



IMPAIRED DRIVING REHABILITATION PROGRAMMES

Evaluation Report

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Executive Summary

Impaired driving is a significant issue in Aotearoa New Zealand, leading to crashes, injuries, and deaths. The Impaired Driving Rehabilitation (IDR) Programmes aim to reduce reoffending, harmful substance use, and antisocial attitudes to driving while impaired. The programmes, established in 2014, work with recidivist drink or drug driving offenders. It is currently delivered by 10 providers across the country, including NGOs and one Health New Zealand Te Whatu Ora (Health NZ) district. Health NZ engaged Dovetail to conduct a whole-of-service evaluation to capture the impacts and benefits of the IDR programmes on health, social and community outcomes.

The evaluation took place between July 2023 and October 2024. It involved: interviews with participants (n=35), providers (n=27) and other stakeholders (e.g. whānau, probation and police officers) (n=6); an online survey n=104); review of programme data and documentation, including end-of-programme evaluation forms; and economic analysis. It was underpinned by the Value for Investment (Vfi) evaluation approach, which helps determine whether an investment is worthwhile on the basis of observable features of programme delivery, immediate outcomes, contribution to longer-term outcomes, and agreed definitions (i.e. criteria and levels of standards) of what good performance and value would look like.

Findings are primarily structured around six Key Evaluation Questions (KEQs) and overarching themes set out in a ‘theory of value creation’: equitable and economic resource management; programme delivery that is equitable and efficient; and the effective generation of social value for families, communities and taxpayers. Findings also cover participant demographics and characteristics and satisfaction. There are several limitations with this evaluation and these are outlined in the body of the report.

Participant demographics and characteristics

The IDR programmes mainly serve repeat impaired drivers as intended, with referrals from various sources including the Department of Corrections, self-referrals, police, judges, and addiction treatment services. Data from 2018/19 to 2023/24 shows that most referrals came from the Department of Corrections. The majority of participants were male (86%) and had Māori and European ethnicities. Participant needs centre on criminogenic, psychosocial, engagement, and cultural needs.

KEQ1: In what ways and for what purposes have the IDR programmes design and delivery evolved?

A mix of new and existing programmes were contracted under the IDR initiative. Providers were initially supplied with evidence-based guidelines to facilitate design and development of these. The core content has remained largely consistent, with providers making updates to reflect new knowledge and practices. Meanwhile, providers have focused on improving accessibility, relevance and effectiveness of their programmes.

This has involved experimenting with and/or making changes around programme length and/or duration, delivery days and times, cultural responsiveness, delivery location, drug related content and processes for managing waitlists. Some providers have also moved to more collaborative approaches and tried different ways to address transport barriers. Further, some changes have occurred in terms of group sizes (e.g. sometimes smaller than the intended 10-12) and to post-programme follow-up processes.

KEQ2: In what ways do the IDR programmes create value, and for whom?

Since 2014, the Ministry of Health has contracted with 10-11 services¹ for IDR programmes, with a view to contributing to a reduction in mortality and morbidity caused by road crashes, reducing re-offending and reducing harm caused by alcohol and other drugs. The annual cost between 2021 and 2023 for the nine programmes included in this evaluation was \$726,000. Overall, these programmes can be shown to generate value through equitable and economic resource management, equitable and efficient programme delivery and the generation of social value for families, communities and taxpayers.

In particular, Health NZ and providers have leveraged existing knowledge (including lived experience), networks and resources. Key programme elements, such as evidence-based, holistic approaches that incorporate te ao Māori and kaupapa Māori practices contribute to equitable and efficient programme delivery, as did strategic design decisions, such targeting funding to areas where it would provide best value for money. These approaches support good engagement, improved wellbeing and better decision-making and consequently, expected programme outcomes.

Evaluation evidence indicates that the IDR programmes reduce impaired driving among participants and the likelihood of incarceration. They also support improved life outcomes across a number of different life domains (e.g. health, employment, family, etc.). An area of value for providers is that the programmes serve as a gateway to their additional services.

Although findings suggest that the IDR programmes may contribute to fewer dangerous driving incidents – through reduced impaired driving – data is insufficient to confirm this. Overall, the programme is well-positioned to promote more efficient use of government resources by potentially lowering costs associated with road deaths, serious injuries and the justice system.

KEQ3: To what extent is current programme delivery meeting the needs of programme participants?

This KEQ explores the extent to which programme delivery meets the needs of participants through the Vfl domains of 'equitable and economic recourse

¹ Since 2023, there have been 10 programmes.

management’ and ‘programme delivery that is equitable and efficient’. Overall, we have rated the IDR programmes ‘good’ in terms of the pre-agreed evaluation criteria² for both these domains. Key findings are summarised in Table 1 and Table 2.

We also note that satisfaction with the IDR programmes was high. Survey respondents and interviewees alike would recommend them to others. Facilitators were considered professional, caring and knowledgeable and the programme described as eye-opening, educational, supportive and life changing.

Table 1: Equitable and economic resource management – rationale and judgement

| Vfl criteria | Key findings/rationale | Judgement |
|--|---|-----------|
| Equitable and economic resource management | Existing knowledge, experience and infrastructure has been leveraged, but there is an opportunity for shared learning across the programmes. | Good |
| | Lived experience is integrated into service design and delivery and is impactful. Consumer voice informs programme development in various ways. | Excellent |

Table 2: Programme delivery that is equitable and efficient – rationale and judgement

| Vfl criteria | Key findings/rationale | Judgement |
|---|---|-------------------|
| Evolving and improving service delivery | Providers have processes in place for assessing effectiveness, including screening tools, and adapt accordingly. Some providers measure impact, but there is no coordinated approach across programmes. | Good |
| | Most participants are fully engaged and meet requirements of the programme. However, one quarter of those assessed do not participate in the programmes. This may be an area for further development. | Good |
| Valuing te ao Māori/Kaupapa Māori | Te ao Māori and kaupapa Māori approaches are highly valued and actively applied. | Good to Excellent |
| Tailoring delivery | Facilitators have the appropriate training and experience to deliver group therapy/education enabling sufficient flexibility to meet needs. | Good |

² Performance against these criteria have been assessed using a set of standards developed through the evaluation design process (detailed in Appendix 2): poor, adequate, good and excellent.

| | | |
|--|---|-----------|
| Non-clinical environment | All programmes are delivered in suitable settings and kai provided. | Good |
| Use of accepted and well-evidenced psychological interventions | All programmes draw on and apply evidence-based psychological interventions (e.g. Cognitive Behavioural Therapy) as well as other accepted and contractually specified approaches. The interactive approach supports engagement and learning. | Excellent |
| Health and wellbeing focus, non-judgmental, non-punitive | A holistic view on health and wellbeing is evident. Participants feel comfortable sharing and trust the process and appear to feel empowered to make changes. | Excellent |
| Whānau connections are built on to support behaviour change | Whānau awareness of participants' involvement is high, but whānau attendance, engagement and influence on change vary depending on programme design. | Good |
| | Whānau relationships are reflected on in all programmes and connections strengthened. | Good |

KEQ4: To what extent are valued outcomes being achieved by programme participants?

Participants attributed several positive outcomes to their participation in the IDR programmes. These changes were mentioned consistently across all programmes, through the survey, interviews and align with the expected outcomes of the programme. They include:

- Increased awareness of alcohol and other drug use.
- Reduced alcohol and other drug harmful use and dependency.
- Increased empathy with victims.
- Changed attitudes to driving while impaired.
- Participants learning and applying alternative strategies to driving while impaired and planning ahead.
- Improved self-efficacy.

These can be seen as necessary preliminary steps to reducing rates of driving under the influence and were corroborated by providers' end-of-programme evaluation forms, follow-up data, whānau surveys and screening tool results.³ There is also evidence that what is being learnt is being shared with family, friends and colleagues, indicating that the IDR programmes have potential to contribute to desired outcomes beyond programme participants.

³ This was available to varying degrees across providers.

KEQ5: What factors contribute to positive outcomes, and what are the barriers to achieving these?

Based on feedback from interviews with participants, providers, and other stakeholders, we identified several factors that contribute to, and inhibit, positive outcomes. Success factors centre on accessibility and transportation, external collaboration and relationships, comprehensive assessment, tailored delivery and content structure, effective facilitation, whanaungatanga, provision of kai, motivation, programme completion and external support (e.g. family). Barriers centre on resourcing and contracting, capacity issues, change in sentencing practices, delivering forensic programme in a health setting, participant characteristics and offending history and a lack of systemic approach for coordinating programmes through the justice system and services.

KEQ6: To what extent does the IDR programmes provide value for the resources invested?

The VfI approach emphasises that ‘value for resources invested’ encompasses not only return on investment through systematic cost-benefit analysis but also the broader social value created by a programme. As such this KEQ explores the extent to which the IDR programmes provide *enough* value through the last VfI domain ‘effective generation of social value for families, communities and taxpayers. It also explores the overall IDR programme’s benefits in monetary terms relative to its costs.

Effective generation of social value for families, communities and taxpayers

Overall, we made the evaluative assessment, against the pre-agreed criteria, that the IDR programmes generate ‘good’ social value for families, communities and taxpayers. However, the extent to which they do so for different criterion vary as illustrated in Table 3.

Table 3: Effective generation of social value for families, communities and taxpayers – rationale and judgement

| VfI criteria | Key findings/rationale | Judgement |
|---|---|--|
| Fewer dangerous driving incidents and crashes affecting communities | Self-reporting, other stakeholders’ observations and provider evaluations suggest that the IDR programmes contribute to a reduction in driving under the influence. This could be substantiated by improving future collection of outcome data. | Adequate (with limited data available) |
| Participants experience improved life outcomes | Participants can identify a range of positive changes across several and/or significant life domains since completing the programme. | Excellent |

| | | |
|---|--|--------------------------|
| Learning supports programme development, is shared more broadly and contribute to evidence base | The opportunity to build a knowledge base and community of practice around IDR programmes has not to date been realised. | Not meeting expectations |
|---|--|--------------------------|

Economic analysis

From available data, the nine providers of IDR programmes being evaluated received funding of \$1.45m over a two-year contract from 1 July 2021 to 30 June 2023, or around \$726,000 per year. Given the average cost per fatal crash for 2022 of \$16.1 million, if this funding enabled the programmes to prevent one fatal crash per 22 years on average, the social benefits would justify the funding provided to the programmes.

The current evidence on the outcomes and effectiveness of the IDR programmes is insufficient to quantify benefits in terms of crashes avoided. However, positive indicators suggest that the programmes generate social value, even if economic value cannot be quantified. To fully assess the return on investment, a more consistent data-gathering approach by all providers is needed, along with a coordinated study of the programmes' impact on road safety. Detailed data requirements for this analysis are outlined in Appendix 6 of the report

KEQ7: What key insights might inform future programme development?

Based on the evaluation findings overall, and the ratings provided against individual VfI domains, we rate the IDR programmes as providing a 'good' value for investment. Findings indicate that the IDR programmes achieve equitable and economic resource management and equitable and efficient programme delivery. They also suggest that the programmes generate social value, but the extent to which they do so is difficult to ascertain with the data at hand. National and regional level insights to inform future programme development are provided. They centre on continued investment, understanding impact, commissioning and funding, changes to sentencing and the IDR programmes in the wider AOD context. Programme level insights are also provided, including aspects of programme delivery that could be applied more widely.

1. Introduction

This evaluation

This document details the findings of an evaluation of the Impaired Driving Rehabilitation programmes (the IDR programmes), applying a Value for Investment (VfI) approach. It is a whole-of-programme evaluation, spanning processes, outcomes and

learning from across 9 of 10 IDR programmes,⁴ and not an evaluation of each individual programme. The evaluation sought to provide:

- An understanding of the design process of the IDR programmes and the evolution of programmes since initial implementation, including responsiveness to participants, whānau and community.
- An exploration of the unique characteristics of each programme, their content, and the extent to which each incorporate Kaupapa Māori and mātauranga Māori notions of rehabilitation.
- An understanding of the impacts and outcomes of the IDR programmes, and the contribution that different approaches are making to outcomes.
- Considerations for potential future service delivery, including emerging and promising practices and service configurations/continuity.

This report is structured into 10 substantive sections that provide contextual information, our approach and the overall synthesis of findings.

- Section 1 provides background information.
- Section 2 details the evaluation design and methods.
- Section 3 shows participant demographics and characteristics.
- Section 4 outlines how the IDR programmes has evolved over time.
- Section 5 explores the way in which the IDR programmes create value, and for whom.
- Section 6 looks at the extent to which the IDR programmes meet participant needs, measured against the pre-agreed evaluative criteria.
- Section 7 looks at the extent to which desired outcomes are achieved.
- Section 8 explores factors that contribute or inhibit successful outcomes.
- Section 9 looks at the extent to which the IDR programmes provide value for the resources invested, measured against the pre-agreed evaluative criteria. It also contains the economic analysis.
- Section 10 provides key insights for future programme development.

There are also appendices to this report that provide more detailed information on methodology, detailed data sources/findings, programme information and data collection opportunities.

Background to this research

Impaired driving is a significant contributing factor in motor vehicle crashes, serious injuries and road deaths in Aotearoa New Zealand. In 2020/21 over 15,000 New

⁴ One programme did not contribute to the data collection phase so has not been included in the evaluation.

Zealanders were convicted of driving while under the influence, and in 2020 162 road deaths involved the use of alcohol or other drugs (NZ Drug Foundation, 2022). Impaired driving is, therefore, a persistent problem and of serious concern for road safety and the safety of others.

NZ Transport Agency Waka Kotahi (Waka Kotahi) has identified Impaired Driving Rehabilitation (IDR) programmes as a key component within the 'Road to Zero' road safety strategy 2020-2030. These programmes have the potential to contribute to a reduction in mortality and morbidity caused by road crashes, reduced re-offending by programme participants, and a reduction in harm caused by alcohol and other drugs.

