

Waitemata DHB CADS Pregnancy and Parenting Service (PPS): Process Evaluation Report

May 2015

A report commissioned by the Health Promotion Agency

ACKNOWLEDGEMENTS

The Health Promotion Agency (HPA) commissioned Paula Parsonage of Health and Safety Developments to undertake this process evaluation to inform HPA, planners and funders and government ministries whether this type of innovative, flexible approach could be replicated in other areas to improve outcomes for families facing adversity.

HPA would like to thank the researcher and author, Paula Parsonage for her work and dedication in undertaking this informative and insightful research. The HPA commission was managed by Sue Paton, Principal Advisor Addictions, HPA.

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Any enquiries about this report should be directed to HPA at the following address:
Health Promotion Agency
Level 4, ASB House
101 The Terrace
PO Box 2142
Wellington 6140
Email: enquiries@hpa.org.nz

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For further information on this report contact:

Name	Title	Organisation	Contact
Cath Edmondson	Manager Policy and Advice	Health Promotion Agency	(04) 917 0244 c.edmondson@hpa.org.nz
Paula Parsonage	Director	HSD	09 3781843 hsd@xtra.co.nz
Marijke Cederman	Clinical Team Leader	Pregnancy & Parental Service CADS Waitemata DHB	09 8155830 ext 5123 marijke.cederman@waitematadhb.govt.nz

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EXECUTIVE SUMMARY

Reducing harm for children affected by parental addiction and reducing unequal access to addiction services are key priorities for the Health Promotion Agency (HPA). Waitemata District Health Board (DHB) Community Alcohol and Drug Service (CADS) Pregnancy and Parenting Service (PPS) provides an intensive assertive outreach case coordination service for parents of children aged under three-years-old and pregnant women who are experiencing problems with alcohol and other drugs that are poorly connected to health and social services. HPA commissioned an independent process evaluation in order to understand more about the PPS model and explore considerations for service replication in other regions. Findings are summarised in this report.

PPS aims to reduce harm and improve the wellbeing of children by addressing the needs of parents and working to strengthen the family environment. The service is targeted at families experiencing multiple and complex issues related to, for example, alcohol and other drugs, stigma, mental and physical health, pregnancy, poverty, parenting, family violence and abuse including child neglect and abuse, custody issues, fear of involvement with child welfare agencies and criminal involvement (Community Alcohol and Drug Service [CADS], 2013). PPS is delivered by a 5-Full Time Equivalent (FTE) team of nurses and a part-time peer support worker, supported by a team leader, a part-time psychiatrist (.2FTE) and a part-time psychologist (.2FTE). The team is expanding and will include other disciplines in future.

PPS sees approximately 100 clients per year. Most clients are female aged between 21 and 40 living in areas with a high deprivation index. A majority are Māori, being 54% of the client group for the 2012-2014 period. A key rationale in providing this resource intensive service is the emerging evidence indicating that the best return on investment comes from early intervention i.e. under five years.

Evaluation findings suggest that the PPS model of service provides an example of a promising approach to reducing harm for children at risk and supporting equity of access to addiction treatment. Findings indicate that PPS is operating as intended and is successfully reaching and engaging the intended target audience. The service objectives and approach align with Government goals and are underpinned by available evidence.

In consideration of replicating the PPS approach, the identified key success factors and challenges summarised below will need to be accounted for.

Key factors linked to the success of PPS include:

- An evidence-based service objective: PPS aims to prevent and reduce harm to children aged under three-years-old. There is evidence to support early intervention with infants and children and a focus on modifying the child's environment.

- Effective engagement of the target client group: PPS engages clients facing multiple issues, including a high number of Māori women and a high number who are not otherwise accessing CADS or any other alcohol and other drug (AOD) service.
- The PPS model. Critical aspects of the PPS model include:
 - *a service philosophy/principles*: Incorporating a strengths focus, a non-stigmatising approach and a broad scope encompassing multiple complex issues
 - *accessibility* is enabled; 39% of PPS clients self-refer
 - *assertive outreach*: An assertive outreach approach supports accessibility and ongoing engagement; approximately 50% of clients are engaged for 6-18 months and a further 30% for longer
 - *intensive case management, open ended, provided to a capped caseload*. This enables clients and families to make real gains
 - *robust risk management combined with a team approach*. PPS multi-disciplinary team meeting and clear risk assessment and management processes are key mechanisms within the model
 - *strong effective relationships with other services*: the PPS model relies on this aspect of service delivery.
- Professional Workforce and robust organisational infrastructure. PPS is provided by a professional workforce supported by strong leadership and sited within a robust organisation where senior managers support and advocate for the service to ensure it is sustained.

Key challenges in providing a PPS type service include:

- Recruitment and lead in time: Recruiting staff who can work across the broad scope of PPS is challenging and the time needed to get staff up to full speed must be accounted for.
- Staff support and development: Robust staff support, supervision and training mechanisms are required. Systems must prioritise staff health and safety.
- Capacity: Making best use of limited service capacity requires active ongoing management to ensure that the service is provided to those who need it in sufficient intensity and duration to effect change. Inclusion of, or access to peer-support in the disengagement/discharge phase can assist this.
- Overheads: Inefficiency arises from having a small mobile team covering a wide geographical area. This challenge is likely to apply anywhere in New Zealand. Time intensive risk management practices are a further essential overhead to factor in. While the costs were acknowledged, the requirements of having a co-located team and time-intensive risk management practices were consistently emphasised.
- Locating the service within an organisational 'home': A service such as PPS needs to sit within a strong organisation. Given the broad scope of the service, locating it within a non-addiction service could work provided the home organisation supports the broad scope and the clients are well supported to address their AOD related issues.

Key informants universally support the development of PPS-type services in areas of high need. The experience that has accrued from Waitemata DHB CADS PPS provides a useful blueprint for a promising model. The lessons learned and the expertise now available within CADS could provide invaluable support for further development.

INTRODUCTION

Reducing harm for children affected by parental addiction and reducing unequal access to addiction services are key priorities for HPA. HPA is interested in how specialist services can better meet the needs of pregnant women facing multiple issues including family violence, addiction, health issues, including those related to antenatal care, inadequate housing and lack of social support.

Waitemata DHB CADS provides an Auckland-based outreach PPS service for parents of children under the age of three and pregnant women who are poorly connected to health and social services and who are experiencing problems with alcohol and other drugs.

The aim of PPS is to reduce risk and improve outcomes for the children. PPS is the only service of its kind in New Zealand and the PPS model of service is viewed by many stakeholders as gold standard. The service covers a wide geographical area in the Auckland metropolitan region covering the resident populations of Waitemata DHB, Auckland DHB and Counties Manukau DHB which cover approximately 1,415,550 people as at the 2013 Census (Statistics New Zealand, 2013). PPS provides case consultation, coordination and case management services to approximately 100 clients per year.

HPA commissioned Health and Safety Developments to undertake a process evaluation¹ of PPS in order to understand more about the service model, identify implementation successes and challenges, and explore considerations for service replication in other regions. The evaluation took place during the period from November 2014 to March 2015.

¹ A process evaluation is being undertaken on the understanding that an outcomes evaluation of PPS is intended in the

EVALUATION OBJECTIVES AND PROCESSES

The evaluation objectives are to identify:

- core service components and delivery mechanisms of PPS
- key service implementation successes and challenges
- considerations for service replication into other regions.

Evaluation processes included:

- Review of key documentation: Relevant documentation on the development of the service and current operations was sourced in discussion with the PPS clinical team leader and CADS senior management. Documents were reviewed, and relevant content or reference to this is summarised in this report.
- Key informant interviews: All PPS staff, relevant CADS senior staff and a wide range of external stakeholder representatives were invited via email to contribute to the evaluation by participating in a one on one interview. Informed consent procedures were followed with those who elected to participate. A written summary of the interview was provided to each participant to verify accuracy and comprehensiveness. Interview results were analysed for key themes which are summarised in this report.
- Analysis of relevant service data: Data pertaining to the client population and service utilisation was sourced via Waitemata DHB. Key points from the analysis are outlined in this report.

RESULTS

Data obtained

Data were obtained as follows:

A total of 17 key informant interviews were undertaken, 12 of these were with PPS team members, CADS senior staff and senior management (referred to in this report as CADS key informants). Seven professional external stakeholders were interviewed (referred to as external key informants) representing the following services and roles that interface with PPS:

- DHB maternal mental health service.
- Community-based parent education and support service.
- Child Youth and Family Service.
- Community health service working mainly with Pasifika families.
- DHB Māori midwifery advisor.
- Community-based co-existing disorders service.
- Māori community development service.

PPS data for 2012-2014 were provided by CADS for new, exit, and entry clients for each annual period. Data include demographic characteristics, referral sources, diagnostic information, episodes of care and discharge information.

Documentation: Documents provided by CADS were reviewed for the evaluation. These included:

- *Client Pathway Pregnancy & Parental Service – CADS.* (Waitemata District Health Board, 2013)
- *Ministry of Health and Waitemata DHB Service Agreement*(Ministry of Health,
- *CADS WDHB Social Bond Pilot Response Form December 2013. Ministry of Health Registration of Interest For Service Outcomes and Service Providers*(Community Alcohol and Drug Service, 2013)
- *Parental Alcohol and Drug Service: Its History and Future Vision* (Community Alcohol and Drug Service, 2013)*Initial Proposal for the Establishment of a Specialist Pregnancy Support Team with Auckland Regional Alcohol & Drug Services* (Cavanagh, 2000)

THE PPS SERVICE: CORE COMPONENTS AND DELIVERY MECHANISMS

As noted above, PPS is an Auckland-based outreach service for parents of children under the age of three and pregnant women who are poorly connected to health and social services and who are experiencing problems with alcohol and other drugs. The aim of the service is to reduce risk and improve outcomes for the children. As noted in CADS documentation:

The focus on infants under the age of three is informed by research which states that eighty percent of a child's core brain function develops in the first three years of life and that the environments the infants are raised in will impact on how they develop essential social and psychological abilities to be successful later in life and as adults.
(CADS, 2013,p.4)

The following service specifications from the National Service Specification Framework apply to PPS:

- Tier 1 Mental Health and Addiction.
- Tier 2 Addiction Services.
- Tier 3 Community Based Alcohol and Drug Services.

PPS is delivered by a 5-Full Time Equivalent (FTE) team of clinicians (nurses) and a part-time peer support worker, supported by a team leader, a part-time psychiatrist (.2FTE) and a part-time psychologist (.2FTE).² The service operates five days per week, Monday to Friday, 0830-1700 hours. The team services approximately 100 clients per year and approximately 10% of these may be offered peer support.

PRACTICE PRINCIPLES

Practice principles on which the service is based are:

- providing services in a flexible, non-judgemental and client-focused way
- supporting parents and whānau self efficacy, empowerment and recovery
- adhering to, and implementing the principles of the Treaty of Waitangi
- using a harm reduction approach
- utilising a strengths/resilience-based model
- practising from a social justice perspective and working within a bio/psycho/social/spiritual model
- improving outcomes for the unborn child and children.

² During this evaluation PPS was poised to undergo a period of significant growth. The evaluation has focussed on PPS up to the end of 2014.

INTERVENTIONS

PPS nurse clinicians work with a capped caseload of up to 12 clients and their families providing the following:

- assertive outreach /client engagement
- assessment and management of biopsychosocial risk areas for parents and children.
- comprehensive assessment and interventions including treating or referring for treatment of alcohol and other drug abuse or dependence; reducing substance abuse impact on pregnancy, connecting pregnant women with antenatal care, improving infant parenting skills, including infant attachment and lactation; preventing infant ill-health including Sudden Unexpected Death of an Infant (SUDI) Fetal Alcohol Spectrum Disorders and Shaken Baby Syndrome; addressing domestic violence; improving general parenting skills; promoting early childhood education; improving mental health; addressing cognitive impairment and physical problems; addressing child care and protection and custody issues; addressing criminal involvement and other legal issues; working inclusively with family, whānau and significant others.
- interventions addressing gambling and nicotine use including Nicotine Replacement Therapy using the Quit Card system.
- formulation and treatment planning with regular comprehensive multi-disciplinary team reviews of goals, treatment and risk management.
- long term case management including overall responsibility for coordinating the care that clients receive, organising regular stakeholder meetings, following up with services on agreed interventions and working with clients to facilitate their engagement with other services and to develop sustainable support networks.
- supporting the links between clients and services by referral or liaison; supporting clients to engage; and supporting services to meet these clients' complex needs through advice, education, advocacy and de-stigmatisation of this group.
- implementing key psychosocial strategies focused on reducing substance abuse and family violence, improving problem-solving skills, and improving infant care and parental skills.
- planned discharge, including transfer of care to other agencies and local community support.

The PPS psychiatrist provides:

- client assessment and pharmacological interventions (as needed for clients not involved with mental health services) including referral for those who need mental health services
- consultation for PPS clinicians
- support/expertise with regards to team reviews of client risk and treatment (see MDT review below)
- consultation and liaison with mental health services.

