mix as part of the overall stepped care model. This was an issue raised by several key informants in late 2019 who suggested a focus going forward on fine-tuning the flexibility of service offerings (including therapy models). The expansion of Piki to all therapists and students at the Victoria University of Wellington counselling service and a workforce survey of therapists at both universities to assess training needs for these Piki workforce groups brought these issues into sharper focus.

Other issues raised by key informants and therapists from various partner organisations at different stages of the pilot include the following:

- a perception that CBT intervention and training may not be fully inclusive of the developmental (youth/young adult) approach to rangatahi
- questioning whether CBT-based approaches are appropriately inclusive of diverse cultural perspectives, in particular, applicability of the model for Māori and Pacific youth
- a view that young people may be less likely to commit to lengthy episodes of care
- a need to match the style and intensity of interventions with the nature and severity of presentation
- observations that within primary care settings young people typically present with a broad range of issues, with mental distress often due to situational concerns rather than anxiety and depression.

Duration of therapy

The number of sessions that the Piki service was able to provide to clients, and the fact that it was a stepped care model, appeared to be something that was not made clear to either therapists or clients in a consistent way, and was also variably implemented for a range of external reasons. This aspect intersects with the degree to which CBT-informed therapy was delivered as this style of therapy usually requires at least 4 sessions.

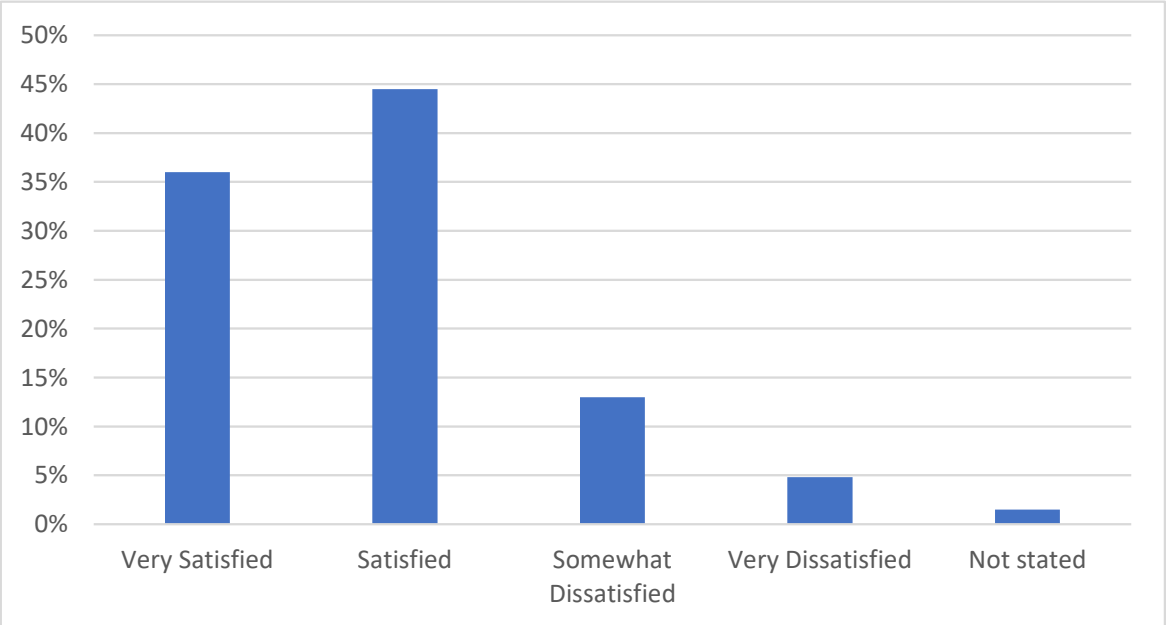
Clinician survey results indicated that the majority felt they were able to see Piki clients for as many sessions as they needed, although 27% reported this as not being the case. Reasons given for this included system pressure to finish after a few sessions, and high demand for services and resultant delays.

In clinician interviews, many expressed concern that there was a gap between service expectations about a low number of sessions per client and the ability to deliver CBT-informed therapies to the extent they felt their clients needed. Some services, however, did allow unlimited numbers of sessions. Another perceived issue was the variability among services and lack of clarity about the stepped care model whereby clients can ideally access as many or as few sessions as required, as one therapist commented:

> *I guess I'd just like to see it sort of somehow more flexible and less flexible at the same time... I think that the boundaries are still a bit blurry and I think young people do like having kind of clear boundaries as much as therapists do.* (SP-PK03)

For the service users, most survey respondents (81%) reported feeling very satisfied or satisfied with the number of therapy sessions received, although a minority were very dissatisfied, as shown in Figure 22.

Figure 22: Client survey responses – satisfaction with number of therapy sessions

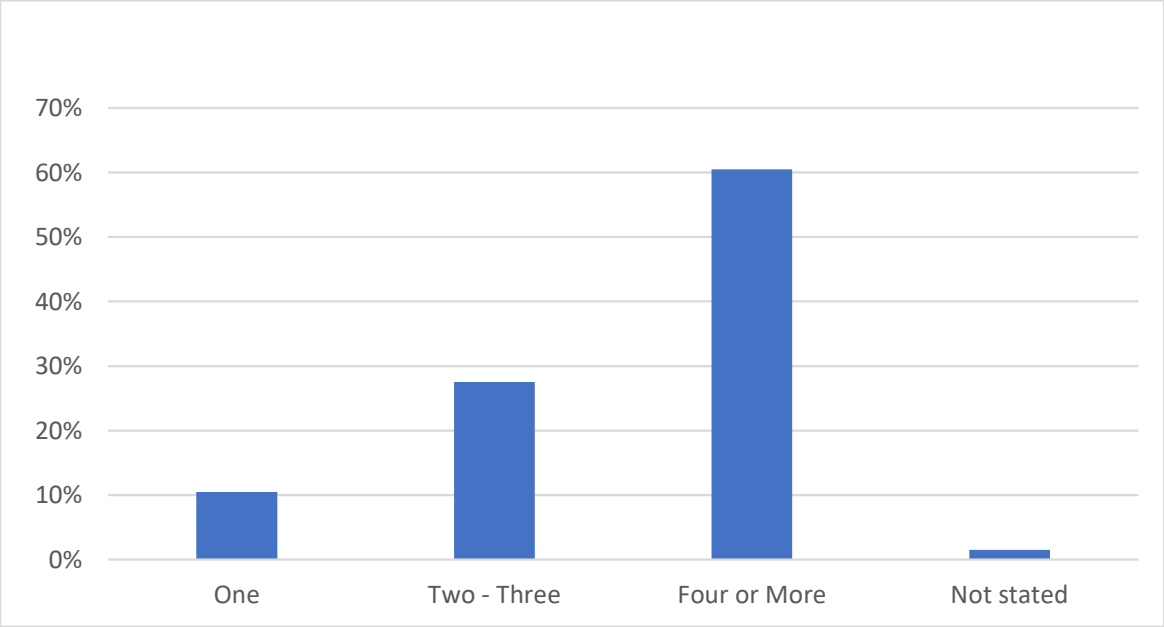


A lower proportion (about 50%) of service users who were interviewed expressed satisfaction with the duration of therapy they had received. Some noted external factors were what had prevented them from having the number of sessions they may have needed, rather than the nature of the service:

> *I probably would have gone to him more but then that's when it hit like the really busy time for uni with exams and stuff.* (SU-PK59 who had 3 sessions)

The duration of therapy reported by service users ranged from as few as 2 sessions up to around 20 sessions (among interviewees), while the results of the client survey showed that the majority (61%) received four or more sessions. It is notable that 10% of survey respondents (61) reported receiving only one session, as shown in Figure 23 below.

Figure 23: Client survey responses – number of therapy sessions reported



Survey respondents were asked for the reason that they had only one session, and while some had been waiting for another appointment or felt that one session was all they needed, others felt their therapist had not been a good fit, didn't like the help they received or stated they had only been offered one session.

Table 45: Reasons cited in Piki client survey for having only 1 therapy session

REASON	N
Counsellor/therapist wasn't a good fit for me	11
Found help somewhere else	8
Only offered one session	8
Waiting for an appointment	8
One session was all I needed	8
Didn't like the kind of help I received	4
Moved away	2
Covid19*	2
Long wait times*	1
Inappropriate severity for the service*	1
Counsellor took sick leave*	1
Not stated	7
Total	**54**

* paraphrased from a free text response

Some clients believed they had a finite amount of therapy sessions after which support would cease (usually around 6-10). It is unclear whether this was communicated within Piki, or perhaps (as this is a model commonly used within some practices) the service users assumed that Piki would be the same as their previous experiences of having a set number of sessions. Others were aware of flexibility in this regard, with one client noting:

> *it's good having a kind of undetermined amount of sessions. Having a cut-off point is very stressful and it is really negative to the situation.* (SU-PK58)

Session Frequency

One major area for improvement was around waiting times between sessions. A concerning number of clinicians (43%) reported low ability (never, sometimes or about half the time) to rebook clients at the frequency they felt was required, with some clients having to wait as long as 6 weeks for their next appointment. A few service users expressed real dissatisfaction with such waits:

> *because he also only had every three or four weeks, it was difficult to open up and get to a comfortable enough level to work on the trauma I have been wanting to work on.* (SU-PK68)

> *One thing is the gap between sessions. Because of availability, it's quite, it's been like two months, a month and a half between sessions, which is quite a stretch.* (SU-PK61)

There was a considerable range of session frequency among service users interviewed. Of the five who reported weekly (or at times bi-weekly) appointments, all were happy with that. There were also some who were happy with less frequent sessions, such as every 3-4 weeks, but acknowledged that this might be problematic at times, or for some people:

> *when I was good, that was fine but if I had like a really bad couple of weeks then, yeah.* (SU-PK66)

> *I can get through that because I have the support network to do it. For a person who doesn't have such a stable support network, no, it doesn't work for them.* (SU-PK64)

Especially in the early stages of therapy, it was felt that frequent sessions are important but that subsequent sessions could be less frequent.

Employment of more therapists was suggested to address long wait times.

Impact of administrative demands on therapy delivery

Administrative tasks can get in the way of therapy delivery. Both surveys of therapists mentioned above have asked about this. In July 2019, a Tū Ora survey of Piki therapists asked for an estimate of time spent delivering talking therapies. Interpreting the remaining time as administrative, most (63%) reported spending 50-60% on tasks other than therapy delivery, with a few spending only 20-30% on such tasks. Most (74%) reported spending between 10-20% of their time on writing notes, with only three reporting dedicating as much as 40-50% of their time to this task. Little time was reported as being spent on the phone or in SMS contact with people, other than the Piki client.[61]

In January 2020, a University of Otago Wellington survey found most therapists (66%) reported the administrative workload as manageable or better (3-5 on a scale of 1 to 5, where 1 is the least manageable). All therapists reported that they had at least some control of their booking diary, with most (84%) reporting they had control 'always' or 'most of the time'.[60]

Therapy workforce development

As expected, the transition from an existing platform of service delivery to an enhanced service has produced a number of workforce issues. These include the degree to which existing work practices align with the chosen therapy models and styles (as noted above), and the impact on workload of an increased number of clients in this age group, 'time out' for training, and new requirements of therapists regarding assessment and enrolment into Piki.

Using an established university course as a CBT training platform has had many benefits in terms of quality, in-depth learning, and treatment fidelity, but there is a potential mismatch in terms of timing between the academic year and operational workforce training requirements. Provider feedback also indicates that it may be difficult to commit staff time and supervision resources to the current CBT training programme. However, if less intensive and/or shorter training courses are desired, or the range of therapy styles is expanded from 'CBT-informed', attention will need to be paid to the development or sourcing of appropriate (and sufficiently in-depth) training programmes.

It would be advisable to plan well ahead to meet future training course needs for the Piki pilot and beyond as quality training programmes need time to be developed and organised. Consideration should also be given to regularly providing training updates and fidelity testing. A standard CBT update and fidelity course was provided in 2019, but has not been repeated in 2020, due to the broadened definition of 'CBT informed' therapies making it difficult to cover all approaches adequately in a short timeframe.

Interaction between peer support and therapy

Clients who engaged in both peer support and therapy spoke about the fact that these two interventions were quite different in nature, but very complementary. They appreciated the expertise and resources provided by therapists and were much more familiar with the therapeutic relationship and the process. However, clients also enjoyed the more casual nature of peer support, preferring to have some conversations within this more relaxed setting. Overall, the experience of those receiving both services was that it provided a wraparound approach where the client felt supported throughout their time with Piki.

Summary

While Piki has delivered therapy/counselling to a large number of young people, with mostly positive feedback, there has been ongoing discussion from the outset about CBT-based therapy content and style and to what degree there would be variation of both content, duration, and intensity of psychological intervention. As noted previously, this might be interpreted as an element of the co-design process, or alternatively as resistance to innovation and change by reverting to 'business as usual'. Content was also disrupted by COVID-19, in terms of overall volume and therapy type.

Service user experience has also been impacted by therapist availability and resultant wait times. Therapist 'fit' was also raised as an issue: other characteristics of therapists felt to be important in addition to their training included personal qualities as well as having a range of demographic characteristics available among the workforce (gender, ethnicity, and age, with some clients preferring therapists closer to their age) to enable service users to find a good fit.

Depending on the specific needs of the population served, it is appropriate to review both present and planned therapy content and style when incorporating Piki type programmes into the primary mental health platform mix. There should also be national and local discussion about the overall aim of therapy for this age group, and the potential difference between 'mental health first aid', which may be suitable for relatively low acuity problems, and therapy required to address more complex problems or where there is the potential to support longer term behaviour change, and/or to avoid negative trajectories through early intervention. In Piki there has been a trend towards shorter duration therapy inputs for a number of reasons. It is important that therapy is evidence based, tailored to need, and is not driven by workload pressures.

Based on the survey and interview data presented in this section, future services should consider the likely number of sessions available in services when considering the therapies to be delivered and communicate these clearly to all involved. It would be beneficial to engage therapists and service managers in the design of the intervention so there is more buy-in to whatever therapy approach is being used, and if offering standard CBT there needs to be an opportunity to clarify misconceptions about it. Given likely ongoing resourcing issues, it seems likely that ACT-based interventions may prove to be a better fit. The evidence base for ACT, while not as extensive as CBT, supports its use across a range of psychological distress.[69]

5.2 PEER SUPPORT

This section reports on evaluation of the peer support component of Piki. It describes the utilisation of peer support by young people, the workforce and training of peer supporters, and experiences and perspectives of service users, service providers and key informants.

Service utilisation Jan 2019 – December 2020

Peer to peer support services, delivered by PeerZone, were introduced into Piki in July 2019. A total of 155 out of 5,307 individual service users accessed peer support services, or 2.9% of total Piki users. The total number of sessions (defined as a therapeutic interaction with a therapist, counsellor, or peer supporter) delivered by PeerZone was 1,252 out of a total 21,015 sessions, or 5.6% of total Piki sessions. The mean number of peer support sessions per Piki client was 8.1 sessions, with PeerZone reporting the lowest DNA rate (3%; 40/1292 sessions) of all the Piki services.

Workforce

The peer support component of Piki was deliberately set up on a small scale to test how it would work, as befits a pilot. Interim evaluation results indicated that a number of key informants (notably youth) were in favour of more funding being directed towards peer support and some additional funding was made available in the second year of the pilot. The challenges initially faced by a small organisation delivering the peer support service have since been overcome by the transfer of the service to a larger, community-based mental health and social support service organisation, Emerge Aotearoa.

Workforce composition

An initial intake of 12 part-time peer supporters making up 2.4 FTE were recruited and trained by PeerZone in the first half of 2019 with 11 continuing for most of July to December 2019. In early 2020, 2 peer supporters based in the Wairarapa were recruited. The composition of the workforce has changed during the pilot, with some turnover, and an increase in funding which allowed for the additional targeted recruitment in June 2020 of one Pacific and four Māori peer supporters. While the peer support workforce was not originally very diverse, Table 46 shows the demographic characteristics of the peer supporters as of mid-2020 and early 2021. This shows good representation of gender diverse supporters, and of Māori and Pacific at this point, and an increase in the number of males by 2021.

Table 46: Demographic characteristics of peer supporters as of June 2020 and February 2021

	2020		2021	
CHARACTERISTICS	N=17	%	N=18	%
Age				
Under 20	0	0	1	5
20-29	12	71	11	61
30-39	3	18	3	17
40-49	2	12	3	17
Gender				
Male	2	12	5	28
Female	7	41	7	39
Gender diverse	7	41	5	28
Transgender	1	6	1	5
Ethnicity				
NZ European	6	35	7	39
Māori	6	35	6	33
Pacific	2	12	3	17
Māori/Aboriginal	1	6	0	0
Other European	1	6	1	5
Other ethnicity	1	6	1	5

Peer Supporter Training

All peer supporters undergo training with PeerZone over a two week period (9-10 full days).

The training provides an intensive introduction to Intentional Peer Support (IPS), including listening, communication skills, reflection (especially on one's own way of being), and practise in sharing those skills in a one-to-one intentional manner. This is based on the IPS principles of *Connection, Mutuality, World View* and *Moving Towards*. Following this, the training focuses on facilitation skills and running group peer support, using resources and workshop topics developed specifically for Piki. The training is accompanied by a manual on practically applying facilitation skills. Also included are cultural practice reflection, often with guest facilitators and speakers, and activities that demonstrate facilitation and cultural practices.

Supervision

As noted in section 3.4, PeerZone had their own system for supervision which involved attendance at a 1.5 to 2-hour monthly group supervision or co-reflection with their fellow peer supporters for support and professional development.

Experiences of the service

Many of the 26 service users interviewed were not aware of peer support as an option, and those who knew of its existence lacked familiarity with or understanding of the intentional peer support process. Several people described peer support as enforced or paid friendships. This lack of understanding may come from the fact that peer support is not commonplace in our mental health system. One client described peer support as something like what they had in high school, where seniors would support junior students who were having a difficult time fitting in, thereby attaching a negative connotation to the intervention. Those who had peer support accurately defined for them by the interviewer expressed enthusiasm for it, suggesting that if they had known about it earlier, they may have utilised it alongside or instead of therapy.

> *The service is not very visible and flies under the radar. Meaning that a lot of people who would benefit from it would be oblivious to the service.* (SU – PeerZone Survey Free text)

Lack of awareness and understanding of peer support was also evident amongst service providers, which may have also inhibited uptake. There were reportedly successful efforts to counter this, notably by the Piki promoter, especially amongst Māori and Pacific communities and in areas like Porirua. Indeed, there was a brief period in which demand for peer support increased to the point where PeerZone had a waitlist for the first time ever.

Responses from the PeerZone exit survey and from the Piki service user survey were generally positive. Of the 47 PeerZone exit survey respondents, 35 respondents had used the one-to-one peer support, 9 had used both one-to-one and group, 3 had used only group peer support. Most respondents found peer support helpful to at least some degree with 72% indicating it helped them 'quite a bit' (10) or 'a lot' (24), and 2 indicating that it 'didn't help at all'.

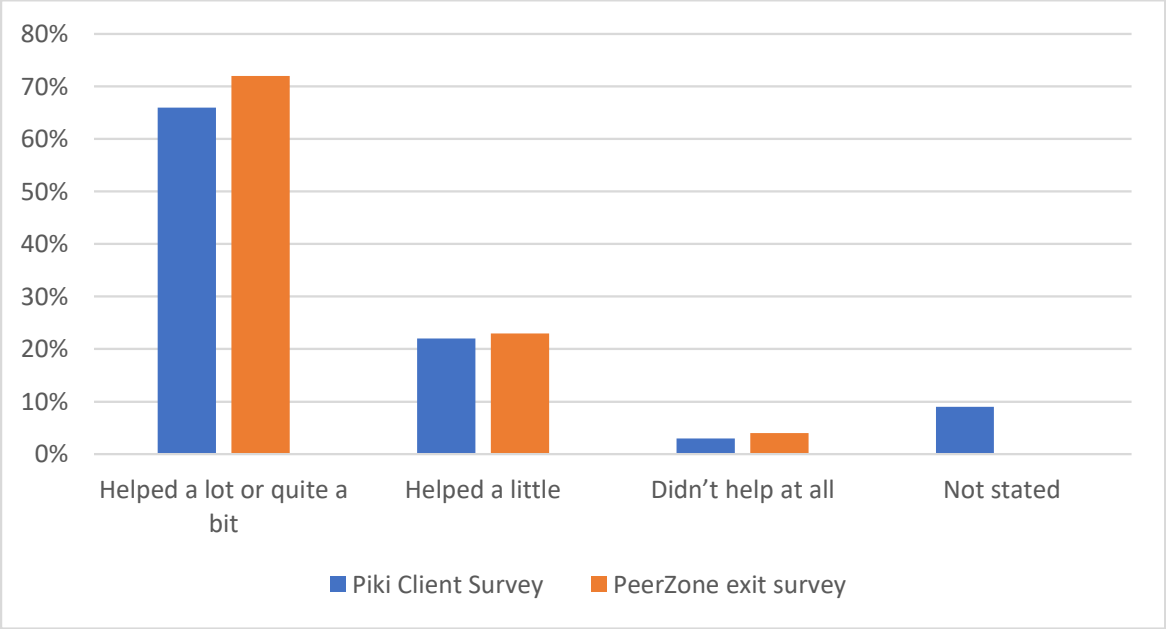
Table 47: Service User feedback from surveys

	PIKI CLIENT SURVEY	PEERZONE EXIT SURVEY
Number of responses[1]	67[2]	47
Helped a lot or quite a bit	66%	72%
Helped a little	22%	23%
Didn't help at all	3%	4%
Not stated	9%	-

1 Note that there is probably overlap between the respondents to each survey

2 67/155 PZ clients responded to Piki Client survey which is 43% of PZ clients. Note that PZ clients were 9% of those that responded to the survey, while only making up about 3% of total Piki clients.

Figure 24: Service user feedback on peer support from two surveys



What do people like about peer support?

Interviewees who had engaged with peer support praised its tailored approach through the ability for clients to choose a peer supporter who best fitted their needs and expressed a desire for a similar process with therapists. Only two interviewees had engaged in group peer support and reported finding it less helpful than one-to-one sessions.

Survey respondents gave positive feedback about the value of having someone who had experienced similar struggles to talk to in a safe space where they felt understood in a non-judgemental way and justified in the way they were feeling. They enjoyed a more equal relationship with less power imbalance (compared to therapy) and a less clinical experience.

> *With peer support, I show them the same problem and he gives me an example from his life and how he dealt with it or how he would deal with it. So it's a lot more personalised than counselling.* (SU-PK68)
>
> *We were equals as opposed to power and balance.* (SU-PK66)
>
> *One of the most beneficial things about peer support is the lack of pressure and an informal setting coupled with interaction with an equal. Someone who has been through similar things, demonstrates compassion/ empathy, and offers advice from a non-judgemental place. In my case it was more effective than counselling and psychologists. The fact that you feel as if you aren't in an interrogation and are just having a back and forth conversation with a peer is great at making you feel as if you are not alone and that what you are going through/ feeling, is valid.* (SU – PeerZone Exit Survey Free text)
>
> *I think the de-stigmatisation and normalising and validation of things is huge and it's never going to work coming from the therapy.* (SP-PK109)
>
> *As someone who struggled with traditional counselling in its clinical approach to treating mental health, peer support provided me a platform to decide how my sessions would go to best serve the issues I wanted to deal with.* (SU – Piki Client Survey Free Text)

Service users also mentioned the value of having someone to talk to with a different perspective from friends and family, and the availability of peer supporters.

> *Just having a really good chat about things that maybe I wasn't comfortable chatting to my friends about.* (SU-PK65)
>
> *I can rant about my problems and getting it out because my friends don't want to listen, and I can't talk to my parents cos they're the majority of the problem.* (SU-PK68)
>
> *they were far removed enough from the situation that they didn't know anything personal but also they were more involved than say a psychologist or a counsellor.* (SU-PK66)
>
> *Just knowing that I can, like I can even just text them maybe if I'm having a hard time like after hours like when they've stopped working.* (SU-PK69)

Many talked about the practical advice they received and the value of having someone to 'walk alongside' them, sometimes literally e.g., accompanying an anxious person to the mall.

> *I'm so grateful to have had her walk alongside me during an extremely difficult time in my life.* (SU PeerZone Exit Survey Free text)
>
> *I could kind of use my strategies with my peer supporter. She offered to take me to the mall a couple of times just to walk around and get used to it and honestly that was super helpful.* (SU-PK70)
>
> *the one client I have referred to peer support was in social isolation, was lonely, so I thought she would be perfect, just someone to walk alongside her more than I could.* (SP-Focus Group participant)

A few people praised their peer supporters for going above and beyond by being available regularly as well as contactable outside of the sessions. Several enjoyed the social catch-ups set up through PeerZone and Piki, with one person dubbing them the *'anti-loneliness meetings'* (SU-PK72).

Some service providers and key informants noted that peer support may be a good fit for Māori and Pacific, and sometimes even a better fit than the therapy model. This is supported by the Piki promoter's feedback that people from these communities respond positively that *'that kind of sounds more like us'* (KI-PK94).

> *I think the PeerZone is awesome like for Pacific, like their peer groups.* (KI-PK43 – Pacific)
>
> *Having something like peer support on campus where they don't feel that they're going to ask for help, but they have peer support is probably a better fit for Māori and Pacific that are less likely to reach out.* (KI-PK112_113 – Referrers)
>
> *I've had a lot of success with PeerZone in particular with Māori and Pasifika young people, more success than I've had with counselling... when I've talked about peer support to that group in particular, they've been really enthusiastic about it from the very first time I mention it whereas with Pākehā young people you kind of have to ease them into it a lot more, they're a lot more hesitant about group stuff whereas it seems to be something that Māori and Pasifika can kind of get behind more easily.* (SP-PK03)

What were some of the downsides of peer support for service users?