The Ministry of Health established the IDR programmes in 2014, which were subsequently administered by Health New Zealand Te Whatu Ora (Health NZ).⁵ The programmes were set up to work with recidivist drink or drug driving offenders to:

- Reduce reoffending.
- Reduce alcohol and other drug harmful use and dependency.
- Change antisocial attitudes to driving while impaired.
- Increase victim empathy.
- Provide education on alternative strategies to driving while impaired and the importance of planning ahead.

The IDR programmes

When the IDR programmes were first initiated, a mix of 11 existing and new programmes were funded. Today, the programmes are delivered by 10 providers across New Zealand, including nine non-governmental organisations (NGOs), one Health NZ district (Te Tai Tokerau) and four Hauora Māori partners. The programmes covered in this evaluation (9), and their locations, are outlined in Table 4.

Service delivery is course-based, and typically involves a series of workshops of variable length and duration conducted either on the weekend or during weekday days or evenings. Providers incorporate a range of activities, with participants given the opportunity to take part in group discussions and interactive role play, practice new skills, and reflect on their learning. Topics covered vary considerably and range from those linked to alcohol and other drug use (e.g. relapse prevention) through to problem-solving skills and stress management strategies.

In addition to offenders convicted of repeat drink or drug driving the IDR programmes may also include first time offenders with a particularly high alcohol level. In some

⁵ The Ministry of Health was the original contract holder for the IDR programmes. It is now managed by Health NZ. Hauora Māori Services Directorate administers contracts with Māori partners.

programmes, whānau members or other support people are invited to participate alongside participants.

Table 4: Programme details

| Provider | Programme | Geographic coverage |
|--|---|--|
| Harmony Pasifika | One for the Road | Greater Auckland, rural Waikato (e.g. Thames, Te Awamutu) |
| Manaaki Ora Trust (Manaaki Ora) | Waka Ora | Health NZ Lakes' catchment area. Extends to Turangi, Taupo |
| Odyssey House Trust Christchurch (Odyssey House) | Driving Change | Christchurch and surrounding areas (e.g. Rangiora, Kaikoura) |
| Ngāti Kahu Hauora | Intensive Drink Driving Programme | Western Bay of Plenty |
| Eduk8 Charitable Trust (Eduk8) | The Right Track Repetitive Impaired Driver (TRTRID) | Waikato |
| Health NZ Te Tai Tokerau | Impaired Driving Programme | Whangarei (used to also cover Mid and Far North, Dargaville) |
| Downie Stewart Foundation | He Waka Hou | Dunedin |
| Te Paepae Arahi Trust (Te Paepae Arahi) | Impaired Drivers Awareness Course (IDAC) | Wellington region, including Kapiti Coast |
| Tūhoe Hauora Trust (Tūhoe Hauora) | He Waka Oranga | Eastern Bay of Plenty |

2. Approach and methods

Value for Investment

Our evaluation is underpinned by the Value for Investment (Vfi) evaluation approach. This interdisciplinary approach, combining methods from programme evaluation and economics, helps determine whether an investment is worthwhile on the basis of observable features of a programme such as its resource investment, delivery, immediate outcomes, contribution to longer-term outcomes. In line with the Vfi approach, the evaluation developed a 'theory of change' and a Vfi-specific 'theory of value creation'.

- A theory of change provides an important reference point for understanding the intended process of change and outcomes, contributing to programme definition and theory-based approaches to causal inference.
- A theory of value creation (or value proposition) details the ways in which an intervention, programme or service is intended to use resources economically, efficiently, effectively, equitably and create sufficient value to justify the resources used (i.e. value for money).^{6,7}

The theory of change and the theory of value creation for the IDR programmes are summarised in Figure 1. This Vfl evaluation focuses primarily on the *theory of value creation* (grey boxes on right hand side of diagram), but also takes into consideration the theory of change. Of note is that the Vfl approach differentiates between impact and value.

- Impact: Real differences in people, places and things, caused by organisational actions (this includes short to long-term outcomes; intended/unintended; and can be measured using a range of both qualitative and/or quantitative methods).
- Value: The merit, worth, or significance that people and groups place on something.⁸

Consequently, the ‘social value’ items in the top grey box of the theory of value creation are different from the impacts at the top of the theory of change (Figure 1). The theory of change and theory of value creation were developed through engagement processes with Health NZ and provider stakeholders in the design phase of the evaluation, where we identified aspects of impacts and value that particularly mattered to them. For a more detailed description of the Vfl approach and the theory of change and theory of value creation, see Appendix 1.

Key Evaluation Questions

The Key Evaluation Questions (KEQs) guide the evaluation and provide a structure for reporting. Answering the KEQs enables ‘testing’ of the theory of change and theory of value creation and identifies what could be improved. The following KEQs were developed in collaboration with stakeholders and guided the evaluation:

1. In what ways and for what purposes have the IDR programmes design and delivery evolved?
2. In what ways do the IDR programmes create value, and for whom?

⁶ King J. 2021. Expanding theory-based evaluation: incorporating value creation in a theory of change. *Evaluation and Program Planning*

⁷ More information on theories of value creation can be found at <https://www.julianking.co.nz/vfi/tovc/>

⁸ Gargani J, King J. 2024. Principles and methods to advance value for money. *Evaluation*, 30(1), 50-68. DOI: 10.1177/13563890231221526

3. To what extent is current programme delivery meeting the needs of participants?
4. To what extent are valued outcomes being achieved by participants?
5. What factors contribute to positive outcomes, and what are the barriers to achieving these?
6. To what extent do the IDR programmes provide value for the resources invested?
7. What key insights might inform future programme development?

Evaluation criteria and standards

Another key aspect of the Vfl approach is the use of evaluation criteria and standards (collectively referred to as 'rubrics'). Rubrics provide a transparent way of making evaluative judgements, by explicitly identifying how well the programme is expected to perform against key criteria (aspects of performance) and standards (levels of performance). Subsequent to the evaluation planning activity with Health NZ and IDR programme providers, a detailed set of criteria and standards were developed, agreed and used to guide transparent evaluative judgements made throughout Sections 6 and 8 of this report. These are summarised in Appendix 2.

Data collection

A detailed evaluation framework and data collection tools were developed and approved by Health NZ, and subsequently Aotearoa Research Ethics Committee (AREC24_05) which then enabled data collection to proceed.

The following data collection streams were used:

- Interviews⁹ (group and individual) with past (n=23) and current (n=12) participants, and whānau (n=1).
- An online survey of past (n=41) and current participants (n=63).
- Interviews with provider leadership and programme facilitators (n= 27) across nine providers.
- Interviews with other stakeholders such as probation officers, police officer and a judge (n=5).

In addition, programme data, end-of-programme evaluation forms, narrative reporting and self-commissioned evaluations supplied by Health NZ and providers were analysed for reflection against the KEQs and evaluation criteria. Table 19 and Table 21 in Appendix 3 shows how data is spread across providers.

Participating programme participants were initially approached by providers to gauge their interest in taking part in interviews and/or the survey. Whilst this means that the

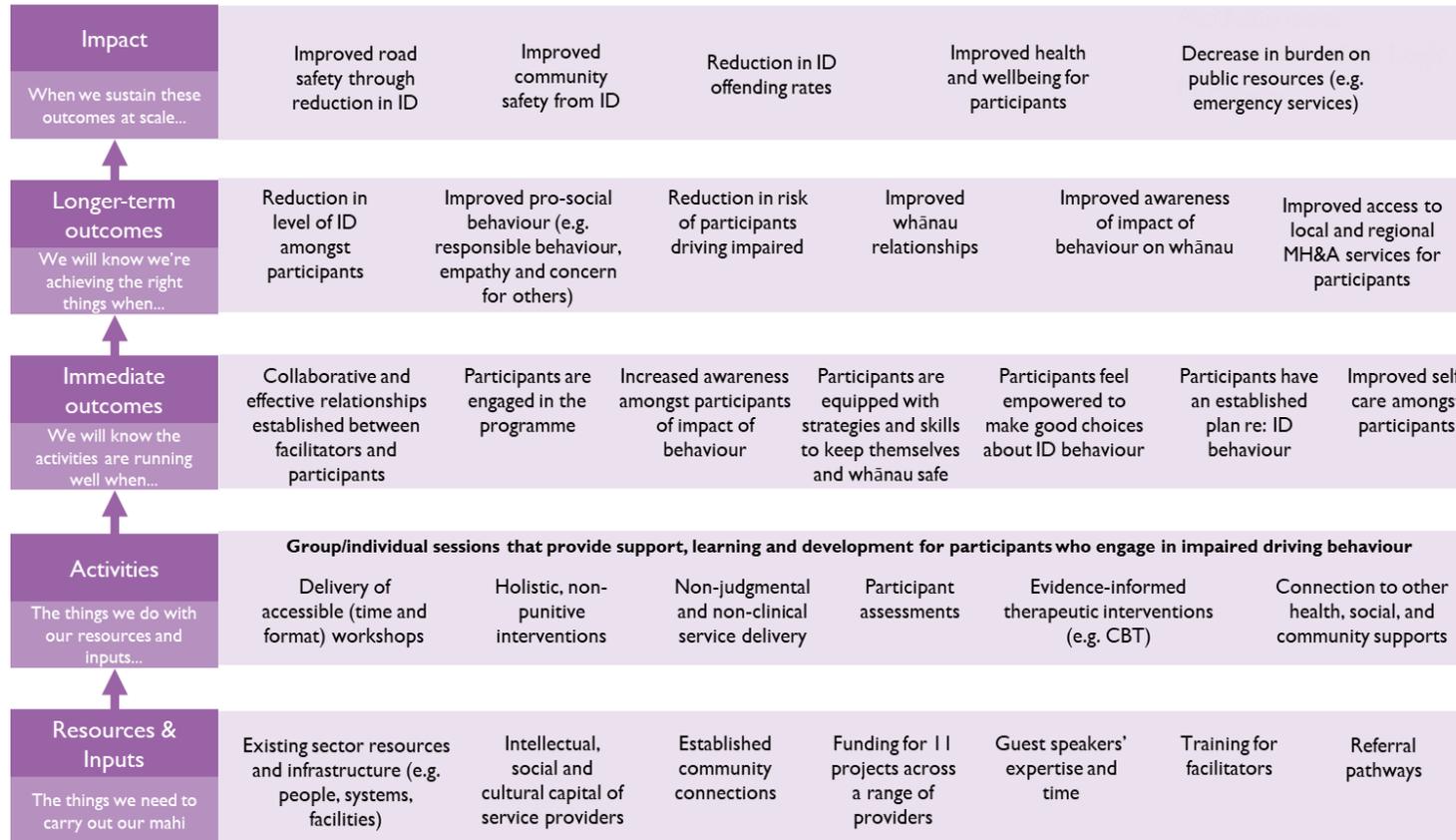
⁹ All interviews were semi-structured meaning they were guided by a pre-determined set of open questions but allowed for interviewees to explore particular themes or responses further.

participants are not necessarily representative of people accessing the IDR programmes, they were in a position to offer meaningful reflections on their experience. Hauora Māori partners were engaged with by Māori interviewers. Informed consent was sought from all interviewees and survey responses were kept anonymous. Interviews were voice recorded with permission.

Each strand of data collection was independently analysed.

Figure 1: Theories of change and value creation

Theory of Change: Impaired Driving Rehabilitation Programmes



Value Proposition

The effective generation of social value for families communities, and taxpayers

Participants develop or build on connections with whānau to support their behaviour change and personal development
 Participants experience improved life outcomes
 Fewer dangerous driving incidents and crashes affecting communities
 More efficient and equitable use of government resources (e.g. Healthcare, Emergency Services, Police, Corrections)
 Building a body of knowledge for IDR programmes

Programme delivery that is equitable and efficient

Evolving and improving service delivery to overcome barriers to engagement/participation
 Valuing of te ao Māori and Kaupapa Māori approaches (e.g. whakawhanaungatanga)
 Tailoring delivery to meet needs of participants
 A non-clinical and 'family' environment for participants
 Adoption of accepted and well-evidenced psychological interventions
 An overall health and wellbeing focus which is non-judgmental and non-punitive
 Delivery that is adequately resourced and which meet intended outputs and outcomes

Equitable and economical resource management

Design and knowledge base draws on existing infrastructure and expertise of provider organisations
 Service design that values consumer voice/lived experience

Economic analysis

Economic analysis of IDR programmes involves comparing the benefits of the programmes in monetary terms with the costs. This requires information about:

- Estimates of causal impacts of the programmes on relevant outcomes that generate social benefits.
 - Preventing road crashes caused by impaired driving and avoiding the associated social costs of deaths and injuries are a substantial source of potential benefits.
 - Other potential benefits include avoided justice and corrections costs associated with instances of impaired driving (even if these do not lead to crashes), improved employment outcomes and physical and mental health of participants.
- The social value of those impacts, such as the costs of deaths and injuries that are avoided due to IDR programmes (i.e. the monetary value of benefits).
- Programme activity levels, e.g. numbers of participants and graduates.
- The costs of the programmes.

Data limitations prevent a full economic analysis of the IDR programmes being evaluated at this stage. Suggested improvements to data collection from IDR providers to support future economic analysis are provided (Appendix 6).

Limitations of the evaluation

This evaluation presented an important opportunity to take stock after 10+ years of delivery. A strength of the evaluation is that all but one contracted providers were involved (9/10). However, there are some limitations that need to be noted. These include:

- There was limited or no quantitative data to understand programme impact on recidivism and road crashes.
- There was variable levels of participation by providers in the evaluation.
- Participants from all participating programmes took part in the survey. However, 53% of survey responses were from only two providers, and some providers only had two responses. See Appendix 4 for profile of survey respondents and spread across providers.
- Most survey responses were from current participants, meaning they had not yet experienced all the programme content, and there had been little time for behaviour change to occur and/or be sustained over time. Their responses will reflect current programme models only.
- Some participant interviewees also completed the survey.