The PPS psychologist provides:

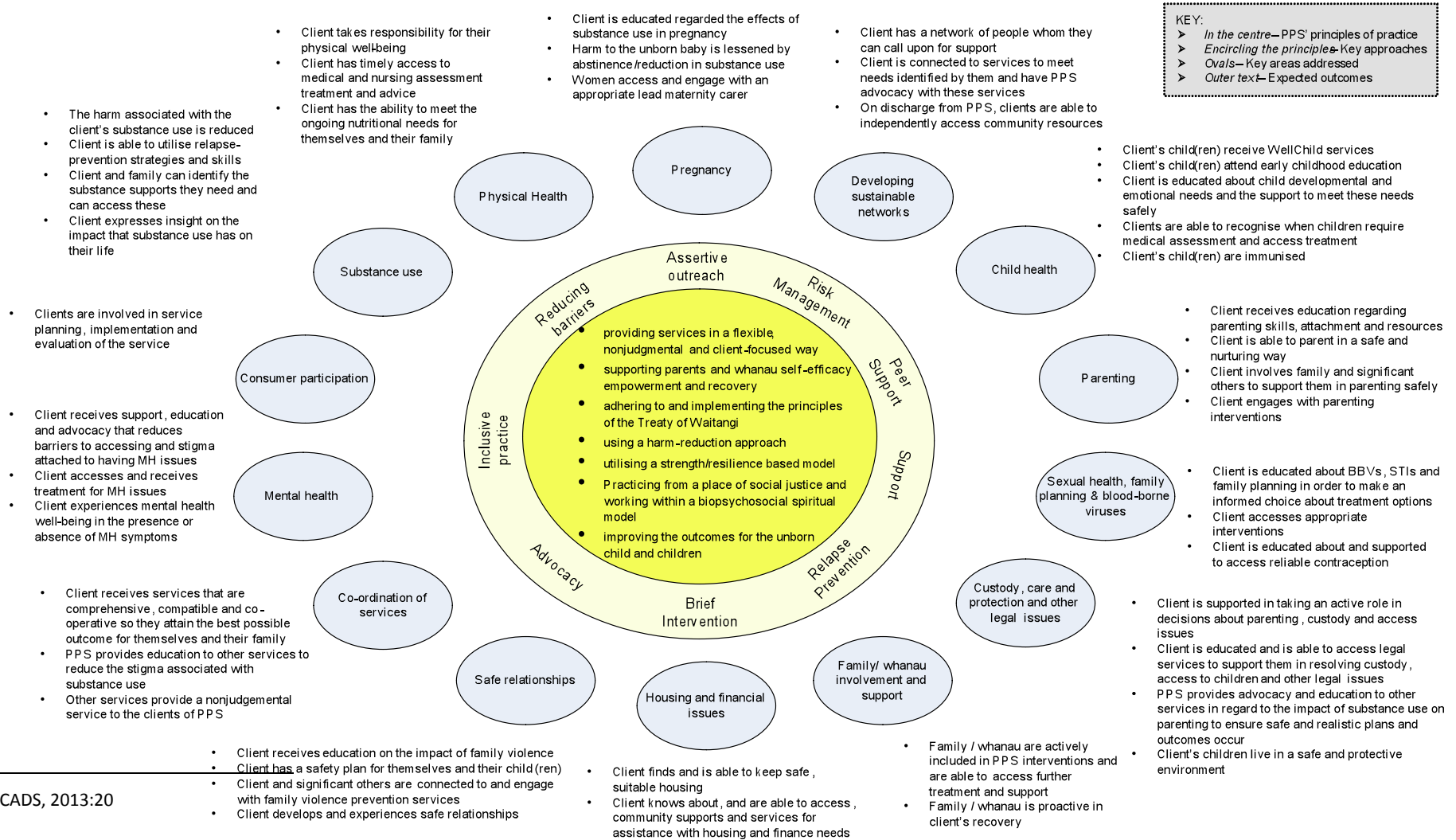
- client assessments and interventions
- consultation for PPS clinicians with treatment planning and psychosocial interventions
- support/expertise with regards to team reviews of client risk and treatment (see Multi-Disciplinary Team (MDT) review below).

The peer support worker:

- models positive recovery to enhance clients' self-efficacy
- supports clients to engage with the wider community, and support clients through regular peer groups.

Figure 1 below sets out a detailed summary of the key areas which PPS addresses and specifies the outcomes sought in each of these areas. Within these key areas, the service is tailored to the needs of the clients and their children (born and unborn). Accordingly the duration of involvement with PPS varies from client to client.

Figure 1. PPS Model³



³ CADs, 2013:20

KEY COMPONENTS OF PPS CLINICAL PATHWAY

Clients are referred to PPS via multiple⁴ avenues including self-referral (39% of PPS clients self-refer). Self-referral clients have typically heard about the service through friends or family members who have previously been clients. Following referral, an assertive outreach approach is taken as required with the aim of engaging the client and undertaking an assessment to determine the services (including PPS service) required.

Once the client is engaged, an assessment (generally undertaken in the community by two PPS clinicians as a safety measure) occurs within the first two face-to-face contacts. The PPS standard assessment form guides the assessment process. The outcome of the assessment is a negotiated goal plan (*PPS Goal Plan*)⁵, developed in collaboration with the client. The goal plan is reviewed at each contact and is reviewed by the whole team at the MDT meeting not less than three-monthly (see below MDT review).

Typically clients need services from a variety of agencies and PPS takes an overall coordination and monitoring role within a framework of providing active ongoing support and education.

The client's duration of stay in PPS is not fixed. *PPS Client Pathway* states that discharge occurs when goals have been achieved or when the client indicates they do not want further contact with the service. An overview of the PPS clinical pathway is shown in Figure 2 Appendix 1.

PEER SUPPORT

Peer support is a supplementary service within PPS offered to clients where there is an identified need. Typically this occurs when clients have been engaged with a PPS clinician for an extended period and are within three to six months from discharge due to having progressed towards their goals. PPS peer support aims are:

- clients experience increased self esteem
- clients are supported to connect and engage with the wider community
- clients are supported to disengage with PPS (discharge planning).

⁴ Referrers include lead maternity carers, hospital social workers, mental health services, Child Youth and Family and non-government organisations.

⁵ Further information on PPS forms including risk summary and goal planning forms can be obtained from CADS PPS Team Leader.

MDT REVIEW

PPS holds an MDT meeting weekly to provide team input and oversight for all PPS clients. Reviews are undertaken as follows:

- After initial assessment and not less than three monthly thereafter.
- Before discharge (planned or unplanned).
- At the request of the client or clinician.

The review is documented and a client's progress can be tracked by reading the MDT form, risk summary and goal plans.

RISK MANAGEMENT AND RISK REVIEW MEETING

Risk identification, monitoring and management are key focuses in the service. The team attends a weekly risk review meeting where all new or increased risk is presented and discussed. The *Client Pathway Pregnancy & Parental Service – CADS* (Waitemata District Health, 2013) stipulates that:

- clients are reviewed at the risk meeting if they did not attend (DNA) or cancelled three appointments
- clients are reviewed at the risk meeting if there has been no contact for six weeks or if there are concerns regarding lack of contact prior to six weeks
- plans resulting from the risk review meeting are documented on the risk summary.

MORNING RISK CHECK-IN MEETING

In addition to the risk management and risk review meeting, the team begins each morning with a risk check-in meeting. If any risks are identified the team devises a management plan.

FLEXI-FUND

The service administers a small flexi-fund of \$10,000 per annum. The fund is used to support a need linked to the client's goal plan that will produce ongoing benefits.

HOW AND WHY PPS WAS DEVELOPED

Service documents and information from key informants indicate that PPS was initiated in 2000, prompted by an initial proposal from a clinician based in the Auckland Regional Methadone Service (Cavanagh, 2000). The proposal put forward a rationale based on international data suggesting the likelihood of a large untreated population of at risk women and children in Auckland. The proposal and other early documentation⁶ indicated that there was a need to reach pregnant women who were using substances in ways that put children at risk, and specifically to address:

- poor identification of pregnant or parenting women with substance use issues
- multiple barriers to accessing treatment including lack of transport and childcare and lack of information about treatment options
- poor retention in treatment attributed to stigma and uncoordinated services.

Initially the proposed service was aimed at developing a pregnancy specialist service providing case management support for CADS services and education and liaison for professionals (CADS and external). CADS succeeded in gaining funding for the service and the PPS⁷ start-up team comprised two clinicians and one team leader⁸. CADS grew the team over time to the current 5FTE in the PPS team by re-allocating resources within the organisation.

CADS had internal strategy of allocating resources to front line and this helped to grow the service.

CADS key informant

As the service evolved, the focus shifted to providing more direct access and case management services to clients, referring clients to other CADS services and other AOD treatment services for their addiction-related treatment needs. This represented an important change of pathway, in that PPS began to access clients that were high risk and who were not accessing CADS services, rather than accessing clients already engaged with CADS.

The PPS model has been refined over time and has been informed by some key reports and examples of similar services. The report on the investigation into the death of Riri-o-te-Rangi (James) Whakaruru, written by the Office of the Commissioner for Children in 2000 was formative for PPS. This report among other things made a strong recommendation for improved communication and coordination of services where there was an identified risk to children.

The PPS model has also been informed by North American approaches, namely the Parent Child Assistance Programme (PCAP), Seattle USA and The Sheway Programme, Vancouver Canada. For example:

⁶ Including a response to an RFP presented to the Health Funding Authority (no date)

⁷ The service was originally named the Parental Alcohol and Drug Service.

⁸ A further two clinicians were located in within Te Atea Marino and Tupu services.

New model was informed in part by international models – Parent Child Assistance Programme (PCAP) Seattle USA; The Sheway Programme, Vancouver Canada an example of a home based service.

CADS key informant

A CADS literature review entitled *Parental Alcohol and Drug Service: Its History and Future Vision* (n.d.) undertaken by CADS early in the life of PPS refers to an evaluation report on the Sheway outreach programme as an example of emerging best practice. The Sheway project evaluation report (Poole, 2000) indicated that the Sheway service was successfully engaging women experiencing a range of complex and serious health and social issues, engaging them in pre and postnatal care and helping them in relation to a range of issues. This achieved particular success in the areas of housing stability, nutrition and retaining care of their children. PPS has been informed by the Sheway model in terms of the overall approach and utilises some of the tools and processes developed by Sheway. This was noted by CADS key informants as providing a key foundation for PPS, for example:

Access to a model – that has been inspirational. PPS has taken ownership of the model and they have built a profile. The model has provided a framework for the work of the service, recognition and validation; enabled the service to consolidate.

CADS key informant

Staff who have been involved with PPS over a long time commented that the service has evolved with a view to continuous improvement.

BROAD INDICATORS OF EFFECTIVENESS

To date CADS has relied on broad indicators to gauge the effectiveness of PPS in reducing the harm to children (A formal outcomes evaluation of PPS is in the planning stage). PPS and CADS managers monitor events within the client population such as shaken babies and other serious injuries and deaths resulting from abuse and SUDI. As an example, approximately 10 years ago four babies from PPS families died within a period of a less than one year. While a review confirmed that this rate of infant death was within the expected range for the client population, PPS sought to improve practices in educating clients on SUDI and shaken babies. As part of this, two educational resources were developed specifically for PPS, 'Safe Sleep for Baby' and 'Never Shake a Baby'⁹. These are now used routinely. There has been one infant death in the subsequent 10-year period. The following comment illustrates how indicators are used:

We look at statistics for broad indicators of success - for example: SUDI; domestic violence; children killed by caregivers. When we look at rates of death and injury in our client group, the absence of these is a good indicator that our service is working. Typically we would expect to see certain levels or instances of these [poor] outcomes in our client group. The indicators are rough – we want to make intergenerational

⁹ An electronic copy of these resources can be obtained from CADS PPS.

change and we have no way yet of measuring whether we are making a difference to that. We are working on developing an outcomes measurement tool.

CADS key informant

RATIONALE FOR INVESTMENT IN EARLY INTERVENTION

PPS is a resource intensive service. For example, approximately 100 clients (and their families) access PPS annually and based on most recent information this is at a cost of approximately \$1.8million.¹⁰ Recognition of the importance of investing in early intervention for under three-year-olds is a key driver. For example:

The service is important - this target group is an important group for the sector to invest in. We've had it wrong for a long time – we have made a big investment in adults who often have entrenched problems; there is very modest return for society. There is growing argument that the best return on investment is early intervention i.e. 0 - 5 years.

CADS key informant

CADS management acknowledged that the decision to invest in a low-volume high-intensity service has to be defensible. They draw on supporting evidence and note that the PPS model aligns well with government policy in the area of vulnerable children. For example, the *White Paper on Vulnerable Children: Volume I* states that:

We need to find, assess, and connect the most vulnerable children to services earlier and better.

(Ministry of Social Development, 2012, p 9)

The *White Paper* strongly supports interagency working and “multi-compartmental” approaches which are broad and flexible and can respond effectively to the wide range of related factors that can affect child development.

CADS key informants pointed to the work of James Heckman (2015), Professor of Economics at the University of Chicago and an internationally recognised expert in economics of human development. Heckman’s body of research provides evidence in support of the economic benefits of investment in the well-being of children in the 0-3 age group. Critically the evidence supports the cost benefit of investing in early intervention for children rather than in rehabilitation services later in life. A key message is the importance of focusing on the family environment in which the child is situated, utilising home visits and focusing on the quality of parenting. PPS reflects much of this. The following comment is typical:

Strong focus on preventing further harm particularly for the 0 – 3 group. It is the right approach for working with families with complex needs. Children are at risk of brain damage, violence, trauma and death – this service works to prevent those things;

¹⁰ Based on contract price for the 2014 – 2015 contract extension of PPS which indicates the cost of 6FTE across PPS roles (Email from CADS Regional Manager to Ministry of Health, December 2014).

keep kids in homes and take kids out of the home if it becomes untenable for them to stay.