While clients enjoyed their time with peer supporters, a minority reported finding it too casual or unstructured at times and would have valued sessions with more direction. Some found the sessions a bit awkward, especially quieter clients who found peer supporters working to fill silences (and the slightly unusual role of peer supporters being like a friend but not a friend). A small number mentioned the difficulty of arranging to change to a different peer supporter if they weren't comfortable, partly due to the feeling that the relationship was a bit more like a friendship. Also, some didn't like the activities/worksheets their peer brought to the session.

> *sometimes the lack of structure presented an obstacle.* (SU-PK67)
>
> *I often find that sometimes they do talk a bit too much about themselves but, because I'm quite quiet so I think maybe they feel like they've got to fill the silence sometimes.* (SU-PK53)
>
> *I could've asked to change to someone else, that might've helped but it's sort of hard to, when you're talking to someone and you've been seeing to say, 'I'm not enjoying our conversations, can I talk to someone else instead,' and they all know each other.* (SU-PK61)

Service provider reservations

A lack of information/knowledge about peer support made some service providers less likely to recommend clients to this service, with a few expressing a desire to meet peer supporters in person so they know who they are referring to. A very small minority were resistant to the concept of peer support, and some were concerned about the appropriateness of peer support for more severe clients (which has been disputed by PeerZone).

> *That's something that hasn't sat very well with me: the idea of ... potentially vulnerable people supporting other vulnerable people. So there's been a lot of uncertainty around this for me and I actively haven't referred anyone for peer support.* (SP – Focus group participant)
>
> *if there is some sort of more severity around what the young person is experiencing, I'm not going to refer that person on to peer support. If it's something more of, I'd say a lot around social isolation and loneliness is what I'm referring on to peer support. Other than that, if it's something, anything risk related, that wouldn't be something that I would refer to peer support.* (SP – Focus group participant)

Suggestions for improvement from both interviews and the surveys included clearly communicating the definition of peer support to manage expectations, having a dedicated focus for sessions, the addition of an option to meet in a private location, and more peer supporter availability in general.

Interaction between peer support and therapy

Most of those who accessed peer support also used the therapy services of Piki, including Puāwaitanga and Explore (n=118/135), with only 17 clients using peer support only. As mentioned in the previous section on therapy, clients who engaged in both peer support and therapy noted that the two interventions were quite different but very complementary: they appreciated the expertise and resources given to them by therapists, but also enjoyed the more casual nature of peer support and the more relaxed setting. Overall, those receiving both services valued what felt like a well-supported, wraparound approach.

There was no interaction between the therapists and peer supporters, though some therapists would like to see this happen potentially. One suggested way of using them in a complementary manner was for therapists to work on developing strategies for clients to try and for clients to then work on putting them into practice with their peer supporter. Another suggested way for them to work together was sequentially: therapy followed by peer support.

> *it was helpful because I could bring, not concerns, but like strategies addressed with the counsellor to my peer supporter, who I felt like closer to and then I could discuss things more in-depth and not worry about asking like the wrong questions. ...I couldn't figure out how to put them into my life without like having the piece of paper on me ready to look at it at all times, which is why I think it was so good to then take that to my peer supporter and then just like talk it out with her.* (SU-PK72)
>
> *I've got one client who comes to therapy and goes to PeerZone and she finds that very useful, very helpful and kind of building her confidence in terms of maybe taking on some of those sorts of behavioural experiments.* (SP-PK108)
>
> *we can... give them some key strategies, you can absolutely achieve that in four sessions and then say, well you know there's still a bit of hesitation and worry that they might not keep doing it, well, nice thing for peer support to come in and keep that encouragement on, that sort of affirmative, that affirmation, validation, yes you can do it and someone with likeminded, like age can say you know it's tough doing this but walks alongside and then it's a scaffolding and pulling away.* (KI-PK95)

Summary

Peer to peer support services are becoming an increasingly valued component of mental health service delivery, despite many service users being unfamiliar with the intentional peer support process. The experience from the Piki pilot is that considerable attention and resourcing is required to introduce and fully integrate this service with more commonly used and understood service options. As a new type of Piki service, it took time to inform service users (and other providers) about the service, and PeerZone, the provider organisation, also had to develop a tailored version of their service for youth, as an age-targeted service was new for them, and this inevitably entailed additional start up time. They now offer a very diverse peer support workforce and have been able to rapidly increase cultural diversity to address the equity aims of the project, partly due to the lower demands of training compared to therapists.

While only a small percentage of Piki users (2.9%) used the peer support service, the feedback collected from service users was very positive. They mentioned the value of having someone who had experienced similar struggles to talk to in a safe space where they felt validated and understood in a non-judgemental way. They enjoyed a more equal relationship with less power imbalance (compared to therapy) and a less clinical experience.

Suggestions for improvement from interviews and the surveys included:

- clearly communicating the definition of peer support to manage expectations
- having a dedicated focus for sessions
- the addition of an option to meet in a private location
- more peer supporter availability in general.

5.3 DIGITAL MENTAL HEALTH APP (MELON)

This section provides commentary on the uptake and perceived utility of the Melon digital app and its constituent elements and assesses the feasibility of the original concept of providing an 'integrated digital hub' for the Piki service.

Utilisation

Enrolments in Melon overall, as shown in Table 48 have been significantly lower than expected. In 2019 around 50% of all Piki clients registered (for the period Melon was available from late April). By the end of 2020 cumulative enrolments had declined to 30% of all Piki clients. (A total of 207 Piki clients enrolled only in the Melon app i.e., they accessed no other Piki services. Supporting clients with no therapist involved was not part of the original brief for Melon but evolved as part of successive design iterations).

Table 48: Unique Individuals enrolled in Melon (April 2019 – December 2020)[1]

MELON ENROLMENT	COUNT	TOTAL PIKI USERS	% ENROLLING IN MELON
Both years	1669	5307	31.5%
2019	716	1529[2]	46.8%
2020	953	3217	29.6%

1 User statistics as provided by Tū Ora
2 Denominator only covers enrolled 26/4/19-31/12/20 in line with Melon availability

The recent client survey (Nov – Dec 2020) was consistent with these figures: 25% of the survey respondents (180/730) reported they had used Melon (almost all in conjunction with another Piki service).

Table 49 describes the cohort of Piki users enrolled in Melon from the introduction of the Melon app in April 2019 up until 31 December 2020. The Piki clients predominantly enrolled in Melon appear to be female, European and those in the least deprived areas. In particular, the proportion of Māori users enrolled on Melon was somewhat lower than the proportion accessing Piki overall.

Table 49: Description of Piki clients enrolled in Melon

CHARACTERISTICS	COUNT	% OF TOTAL MELON COHORT (N=1669)	TOTAL PIKI COHORT %
Gender			
Male	369	22.1%	29.9
Female	1163	69.7%	65.3
Gender Diverse	2	0.1%	0.2
Unknown	135	8.0%	4.6
Ethnicity			
European	1170	70.1%	69.9
Māori	179	10.7%	13.7
Pacific	43	2.6%	3.5
Asian	105	6.3%	6.4
MELAA	19	1.1%	6.5[1]
Other/unknown	153	9.2%	
Quintile			
1 least deprived	323	19.4%	18.7
2	303	18.2%	17.6
3	300	18.0%	19.1
4	294	17.6%	20.8
5 most deprived	208	12.5%	14.5
Not known	241	14.4%	9.2

1 This figure includes MELAA and 'other'

Melon User Statistics

Melon has provided the additional user and activity statistics summarised below. These also cover the period 26 April 2019 to 31 December 2020 (see tables 50-53).

Table 50 shows that only half of all Piki clients were invited to enrol on Melon. Of these, only about 60% went on to sign up (thus a smaller proportion of the total Piki population (30%) was enrolled. The majority of those who signed up returned to Melon at least one more time (87%).

Table 50: Overall use of Melon by Piki clients

OVERALL USAGE	COUNT	(%)
Clients invited to Melon	2682	50.5% of total Piki population
Clients enrolled with Melon	1568[1]	29.5% of total Piki population, 58.5% of those invited
Clients returning after one day as opposed to signing up and never returning	1358	86.6% enrolees

1 This figure is slightly lower than the one provided by Tū Ora

Table 51 summarises aggregated usage statistics for the Diary/Health Journal function and other resources on the Melon app. Approximately 70% of enrolled clients were recorded as accessing the diary/health journal feature. This allows for tracking of sleep, exercise, energy, and mood. The Diary/Health Journal is the landing page on Melon, so the access numbers noted in the table below are partly accounted for by users always being taken to this page first when entering Melon. Nearly 30% of Melon enrolees accessed and read a variety of other resources (articles, videos, images, podcasts, quizzes, tools etc).

Table 51: Use of Melon Diary/Health Journal and Resources

MELON FEATURES	COUNT
Diary/Health Journal[1]	
Diary entries with trackables[2]	7444
Diary entry trackers[2]	580
Health Journal entries	31,459
Health Journal enterers (number of individuals entering information)	1115
Resource Use (Articles, videos, images, podcasts etc)	
Resource views	2560
Resource viewers (number of individuals)	459
Active clients that read resources	29.3%

1 Trackables/trackers include logging pattern of sleep, exercise, energy, and mood in the Health Journal.
2 The original diary system only allowed users to track their metrics once per day and aggregated all metrics under a single 'entry'; the new Health Journal system (from Feb 2020) allows users to track multiple times per day, and categorises entries (e.g., mood diary, activity, sleep)

The Melon online community forum provides a place for users to post questions/comments on issues at front of mind. Table 52 shows that just under 25% of those who enrolled posted on the community forum, with a smaller proportion messaging either a community manager or a coach. Anecdotal reports from Melon staff to the Operations Group suggested there was relatively *'a lot of activity'* in the online community by members of priority groups, including Māori and Pacific young people who tended towards *'heavy posts'* (i.e., potentially placing them outside the mild-to moderate category).

Table 52: Melon Community Forum Posts and Interactions

COMMUNITY FORUM ACTIVITY	COUNT
Posts (online community)	
Number of Posts	840
Number of Posters (individuals who post)	363 (23.2% of enrolees)
Number of Replies (to post)	900
Number of Repliers (individuals who reply to posts)	222
Average post per client	2.3
Average replies per client	4.1
Posts requiring further assessment/intervention	
Clients requiring supportive intervention based on post content	21
Posts requiring deletion	9
Community Manager interactions	
Number of messages from clients to community managers[1]	4040
Number of individuals who sent a message to a community manager	127 (8% of enrolees)
Coach participation (Piki counsellors)	
Coaches invited to Melon[2]	108
Coaches active during December 2020	51
Interactions between clients and coaches (Piki Counsellors)	
Number of clients who sent message to a coach	148 (9% of enrolees)
Number of messages in conversation with a coach	740
Number of video calls with coach	106

1 Melon users can't message each other, only the Community Manager or their coach.
2 This includes all therapists invited since the beginning of Melon, including all University therapists (Victoria/Massey) as from June 2020.

Table 53 below shows the main themes of posts appearing on the online community from December 2019 to December 2020 (as summarised by Melon). The Melon Community Manager reported that the responses from Piki users were supportive and helpful, there were often multiple replies, and that rangatahi appeared to use the forum as a safe place to express feelings and challenges.

Table 53: Online community themes over 13 months (Dec 2019-Dec 2020)

TOPIC	N OF MONTHS TOPIC RECURRED
1. Emotions	
sharing feelings (low mood, depression, bad day, hopelessness, anger, grief, vulnerability)	11
overwhelm	4
gratitude	4
mood management, difficulty releasing emotions	5
frustrations with the system	1
unmotivated	1
2. Physical health/medications	
general issues/concerns/medical	4
medication/ Therapy vs meds	6
sleep issues	6
3. Work/Employment	
anxiety re communicating with co-workers; starting new jobs	9
taking sick leave because of mental health	2
financial, general	2
4. Relationship issues	
boy/girlfriends, friends, 'ex's, parents, flatmates)	12
family-related	4
no friends/Isolation/lack of connection/loneliness, feeling like a burden	4
space from people who don't help	1
communication	1
5. Self/self-care	
self-awareness, self-love, progress	3
self-destructive, self-sabotage, self-critic	4
body image	1
general	4
6. Anxiety	
general	6
around upcoming family events around Xmas	1
around gender issues/appearance	1
social anxiety	1
stress	2
panic attacks	3
7. Covid related	
feeling scared, feeling trapped, understanding own emotions (Mar-Apr 2020)	2
helpful experiences/activities during lockdown (Mar-May 2020)	3
post lockdown (Jun-Nov 2020)	4
8. Peer support	
sharing things going well, wanting to give hope, questions, what works for others	2
sharing knowledge and information like podcasts and articles	1
sharing stories about own journey and going backwards to move forward	1
ideas and practical tips	2
asking for advice or venting concerns about others	3
needing Melon community support	1
9. Neurological differences	
ASD (Autistic Spectrum Disorder)/ADHD/OCD	5
brain healing/ head space/brain fog/concentration	4

TOPIC	N OF MONTHS TOPIC RECURRED
10. Trauma	
sexual abuse	1
sexual harassment	1
domestic violence/physical abuse	3
PTSD	1
general	1
11. Professional support	
psychiatrist/counsellor/counselling	3
ED Crisis Team	2
wanting to speak with a Community Manager	2
12. University/tertiary study related	6
13. Alcohol/Substance use/addiction	
substance/alcohol abuse and trying to stop	3
addiction (recovery)	2
eating disorder	1
14. Connecting	
with others on community through images or text, supportive memes	3
common interests and requests to meet up - facilitated by the Community Manager	1
15. Sexuality/Sexual orientation	3
16. Self-harm/ feeling suicidal/suicide attempt	3

Workforce and training

Melon ran a series of training sessions with Piki service providers in the various partner organisations throughout the pilot, both in person and on-line. Two peer supporters were trained to be community moderators for Piki Melon although only one took up the role. Training sessions for therapists included how to communicate Melon to rangatahi and brochures were provided for that purpose. Melon reported that training sessions with therapists were often taken up with explaining what the Piki service was and how Melon was intended to fit in. (This was possibly due in part to staff turnover in the provider organisations). Counsellors and therapists also required familiarisation with the various elements and technical aspects of the Melon platform so they could understand how it could augment their service. This information was included in the Operations Manual in 2020, along with details of the registration process, but providers reported that the lack of a 'dummy' client profile made it challenging for them to understand how clients could best make use of the app.

> *I tried to get in it when it first came out and they were talking about the Melon app, but ... like it would be really good if there was like a demo that services could have a look at so that we can actually explain that a lot better to our young people.* (KI-PK118_PK119_referrer)

It proved difficult for Melon to get time with provider teams to provide ongoing in-person training on later iterations and to provide follow up support for Melon integration. Digitised training options were provided, and a Melon newsletter was launched for therapists to support them with the process, inform them of updates and encourage feedback. At the request of the Operations Group, a dedicated therapist community was also set up on Melon to provide a safe space for therapists to support each other, collaborate, problem solve, share resources, and provide/receive peer support; however, this was seldom used.

In 2021 Melon employed a Māori Community Support Worker to support rangatahi on the Piki community forum and recruited a group of 5 rangatahi Māori interns to incorporate Te Reo Māori and make the user interface more culturally responsive.

Service user experiences and feedback

The service user interviews and survey in 2020 showed a wide range of views on the Melon digital app specifically and on digital mental health support apps in general.

Interview and survey comments

Interviewees who had not registered with Melon at all, cited one or more of the following reasons:

- they were interested but not enough to follow through
- they did not understand the purpose of the app
- they did not want another app cluttering their phone
- they were not interested in engaging with this particular app
- they lacked interest in technology in general.

There was positive feedback overall from a small number of clients interviewed and surveyed who had used Melon, though it was clearly seen as supplementary to in-person support.

> *I think as a second option it's definitely a good option, but I don't think it should be the primary support.* (SU – Client survey free text)

One interviewee commented that it was helpful to use Melon in the context of therapy sessions.

> *Quite good actually cos we, she was able to tell me like the score that I had had from the first survey that we did together compared to the last one. Like I, she told me the improvement that I had made.* (SU-PK54)

Specific reference was made to mood tracking, the diary, the well-being resources, and the community forum; the latter was described as a good way to put things in perspective and ease loneliness.

> *I didn't use the community thing but I did read through it, so I found that nice as well. So I didn't want to interact but at least I could see what's going on.* (SU-PK55)

> *Like Facebook for sad people, which was really cool when people discussed like things they wanted to achieve.* (SU-PK72)

A larger number of participants felt negative or apprehensive about Melon, with specific reference to technical aspects (e.g., bad design/user interface, or the app being 'buggy'), security concerns (e.g., unclear privacy/data management, or lack of trust in the security of the app), and the large number of notifications they received via email and the app.

> *The interface is not very good and not helpful for logging mood disorders especially if you have trouble putting your feelings into words.* (SU – Client survey response)

> *The user experience is not wonderful from a consumer point of view, Youth Reference Group feedback, it's not great, it's kind of the resources are a bit jumbled, the curation is not ideal, the navigation is not a wonderful thing, it's not great.* (KI-PK44c)

> *There was a reminder email every day to fill out your, how you were feeling and stuff like that. It would go straight to my junk email, but it was every single day reminder.* (SU-PK58)

Others commented they found the community forum posts triggering or had no use for it.

> *...reading other people's unfiltered thoughts feels pretty awful.* (SU – Client survey free text)

While some clients liked the anonymity, there were also those who disliked this feature. Other feedback was around how well this type of intervention suited them (or not), with some feeling ill-suited to it because they considered themselves 'a private person', lacked motivation to use it, or preferred in-person contact.

> *I only used it once. I preferred in person sessions with my psychologist.* (SU – Client survey free text)

Another commented on resource allocation saying that they would prefer money to go towards supporting employment of more therapists and peer supporters instead of going into a digital app. Suggestions for improvement included adding the ability to direct message other users, and the inclusion of peer supporters as coaches within the app (as is the case for therapists).

As shown in Figure 25, the majority of the 180 clients in the survey who had used Melon found it helpful to a greater or lesser extent. Fifteen percent (15%) said it 'helped a lot or quite a bit'; and 48% said it 'helped a little'. However, a third (33%) reported they did not find it useful at all.

Figure 25: Client survey responses – 'How well did the Melon app help you with the issue that you were struggling with?'

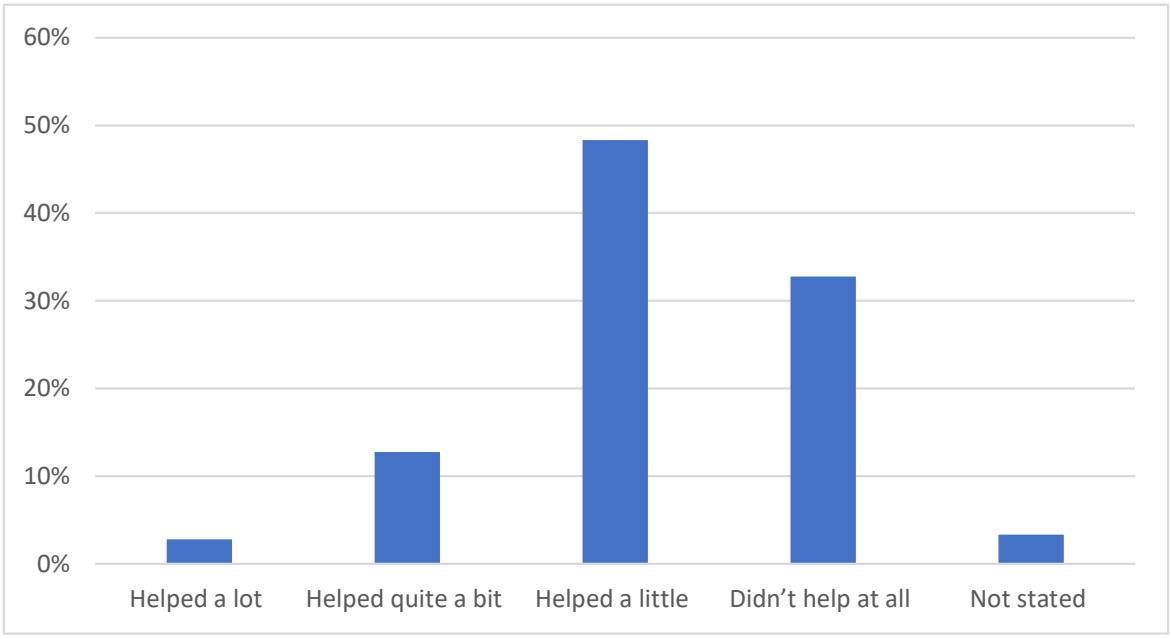


Table 54 summarises the features identified as most useful in the client survey: the wellbeing resources, personal diary, and community forum received the most ticks. (Free text comments and other qualitative client feedback on these components were still mixed).

Table 54: Responses to: What features of the Melon App did you find most useful? (could tick >1)

MELON FEATURES	%
Wellbeing resources	45%
Personal diary	41%
Community Forum	33%
Measures (GAD, PHQ9 etc)	15%
Messaging coach	12%
Webinars	8%
None were useful	25%

Service provider commentary and feedback

The place of digital apps

The overall balance of opinion from providers and key informants echoed that of service users; namely that digital resources and interactions can be useful complementary options within an in-person therapeutic support package for some young people.

> *Quite often we sort of find that with very mild presentations, especially initial presentations for clients, after sort of one to two sessions, they're actually, they report doing okay. So what we tend to do is actually refer them onto Peer Support Services and access to the Melon app in particular.* (SP-PK74)

> *It's possibly got some utility for at the exit point I feel by to feel okay, you know, like I've addressed some things, but I want some kind of continued support, it might be good to transfer them onto Melon and go well this is part of the Piki programme so stay engaged with the programme.* (SP-PK02)

There was also consensus, echoing the views of service users, that the value of digital mental wellbeing apps should not be assumed or over-emphasised, and that they are not a 'standalone' option or replacement for in-person support.

> *A lot of them are just so not interested in more apps, they're just like, 'I just need to talk to somebody.'* (KI-PK84)

> *I do think that we need to look at the role of the e-therapies within Piki ...are we wanting to create a parallel app world like we've got in Melon or are we wanting to create a digital experience connected with your counsellor that augments that?* (KI-PK107)

Some providers also questioned whether a single, tailored digital app or platform is necessary and/or the most useful and cost-effective approach.

> *... every dollar you're throwing into an app is a dollar less that you're not spending on delivering sessions and counselling.* (KI-PK107)

Components of Melon

As for service users, there were positive comments from providers and key informants about the utility of certain resources within Melon (e.g., mood tracking).

> *I think the resources on Melon are excellent... I'll have some that have used Melon and come to therapy and they might share some of the work that they might have done in diaries online.* (SP-PK108)

There was also feedback from providers that service users found a range of the Melon components useful and appreciated the opportunity it gave to be part of a community and also to structure issues by writing things down.

Views on the community forum were more mixed:

> *Again, people are increasingly using Melon and communicating on the community and so I think that that's a success.* (KI-PK38_PK39)

> *So there's a conversation community ...So I love the fact that through Melon what we are seeing is that the young people are forming this community with the intention of supporting each other and almost universally the postings on that community and the responses on that community are strength based and positive.* (KI-PK07)

> *Not so much the chat rooms. I've heard a few people say they just avoid those things, they didn't like them.* (SP-PK02)

> *I think coming into the forum, I think a lot of my clients find that quite daunting, but I don't know how you would change that either, like I think it just works for some people.* (SP-PK73b)

Access and engagement

Whilst some providers and key informants were pleasantly surprised by the level of uptake, others expressed concern about low levels of engagement, and particularly that few service users or providers utilised all aspects of an integrated platform approach.

> *I was pleasantly surprised by the uptake of the Melon app.* (KI-PK34 Youth Reference Group)

> *Probably less than half actually sign up and of those very few engage meaningfully with it.* (SP-PK03)

Applicability to different populations

There were differing views on how well the platform worked for different population groups. One therapist commented:

> *I think that things like Melon, the Māori population are not interested at all.* (SP-PK02 – therapist focus group)

Another key informant working within a Hauora Māori setting commented that they considered Melon to be a useful resource for their rangatahi and felt that whilst it was important to be culturally inclusive, it was not essential for all components of an integrated service like Piki to be specifically Māori-focused to be of use.

Multiple providers described a preference by Māori for in-person interaction, rather than using a digital app, with more mixed commentary about the utility of apps for Pacific young people.

> (answering question re cultural component in Melon for Māori/Pasifika) *... it's hard to, I mean I wouldn't get that online. I would want that face-to-face.* (KI-PK116)

> *... definitely a lot better than like giving a whole lot of pamphlets and things then it's usually because it's more accessible on their cell phones.* (KI-PK43 - primary care referrer, commenting on Pacific youth)

Privacy and data security

Some providers raised potential privacy and data security issues, given the wide array of personal information collected and stored within the platform, despite efforts by Melon to allay these concerns.

> *... because I don't know how trackable that is, whether its audited, who else has access, I actually tell my young people that I don't think it's secure.* (SP-PK03)

In response to concerns about the sharing of information via email, Melon removed all personal information from email notifications. To ensure data security and privacy of individual users, Melon also uses a private anonymised user analytics system that they wrote themselves, as opposed to using third party tools that allow sharing of data (i.e., no third party has access to the data). The privacy policy and T&C's are available online in plain language but may not have been read or fully understood. Some providers were also uneasy about aspects such as all coaches having access within Melon to the posts by all clients (not just their own clients). Information on Melon's privacy policy was also added to the Piki website in response to feedback on this aspect.

Workload and practice implications

In the initial concept for Piki, an integrated digital hub was perceived as providing efficiency and effectiveness by enabling service users, providers, and partner organisations to use different elements of the app as part of core activities. However, many service providers perceived engaging with the Melon app as additional work for both themselves and their clients rather than being helpful to business as usual.