- The scope of the evaluation did not include a matched control group to help establish impacts of programme participation as distinct from other factors.
- We did not have background data on participants, such as severity of offending or substance use disorders, co-existing disorders and levels of need to determine who is most/least likely to benefit from the programme.
- People with positive experiences are more likely to volunteer to participate in evaluations. As such, there may be a bias to the findings.
- Current information about impacts of the programmes being evaluated is insufficient to support a robust monetary estimate of benefits for comparison with costs of the programmes.
- Information about costs and activity levels of the programmes is limited and may not be complete. Discrepancies in reporting may indicate inconsistent approaches were used across providers, or other data quality issues that are beyond the scope of this evaluation to resolve. These issues may affect some of the quantitative results presented in this report and all numbers are indicative only following best endeavours to analyse the data provided.
- Substantial staff turnover in the ten years the IDR programmes have been running limits the input of Ministry of Health and Health NZ in exploring the programmes' origins. Similarly, some staff turnover have occurred within providers and it was difficult for them to recall the initial design process.

3. Participant demographics and characteristics

Eligibility criteria

As indicated elsewhere, the IDR programmes are for people convicted of repeat drink or drug driving and first-time offenders with a particularly high alcohol level. We do not have data on participants' offending history, but the majority of providers reported eligibility criteria of at least two excess breath alcohol (EBA) tests. Feedback suggests that some providers have participants with consistently high EBAs. One provider, with three EBAs as their criteria, reported an average of four over the last 10 years of programme delivery, but ranging between 3 and as high as 14. The highest reported EBA by participant interviewees was seven.

Some providers have more open criteria and take referrals without EBAs, provided there is a history of impaired driving and a desire to change behaviour. Some programmes exclude people who are not able to read or write, as this is required of the programmes, while others do not. These deviations are not mentioned in service specifications. We

note that some participants come through the programme more than once. It is unclear to what extent this occurs.¹⁰

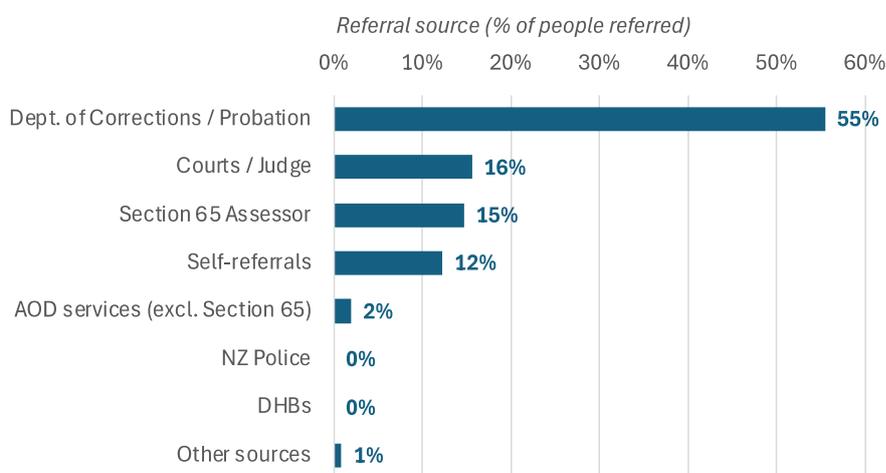
In some programmes, whānau members or other support people are invited or expected to participate alongside participants.

Referral sources

Referrals come from a range of sources, including Department of Corrections, self-referrals, police, judges and addiction treatment services. Some participants are going through court, or are about to, and have either been mandated by a judge to complete the programme or advised by their lawyer to do so in an effort to potentially lessen their sentencing (thus self-referring). Some participants have been indefinitely disqualified from driving under Section 65 of the Land and Transport Act 1998 and access the programme to meet criteria for regaining their driver’s license. Feedback suggests that some of these disqualifications can be years, or decades old.

As illustrated in Figure 2 , Department of Corrections was the source of just over half of referrals to the programmes, while around 12% were self-referrals.

Figure 2: Sources of inward referrals (2018/19 to 2023/24 combined).

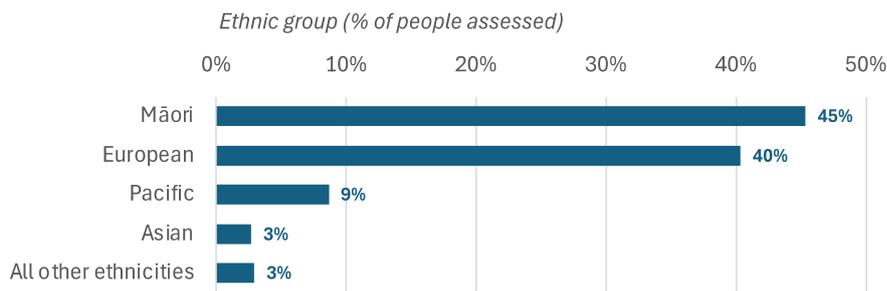


Demographics

People assessed by the programmes between 2018/19 and 2023/2024 were predominantly male (86%). Māori and European ethnicities were most common (Figure 3).

¹⁰ Subsequently, this has not been considered in the economic analysis in this report.

Figure 3: Ethnicity of people assessed (2018/19 to 2023/24 combined).



Participant needs

Evaluation feedback suggests that participant needs centre on:

- Criminogenic needs, such as antisocial attitudes, substance abuse, low self-control, anger, lack of empathy, impulsive behaviour.
- Psychosocial needs that may underpin impaired driving and/or substance use behaviour.
- Engagement needs, including ability to get to the programme, confidence and motivation to engage and specific learning needs (e.g. literacy, language, neurodivergence).
- Cultural needs, such as the ability to relate to and understand content and delivery through one's world view and cultural references.

Feedback suggests that participants' needs sit on a broad continuum of level of need (i.e. low to high need) and range of needs (i.e. low to high number of needs). The further along the continuum, the more difficult it can be to meet the needs.

4. In what ways and for what purposes have the IDR programmes design and delivery evolved?

Programme design

In designing programmes at the outset, providers were initially supplied with Matua Raki 'Impaired Driver Treatment guidelines for addiction practitioners',¹¹ with key content based on established good practice and evidence-based models. This approach facilitated efficient establishment of new programmes and ensured some consistency across the programme as a whole, and within these guidelines providers

¹¹ Matua Raki. 2012. *Substance Impaired Driving: Treatment guidelines for addiction practitioners*. Matua Raki, Wellington.

were given latitude to innovate and develop offerings to meet the needs of their specific communities.

Alongside the impaired driver treatment guidelines, providers have leveraged their own clinical, education and cultural expertise, and drawn on external resources, such as those produced by Drug and Alcohol Practitioners' Association Aotearoa New Zealand (dapaanz).

A brief overview of the programmes can be found in Appendix 5.

Programme content

In response to requests regarding intellectual property, we do not describe the content of each programme in this report. However, there is clear evidence – from provider and participant feedback, review of programme documentation and workbooks and in-programme observation – that each programme adheres to specifications set out in 2016 contracts that the programmes should cover:¹²

- Substance use: Definitions of use, reasons for drinking, self-monitoring using AoD diaries, information about standard drink sizes and alcohol, and information about different drugs and their effects.
- Anti-social attitudes: Challenging justifications for driving while impaired, dealing with peer pressure, understanding the effects of poor planning, and considering the cost-benefit analysis of substance use.
- Victim empathy: Understanding the concept of victim empathy, demonstrating compassion, and seeing things from someone else's perspective.
- Recovery focus: Identifying pro-social behaviours, taking a holistic perspective of the individual, future planning, and relapse prevention.
- Principles of adult learning: Using a variety of activities that cater to different learning styles, such as group discussions, role plays, and learning reflection. Providing food or refreshments if needed.
- Culturally specific methods: Incorporating culturally specific principles, practices and models such as manaakitanga, whanaungatanga, Te Whare Tapa Whā.

These aspects of service delivery are reflected throughout the report.

Evolution of programme design and delivery

Since inception, the core content of programmes has remained largely consistent, with individual providers making updates to reflect new sector knowledge and practices,

¹² These are set out in the 02 variation of service agreements commencing July 2016. Previous agreements do not specify expected programme content.

such as changes to measuring standard drinks and new developments in neuroscience. However, there has been a shift towards greater flexibility and adaptability in programme delivery, with providers increasingly tailoring their approaches to meet the specific needs and cultural contexts of participants, addressing barriers to attendance, and becoming less prescriptive.

The COVID-19 pandemic prompted further refinements. During lockdowns, many providers adopted online or hybrid models to maintain participant engagement. While all have since returned to in-person delivery, the disruption of the pandemic provided an opportunity to further refresh their course structures and content. Despite a desire for further innovation and development, providers noted that more resources are needed to support these changes.

Changes have been made by individual providers rather than as a coordinated programme-wide effort, focusing on improving accessibility, relevance, and effectiveness. Some providers acknowledge there has been a tension between adhering to evidence-based approaches and adapting programmes to ensure they are relevant to the local context and participants' needs.

The key areas of programme evolution are discussed in more detail below.

Programme duration and contact hours

Many providers refined their programmes over the past ten years, experimenting with various formats to find an optimal intervention length that balances engagement, completion rates, and commitment to change. There has been a general shift towards shorter, more compressed models, for example moving from 12-week formats to options like six-week programmes or intensive sessions over fewer days. These shorter formats reportedly reduce attrition, accommodate participants' work and family commitments, and lower barriers such as transportation. For instance, one provider in a remote area found that a shorter programme was easier to promote and led to better retention. A few participants also expressed that the 12-week programme felt excessively long and financially burdensome due to lost earnings.

While participant needs often drive these changes, factors such as facilitator availability and logistics also play a role. One provider discovered that conducting sessions over two consecutive days worked well for both participants and facilitators, simplifying logistics across multiple sites. However, not all programmes have shortened their duration; one was extended from 10 to 22 hours to allow for greater depth of engagement and improved retention rates.

The current duration and contact hours of the programmes are outlined in Appendix 5. Most programmes, in line with best practices,¹³ are delivered in multiple sessions, over multiple weeks, ranging from 12 to 43 hours.¹⁴ Nonetheless, shorter formats have sometimes been necessary to ensure programme viability in specific locations.

Programme days and times

Programmes are delivered at various days and times, with providers again testing and experimenting over time to find the most effective approach. Currently, many programmes are held during the day, with the expectation that participants will arrange time off from work to attend. Some providers however offer evening sessions to accommodate those with daytime commitments.

One provider avoids running programmes in winter, citing shorter days, cold weather, and lower motivation as challenges. Another tried offering evening classes based on participant requests but experienced higher dropout rates, as motivation to attend dropped after the workday. Additionally, running evening sessions posed challenges for some providers, such as staff expecting time off in lieu and expressing safety concerns.

Group sizes

Contracts specify that services will be course-based programmes with up to 10-12 participants per group. Evaluation findings indicate that group sizes are for the most part adhered to but that they fluctuate somewhat depending on the number of referrals and/or 'withdrawals'/'did not starts'. For example, in some instances, people's sentencing is complete by the time the programme starts so they choose not to attend. Providers tend to assess more people than the specified group size to cover for potential attrition and when attrition is low, numbers may exceed 10-12.

One provider has consciously moved to smaller groups to foster a non-threatening environment and deeper engagement across the group. They also offer 1:1 provision for those who are not able to participate in the groups (e.g. due to social anxieties, illness, work commitments).

... being able to tailor it to your specific cohort or people that you're working with, being able to adapt it to the communities to meet their needs has been important. (Provider)

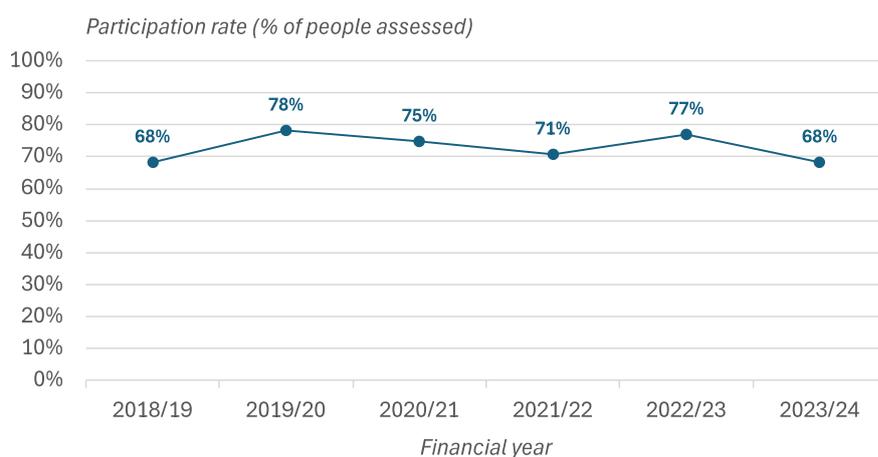
¹³ Thomas J, Burton J, Thomas F, Frith B, & Malcolm L. (2022). *Effective alternatives to penalties for repeat driving offenders* (Waka Kotahi NZ Transport Agency research report 704).

¹⁴ We note that there is no clear consensus in the literature around optimal number of contact hours, but there are indications that 20 hours or more is most effective for repeat offenders.

Assessment, follow-up and continued support

Each programme is to include 1-2 individual sessions for comprehensive assessment to determine suitability and post-programme follow-up. Feedback indicates that a comprehensive assessment occurs across all providers with all referrals that are contactable. The available longer-term reporting from providers shows that participation has generally been stable over time with around three-quarters of people assessed going on to participate across all providers combined (Figure 4).

Figure 4: Programme participants as a proportion of those assessed.



Some providers reported that they no longer do the post-programme follow-up due to capacity and resource constraints, and there is no data on follow-up. Nonetheless, providers still include at least two individual sessions; the assessment and a ‘catch-up’ session when participants are unable to attend.

Some providers also offer continued support as part of their wider services. For example, Harmony Pasifika offers an ongoing impaired driver programme graduate group as well as counselling services, Tūhoe Hauora iwi partner provides follow-up support for graduates and Eduk8 has a graduate Facebook page, allowing past participants to stay connected. Some graduates go on to work and/or volunteer for the programme (e.g. in tuakana teina role).