CADS key informant

New Zealand research, specifically the Dunedin Study¹¹ was also cited by CADS key informants as evidence that supports the PPS approach, particularly in relation to the positive outcomes that can ensue from modifying the environment in which children are developing.

Modifying the environment in a positive way remains the key for influencing how people's lives turn out.....The environment is where the action is.

(Poulton, 2008, p.5)

¹¹ See: The Dunedin Multidisciplinary Health & Development Study. Available at: <http://dunedinstudy.otago.ac.nz>

PPS CLIENT GROUP

Data, information from documentation and comment from CADS and external stakeholders have been compiled and analysed to provide a profile of the client group served by PPS.

THE TARGET GROUP

The client group that PPS serves is described as having:

.... multiple complex and interacting issues which include: medical complications related to mother and infant health, mental health and substance abuse or dependence disorders, personality disorders, cognitive impairments, history of suicide and self-harm attempts, history of childhood neglect or abuse, low educational achievements, history of domestic violence and poverty, lack of adequate housing, current and past criminal charges, current and past child protection agency involvement, history of poor service uptake (including maternity services) or multi-generational dysfunctional family patterns.

The male partners of the clients of this service have similar issues, their legal issues often involving charges relating to violent crime and drug convictions.

(CADS, 2013, p. 5)

The service is targeted at those who are not well engaged with services for a number of reasons including AOD issues, mental health issues, poverty, limited access to transport, lack of childcare, fear of stigma and judgement and fear of involvement with child welfare agencies (CADS, 2013).

Key informants confirm that this is the group that PPS is serving, for example:

PPS manages the most complex end of the spectrum – involved with CYFS, women with high levels of distress; a high risk area.

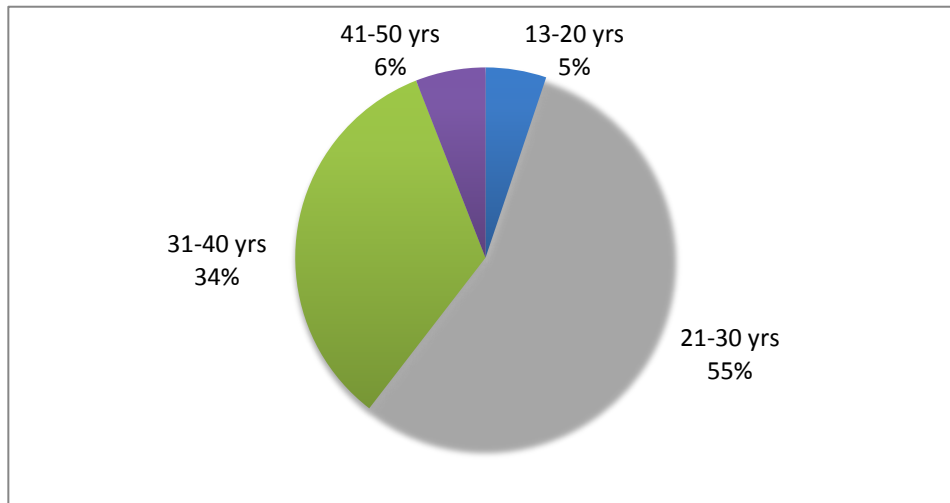
External key informant

PPS CLIENT DEMOGRAPHICS

Data pertaining to PPS clients for 2012, 2013 and 2014 calendar years show that PPS has seen a total of 119, 129 and 140 clients per year respectively, a total of 388 clients. All clients but one were female.

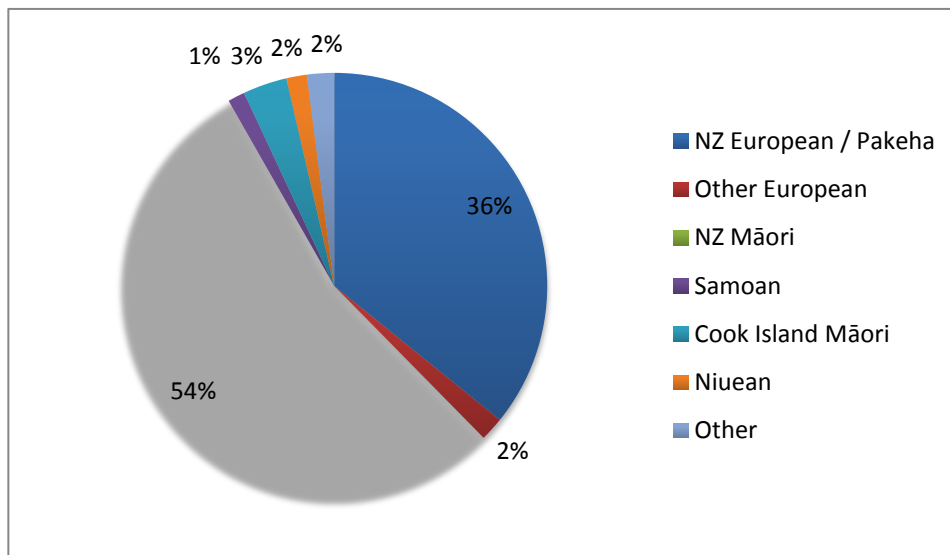
The majority of clients predictably fall within the child-bearing age range; 55% of clients were aged between 21 to 30 years with a further 34% being aged 31 to 40 years. Numbers of clients aged between 13 to 20 are small (20 in total over three years) with an average of 5% of the total client group being in this age bracket. Similarly those aged over 40 years represent an average of 6% of the client group over three years (23 clients in total). This is shown in Chart 1 below.

Chart 1. PPS clients by age, 2012-2014



A majority of PPS clients are Māori, being 54% of the client group for the 2012 to 2014 period. The next largest group is NZ European/Pakeha being 36%. The remaining clients are Cook Island Māori (3%), Niuean (2%), Other European (2%), Samoan (1%) and Other (2%). This is shown in Chart 2 below.

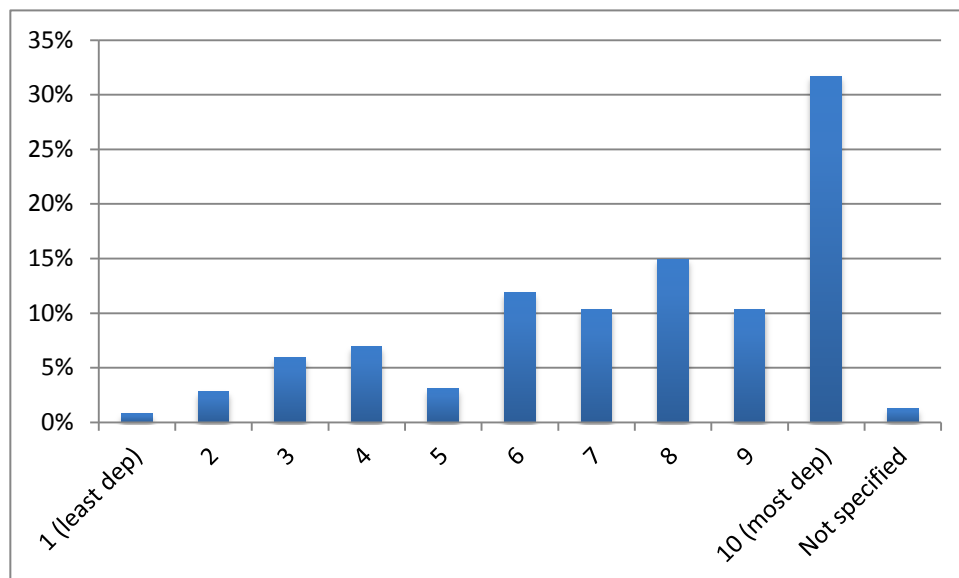
Chart 2. PPS clients by ethnicity, 2012-2014



Most PPS clients live in areas with a high deprivation index.¹² In the 2012 to 2014 period 79% of clients lived in areas with a decile rating of 6 or greater with 32% living in a decile 10 area (the highest level of deprivation). Data are shown in Chart 3 below.

¹² The New Zealand Deprivation Index is a measure of the level of socioeconomic deprivation in small geographic areas. The index ranges from 1 to 10. A score of 1 indicates that people are living in the least deprived 10 percent (decile) of New Zealand. A score of 10 indicates that people are living in the most deprived 10 percent. The deprivation index uses Census data for car and telephone access; receipt of means-tested benefits; unemployment; household income; sole parenting; educational qualifications; home ownership and home living space. Salmond et al. 2007 cited in <http://www.od.govt.nz/resources/research/outcomes-for-disabled-people/nz-dep.html>

Chart 3. % PPS clients by deprivation index, 2012-2014



ISSUES EXPERIENCED BY PPS CLIENTS

There is very limited quantitative data on the nature of the issues experienced by PPS clients.

All of the key informants (internal and external to CADS) spoke of the complexity and severity of the issues which most clients are experiencing which bring them into contact with PPS. The following comments provide examples:

....the families can be all over the place.

External key informant

PPS is working with a clientele who have a high profile; risk of death, neglect of children, violence etc; there is potential for things to go very badly.....[The] focus is on multiple issues; complexity not necessarily acuity.

CADS key informant

PPS works on overcoming the barriers that the clients face, for example, transport, physical health, housing, justice issues, custody issues, violence; history of abuse.

External key informant

Key informants note family and whānau relationship issues, including child safety and other parenting issues and family violence issues and trauma (current and historical) as being highly prevalent. An estimated 20 notifications per annum are made by PPS to Child Youth and Family Services. The following comments are indicative of some of the issues, for example:

It is very hard to know that sometimes your client cannot parent their child and you are part of the team decision to remove the child from the home. This is a hard thing to sit with.

CADS key informant

Ninety percent of our clients have a history of trauma and abuse; we are often working alongside the perpetrators – there is a lot of family violence among the client group.

CADS key informant

[A challenge can be].....getting up to speed in the role – working with domestic violence; working with the risk involved with AOD and child protection; the legal stuff – the FGC (family group conference), Family Court, lawyers, trespass order, custody issues, protection order – you have to understand all of these things.

CADS key informant

Domestic violence is a big focus, so staff need good knowledge of working with this.

CADS key informant

Limited available data indicate that approximately 27% PPS clients (68 of 250 clients seen in the period 2012 to 2014 for whom data was available) had contact with a mental health service. No specifics about the nature or duration of this contact were able to be accessed.

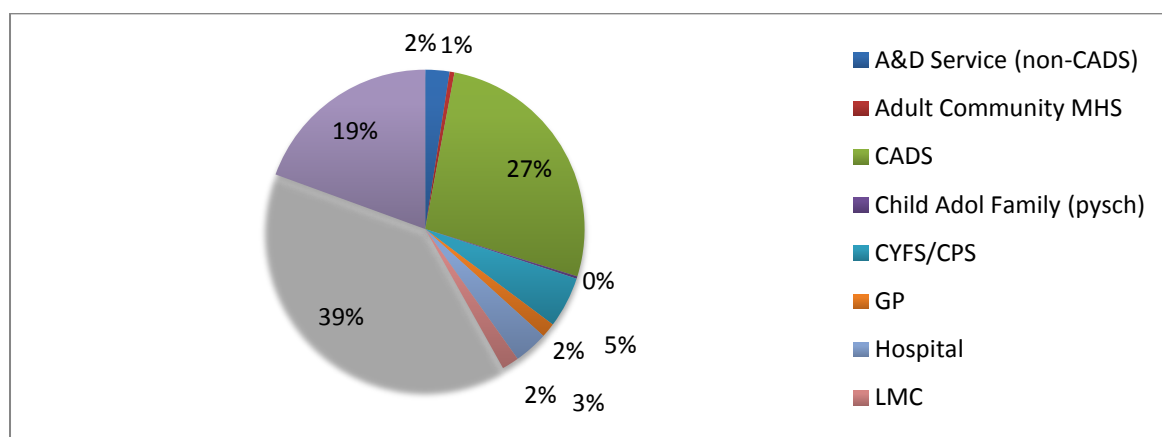
PPS SERVICE ACCESS AND UTILISATION

PPS service access and utilisation are outlined in the section below.

Referral source

Data for the period 2012 to 2014 show that over the three-year period 39% of PPS clients self-referred, making this the largest referral source category. A further 27% of clients are referred from within CADS. There is a large group, comprising 19% of all referrals, for whom the referral source is not specified. Other referral source categories are small with 5% being referred by Child Youth and Family Services, 3% from hospitals, 2% by lead maternity carers, 2% from other addiction services. Referrals from other groups comprise 1% or less. Results are shown in Chart 4 below.

Chart 4. PPS referral sources, 2012-2014



Appointment counts

Data show that between 50 to 58% of clients who exited treatment 2012-2014 received more than 21 appointments with PPS. The range for those receiving 10-20 appointments was 16 to 21%. A range of 25 to 28% received 1 to 9 appointments. This demonstrates that a majority of clients are well engaged with PPS. Data are shown in Table 1 below.

Table 1. No. of appointments per client for exit* clients 2012, 2013, 2014

Appt count	2012				2013				2014			
	1-4	5-9	10-20	21+	1-4	5-9	10-20	21+	1-4	5-9	10-20	21+
No.	10	9	14	34	7	11	14	42	11	6	11	39
%	15%	13%	21%	51%	10%	15%	19%	57%	16%	9%	16%	58%

* Exit clients are those who exited the service in the years 2012 – 2014.