> *If they want Melon, they can refer for it themselves and we don't manage it, I think that's, for me it's just more for us to do and we're doing enough as it is.* (SP-PK02 – therapist focus group)

> *The Melon side of things, they find that very tedious, they feel a bit like salespeople so that doesn't work that well in terms of signing up. When people who have had clients who have signed up, they don't find that it's used that often and they've been finding that all ages of clients have actually preferred to not engage in that virtual sense unless it's about looking at specific resources but that's kind of been the limit of where they've engaged with.* (KI-PK90)

Reluctance to change usual practice was also a barrier to uptake for some therapists. For example, some preferred to use the existing digital wellbeing resources with which they were familiar, did not want clients direct messaging them via the app, or felt they lacked time to tell clients about Melon.

> *It's difficult cos Melon is just one app that has very broad, it's very holistic in that it has a bunch of different things on it, but if I'm kind of looking at working with one specific thing with a client, it's easier to pick one app that's targeted at one thing instead of having a bunch of different things in one app.* (SP-PK02 – therapist focus group)

Engagement with the platform has been further compromised by different ways of working within the various Piki partner organisations (e.g., therapists routinely collect data on different PMSs used by the partner providers). Puāwaitanga managers also reported that therapists did not want to use an external app or digital platform as it would impact negatively on their work. (They have since developed their own website/app to support virtual therapy and appointment setting).

Integration and clarity of purpose

A key proposed innovation of Piki was the use of the Melon app as an 'integrated digital hub' to provide timely access to various wellbeing support components, along with an information and communication dashboard for therapists (coaches) and clients. It was also intended to facilitate systematic completion of an agreed set of psychological measures, thus allowing the app to function as a data collection tool for clinicians and for the purposes of the evaluation.

The initial aim therefore was for all Piki clients to be registered on the Melon app (see 3.3). However, the method and timing of enrolment into Melon was never a 'hard-wired' or consistent feature of the intake process – the system continued to evolve during the course of the pilot (see section 3.5 for details). Clients had to be invited to register in order to access the app (i.e., this was not possible directly from the website), and the uptake of Melon by clinicians has also been gradual. These factors inevitably had an impact on uptake by both clients and therapists (which has remained variable), as reflected in the utilisation figures presented above.

As detailed in section 4.3, it was also intended that Melon would be used to collect psychological measures (GAD-7, PHQ-9, WHO-QoL etc) to support the evaluation of the Piki project. This aim was not realised, due in part to early decisions not to make either registration on Melon or systematic completion of an agreed set of measures compulsory. Other technical and systems issues also played a part (e.g., the non-interoperability of different practice management systems with Melon, and between Melon and the Piki website).

> *we've got an excess reliance on the Melon as the delivery mechanism for those outcome measures.* (KI-PK44c)

A lack of direct engagement with therapist teams in the early stages of the pilot also meant there was insufficient shared understanding of the relevance of routinely completing screening and outcome measures within Piki (for clinical and/or evaluation purposes), and how or when these should be undertaken and recorded.

> *Those kinds of things are just not useful for us clinically here in that way, shall I say. It's not that they're not useful at all, it's just that way doesn't work for us here.* (KI-PK41b)

Finally, as noted above, the lack of a good 'demo' version allowing service providers to explore the app and its components, also meant it was difficult to socialise the use of Melon as an integrated platform.

In response to client and therapist feedback, Melon did undertake significant development work within the survey feature of the app to encourage greater uptake during 2020. This included allowing therapists to complete psychometric surveys for the clients; removal of some automatic prompts; providing interpretations of completed survey result to clients *(what does my survey mean?)*; providing links to relevant resources; and adding other surveys (e.g., WHOQOL-Bref, which was originally only available on Melon as a web link).

Overall, the evaluation findings suggest that whilst the idea of a fully integrated 'digital hub' as originally conceived remains an exciting concept in theory, in practice it is unrealistic at this time and probably has limited utility within a complex multi-service context such as Piki. Reviewing international practice also suggests this may be an idea before its time.

> *There's the kind of the concept of a digital adjunct and then there's the reality of how Melon has performed in that role, do you know what I mean, so they have, it's not been well integrated into the Patient Management System that the therapists use for their day-to-day work. Ideally, you'd have one integrated syste.* (KI-PK44c)

The above conclusions notwithstanding, feedback received from clients and providers indicated there was room for additional integration between Piki service components within the current configuration of Melon/Piki, particularly in relation to integrating peer support into Melon (or vice versa) and using technology to facilitate closer collaboration between therapists/counsellors and peer supporters.

Summary

Contrary to what may be assumed, digital support via an app does not appeal to all young people. The quantitative data and qualitative feedback from the evaluation both indicate that while some young people value having access to a range of digital options on an app to support their mental health and wellbeing, a significant proportion have little or no interest in this kind of support.

Nevertheless, the Melon app has successfully provided a range of useful inputs to a subset of Piki clients and providers, and has progressively expanded its range of resources, activities, and operational features over the duration of the pilot. As such, Melon has also been a useful testbed for the utility and acceptability of various possible components of digital platforms and resources, and for how these can most usefully be integrated into a youth-oriented service.

To date it has not proven possible to achieve the ambitious aim of creating and sustaining a fully integrated digital hub within Piki. This outcome has been influenced by several interrelated factors:

- the compressed timeframe at the start of the pilot period and the need to deliver services from a basis of 'business as usual' before new components were rolled out – these constrained the ability to co-design a digital app that took all needs and perspectives into account
- technical and operational difficulties in producing an integrated platform, including challenges created by non-interoperable PMS's and ongoing changes in referral and intake processes within Piki more widely as the pilot evolved
- difficulty in achieving sufficient access and uptake by service users and service providers
- underestimation of the scope and scale of the original concept.

5.4 PUĀWAITANGA/1737

These two phone counselling services are provided by HomeCare Medical and as noted above, have distinct functions: Puāwaitanga is a referral only service that provides a series of counselling sessions with one counsellor whereas 1737 is an open access phone service that is available 24/7.

Puāwaitanga

Service utilisation

A small percentage of Piki clients used the telephone counselling service of Puāwaitanga: 185 individuals out of a total of 5307 unique Piki clients (3.5%) over the period to 31 December 2020. Their session DNA rate for Piki clients was 27.9% (273/977). This appears high but may be explained by factors noted below such as the use of the service to cope with high demand, rather than as a client choice.

Puāwaitanga Workforce

Puāwaitanga's workforce has increased significantly over the period with the doubling of their contract staff (from 15 to 31) in addition to their core 5-6 staff. The ethnic diversity of their workforce is slightly above the in-person providers with 2 Māori, 3 Pacific (of Samoan, Tongan and Fijian backgrounds) and 6 of Asian and Latin American background as of 2021. All the non-European counsellors (bar one) are contractors.

Most of the workforce has counselling qualifications, and a large proportion have CBT training.

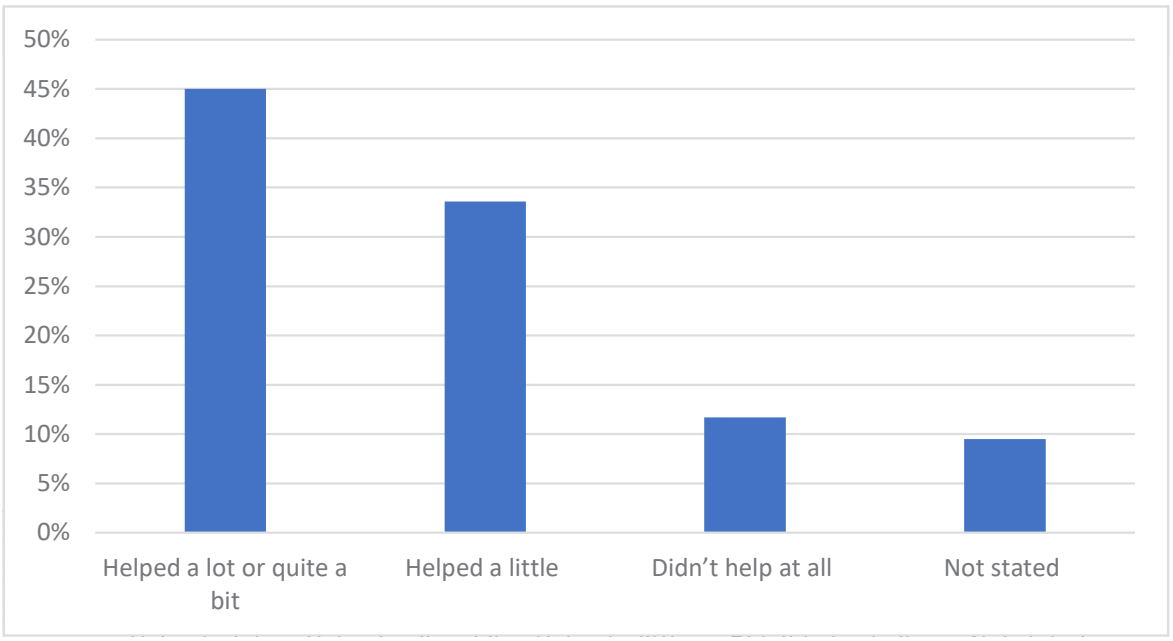
Table 55: Puāwaitanga Workforce

	JUL 2020	FEB 2021
Gender		
Male	Not reported	6
Female		30
Ethnicity		
European*	12	25
Māori	1	2
Pacific	3	3
Other	4	6
Qualification		
Counsellor	10	19
Mental health nurse	2	3
Social Worker	2	9
Psychologist	2	4
Occupational Therapist	2	1
Psychotherapist	2	
CBT-trained		
Yes	17	13
No	3	6
Not reported		17
Total Workforce	20	36

Service User experiences and feedback

The Piki client survey asked about use of 'phone counselling (with Puāwaitanga)' but it is possible that respondents may have misinterpreted this, and some responses may have been with regard to phone counselling that they accessed in other ways (e.g., with their regular counsellor during the Covid-19 lockdown). A relatively large number of responses to this section were received (137 or 18% of the total responses, a much larger proportion than the 3.5% of total Piki clients that Puāwaitanga clients made up). Of these, 45% felt that the service had helped them a lot or quite a bit.

Figure 26: Client survey responses – 'How well did Puāwaitanga counselling help you with the issue that you were struggling with?'



While only 34.3% of respondents received 4 or more sessions, most were satisfied with the number of sessions received (65.7% being satisfied or very satisfied), as shown in Figures 27 and 28.

Figure 27: Client survey responses – number of sessions of Puāwaitanga counselling

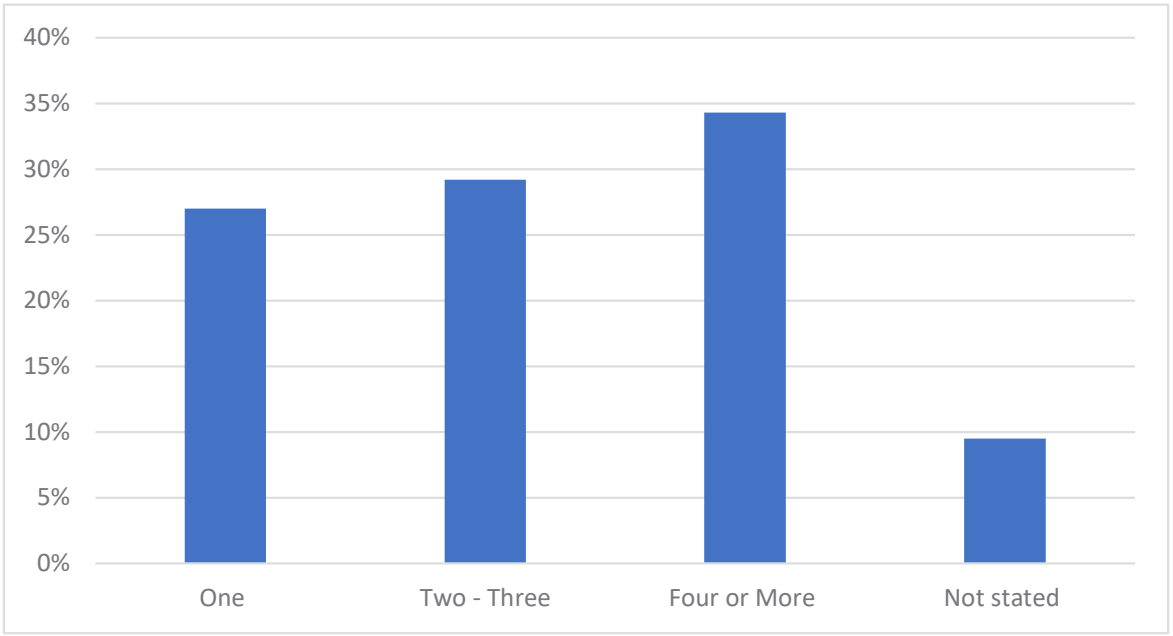
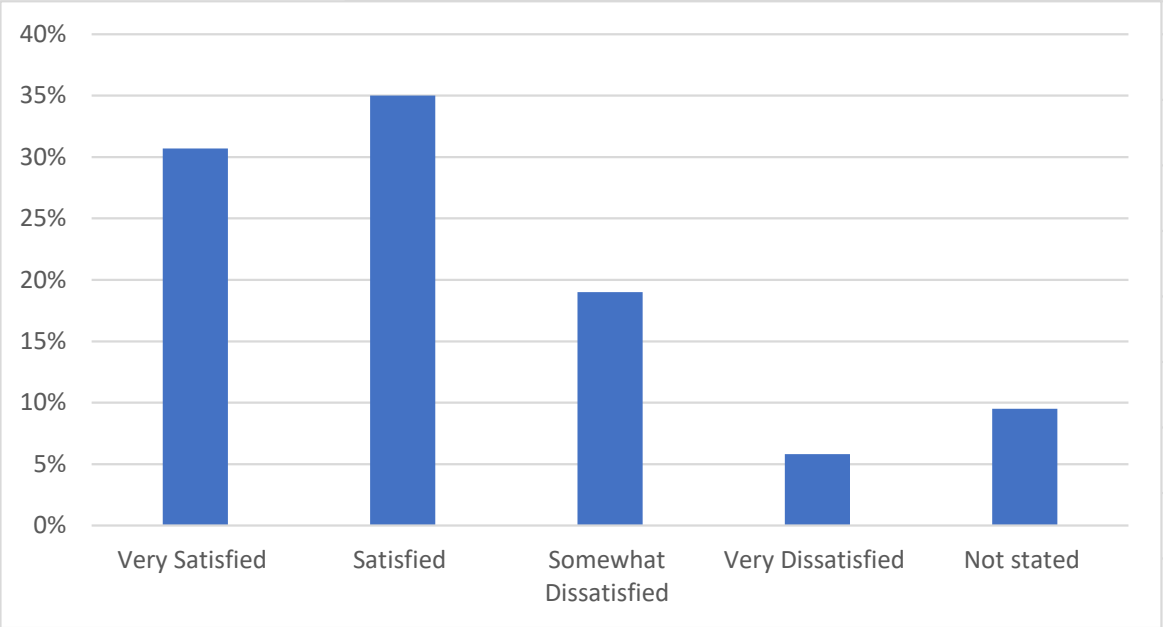


Figure 28: Client survey responses – satisfaction with number of Puāwaitanga sessions



Positive feedback on the service (from the survey and from the one service user interviewed who had used the service) focused mostly on the design features of the service that are intended to overcome barriers to access such as location, times, and long waiting lists:

> *Ease of appointments being over the phone meant I could take the call anywhere (like in a private space) which was really convenient.* (SU – Client survey respondent)
>
> *that was really, really nice to have it so accessible … I think I went to go to the Uni counsellor once and they were blocked up like three months in advance … it was nice to get that kind of that instant contact and then also being able to just keep that up on a weekly basis.* (SU-PK65)
>
> *I found the phone counselling very helpful as it worked around various hours of work and I was still able to connect and resolve things from the comfort of my own home.* (SU – Client survey respondent)

A few users stated a preference for phone rather than in-person when talking about confronting or emotional issues:

> *Amazing took away the shame and anxiety and like worry of crying in public and being able to do it in an environment I felt safe and comforted in and made me set myself some alone time.*
> (SU – Client survey respondent)
>
> *sometimes it made it easier to say things that I found really hard to say in person, you know, so there are some things that are really confronting and it's really scary to kind of say them to someone in person, but it's a lot easier when you kind of don't have, when they don't see you, you know.* (SU-PK65)

In contrast, some services users found the phone sessions less useful, citing the lack of face-to-face connection, the limited time available and issues with privacy of calls in their personal circumstances:

> *It was a little awkward just talking to someone on the phone – lacked some of the connection that helps you open up in face-to-face therapy.* (SU – Client survey respondent)
>
> *I felt like the length of the calls weren't long enough to be effective.* (SU – Client survey respondent)
>
> *Feel like it should be more sessions seeing as they're so short.* (SU – Client survey respondent)
>
> *I live in a flat with 6 other people and the walls are very thin so I felt I couldn't open up about my issues and would really like to see someone in person so I can finally address my problems.*
> (SU – Client survey respondent)

Other commentary

This service was created 'to provide support to those who may have barriers to attending traditional face to face counselling services'.[70] This is achieved by offering phone counselling which can be accessed from any location, with a wider range of times than usual (7 days a week, 9am-9pm), in a range of languages. The service was developed with a specific focus on meeting the needs of Māori. Being a general, nation-wide service that is accessed through referral from organisations who have a contract with the service, it is not specifically aimed at youth. They offer CBT-informed therapies, but are not limited to them, and their sessions tend to be shorter (30-35 mins). They offer a Package of Care (POC) that lasts 12 months (usually an average of 5 sessions, with the option to negotiate more if necessary, an opt-out booster sessions 3 months later). This model is perceived by some key informants as cost effective and scalable but the downside of this cost structure is that payment is made for each client for a POC, regardless of how many sessions the client accesses.

The structure of their workforce (a core staff plus a pool of contractors) means that there is capacity to absorb spikes in demand.

As a pre-existing nationwide service, it was not able to be co-designed for the Piki youth mental health service. Nor were their systems able to be integrated with those of Piki as they have their own outcome measures (Duke) and software (Input Health). This system allow clients to choose a counsellor (based on their online bio and availability), choose the time of their appointment, and to complete the Duke outcome measures. It also allows messaging between clients and counsellors (including the ability for counsellors to send out resources). We understand that an App version will soon be available that will also allow video calls as an alternative to phone sessions.

In addition, given that their counsellors provide services nationwide, their ability to engage with clients as part of a wider integrated service that also offers peer support and a digital app was limited, and these aspects of Piki were not likely to be mentioned to clients by Puāwaitanga counsellors.

While the service provider does not position phone counselling as an equal option to in-person, it is seen as an important option to have available. Education for both service providers and users as to the potential benefits of phone counselling may be required since it is often assumed that phone counselling will not be an effective experience but often people are surprised by its value.

> *people who have not had experience of counselling at all will view Puāwaitanga as being like the helplines, which is not what we do but it's about giving that education and knowledge... we do have people come through who, definitely phone counselling is not their first choice. They've come through to us because they wanted face-to-face, but they didn't want to wait and they need support now and this was the option and so they're giving it a whirl.* (SU-PK106)

One feature of the service that other Piki services do not yet offer is the ability for clients to select their own counsellor online. This feature of Puāwaitanga was not mentioned by service users in their feedback but one service provider organisation cited this as a benefit (KI-PK84).

The role of Puāwaitanga within the Piki service has not been entirely clear. The Piki Service Operations Manual developed in 2020 listed three reasons that rangatahi may be referred to the service (user preference, wait times, or logistic barriers to accessing other counselling). In practice, however, the service was not offered as a true option to users. While the self-referral form allowed clients to select phone or video counselling, there was little information on the benefits or how this differed from the 1737 service which more would be familiar with. It was thus not a transparent option on the Piki website (with 1737 the only phone counselling services mentioned):

> *if you were just on the website thinking 'is this something that I want to refer myself to? - I'm rural so going face-to-face isn't going to be helpful', you've got no knowledge that there's an option for you to do the same as you would face-to-face but over the phone. What you get is, you can call the helpline and the helpline by no way provides the level of support that face-to-face or Puāwaitanga would.* (SP-PK106)

In addition, many service providers were initially unaware of the service option. In fact, the service seems to have been used principally as way of managing surges in demand when wait times became unacceptably long.

> *We only just became aware of it when our waitlists got high. We weren't aware of that at all.* (SP-PK73)

This means that the service was not used for the purpose it is principally designed for, which was to overcome a range of barriers to accessing mental health support services, including barriers relating to geographical location, language, and time availability.

> *some of our communities are very low socio economic or just struggle to get to things and only have X amount of availability. So like have we, having known phone counselling and all of that beforehand, I think it might have been a different game changer, potentially, we don't know.* (SP-PK73)

When offered to clients as an option instead of waiting for in-person counselling when there was a need to manage demand, there were reports that a few service users felt that they were being forced to access phone counselling. Puāwaitanga staff felt that this was counter-productive:

> *If they've said I don't, face-to-face is what I want to do, then coming through to us is both wasting their time and our time because them engaging, the likelihood of it is very low.* (SP-PK106)

1737

Piki clients, like anyone in Aotearoa New Zealand, can text or phone 1737 at any time to talk to a trained counsellor. This phone service is listed as an option on the *Crisis* page of the Piki website for non-emergency help as well as on the FAQ page and may have been mentioned to clients by Piki service providers or intake co-ordinators/administrators. The service has been suggested as being suitable to mention to new Piki clients to access while they are waiting for an in-person appointment, but it is not known how widely this was done. In addition, a plan to allow webchat to 1737 counsellors through the Piki website has been discussed but not implemented yet.

Service Utilisation

When Piki clients contact 1737, they may or may not mention or be asked whether they are a Piki client. For this reason, the number of Piki clients who contacted 1737 is unavailable.

Given that 1737 is an open access resource, there has been a lack of clarity about referral pathways. Referral both into 1737 and from 1737 to Piki was discussed at the beginning of the pilot but it appears that referral per se is not how this service works. As noted in section 5.5, very few self-referrals into Piki cited 1737 as being how they heard of the service (2-6 mentions per quarter).

Workforce issues

During the Piki pilot, questions have been raised as to how well-trained or prepared 1737 counsellors are for working with youth, particularly with Rainbow youth (in the light of a single complaint about inappropriate talk from a 1737 counsellor). There was discussion of addressing this with more training for the counsellors, but it is unclear whether this has been carried out.

Service user feedback

Among the 26 service users who were interviewed, many were not aware of the service. Only six interviewees had used (or tried to use) the service. Wait times for texting in were reported as much longer (1-2 hours) than when phoning in (5-30 mins). The two people who had phoned in had found 1737 to be helpful once they were able to talk to a counsellor, and valued the fact that support was available 24/7, for example being able to call in at 2am. One noted an unavoidable drawback of the service was that the call-takers do not know the caller's history. Those who had texted the service found the longer wait times sometimes made the support redundant by the time it was available. One service user had formed the impression that the 24/7 availability of the service implied that help could be accessed *'in the moment [if you] needed something right then and there, which is what it says it's there for'* (SU-PK54) and was thus disappointed when this wasn't the case. Two people reported a sense that calls were sometimes closed before they were ready to stop talking:

> *I was still kind of lost and they kind of just finished it off when I wasn't ready to.* (SU-PK93)
>
> *As soon as I've calmed down... it feels like to me that they want to hang up.* (SU-PK68)

Service users understood that this may be due to demand pressures – *'it's somebody else's turn'* (SU-PK68).

The Piki client survey did not include questions about 1737 use.

Summary

Overall, the option of having telephone counselling services as part of the integrated services offered by Piki was well-received, particularly the Puāwaitanga service which aims to replicate in-person counselling via remote delivery. This service was not utilised to its full extent in the way that was originally envisaged, i.e., as an option for those clients who faced barriers to access or preferred a remote mode but was instead used as a response to excess demand for services. This can be counterproductive in that clients may perceive a lack of choice that can work against successful support for mental health. The 1737 service fulfilled a role for reasonably immediate support at any time of the day or night, although phoning appeared to be more responsive than texting. Both these services have a place within an integrated service.

5.5 WEBSITE/SELF-REFERRAL

The Piki website, provided by HomeCare Medical, has provided information on Piki and self-referral into it since its official launch on 6 May 2019 (at VUW) with the aim of reducing barriers to accessing services.

Website utilisation Statistics

All data in this section has been supplied by Homecare Medical and covers the period from October 2019 when reporting on website statistics commenced. Figure 29 shows the cumulative Piki website viewer count over time from October 2019 to the end of December 2020.

Figure 29: Cumulative Piki website viewer count

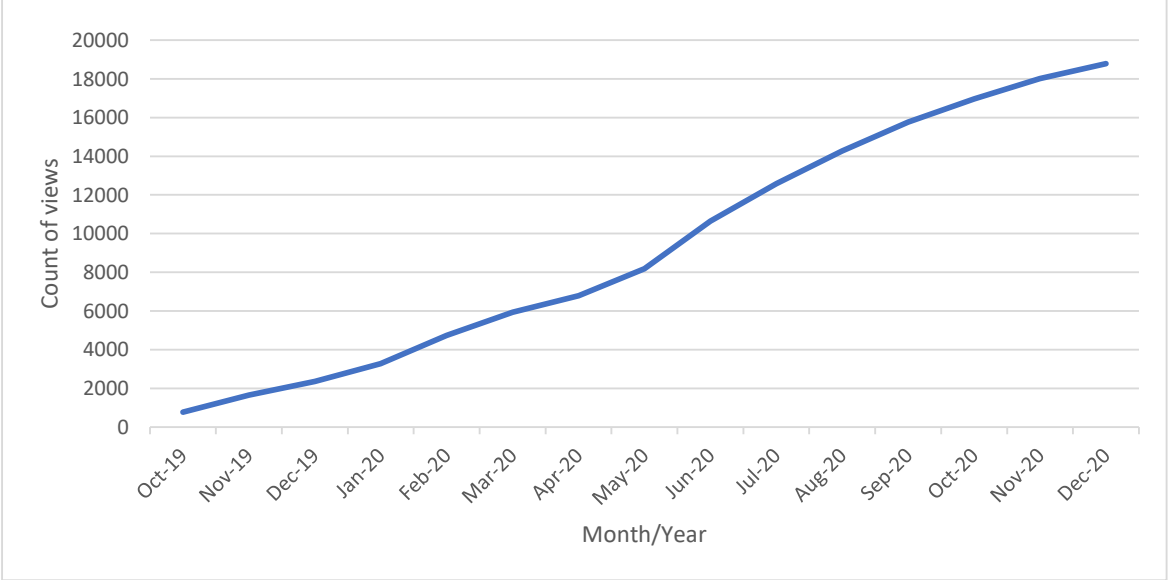


Table 56 details a monthly breakdown by users, average pages per session and average session duration. New users steadily increased through to January 2020, with a large increase in February 2020, possibly due to students returning to university. May and June 2020 saw another surge which may reflect post Lockdown access. New users then steadily declined from July 2020 through to December 2020.