Cultural responsiveness

All providers consciously seek to provide culturally responsive practices. It is also evident that for many, their practice has developed over time. This includes enhancing responsiveness to Māori such as incorporating karakia and whakataukī, placing greater emphasis on whakawhanaungatanga and manaakitanga, and the provision of kai to support participation. Some providers are also reporting increasingly using a te ao Māori lens to consider holistic wellbeing and the influence of behaviour across different dimensions of life and tailoring approaches where appropriate to meet the specific

needs of Māori participants, such as exploring the impact of colonisation and land loss on alcohol use.

Providers with participants from more mixed backgrounds (e.g. Eduk8 and Harmony Pasifika) have also worked to ensure responsiveness to a range of cultures. This includes employing more ethnically diverse staff, using other culturally relevant health and communications models such as the Pasifika Fonofale and Talanoa approaches, and increasingly exploring participants' alcohol and other drug use and impaired driving from different cultural lenses.

Delivery location

Providers have experimented with different delivery locations and found that location significantly impacts programme attendance, particularly in relation to transport access. Programmes have been held in various settings, including Community Corrections premises, community venues, and more culturally oriented spaces. Many providers have shifted from clinical or probation settings to community-based or cultural venues to create a more neutral, wellbeing-focused environment, as opposed to a clinical or judicial feel. However, one provider noted that this shift appeared to reduce participant motivation.

To improve accessibility, some providers expanded their delivery to remote rural locations when sufficient participant numbers are available, helping to address transport barriers.

Increased focus on other drug use and drug-impaired driving

The IDR programmes were always intended to cover both alcohol and other drugs. However, providers have moved to address drugs and drug-impaired driving more explicitly, updating content and terminology to better encompass both alcohol and drugs (e.g. from 'drink driving' to 'impaired driving'). This shift reflects changing participant demographics, such as the growing number of drug-impaired drivers, and the specific needs of the communities they serve, as they are beginning to see a higher proportion of drug drivers entering the programme.

The truth is, here, people drive fried, people drive blazed, people drive drunk, this all contributes to our road deaths, so we wanted to be responsive to that also. (Provider)

For some providers, this broadened focus has led to increased participation. One provider, struggling to meet enrolment numbers, saw uptake rise after adopting more inclusive language.

Managing waiting lists through innovation

In response to high demand, some providers have developed innovative strategies to manage waiting lists. Some offer interim support, such as half-day sessions or one-on-

one support, for participants who are waiting for a place in the full programme. These shorter sessions provide an option for those who require some level of support while they wait. Manaaki Ora have no wait list, and instead allocate a counsellor to those who can't get on the programme right away, who guides them through the programme components individually. This approach ensures that even those who cannot join group sessions immediately receive some intermediate support.

Collaborative models

More collaborative models have emerged among providers, involving partnerships with police, probation services, NGOs, and iwi. Tūhoe Hauora Trust, for example, has transitioned to an iwi-led model, emphasising the importance of building strong relationships with other iwi and stakeholders to ensure successful programme delivery.

Eduk8 has a wide range of contributors to, and supporters of their programme – many of whom have been involved since inception. These include judges, community magistrates, courts, NZ Police, NZ Fire Service, St. John Ambulance, trauma teams, spinal units, and different presenters. This collaborative approach was seen by the provider to contribute immensely to the effectiveness of the programme.

For many, growing networks of referrers, including community organisations and health services, have been key to enhancing programme reach. Providers have increasingly strengthened these collaborations, tapping into existing sector infrastructure to provide more comprehensive support for participants. This includes connecting participants to aftercare or community services, helping them access detox programmes, counselling, and other forms of support as needed.

Collaborations have also helped address barriers to programme delivery, particularly in remote rural areas. By sharing venues and resources, providers have been able to reduce transport challenges and improve programme accessibility. In addition, collaboration has helped providers increase awareness of their services, particularly when referral numbers are low, ensuring they can continue to deliver programmes effectively.

Addressing transport barriers

Providers have trialled various ways to address transport barriers, which remain a significant challenge, particularly in rural areas. Checking participants' transport options is now a routine part of the comprehensive assessment for some providers. To support access, they offer petrol vouchers, taxi chits, or arrange pick-up and drop-off services. These efforts have notably increased participation, especially in areas with poor transport connections. In some instances, providers have collaborated with police, probation services and community organisations. Health NZ Te Tai Tokerau used hospital shuttles to help participants in some of Northland's remote regions, where transport issues contributed to low referral numbers. They also trialled family

days and offering kai to engage participants. However, access challenges remained too high for many participants and programme provision in some areas ceased.

Some providers expressed a desire to explore alternative delivery methods, such as Zoom or online learning, to remove transport barriers for rural participants with internet access. While Zoom proved effective during COVID-19, they acknowledge that not all whānau have access to the necessary devices or reliable connectivity. However, they felt it is an option that should be further explored.

5. In what ways do the IDR programmes create value, and for whom?

The theory of value creation, developed with stakeholders at the outset of the evaluation, proposed key features of the IDR programmes that contribute to:

- Equitable and economical resource management
- Equitable and efficient delivery
- Effective generation of social value for families, communities and taxpayers.

The theory of value creation was validated and refined through subsequent stakeholder engagement and analysis. In summary, the features identified below enable the programme to leverage value from the resources invested in it.

Equitable and economical resource management

Since 2014, the Ministry of Health has contracted with 10-11 services¹⁵ for IDR programmes, with a view to contributing to a reduction in mortality and morbidity caused by road crashes, reducing re-offending and reducing harm caused by alcohol and other drugs. The nine providers included in this evaluation received funding of around \$1.45 million in a two-year contract from July 2021 to June 2023 (around \$726,000 per year).

Value was generated through making use of the funding to leverage and build on existing knowledge, networks and resources (rather than starting from scratch) and targeting the funding to areas where it would provide best value for money. This was indicated by:

- Working through established providers with their own infrastructure, including the experience and expertise inherent in their organisation (e.g. impaired driving, Alcohol and Other Drug (AOD) treatment, Kaupapa Māori, group therapy), and professional and community networks to be able to reach and be acceptable to the target group.
- Funding a mix of established, new and extended programmes allowing for existing foundations, systems and processes to be drawn on while also expanding into areas where there were previously no existing IDR initiatives.
- Funding a mix of providers, including Kaupapa Māori, Pacific and culturally aware providers and in so doing cater for Māori, Pacific and migrant participants.

¹⁵ Since 2023, there have been 10 programmes.

- Valuing lived experience of addiction and/or driving impaired in programme design and delivery, and in so doing, enabling participants to better relate to facilitators and content.

We also found that providers are accessing the value of existing community knowledge, networks, capacity and infrastructure by collaborating with local police and/or Community Corrections Services in regard to programme delivery, coordination, transport and referrals.

Programme delivery that is equitable and efficient

This level of the theory of value creation is primarily concerned with the delivery of the programme, ensuring that it is undertaken in an equitable and efficient way. It gives primacy to the concept of equity, in terms of reaching people who have higher rates of impaired driving offences, ensuring the offering is suitable to them. Notable agreed VfI areas in which value is created through the IDR programmes are the following:

- Utilising evidence-based interventions that are known to work and have the desired impact.
- Applying non-punitive approaches that support participants to make better choices for themselves, serving them better in the longer-term.
- Providing services in non-clinical settings where participants feel comfortable and safe.
- Valuing holistic, te ao Māori and Kaupapa Māori approaches (e.g. Te Whare Tapa Whā, Whānau Ora, karakia and sharing of kai) thus achieving good engagement and value across all aspects of wellbeing (e.g. wairua, hinengaro, tinana, whānau).
- Allowing flexibility to adapt individual programmes to meet the needs of participants, particularly when/where they face barriers in engaging/attending.
- Positioning programmes within providers that can offer additional support services (e.g. counselling) internally, including post-programme support in some instances, and/or have the connections to refer out.

Key decisions taken in the design and establishment of the IDR programmes also contributed to its ability to generate value from the investment of resources:

- Initially drawing on up-to-date impaired driver treatment guidelines to facilitate efficient establishment of new programmes and ensure some consistency across the programmes overall.
- Using Court data to identify the areas with the highest numbers of repeat drink-driving offences and channelling funding to these areas.

- Focusing the programme on impaired driving, rather than alcohol and other drug rehabilitation, thus targeting the issue at hand, and complementing other rehabilitation programmes.

These approaches allow the IDR programmes to achieve good engagement, improve wellbeing, and support participants to make better choices. Evaluation evidence indicates that the IDR programmes contribute to desired outcomes, such as reduced re-offending, reduced alcohol and other drug harmful use, changed attitudes to impaired driving, increased victim empathy and ability to plan ahead.

The effective generation of social value for families, communities and taxpayers

Evaluation evidence indicates that participants are less likely to drive impaired as a result of the IDR programmes. It also indicates that the programmes support improved self-efficacy and improved psycho-social skills. This helps generate value for participants in terms of improved family/whānau relationships and life outcomes (e.g. reduced judiciary consequences, ability to gain or retain employment, ability to abstain or reduce alcohol and other drug intake).

There was a widespread sense among participant interviewees, and echoed by providers, that this in turn generates positive value for whānau and families as participants are able to be involved in and contribute to family/whānau life. For example, by retaining their driver licence, some participants have been able to remain employed and help transport children to activities. Feedback indicates that providers also derive value from the IDR programmes, mainly as they serves as an entry point to their other services, although this has not been thoroughly explored.

Findings around impacts and outcomes from a range of sources suggest it is highly probable that the programmes contribute to fewer dangerous driving incidents and crashes affecting communities through a reduction in impaired driving. However, there is insufficient data to verify this, and to what extent.

Taken together, the programmes are in a good position to support more efficient and equitable use of government resources (e.g. healthcare, emergency services, police, corrections) by contributing to reduced costs from road deaths and serious injuries, as well as costs through the justice system.

Looking ahead, there is an opportunity for the IDR programmes to generate further social value by collecting better evidence of outcomes and building a community of practice and a steadily developing body of knowledge to support delivery across programmes.

6. To what extent is current programme delivery meeting the needs of participants?

This section explores the extent to which programme delivery meets the needs of participants¹⁶ through the Vfl domains of ‘equitable and economic recourse management’ and ‘programme delivery that is equitable and efficient’. These domains contain the criteria outlined in Table 5. The criteria focus systematically on key aspects of value creation as described under the previous KEQ.

Table 5: Criteria for meeting needs of participants

| Equitable and economic resource management | Programme delivery that is equitable, efficient and effective |
|--|---|
| <ul style="list-style-type: none"> • Design and knowledge base draws on existing infrastructure and expertise of provider organisations • Service design that values consumer voice/lived experience | <ul style="list-style-type: none"> • Evolving and improving service delivery to overcome barriers to engagement/participation • Valuing of te ao Māori and Kaupapa Māori approaches • Tailoring delivery to meet needs of participants • A non-clinical and ‘family’ environment • Adoption of accepted and well-evidenced psychological interventions • An overall health and wellbeing focus which is non-judgmental and non-punitive |

The following sections contain tables that outline the relevant evaluative criteria, our evaluative judgement and our rationale for making this judgement. The tables are then followed by the evidence to back up the judgement. The standards and criteria used for making judgements are set out in Appendix 2 and define four levels of performance as illustrated in the following table.

¹⁶ We note that service specifications require that people who are identified with addiction and substance use disorders through the comprehensive assessment are referred on to appropriate treatment services rather than accepted into the programme. As such, we have not explored whether these findings apply to this particular cohort, even if they do make it into the programme.

Table 6: Evaluative judgement standards

| | | | |
|--------------------------|---|--|--|
| Not meeting expectations | Adequate (meeting minimum expectations of delivery or outcomes) | Good (below excellent, but more than adequate) | Excellent (meeting or exceeding all reasonable expectations) |
|--------------------------|---|--|--|

Equitable and economic resource management

The theory of value creation posits that equitable and economic resource management needs to underpin the IDR programmes if it is to be effective and generate social value. Overall, we have rated the IDR programmes ‘good’ in terms of the pre-agreed evaluation criteria for this Vfl domain (Table 7).

Design and knowledge base draws on existing infrastructure and expertise of providers

Table 7: Design and knowledge base evaluative judgement

| Vfl criteria | Sub-criteria | Judgement | Rationale |
|--|--|-----------|--|
| Equitable and economic resource management | Use of provider and/or local expertise, infrastructure and learning in design, implementation and planning | Good | Existing knowledge, experience and infrastructure has been leveraged, but there is an opportunity for shared learning across the programmes. |

Providers have leveraged existing knowledge, experience and infrastructure.

The organisations contracted for the IDR programmes were well-established, with extensive experience delivering impaired driving programmes and/or other relevant services such as AOD treatment and/or mental health services. Among them were four Hauora Māori partners and one bi-cultural service. Their wealth of experience and expertise has informed design and delivery, including knowledge of what works best for the people they serve. Local knowledge from other service providers, Community Corrections, police, judges, and iwi is also utilised.

Further, providers leveraged their own existing physical infrastructure and local community resources for efficient and accessible programme delivery. This approach supported cost-efficiency and also simplified engagement for participants.

Funders have not drawn on learning for future planning

Feedback revealed that the Ministry of Health and Health NZ have had a distant relationship with providers since service inception and have not leveraged learning across different initiatives for future planning. We understand the disconnect can to some extent be attributed to government restructures, staff turnover and the impact of Covid-19.

Service design that values consumer voice/lived experience

Table 8: Consumer voice/lived experience evaluative judgement

| Vfl criteria | Sub-criteria | Judgement | Rationale |
|--|--|-----------|---|
| Equitable and economic resource management | Lived experience and consumer voice are prioritised to meet the needs of participants. | Excellent | Lived experience is integrated into service design and delivery and is impactful. Consumer voice informs programme development in various ways. |

Lived experience is integrated into service design and delivery

All providers, bar one, integrate lived experience into service design and delivery.