Appointment attendance rates

Appointment attendance rates for clients exiting the service indicate that rates of attendance are high, between 77% and 82% over a three-year period. Again these data indicate a high level of engagement and support the effectiveness of the assertive outreach approach. Data are shown in Table 2 below.

Table 2. Appointment attendance rates exit clients, 2012, 2013, 2014

Appointment status	2012			2013			2014		
	Attend	DNA*	Cancel	Attend	DNA	Cancel	Attend	DNA	Cancel
No.	2250	399	263	2921	453	333	2761	339	283
%	77%	14%	9%	79%	12%	9.0%	82%	10%	8%

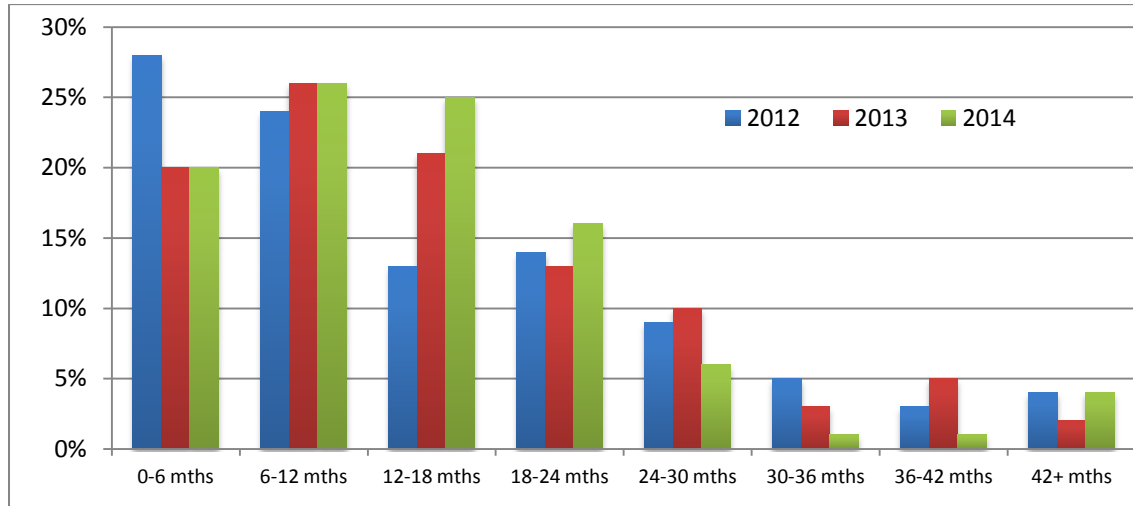
*DNA = did not attend

It is important to note that numbers of appointments and appointment attendance rates provide only part of the service picture. Case coordination activities such as telephone calls, meetings with other whānau members and professional meetings are a large part of the service and typically include work aimed at linking clients and whānau to services and groups as well as advocacy-related activities. This is a critical aspect of the service.

Period of engagement

Exit client data shown in Chart 5 below provide an indication of the expected periods of engagement for PPS clients. Data are fairly consistent across the three-year period and indicate that approximately 20% of clients are engaged for up to six months, a further 25% for up to 12 months and a further 25% for up to 18 months. Approximately 15% remain engaged for up to 24 months, with the rest staying engaged longer.

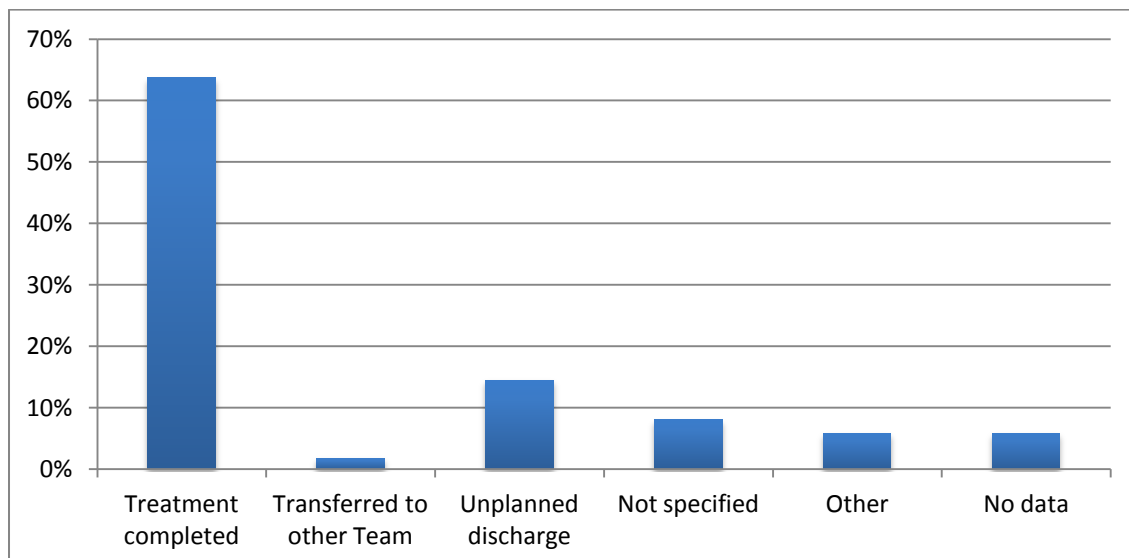
Chart 5. PPS exit clients period of engagement, 2012, 2013, 2014



Reasons for discharge

Data regarding reasons for discharge show that for the period 2012 to 2014 64% of those leaving PPS had completed treatment and 2% were transferred to another team or service provider. Just 14% are recorded as having an unplanned discharge. For the remaining 20% the reason for discharge is either not specified (8%), is recorded as 'other' (6%) or there is no data recorded (6%). This indicates that the majority of PPS clients have planned discharges on completion of treatment.

Chart 6. Exit clients reasons for discharge, 2012 - 2014



STRENGTHS OF PPS

There was a high level of agreement among stakeholders regarding the strengths of the service. Key themes are summarised below.

SERVICE PHILOSOPHY, PRINCIPLES AND SERVICE OBJECTIVE

Key informants consistently commented that the philosophy and principles that guide PPS are a key strength, emphasising that these support the service in achieving the objective of a positive outcome for the child. This objective is always paramount and guides all clinical decisions. For example:

There is a clear objective of getting the best outcomes for at risk children – this is a very ‘helpful compass’ for clinical decision-making. The target group is the parents but the objective relates to children.

CADS key informant

A strength is the ‘obsessive’ focus on care and safety for children.

CADS key informant

Key questions consistently asked about practice are: “Is this improving parenting” and “how will this improve outcomes for this child?”

CADS key informant

Viewing the client as a parent, within the social context of family and whānau relationships was noted as a key strength and, by some, as being somewhat unique to PPS as an addiction service. For example:

PPS focuses on the relationship with the mother and the baby and supporting that relationship. Other addiction services including CADS services, don’t have the capacity to do that – they work with the mother only not the relationship between the mother and baby.

External key informant

Got to have respect for culture; got to understand where the family fits in.

CADS key informant

PPS works with the parent, recognise the ‘mum’ – accept and understand that the mum has responsibility for her kids.

External key informant

Additionally there is a strong whānau inclusive focus. This means that PPS is working with the whole whānau, as a means of supporting sustained change for that whānau. For example:

The ‘client’ can become a lot of people....partners, extended family etc....so the caseload can be quite big.

CADS key informant

A focus on strengths¹³ and recovery and a strong non-stigmatising, non-judgemental philosophy were highlighted by those both internal and external to CADS as critical to engaging and successfully working with PPS clients. The underpinning social justice principle was highlighted as being significant. For example:

The peer team at [my service] likes working with PPS because the PPS clinical staff are very recovery focused.

External key informant

They go into homes. Don't wear a uniform. Sit and talk, listen to the women, really listen and don't patronise them. The women tell them stuff. They look at where to from here – they seem to have a very good procedure for that.

External key informant

The service is strengths-based, we don't judge the clients, they are already judged by so many others.

CADS key informant

There is a strong spirit of social justice in the team. There is a sense that everyone is striving for fairness.

CADS key informant

THE MODEL OF SERVICE

The PPS model with its clear target, wide scope and considerable flexibility was consistently noted as a key strength. The flexibility and scope of the service (referred to by some as 'whatever it takes') allow PPS to focus on what is important to the client which assists engagement and supports clients to achieve positive changes in their lives and the lives of their children. For example:

They have a very genuine interest in helping the mothers with addiction or whatever they need.

External key informant

'Can do' approach. Help with whatever – housing, courses, meetings etc. They think outside the square.

External key informant

PPS works on overcoming the barriers that the clients face – e.g. transport, physical health, housing, justice issues, custody issues, violence; history of abuse.

External key informant

Flexibility of approach applies not just at the client interface but also in broader aspects of service operation for example:

PPS gets involved in broad initiatives aimed at improving child health and safety. For example we are Pe-pi Pod distributors; we are starting to provide a Circle of Security

¹³ The following tools are used to support a strengths-based approach: Strengths cards; Strengths profile; Difference game (from the Parent-Child Assistance Program) and the Recovery capital tool.

Programme (attachment programme). We are also involved in forums such as Te Aka Ora forum and COPMIA (Children of Parents with Mental Health and Addiction) advisory groups.

CADS key informant

Critical aspects of the model identified by key informants included:

- the assertive outreach approach with a focus on engagement and intensive follow-up
- comprehensive intervention which is not time limited
- capped caseloads (approximately 12 families) supporting both of the above.

CADS key informants consistently emphasised that the PPS model is built around the importance of engagement and that considerable effort and time are given to engaging clients in the service and remaining engaged with them. Clients are seen in the environment of their choice, typically this is at their home. Many attempts can be made to see a client before an assessment is completed and many attempts are made to re-engage clients who disengage in an unplanned way. The legitimising of this investment of resource is seen as key to PPS success in engaging a client group that is typically viewed as “hard to reach”. For example:

Assertive outreach: includes going to the home, working intensively to build rapport and engage people, hanging in there for as long as needed and providing practical help (this last aspect is very important). For some women this means that they make significant changes over the time that the service is involved.

CADS key informant

Outreach: we take the time to engage clients. That process is seen as a legitimate part of the job. If you have to get in the car and go out to Manurewa to try to see a client that you can't get hold of that is not questioned, it's accepted.

CADS key informant

Outreach: this was huge; not the three strikes approach which most services have; clients really appreciated not being given up on.....

CADS key informant

PPS works in people's homes, in the community, not just in the office. You get a much better idea about what is going on with the client e.g. you can see the broken window. It is easier for people to be honest.

External key informant

Intensive assertive outreach:

- *We go to them.*
- *Once we have the initial consent to contact we do a fair bit of chasing.*
- *We stay engaged.*

CADS key informant

The outreach approach was noted as being helpful with Māori and Pacific clients, for example:

The team doesn't engage all Māori and Pacific clients but generally the assertive outreach approach seems to work well with Māori and Pacific clients.

CADS key informant

Engage the clients; seem good across all cultures; observe the protocols and have cultural sensitivity.

External key informant

CASE COORDINATION AND WORKING WELL WITH OTHER SERVICES

PPS clients generally need input from a range of services and coordinating this and working with other agencies is a key aspect of the PPS model. Many key informants commented on the importance of case coordination and noted that PPS does this well.

Coordination: this was very important; if we didn't do it a lot of things would go pear shaped. Services tend to work in isolation.

CADS key informant

We are very careful with our consent systems so that we are able to communicate with other services – there is heaps of paperwork.

CADS key informant

[Staff are] well connected to the community – they connect their clients to the right resources. Staff are expert in doing this. They know the community. Again you don't get that in CADS [other services].

External key informant

The importance of developing and maintaining strong and effective relationships with other services was highlighted by all. For example:

To work well with other services you have to be non-judgmental and diplomatic – it is the same as working with the clients in some ways. PPS does that well. We all had a genuine passion for the work and respect for others.

CADS key informant

Staff have a sophisticated way of looking at and working with all of the issues that the clients may face. This includes handling significant tensions, for example, making CYF notifications while still keeping the client engaged; learning to navigate the inadequacies of CYF sometimes.

CADS key informant

PPS has high quality staff. They build relationships with stakeholders; don't judge the other services; present a balanced view of other services, including CYFS, to the client. They don't try to exclude CYFS. Some services advocate so hard for the parents that this can overshadow the needs of the child; PPS doesn't do that.

External key informant

Really good with communication when co-working, also very prepared to look at 'who can do what' depending on what the client needs. Good at sharing information, for example, when a client was really hard to get hold of [the PPS nurse] knew her well, knew the family, knew where it was safe to see her etc. This helped us work with the client.

External key informant

STRONG ORGANISATIONAL INFRASTRUCTURE

PPS sits within a large government health organisation. CADS key informants noted this as a key strength of the service, citing the robust management and clinical systems which exist within CADS as essential to support the work of PPS. For example:

CADS infrastructure has been helpful. PPS was set up in the context of a very well established service.

CADS key informant

The importance of attending to the managerial aspects of the service was noted by many, with strong management being cited as a key strength. For example:

The governance model [is a strength] - strong clinical leadership and strong management. The senior managers have become businessmen; they wear a strong business hat. This is very important for sustaining and growing the service.

CADS key informant

It was noted that PPS is a somewhat unique service within the context of more traditional addiction treatment and that it falls to management to justify the approach in terms of effectiveness and cost effectiveness (i.e. the value in taking a holistic approach and of investing in early intervention for under three-year olds) to ensure that the resources are there to sustain the service. For example:

There is tension between running CADS units which see 10,000 people per annum and running PPS which has an intense resource allocation for 100 clients per annum.