Average pages viewed per session range from 1.3 to 2.2. The average time spent on the website per session ranges from one minute to just over two minutes.

Table 56: Piki website views by month

MONTH	NEW USERS	TOTAL USERS	AVERAGE PAGES PER SESSION	AVERAGE SESSION DURATION
Oct 2019	637	772	2.29	2:10
Nov 2019	777	887	1.36	1:33
Dec 2019	626	706	1.39	1:37
Jan 2020	819	905	1.38	1:26
Feb 2020	1365	1470	1.31	1:08
Mar 2020	1061	1189	1.34	1:05
Apr 2020	784	855	1.32	1:30
May 2020	1297	1399	1.52	1:37
Jun 2020	2333	2457	1.53	1:41
Jul 2020	1776	1939	1.55	1:41
Aug 2020	1543	1696	1.53	1:44
Sep 2020	1340	1491	1.55	1:49
Oct 2020	1063	1198	1.53	1:46
Nov 2020	911	1042	1.57	1:56
Dec 2020	671	777	1.78	2:02

Table 57 shows the pages (and frequency of views) viewed within the website. The most frequently accessed pages were the *Home page, Enrol now, About* and *FAQs*. The number of visits to the Piki homepage more than doubled over the period of the pilot. Information about the Melon App was not added to the website until the end of 2019.

Table 57: Unique Pages viewed within Website

	OCT – DEC 2019	JAN – MAR 2020	APR – JUN 2020	JUL – SEP 2020	OCT – DEC 2020	TOTAL
/Home	1840	3002	4014	4300	2720	15,876
/enrol now	992	1009	1300	1597	1052	5950
/about	261	245	323	606	288	1723
/resources	212	152	141	270	202	977
/faqs	184	473	162	130	55	1004
/support	178	133	224	367	249	1151
/support for myself	194	269	287	266	115	1131
/support/peer support	294	114	229	277	186	1100
/support/for someone else	65	-	11	-	-	76
/contact us	50	19	-	-	-	69
/melon	-	110	146	185	97	538
/in crisis	-	29	-	-	-	29
/step-7/success	-	-	314	588	383	1285
/step-7/thank-you	-	-	19	-	-	19

Table 58 describes how the viewer accessed the Piki website, that is, through which website or search engine. Most users went directly to the site, with a large number also coming via google. Access via Healthpoint or Victoria University of Wellington was also common.

Table 58: Users by Source (i.e., how did they get to the Piki website)

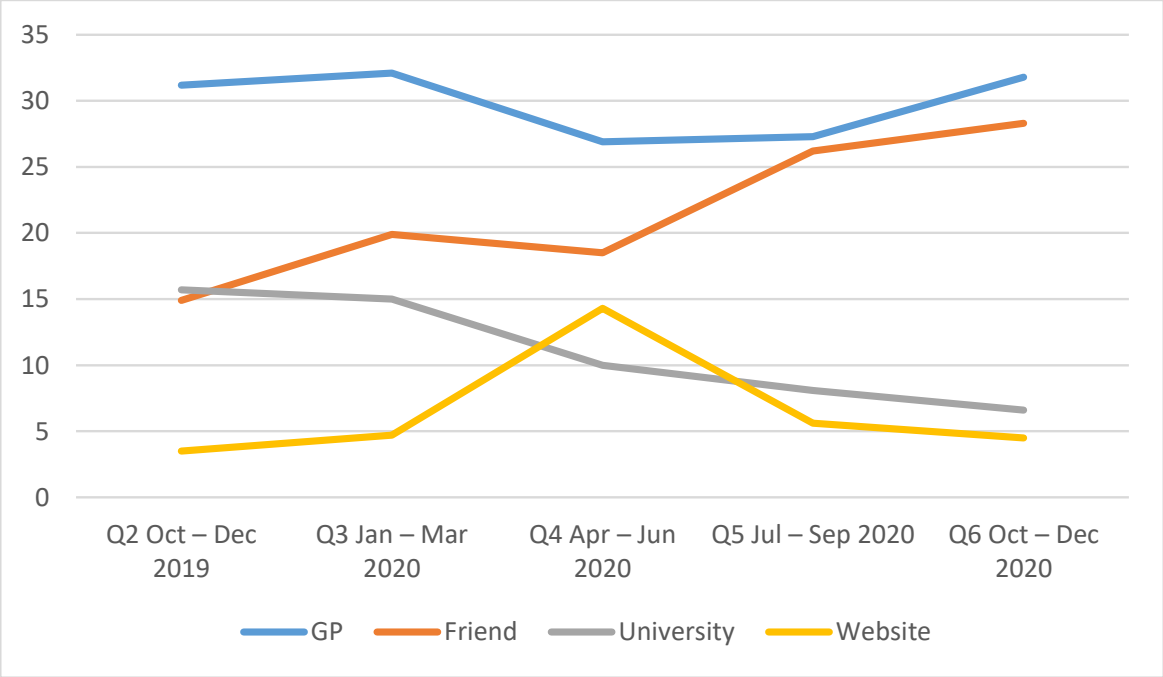
SEARCH ENGINE OR SITE	OCT – DEC 19	JAN – MAR 20	APR – JUN 20	JUL – SEP 20	OCT – DEC 20	TOTAL
Direct	1470	1859	1815	1938	918	8000
Peerzone.info	41	13	-	-	-	54
Google	269	1129	1564	2494	1657	7113
bing	49	46	27	86	70	278
yahoo	5	-	-	-	-	5
ecosia	6	-	11	4	17	38
Baidu.com	0	13	-	44	14	71
Facebook	60	30	34	202	-	326
Healthpoint.co.nz	120	105	43	70	47	385
Healthcentral.nz	20	5	-	-	-	25
Educationcentral.co.nz	6	-	-	-	-	6
Weltec.ac.nz	6	11	-	-	-	17
Victoria.ac.nz/wgtn.ac.nz	191	27	3	-	-	221
Otago.ac.nz	-	7	-	-	-	7
Massey.ac.nz	-	45	52	72	33	202
Whitireia.ac.nz	-	12	-	-	-	12
Homecare medical	-	-	-	5	-	5
Tū Ora	-	-	-	-	22	22
Instagram	-	-	3	-	-	3
bottraffic4free.club	-	-	201	-	-	201
3d.healthpathways.org.nz	-	-	4	-	-	4
duckduckgo	-	-	-	-	10	10
Social Media – Facebook and Instagram	-	-	761	-	-	761

The number of Piki self-referrals received between October 2019 and December 2020 was 2,254 (out of a total of 5307 Piki service users for all of 2019 and 2020). Table 59 describes the number and type of Piki clients who self-referred through the Piki website, and where they heard about Piki from October 2019 through to December 2020. The majority were female and non-students.

Table 59: Demographic details of Piki self-referrers

DEMOGRAPHICS	Q2 OCT – DEC 2019		Q3 JAN – MAR 2020		Q4 APR – JUN 2020		Q5 JUL – SEP 2020 2020		Q6 OCT – DEC	
	N	%	N	%	N	%	N	%	N	%
Total referrals	369	-	386	-	428	-	675	-	396	-
Gender										
Female	236	64.0	267	69.1	303	70.8	467	69.2	256	64.6
Male	114	30.9	105	27.2	108	25.2	189	28.0	120	30.3
Gender Diverse	19	5.1	14	3.6	17	4.0	19	2.8	20	5.1
Occupation										
Students	129	35.0	147	38.0	136	31.8	261	38.7	37	9.3
Non- students	240	65.0	239	61.9	292	68.2	414	61.3	359	90.7
Source - Where did you hear about Piki?										
GP	115	31.2	124	32.1	115	26.9	184	27.3	126	31.8
Friend	55	14.9	77	19.9	79	18.5	177	26.2	112	28.3
Community Org	24	6.5	20	5.2	15	3.5	37	5.5	15	3.8
Social Worker	14	3.8	9	2.3	11	2.6	32	4.7	15	3.8
1737	2	0.5	2	0.5	6	1.4	2	0.3	1	0.3
University	58	15.7	58	15.0	43	10.0	55	8.1	26	6.6
School	1	0.3	7	1.8	6	1.4	9	1.3	7	1.8
Family	16	4.3	16	4.1	22	5.1	47	7.0	27	6.8
Poster	2	0.5	6	1.6	8	1.9	3	0.4	7	1.8
Website	13	3.5	18	4.7	61	14.3	38	5.6	18	4.5
Other	60	16.3	49	12.7	62	14.5	91	13.5	42	10.6

Figure 30: Trends in 4 selected ways that self-referred Piki clients reported hearing about the service



The figures in Table 59 and Figure 30 show that although GPs could directly refer clients to Piki, a steady one third of all self-referrals through the website were from clients who heard about the service from their GP. Friends were the second largest source of information about the service by the end of 2020, having steadily risen from 15 % to near 30%. This indicates the importance of this method of spreading the word as more people heard about and experienced the service, and supports anecdotal comments of the importance of word of mouth among peers. The portion of self-referrals who had heard about Piki through a university declined over the period. The peak in hearing about the service via a website appears to coincide with the Covid-19 lockdown period, which is not surprising. The other sources of recommendations to Piki were spread at low levels among the remaining sources.

Evaluative commentary

The appearance of the website, including imagery and language, was initially informed by consultation with the youth reference group with the aim of making it appealing to youth and to target audiences by being positive, uplifting, bright and simple. While some feedback from key informants has been positive about the inclusiveness of the imagery and the appropriately pitched language, there has been continued feedback on the need for greater diversity to be represented. In response to this, Māori words have been added to the website although some feeling remains that more could be done to increase language diversity:

> *it's very ... monocultural... there's some Māori words and stuff but there's not quite enough and then none of ... other cultures as well.* (KI-PK40)

> *we've had lots of comments like 'why aren't there more Māori and Pacific Island faces on those posters and on the website too?'.* (KI-PK14_PK114)

There has been discussion of incorporating Pacific languages into the website, but this has not been implemented yet, at least partly due to challenges around the diversity of languages involved.

In response to early feedback from the Youth Reference Group and reportedly from Māori and Pacific clients, there is a plan for service users to be able to browse photos and bios of the practitioners available and to book an appointment with them directly through the website, with this being integrated with service organisation patient management systems and practitioner diaries. (Operations Group Minutes 2 Dec 2020) This is challenging to implement. Initial plans are in process to add phots and bios in 2021.

Delays in updating and developing the website appear to have been exacerbated by the work being contracted out rather than being easily edited at the level of text and wording.

The ability to self-refer through the website was noted as an important feature by key informants and service providers and being on-line was perceived as appropriate for youth:

> *I think the biggest thing is the ease of access because people can self-refer through the Piki website, it increases their options or their ability to access the Service.* (SP-PK89)
>
> *people can literally just jump on the website, spend five minutes, and self-refer.* (KI-PK02)
>
> *it's a lot easier for them to refer into cos they can go on the website and a lot of youth that's how they like to start things, it just feels a little easier for them to make that initial contact.* (SP-PK106)

Some health professionals may walk their clients through the self-referral process online rather than making a referral themselves. Self-referral may be important as a pathway to accessing peer support as word of this service spreads.

As on-line self-referral is a feature new to mental health services in the region, establishing appropriate and effective processes to manage this innovation in a timely way has been a challenge for the service. It has also raised questions about managing entry criteria since self-referral allows open entry, while the service is aimed at those experiencing 'mild to moderate distress'. This in turn leads to issues of risk management raised by clinical staff, with the psychological measures mentioned above used to manage this. (See Section 4.3 for further detail). There is a tension between the need to collect this and other information that may be useful initially, and the need to avoid making the referral process too lengthy and thus a barrier to completion.

Others are less sure that having web-based self-referral alone is sufficient as they perceive that some young people would prefer to have more immediate acknowledgement of contact or would prefer to speak to a real person.

> *I think it's a shame that there isn't a number that they can call. I think some students are going to find that a bit of a barrier ... it's that whole thing of I've reached out for help but now I've got to wait ... maybe even a chat function ....they would prefer speaking to someone straight away, even if it's just to be told someone is going to call you back, they prefer that human approach rather than putting your referral in and then maybe not knowing whether it's gone through or not.* (KI-PK112_PK113)

The idea of a chatbox has been mooted but not implemented, and this has potential for providing immediate feedback to self-referrers. The difficulty with ensuring timely responses to online referrals can lead to situations as described by one service user who found that help was eventually obtained in a general practice where there was immediate help available within minutes down the corridor from their GP. This model is one that also needs to be pursued as a way of enabling timely help to be accessed.

Service User Feedback

Service users were asked about their experiences with website in individual interviews. The Piki client survey did not ask about this and none of the respondents commented on it.

Most of the 26 interviewees were unaware of the website's existence, mainly because they had been referred through their GP and had not had a need for it. Most of those who had used the website, had only used it at the self-referral stage of the process and were unaware of the resources page. There was positive feedback on ease of self-referral through the website:

> *Pretty easy.* (SU-PK93)
>
> *The website was really good. If I searched just Piki straight up in Google, it didn't come up with that website first, it came up with something else, which was quite strange that it was unrelated, but once I found the website, it was really good. I found it very easy to navigate, it's easy to find the places that you're looking for and it's got good explanations of what goes on.* (SU-PK72)

The only negative feedback received from users on the website was the lack of the ability to directly make appointments through it (SU-PK68).

The existence of the self-referral pathway sometimes caused confusion when other services were recommending Piki to clients. One service user reported delays resulting from miscommunication about who would make the referral: the service (Crisis Resolution Services) had recommended the service to the user who then assumed they would make the referral when they intended that the user follow the self-referral pathway (SU-PK54). In other cases, it was apparent that users had completed the self-referral in addition to their GP putting through a referral. This confusion would probably reduce over time as clinicians and services become more familiar with the pathways in to Piki and are able to communicate to clients more clearly.

Summary

The substantial percentage of self-referrals through the website indicates that this is working well to increase accessibility of services, with positive qualitative feedback about the process. Providing the services to meet the demand generated by self-referral needs to be carefully planned for when introducing such an innovation. There is further room for development of the website overall which was not able to be prioritised within the timeframe and other constraints of the pilot.

5.6 TELEHEALTH DELIVERY BY IN-PERSON SERVICE PROVIDERS

This section addresses the use of telehealth service delivery as part of standard therapy or peer support options, as opposed to the dedicated phone counselling services offered by Puāwaitanga or 1737.

Service utilisation

The option of conducting individual sessions using telehealth (video or phone) was always theoretically an option for all therapists and peer supporters within Piki, although it was little used until it became an imperative during the 2020 Covid-19 lockdown. Video-calling is a feature of the Melon app and other technologies for teleconferencing were also available, and there were plans to offer this more consistently to overcome barriers to access for clients in specific circumstances (e.g., rural location, too unwell to meet in-person).

During the lockdown period, all therapy and peer support sessions quickly transitioned to telehealth, with clients also being offered the option of deferring sessions until in-person options returned. Some clients opted out of telehealth delivery, but many did continue with therapy or peer support in this way. Sessions were conducted on a range of platforms including Zoom, doxy.me, Microsoft Teams, Melon video-calling and phone. The choice of mode was a mixture of client and service provider preferences, with some clients reportedly preferring phone to video. Interviews with 8 therapists in May 2020, indicated that most therapists tended to prefer one platform over the others and chose to predominantly use their preferred one, with Zoom being the most used video conferencing platform amongst this sample.

PeerZone used phone for individual sessions and Zoom for group sessions. PeerZone quickly reverted to in-person sessions as COVID-19 levels changed, aided by their ability to meet outdoors to reduce risk of transmission. Therapy sessions transitioned more slowly back to in-person, with some variation between service organisations.

The sudden transition to telehealth for all therapy and peer support services during the lockdown provided an opportunity to investigate experiences of this mode of delivery. The evaluation team conducted Zoom interviews with a small sample of 8 therapists and 3 peer supporters, whose experiences are reported below. A few of the service users interviews also contained comments of their experience of telehealth service delivery.

After the lockdown, telehealth continued to be available to clients as an option, with the expectation that it would be used where appropriate, according to individual preference and other contextual factors (as originally planned). Data was not routinely collected by the various service providers on the number of telehealth sessions that occurred so we cannot comment on whether its use increased after lockdown relative to its baseline use beforehand.

Its usefulness for those in remote locations, with childcare issues or social anxiety, for example, is acknowledged. Recent international evidence suggests that electronically delivered CBT-based therapy facilitates access, and is at least as effective as in-person delivery.[71] It will be important to monitor the acceptability and effectiveness of therapy delivery via telehealth for different sub-groups of young people in the Aotearoa New Zealand context. Despite telehealth being an option, most clients have a preference and opt for in-person service delivery.

Telehealth training for service providers

The majority of Piki therapists had no prior experience with telehealth prior to lockdown. None of the therapists had video training pre-COVID; however, training sessions were provided by Tū Ora and Te AHN with varying results (and a recording of the training was made available to all Piki partner organisations). Some therapists found these sessions helpful, although one felt the training was minimal and would have liked more advice about ethics and professional issues. One therapist reported receiving no specific training and consequently felt unprepared, having to rely on existing client knowledge and skills.

The peer supporters were offered training by PeerZone specifically for running workshops over lockdown using Zoom, including aspects of privacy and security. Weekly co-reflection sessions were provided to talk over technical issues and provide strategies for working online. Two of the peer supporters were already familiar with Zoom, but one was not confident with online technology. One peer supporter remarked that there was no specific training for one-on-one sessions; the expectation was that whatever happened in in-person could be replicated via Zoom or phone.

Experiences of telehealth delivery

Service provider experience of telehealth

Piki service providers felt their experience using telehealth over the lockdown period was, overall, a positive one, with the three peer supporters all mentioning that they felt 'surprisingly' positive towards the remote sessions. Nevertheless, all emphasised that they much preferred in-person sessions. Some providers initially felt nervous, pessimistic or sceptical about moving to remote sessions, mainly because they had had little or no experience with telehealth prior to lockdown. Many were pleasantly surprised when their expectations of, for example, an increase in dropout rates or negative experiences for service users were not realised. In general, service providers increased in the comfort they felt with holding remote sessions. In the end, most therapists felt that the remote sessions were as effective as in-person for their clients, although this may be harder to judge with new clients who had only been seen remotely. Two out of the three peer supporters interviewed found the remote sessions as effective as in-person.

All but one therapist felt that the experience had exceeded their expectations, although they were aware of the limitations of telehealth as a medium. One therapist began to really enjoy telehealth and felt her sessions became *'deeper'*. One therapist remained less than positive about the remote sessions.

Challenges

The predominant challenges voiced by all therapists interviewed were the loss of non-verbal cues normally picked up during in-person sessions. Service providers felt that they and their clients missed having in-person sessions, with one therapist saying they generally found the remote sessions to be *'very difficult'* (PK81). Two therapists mentioned they found it hard to ascertain whether a client was crying or not, mainly over the phone but sometimes during Zoom sessions. One therapist felt that her usual grounding and guided techniques for less stable clients were not as effective, while another therapist said that clients were less engaging. One therapist said that some clients became distressed over the phone and it was very hard not being in the same room to give support. One therapist found he was able to better pick up on visual cues towards the end of lockdown, as well as making himself appear more relaxed in video sessions. Other therapists felt that some clients talked incessantly over the phone and it was very hard to get a word in. Three therapists felt the remote sessions were not as effective as in-person, at least partly due to the difficulty with visual cues.

There was a feeling that use of remote media became easier with use. One therapist found it initially challenging to place boundaries on the length of her remote sessions but improved over time.

Most therapists struggled with not being able to use physical or visual resources, such as whiteboards for illustrating techniques or diagrams, or workbooks. One therapist felt she had to be very organised by emailing out resources prior to a session or having them ready to share on-screen. Another therapist who requested video sessions so that he could show clients something, found they were not always willing to do this and only wanted their sessions via phone.

Back-to-back phone and video sessions were felt to be much more tiring by one therapist and one found the remote sessions increasingly tiring over time.

For the peer supporters, one felt that shifting to remote sessions changed the whole dynamic of her sessions. Workshops were much harder to run via Zoom, in terms of difficulties in building rapport among participants.

Benefits

Many of the benefits mentioned by service providers related to the ability to be able to continue providing support in the specific context of the lockdown. More generally, one therapist and one peer supporter felt that the window into each other's lives offered by video calls contributed to their relationship with service users, the peer supporter commenting that some conversations felt more intimate by being able to see each other's rooms.

An additional benefit for one peer supporter was ease of access to online resources, allowing creative use through screen-sharing of online quizzes, a university website to show resources, and yoga videos, whereas pre-lockdown they would have been limited to PowerPoint.

Attitudes to Future Use

Although all therapists and peer supporters preferred in-person sessions, all but one would continue to offer telehealth as part of their services.

On average, the preferred percentage of remote sessions in the future was given as 20-30% of interactions by all service providers, (although one therapist remained negative toward telehealth and would opt for 100% in-person). While at least one therapist admitted that from the service provider point of view, it may be attractive to conduct 50% of sessions remotely for lifestyle reasons, 20-30% was a more realistic expectation.

Service user experiences of telehealth

This section is based on the perceptions of service providers with the addition of comments from service user interviews that related to this.

While some clients were reported by therapists and peer supporters to have deferred therapy during lockdown until in-person sessions were available, most did move to remote sessions, with some preferring to use the phone and others using video conferencing. One therapist suspected that some clients may have used internet issues as 'excuses' for not wanting video calls. One therapist felt that young clients preferred the remote sessions as they are already more familiar with the digital world and have no difficulties with this form of communication.

Most service users were positive regarding telehealth and felt it provided much needed support over lockdown. This was supported by the following service user comment:

> *The phone sessions were fine... I would have preferred to continue face-to-face but obviously because of the circumstances that wasn't possible ... I think the sessions supported me well in terms of being able to kind of continue having the conversations that I needed to have but also keeping that sense of consistency across what we had built over the months before Lockdown.* (SU-PK86)

Some clients expressed a preference for remote sessions and appeared to be more relaxed, particularly those with anxiety, who were also noted as being among those who preferred phone calls to video sessions. One peer supporter saw an increase in engagement and attendance with such service users, observing that they seemed to speak more freely over the phone about certain sensitive topics due to not having to make eye contact. This was supported by one service user who noted simultaneous pluses and minuses to phone sessions:

> *obviously it's much harder than doing it face-to-face because I'm just kind of talking to a phone, ...[but] I guess it might make it a bit easier to explain things because I don't have someone staring at me and then I don't have to like get nervous.* (SU-PK69)

The flexibility provided by using telehealth in the context of lockdown was beneficial to service users, particularly those with children who no longer had childcare issues and were able to move around their home environments more freely. Some therapists reported a reduction in DNAs over this period due to the increased flexibility, although one mentioned that her clients would sometimes forget their appointments. Therapists working from home during lockdown were able to offer more flexible appointment times such as evening or weekends which increased accessibility for some clients. Overcoming physical distance was another obvious benefit of this mode of delivery, with those living in rural areas appreciating not having to travel to in-person sessions.

Service providers also observed some disadvantages of the modality for some clients. Some clients struggled with limited data to access video conferencing and service users living in flats or with family sometimes had issues with privacy, for example the following service user:

> *Zoom was just a bit ... weird, I mean I'm just in my room on my computer chatting about all this stuff and it's not confidential really anymore because, I mean I live in a flat and the walls aren't that thick so it's like anyone could really hear.* (SU-PK85)

Some clients also seemed to be self-conscious about the use of video and having to see themselves, with technical issues like visual freezing also being off-putting. One peer supporter was surprised that service users would feel uncomfortable in front of the camera. Resistance to use of video conferencing for some meant that service providers had difficulty at times when wanting to share visual resources. However, one therapist noticed more clients choosing Zoom instead of phone over the course of the lockdown period, indicating increasing comfort with the idea. Some clients also appeared to be easily distracted in their home environment.

Service providers reported no strong patterns between service users with different characteristics. There were some comments that, in general, men were found to be less communicative and often had shorter sessions, with some opting not to do remote sessions at all. Most service providers reported no age-based or ethnic differences. However, one therapist noted some DNAs among Māori and Pacific clients and mentioned that Pasifika tend to have less family support and understanding around mental health issues.

Summary

Overall, the natural experiment afforded by the unexpected widespread use of telehealth options during the Covid-19 lockdown resulted in a clearer picture of service user and provider experiences of this mode of delivery than would otherwise have been available.

While both users and providers were often pleasantly surprised at how effective phone or video sessions could be, and there were some service users for whom the remote mode was preferable, in general in-person therapy or other support remains the preferred modality in most cases. It is heartening to see indications here that if required, telehealth service delivery is a viable option that can mean that support can be offered when circumstances demand.

5.7 INTEGRATION OF PIKI SERVICE COMPONENTS AND INFRASTRUCTURE

This section discusses the extent to which Piki has achieved its goal of delivering an integrated therapies service with multiple components (some innovative) delivered by different regional and national providers to clients across the wider Wellington area.

Value of an integrated approach

As the Piki pilot service has matured, it has made progress towards the key objective of offering a more seamless and integrated service for clients with a balance between a shared 'kaupapa' and key features, and allowance for local variations.

Self-referral through the website and integration with general practice and primary care appears to be working well, with many clients having heard of Piki (or been referred) through their GPs, nurses, or other members of practice teams, including more recently Health Improvement Practitioners and Health Coaches. Links between Piki and other health/social services and with community organisations are also progressing.