Common approaches for doing so centre on:

- Inviting past participants as guest speakers for each new course, sharing their personal journeys to inspire current attendees.
- Facilitators drawing on their own experiences to build rapport and trust with participants.
- Featuring presentations from victims or survivors of impaired driving ('victim statements').
- Featuring staff from police and/or emergency services who share their experiences of attending crash sites and/or dealing with the aftermath of a crash (e.g. hospital staff).

Most providers utilise a combination of these approaches which offer multiple perspectives on impaired driving and its consequences.

Lived experience is impactful and supports relatability

Providers highlighted the value participants gain from incorporating presentations from victims and staff from emergency services, frequently noting these sessions as memorable and meaningful. Likewise, nearly all participant interviewees rated these as their strongest memories and most impactful aspects of the IDR programmes.

Participant interviewees also consistently indicated that lived experience helps make content and delivery relatable. Having the facilitator share their experiences with, for example, alcohol and other drug harmful use makes them feel understood and safe, which supports trust building and connection.

We're all there together. Rowing the boat together. (Participant interviewee, Downie Stewart Foundation)

Consumer voice informs programme development

All providers use participant feedback to inform programme developments. Feedback is gathered through programme evaluation forms, informal channels (e.g. chats with

participants) and more formal reflection sessions and consultations. Providers consistently update their resources based on participant feedback. For instance, Downie Stewart Foundation revised their course workbook using feedback to improve engagement and relevance.

Some larger provider organisations also report drawing on their consumer teams for feedback to shape programmes. One provider involves both individuals with lived experience and graduates in reviewing and redesigning programme elements. Further, some providers have worked with whānau participants to refine programme design and delivery.

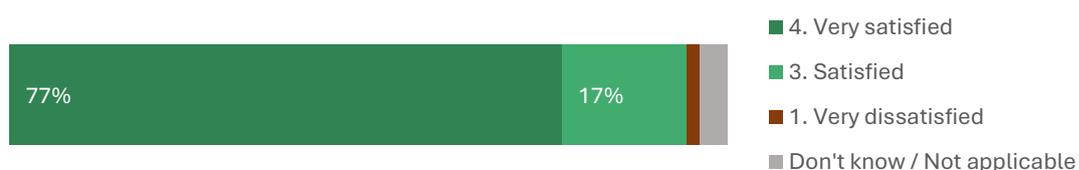
Programme delivery that is equitable and efficient

The theory of value creation also posits that the IDR programmes' delivery needs to be equitable and efficient to generate social value. This section first looks at participant satisfaction of the programmes, which was very high across the board, as a marker of efficient delivery. It then looks at each of the criteria for this Vfl domain in turn. Overall, we have rated the IDR programmes 'good' in terms of the pre-agreed criteria for equitable and efficient delivery.

Participant satisfaction

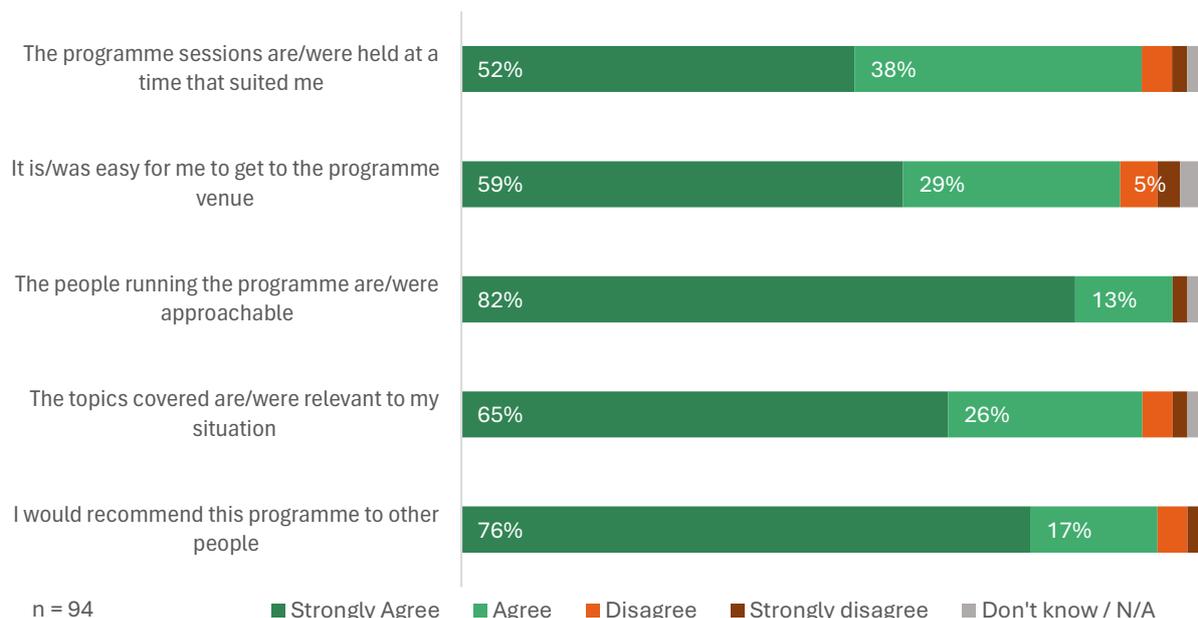
Satisfaction with the IDR programmes was extremely high across the board. Overall, almost all survey respondents were highly satisfied with the programme, as illustrated in Figure 5.

Figure 5: Survey respondents' satisfaction (n=104)



Similarly, survey respondents (n=94) found the time and location of programme sessions suitable and easy to attend (90%), that the people running the programme were approachable (95%) and the topics covered relevant (91%). Further, 93% agreed that they would recommend the programme to others (Figure 6).

Figure 6: Survey respondents' agreement levels on their experiences with the programme



Participant interviewees consistently commented that the facilitators were professional, caring, knowledgeable and understanding. When asked to sum up the programme in three words, participant interviewees used the words illustrated in Figure 7. Eye opening, educational, supportive and life changing were the most common words. Many participants wished they had accessed the IDR programme earlier in life and believed it would be good to provide similar information to youth, or as part of your driving test.

Figure 7: Words to describe the IDR programmes

mana outstanding relatable valuable engaging
 insightful grounded **eye opening** good
educational awesome welcoming fun
 easy comfortable wairua **informative**
supportive enjoyable tautoko/awhi real
 strengthening **life changing** thorough
 invigorating friendly thought provoking practical

Evolving and improving service delivery to meet barriers to participation and/or engagement

Table 9: Evolving and improving service delivery evaluative judgement

| Vfl criteria | Sub-criteria | Judgement | Rationale |
|--------------|--------------|-----------|-----------|
|--------------|--------------|-----------|-----------|

| | | | |
|---|---|------|---|
| Evolving and improving service delivery | Assessment and adaptation of programme delivery and impact of changes | Good | Providers have processes in place for assessing effectiveness, including screening tools, and adapt accordingly. Some providers measure impact, but not all, and there is no coordinated approach to do so across programmes. |
| | Participant engagement and attendance | Good | Most participants are fully engaged and meet requirements of the programme. However, one quarter of those assessed do not participate in the programmes. This may be an area for further development. |

Providers have processes in place for assessing effectiveness and adapt accordingly

As illustrated in Section 6, there is clear evidence that providers adapt service delivery to meet engagement and access needs of participants. Providers undertake ongoing assessments of programme effectiveness to identify areas for improvement. These assessments are in the least based on participants’ end-of-programme evaluation forms and facilitators’ observations and reflections during and after programme delivery. Some providers also collect feedback after each session, which is another tool for refining delivery in real time. Follow-up is used by some to assess effectiveness, and most providers gather feedback from participating whānau or other support persons to glean multiple perspectives.

Screening tools are used

All providers are required to report Alcohol and Other Drug Outcome Measure (ADOM) scores, but it is unclear whether providers or Health NZ use this data to understand programme effectiveness and impact. Other screening tools are also used but vary between providers. For example, Harmony Pasifika use the Leeds Dependence Questionnaire and have developed their own self-assessment screening tool to ascertain risk of driving drunk (RODD), whereas Health NZ Te Tai Tokerau collect pre and post Alcohol Use Disorders Identification Test -Consumption (AUDIT-C) scores.

Some providers assess impact of changes, but not all

Some providers have self-commissioned evaluations and/or extracted recidivism data from police from time to time (e.g. Harmony Pasifika, Eduk8, Odyssey, Health NZ Te Tai Tokerau) to help them understand the impact of their programmes on reoffending. However, there is no evidence that providers across the board assess impact and there is no consistent approach prescribed across programmes.

Most participants are fully engaged and complete¹⁷ the programme

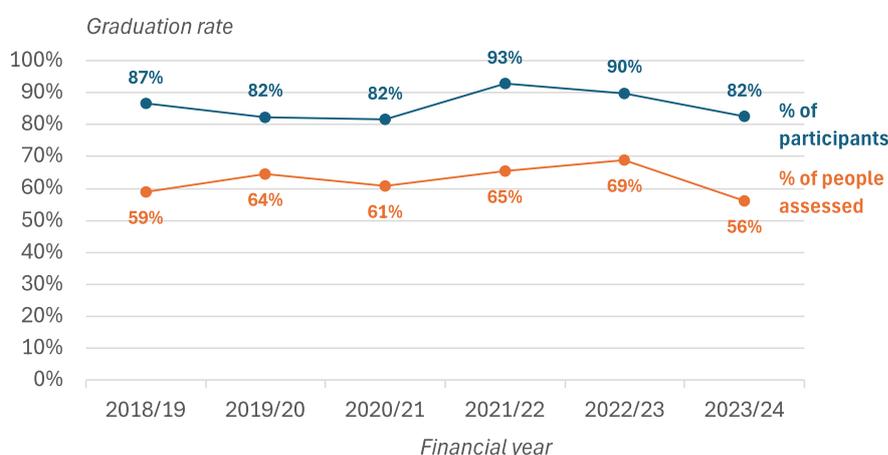
Provider feedback, and evaluators' observations, indicate that most participants are fully engaged, once they are in the programme. Full engagement can take time to build though and require a level of trust to grow between participants and with facilitators.

Most providers are strict about attendance but accept that unforeseen circumstances do occur. They allow for one or two missed sessions if there is an acceptable reason for not attending (e.g. being sick, tangi), and will provide a catch-up session to make up for it. If more sessions are missed, and/or participants do not advise of their absence prior to the session, they will likely be exited from the programme

Numbers of IDR programme participants and graduates between July 2021 and June 2023 are available for eight out of nine providers funded during this period,¹⁸ but reporting for two providers is only available for one out of the two years.¹⁹ During this two-year period, 765 people were reported as being assessed for the eight programmes for which data is available, with 565 (74%) of those participating in a programme and 515 (67% of people assessed and 91% of participants) reported as graduating.²⁰

The overall graduation rate between 2018/19 and 2023/24 was 86% of programme participants and 62% of people assessed. There are no clear trends in these rates over time (Figure 8).

Figure 8: Calculated graduation rates.



¹⁷ It is assumed that those who graduate from the IDR programmes have attended all sessions and met any other programme requirements (i.e. completing necessary book work).

¹⁸ The remaining provider reported numbers that can't be reconciled in 2021/22 and no report is available for 2022/23.

¹⁹ For one of these two providers, courses in 2021/22 were reported as being cancelled. It is not known if funding was adjusted to reflect this.

²⁰ Numbers of participants were not reported directly and were calculated as the reported number of people assessed minus the reported numbers who declined, withdrew, or did not start a programme, across all providers in each year.

This data indicates that the attrition between assessment and programme start is about one quarter of those referred and could be an area of opportunity. Reported reasons for this attrition vary, but include people being lost to follow up, people withdrawing (e.g. due to work commitments or people’s sentencing being complete) and people being declined (e.g. due to dependency, mental health, literacy needs).

Valuing of te ao Māori and kaupapa Māori approaches

Table 10: Valuing te ao Māori and kaupapa Māori approaches evaluative judgement

| Vfl criteria | Sub-criteria | Judgement | Rationale |
|-----------------------------------|---|-------------------|--|
| Valuing te ao Māori/Kaupapa Māori | Inclusion of te ao Māori/kaupapa Māori approaches | Good to Excellent | Te ao Māori and kaupapa Māori approaches are highly valued and actively applied. |

Te ao Māori and Kaupapa Māori approaches are highly valued and actively applied

All providers value te ao Māori and kaupapa Māori approaches. However, the extent to which they draw on and/or apply these approaches vary. Naturally, at one end of the spectrum, Hauora Māori partners deliver kaupapa Māori programmes. These are characterised by:

- Te ao Māori being an integral part of what they do and how they do it, i.e. framing content and delivery through a te ao Māori lens.
- Being grounded in tūāpapa, mātāpono – values of whakawhanaungatanga, manaakitanga, whakapapa, aroha ki te tangata.
- Cultural experiences (e.g. connecting to whenua, waka experience).
- Whānau-centred.
- An emphasis on relationship building and connecting participants to each other, the provider and other services in a whānau centred and holistic way.
- Acknowledgement of whakapapa connections when participants and/or their whānau are known to the provider.
- Iwi involvement.
- Kaumatua/kuia involvement as a natural contribution when around.

Nearly all other programmes also reflect many of these characteristics and have te ao Māori and/or kaupapa Māori approaches well embedded in design and delivery, meaning they are present whether there are Māori participants or not. Aspects such as mihi whakatau, whanaungatanga, karakia, waita, sharing of kai, and use of te reo Māori and Māori health models such as Te Whare Tapa Whā and Maherehere were consistently evident. For some providers, this is merely an extension of how they work as an organisation. For example, Downie Stewart Foundation is a bi-cultural organisation, but their foundations are tikanga Māori so te ao Māori and kaupapa Māori approaches naturally flow through to their IDR programme.

Some providers worked hard from the outset to upskill and bring in te ao Māori and kaupapa Māori approaches into service design and delivery. Eduk8 for example starts every programme with a mihi whakatau, invite karakia at the start and end of every session, involve whānau as active participants and provide kai. Conversely, one provider noted that their programme model lacks cultural input, and while they are making inroads, there is still some way to go before they will be appropriately responsive to Māori. One participant interviewee described the difference the te ao Māori approach made for him.