CADS key informant

Service advocacy is necessary. The team serves a small number of marginalised people, [there is a] high level of stigma for the clientele - hard to generate empathy for this client group.

CADS key informant

A further related point was the ability within CADS to link to the wider workforce, such as psychiatrist and psychologist input (beyond the small FTE allocation to PPS) and workforce development systems such as strong supervision systems. For example:

Robust supervision arrangements: supervision is a priority, group supervision is provided and now there is a new clinical nurse specialist role to support the team.

CADS key informant

Staff support includes regular supervision, training opportunities, and opportunities to be involved in projects that give a break from client work, i.e. representing the service in vulnerable women's forums, doing service presentations to various organisations. Regular teaching/service presentation slots with midwifery and nursing students. Also teaching regarding AOD use in relation to pregnancy and parenting to various organisations.

CADS key informant

RISK MANAGEMENT SYSTEM

All CADS key informants noted the PPS risk management system as a strength of the service. The clear and comprehensive risk management approach in CADS was consistently noted as crucial to the effective and safe functioning of PPS. There is wide acknowledgement of the risks that must be identified and managed in delivering PPS. As noted above, this is reflected in the PPS client pathway, which includes continuous risk identification, monitoring and management by the clinician with structured input and oversight of the whole team. Documentation via the risk summary is an important mechanism of the system. CADS key informants also commented that these systems are of necessity, demanding and time consuming. For example:

Our risk management systems are clear and effective – we assess risk of self-harm/suicide; harm to others – especially kids; harm from others – often the partner; medical/psychiatric status; pregnancy and substance use. We flag and review clients that disengage e.g. if not seen for six weeks or if DNA three times. (Likely to increase efforts at contact).

CADS key informant

Flexibility of what the service can offer – skilled knowledgeable staff; solid systems – otherwise the service would be unsafe. There is a strong service and professional framework; clear risk management.

CADS key informant

The MDT manages risk [via the MDT meeting]: we always look at the risk issues first and also every client is reviewed three-monthly. It is an opportunity to contain and share the issues; exchange ideas. It is a very long meeting and can be hard; people can get defensive; there is challenge sometimes regarding approaches etc.

CADS key informant

Things get done properly – good systems and accountability. I like that way of working. But it is time-consuming. Our notes are over the top – but that is not just our service, that is all services.

CADS key informant

The willingness of PPS to manage risk was noted as a stand out strength of the service by one external key informant:

[They] manage the most complex end of the spectrum – involved with CYFS, women with high levels of distress; a high risk area – PPS acknowledge the risk and even when it is very high they 'do the right thing' – a lot of services would not take on the risk.

External key informant

Risk to staff is also accounted for in PPS systems. Initial assessments are generally carried out in pairs and there are systems for reporting in to ensure that the service has knowledge of where staff are while they are working. In some circumstances staff safety can be under threat, usually from the partner of a client. In these circumstances staff security is a priority. For example:

We arrange special security measures if there is any suggestion that staff may be at risk.

CADS key informant

THE PROFESSIONALISM OF THE STAFF AND THE SERVICE

Staff are universally regarded as skilled, knowledgeable and experienced. CADS as an organisation provides a structured approach and a professional framework. For example:

They are very professional but this is not a barrier. The women trust them. Most of the women are Māori and the nurses are Pakeha but it seems to work. They [the nurses] have an understanding and a willingness.

External key informant

They are all health professionals so that probably makes it easier.

External key informant

Staff are a strength. Extremely hard working; have a passion for the job – they are there because they want to be there. They really understand the issues.

External key informant

A high standard of professionalism is needed – the team is working with a very marginalised, stigmatised group. They have to be able to engage other services and advocate for the clients. This takes skill.

CADS key informant

STRONG CONSISTENT LEADERSHIP

Internal and external key informants noted that the leadership in PPS and CADS support the practice of the team.

[The] team leader has given a lot of consideration to the leadership of the service.

CADS key informant

Having a dedicated team leader who has had ongoing commitment to the service has played a large part in the success of the service; having a good leader who stays around seems to be a feature in common with other successful smaller services in CADS. The team leader is a strategic thinker who is also practical; no nonsense; takes the lead; reflects on what is happening and on their own leadership. Has knowledge of the clients. With a small team this seems to be do-able.

CADS key informant

Excellent manager, realistic, quick to respond and very knowledgeable.

External key informant

TEAM APPROACH

A cohesive team approach is considered essential to provide a sustainable service and to ensure safety. The MDT meeting was noted by many as providing a key mechanism for implementing the team approach. For example:

The MDT is one mechanism for keeping the objective clear. All work comes under the eyes of the team, everyone has a voice; the team members remind each other of the objective.

CADS key informant

Overall the MDT provides support, a sounding board and a range of perspectives.

CADS key informant

Team support is very good – this is the key to it. The MDT is a strength (although too long), everyone is acknowledged in the process.

CADS key informant

The challenges in a strong team approach were also noted. There is a requirement that individual clinicians will follow the direction of the team and this at times presents issues and threatens professional autonomy.

Team approach. Really important but need to guard against micro management. Collegial relationships were great and helped to sustain us in the work.

CADS key informant

You have to do what the team directs and that can be hard.

CADS key informant

PEER SUPPORT

The peer support component of PPS was noted by many as a very useful addition to the clinical service and a key strength of the service.

Peer support adds to the continuum of service; validates the centrality of the client. PPS has always been an innovative service, CADS consumer aspect is strong and the right person emerged. Potentially peer support could be provided externally to the team, provided there was a strong relationship with the peer support service.

CADS key informant

Peer support is a very important voice in the team; has been a fantastic addition.

CADS key informant

FLEXI-FUND

Access to the flexi-fund was noted as a strength by some key informants. As noted above this provides an additional resource to support clients with their goals and is used to support the purchase of items or services that will provide ongoing benefit to the client. For example:

PPS has a flexi-fund. Usually other services look to us for funds when needed.

External key informant

CHALLENGES IN PROVIDING PPS

Key informants were asked to comment on the challenges of providing PPS. Key themes are summarised below.

CAPACITY OF A SMALL TEAM

The limited capacity inherent in such a small service was acknowledged by most key informants. In simple terms, this means there is more demand than supply which can put pressure on the service as a whole. A small team is also vulnerable to being reliant on individuals e.g. those in management roles. Additionally staff absences and vacancies can have a big impact in further limiting capacity. The following comments provide examples:

Insufficient capacity in the service [is a challenge]. There is a lot to do, you have to juggle things constantly, keep track and worry if you may have lost track or missed something. Not sure how sustainable that is.

CADS key informant

Sometimes the capacity of the service is overestimated by stakeholders. There can be an expectation that the service can see more people and/or respond more immediately. Important to keep stakeholders informed and manage expectations.

CADS key informant

Wish there were more of them in the Auckland region. Appreciate when they are on board. Celebrate when they get new roles (like peer support role) but also know that they need more resources to do their work.

External key informant

Some also noted that it can be a challenge for a small team not to become too insular.

Small team and strong systems – good but it can get a bit dark, intense and inflexible.

CADS key informant

Being a small team there is a risk that it can become insular; developing a “siege mentality” and overworking are risks – you need to guard against that happening. Staff members get to see other services and interface with the paradigms of other services so that helps.

CADS key informant

Linked to capacity is the inefficiency of a small team providing service over a large geographical area which means that a lot of staff time is spent travelling. Clinicians have to build a vast knowledge of networks in multiple localities and it is not possible to run client groups because clients are not located within a manageable area. While this was noted by many as a challenge and in some respects a limitation, it was also stressed that a cohesive team is essential and that having a fragmented team (e.g. single clinicians attached to

community AOD or mental health teams) would create increased risk for all parties, increased stress for clinicians and a less sustainable service overall.

Being a mobile team there are some overheads in terms of travel and building up networks.

CADS key informant

Being regional there is some inefficiency, a lot of driving and it limits the group work that can be done because the clients are so spread out.

CADS key informant

The team is small and has to cover a huge area.

External key informant

It is important to have a team to support the team approach. It would not work if the team was broken up or fragmented....single staff positions sitting in AOD teams.

CADS key informant

Many also noted that alongside the challenges there are advantages in having a small team in terms of the ability to develop and maintain shared understanding of the approach, consistent ways of working and effective team communication. For example:

The team is small and while this means it can coalesce really well, it is vulnerable for example when there are resignations.

CADS key informant

RECRUITMENT AND LONG LEAD-IN TIME

It was noted that recruiting and supporting staff who are able to work across the broad scope of the service is challenging. A number of CADS and external key informants commented that “you have to recruit the right people”. CADS key informants at both managerial and clinician level noted that it takes up to a year for team members to be “fully up to speed” in their role i.e. no one comes “ready to do the job”. Depending on the level of staff turnover this can mean that the team operates ‘under par’ for periods of time and this needs to be factored in to service capacity expectations. For example:

Finding the workforce [can be a challenge]. If you want to run a professional service you have to find professionals who want to work in this area; PPS has been delivered by nurses, we are about to broaden out. Other professionals can deliver this service, it depends on how you do the work.

CADS key informant

[Staff] have to link with a huge number of services; it can take a long time to bring new staff up to speed.

CADS key informant

Getting up to speed in the role – working with domestic violence; working with the risk involved with AOD and child protection; the legal stuff – the Family Group

Conference, Family Court, lawyers, trespass orders, custody issues, protection orders – you have to understand all of these things.

CADS key informant

STRESSFUL AND CHALLENGING ROLES

Many commented that PPS work can be stressful. Many stakeholders noted the level of clinical risk that the team carries (see also below organisational risks). This requires ongoing active management. For example:

High level of stress in the role; dealing with children and their safety – it can get too much. The clients can be very hard.

CADS key informant

Supporting the nurses [is a challenge]: it's important to build resilience, staff members need a supervisor and a problem solver, they hear a lot of traumatising stories.

CADS key informant

Linked to this, many (both CADS and external) noted the tensions inherent in the child protection aspect of the service where the interests of the child may conflict with the interests of the mother and clinicians must act to ensure the well-being of the child and at the same time make every effort to keep the mother engaged in the service. PPS has developed expertise in managing this tension, however it was noted consistently as a challenge. For example:

Have to make the hard calls based on the best interests of the child and at the same time keep the client engaged.

CADS key informant

We focus on the child and sometimes have to take a hard line on that. Other services, including CADS services sometimes, don't necessarily understand. There needs to be more information, education and promotion about the service to help other services understand our role.

CADS key informant

We do a lot of things that the client does not want or like, but they stay engaged. It is all about trust and transparency, about being trustworthy.

CADS key informant

Working with family violence was consistently noted as both a stressful and necessary component of the role. A number of CADS key informants noted that training and support in this area of work is essential and emphasised the importance of risk management and a team approach as mechanisms for mitigating both the risk and the stress inherent in the work.

Very important to have training in working with domestic violence.

CADS key informant

ORGANISATIONAL RISKS

CADS key informants noted that there are organisational risks in running a service like PPS. Most acknowledged that there is a high risk that things might go wrong and a high risk of poor outcomes if things are not done well. There are also risks in being reliant on other agencies to do their part and having limited control over this. These points link back to the importance of developing strong and effective relationships with other services. For example:

There are some risks in running a service like PPS:

Failure – risk of being unsustainable; ineffective.

Political – high risk population; potential for fatality; mistakes can be made; negative consequences for doing something ‘not well’ can be big.

Staff safety – needs to be managed, for example, no details on electoral role; relationship with Police is important, good to ensure Police are aware of the service; mostly the families are well known to them.

CADS key informant

You are dependent on other agencies – you don’t have any authority over them; you don’t hold their budget – it is all about influence and working relationships. It is important to contain the caseloads to enable this to work.

CADS key informant

A NON-TRADITIONAL ADDICTION SERVICE

As noted above, PPS is not a traditional addiction service and the challenges of advocating for the ongoing provision of this service have already been noted. It is important to underscore this challenge and the importance of organisational support for the approach. For example:

There needs to be a wide organisational tolerance for working holistically. A lot of what PPS provides does not look like a typical clinical intervention. The perspective is different.

CADS key informant

CONSIDERATIONS IN REPLICATING THE PPS APPROACH

Comment from key informants raised a number of themes relevant to consideration regarding the possibility of replicating the PPS approach in other locations. These are set out below.

THE MAKE-UP OF THE TEAM

As noted, up until December 2014 PPS has employed clinicians with nursing qualifications (albeit with differing experience in a wide range of clinical contexts). Most key informants speculated that while this has been effective for PPS there is likely to be some benefit in having other disciplines represented, particularly in view of the very broad scope of the role and at the time of the evaluation, PPS was in the process of recruiting clinicians from other disciplines.¹⁴ For example:

Other professionals can deliver this service, it depends on how you do the work.
CADS key informant

Has been nurses..... I was always big on this – now I can see advantages and disadvantages.
CADS key informant

Nursing professional framework – strong boundaries. In the set up it was good to have all nurses; it is also good to have multiple perspectives.
CADS key informant

The thing is that no one professional group has the full range of expertise to work with this group. “You don’t come ready to do the job.” The expertise has to build. The staffing has to be flexible, multi-disciplinary – good at working with complexity; good at priority setting.
CADS key informant

Some added a note of caution regarding introducing non-nursing personnel, mainly in relation to covering the more medical aspects of the role, stating that nurses pick up issues that others may not know to look for. For example:

With OTs [Occupational Therapists] and SWs [Social Workers] – they still need a bit of a medical bent; need to know what to look for.
CADS key informant

The inclusion of a social worker was viewed by many as likely to provide additional benefit, and similarly an occupational therapist. The potential to include other disciplines such as counsellors and youth workers was discussed by some. The value in expanding the psychology role was also noted.