> *but to me it should be any door is the right door, so if somebody comes through the website registers for Piki you know Piki's response should be what are your needs and how can we meet those. And actually, maybe that as a service Piki can't meet those needs but can connect them with the right service that can.* (KI-PK02)

Clients interviewed or surveyed were generally very positive about the kinds of support they received through Piki. As illustrated in the interview excerpt below, young people in this age group clearly value having a single point of contact and the ability to choose between different options when they are looking for support with their mental health and wellbeing.

> *This really lovely lady called me and she just kind of listened to what I was going through ... and then gave me my options and of which I then chose the phone counselling and the peer support and it was actually really cool to see how quick it all went cos obviously with like a lot of the time with Mental Health Services, it's a really slow process because there's so many people but I found with the referral from Piki, I got a phone counselling session, I think it must've been a few days or a week after or something, like it went really fast and the peer support stuff too was pretty quick considering that I was kind of in and out of Wellington cos of visits home. Like the lady was so understanding, it was really nice to just have that, it wasn't just a what can we kind of like, what service can we provide for you, it was a like how you are doing, what is it you're struggling with, and then kind of the recommendations.* (SU-PK65)

Service providers and key informants echoed these sentiments, noting the value for this age group of having a central entry point to a range of services that can then be accessed according to their individual needs and preferences.

> *it's just nice that it's a central point of if you're in this age group in this catchment area, here's where you go, rather than there's five different places, five different organisations and they each do slightly different things and you having to work out which one's gonna be best for you.* (SP-PK106)

Integration of service components

Development of a service built on the concept of 'integrated psychological therapies' was the core objective of Piki. The utilisation data summarised in earlier sections indicates that clients have indeed accessed a range of services, although the predominant service delivered has been one-to-one therapy and counselling. Nevertheless, there has been good uptake of less traditional services such as peer support, telephone counselling and digital support via the Melon app, as these have become available, and clients who accessed more than one service reported largely positive experiences.

> *I looked up the website several times before I actually asked for help because like I guess I was just like worried cos there wasn't like too much information about it, like Vitae, it's like everywhere. But I was so glad that I did like end up reaching out and so I saw a counsellor first and then I was put in touch with a peer supporter pretty much straight off the bat and that was epic.* (SU-PK72)

> *So I called them, well, I booked an appointment for a call and it was just like fifteen minutes talking about very loosely what I wanted to have looked at and what I wanted to discuss in these sessions and like straight away they said okay well we offer counselling, but we also offer peer support and I was really interested in peer support and a little scared about that but I (laughter) you know I went anyway.* (SU-PK67)

However, feedback from both service users and providers indicates that more could be done to improve young people's awareness of services other than therapy and their understanding of what these can offer and how they can complement each other.

> *In theory I believe the Piki model that includes therapy, peer support and digital options is positive however most of the Piki clients we work with do not seem to utilise the peer support or digital alongside their therapy.* (KI-PK117)

Interviews with service users revealed a widespread lack of knowledge around what support was available, other than in-person psychological therapy or counselling which have remained the primary focus for most. When asked about what peer support, telephone counselling, and the resources on Melon or the website could offer in addition to or instead of traditional forms of therapy and counselling, many could not comment as they were not made aware of these alternatives. If clients are to have genuine choices regarding service type, provider, and modality (including face-to-face vs. telehealth), services like Piki will need to proactively provide this information. Suggestions for improvement included better advertising, clearer information on the website, as well as greater clarity and discussion around what supports are available at the time of referral and initial appointments (along the lines illustrated in the interview excerpts above).

There is also clear potential for greater inter-professional coordination between Piki providers offering different services. There was a perception from providers that they were still working largely in professional and organisational silos (see also 5.2 above).

> *The Piki service comes across as integrated but we're not really integrated.* (SP-PK02)

> *it just kind of feels like we get the referrals, and we provide the support and then away we go, rather than it being a collaborative back and forth type of relationship.* (KI-PK106)

The working relationships needed for true integration take time and effort to build, especially in a rapidly evolving and organisationally complex new service. For example, by mid-2020, when the peer support service was well-established and growing, the potential for peer supporters and therapists to work more closely together was starting to be formally recognised, as illustrated by the excerpt from the minutes of the Practitioner Advisory Group below.

> *Suggestion for a stepped approach – 1. Two sessions peer support 2. One session counsellor 3. Two more with peer supporter. Peer support is physical, go for a walk and talk.* (Practitioner Advisory Group Minutes: 05/08/2020)

Ongoing training and opportunities for staff to network across organisational and service boundaries are also important. For example, as noted in section 5.3, Melon trainers reported encountering a lack of clear understanding amongst providers of the various Piki components and how they fitted together. This is understandable and perhaps unsurprising in an environment where there is regular staff turnover, as well as an orientation to existing services in different organisations.

> *where we are lacking in Puāwaitanga is having more knowledge of all of the things that Piki can provide so that if you do have a client who says, for example who would really benefit from peer support, that you can actually say, 'You can get that from Piki, you've referred into that, you can actually access that through your current, who you already contacted and here's how you can get back in contact with them.' So I think we're missing that connection.* (KI-PK106)

One interviewee suggested it would be helpful to develop a more consistent and clearer 'mapping out' of the service model for both providers and clients.

> *this is what's available, ... this is the expectation for each of the roles or each service and this is what it looks like, cos I did one for our service initially for Piki, like what it looked like and then what the options were for Piki, so clients could have a visual, like when you come into Piki this is, you can have virtual, you can have phone ... I just think structurally for anybody rolling out a service, having like a visual aid of expectations or what is available, linear, just makes it so much clearer that everyone's delivering the same.* (SP-PK73b)

Integration of systems and infrastructure

The operational infrastructure required for an integrated therapies service involving multiple provider organisations over different geographical areas and settings is inherently complex and requires a high degree of collaboration and goodwill.

> *Like all health projects that have many organisations that are learning to dance, it's taken us a little while to get our rhythm going and I guess understand the role that everyone plays in the orchestra and so everyone's got a role but just because you can play the piano doesn't mean you should, you perhaps should stick to the violin... I mean I think it's been a great project, it's been very collaborative, I've really appreciated some of the behaviours of all of the parties ... I've not seen any bad behaviour play out which I think's a really, unfortunately a rare thing in the health system.* (KI-PK107)

The systems that were developed within Piki provided the necessary cohesion and inclusivity, but the inherent complexity also led to challenges. These included the fact that the partner organisations each had their own established processes and procedures, including different patient management systems in some cases. The addition of the Melon app with its dashboard feature for therapists added further complexity to this landscape.

Other technical issues included aligning data collection and collation across the partner organisations, the accuracy and consistency of which was an ongoing challenge, exacerbated by the timing of an 'IT transformation' at Tū Ora.

As already noted, setting up effective systems for collecting psychological measures from clients was also problematic. Completion of these measures can be beneficial for clients and service providers as part of therapy, but they are also essential for evaluation purposes. By the end of 2020, there were several ways in which these were able to be collected: on the online self-referral form, on the Melon app, and facilitated by a service provider in person/on paper. This variability made it impossible to establish a consistent data set.

Setting up consistent and workable referral pathways also presented considerable challenges throughout 2019, which also impacted on service integration (see 3.2). However, clients interviewed or surveyed during 2020 have been positive about ease of access to multiple services through the referral process.

> *it was really easy, I just clicked on the website and filled in all of that, and I got an email a few days later and made an appointment for the intake call and then within a few weeks I had been assigned a peer support person, counsellor and things and had access to group sessions, so that was really great.* (SU-PK68)

Ongoing high levels of demand and constraints on the availability of in-person therapy meant often lengthy waiting times before a client could start counselling, and longer than ideal intervals between sessions. The availability of other services provided a way to safely manage and/or mitigate these demand surges, for example by referring clients to peer support, telephone counselling or the Melon app. Whilst this strategy was advantageous logistically and meant young people could receive some support while they waited, it risked cutting across the wider objectives of providing therapies in an integrated way and using different modalities to address access issues. For example, there were reports that some clients were surprised to find they had been enrolled in a telephone counselling service.

> *and I think one of the things that drives that for me is that there is no mention of phone counselling on the website.* (KI-PK106)

Integration of Piki with existing services or 'brands'

As is common for new initiatives, Piki was developed and delivered in the context of multiple organisations with existing services and/or structures which did not always map neatly onto the target age group, locality, or other aspects of the Piki design and/or operations. This added further complexity to the implementation of Piki, as well as impacting on existing business as usual in some cases. For example, both Tū Ora and Te AHN were already providing free mental health services for youth in age ranges that overlapped with that of Piki. In the case of Tū Ora, all clients in the Primary Solutions service who were in the 18-25 age group were deemed to be Piki clients from the start, but later in the pilot when Tū Ora rolled out its Access and Choice initiative, the 18-25 year old age group was excluded because they were already catered for within Piki.

Victoria University (VUW) provides an interesting case study of other issues that can arise when attempting to integrate a multi-provider initiative into an existing large service with its own well-developed systems and kaupapa. The VUW counselling service caters for the entire student population of over 20,000, most of whom (but not all) are in the Piki age range. As noted in 3.3 the place of Piki within the existing counselling services and referral pathways for students evolved over the course of the pilot. Limited resourcing for additional therapists dictated that access to Piki was initially not offered to all students. This resulted in a 'two-tier system' which created operational complexities and potential inequities of access, as well as affecting the internal functioning of the university counselling team (see 3.3 and 3.5). In early 2020, the Victoria University service expressed a desire to extend access to the Melon app to all students as part of a move to make Piki elements more widely available within their service. Other partner organisations expressed concern about the inclusion of students outside the Piki age range on the Melon community forum in particular. (i.e., because other users would be unaware that older people may be participating). It was agreed that Melon would not be offered to older or international students (the latter being ineligible for publicly funded health services), but that it would be made available to all 18-25 year old students. Subsequently (from June 2020), the whole 18-25 age cohort of counselling service users at Victoria University was counted as part of the Piki service, even though the numbers of Piki-funded counsellors had not increased.

A different set of complications arose in the case of the telephone counselling services Puāwaitanga and 1737 provided by another partner organisation, HomeCare Medical. This is a nationwide service that is not specifically youth-focused, making it impossible to fully integrate with Piki in terms of systems and records, and (as alluded to above) also making it less likely that providers would link clients with other Piki components (as discussed in 5.4 and above).

Summary

Piki has demonstrated that it is possible for multiple partners within a region to work together to deliver comprehensive mental health and wellbeing support for young adults, encompassing the integration of psychological therapies with the innovative services of peer support and a digital wellness app.

Ongoing attention does need to be paid to the balance of the different components and levels of support, and how these can best be integrated across multiple providers. Consideration of the relative resourcing and accessibility of each component, the maintenance of client choice, strategies for enhancing client and provider awareness of all components, and the development of robust information and management systems are all important factors supporting success.

While there are additional compliance costs involved in developing and operating an integrated primary mental health programme such as Piki, overall, the value of combining these different elements is likely to outweigh the cost and additional effort required.

PART 6:
DISCUSSIONS AND CONCLUSIONS

Part 6: Discussion and conclusions

In this final part of the report, we provide an outline discussion and present conclusions, as assessed against the original aims and objectives of the Piki programme. We summarise the successes of the pilot programme and provide commentary on the main complexities and challenges encountered (see pp. 23-25 for our recommendations on key issues relevant to the continuation and/or wider rollout of Piki or similar models in 2021 and beyond).

6.1 DISCUSSION

The original aim of Piki was to supply a pilot primary mental health service, free to all youth (aged 18-25) with mild to moderate mental health problems. Key innovations were intended to include co-design with youth including young service users, and to provide an integrated service of psychological therapies with peer support services and a digital wellbeing app. An important focus was to improve equity of access for young people from underserved groups (including Māori, Pacific, LBGTQIA, high deprivation).

There was also a recognition that the pilot would involve a transition from existing platforms of primary mental health activity within the Wellington region to the new integrated service delivery model with multiple possible entry points, where 'any door is the right door'.

(a) Summary of findings – Overall successes and challenges

As described in detail elsewhere we feel that overall, the Piki pilot represents an ongoing success of a complex and innovative mental health programme. After 24 months of operation, Piki continues to enable multiple partners to work together to deliver comprehensive and integrated support to young adults in the Wellington, Porirua, Hutt, Kāpiti and Wairarapa regions. Over this period (which included the COVID-19 lockdown period) Piki has delivered approximately 21,015 therapy or peer support sessions to 5307 clients.

The utilisation data we collected indicates clients accessed a range of services and while one-to-one therapy has predominated, there has been good uptake of peer support and telephone counselling, and modest registration with the Melon app. Clients interviewed or surveyed have been very positive about the support they received through Piki, and about the ease of access through the referral process. They affirmed the value of the original intention of Piki as a free easily accessible service.

Unsurprisingly, the pilot also faced challenges. These were driven by a range of factors including the complexity of the programme design, the effects of the compressed timeframe, the number of different organisations and stakeholders involved, the ability to be responsive to differing expectations of co-design, and new pressures created by emergent changes in the wider policy, health sector and political landscapes.

There are important lessons to be learned from this pilot about the potential scale up and roll out of Piki or Piki-type initiatives. In the original Request for Proposals, the project was described as a pilot (or test bed) to develop a model that could potentially be scaled up. This included assessing the extent to which the UK IAPT model could be adapted for an Aotearoa New Zealand context. Whilst Piki encompasses the development and provision of a new integrated service and model of care, the primary objective was not the development of a specific local service in and of itself.

The Piki pilot has provided an opportunity to develop and trial several innovative elements, and to comprehensively evaluate over time the feasibility and effectiveness of these, both as individual components and as part of an integrated model. As expected in pilot projects, not everything succeeded as envisioned, necessitating refinements and rethinking along the way. However, this process also provided unanticipated opportunities and successes.

We have also observed a converse risk. Building on an existing platform may make it harder to maintain a focus on innovation in the face of a tendency for 'business as usual' to prevail. There is thus a need to align expectations with reality and to maintain a clear focus on evaluation and learning from experience to inform future rollout along similar lines.

(b) Treaty obligations/Engagement with Māori

We refer in our section on equity to the challenges encountered by Piki in respect to fulfilling the original target aims of prioritising specific groups and in particular fulfilling obligations to the Treaty of Waitangi and ensuring appropriate engagement with Māori. In our conclusions and recommendations, we emphasise the importance of co-design with both young people (rangatahi) and with Māori communities. We highlight again how compressed timeframes can compromise the principles and process of co-design, and the importance of engagement with Māori communities from the outset of project design.

Enrolment numbers of Māori and Pacific clients remained low relative to likely need, despite thoughtful and energetic attempts in the later stages of the evaluation timeframe to appoint new staff in high need areas and deliver services for Māori and Pacific clients from a workforce fully culturally responsive to their needs.

There is also an ongoing discussion as to whether this type of service is appropriate for groups such as Māori and Pacific.

(c) What do young people want?

Several of our recommendations outline the need to develop a service that is attuned and appropriate for young people. These recommendations are drawn from different sections in the report, but have as an overarching theme a response to the question 'What do young people want?', and as a subsidiary 'To what extent should young people, and young service users themselves have control and agency over the service development'?

We have noted that there is often an appropriate balance and range in young people's views, indicating that not all young people want the same thing or at the same time. Services for young people cannot be 'one size fits all'.

Some of the issues include the ability of the service and therapists to be approachable good listeners, and to be able to reflect the service users' own lives. This provides challenges that are worth taking up including the acknowledged need for a more diverse workforce (especially in terms of ethnicity and gender identity) and for more comprehensive staff training so that the workforce in general is better able to relate to the range of experiences of youth.

Youth and service user representatives were particularly keen to have a positive frame on the service, rather than the deficit model reflected in the use of words like 'distress', 'disorder' or 'problems'. The tension between a strengths model and a deficit model, and between 'risk' and 'need', reflects the different perspectives and priorities of service users and service providers, and highlights the importance of the language and model of care used throughout the project.

Young people also clearly expressed a desire for being able to access services in an integrated, coordinated way – a unified and easily navigable 'shopfront' rather than fragmented and separate services.

If we were to summarise a response to the question of what 'young people want', it is perhaps best encapsulated in a reflection for services to be, and for young people to feel, 'connected'.

> *there has to be like a real human element to it... the fundamental missing thing is that people need to be connected and feel like they're a part of something and feel like they've got a bit of purpose in life.* (KI-PK34)
>
> *what people actually need is connection with a human being and I think throwing apps at people is almost a little bit counterproductive and a little bit insulting because it's not what helps, like people feel better isn't, people need that human connection.* (Peer supporter focus group)
>
> *So the most helpful thing was the human connection.* (SU – Client survey response)

(d) Workforce issues

Workforce and workload have been important themes for Piki and for the evaluation. We have recognised the challenges regarding the training, recruiting, and retention of both new and existing staff throughout the duration of the Piki pilot, and made commentary on the need to obtain an appropriate mix of different types of staff. Overall, the Piki pilot managed successfully to train and retrain a workforce that was largely 'fit for purpose' for the new and innovative Piki pilot environment. This workforce, alongside with the rest of the health sector, managed to transition successfully to online and 'virtual' working in the face of the COVID-19 pandemic.

Workforce conclusions and recommendations are also made in the light of the rapidly changing primary mental health environment and the inclusion of new workforce team members in the form of Health Improvement Practitioners (HIPS) and health coaches. It is not clear exactly what the final skill mix and allocation of different team members will be in primary mental health settings. As a result of the experience with Piki and our observations following the recent introduction of revised team membership it is important that there is clarity of purpose about who is in the team, and for what, and to recognise that there is requirement to redefine the desired role of existing primary care team staff.

(e) Trade-offs and tensions

This report contains information about our two-year observation of an innovative mental health pilot. We have been able to make firm conclusions in many areas, but there are some issues where we recognise trade-offs and tensions that must be considered and that will be different for different settings. We believe it is important that service planners and co-design partners take the time to consider these issues in the light of their own context and in the light of an increasing evidence base of which this report is a part.

Development from existing services vs a 'blank slate'

Piki was designed to develop from an already functioning and established platform of existing services, and the advantages and challenges have been described. Further development of services could be based on an existing platform model, or as in the UK IAPT, a decision made to establish new more 'stand-alone' services in parallel. The trade-off is a clean start, the tension is the need to combine with often successful existing services and avoid reduplication.

Provider-led service development vs a Service user/community-led approach

Piki was designed in response to a clear request from a Ministry of Health RFP, with much of the design specification based on the UK IAPT model. This provided a clear advantage and trade off, in terms of planning and activity starting points; the service was able to transition and start up with commendable speed. The tension became clear in various ways, such as feelings of a lack of engagement with key stakeholders, including service users and Māori and Pacific communities, from the very outset of the design of the project.

While there will always be an appropriate wish for some degree of agency from a sponsor, in this case the MOH, we can see with our observation of Piki the real advantage of deep and early engagement with service users and communities.

Response to Priority groups vs ever-increasing demand

Piki had as its aim the twin challenges of providing ease of access and at the same time responding to the needs of priority groups and increasing equity for different targeted groups of interest. In the Piki pilot, we recognised the tension of attempting to resolve at times unexpected peaks in demand with the provision of time and resource that could have been used to respond to equity challenges. While difficult, we feel that constant attention to this issue, potentially using our 'embedded evaluation' methodology will at least make this tension clear to a service.

Tailored services vs 'one size fits all'

As part of a national primary mental health strategy thought should be given to the balance of providing an overall blueprint of consistent national patterns of service and service delivery and allowing tailoring of services to local need and demand. In the Piki pilot it was clear that there was a need to tailor services to both local geographical and community interests, and this produced a tension regarding overall service consistency. While there cannot be a total 'one size fits all', and neither is it appropriate, it is important that there is clarity about the compliance and other costs of providing different services within any particular service delivery model.

Place of national services within a locally delivered service

Piki utilised the services of nationally developed and delivered organisations such as the 1737 phone lines and Puāwaitanga telephone counselling service operated by Home Care Medical. We recognise a trade-off and tension between the degree to which local services access national resources, and the degree to which local services are designed for and delivered within a local context.

Acknowledgment of the complexity within project innovation

Piki was designed as a pilot project in which there were many partners, interests and 'moving parts'. While this produced a trade off in terms of potential multiple sources of help for service users, it required acknowledgement of the tensions between the relative resourcing of each component, their accessibility, and the facilitation of client choice, as appropriate to the local community.

6.2 CONCLUSIONS

Piki has operated and adapted within a broader primary mental health environment, which is also undergoing significant change and managing a range of opportunities and challenges in service provision and implementation.

In this final section, we present conclusions, as assessed against the original aims and objectives of the Piki programme. We summarise the successes of the pilot programme and provide commentary on the main complexities and challenges encountered.

Key findings

Overall

- Piki represents successful development of a complex and innovative youth mental health pilot programme. The pilot has shown that it is feasible to transition from an existing platform of primary mental health service delivery, and to introduce and sustain innovations.
- The engagement of multiple partners and the incorporation of an embedded evaluation stream has enabled the programme to deliver services and adapt to a range of challenges and unexpected events.
- It has been possible to accommodate local variations, while maintaining an adequate degree of programme cohesion.
- Clients have been able to access a range of services including the innovative elements, despite challenges to delivery at different times of the pilot.
- Barriers to access have been reduced by good uptake of the website self-referral, although wait times for services remain an issue. This may be due in part to high demand as result of the increased ease of access offered by the self-referral pathway and may also reflect the extent of distress that youth are experiencing and ongoing unmet need for support.
- The original service delivery target in the Piki Charter was not reached. (This was an aspirational rate of approximately 4500 clients per year for the duration of the pilot, with a representative mix of urban, rural, mainstream, and marginalised populations). Realistic strategies for reaching such targets in future will need to take account of workforce development and capacity, the likelihood of unexpected fluctuations in demand, and other systems constraints.
- The Piki pilot has given insight into the relative benefits or otherwise of having an integrated programme as opposed to modular components. While an integrated primary mental health programme may be more resource-intensive initially, with appropriate strategic planning the benefits add up to more than the cost of individual parts.
- The aim of increasing integration of therapy services with general practice, community organisations, a digital wellness app and peer support was an ambitious and challenging goal, with a great deal of complexity. As Piki matured, it was able to offer a somewhat more 'seamless' interface and integrated service. However, clients (and therapists) often lacked clarity about the full range of component services Piki offered in addition to or instead of traditional forms of therapy and counselling which have remained the primary focus for most.
- Piki had a complex management and operations structure in order to provide an integrated comprehensive service across different organisations, geographical areas, and settings. This provided cohesion and inclusivity, but also created operational challenges and significant systems complexity.
- We recognise the considerable challenge in introducing the very significant innovations developed in Piki to service platforms of business as usual which vary widely across the primary care sector in NZ.

Equity and priority populations

- There were delays in operationalising the focus on improving equity of access and outcomes to priority groups. Piki has faced challenges in fulfilling obligations to Te Tiriti o Waitangi, and in providing sufficient culturally responsive services. Unexpected difficulties in prioritising this objective notably included an early increase in demand pressure on the service, and disruption due to COVID-19.
- More recently, targeted marketing to Māori and Pacific youth using brief social media marketing and local community promoters had started to show promising results. However, it is too soon to say how successful this will be in terms of improving access by these groups.
- Earlier engagement with target groups and local communities in a co-design or tikanga process may lead to a better outcome than the provision of largely pre-designed services.

'Co-design'

- The use of co-design with youth/service users within the project has been a mix of successes and challenges. We applaud the fact that co-design was recognised as important and that efforts were made to seek the input of service users and youth throughout the pilot. Multiple partners were given opportunities to modify aspects of project operation and ongoing design through the project. It is clear, however, that in several areas outlined in this report the ideal of co-design was compromised and project partner input was not fully utilised.
- Co-design needs to be fully understood by all parties involved, have transparent parameters, and have sufficient time and resources allocated to be well carried-out.
- Logistical details of how co-design processes are implemented need to be carefully thought through to avoid unintended consequences.
- Careful consideration also needs to be given to of the use of the terminology (whether 'co-design' truly describes the processes being used), and who should be involved in the co-design process (e.g., relevant communities who the service aims to reach).

Therapy models, duration, and intensity

- Debate continues within Piki around the most appropriate therapy models for this context, the optimal duration and intensity of talk therapy, and issues with measuring outcomes. This has included discussion around whether the initial Piki treatment framework of CBT-based therapy model and style should remain fixed, or to what degree there could be variation of both nature, duration, and intensity of psychological intervention.
- Although Piki was aimed at those with mild-to-moderate mental distress, there must be systems in place to provide or arrange appropriate care for those presenting with any level of distress. A service like Piki thus needs to have well-developed stepped care pathways.
- The implications for training and supervision of new and existing staff in evidence-based therapies, and for the apportioning of the workforce to achieve optimal effectiveness and equity are significant. This is particularly pertinent given the multiple new roles currently evolving in the primary mental health care sector.

Peer support

- The intentional peer support service has shown great promise, and the evaluation evidence supports its continued development as a component of youth mental health services.

Telehealth and digital options

- The Piki pilot displayed commendable agility and flexibility in adapting quickly to the unexpected demands of the COVID-19 pandemic by continuing to provide services using telehealth.
- Delivering mental health support through telehealth can be effective and acceptable to service users and providers, when required in some situations and at some times.
- Telehealth should be offered as an option for mental health support, but in-person delivery remains the overwhelmingly preferred mode of delivery and should be prioritised.
- While telehealth, and digital mental health support options are now an integral part of primary mental health support, there was limited evidence of support for a dedicated and fully integrated digital app component to the service.
- The Melon Health Piki digital app was a valuable additional support option for some young people but did not appeal to all, as evidenced by the fact that by the end of the evaluation period only one third of all Piki clients had enrolled on the app (down from one half at the end of Year 1), and not all enrolees actively engaged with the app. Those who did found the community forum and some other features useful.
- The original aim of the Melon platform being an integrated digital hub (a conduit for information, referrals, and evaluation data as well as for client-therapist communication and peer community engagement), was not fully realised. In hindsight, this was probably too ambitious.