With Pākehā questions, I can't really answer them. Only sometimes. I prefer the Māori part and that's probably why I enjoy [the programme]. (Participant interviewee, Tūhoe Hauora)

Feedback suggests that in some cases, there is a reliance on Māori clinicians to lead culturally responsive practices, rather than embedding them directly into the programme design.

Tailoring delivery to meet needs of participants

Table 11: Tailoring delivery to meet needs of participants evaluative judgement

| Vfl criteria | Sub-criteria | Judgement | Rationale |
|--------------------|--|-----------|---|
| Tailoring delivery | Knowledge of group dynamics and/or therapy and confidence to adapt | Good | Facilitators have the appropriate training and experience to deliver group therapy/education enabling sufficient flexibility to meet needs. |

Facilitators have the appropriate training and experience

Feedback indicates that IDR programme facilitators have relevant registrations and experience in alcohol and other drug counselling, social work, psychology and/or education that enable them to tailor delivery to meet needs of participants. Further, facilitators reported having many years of experience in delivering group therapy specifically and are able to adapt their approach depending on a particular intake, and/or 'in situ' depending on where participants are at.

It's about 'what do you need?' But not even asking that, just seeing what they need and being open to that and picking the moments, the window of opportunity, and then delivering the programme in a way that meets the need of the group. (Provider)

As mentioned elsewhere, providers need to address a range of participant needs, such as literacy, neurodivergence and anti-social attitudes and highlighted the importance of

a flexible delivery style to cater for this. Participant feedback reflected the ability of facilitators to do so.

Despite the challenges we had in our class with certain individuals, the team still pulled through with patience, kindness, respect and a high level of professionalism. (Survey respondent, Harmony Pasifika)

Some providers have found tuakana teina useful for supporting participants with literacy needs.

A non-clinical and ‘family’ environment for participants

Table 12: Non-clinical and ‘family’ environment evaluative judgement

| Vfl criteria | Sub-criteria | Judgement | Rationale |
|--------------------------|---|-----------|---|
| Non-clinical environment | Sessions delivered in suitable settings, in appropriate and welcoming venues with refreshments/food on offer. | Good | All programmes are delivered in suitable settings and kai provided. |

All programmes are delivered in suitable settings, made to be welcoming

The venues for delivering programmes vary across providers. Some are more community/family oriented (e.g. residential dwelling, marae, community venue), but more clinical or judicial spaces (e.g. Community Corrections, Health NZ premises) were also perceived as suitable by participant interviewees. Some venues have programme related content pinned to the walls to make them feel more relevant. One Hauora Māori partner delivers on marae at times. These programmes have ranged from intensive noho (overnight stays) to day programmes.

Some providers have found that delivering programmes at Community Corrections sites improves engagement by allowing participants to attend sessions while reporting in, which also helps strengthen relationships between providers and probation services.

All providers offer kai to participants which was seen to help make spaces feel more welcoming and relaxed. In addition, nearly all programmes deliver some of the content in other settings such as court rooms, hospitals or in nature which adds variability and contextual learning.

[Provider made] you feel at home. You get there, have a cup of coffee, have some biscuits and then on the last night, [facilitator] made a big boil up. That was the cherry on top. (Participant interviewee, Manaaki Ora)

Adoption of accepted and well-evidenced psychological interventions

Table 13: Adoption of well-evidenced psychological interventions evaluative judgement

| Vfl criteria | Sub-criteria | Judgement | Rationale |
|---|---|-----------|--|
| Accepted and well-evidenced psychological interventions | Widespread uptake of well-evidenced psychological interventions, and improved knowledge of effective practice amongst providers | Excellent | All programmes draw on and apply evidence-based psychological interventions as well as other accepted and contractually specified approaches. The interactive approach supports engagement and learning. |

All programmes draw on evidence-based psychological interventions

The Matua Raki guidelines that supported the design and development of the IDR programmes,¹¹ and more recent literature¹³ suggest that impaired driving rehabilitation programmes for repeat offenders should include therapeutic interventions such as motivational enhancement and cognitive behavioural strategies. Programme design and facilitation clearly draw on a range of evidence-based psychological interventions. Cognitive Behavioural Therapy (CBT), Relapse Prevention and Motivational Interviewing were most commonly mentioned. Other interventions and/or psychological theories used or drawn on include Gestalt Therapy, Transactional Analysis, Tripartite Brain Theory, Transference, Narrative Theory and Trauma Informed.

One provider describes their programme as more ‘experiential’ than educational (i.e. therapy that brings the person into the experience, instead of simply talking about it). This experiential aspect is evident across all programmes. In line with service specifications, they are interactive in nature (e.g. role play, group discussions, excursions), action based and have a strong focus on emotional influence through for example, lived experience.

Other accepted and contractually specified approaches are evident

Other recognised approaches for impaired driving intervention programmes¹³ such as self-observation and reflection, discussion and confrontation and the development of new, alternative behaviours were also evident across the IDR programmes. Many participants valued the opportunity for deep reflection, emphasising that it allowed them to engage with the material rather than "just gloss over things.". One survey respondent reflected other participant feedback about the ability of the programme to instil change.

*I have done many programmes in my life; this is the one that changed me.
(Survey respondent, Harmony Pasifika)*

The educational part, well it made me think, put my thinking cap on, and it was educational cos we're filling out things and writing down, explain our thoughts. You get something out of the programme. (Participant interviewee, Tūhoe Hauora).

Providers appear to keep up to date with evidenced based practice and adapt accordingly.

The interactive approach supports engagement and learning

Participants noted that the interactive nature of the programmes was crucial for maintaining their interest and engagement. They appreciated the balance of theory with thought-provoking and at times 'fun' exercises that reinforced learning in practical ways. For instance, many participants highlighted the use of 'impairment goggles' as an effective tool for understanding impairment. They also learned about the concept of a 'standard drink' through interactive activities. Additionally, 91% of survey respondents agreed they had learnt a lot of new information from attending the programme.

So, we went through an exercise where we had to pour what we thought was a standard drink and I took the largest vessel and then filled it up and said 'well this is my like standard drink' but it was a lot more than [a standard drink]. So, I [used to] sit there and I could drink a couple of those and still be fine, but I'd be like way over the limit. I didn't know that. (Participant interviewee, Downie Stewart Foundation)

An overall health and wellbeing focus which is non-judgmental and non-punitive

Table 14: Health and wellbeing focus evaluative judgement

| Vfl criteria | Sub-criteria | Judgement | Rationale |
|--|--|-----------|---|
| Health and wellbeing focus, non-judgmental, non-punitive | Participants trust the process and feel empowered to make positive changes | Excellent | A holistic view on health and wellbeing is evident. Participants feel comfortable sharing and trust the process and appear to feel empowered to make changes. |

A holistic view on wellbeing is evident

Many providers have increasingly adopted an enhanced focus on holistic wellbeing, often integrating culturally responsive models such as Te Whare Tapa Whā, Mauri Ora and Maherehere into their programmes. These frameworks address not only participants' physical health but also their emotional and spiritual wellbeing, supporting their overall recovery and growth. Some providers noted that focusing solely on the behaviour, like drink-driving, is insufficient without addressing the broader context and life factors contributing to it.

It has to be holistic. It can't be 'you must just focus on your drink drive', like we know that what leads people to that is every other factor that's going on in life. (Provider)

Participant feedback highlighted the IDR programmes' effectiveness in uncovering the underlying causes, events, and emotions that may lead someone to drive impaired.

So, drink driving is a byproduct of my inability to cope with life. Something has happened, be with a family member or a person or in my life, I felt something, I've chosen to drink and then I've chosen to drink drive. So, for me, it was like 'well, I drink drive' but I didn't understand what led me to that. (Participant interviewee, Harmony Pasifika)

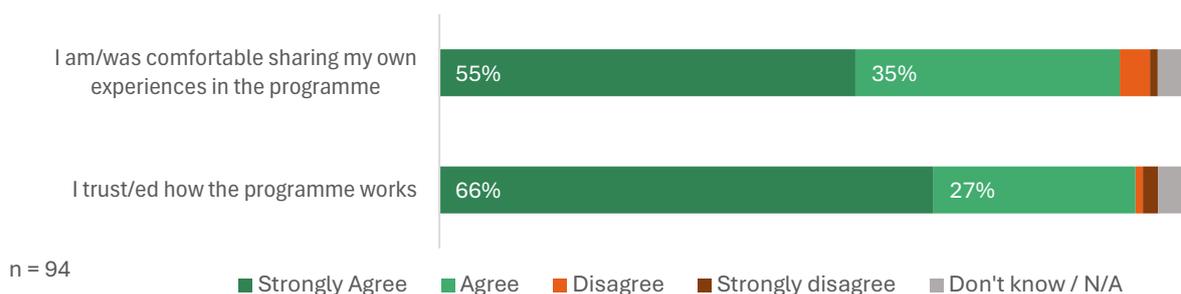
Participant interviewees described a deeper understanding of wellbeing through Whare Tapa Whā multi-dimensional approach, which has supported healing and making positive choices.

Cos like before the whare tapa whā come along, I didn't know, I didn't really focus on my hinengaro [mental], tinana [physical], whānau [family], moko [grandkids'] [wellbeing], there wasn't really wairua [spiritual] [wellbeing]. (Participant interviewee, Manaaki Ora)

Participants feel comfortable sharing and trust the process

Providers highlighted the importance of a non-judgmental environment, as this helps create a safe space for participants to engage, share and be vulnerable. There is clear evidence that participants feel comfortable and safe to do so. Of survey respondents, 93% (n=104) indicated that they trust how the programme works and 90% said they felt comfortable sharing their own experience throughout the programme (Figure 9).

Figure 9: Survey respondents' agreement with feeling comfortable and safe



Meanwhile, many participant interviewees used the term 'non-judgmental' to describe how they perceived the IDR programmes. This applied to both facilitators and peers. The vast majority also indicated that they felt comfortable sharing with and opening up to the group.

The programme itself made me feel safe and just like [name] said, it's safe to share, not feel judged, criticised, ostracised and that was really important for

me, feeling comfortable enough to be vulnerable, cos, it's a vulnerable place. You're sharing about things that are really personal to yourself, things that you probably already have been judged for. (Participant interviewee, Downie Stewart Foundation)

Participants appear to feel empowered to make positive changes

Many participants talked about how the non-judgmental and safe environment enabled strong connections to develop between people in the group. Knowing they were on the same journey, going through similar emotions, learning together and striving for a similar goal made it easier for participants to start making changes to their behaviour and/or make other changes in life.

In the IDR programme environment, they are not judged for what they've done – but also not judged for the changes they are trying to make, which may be the case in other settings where the drink driving culture is still strong (e.g. home, work, friends, whānau). Feedback pointed to a sense of kotahitanga amongst participants and a way to find support and strength in each other.

It doesn't matter what path we're all taking, when we come together, we're strengthening each other and everything surrounding us. (Participant interviewee, Manaaki Ora)

Participants develop or build on connections with whānau to support their behaviour change and personal development

Figure 10: Connections with whānau evaluative judgement

| Vfl criteria | Sub-criteria | Judgement | Rationale |
|---|--|-----------|---|
| Whānau connections are built on to support behaviour change | Whānau awareness and involvement in the programme and maintaining/developing connections | Good | Whānau awareness of participants' involvement is high, but whānau attendance, engagement and influence on change vary depending on programme design |
| | Participant connections with whānau are maintained and/or strengthened | Good | Whānau relationships are reflected on in all programmes and connections strengthened. |

Whānau awareness of participants' involvement is high

Participants consistently said that whānau are aware of their involvement in the IDR programmes and that whānau often support their participation by driving them to and from sessions. Many providers encourage participants to share course work with whānau so they can spread what they've learnt, and to instil a sense of accountability.

Whānau attendance and engagement vary depending on programme design

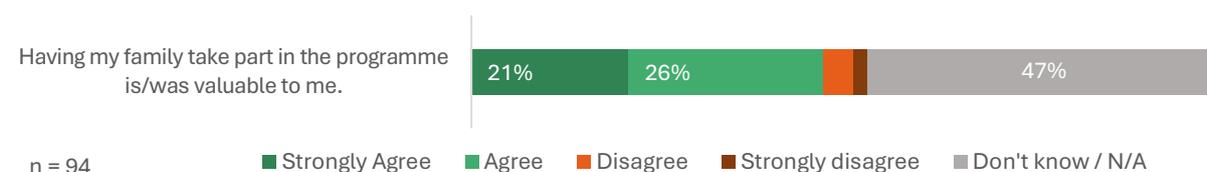
All programmes, bar one, offer opportunities for whānau (or support people) involvement at various levels and/or at different points. It is most common at graduation, and in the first session of the programme. Providers highlighted the value of whānau involvement at graduation as participants are able to share their achievements with them. This instils a sense of pride and ongoing accountability.

Many providers encourage regular whānau attendance, but uptake is generally low due to other commitments, and often participants prefer not to involve them. More active whānau involvement would require a different therapeutic approach and additional resource according to some providers.

Eduk8's TRT/RID is the only programme where whānau (or support person) are in attendance throughout the duration of the programme, and actively engage in group sessions alongside participants. Whānau are there as 'supporters', both in terms of helping get participants there each week, but also for ongoing reflection and discussion about the programme outside of programme hours. Data suggest that at their level of whānau involvement, whānau (or other supporters) play an important role in the change process for participants. Doing the programme together provides an opportunity for shared experiences, which helps strengthen relationships.

Just under half (47%) of survey respondents agreed that 'having my family take part in the programme is/was valuable to me'. Reflecting that whānau involvement is not very common, the same number of respondents either did not know or felt the question did not apply to them. The remaining 6% found family involvement to not be valuable (Figure 11).