¹⁴ A PPS Social Worker Position Description is provided in Appendix 2.

Both CADS and external key informants commented that there is likely to be value in having a broader cultural representation within the team.

Would be great to have a Māori and a Pacific clinician in the team to add the broader perspective to the team.

CADS key informant

It would be great to have some Māori nurses in the team.

External key informant

Consider the best way to ensure Māori perspectives are included in the service delivery – PPS works closely with Māori services; there may be other ways.

CADS key informant

Some raised the idea that employing men might bring balance to the team and assist in engaging fathers in the service. For example:

....some gender balance might be a good thing, although it is hard to know whether a male would be as effective in this role.

CADS key informant

Could be great to have some male team members; might attract more fathers to access the service.

CADS key informant

DOES A SERVICE LIKE PPS NECESSARILY SIT WITHIN AN ADDICTION TREATMENT SERVICE SPECTRUM

Given the wide holistic scope of PPS, key informants were asked to comment on whether or not a service like PPS needs to sit within the addiction treatment spectrum. Views on this were mixed. Some commented that the service could sit within mental health or another sector provided there was high tolerance for a holistic approach and a low level of stigmatising views in regard to the client group, particularly in relation to substance use. For example:

There is low stigma/low judgement of this client group within the organisation – this is very important.

CADS key informant

Service could sit in a non-addiction service setting. AOD is a small part of what PPS does, however the clients are definitely AOD clients.

CADS key informant

Others thought the AOD focus was important given the risks to children that can be associated with parental AOD use and for this reason clinicians must have the skills to identify AOD issues and support AOD recovery. For example:

The focus on addiction is important; big risk factor for children; really valuable to work with that lens/focus.

CADS key informant

UNIVERSAL SUPPORT FOR DEVELOPING SERVICES LIKE PPS IN OTHER AREAS

All key informants are in favour of more PPS-like services being offered in other parts of New Zealand, particularly in areas of high socio-economic deprivation. The service is seen as filling a gap for a high risk group of women and children who more often than not do not access addiction treatment or other services that could assist. For example:

Roll it out in big centres and large towns; focus on high deprivation areas; use CADS team leader as a consultant to support the set up.

CADS key informant

The pressure to engage this client group will not go away. We need to create ways of doing it on a larger scale.

CADS key informant

Amazing service should be in every DHB.

External key informant

100% support services being developed in other areas. Need to be situated in areas where there is high unemployment; focused on clients that are hard to reach. Definitely need more services like PPS with clinical focus – they make the clinical palatable to the clients.

External key informant

Absolutely support more services like PPS being developed – in the community, in people's homes.

External key informant

DISCUSSION

In my role I have passion in wanting to help; I work to understand where the person is coming from, offer strategies and choices – nothing is forced; you can't bring a social service mentality; have to bring heart to the job; never give up, be consistent, let the client know "you are not a waste of time".

CADS key informant

The quote above captures the essence of the overall PPS approach. PPS provides an intensive outreach service which consistently focuses on the wellbeing of children while addressing the needs of parents and working to strengthen the home environment. Central to the approach is the unwavering focus on engaging the client and staying engaged. This is a key feature inherent in the model of service that sets PPS apart from many other services that do not have such a mandate.

The information summarised in this report suggests that the PPS model of service provides an example of a promising approach to reducing harm for children at risk and supporting equity of access to addiction treatment. Findings indicate that PPS is operating as intended and is successfully reaching and engaging the intended target audience. The service objectives and approach align with Government goals for improved outcomes for children and a multi-compartmental approach. The focus on improving a child's environment and on investing in early intervention is underpinned by available evidence.

The planned outcomes evaluation will provide further information regarding the areas in which PPS is most effective, however on the basis of the information available at present a number of conclusions may be drawn as outlined below.

CORE COMPONENTS LINKED TO SUCCESS

The following components of the PPS service have been identified as being linked to the success of the service and would need to be incorporated into service development in other areas if this is to take place.

1. An evidence-based service objective. PPS is aimed at preventing and reducing harm to children aged under three-years-old. This objective aligns with Government priorities and investment in this group is well supported by available evidence.
2. Engaging the target client group. The service is engaging clients living in low decile areas who are facing multiple issues; it is engaging a high number of Māori women. Additionally PPS is engaging a significant group who are not accessing CADS (only 24% of PPS referrals are from CADS).

3. The PPS model. Critical aspects of the PPS model have been identified as follows:
- Service philosophy/principles: Incorporate a strengths focus, support a non-stigmatising approach and mandate a holistic service scope (i.e. broad enough to encompass multiple complex issues).
 - Accessibility is enabled and barriers to entry are minimal; 39% of PPS clients self-refer.
 - Assertive outreach: Supports accessibility and engagement. Engagement is approached from both the client and service perspective, i.e. the model enables client engagement and supports the clinicians to stay engaged with the client.
 - Intensive case management: Open ended, provided to a capped caseload. This enables the client and service to work on a range of typically long standing issues and to make real gains.
 - Robust risk management combined with a team approach. The MDT meeting and clear risk assessment and management processes support both risk management and a team approach.
 - Strong effective relationships with other services: the PPS model relies on this aspect of service delivery.
4. Workforce and infrastructure. PPS is provided by a professional workforce supported by strong leadership and sited within a robust organisation where senior managers support and advocate for the service to ensure it is sustained. The professionalism within the PPS approach is evident at all levels and this appears to allow the service to weather the challenges and to provide a credible and sustainable service.

LESSONS LEARNED FROM CHALLENGES AND CONSIDERATIONS FOR REPLICATION OF PPS

There are lessons to be learned from the key challenges which have been identified. These would require consideration and careful management in the development of any PPS type service. Key challenges include:

Recruitment and lead in time: As noted, recruiting and supporting staff who are able to work across the broad scope of the service is challenging and there has to be a level of tolerance in terms of staff getting up to full speed in their roles. In the set up phase of a service like

PPS this would be exacerbated as the team would all be new and the service profile would take time to establish.

Staff support and development: Linked to the above, it is essential to build robust staff support mechanisms into the service. There are risks for professionals in working to the very edges of their professional scope, something that is inherent in this model where expertise across a wide range of issues is required. It is vital to ensure staff members receive appropriate training and ongoing support. Family violence and child protection were identified as key areas where staff are likely to need ongoing training. Additionally there are evident stressors in working with trauma, violence, abuse etc. Careful recruitment, a team approach, professional supervision and supportive and accessible leadership help to mitigate the needs. Systems are required to prevent staff from personal risk and to enable them to intervene if risk presents.

Capacity: An intensive service model is relatively costly and is therefore typically limited in capacity. The PPS experience reflects this. Making best use of limited service capacity requires active ongoing management to ensure that the service is provided to those who need it in sufficient intensity and duration to effect change. This must be balanced with the ongoing demand. Feedback suggests that active and regular review processes and communication about service scope and capacity with referrers help to mitigate limited capacity. The addition of a peer support component to actively support the disengagement/discharge phase of intervention can also help with this. As noted, while PPS has a peer support worker on the team, this could be managed in partnership with an external peer support service (where this is available).

Overheads: Inefficiency arises from having a small mobile team covering a wide geographical area. This is something that is likely to be faced by any service set up in New Zealand and is something which many key informants spoke of as inevitable. No solutions to this emerged from the evaluation. Similarly the time intensive risk management practices were also highlighted as a necessary overhead. While the costs were acknowledged, the requirements of having a co-located team and time-intensive risk management practices were consistently emphasised.

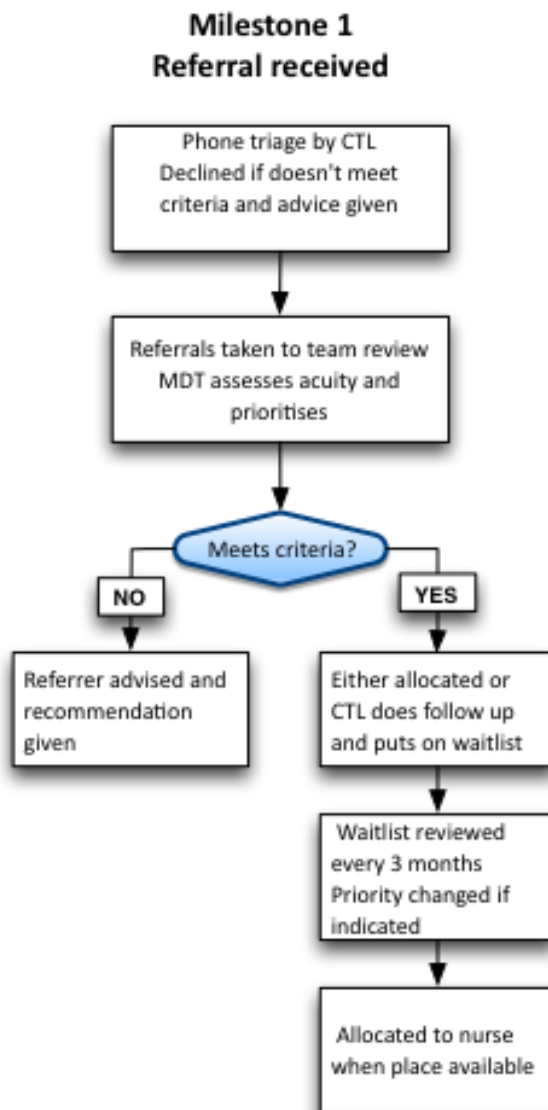
Providing the service with a 'home': This evaluation highlights the importance of placing a service such as PPS within a strong organisation. While there were mixed views on whether the larger organisation needs to be an addiction service, all feedback suggests that a PPS-type service needs a home organisation rather than being a stand-alone service. A key need is for the home organisation to be supportive of the service approach and able to ensure that clients are well supported to address their alcohol and other drug related issues.

REFERENCES

- Cavanagh, B. (2000). *Initial proposal for the establishment of a specialist pregnancy support team with Auckland Regional Alcohol & Drug Services*. Waitemata District Health Board. Auckland.
- Community Alcohol and Drugs Service. (2013). *CADS WDHB social bond pilot response form December 2013. Ministry of Health registration of interest for service outcomes and service providers*. Waitemata District Health Board. Auckland.
- Community Alcohol and Drugs Service. (n.d.). *Parental Alcohol and Drugs Service: Its history and future vision*. Waitemata District Health Board. Auckland.
- Heckman J. (2015) The case for investing in disadvantaged children. Retrieved from <http://heckmanequation.org/content/resource/case-investing-disadvantaged-young-children>
- Ministry of Health. (2014). Ministry of Health and Waitemata DHB Service Agreement. Ministry of Health. Wellington.
- Ministry of Social Development. (2012). The White paper for vulnerable children:. Volume I. Wellington: Ministry of Social Development.
- Poole, N. (2000). Evaluation report of the Sheway Project for high-risk pregnant and parenting women. Vancouver: British Columbia Centre of Excellence for Women's Health.
- Poulton, R. (2008). The nature of our nurture: Genes x environment = human behaviour. *Best Practice*(16), 4-5.
- Statistics New Zealand. (2013). 2013 Census usually resident population counts. From http://www.stats.govt.nz/browse_for_stats/population/census_counts/2013CensusUsuallyResidentPopulationCounts_HOTP2013Census.aspx
- Waitemata District Health Board. (2013). Client Pathway Pregnancy & Parental Service – CADS. Auckland: Waitemata District Health Board. Auckland.