Impact of COVID-19

- Negative impacts of the COVID-19 pandemic included delays in work in some areas (particularly equity targets, rollout of staff training development for DBT/group therapy, and the development of MDTs).
- The psychological impacts of the pandemic and the lockdown are also likely to have increased demand for the service.

Evaluation

- The collection and interpretation of quantitative data on service utilisation and outcomes has been challenging. Issues arose with routine collection of utilisation data and outcome measures relating to service user preferences, health information systems, and health provider concerns and perceptions. This aspect will require a great deal of careful planning in future, especially when working across multiple organisations.
- Clear consensus and communication is required on the use, utility, and selection of outcome measures, for both therapeutic and evaluation purposes.
- Embedding an ongoing evaluation into Piki from the outset all allowed ongoing feedback to all parties and provided opportunity for immediate response to suggested course corrections as the pilot progressed. The experience from this pilot supports including continuous evaluation as an integral part of all new mental health initiatives, especially given the very significant sums of funding being invested, and the relative lack of an evidence base.

piki

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APPENDICES

Appendices

APPENDIX 1: TŪ ORA SURVEY OF PIKI THERAPISTS (JULY-AUG 2019) – QUESTIONS

Note: full summary available on request

Cultural identity or ethnicity

Gender identity

Job title

Please select your profession

How many years of experience do you have working in mental health or addictions?

Training/experience with certain types of therapy (Expert/Beginner/Competent/No training)

- Cognitive Behavioural Therapy
- Motivational Interviewing
- Dialectical Behaviour Therapy
- Family therapies (family systems, dynamic family therapy, etc.)
- Solution Focused Brief Therapy (SFBT)
- Mindfulness based therapies
- Brief Psychotherapy
- Problem Solving Therapy (PST)
- Acceptance and Commitment Therapy (ACT)
- Supportive counselling
- Brief intervention
- Group therapy and skills training
- Eye Movement Desensitisation and Reprocessing (EMDR)
- Cognitive Processing Therapy (CPT) and/or Trauma-Focused CBT (TF-CBT)
- Other talk therapies

Assessment Skills (Expert/Beginner/Competent/No training)

- Mental health assessment (this covers screening for common conditions such as anxiety and depression)
- Alcohol and other drugs, gambling, and addictive behaviours
- Psychological conditions (this includes the use of formal psychological assessments such as the MMPI-II, PAI, WISC, and WAIS)
- Risk assessment
- Neuropsychological (this includes use of the RBANS, Stroop, and other neuropsychological assessments)
- Other assessments (please elaborate)

Time allocation (percentage estimates):

- Delivering talking therapy
- Writing notes
- Phone calls and text messages to patients
- Phone calls and text messages to people other than patients (GP's, parents, etc.)
- Meetings other than with patients

What other functions take up your time during the week?

Frequency of following behaviours (Occasionally/Never/Sometimes/Always/Often)

- Inclusion of cultural practices (such as referral to cultural advisors or services, co-working with cultural services, cultural supervision).
- Inclusion of a person's preferences (for example, their spiritual values, choice of therapy or therapist).
- Family or whānau member involvement (either directly in therapy or by consultation).
- Identifying and addressing co-existing problems (such as addictions, mental health, physical health, long-term physical illness, and disability).

Type of training required (please include details of actual training courses if relevant)

Are there any talking therapies that you think could be made more available in your service and why?

What type of talking therapy supervision do you receive (e.g., one-to-one or group) and how often do you receive it?

- Individual supervision with another supervisor
- Individual supervision approximately fortnightly with an Explore supervisor
- Free Text

What further supervision, if any, do you require?

Do you provide supervision of talking therapies to other practitioners?	Yes/No
Do you assess the progress that a person makes in talking therapy?	Yes/No
Do you assess the effectiveness of the therapy you deliver?	Yes/No
Do you routinely use progress and outcome measures within your talking therapy practice?	Yes/No
Do you think current delivery of talking therapies is meeting demand?	Yes/No

Please briefly describe reasons for your answer to the previous question.

What do you think are the main strengths of the current delivery of talking therapies?

What do you think are the main areas for development?

What development is required to meet the needs of cultural and ethnic groups?

Do you have any further comments about current delivery of talking therapies within your service or practice?

APPENDIX 2: OTAGO UNIVERSITY SURVEY OF PIKI THERAPISTS (JAN-FEB 2020) – QUESTIONS

Note: full summary available on request

What is your role title in the Piki service?

- Mental Health Nurse /Counsellor /Psychologist /Social Worker/Mental Health Practitioner

Which ethnic group do you belong to? (Tick as many as you need)

- New Zealand European
- Māori
- Samoan
- Cook Island Māori
- Tongan
- Niuean
- Chinese
- Indian
- Other (such as DUTCH, JAPANESE, TOKELAUAN please state) _____

Please tell us your gender

- Male /Female /Gender diverse

Please tell us which age band you belong to:

- 20-29 /30-39 /40-49 /50 plus

Please tell us which organisation you work for (are contracted by) for Piki

- Te Awakairangi Health Network
- Massey University Student Health
- Tū Ora Compass Health
- Ora Toa
- Victoria University Student Health
- Explore Psychological Services
- Puāwaitanga

What proportion of Piki clients are you using Beckian CBT with?

- None /Some /About half /Most /All

With what proportion of Piki clients are you doing in or out of session behavioural experiments to test specific predictions?

- None /Some /About half /Most /All

With what proportion of Piki clients are you setting homework or between session tasks?

- None /Some /About half /Most /All

With what proportion of Piki clients are you setting a specific agenda for the session?

- None /5-25% /26-50% /51-75% /76-100%

What is your FTE per week on the Piki project?

- 0 - 0.2 FTE / 0.2 FTE - 0.4 FTE / 0.4 FTE - 0.6 FTE / 0.6 FTE - 0.8 FTE / 0.8 FTE - 1.0 FTE

How many Piki clients do you see a week on average?

- 1-5 / 6-10 / 11-15 / 16-20 / 21-25 / 26-30

Do you feel that you are able to see Piki clients for as many sessions as they need?

- Yes / No, please explain / Not sure

Are your Piki clients mostly mild/moderate?

- Only mild to moderate / Mild to moderate with a small number of severe / More numbers of severe than I was expecting / More severe than mild to moderate

Do you consider the administration workload required for Piki clients to be manageable?

1 (1)
2 (2)
3 (3)
4 (4)
5 (5)

Do you have control of bookings made in your diary?

- Never / Sometimes / About half the time / Most of the time / Always

To what extent are you able to re-book clients at the frequency you believe they require?

- Never / Sometimes / About half the time / Most of the time / Always

If you use Kaupapa Māori based models with Piki clients, please identify which main frameworks you use.

- Te Whare Tapa Whā / Tikanga / Poutama Powhiri / Kahui Ao / Te Wheke / Dynamic of Whanaungatanga / Tika, Pono, Aroha / Hua Oranga / Not applicable

What do you see as the main strength of Piki service delivery model?

Are there any changes you would like to make to the Piki service delivery model to make it more effective for clients?

APPENDIX 3: SERVICE USER SURVEY (DEC 2020) – QUESTIONS AND FULL SUMMARY

Questions:

Demographics

Which ethnic group do you identify with? Tick all that apply to you.

- New Zealand European
- Māori
- Samoan
- Cook Island Māori
- Tongan
- Niuean
- Chinese
- Indian
- Other such as Dutch, Japanese, Tokelauan. Please state. _____
- Choose not to answer

What is your gender identity?

- Female/Wahine
- Male/Tāne
- Trans woman/Whakawahine
- Trans man/Tangata ira tāne
- Intersex
- Different identity, state if you wish
- Choose not to answer

Service Use

Please tell us which of these services you used? Tick all that apply.

- Face to face counselling/therapy (incl video or phone during Lockdown)
- Phone counselling through Puāwaitanga
- Peer support
- Melon Wellbeing app

Face to face counselling/therapy

How many sessions of face to face counselling/therapy did you have?

- One only
- Two or three
- Four or more

How satisfied were you with the number of counselling/therapy sessions you had?

- 1 (very unsatisfied)
- 2 (somewhat unsatisfied)
- 3 (satisfied)
- 4 (very satisfied)

You indicated that you only had one counselling/therapy session. Why was that?

- One session was all I needed
- I found help somewhere else
- I didn't like the kind of help I received
- The counsellor/therapist wasn't a good fit for me
- I moved away
- Other

If How satisfied were you with the number of counselling/therapy sessions you had? = 1 (very unsatisfied) or 2 (somewhat unsatisfied):

- Did you know that you can self-refer to Piki again, even after if you have received support before? If you would like to get more support, go to the Piki website and complete the self-referral.

Comments on the number of sessions? (Free text box)

Please tell us how well face to face counselling/therapy helped you with the issue that you were struggling with?

- 1 (didn't help at all)
- 2 (helped a little)
- 3 (helped quite a bit)
- 4 (helped a lot)

Comments on the counselling/therapy you received? (Free text box)

Peer support

How many sessions of peer support (individual or group) did you take part in, in total?

- One only
- Two or three
- Four or more

Please tell us how well peer support helped you with the issue that you were struggling with?

- 1 (didn't help at all)
- 2 (helped a little)
- 3 (helped quite a bit)
- 4 (helped a lot)

Comments on peer support? (Free text box)

Melon app

What features of the Melon app did you find most useful? Tick all that apply

- Messaging coach
- Online community forum
- Personal diary
- Completing measures such as the PHQ9 or GAD7
- Wellbeing resources
- Webinars
- None of them were useful

Please tell us how well the Melon app helped you with the issue that you were struggling with?

- 1 (didn't help at all)
- 2 (helped a little)
- 3 (helped quite a bit)
- 4 (helped a lot)

Comments on how well the Melon App helped you. (Free text box)

Puāwaitanga

- How many sessions of phone counselling (through Puāwaitanga) did you have?
- One only
- Two or three
- Four or more

How satisfied were you with the number of phone counselling/therapy sessions you had?

- 1 (very unsatisfied)
- 2 (somewhat unsatisfied)
- 3 (satisfied)
- 4 (very satisfied)

If 'How satisfied were you with the number of phone counselling/therapy sessions you had? = 1 (very unsatisfied) or 2 (somewhat unsatisfied)', the following was displayed:

- Did you know that you can self-refer to Piki again, even if you have received support before? If you would like to get more support, go to the Piki website and complete the self-referral.

Please tell us how well the phone counselling helped you with the issue that you were struggling with?

- 1 (didn't help at all)
- 2 (helped a little)
- 3 (helped quite a bit)
- 4 (helped a lot)

Comments on phone counselling with Puāwaitanga (Free text box)

Reasons for seeking support

Why did you decide to seek mental health support through the Piki service?

- Depression
- Anxiety
- Anger
- Relationships/interpersonal
- Life stress
- Self esteem
- Study problems
- Sleep problems
- Sexuality issues
- Substance use
- Eating disorder
- Trauma
- Guidance
- Not sure
- Other (specify if you wish) _____

Comments on why you wanted support. (Free text box)

Wait time

Did you find the amount of time you had to wait to have your first session acceptable?

- 1 (unacceptable) (1)
- 2 (neutral) (2)
- 3 (acceptable) (3)

Comments on wait time. (Free text box)

General

What was the most helpful thing about the services you received? (Free text box)

Any other suggestions or comments you would like to make about the services you received? (Free text box)

How likely would you be to recommend this service to a friend or family/whānau member?

- 1 (not at all)
- 2 (somewhat)
- 3 (neutral)
- 4 (quite likely)
- 5 (very likely)

Comments about recommending the service or not? (Free text box)

Further demographics

Please tell us a bit more about yourself –- just 3 more questions
How old are you?

- 18 - 19 years or younger
- 20 - 21 years
- 22 - 23 years
- 24 - 25 years or older

Which of these best describes you? Tick as many as apply.

- At school or studying
- Working part time
- Working full time
- Looking for work
- Caring for children or another person
- Training/apprenticeship
- Not working or studying or unable to
- Receiving a benefit
- Other, please state
- Choose not to answer

Where did you use the service(s)?

- Wairarapa
- Kāpiti
- Porirua
- Wellington
- Hutt Valley
- University counselling
- Other (e.g., remotely)

Results

The Piki evaluation team developed an online survey (using Qualtrics). The link to this survey was sent via text message (or email where no mobile number was recorded) to all Piki service users who had attended a Piki session or enrolled with the Melon App between 1 January 2020 and 30 September 2020 (n=3278). The initial text was sent on 1 December 2020 and followed by two reminder texts (22 December 2020 and 21 January 2021). Respondents were offered to opportunity to enter a draw for $100.

As of the survey's close, there were 730 responses, a response rate of 22% (730/3278). Table 1 shows the demographic characteristics of the respondents, with the majority being female and Pākehā.

Table 1: Demographic characteristics of survey respondents

CHARACTERISTICS	TOTAL (N= 730)	PERCENT
Gender		
Female/Wahine	516	70.7
Male/Tane	133	18.2
Trans Man	15	2.1
Trans Woman	8	1.1
Other*	31	4.3
Not stated	27	3.7
Ethnicity		
Pākehā	483	66.2
Māori	133	18.2
Pacific	25	3.4
Asian	41	5.6
Other	48	6.6
Age range		
18-19	151	21.3
20-21	183	25.8
22-23	159	22.4
24-25	139	19.6

*Non-binary = 8, Takatāpui = 1, Agender = 1, Genderfluid = 4, Transmasculine = 1, other = 1

Table 2 shows how many respondents used each component service, with Piki clients able to use more than one service, as well as where they had accessed the service. Most had used counselling/therapy (in-person) and a quarter of respondents had used the Melon App. The largest number of respondents had accessed services in Wellington or at a university counselling service.

Table 2: Services used and where used

SERVICE USE	TOTAL	PERCENT
Service Used (could tick multiple)		
In-person counselling/therapy	582	82.1
Phone counselling (Puāwaitanga)	137	19.3
Peer Support	67	9.4
Melon App	180	25.4
Total who answered question	698	
Where did you use the service? (n=730)		
Wellington	322	44.1
University counselling	133	18.2
Hutt Valley	73	10.0
Porirua	54	7.4
Wairarapa	24	3.3
Kāpiti	16	2.2
Other (e.g., remotely)	10	1.4
Not stated	98	13.4
Total	730	

Therapy/counselling

Of 730 respondents, 582 reported using face to face counselling. Around 64% of these respondents felt that therapy/counselling had helped them a lot or quite a bit. Table 3 lays out the number of sessions received, satisfaction with number of sessions, and how helpful respondents found in-person counselling.

Table 3: Survey responses with respect to therapy/counselling

NUMBER OF SESSIONS	COUNT	PERCENTAGE
One	61	10.5%
Two - Three	160	27.5%
Four or More	352	60.5%
Not stated	9	1.5%
Satisfaction with number of sessions		
Very Satisfied	210	36.0%
Satisfied	259	44.5%
Somewhat Dissatisfied	76	13.0%
Very Dissatisfied	28	4.8%
Not stated	9	1.5%
How helpful was counselling		
Helped a lot	181	31.0%
Helped quite a bit	189	32.5%
Helped a little	141	24.2%
Didn't help at all	44	7.6%
Not stated	27	4.6%

Approximately 10% of respondents had received only one session. If this was the case, they were also asked what the reason for this was as shown in Table 4. The reasons varied with the most common relating to the fit of the individual therapist to the respondent.

Table 4: Reasons stated for having only one session of therapy/counselling

REASONS FOR ONLY ONE SESSION	
The counsellor/therapist wasn't a good fit for me	11
I found help somewhere else	8
I was only offered one session	8
I'm waiting for an appointment	8
One session was all I needed	8
I didn't like the kind of help I received	4
I moved away	2
Covid19	2
Wait times	1
Inappropriate for the service	1
Counsellor took sick leave	1
Total	**54**

Free text on number of therapy sessions

Respondents were asked for any further comments about the number of therapy sessions they had received. Many were happy with the amount received:

> *I was able to go every month before the new changes were made. it was wrapped up incredibly well and I have full faith that the 6 sessions will work extremely well for people as it did for me!!*
>
> *Was a good amount and felt comfortable asking for more sessions if I needed.*

A number of respondents expressed a desire for more or unlimited sessions:

> *The service is amazing but to make a permanent difference to my mental health unlimited sessions would be best as then you could get into more detail.*
>
> *I had a good experience with the counselling and counsellor however it would have been nice to have more sessions!*

Some also said they felt pressured to be 'finished' due to demand for the service being too high:

> *It would have been nice to have some more sessions, I felt pressured to be 'finished' and 'well' after a certain number because only a certain number of sessions were free.*
>
> *It kind of felt like they were just trying to get rid of me because there were so many others on the wait list.*

A large number of respondents identified that the wait time between sessions or from referral made it difficult to make progress and that more frequent or consistent sessions would be helpful.

> *The main issue wasn't the amount but how sporadic the sessions we're, it's hard to make progress if there's a two month gap in between.*
>
> *It was a shame that the waiting list for each appointment was so long. Having an appointment every week would have been much more effective and helpful than once a month.*

Free text on therapy received

Respondents were asked if they had any further comments on their experience of counselling/therapy.

Most respondents were positive about the therapy they received, with many these comments naming specific therapists who had helped.

> *I felt safe, respected and understood. It was really nice and some of the best counselling I've received.*
>
> *I loved my counsellor, she was wonderful. I'm really grateful I was able to go to her, even if it wasn't for as long as I would have liked.*

Again, there was a desire for more sessions and shorter wait times:

> *Not enough time to go through things and the time in between sessions is too long it feels like no progress is made.*
>
> *Long waiting times made it difficult to address some issues properly.*

Those who had had negative experiences with the therapy they received mainly mentioned therapists seeming dismissive, scripted, or uninterested:

> *Counsellor just read off a website/referred me to the same website for homework, didn't know how to help with issues other than mild depression and anxiety, often felt like it was a waste of both of our time.*
>
> *I had a lot of trouble with therapists not getting back to me, no communication, etc and a lot of the things I went over in sessions were repeated and were not helpful.*
>
> *counsellor wasn't really present in conversation, only asked me basic questions and allowed me to come to conclusions.my problems seemed too far out of their depth.*

Some respondents also had difficulty with counsellors who did not understand or were not a good a fit for aspects of their experience and identity:

> *Over a few years have noticed that mental health staff generally don't have a good understanding of transgender identities or how to use gender neutral pronouns and/ or appropriately gendered language.*
>
> *Wish there were Māori counsellors available near me.*
>
> *Some sessions were good but some I left feeling worse than I came in and I felt like my Christianity was being judged and I didn't like my therapist's suggestion to explore other religions.*

Peer support

Of 730 respondents, 67 reported accessing peer support. Around 66% of these respondents felt that peer support had helped them a lot or quite a bit. Table 5 lays out the number of peer support sessions received, and how helpful respondents found peer support.

Table 5: Survey responses with respect to peer support

NUMBER OF SESSIONS	COUNT	PERCENTAGE
One	11	38.8%
Two - Three	7	10.4%
Four or More	43	64.2%
Not stated	6	9.0%
How helpful was Peer Support		
Helped a lot	26	38.8%
Helped quite a bit	18	26.9%
Helped a little	15	22.4%
Didn't help at all	2	3.0%
Not stated	6	9.0%

Free text on peer support

Respondents were asked if they had any further comments on their experience of peer support. Comments on peer support were largely positive, with only minor critiques regarding some difficulty in changing peer supporter, or that it wasn't a good fit personally.

> *It was really beneficial for me, I enjoyed both the peer support and group sessions. Really happy to have participated and have someone my age with similar experiences to korero with.*
>
> *Honestly changed my life [...]. My brilliant peer supporter [name redacted] is much of the reason I even had a secure connection during this turbulent year. The personal connection provides a deeper understanding and allows deeper compassion to someone really struggling. [...] I really could go on about how amazing this service has been for me. I just wanted to make sure I put it out there.*
>
> *I had two sessions with one peer supporter but didn't feel it was quite the right fit, so I have now been paired with another. I have had one session with the new one since and have found it much better and I'm looking forward to more sessions with her.*

Melon Wellbeing app

Of 730 respondents, 180 reported using the Melon app. Around 15% of these respondents felt that the app had helped them a lot or quite a bit. Table 6 lays out which features of the app were found to be most helpful, and how helpful the Melon app was overall.

Table 6: Survey responses with respect to the Melon Wellbeing App

WHAT FEATURES OF THE MELON APP WERE MOST HELPFUL	COUNT	PERCENTAGE
Wellbeing resources	80	44.5%
Personal Diary	74	41.1%
Online Community Forum	59	32.8%
Completing measures such as PHQ9/GAD7	27	15%
Messaging coach	21	11.7%
Webinars	14	7.8%
None of them were useful	44	24.4%
How helpful was the Melon App		
Helped a lot	5	2.7%
Helped quite a bit	23	12.7%
Helped a little	87	48.3%
Didn't help at all	59	32.7%
Not stated	6	3.3%

Free text on Melon

Respondents were asked if they had any further comments on their experience of the Melon App. The majority those who commented said either they hadn't really used Melon or didn't find it useful. Those who did find it useful used it to track progress, and some found the community forum comments helpful to read through. Conversely, some respondents found the community forum *'depressing'* or *'triggering'* to read.

> *I didn't use it much. Didn't understand the concept behind it.*
>
> *A lot of what is on the melon app is, if you've struggled with mental illness for a long time, resources or ideas or copying methods you've seen and tried a long time ago (in my experience). The forum was really nice to read through, but I didn't find any resources that particularly helped me.*
>
> *I enjoyed being able to see the graph of progress for sleep and exercise as it helped me keep track of progress and link events to dips in my consistency.*
>
> *I found the community function pretty triggering, reading other people's unfiltered thoughts feels pretty awful. The resources might have been helpful tbh, but I just didn't have the energy or motivation to try use them, the way they were categorised, and stuff was a little overwhelming.*

Puāwaitanga phone counselling

Of 730 respondents, 137 reported using phone counselling through Puāwaitanga. Around 45% of these respondents felt that Puāwaitanga had helped them a lot or quite a bit. Table 7 lays out the number of sessions received, satisfaction with number of sessions, and how helpful respondents found phone counselling.

Table 7: Survey responses with respect to Puāwaitanga phone counselling

NUMBER OF SESSIONS	COUNT	PERCENTAGE
One	37	27.0%
Two - Three	40	29.2%
Four or More	47	34.3%
Not stated	13	9.5%
Satisfaction with number of sessions		
Very Satisfied	42	30.7%
Satisfied	48	35.0%
Somewhat Dissatisfied	26	19.0%
Very Dissatisfied	8	5.8%
Not stated	13	9.5%
How helpful was Puawaitanga		
Helped a lot	32	23.4%
Helped quite a bit	30	21.9%
Helped a little	46	33.6%
Didn't help at all	16	11.7%
Not stated	13	9.5%

Free text comments on Puāwaitanga

Free text comments about phone counselling through Puāwaitanga were mixed. As with face-to-face therapy, many respondents named specific counsellors who had helped them. Benefits of phone counselling mentioned were the flexibility and freedom to have the session in a safe environment. Some however expressed that they found it hard to get the support they wanted over the phone, and a number expressed a preference for face-to-face counselling. A small number of respondents also expressed the desire for more frequent and ongoing support.

> *My therapist was the perfect match for me. They guided me, supported my journey, and I wouldn't want to have anyone else helping me. Would absolutely recommend them to anyone struggling.*
>
> *Amazing took away the shame and anxiety and like worry of crying in public and being able to do it in an environment I felt safe and comforted in and made me set myself some alone time.*
>
> *Was helpful but ended up going to a private counsellor as needed more frequent and ongoing support.*
>
> *It was a little awkward just talking to someone on the phone - lacked some of the connection that helps you open up in face-to-face therapy.*

Why did you seek mental health support?

Respondents were asked why they decided to seek mental health support through the Piki service. Reasons for accessing mental health support are laid out in Table 8. Respondents were given a list of options and could select more than one, as well as a free text option for 'other'. The most common reasons for seeking support were anxiety and depression.

Table 8: Reasons stated for seeking mental health support

REASONS (CAN TICK MULTIPLE) N=709	COUNT	PERCENTAGE
Anxiety	539	76.0
Depression	484	68.3
Life Stress	393	55.4
Relationships/Interpersonal	265	37.4
Self Esteem	261	36.8
Trauma	212	29.9
Sleep problems	193	27.2
Guidance	164	23.1
Study problems	111	15.7
Eating Disorder	81	11.4
Anger	69	9.7
Substance Use	62	8.7
Sexuality or gender issues	51	7.2
Other (see below)	40	5.6
Not sure	10	1.4
Prefer not to answer	4	0.6

Various other responses were mentioned in the free text box. Another free text box was included for 'any further comments on your answer?' The majority of these comments elaborated on or gave further context to the answers above.

Was the wait time acceptable?

Respondents were asked if the wait time for their first session was acceptable. Table 9 shows that just over half found the wait time acceptable.

Table 9: Acceptability of wait time for first session

WAS THE WAIT TIME FOR YOUR FIRST SESSION ACCEPTABLE (N=618)	COUNT	PERCENTAGE
Acceptable	315	51.0%
Neutral	212	34.3%
Unacceptable	91	14.7%

Free text comments on wait times

Respondents were asked for any further comments on their answer. While some respondents had very little wait time for their first session, a large proportion of comments identified long wait times as an issue, particularly for those who are in a more vulnerable state:

> *It was a bit long, but I personally didn't mind. Could have been a different if my situation was in a worse state.*
>
> *Considering the low state I was in when my referral went through, it was quite disappointing to have to wait 6 weeks before my first session.*
>
> *It wasn't a super long wait as I wasn't in crisis. It would have been an unacceptable wait time if I was in need of immediate support.*

There was also an understanding that because the service is free the wait times were somewhat expected:

> *If someone's in need, help should be available within days – but still for a free service I was able to receive help rather fast. I just worry that if I was in more immediate need that 2/3 weeks would have been too long.*
>
> *Because it was free, I am reluctant to criticise how long it took to get appointments. That being said – going months between booking and actually getting the appointment wasn't great.*
>
> *It was awful waiting so long but that's just what you have to expect.*

A small subset also found there were difficulties with the referral process:

> *My doctor sent 3 referrals, but we never heard anything back then after 6 weeks more or less then I sent a self-referral and heard back within a week.*
>
> *There was noncontact for so long and my psychologist had to keep checking the referral and pushing for it.*
>
> *I felt like there were too many barriers to get to the first session, while going through depression making any steps are extremely difficult only to go through strenuous bureaucracy.*

Most helpful thing

Respondents were asked what the most helpful thing was about the services they received.