Figure 11: Survey respondents' perceptions on whānau involvement



Some participants believed that some form of ongoing support or ability to maintain contact with other programme graduates – particularly for those who don't have family/whānau support to lean into – would help sustain attitudinal and behaviour change. As indicated elsewhere, some programmes already provide this, but in different forms. For example, through other inhouse services, referrals to external services, social media, opportunities to become peer-supporters and graduate support groups. Participant interviewees who accessed continued support felt it supported them on their change journey.

Whānau relationships are reflected on in all programmes and connections strengthened

All programmes offer opportunities for participants to reflect on whānau relationships and connections. For example, at Harmony Pasifika, relational and/or family systems approaches are applied where relationships are explored 'in situ' (e.g. through role play and/or with attending whānau). This helps bring more awareness around family patterns, emotions and interactions and may encourage and develop positive communications skills.

Many participants indicated through the survey and interviews that they have been motivated to put more effort into whānau relationships as a result of the IDR programmes. They also felt better equipped to do so, through strengthened interpersonal skills, ability to be more honest and increased awareness around the impacts of alcohol and other drug harmful use and impaired driving behaviour.

75% of survey respondents said their relationship with their family has improved as a result of their participation in the IDR programmes. This was reflected to a similar extent in participant interviewee feedback.

7. In what ways are valued outcomes being achieved by participants?

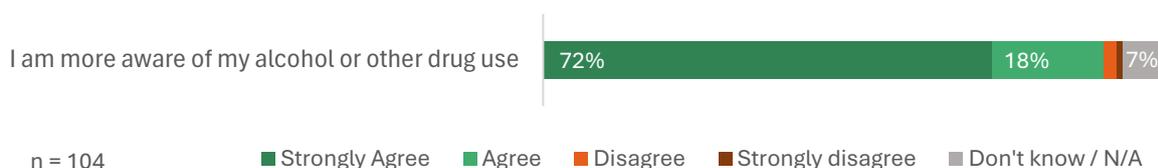
The IDR programmes set out to work with recidivist drink or drug driving offenders to reduce alcohol and other drug harmful use and dependency; change antisocial attitudes to driving while impaired; increase victim empathy; and provide education on alternative strategies to driving while impaired and the importance of planning ahead. As illustrated in this section, evaluation evidence indicates the programme has been effective in doing so.

Increased awareness of alcohol and other drug use

Many providers highlighted that their IDR programmes are not alcohol and other drug treatment programmes, and this was echoed in our discussions with Health NZ staff. If a participant is deemed to have an alcohol and/or other drug dependency, most providers will refer them on to appropriate treatment services. Nonetheless, programmes offer participants the opportunity to learn about the harms and effects of alcohol and other drugs and to reflect on their use.

Evaluation data indicates that the IDR programmes contribute to increased awareness of alcohol and other drug use. 90% of survey participants (n=104) reported that they felt more aware of their alcohol and other drug use since participating (Figure 12). Although not specifically asked, some respondents also reported through free text options, increased harm awareness and actively monitoring their alcohol intake through an increased understanding of standard drinks.

Figure 12: Survey respondents' agreement on increased alcohol or other drug use awareness



Meanwhile, participant interviewees consistently reported:

- Increased understanding of the potential negative impact of harmful alcohol and other drug use on mental, physical, social, emotional and spiritual wellbeing.
- Increased understanding of the effects of alcohol and other drugs on cognitive functioning, including about homeostasis.
- Learning what constitutes a 'standard drink' measure – which was substantially less than participants had previously thought.

- Becoming more aware of the financial cost of their alcohol and/or other drug use.

Participant interviewees also talked frequently about having identified what triggers their alcohol and/or other drug use, and how this may subsequently lead to bad decision making.

Reduced alcohol and other drug harmful use and dependency

Again, although the IDR programmes are not addiction treatment programmes, they provide skills, strategies and motivation for change. Amongst survey respondents, 85% reported a reduction in their use of alcohol and other drugs. Although not specifically asked, some respondents (19%) also indicated through free text alcohol abstinence (n=96).

I am happy to say, I am now alcohol free! (Survey respondent, Te Paepae Arahi)

Participant interviewees across all programmes indicated that they had reduced their alcohol consumption as a result of the IDR programmes, and some indicated they had ceased drinking alcohol completely. Some also indicated lower or ceased drug use.

[The programme] made me step back and look at life a whole lot differently and I haven't touched any drugs since I was on the course. My drinking is 10% of what it used to be. I don't think I would have got to that point without being [at the programme]. (Participant interviewee, Odyssey House)

I was still using weed when I started, but I managed to go cold turkey at New Years this year. (Participant interviewee, Health NZ Te Tai Tokerau)

These and other related changes were also reflected in some provider data. For example:

- 94% of participants from Downie Stewart Foundation's (n=17) September 2022 and May 2023 intakes agreed that they had stopped or greatly reduced their addictive behaviour while in the programme.
- Participants from Eduk8 describe goals to abstain or limit alcohol intake in end-of-programme evaluations.
- Harmony Pasifika's analysis of Leeds Dependency Questionnaire scores between 2014 and 2024 indicate moderate to high dependency (>10) and a reduction in pre-programme (7.68%) and post programme (1.72%) scores (n=2668).
- Most whānau responses in a Health NZ Te Tai Tokerau whānau survey (n=72) conducted between 2013 and 2024 consistently reflect observed positive

changes in their family members' drinking behaviours. Common themes were reduced or no observed drinking, higher motivations to stop drinking and more awareness/weariness around drinking.

We note that some programme participants undertake other AOD related programmes at the same time as the IDR programme. Salvation Army's Bridge programme and Alcoholic Anonymous (AA) were referred to by some. For someone who comes through the Drug Treatment Court, the IDR programme is part of a wider package of AOD programmes and supports. Meanwhile, one provider takes referrals from their therapeutic community. For these participants, the IDR programme is part of a wider package of treatment modalities.

For those who take part in other programmes, there is likely a cumulative effect on their drink and/or drug use. One participant admitted it was hard to tease out which programme was influencing the most. However, they believed the programmes complemented each other and that there is value in each.

AA, although it helps you to sort of maintain your abstinence, [the IDR] programme gave me the reasons why you should be abstinent and also some of the practical tools as well. (Participant interviewee, Harmony Pasifika)

Increased empathy with victims

Evaluation data consistently indicates that the IDR programmes greatly influence participants' sense of empathy for those who may be impacted by impaired driving. This includes empathy for direct victims of a crash, indirect victims such as family and friends and those involved in the emergency response.

Just the way that they got us thinking about other things instead of just the drink driving, there was [sic] other things involved too, like friends, family, emergency services, everyone it affects. (Participant interviewee, Odyssey House)

Victim and lived experience statements gave participants a 'reality check', an emotional connection to potential consequences and an opportunity to put themselves in 'someone else's shoes'.

I think I had that transformation [...] here is this person who was deeply affected by a drink driver [...], and you realise at that moment, in your selfishness, you never considered anyone else and here is this person that could potentially have been one of your victims and he is a person, he is a human. (Participant interviewee, Harmony Pasifika).

I think it was good [to have] that real, that life experience stuff, cos up till then it was just theory, [...] but actually having someone that had been in that

position and actually then talk about it for themselves, [...] was like 'oh shit', cause I've always used the excuse of 'I haven't crashed or hurt anyone so it's not a problem'. (Participant interviewee, Downie Stewart Foundation)

Changed attitudes to driving while impaired

All programmes have a strong focus on changing attitudes around driving impaired. There are different approaches to doing so, but they centre largely on making impaired driving a moral, value-based or relational issue as opposed to a legal one. Providers frequently noted that participants become more in tune with their own values and more emotionally mature, which contributes to shifts in attitudes. Meanwhile, participants often mentioned increased empathy as a key contributor to attitudinal change.

A common theme in participant interviewee feedback, was that the programme had been 'eye-opening' or a 'wake-up call'. Participants shared how they have realised through the programme how their past actions might have impacted their loved ones and what the potential consequences could be in future if their impaired driving continues.

[...] for myself, mine was doing drugs and driving every day and I never looked at it as a thing, ever, actually 'just is my lifestyle' but doing the course, seeing the effects that it can have on not only me but my family and other people that I affect, could affect, was quite eye opening. (Participant interviewee, Downie Stewart Foundation)

... I mean to look at it from [a sober] point of view, I mean it's definitely, you look at it very much so differently, what if I had crashed, what if I did hit someone else, and it definitely opens your eyes to a point where you're thinking about it twice (Participant interviewee, Ngāti Kahu Hauora).

Many participant interviewees were at the point of going to jail or losing their licence if they were caught driving impaired again. Although avoiding these consequences had been an initial driver for them to not to drive impaired again, it is no longer the only reason.

So that was my third DIC, second in about two and a half years. So basically, if I go back to Court for that now, it's off to jail sort of thing. So, there were some pretty serious consequences to it and like I guess I'd only ever really considered the, shit I'm going to lose my licence and how am I going to get around and stuff like that. Like coming here and looking at it differently and it wasn't just that, it was how it would impact me financially and others around me and there was so much more that I never even really thought about. So, I guess these [programme facilitators] just put everything in perspective and,

yeah, it gave me a very different outlook. (Participant interviewee, Odyssey House)

Participant interviewee feedback and end-of-programme evaluation form responses reflect changed mindsets – from having been stuck in old ways, doing ‘what we always did’ and playing an active role in New Zealand’s ‘accepted’ drink driving culture, to considering impaired driving ‘unacceptable’, ‘a bad decision’, ‘stupid’, ‘not worth it’, ‘not cool’ and ‘bad’.

Over the 12 weeks [the programme] has changed the way I think and feel about drinking and driving. I don't like it and I'm not shy to tell other people not to. (End-of-programme evaluation form respondent, Health NZ Te Tai Tokerau)

The programme was the best thing because [that] attitude of "she'll be right" has gone out of my head now. (End-of-programme evaluation form respondent, Eduk8)

Other data also point to attitudinal change. For example, a NZ Police report on Eduk8’s The Right Track programme describe observations by participating police on attitudinal change from the programme.

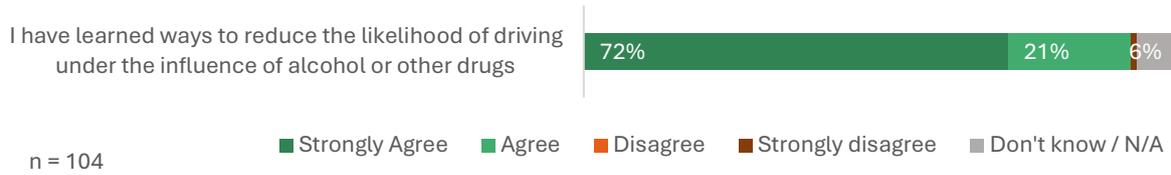
Throughout the [Right Track] courses, anecdotal evidence has emerged about how learners have stood up to mates, taken car keys off them and worked to change attitudes within peer groups. One learner rang police after his mate refused to give him the keys and drove away. I believe such attitude changes of participants and supporters, has a positive impact on the safety of our roads. (NZ Police Report, 2013)

Although attitudinal change appear to be commonplace, a few participants from one provider (n=3) did feel hard done by the system for their impaired driving offence – feeling their “freedom had been taken away” by the lower allowable alcohol limit brought in in 2014 and felt they were being treated or looked at worse by the legal system than violent offenders, which they didn’t feel was right. This suggests a reluctance to attitudinal change amongst some.

Applying alternative strategies to driving while impaired and planning ahead

Nearly all survey respondents (93%) agreed that they have learned ways to reduce the likelihood of driving under the influence since taking part in the programme (Figure 13).

Figure 13: Survey participants' agreement on reducing likelihood of driving under the influence



Unprompted, 19% of survey participants (n=83) also indicated that they now create and follow safety plans before drinking.

I make sure now to have a sober d, to book an Uber or get my wife to drop off and pick up.” (Survey respondent, Te Paepae Arahi)

Similarly, participants consistently reported, through interviews and end-of-programme evaluation forms, having learned alternative strategies and that they were actively using them. This includes:

- Organising sober drivers, having family/whānau on standby for pick up/drop off and/or using taxi services.
- Leaving vehicle at home if there is a chance of consuming alcohol or other drugs.
- Having a plan A and B, to ensure multiple scenarios are covered.
- Stocking up on food, snacks and beverages ahead of a gathering to minimise the need to go anywhere.
- Abstaining from drinking, and/or monitoring standard drink intake.

These changes are reflected in the following quotes.

I feel like its's given like the people that's taking these classes, that it's giving us a plan and alternatives to turn to and have because like, were just out in the world, no plan A, no plan B, so when shit hits the fan, you just act on your thoughts. (Participant interviewee, Harmony Pasifika)

Yeah, forward planning. So, knowing my triggers and knowing that if I go to the pub and have one, it's probably going to be four, and if I've got the car well, I'm just going to drive it home. So, it's become, 'okay well, I'm going to the pub, I intend on drinking, so let's not take the car'.” (Participant interviewee, Odyssey House)

I think the most important [step] now [...] is to plan my drinking better. If I don't have a sober driver or money for an Uber then I won't be drinking. (End-of-programme evaluation form respondent, Eduk8)

So [I've learnt], it's pretty much a habit of preplanning. Preplanning and like, just staying on top of the game, like get sober drivers, if you're hosting you prep pretty much everything, maybe collect all the boys' keys before and just limiting drinks (Participant interviewee, Ngāti Kahu Hauora)

Other data sources also point to the use of alternative strategies. For example, most respondents to a 3-month follow up survey conducted by Health NZ Te Tai Tokerau between 2014 and 2015 (n=91) shared examples of how they had made changes to their lives to commit to not drink and drive since completing the course, such as instilling drink limits and preplanning.

Improved self-efficacy

In addition to the desired outcomes described above, evaluation data indicates that many participants have developed a strong belief in their ability to manage their behaviours and make safer decisions regarding driving and alcohol and other drug use. In particular feedback through the survey and interviews suggests that participants feel more confident in their capacity to avoid driving impaired and implement the strategies they've learnt. They also displayed a higher resilience to challenges, such as feeling better equipped to handle peer pressure. There were also indications that some participants had set longer-term goals and accepted and/or sought additional support to help with any underlying needs.

