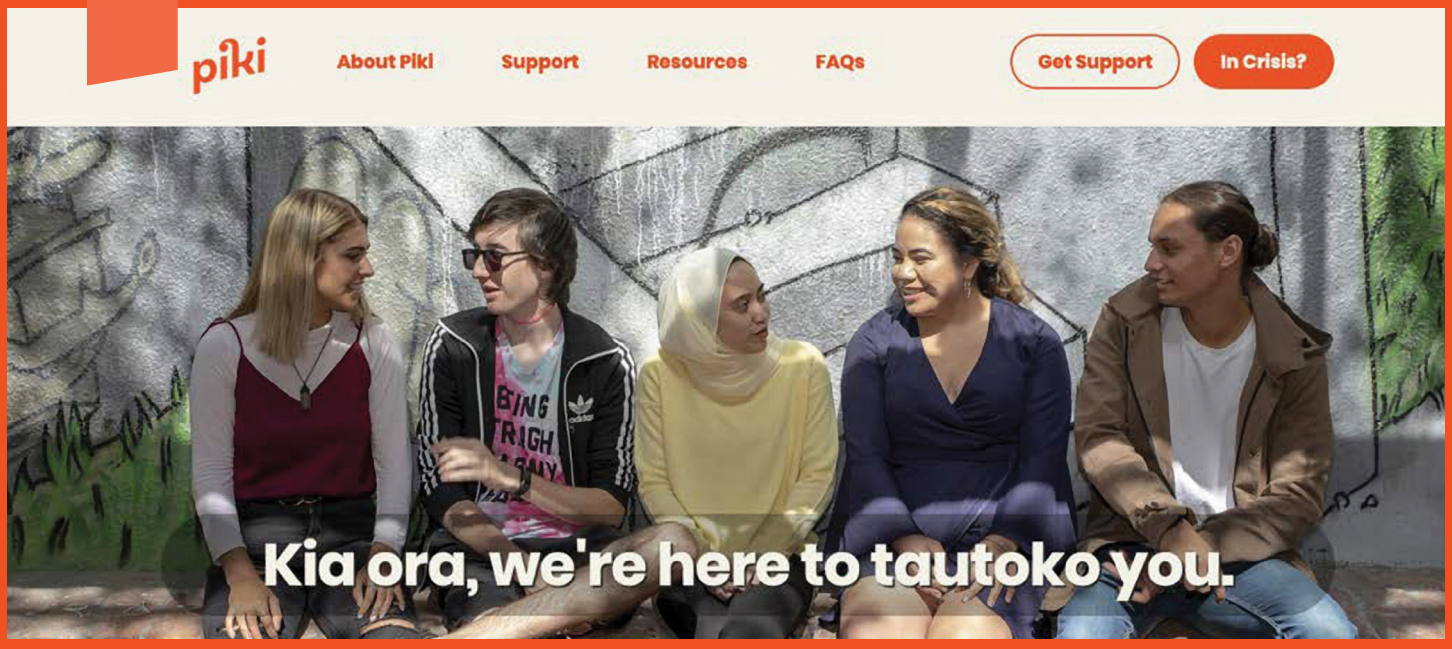
Evaluation of the Piki Pilot Project
(January 2019 – December 2020)

INTEGRATED THERAPIES FOR 18-25 YEAR OLDS

Final Report: Summary and Recommendations

May 2021



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CONTENTS

KEY POINTS

What is Piki?

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

Why was Piki established?

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

What did Piki aim to achieve?

The overall aims for the pilot service were:

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

How did we do the evaluation?

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

What innovations did Piki test?

Key innovations included in the pilot were:

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

Elements of success

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

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

Challenges

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

Challenges included:

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

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

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

Key recommendations

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

FULL EXECUTIVE SUMMARY

1. Introduction

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

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

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

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

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

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

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

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

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

a Now *Whakarongorau* Aotearoa

2. Methodology

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

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

QUANTITATIVE METHODOLOGY

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

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

QUALITATIVE METHODOLOGY

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

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

3. Programme description and development over time

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

GOVERNANCE AND OPERATIONAL GROUPS

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

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

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

KEY FEATURES OF THE PROGRAMME

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

WORKFORCE COMPOSITION AND TRAINING

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

CLIENT JOURNEYS AND CLINICAL PATHWAYS

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

BRANDING, PROMOTION & MARKETING

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

DEVELOPMENT BEYOND THE EVALUATION TIMEFRAME

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

4. Outcomes & Effectiveness – Piki Service Overall

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

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

DESIGN AND MANAGEMENT PROCESSES

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

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

OVERALL SERVICE UTILISATION

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

PSYCHOLOGICAL MEASURES

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

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

EQUITY AND TARGET POPULATIONS

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

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

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

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

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

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

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

SERVICE ACCESSIBILITY AND FLEXIBILITY

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

5. Outcomes & Effectiveness – Piki Components

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

THERAPY

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

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

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

PEER SUPPORT

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

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

Suggestions for improvement from interviews and the surveys included:

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

DIGITAL MENTAL HEALTH APP (MELON)

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

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

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

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

PUĀWAITANGA / 1737

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

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

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

WEBSITE/ SELF-REFERRAL

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

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

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

TELEHEALTH DELIVERY BY IN-PERSON SERVICE PROVIDERS

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

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

INTEGRATION OF PIKI SERVICE COMPONENTS AND INFRASTRUCTURE

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

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

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

6. Discussion and conclusions

DISCUSSION

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

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

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

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

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

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

CONCLUSIONS

Overall

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

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

Equity and priority populations

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

'Co-design'

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

Therapy models, duration, and intensity

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

Peer support

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

Telehealth and digital options

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

Impact of COVID-19

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

Evaluation

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

RECOMMENDATIONS

Key messages

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

Recommendations for the current Piki service in the Wellington region

Continuation

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

Implementation of equity & targeting focus

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

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

Model of care and workforce capability

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

Digital elements

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

Lessons for wider scale up and roll out

General recommendations

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

Innovation transfer from the Piki pilot

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

Equity, 'co-design' and engagement

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

Workforce

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

Therapy

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

Outcome and utilisation measures and evaluation

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

NOTES ON TERMINOLOGY

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

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

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

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

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

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

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Evaluation of the Piki Pilot Project
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INTEGRATED THERAPIES FOR 18-25 YEAR OLDS

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