Counselling overall was highly favoured, with some of the most common responses focusing on the advice, tools, and resources they had found through therapy:

> *Having a therapist who cared to get to know you. I liked the mix of talking therapy and homework to push myself to challenge my negative patterns of thinking. Walking away feeling like I have a set of tools I can use to manage my anxiety and not let it control me.*

> *The skills I learnt to handle things on my own, outside of sessions.*

Many respondents valued having someone to talk to in a safe space outside of their own life:

> *Face to face counselling meant that I had someone to speak to who had an unbiased viewpoint and was completely understanding, while helping me understand what I was feeling and thinking critically about my thoughts.*

> *Having someone to talk to and provide a clearer and outside perspective and help get to the roots of certain issues.*

Kindness, approachability and understanding from counsellors was valued:

> *My counsellor was patient, kind, and genuinely seemed to care about my well-being. She gave fantastic guidance and support, as well as helping me learn about myself and my issues.*

> *The understanding my councillor gave me, they helped me really break down each issue and provided techniques that I still use on a daily basis. I felt heard, I felt cared for and best of all, I felt like I could begin to heal.*

Ongoing support and check ins were also valued:

> *Ongoing support from professionals who I felt listened and made the extra effort to accommodate for me.*

> *Consistent check ins to keep me on track.*

Ease of access and the lack of financial barriers was seen as most helpful by some:

> *They're easy to access and I've felt accepted and encouraged in seeking the help I need.*

> *I'm just so grateful for the support I received and that it didn't come with a financial pressure as well because I wouldn't have reached out for help had there been a cost due to not being able to afford it.*

Peer support was mentioned as the most helpful aspect of the service by several respondents:

> *I loved both but one on one peer support was the most helpful and relevant in my situation.*

> *Having someone to vent with, and once I knew my peer supporters better, having a safe space where I felt comfortable and self-confident socialising.*

A small number also found phone counselling and the Melon app the most helpful:

> *I got to be introduced to the Puawaitanga phone sessions.*

> *That I could message someone on Melon at any time between sessions to talk to.*

A small number of respondents found the service hadn't helped at all or had been actively unhelpful:

> *I can't think of any. It actually upset me more than it helped. My experience put me off Piki completely.*

Other suggestions or comments

Respondents were asked if they had any other suggestions or comments about the services they received.

Several respondents commented on their appreciation for the service and recommended the service be scaled up and more widely advertised:

> *I'm really glad this service exists. I think it is so crucial to support rangatahi who are struggling with their mental health but who are unable to afford to pay for private support. I really hope that it gets scaled up massively.*
>
> *I'm very grateful for these services and wish they were more widely advertised.*
>
> *Please increase funding to this service. I'm sure this service has saved lives and can help so many people.*

Again, several respondents wanted there to be more/unlimited sessions available:

> *Is there a possibility to continue on with the service past the max number of sessions – even at a cost? I find short term help not as beneficial as sometimes problems cannot be properly uncovered and resolved within a specific timeframe and the session cap almost put me off trying the service. What happens after? What if the individual requires more ongoing support?*
>
> *Please more sessions would help a lot because I feel that I'm rationing mine out.*

Several respondents would have preferred more choice regarding which counsellors they saw:

> *Perhaps instead of being assigned to a counsellor, being given a few options with their specialties and personalities etc to find a good fit.*
>
> *Maybe have a way of making sure the counsellor fits the person seeking help.*
>
> *You are very short staffed and there needs to be more young professionals since they tend to understand young people's issues more.*

Some also noted the lack of resources and pathways to more specialised care for people beyond the mild to moderate range of distress:

> *Would help if counsellors had more resources at hand and knew how to deal with more complex issues or where to direct people to if they aren't able to help personally.*
>
> *Having more options and resources for people who have severe mental illnesses.*

Likelihood of recommending the service

Respondents were asked how likely they would be to recommend the service to a friend or family/whānau member. Table 10 shows that nearly 75% of respondents felt they were very likely or quite likely to recommend the service, with a minority of nearly 5% stating that they would definitely not recommend it.

Table 10: Likelihood of recommending the service to others

HOW LIKELY WOULD YOU BE TO RECOMMEND THE SERVICE TO A FRIEND OR FAMILY/WHĀNAU MEMBER?	COUNT	PERCENTAGE (N=631)
Very likely	290	45.96%
Quite likely	182	28.84%
Neutral	69	10.94%
Somewhat likely	56	8.87%
Not at all	34	4.92%

Free text comments about recommending service

Most comments here were from people who had already recommended the service to friends, or who had had an overall positive experience with the service.

> *I have recommended this to multiple friends and they have all found it super useful. Piki is far less intimidating than other ways to access these services and I'd love to see this continue.*

> *Overall I think Piki is an amazing service and I've recommended it to a few of my friends already.*

A small number of comments identified that they wouldn't recommend engaging with Piki for someone who was beyond the point of 'low-level' distress:

> *There's no point in engaging with these services if you're under any mental duress.*

> *If they are struggling with low level/high functioning Depression or Anxiety, then I would suggest Piki. If they are experiencing anything more then I would suggest they seek help elsewhere.*

There were also a small number of comments noting that Piki was the only free service available:

> *Although I have had issues with getting into the program etc, there aren't really any alternatives for free mental health services.*

> *It's the only free thing available, so I guess it's better than nothing at all. The counsellors are quite good, it's just severely understaffed.*

APPENDIX 4: PEERZONE CLIENT EXIT SURVEY (2020) – QUESTIONS & FULL SUMMARY

A: Questions

Please tell us about your gender, I am:

- Male / Female / Gender diverse / Other, please state

Please tell us about your ethnicity, I identify as:

- NZ Māori
- Pacific
- Asian
- European
- Middle Eastern, Latin American, African
- Other, please state: _____

Please tell us which Piki Peer Support service you used:

- One-to-one peer support
- Group peer support
- Both one-to-one and group

Why did you choose the Piki Peer Support services?

- It was suggested by the Piki Intake Coordinator
- A friend recommended it
- I saw it on the Piki website
- I used it while waiting to see a counsellor
- My counsellor suggested I use it
- Other

Did the Piki Peer Support service help you with the issue that you were struggling with?

- Helped a lot
- Helped quite a bit
- Helped a little
- Didn't help at all

What was the most helpful thing about using Piki Peer Support?

Do you have any suggestions for the Piki Peer Support service?

Do you have other comments about the Piki Peer Support service?

B: Summary results

From early 2020, PeerZone asked the young people who were exiting their service to complete a short online survey (using Qualtrics) about their experience of peer support. 47 out of 155 young people who were supported by PeerZone had completed this survey by 30 January 2021, giving a response rate of 30.3%. In the survey, PeerZone clients were asked to select which type of peer support they received, their reasons for choosing PeerZone and how helpful the service was. There was also space provided for free text responses. Quotes from free text responses below are identified using participant IDs for this survey (PZ01-PZ47).

The following tables shows the demographic characteristics of the respondents, most of whom were female and European background and a summary of the results.

Table 1: Peer Zone Survey Respondent demographic characteristics

GENDER	COUNT	% OF TOTAL SURVEY RESPONDENTS	TOTAL PEER ZONE COHORT UP TO 31 DECEMBER 2020 N (% OF COHORT)
Female	32	68.1	106 (63.4%)
Male	10	31.3	47 (30.3%)
Gender Diverse	5	10.6	2 (1.3%)
Ethnicity			
NZ Māori	3	6.4	16 (10.3%)
Pacific	4	8.5	9 (5.8%)
Asian	4	8.5	19 (12.3%)
European	36	76.6	108 (69.7%)
Total	**47**	**100**	**155 (100%)**

Table 2: Peer Zone Survey Results

TYPE OF PEER SUPPORT	COUNT	% OF TOTAL SURVEY RESPONDENTS
Group only	3	6.4
One to one only	35	74.5
Both	9	19.1
Reasons for choosing		
Friend recommended	7	14.9
Saw it on Piki website	5	10.6
Used while waiting to see counsellor	4	8.5
Suggested by Piki intake coordinator	10	21.3
Counsellor suggested it	12	25.5
Other (Te Haika/GP/School/Tū Ora/Facebook ad)	9	19.1
How helpful		
Helped a lot/quite a bit	34	72.3
Helped a little	11	23.4
Didn't help at all	2	4.3

Reasons for choosing peer support

There were a variety of reasons for choosing peer support. Most respondents (22, 46.8%) had chosen to use peer support at the suggestion of a Piki intake coordinator or a counsellor. A smaller number had heard about it from another source such as Te Haika, their general practitioner or school, or had seen a Facebook advertisement (n=9, 19.1%). Recommendations from friends were less common (n=7, 14.9%), as was seeing the service advertised on the Piki website (n=5, 10.6%). A few used the service while waiting to see a counsellor (n=4, 8.5%)

How helpful was peer support?

Nearly all respondents provided free text responses when asked how helpful they found peer support was. The majority of respondents indicated that the service 'helped a lot/quite a bit' (n=34, 72.3%).

What was most helpful about peer support?

The free-text responses to the survey were generally very positive about the service. Respondents felt that peer support provided a friendly, non-judgemental and safe space, which they appreciated:

> *Having someone who is there to provide you with support and advice but isn't clinical resulted in a friendly safe environment where I was able to address my mental distress and start to deal with it at my own pace.* (PZ33)
>
> *Knowing I had a safe space to talk about anything.* (PZ02)
>
> *Having someone to talk to who is friendly, non-judgemental and understands.* (PZ20)

Respondents appreciated talking to peers who had a lived experiences of mental health issues:

> *Having someone who had similar struggles to talk too.* (PZ01)
>
> *Having someone to talk to who cared and had had similar experiences but wasn't in a position to judge me.* (PZ32)
>
> *It helped having not only someone to talk and vent things too but also to have her give me advice and help me channel my emotions into positive action.* (PZ04)

Some noted it was helpful to talk to somebody who felt like a friend but was outside of their social or family circle:

> *Having someone separate from your life to give a fresh perspective.* (PZ18)
>
> *Talking to someone who is separate from your social and family circle.* (PZ25)
>
> *Developing a personal relationship that was fulfilling but also useful as an objective view on personal issues.* (PZ38)

Others felt that peer support provided a less formal, alternative to traditional counselling or therapy services, which was perceived by some respondents to be more helpful:

> *In my case it was more effective than counselling and phycologists. The fact that you feel as if you aren't in an interrogation and are just having a back and forth conversation with a peer is great at making you feel as if you are not alone and that what you are going through/ feeling, is valid.* (PZ46)
>
> *I thought as an alternative to traditional counselling one on one Peer Support was exactly the kind of safe emotional environment I needed to work through my emotions and life issues, rather than being offered 'skills and tool' and being talked at by a traditionally trained counsellor/therapist.* (PZ34)
>
> *In my case with peer support it was ridiculously helpful. It provided me with someone who was empathetic and understanding. Someone who had experienced similar things and unlike a counsellor, would never push topics or make suggestions that would go too far.* (PZ33)
>
> *The human connection made me feel more comfortable than I had ever been with a counsellor.* (PZ09)

Suggestions for peer support

Some respondents felt that the ten peer support sessions provided were not enough, and that the duration of sessions was not as long as they would like:

> *I suggest the hours to be put up. I only got to see my peer for an hour and that wasn't even enough time to make a plan also we should be able to have our peer longer than 10 weeks.* (PZ35)
>
> *Having an extra couple of sessions really helped me, 10 sessions didn't quite feel like enough.* (PZ40)

Others thought that the service needed to be promoted more widely:

> *The service is not very visible and flies under the radar. Meaning that a lot of people who would benefit from it would be oblivious to the service.* (PZ46)

> *More promotion of smaller group services in local area.* (PZ03)

There appeared to be a lack of clarity about what peer services entailed from the outset:

> *Make it more clear what Peer Support involves. I'm still not entirely sure.* (PZ02)

> *More information available to me before going through it. I asked but did not receive much.* (PZ30)

There were issues with the group sessions, for some respondents, although others indicated they liked the group approach:

> *Because there were two people that I knew of in my group even though they never showed up two of the times I didn't feel comfortable being in the group, maybe they felt the same? Would be good to know if I had of known anyone before joining the group.* (PZ 31)

> *Different variety of group sessions and more group sessions. I was unable to attend due to the limited timings available.* (PZ20)

Some respondents expressed concerns that there was not enough follow-up from some peer supporters, although there was some confusion around terminology and thus uncertainty whether these remarks refer to peer supporters or counsellors:

> *Yes FOLLOW UP WITH YOUR CLIENTS! This so important and especially when you are dealing with people going through mental health problems this just made me feel worse and unworthy.* (PZ31)

> *Follow up more regularly in terms of one on one councillor. Felt like I was being put into a group, as soon as I was, I never heard from the one on one counsellor.* (PZ06)

There was also concern about staffing and the importance of keeping the service well-resourced to minimise access barriers:

> *Only to keep offering the level of support they are and to make sure not to fall into the pit falls of many mental health services where in the services are made inaccessible to people due to not keeping up with demand.* (PZ34)

> *Have greater access for everyone.* (PZ38)

> *More staff.* (PZ28)

Other comments

A couple of respondents felt the service needed better organisation and could be unreliable:

> *Would not be recommending. Sorry but maybe over time this service can evolve but now it is nowhere near a reliable source. I know Piki services is still fairly new but needs a lot of work to become a good source.* (PZ31)

> *Needs better organisation.* (PZ06)

However, there was an appreciation for the reduction in access barriers the service provides, with one respondent noting this could be a preventative measure against higher mental-health related costs in the future:

> *I think it was really good. It has the potential to alleviate some of the issues faced in accessing counselling, and can reduce potential cost barriers, with the potential to increase efficiency of providing support services by referring people to less costly forms of support, which may help prevent people from requiring further and more involved support in the future.* (PZ15)

Overall, the feedback was positive for the peer support service. Most respondents felt it had helped them and that they hoped the service would continue:

> *It is a very good service, and I would recommend it to more friends because it really helped me, and it provided a service I'm not sure I would have had access to otherwise.* (PZ44)

> *Please continue doing this. It helps a lot of people.* (PZ29)

> *I'm so grateful for the Piki peer support service. It's helped me so much with personal and social issues. I've learned so much from my mentor and my peers.* (PZ13)

APPENDIX 5: KEY INFORMANT INTERVIEWS (2019) – QUESTIONS

Questions used in round 1 (Oct-Dec 2019) – adapated as appropriate to the interviewee

Question Zone 1 – Introduction / Background

How did you come to be a part of the Piki pilot? *(What made you want to be a part of the Piki project?)*

Question Zone 2 –Piki Operations

Roles

What has been your main role in Piki so far?

When did you first get involved?

What other roles do you have (if any)? *(What are the pros and cons of having multiple roles in the project?/ What Piki related groups are you part of? E.g., Piki committees/groups (Steering, Clin Advisory, Ops), Piki related groups internal to own organisation)*

General evaluation. Thinking back to the start of your involvement with Piki:

What has worked well about Piki so far?

What can be improved?

What's not working so well?

3 month focus (backward/forward). Now, thinking about just the last 3 months:

What has been the most significant development or change?

Is there anything in the last 3 months that has worked particularly well or not so well?

What are the most important issues or challenges at the moment?

Thinking about the next 3 months, how confident to you feel in the direction Piki is headed?

Priority (under-served) populations

What groups do you think are in this category? *E.g., Pasifika, Māori, lower SES, rural, gender diverse?*

How well do you think Piki is doing on providing / promoting services to these populations?

What resources/strategies do you think are working? Or are needed? *E.g., targeted digital marketing; direct contact with community groups inc churches, sports groups*

How culturally responsive do you think Piki communications have been? *E.g., website, leaflets, posters, media releases, social media) / How could they be improved?*

Who do you think should be consulted about/involved in developing these strategies? *Do you have some specific suggestions about who to consult / what to do?*

Training/professional development [for those managing Piki front-line staff]

What Piki related training or professional development has been made available to you or your staff? *Types/modalities: Face-to face training AND Online/print resources / CBT training/fidelity; Melon (different aspects – enrolling clients, online community, communication with clients); Rainbow diversity through InsideOut; Pasifika through Le Va. How much do you know about what has been offered (detail)/how familiar are you with the offerings?*

How happy have you/your staff) been with the face-to-face training offered/provided? *(Useful? / Adequate? / Any gaps not addressed?)*

How happy have you (and your staff) been with resources

How has the timing of training worked for you and your staff? *(Timing of what has been offered / Time required to do training - workload implications)*

How well have the challenges of catering for different needs at different times been handled? *(i.e., new staff cf. existing staff moving into a new role cf. staff joining Piki later in the pilot)*

Clinical supervision / co-reflection [esp for managers]

How well do you think the clinical supervision available in Piki is working?

Is there sufficient opportunity for practitioners (including peer supporters) to interact, compare notes, learn from one another?

Resource Allocation [esp for managers/members of provider organisations]

Do you have any comments on resource allocation within Piki? *(Budget, training, IT support, other? / To your organisation and/or to other organisations? / Different geographic areas / parts of the youth population?)*

Question Zone 3 – The development/design process

Before we discuss the development and design process, how would you sum up the main goal or aim of the Piki pilot?

What has been your / your group or organisation's role in the development process and/or pilot service delivery?

What has worked well about the design process?

What has been the biggest challenge in the design process? *(timeframe for the development process? / communication between different working groups / provider & stakeholder groups during the process? / overall make-up of the wider Piki development team and/or sub-groups?)*

Has there been appropriate input from each of the organisations/groups involved in the design process? *Has there been appropriate / sufficient input from youth and service users from a range of target populations?*

Do you feel that any particular organisation or grouping has had more power/influence in the design process?

How clearly have the roles of the different groups and organisations been defined in the design process? (And how have these evolved?)

[If time] In general, what do you think are the enablers or barriers to achieving change in mental health services?

Thinking back to your definition of Piki's main goal, how well do you think it is tracking towards meeting this goal overall? (In terms of improving mental health services for youth and in terms of being a pilot/test bed *(for what works for this demographic and for possible future scale up / rollout?)*

Question Zone 4 – Co-design aspect

How would you describe/define 'co-design' and 'co-production', as operationalised in the context of Piki?

What have been the strengths and challenges of the co-design aspect of the process? *(To what extent has co-design occurred?)*

Looking ahead, how can/should co-design be better incorporated into the Piki pilot *(90 day reviews, Refinements to service, Evaluation, Possible future scale-up and wider rollout to other areas)*

What practical suggestions do you have for how co-design can be used in the development of mental health services?

Question Zone 5 – Evaluation

Is there anything particular that you would like to find out from the evaluation?

Are there additional questions you think the evaluation team should explore with others involved in Piki? In particular, with practitioners (i.e., therapists, peer supporters etc) or with clients/users

Finally

Would you like to add/talk about anything else?

May we contact you again to ask follow-up questions, if necessary?

APPENDIX 6: SERVICE PROVIDER INTERVIEWS AND FOCUS GROUPS – QUESTIONS

Variations on these questions were used in focus groups with therapists and peer supporters as well as in some additional interviews with these and with 3 referring organisations to Piki

Question Zone 1 – Introduction / Personal experience

- Introduction and overview of the interview / focus group question zones
- How did you come to be a Piki therapist? What made you want to be a part of the Piki project? How did you find out about it?
- What was the impact of Covid-19 on your workload? (briefly)

Question Zone 2 – Perceptions of the Piki service

General

- How much do you know about the range of services offered via Piki?
- Do you feel the overall Piki service is working well?
- Do you feel your service/organisation's contribution to the service is working well?
- Do you feel your service/organisation was well integrated into the overall service?
- What are the best aspects/features of the Piki service?
- What are the shortcomings/downsides of the Piki service?
- Are the range of services on offer the right mix?
- Are the different services well integrated?

More specific

- What were your impressions of the Melon App?
- How important/useful do you think the online tools offered by Melon were as part of the overall mix?
- How well did the referral process work?

Fit

- How good a fit do you think the Piki model of care is for the youth community needs you are aware of and/or the clients you see?
- If needed (not covered in responses to previous): From your experience, do you think the Piki service has improved access for the target populations? Are you successfully referring/seeing more of these groups than before?
  - Māori
  - Pacific
  - Asian
  - those with substance use issues
  - those with diverse gender identity (or sexuality)
- other clients less likely to use services? (and who are these?)
- What have been the barriers or facilitators to specific target groups accessing the service?
- Did some target groups respond better to some elements than others?
- Is the Piki service in general and/or Piki peer support in particular perceived as culturally appropriate to the various target groups?

Training and Supervision

- What are your views of the therapist training &/or accreditation conducted as part of the pilot?
- How effective has the support/supervision been?
- Did you feel prepared for supporting clients?

Question Zone 3 – Relationship between peer support and therapy

- Have any of your clients also seen a peer supporter? Have you had any interaction with peer supporters for service users who are seeing one?
- If so, did you notice any differences between clients who received peer support only / CBT only, and those who received both CBT and peer support?
- Did you have any interaction with peer supporters for service users who are seeing a peer supporter as well as a therapist?
  - How was that? / How was the relationship between PSs and CBT therapists? Why good or not?
- What are your thoughts about the benefits for service users of having peer support as well as therapy?

Question Zone 4 – Perceptions of client benefits / improvements

- How do you feel clients responded to the Piki service?
- What factors have influenced young people to use Piki (i.e., what has attracted them to it or why did they decide to try it?
- How well did the client pathways work for your clients?
- Is the service perceived as culturally appropriate to the various target groups?
- Can you give me your definition of recovery?
- Do you think the Piki service has improved mental wellness for the target population?
- Do you feel the Piki service is an improvement on the previous services?
- What would you change about the Piki service if you the chance?
- How could mental health services for youth be (further) improved?
- Any other challenges we haven't covered? Or other comments?

Possible Question Zone (if time or spontaneously raised) - Design process

- What are your thoughts on the development/design process for Piki?
- Do you have any suggestions for how Piki could be designed to better serve its target population?
- Do you have any suggestions for how the design process could have been/should be carried out in future?

APPENDIX 7: SERVICE USER INTERVIEWS (FEB-NOV 2020) – QUESTION ZONES & FULL SUMMARY

A: Question Zones - Service User Interviews (conducted Feb-May & Oct-Dec 2020)

Note: [The intervention] is either CBT, Peer Support, or a combination of both.

Question Zone 1 –Background

- Have you accessed mental health support other than Piki before? How did you find that experience?
- Based on that experience what was your perception of mental health services before you enrolled in Piki?
- How would you describe your mental health before you accessed Piki?
- How did you come across Piki?
- What made you engage with Piki?
- Can you describe the steps you took to get the support you needed?
- How smooth did the Piki referral process work? Was it accessible?

Question Zone 2 –Experiences of support accessed

- When did you access Piki and when did you leave? How many sessions did you have?
- Did you feel like you got enough sessions? Was it frequent enough for you?
- Was there any particular reason why you chose [the intervention]?
- What was a typical session like? What was the focus in sessions?
- What was most helpful? / What wasn't helpful? / Did you learn any specific strategies?
- Were things explained to you in a way you understood? (the process of Piki or the process of CBT or what CBT was)
- Is there anything you would have liked that you didn't get? Is there anything you would change?
- How well do you feel your support person addressed your concerns? Do you feel they were able to meet your needs, and if not, what happened?
- Did you feel heard and respected by your support person? In what ways weren't you? How could they do this better?
- Did you engage with other services Piki offered (1737 and Melon) before seeking [the intervention] support? Did you like the website resources?
- If yes, how helpful did you find the online/phone services?

Question Zone 3 – Recovery

- Can you give me your definition of mental health recovery?
- What does your 'recovery' look like to you?
- How did [the intervention] minimise your distress? What was most helpful to you?
- What tools were you taught by this [the intervention]? How did you find them?
- How did [the intervention] help your recovery? What was most helpful to you? How have things improved?
- How would you describe your mental health now?
- Did the Piki service improve your mental wellness?

Question Zone 4 – Improvements

- Would you use [the intervention] again if you needed it?
- How can Piki be improved for youth?
- How can mental health services in general be improved for youth?
- What does positive mental health look like for you in future (as you get older)?
- Any other thoughts?

B. Summary of Service user interviews – experiences and feedback

This section briefly summarises the results of a framework analysis of 26 interviews with a diverse sample of clients who were enrolled in Piki between June 2019 to November 2020. The table below shows the demographics of the clients interviewed.

Table: Description of Interviewed Client Demographics (Total n = 26)

	N		N		N
Gender		**Occupation**		**Rainbow**	
Female	17	In employment	8	Yes	6
Male	5	Unemployed	4	No	19
Non-binary	3	Student	13	Unanswered	1
Unanswered	1	Stay at home parent	1		
Ethnicity		**Geographical Area**		**Support Type**	
NZ Māori	9	Wellington	16	Therapy only	17
Pacific	4	Lower Hutt	5	Peer Support only	2
Asian	3	Upper Hutt	1	Both	7
European (including NZE)	10	Porirua	3		
		Kāpiti Coast	1		
Highest education		**Substance misuse**		**Referral**	
NCEA 2 or 3	11	Yes	6	GP	13
Diploma	2	No	18	Self	9
Bachelors	9	Unanswered	2	Both	2
				Unsure	5

The interviews followed a question schedule which was co-designed with youth members of the Service User Reference Group (SURG). Question zones included previous experience of mental health supports and how that shaped their perceptions of Piki, experiences of accessing support through Piki, recovery as it pertains to various Piki interventions, and suggestions for future improvements. The purpose of these interviews was to provide a snapshot of how these clients had experienced the Piki service as a whole, as well as the individual components being accessed.