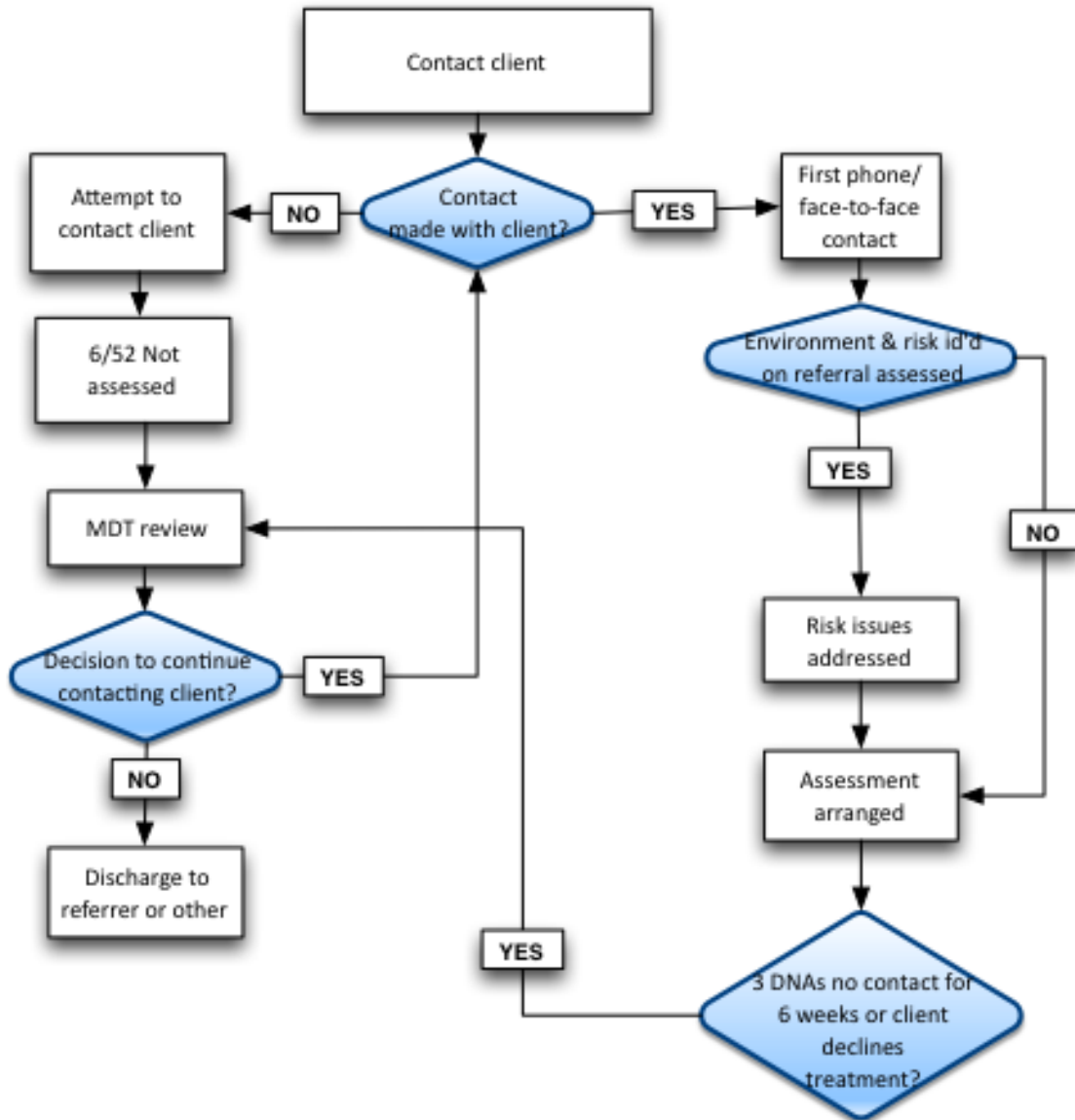
APPENDIX A PPS CLIENT PATHWAY OVERVIEW

Figure 2. PPS client pathway overview¹⁵

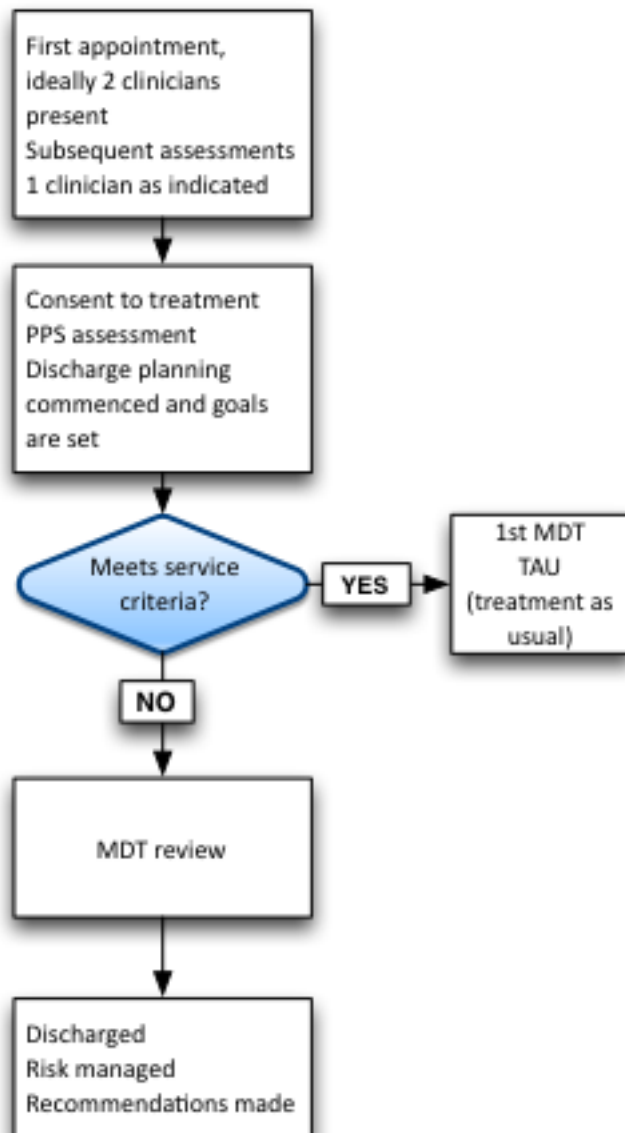


¹⁵ CADS, 2013:21-22

Milestone 2 Assertive outreach



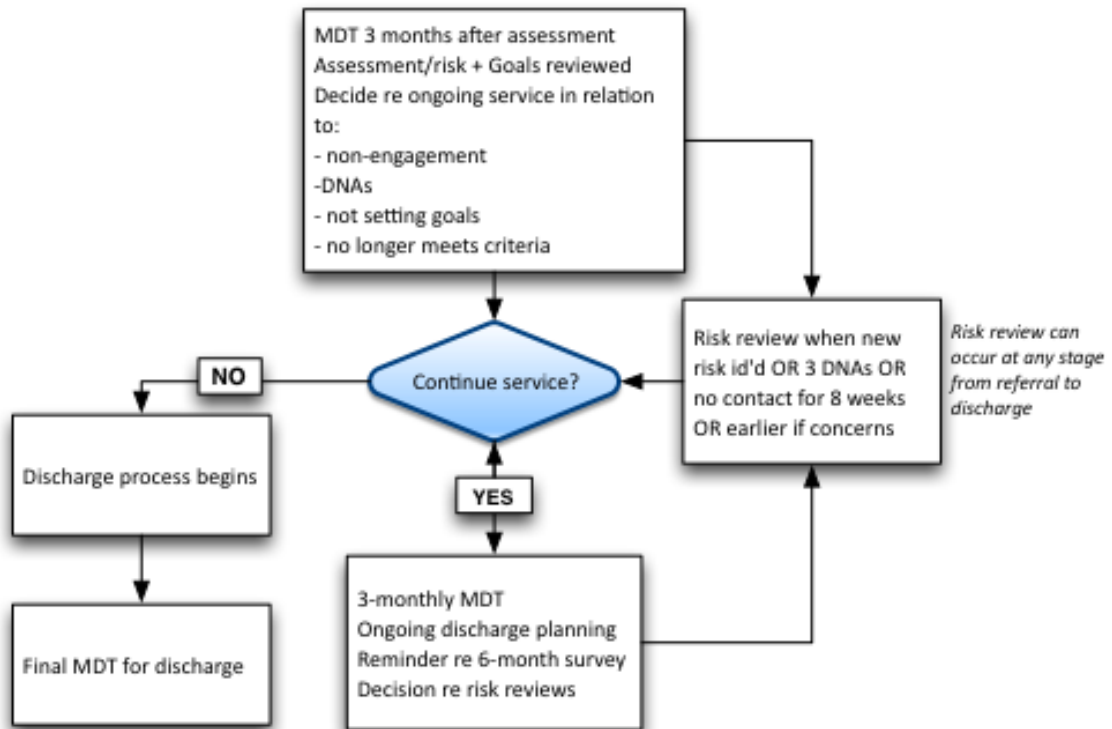
Milestone 3 Assessment process



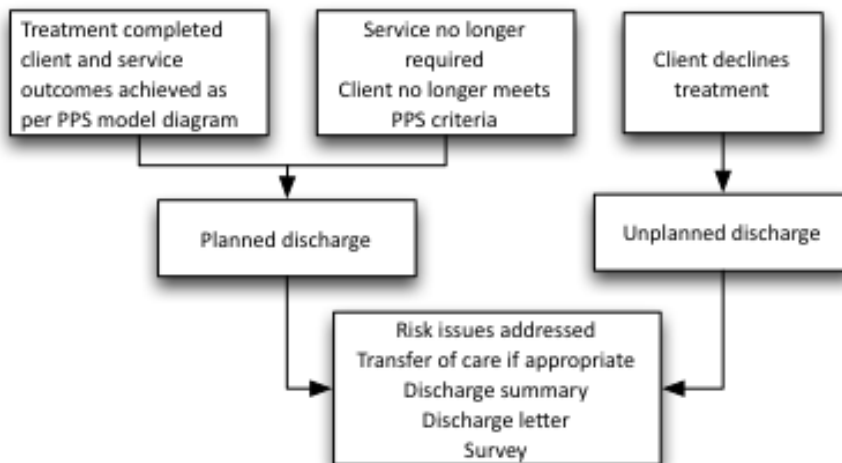
Milestone 4 Treatment as usual

Refer to PPS Model diagram

Parallel process



Milestone 5 Discharge



APPENDIX B PPS POSITION DESCRIPTIONS



Registered Nurse Pregnancy and Parental Service

Position Description

Date: August 2014

- Job Title** : **Registered Nurse**
- Department** : Pregnancy and Parental Service (PPS)
Community Alcohol and Drugs Services (CADS)
- Location** : Pitman House, 50 Carrington Road, Pt Chevalier
- Reporting To** : Clinical Team Leader, PPS
- Direct Reports** : Nil
- Functional Relationships with** : Internal
Cads Services and staff
- External
Lead maternity caregivers
Maternal mental health services
Community Mental health Services
AOD services both community and residential
Child and family focused DHB services across the Auckland region
General Practitioners
Public health nurses
Plunket
New Zealand Child Youth and Family Service
Work & Income New Zealand
Housing New Zealand
Non Governmental organisations
- Purpose** : Provision of high quality case consultation, co-ordination and case management services to clients who are pregnant or parents of children under three years of age, who experience Alcohol and Drug issues and are poorly connected to health- and social services.

KEY TASKS	EXPECTED OUTCOMES
<ul style="list-style-type: none"> Facilitate engagement and retention of clients in alcohol and other drug services, antenatal and postnatal services. 	<ul style="list-style-type: none"> Reduction of harm from the effects of alcohol and drug use to pregnancy, unborn child and children.
<ul style="list-style-type: none"> Develop and implement case coordination/goal plans in conjunction with client and relevant stakeholders. 	<ul style="list-style-type: none"> Coordinated provision of services to pregnant and parenting clients and their families/ significant others.
<ul style="list-style-type: none"> Utilise relevant expertise to contribute to multidisciplinary review. 	<ul style="list-style-type: none"> Increased awareness and management of clients' specific issues.
<ul style="list-style-type: none"> Coordination of Well-Child services. 	<ul style="list-style-type: none"> Client's child(ren) receive ongoing health and development assessments and appropriate interventions
<ul style="list-style-type: none"> Screening for child protection issues are in accordance with the CADS child protection Standard Operating Procedure and WDHB abuse reporting policy guidelines. Provide advocacy and support on custody, and care and protection issues. 	<ul style="list-style-type: none"> Appropriate action plans are developed and implemented in conjunction with child protection services. Families are supported to keep their children safe.
<ul style="list-style-type: none"> Assist client to engage with parenting interventions. Provide advocacy and support on parenting issues. 	<ul style="list-style-type: none"> Client receives information and support regarding parenting support and skills. Client is able to parent in a safe and nurturing way
<ul style="list-style-type: none"> Mental health issues are screened and appropriate referral is made. 	<ul style="list-style-type: none"> Clients have access to appropriate mental health treatment.
<ul style="list-style-type: none"> Education is provided on HIV, Hepatitis C and STD's. Screening is provided as necessary Clients are referred to appropriate treatment interventions. 	<ul style="list-style-type: none"> Client has information about HIV, Hepatitis C and STDs and access to screening. Client has strategies that reduce disease transmission, improve resistance to disease and promote good health. Client accesses care related to HIV, Hepatitis C and STDs.
<ul style="list-style-type: none"> Provide a community based outreach service to clients. 	<ul style="list-style-type: none"> Access clients who are not engaged with health and social services with the aim of engaging them in these services.
<ul style="list-style-type: none"> Alcohol and drug screening and provision of brief interventions. 	<ul style="list-style-type: none"> Development of an appropriate goal plan with the client.
<ul style="list-style-type: none"> Develop and maintain working relationships with community health, social services and Lead Maternity carers. 	<ul style="list-style-type: none"> Ensure sound communication of relevant information takes place between professionals involved in the care of pregnant and parenting clients.