1. Overall Impressions of Piki

All 26 clients interviewed were very positive about the support they received through Piki overall. A number identified the existing youth mental health system outside of Piki as underfunded and overstretched, making access to support extremely difficult. These service users highlighted the importance of keeping Piki going beyond its pilot stage.

Lack of accessibility remains one of the biggest barriers to support-seeking. The fact that the pilot was free was an important advantage to this age group. However, those in full-time employment found it difficult to schedule appointments and it was suggested that more flexible hours of appointments should be provided to address this.

Many stressed the importance of having services such as Piki widely available and were grateful for any and all support they were able to receive. Some clients identified the presence of mental health professionals in their lives as being instrumental to positive mental health outcomes and recovery from mental distress.

All clients had constructive feedback and suggested areas for improvement and enhancements. Clients also expressed that they welcomed the opportunity to give feedback for the purpose of evaluation. This suggests that young people have an interest in directly influencing their own mental health care – a principle the Piki project should continue to uphold through the ongoing process of co-production, if this or a similar service is rolled out in future.

2. Initial stages of contact

Clients were grateful for the largely smooth referral process, and many found the turnaround between referral and intake pleasantly quick. Unfortunately, a few experienced high wait times between referral, intake and first session, with a couple of website self-referrals not being answered and the clients needing to follow up through a GP instead.

Everyone felt respected by their support person(s). However, there was a lack of clarity around what support was accessible. When asked about peer support, 1737, and the resources on the website, many could not comment as they were not made aware of these alternatives to therapy at the outset. There were polarised opinions around the Melon app, details of which are outlined below. Furthermore, as Melon was only available through sign up with therapists at the time these clients accessed Piki services, those who were engaged in peer support or phone counselling did not have access to the app and thus were unable to engage in meaningful feedback.

Suggestions for improvement included better advertising and more clarity around what supports are available.

3. Therapy Feedback

Overall, therapy was seen as hugely beneficial.

Therapist 'fit'

Clients who built rapport with their clinicians saw more effectiveness in relation to their recovery outcomes than those who did not have a strong connection or found their therapist not quite the 'right fit'. All reported feeling heard and respected and felt like the sessions had a clear focus. Many praised their therapists, going as far as stating that their Piki therapist was the best they had ever had. However, some clients felt their therapists were out of touch with youth-related activities and wished for a smaller age gap between therapist and client to build better rapport.

Suggestions for improvement included having therapist photos and profiles available for a more tailored approach (this was consistent with YRG group feedback at co-design stages of Piki)[6], training for therapists in youth lifestyle, more comfortable offices (a few stated feeling anxious due to the office being in what seemed an abandoned, dark building), and being able to see their therapist's notes between sessions.

Duration of therapy

About half of those interviewed were happy with the duration of therapy they had received which ranged from as few as 2 sessions up to around 20 sessions. Sometimes external factors prevented clients having the number of sessions they may have needed: 'I probably would have gone to him more but then that's when it hit like the really busy time for uni with exams and stuff.' (PK59 who had 3 sessions)

Some clients believed they had a finite amount of therapy sessions after which support would cease (usually around 6-10). It is unclear whether this was communicated within Piki, or perhaps (as this is a model commonly used within some practices) the service users surmised that Piki would be the same as their previous experiences of having a set number of sessions. Others were aware of flexibility in this regard, with one client noting 'it's good having a kind of undetermined amount of sessions. Having a cut-off point is very stressful and it is really negative to the situation' (PK58)

Session Frequency

One major area for improvement was around waiting times between sessions, with some clients having to wait as long as 6 weeks for their next appointment. A few expressed real dissatisfaction with such waits: 'because he also only had every three or four weeks, it was difficult to open up and get to a comfortable enough level to work on the trauma I have been wanting to work on' (PK68); 'One thing is the gap between sessions. Because of availability, it's quite, it's been like two months, a month and a half between sessions, which is quite a stretch.' (PK61)

There was a considerable range of session frequency among those interviewed. Of the five who reported weekly (or at times bi-weekly) appointments, all were happy with that. There were also some who were happy with less frequent sessions, such as every 3-4 weeks, but acknowledged that this might be problematic at times or for some people: 'when I was good, that was fine but if I had like a really bad couple of weeks then, yeah' (PK66); 'I can get through that because I have the support network to do it. For a person who doesn't have such a stable support network, no, it doesn't work for them' (PK64). Especially in the early stages, it was felt that frequent sessions are important but that subsequent sessions could be less frequent.

Employment of more therapists was suggested to address long wait times.

6 Note that as of August 2020, there are plans to implement this, after delays caused by the COVID-19 lockdown.

4. Psychometrics/scales/surveys

There was a lot of variation between clients as to what surveys they were asked to fill out. It was difficult to ascertain the specifics around this, compounded by clients not remembering the details of the psychometrics. Some reported positive experiences of surveys as ways of tracking progress, while others found them tedious.

Consistent with the feedback given at YRG meetings, clients did not enjoy filling out SRS scales within the sessions alongside the therapist. Many communicated that they felt obliged to be dishonest and gave higher scores than they wanted, so as not to hurt the therapist's feelings. A few clients who lacked rapport with their therapist did not feel comfortable asking to switch for fear of offending or being told there were no other options.

An improvement suggested would be to find ways for clients to anonymously provide feedback or request to change therapists, with one suggestion being to enable SRS feedback via Melon rather than in a session with therapist.

5. Peer Support Feedback

Many of the service users interviewed were not aware of peer support as an option, and those who knew of its existence lacked familiarity with or understanding of the intentional peer support process. Several people described peer support as enforced or paid friendships. This lack of understanding may come from the fact that peer support is not commonplace in our mental health system. One client described peer support as something like what they had in high school, where seniors would support junior students who were having a difficult time fitting in, thereby attaching a negative connotation to the intervention. Those who had peer support accurately defined for them by the interviewer expressed enthusiasm for it, suggesting that had they known about it earlier, they may have utilised it alongside or instead of therapy.

The 9 interviewees who had engaged with peer support praised its tailored approach through the ability for clients to choose a peer supporter who best fitted their needs and expressed a desire for a similar process with therapists. While SUs enjoyed their time with peer supporters, some clients reporting finding it too casual or unstructured at times and would have valued sessions with more direction. Only two interviewees had engaged in group peer support and reported finding it less helpful than one on one sessions. A few people praised their peer supporters for going above and beyond by being available regularly as well as contactable outside of the sessions. Some enjoyed the social catch-ups set up through PeerZone and Piki, with one person dubbing them the 'anti-loneliness meetings'.

Suggestions for improvement included clearly communicating the definition of peer support to manage expectations, having a dedicated focus for sessions, the addition of an option to meet in a private location, and more peer supporter availability in general.

6. Interaction between peer support and therapy

Clients who engaged in both peer support and therapy spoke about the fact that these two interventions were quite different in nature, but very complementary. They appreciated the expertise and resources given to them by therapists and were much more familiar with the therapeutic relationship and the process. However, clients also enjoyed the more casual nature of peer support, preferring to have some conversations within this more relaxed setting. Overall, the experience of those receiving both services was that it provided a wraparound approach where the client felt supported throughout their time with Piki.

7. Melon

There was a wide range of views on the Melon app.

A few people had never registered with Melon at all for one or more of the following reasons:

- they were interested but not enough to follow through
- they did not understand the purpose of the app
- they did not want another app cluttering their phone
- they were not interested in engaging with this particular app
- they lacked interest in technology in general.

There was positive feedback from a small number of clients with specific reference to the anonymity, the mood tracking, the diary, the well-being resources, and the community forum which was described as a good way to put things in perspective and ease loneliness.

Many participants felt negative or apprehensive about Melon, with specific reference to technical aspects (described as bad design/interface, or the app being 'buggy'), security concerns (unclear privacy/data management on the app and lack of trust in the security of the app), the community forum (finding community posts triggering or simply having no use for it) and notifications (the large number of these via email and the app was considered obnoxious).

While some clients liked the anonymity, there were also those who disliked this feature. Other feedback was around how well this type of intervention suited them (or not), with some feeling ill-suited to it because they considered themselves 'a private person', lacked motivation to use it, or preferred face to face contact.

Another comment concerned resource allocation with the opinion that they would prefer money to go towards supporting employment of more therapists and peer supporters instead into a digital app.

Suggestions for improvement included the addition of the ability to direct message other users and the inclusion of peer supporters within the app (as is the case for therapists).

8. Piki Website

Most of the 26 interviewees were unaware of the website's existence. Those who had used the website, had only used it at the self-referral stage of the process. Nobody had further comments on the Piki website.

9. Phone counselling services

1737

Many were not aware of the services offered by 1737. Those few who had texted the service had experienced long wait times of many hours before a response was received, by which point the support was redundant. Of the two people who phoned in, both experienced waiting times between 5 and 30 minutes, but had found 1737 to be helpful once they were able to talk to a counsellor.

Puāwaitanga

Only one interviewee had used the Puāwaitanga service. The overall feedback was positive in that the phone counselling was felt to be accessible and flexible enough to fit in with their needs. While a lack of in-person contact was raised as a negative, the client further reflected that it that was easier to talk over the phone about certain confronting topics, making phone counselling a viable option in the future.

10. Feedback from a Cultural Perspective

When asked how Piki and mental health services in general can be improved for Māori, Pasifika and other cultural groups, clients had a range of suggestions for improvement.

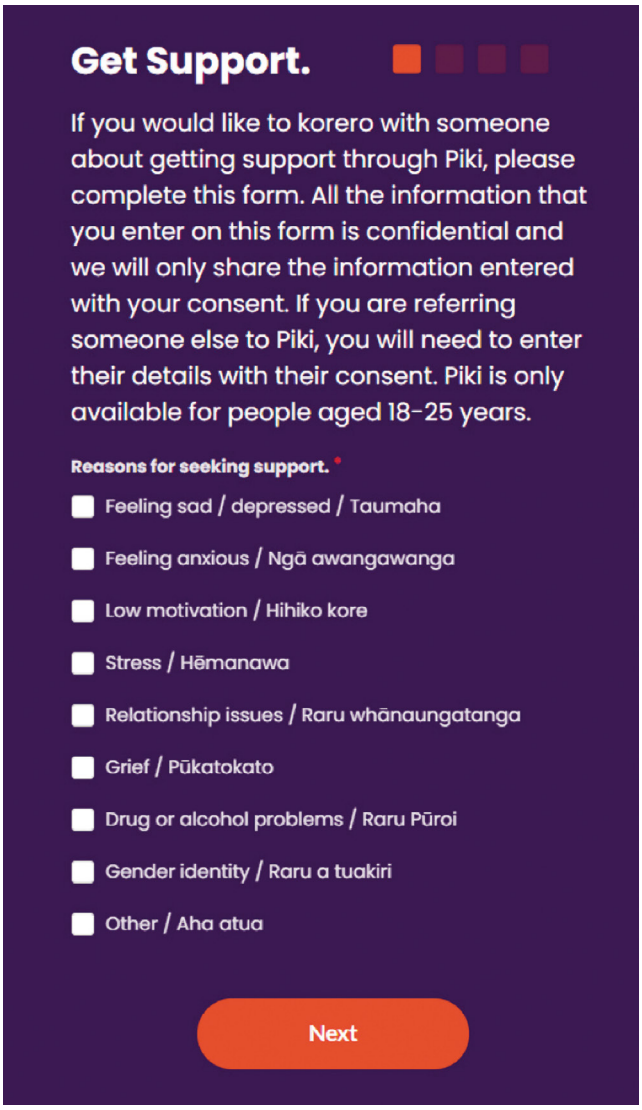
Changes to the workforce were suggested such as employing more people of colour for therapist and peer supporter roles; this is because having support people of the same cultural identity can help clients to build trust and rapport.

It was also felt to be important that support people recognise and embrace the intersectionality of clients and that they encourage clients to embrace their cultures. Avoiding assumptions by asking clients if they want whānau involvement was mentioned as important since responses to this question can vary from person to person and across situations.

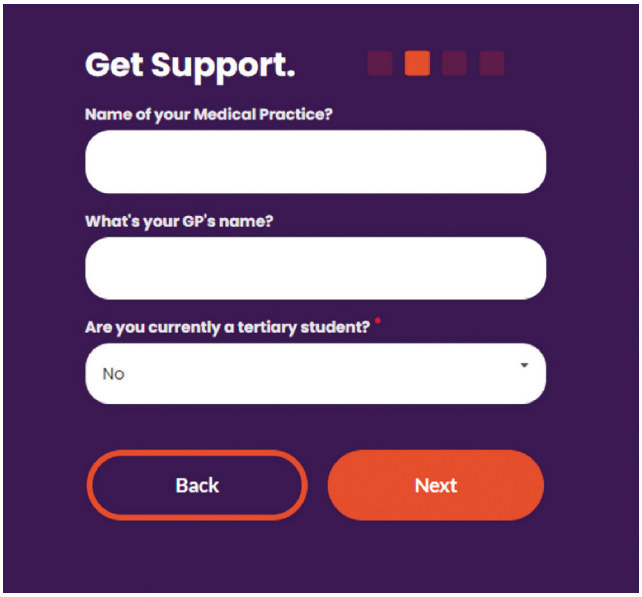
Making services known and accessible was another area for improvement. Suggestions included making sure that advertising to specific underserved groups is done in a way that reaches the potential clients, having therapists and peer supporters on marae to make seeking support more easily accessible, and building relationships with adults in the community as recommendations for support often come from whanau.

APPENDIX 8: WEBSITE SELF-REFERRAL FORM (AS OF MARCH 2021)

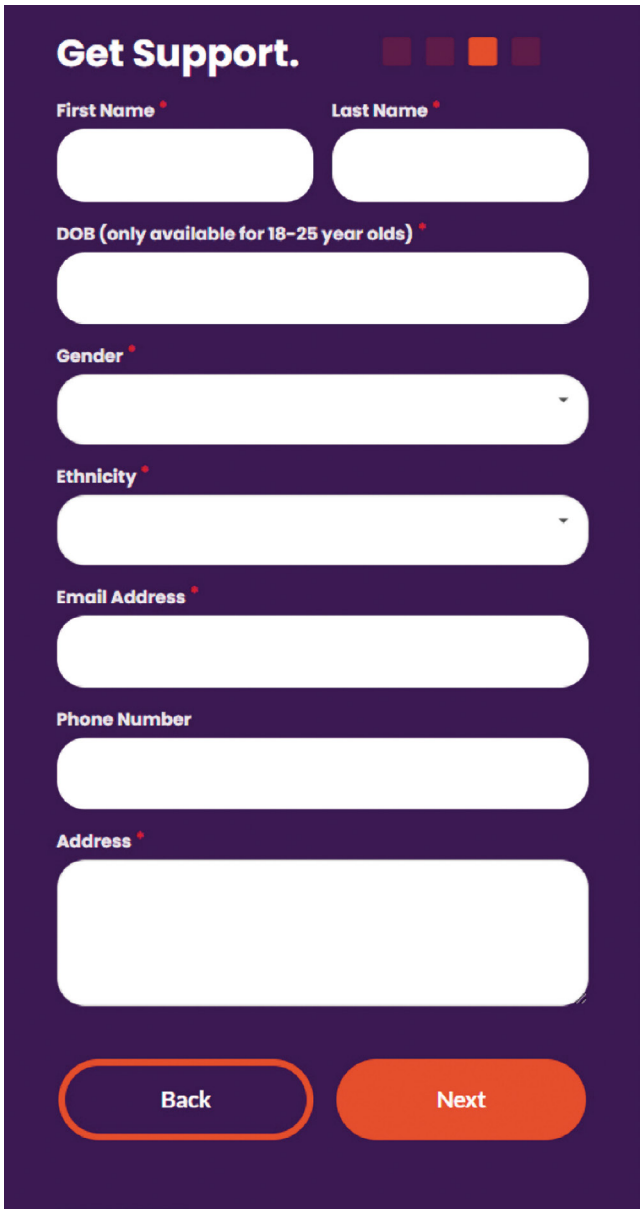
Screen 1:



Screen 2:



Screen 3:



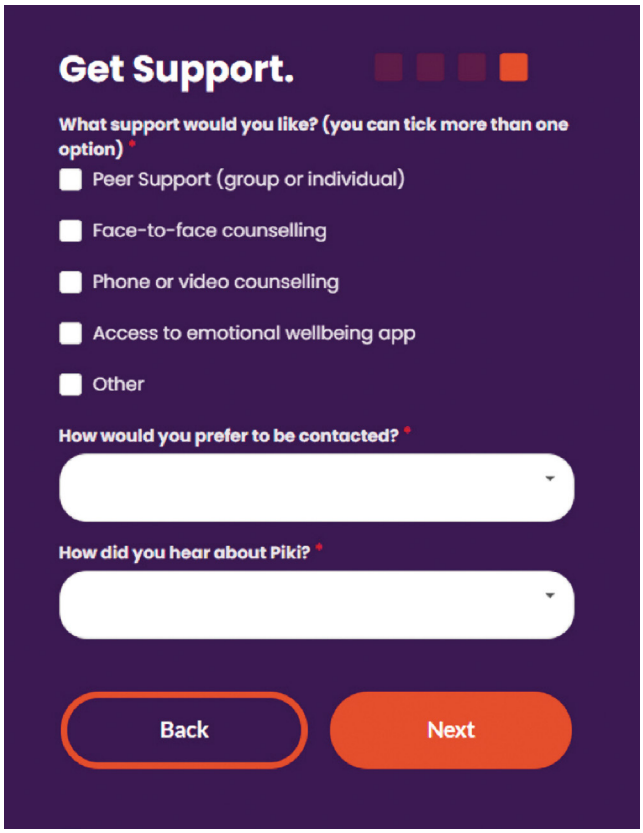
Gender Options:

- Female
- Male
- Gender Diverse

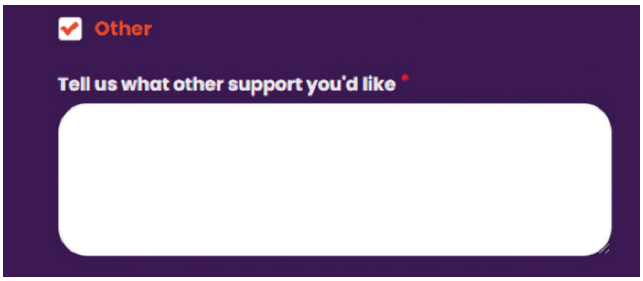
Ethnicity Options:

- Māori
- Samoan
- Cook Island
- Niuean
- Tongan
- Tokelauan
- Other Pacific Island
- Chinese
- Indian
- Other Asian
- New Zealand European
- Other
- Prefer not to say

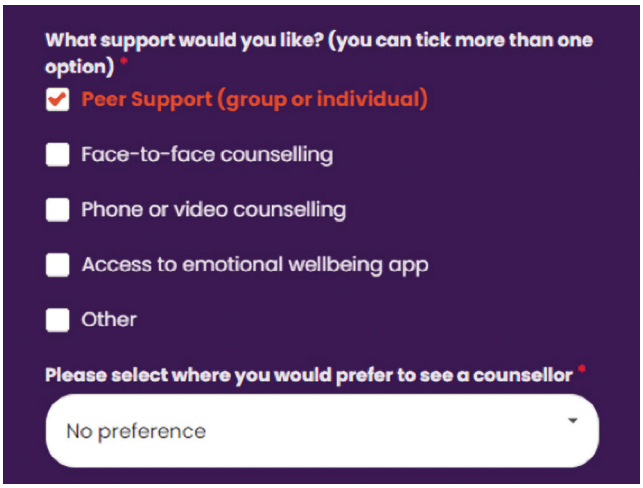
Screen 4:



If 'Other' selected:



If 'Peer support' or 'Face-to-face counselling' selected:



Options for preferred location:

- Whitireia/WelTech Porirua
- Victoria University of Wellington
- Massey University Wellington
- Masterton
- Porirua
- Wairarapa
- Wellington City
- Hutt Valley
- Kāpiti Coast

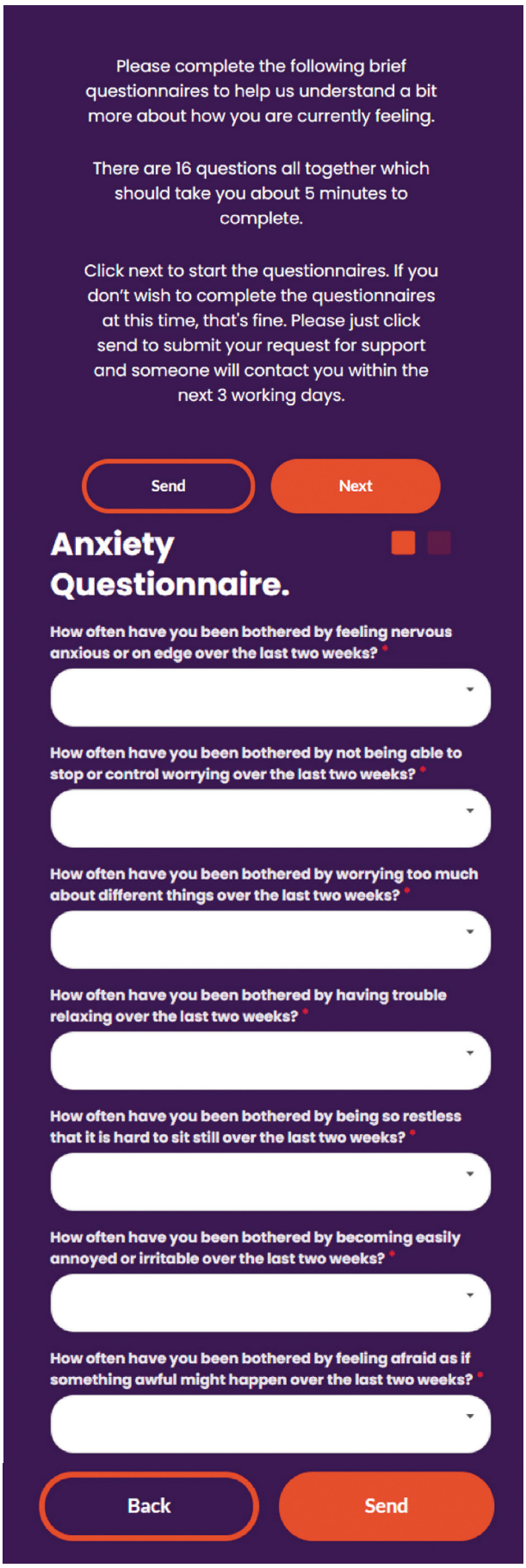
Options for preferred contact method:

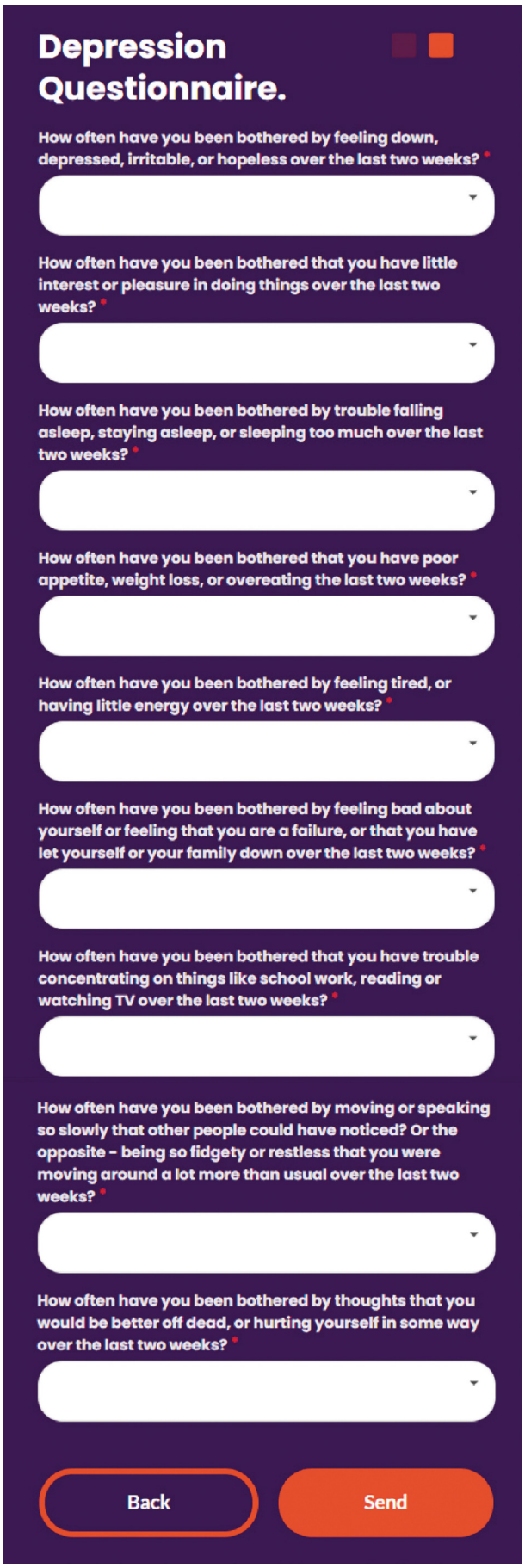
- No preference
- Email
- Phone

Options for 'How did you hear about Piki?'

- 1737 Free National Telehealth Service
- GP
- University
- School
- Friend
- Family
- Community Organization
- Social Worker
- Poster
- Other

Final Screen:





Options for answers:

Not at all
Several days
More than half the day
Nearly every day

piki

Evaluation of the Piki Pilot Project
(January 2019 – December 2020)

INTEGRATED THERAPIES FOR 18-25 YEAR OLDS

Final Report
May 2021

UNIVERSITY of OTAGO
Te Whare Wānanga o Otāgo
NEW ZEALAND
WELLINGTON