KEY TASKS	EXPECTED OUTCOMES
<ul style="list-style-type: none"> • Provide advice and assistance for clients to access support services in direct relation to their social and welfare requirements. 	<ul style="list-style-type: none"> • Social and welfare needs will be met enabling clients to address alcohol and drug issues.
<ul style="list-style-type: none"> • Provide assessment and appropriate referral and advice for domestic violence issues. 	<ul style="list-style-type: none"> • To reduce harm to families from domestic violence.
<ul style="list-style-type: none"> • Provide consultation and education for CADS clinicians, other health and social agencies on issues relating to drug abuse and parenting/social needs. 	<ul style="list-style-type: none"> • Raise awareness and increase knowledge of needs specific to pregnant and parenting clients in order to improve service provision.
<ul style="list-style-type: none"> • Assist in developing and facilitating groups with an education and support focus to pregnant and parenting clients. 	<ul style="list-style-type: none"> • To increase clients knowledge to empower them to make positive life changes and to facilitate clients to support each other.
<ul style="list-style-type: none"> • Include family and/or significant others in goal planning as directed by client. 	<ul style="list-style-type: none"> • Improve family and/or significant others understanding of clients needs so they are better able to support them.
<ul style="list-style-type: none"> • To ensure the provision of high quality, evidence based practice through: <ul style="list-style-type: none"> ○ assessment ○ case management ○ crisis management ○ referral ○ liaison ○ case consultation ○ case coordination ○ multidisciplinary input. 	<ul style="list-style-type: none"> • Referred clients are assessed to determine A&D intervention and biopsychosocial needs. • Provide crisis intervention as required to ensure the immediate safety of persons concerned. • Develop therapeutic alliance with the client acknowledging and respecting diversity of cultural norms. • Treatment/referral processes are implemented using a multi-disciplinary approach and active client participation in decision making. • Internal and external liaison focuses on appropriate and timely service delivery. • Practice standards and ethical conduct conforms to the relevant statutory codes.
<ul style="list-style-type: none"> • Ongoing professional development. 	<ul style="list-style-type: none"> • Continue to develop own knowledge base and skills as required to function effectively within the alcohol and drug field generally and within CADS specifically. • Develop and maintain a high level of expertise in all issues relating to the clinical management of pregnant or parenting substance using clients, keeping abreast of new developments and research. • Attend regular supervision for purposes of reflecting on practice, enhancing clinical skills and adhering to CADS best practice standards and outputs.
<ul style="list-style-type: none"> • Proactive approach to service planning and review processes that guide actions and decision making so as to affect smooth day to day service delivery and continuous quality improvement. This includes: 	<ul style="list-style-type: none"> • Participate fully in service implementation of CADS services and WDH Policy/ Procedure, Practice Guidelines and Practice Standards and statistical reporting requirements. • Participate in and contribute to organisational reviews and audits of Policy/Procedure, Practice Guidelines and Clinical Practice Standards.

KEY TASKS	EXPECTED OUTCOMES
<ul style="list-style-type: none"> • Policies • Standards • Audits • Research • Quality • Training 	<ul style="list-style-type: none"> • Actively participate in service and CADS wide activities that promote the development of best practice standards within CADS. • Participate in and promote all research and quality initiatives within the service.
<ul style="list-style-type: none"> • To ensure that the principles of the Treaty of Waitangi are supported and implemented in delivery of service 	<ul style="list-style-type: none"> • A demonstrated commitment to understanding the implications for Maori health that are implicit in the Treaty of Waitangi and to support and participate in the organisation's commitment to bi-culturalism. • Appropriate referral to Te Atea Marino. Appropriate consultation with Te Atea Marino staff when working with Maori clients. • Attendance at Treaty of Waitangi/biculturalism training when required.
<ul style="list-style-type: none"> • Services are delivered in accordance with the philosophies, priorities and objectives of WDHB and specifically Mental Health Services and CADS. 	<ul style="list-style-type: none"> • Completes orientations and mandatory training as stipulated in the Training and Development and Team policies. • Philosophies and values are known and supported. • Consumer rights and responsibilities are actively supported. Consumer participation is actively encouraged. Functional relationships are maintained with the consumer liaison. • All conduct is ethical and confidential. • Safety standards are known and met. • WDHB's values of openness, transparency, respect, integrity and customer focus are modelled.
<ul style="list-style-type: none"> • To recognise Individual Responsibility • for Workplace Health and Safety • under the Health and Safety Act 1992 	<ul style="list-style-type: none"> • Company health and safety policies are read and understood and relevant procedures applied to their own work activities. • Workplace hazards are identified and reported, including self management of hazards where appropriate. • Can identify health and safety representative for area.

Waitemata District Health Board -JOB DESCRIPTION – Approved WT 05/08/2014

Behavioural Competencies

Adheres to Waitemata District Health Boards 4 Organisational Values of:

“everyone matters”

Every single person matters, whether a patient/client, family member or a staff member.

“with compassion”

We see our work in health as a vocation and more than a job. We are aware of the suffering of those entrusted to our care. We are driven by a desire to relieve that suffering. This philosophy drives our caring approach and means we will strive to do everything we can to relieve suffering and promote wellness.

“connected”

We need to be connected with our community. We need to be connected within our organisation – across disciplines and teams. This is to ensure care is seamless and integrated to achieve the best possible health outcomes for our patients/clients and their families.

“better, best, brilliant”

We seek continuous improvement in everything we do. We will become the national leader in health care delivery.

Our standards of behaviour:

Everyone Matters			
Welcoming and friendly	Respect each individual	Listen and understand	Speak up for others
With Compassion			
Compassion for your suffering	Attentive and helpful	Protects your dignity	Reassuringly professional
Connected			
Communicate and keep people informed	Explain clearly	Teamwork with patients, whānau and colleagues	Give and receive feedback
Better, Best, Brilliant			
Positive we can make a difference	Improve services and ourselves	Safe practice	Efficient and organised

Note: *This job description forms part of an individual's contract of employment with WDHB and must be attached to that contract.*

VERIFICATION:

Employee: _____

Department Head: _____

Date: _____

POSITION TITLE:

	Minimum	Preferred
Qualification	<ul style="list-style-type: none"> • Registered Nurse • Membership of appropriate professional body. 	
Experience	<ul style="list-style-type: none"> • Demonstrated case management and coordination skills. • Willingness/commitment to work within a harm reduction framework. • Demonstrated flexibility to undertake new tasks as required in a developing service. • Facilitate group learning - client and professional. • Excellent written and verbal communication skills. • Good physical and mental health. • Computer literate. • Current driver's license. 	<ul style="list-style-type: none"> • Five years nursing experience • Clinical experience in the alcohol and drug and/or related health and social service field. • Experience in facilitating parenting groups. • Experience in domestic violence and child protection issues. • Existing networks within government and non government health and social service agencies.



Pregnancy and Parental Service Peer Support Worker

Position Description

Date: June 2013

- Job Title** : Specialist Peer Support Worker
- Department** : Pregnancy and Parental Service (CADS)
- Location** : Pitman House
- Reporting To** : PPS CTL
- Direct Reports** : NIL
- Functional Relationships with** : Internal
- Consumers/Tangata Whai ora of PPS
 - PPS CTL and Nurse Case managers
 - Manager, CADS Counselling Service
 - CADS Consumer team

Purpose of the Position : Peer support is based on the concept that people who have had a lived experience of addiction and have experienced recovery can engender hope by providing support and demonstrating recovery.

The purpose of the position is to provide individualised support to PPS clients through the development of strong, supportive and equitable relationships.

Peer support is not like clinical support, nor is it about being friends. There is *mutual responsibility* across peer relationships.

Peer support promotes *critical learning* and the re-naming of experiences.

The culture of peer support provides a sense of *community*.

There is great *flexibility* in the kinds of support peers provide.

Peer support is being clear about and *setting limits* and involves sophisticated levels of *safety*.

Peer support activities, meetings and conversations are *instructive*.¹⁶

¹⁶ Cheryl MacNeil, Ph.D. and Shery Mead, M.S.W. (2003). Understanding What Useful Help Looks Like: The Standards of Peer Support

KEY TASKS	EXPECTED OUTCOMES
<p>To support people to become more active participants in their own recovery process by demonstrating the five Pathways to Recovery:</p> <ul style="list-style-type: none"> • Hope. • Choice. • Empowerment. • Recovery environment. • Spirituality, meaning and purpose. 	<ul style="list-style-type: none"> • PPS consumers receive direct peer support (1:1 or as a group). • PPS consumers are supported to connect to and participate in the wider community. • PPS consumers are assisted to develop their own natural supports and are supported to learn self-advocacy. • PPS consumers are assisted to identify ways they can become more active participants in their own recovery process. • Waitemata District Health Board values of openness, respect, integrity, consumer/ customer focus, compassion modelled.
<p>To establish, develop and maintain a supportive relationship with consumers and their families/wharau, recognising the diversity of people's culture and providing support that is culturally safe, sensitive and appropriate.</p>	<ul style="list-style-type: none"> • Consumers informed of relevant information and supported to make useful connections with these resources eg through maintaining knowledge of community and mental health resources. • Productive relationships developed with consumers and the PPS team enabling consumers to participate in their own recovery process. • Information provided to the PPS team from a specialist peer support worker's perspective. • Nurse/case manager is informed of any issues identified relating to risk and kept updated regarding ongoing goal planning with consumers. • All consumers responded to without regard to their background or history. • Assistance provided in a concise, informative manner using a strengths-based approach.
<p>Attend to own personal and professional development.</p>	<ul style="list-style-type: none"> • Ability to manage own addiction/dependence/treatment/recovery demonstrated. • Relevant training and education specific to specialist peer support undertaken. • Own learning needs identified and development goals set to meet these needs. • Meetings with consumer team attended. • Contact with consumer advisor maintained.

KEY TASKS	EXPECTED OUTCOMES
To ensure that the principles of the Treaty of Waitangi are supported and implemented in delivery of service.	<ul style="list-style-type: none"> • A demonstrated commitment to understanding the implications for Maori health that are implicit in the Treaty of Waitangi and to support and participate in the organisation's commitment to bi-culturalism.
To acknowledge the cultural and social differences of all groups.	<ul style="list-style-type: none"> • Consult and work cooperatively with culturally appropriate staff (Tupu and Te Atea Marino).
Services are delivered in accordance with the philosophies, priorities and objectives of WDHB and specifically MHSG and CADS.	<ul style="list-style-type: none"> • Orientation and necessary training completed. • Philosophies and values are known and supported. • Consumer rights and responsibilities are actively promoted and supported. • All conduct is ethical and confidential. • Safety standards are known and met.
To recognise Individual Responsibility for Workplace Health and Safety under the Health and Safety in Employment Act 1992.	<ul style="list-style-type: none"> • Company health and safety policies are read and understood and relevant procedures applied to their own work activities. • Workplace hazards are identified and reported, including self management of hazards where appropriate. • Can identify health and safety representative for area.

Behavioural Competencies

Adheres to Waitemata District Health Boards four Organisational Values of:

“everyone matters”

Every single person matters, whether a patient/client, family member or a staff member.

“with compassion”

We see our work in health as a vocation and more than a job, We are aware of the suffering of those entrusted to our care. We are driven by a desire to relieve that suffering. This philosophy drives our caring approach and means we will strive to do everything we can to relieve suffering and promote wellness.

“connected”

We need to be connected with our community. We need to be connected within our organisation – across disciplines and teams. This is to ensure care is seamless and integrated to achieve the best possible health outcomes for our patients/clients and their families.

“better, best, brilliant”

We seek continuous improvement in everything we do. We will become the national leader in health care delivery.

Behavioural Competencies	Behaviour Demonstrated
Communicates and works cooperatively	<ul style="list-style-type: none"> Actively looks for ways to collaborate with and assist others to improve the experience of the healthcare workforce, patients & their families and the community and Iwi.
Is committed to learning	<ul style="list-style-type: none"> Proactively follows up development needs and learning opportunities for oneself and direct reports.
Is transparent	<ul style="list-style-type: none"> Communicates openly and engages widely across the organisation. Enacts agreed decisions with integrity.
Is customer focused	<ul style="list-style-type: none"> Responds to peoples’ needs appropriately and with effective results Identifies opportunities for innovation and improvement
Works in partnership to reduce inequality in outcomes	<p>Works in a way that:</p> <ul style="list-style-type: none"> demonstrates awareness of partnership obligations under the Treaty of Waitangi shows sensitivity to cultural complexity in the workforce and patient population ensures service provision that does not vary because of peoples’ personal characteristics.
Improves health	<ul style="list-style-type: none"> Work practices show a concern for the promotion of health and well-being for self and others.
Prevents harm	<ul style="list-style-type: none"> Follows policies and guidelines designed to prevent harm. Acts to ensure the safety of themselves and others.

VERIFICATION:

Employee: _____

Department Head: _____

Date: _____

PERSON SPECIFICATION

POSITION TITLE: Consumer Liaison

	Minimum	Preferred
Experience	<ul style="list-style-type: none"> • Personal experience as a consumer of alcohol and other drug services. • Training and/or experience in Peer support or related work • Knowledge of consumer issues. 	<ul style="list-style-type: none"> • Peer Support Specialist Certificate
Skills/Attributes	<ul style="list-style-type: none"> • Ability to network and liaise with consumers while maintaining professionalism. • Clear verbal, written and interpersonal communication skills including tact, diplomacy and confidentiality . • Exercises sound judgment and negotiation. • Has working knowledge of The Code of Health and Disability Services Consumers' Rights and other relevant legislation e.g. Privacy Act. • Understands and is committed to the principles of a recovery and strengths-focused approach. • Ability to motivate consumers and to model a hopeful and encouraging attitude. • Ability to work in a Multi Disciplinary Team (MDT) and respect the skills and strengths of others in the team. • Excellent communication skills (especially listening). • Good time management. • Ability to work independently and as part of a team. • Culturally safe/sensitive with a commitment to the Treaty of Waitangi. 	

	<ul style="list-style-type: none"> • Knowledge of community resources. • Clear understanding and appreciation of consumer and family/whānau culture and dynamics. • Ability to identify personal limits. • Able to work under pressure. • Able to think innovatively and show initiative. • Driver's license. • Self confident and self motivated. • Sense of humour. • Have an established personal support system. 	<ul style="list-style-type: none"> • Attended Treaty of Waitangi workshops and/or training.
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