Confidence in the ability to avoid driving impaired was reflected in providers' end-of-programme evaluation forms. For example:

- Nearly all (97%) of Harmony Pasifika's graduates from between 2014 and 2024 (n=660) agreed that they will not be drinking and driving over the legal limit in the future, and that they can keep to a 'zero limit' for drinking.
- All participants (n=17) from Downie Stewart Foundation's intakes between September 2022 and May 2023 agreed they felt less likely to drive under the influence in the future.

Sharing learning and influencing others

The majority of survey respondents indicated that they had shared what they had learnt from the IDR programmes with other people (83%). Similarly, participant interviewees frequently talked about teaching friends, family and colleagues about what they'd learnt, and encouraging and/or helping them to change behaviours such as reducing their alcohol and other drug use and/or not driving under the influence. This indicates that the IDR programmes have potential to contribute to desired outcomes beyond programme participants.

8. What factors contribute to positive outcomes and what are the barriers?

This section reviews factors that contribute to, or inhibit, effective programme delivery and achieving positive outcomes. They are drawn from participant and provider interviews, and other stakeholder interview data.

Contributing factors

Accessibility and transportation: Programme attendance can be influenced by transportation issues, scheduling, and convenient locations. Proximity to public transport, such as bus stops, can enhance accessibility. Providers that offer transportation, particularly in rural areas, have seen improved participant engagement and retention. In some instances, programmes have been discontinued due to these challenges.

External collaboration and relationships: Strong relationships with referrers enhance programme success by ensuring appropriate people are referred and correctly informed about the programme. Referrers can motivate participants and support programme coordination. Providing connections to additional resources or support services during or after programme completion can enhance participant success and well-being.

Comprehensive assessment: The pre-assessment allows providers to understand participants' needs (including transportation), motivations, and suitability for the programme. It can enhance engagement and facilitate referrals to additional or more appropriate support services.

Tailored delivery and content structure: The organisation and timing of content and activities are important. A coherent, progressive sequence that allows for time for reflection, at the appropriate times, maximises impact, while appropriate time allocation prevents loss of interest or insufficient engagement with the material. Providers highlighted the importance of being able to adapt and tailor programme delivery to meet the specific needs of participants, enhancing engagement and effectiveness. Overly structured approaches limit the ability to respond to individual circumstances and needs.

Effective facilitation: Successful facilitators create a safe environment for participants to be vulnerable and honest. They balance constructive challenges with support and must engage well with participants to foster connection. Facilitators must also work well together. Feedback indicates that optimal group size is between 5-12 participants. Smaller groups may lose the benefits of collective shifts and learning, while larger

groups can make engagement challenging. However, some providers effectively manage larger groups.

Whanaungatanga and kai: Whanaungatanga helps develop strong relationships within the group (a ‘well formed group’) which fosters trust and openness, enabling participants to share honestly and support one another. Sharing kai (food) was considered beneficial for creating a welcoming environment, serving as a whakanoa (a process to remove tapu/restrictions), and helping to break the ice and re-energise the group.

The groups that are well formed and feel a connectedness within their own group, they often get more out of [the IDR programmes]. I think of them like a tide. They are not moving by themselves, they're moving together as a unit and so the force behind them and the knowledge behind them is much greater and you can tell the difference between a well formed group and those who are not bonded because they don't have the same amount of energy in the group. (Provider)

Motivation and programme completion: Participants’ willingness to change upon entering the programme supports engagement and increases the likelihood of achieving positive outcomes. Participants feeling coerced or forced to take part can influence motivation to engage.

Programme completion correlate with better outcomes. Attendance at the initial session is particularly critical for establishing group bonds and setting a foundation for engagement. Most dropouts occur before the second to fourth session, but those who continue beyond this point are more likely to complete the programme. For example, requiring attendance at the first session has led to improved retention rates.

External support for participants: Support from family and employers such as transportation, moral encouragement, and time off work, can play a crucial role in participants’ ability to engage with the programme, their motivation to change and sustaining change.

Barriers

Several factors that inhibit effective delivery and achieving positive outcomes were also identified. These centred on:

Resourcing and contracting: Some providers reported unchanged funding levels over an extended period, shortage of koha and kai budget, and limited ability to support participants to get to the programme. Short contracting periods and lack of FTE health funding contracts makes it hard to succession plan and prepare in the longer term.

Capacity issues: Delivery requires significant input amidst other responsibilities and roles. Access to back-up personnel who are appropriately trained for when facilitators can't attend can be a challenge.

Change in sentencing practices: Increased use of alcohol interlock devices in the justice system was seen by some as a potential barrier, as it can take people away from moral development and making the 'right choice'. As one provider puts it, "our goal is that people become their own interlock". We note however, that some stakeholders considered the interlock a great tool in the rehabilitation process.

Since interlocks were put in use, there are fewer people mandated for the programme which has impacted on referral numbers. Further, indefinite disqualifications through Section 65 are less common than they used to be and are only applied to those with very high EBAs. Being indefinitely disqualified used to be a strong motivator for people to do the programme.

Forensic programme in health setting: Health clinicians may not be trained in forensic needs associated with criminogenic thinking or understanding recidivism, etc.

Participant characteristics and offending history: Substance dependency impacts on motivation and engagement and prevents participants from focusing on and addressing the impaired driving behaviour. Other underlying issues to impaired driving behaviour (e.g. mental health) may not be possible to address through the programme. Meanwhile, a high number of EBAs generally means more entrenched behaviour that is more difficult to influence. More seasoned impaired drivers may also influence negatively on others in the group ('contamination').

Lack of systemic approach: There is currently no systemic approach for coordinating programmes through justice system services and sentencing. It was described as 'piecemeal' and dependant on particular service centres, areas or the professionals involved.

9. To what extent do the IDR programmes provide value for the resources invested?

The VfI approach recognises that 'value for the resources invested', is not just about return on investment (determined through systematic analysis of costs and benefits), but also about seeing that a programme or service creates 'enough' social value (which may be assessed using any mix of methods appropriate to the context and may capture considerations beyond those included in a cost-benefit analysis).²¹ This section first

²¹ King J, Hurrell A. (2024). [A Guide to Evaluation of Value for Money in UK Public Services: Why cost-benefit analysis alone may be insufficient to evaluate VfM, and how to navigate a solution](#). Verian Group.

looks at the extent to which the programme provides social value and then explores the benefits of the programme in monetary terms against its costs.

Effective generation of social value for families, communities and taxpayers

Overall, we made the evaluative assessment that the IDR programmes generate ‘good’ social value for families, communities and taxpayers. However, the extent to which it does so for these individual groups vary somewhat. The social value for participants and families is at the higher end (good/excellent). The value for communities and taxpayers looks promising but lacks sufficient evidence to make any higher claims (adequate). Finally, until this evaluation, the IDR programme as a whole has not contributed to a body of knowledge about impaired driving programmes (not meeting expectations).

Fewer dangerous driving incidents and crashes affecting communities

The ultimate goal of the IDR programmes is to contribute to a reduction in rates of driving under the influence so that there are fewer dangerous driving incidents and crashes affecting families and communities. There was no recidivism, driving incident or crash data linked to programme participants made available for this evaluation. However, triangulating the data at hand, there is emerging evidence that the IDR programmes contribute to a reduction in impaired driving. Therefore, we have rated this evaluative criterion adequate (Table 15).

Table 15: Fewer dangerous driving incidents evaluative judgement

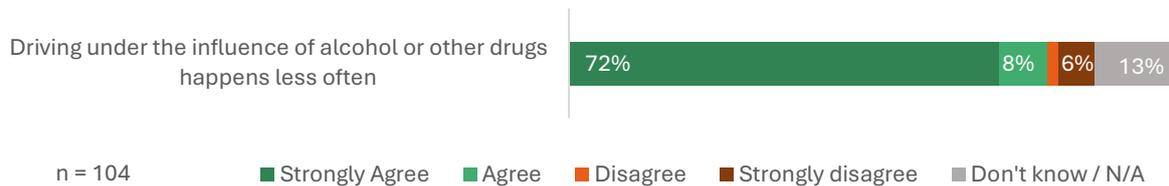
| Vfl criteria | Sub-criteria | Judgement | Rationale |
|---|---|--|---|
| Fewer dangerous driving incidents and crashes affecting communities | Reduction in rates of driving under the influence | Adequate (with limited data available) | Self-reporting, other stakeholders’ observations and provider evaluations suggest that the IDR programmes contribute to a reduction in driving under the influence. This could be substantiated by improving future collection of outcome data. |

A high proportion of participants self-report a reduction in driving under the influence

80% of survey respondents indicated that driving under the influence of alcohol or other drugs happens less often since taking part in the IDR programmes (Figure 14). On

average, past participants were slightly more likely to agree that they have reduced incidences of driving under the influence than current participants (3.8 vs. 3.6).

Figure 14: Survey participants' agreement on driving under the influence less often



Of those who provided free text responses about any lifestyle changes they have made as a result of the programme (n=96), 20% indicated that they have stopped driving under the influence all together.

I don't drive with a drop of alcohol in my system anymore. (Survey respondent, Te Paepae Arahi)

Participant interviewees indicated they have not driven under the influence since taking part in the IDR programmes. For past participants, this change had been sustained for various lengths of time depending on when they graduated, but up to numerous years.

I don't drink and drive anymore, at all [since doing the programme one year ago]. (Participant interviewee, Health NZ Te Tai Tokerau)

[I did the programme] five years and 10 months ago. So, I haven't done [drink driving] since then. So, all in all, I haven't reneged or dishonoured the best support that I needed at the time. (Participant interviewee, Manaaki Ora)

Although these are promising findings, we note some participant interviewees were under a special court condition not to use alcohol and/or other drugs and/or had an alcohol interlock device installed in their vehicle. Subsequently, they are less likely to drink and drive, and/or may be hesitant to self-report drink driving in a survey, even under assurance of anonymity. We can't say whether changes to their impaired driving will be sustained after these conditions are lifted.

Other stakeholders have observed reduced re-offending

Other stakeholders (n=5), such as probation and police officers, have observed reduced rates of re-offending indicated by programme graduates not coming back through their systems. However, we note that these stakeholders were limited in numbers, and only spanned three of the programmes.

I think it has made a big difference, and I can tell by the number of people who are coming back for drink driving offences. You know, it's very minimal. (Probation)

Probation officers commented that their local IDR programmes were the most effective of any programmes that they refer to.

A judge spoken to emphasised how the IDR programmes play an important part wider programmes of work, such as Drug Treatment Courts. Having a combination of different types of programmes, and delivery styles enhances the chances of having an impact.

Likewise, for us [at the Drug Treatment Court], we don't know what is really going to help the penny to drop but usually it's not just one thing. (Judge)

Providers' self-commissioned evaluations have found reductions in re-offending

Some providers have self-commissioned controlled matched evaluations or extrapolated statistics from the Police to understand the effectiveness of their programmes. They have all found reductions in reoffending. Although these studies are dated, the broad approach remains similar with these providers.

- A 2018 evaluation of Harmony Pasifika's IDR programme (One for the Road) found those who completed the programme had a 7.5% recidivism rate compared to a rate of 9.4% for a matched control group of non-participants (a 20% reduction in detected reoffending).²²
- NZ Police data on reoffending rates for people who completed Odyssey House programme (Driving Change) showed a 10% reoffending rate from a group of 40 participants in 2016/17 and a 5% reoffending rate from a group of 36 participants between 2018 and 2021. However, comparisons for these reoffending rates were not provided.²³
- An evaluation by NZ Police of Eduk8's IDR programme (TRT/RID) in 2013 found reduced rates of driving offences and criminal offences after completing the programme. Up to a year after completing the programme, 82% of participants had not committed any further driving offences, while 9% had committed one further offence and 9% had committed more than one.²⁴
- A 2011 evaluation of the Health NZ Te Tai Tokerau IDR programme (SOBA at the time, now the Impaired Driving Programme) found an 8% reoffending rate for people who completed the programme compared to a 34% for those who were referred to the programme but did not start the programme. However, this comparison may be affected by selection bias as those who completed the programme may be more conscientious in general than those who did not.²⁵

²² Waters Gerald. (2019). *One For the Road - An Outcome Evaluation of a Drink Driver Rehabilitation Programme*.

²³ This information is outlined in a Odyssey House Trust PowerPoint presentation from 2023.

²⁴ NZ Police. (2013). *Evaluation Report on "the Right Track – Te Ara Tutuki Pai". Programme 2011-2012*.

²⁵ B Wood. (2011). *Evaluation of Drive SOBA Programme – Mid and Far North Regions of Northland*. Written for Road Safety Trust.

Participants experience improved life outcomes

There is clear evidence that participants experience improved life outcomes through changes across several significant life domains. We have rated this evaluative criterion excellent (Table 16).

Table 16: Improved outcomes evaluative judgement

| Vfl criteria | Sub-criteria | Judgement | Rationale |
|--|----------------------------|-----------|--|
| Participants experience improved life outcomes | Change across life domains | Excellent | Participants can identify a range of positive changes across several and/or significant life domains since completing the programme. |

Participants can identify a range of positive changes across several life domains

Participants identified a range of positive changes that have occurred in their lives, and which they attribute to their participation in the programme. These can be matched against the life domains outlined in Treasury New Zealand’s Living Standards Framework. It captures resources and aspects of our lives that have been identified by research or public engagement as being important for our wellbeing as individuals, families, whānau and communities. Changes are summarised in Table 17. The most frequently cited changes are indicated in bold.

Table 17: Changes across life domains

| Domain | Examples |
|----------------------|--|
| Health | <ul style="list-style-type: none"> • Healthier lifestyle habits, including reduced or ceased alcohol and/or other drug consumption • Increased self-care behaviours and accessing continued support • Improved access to and strengthened connections with support systems • Understanding health and wellbeing through different dimensions • Feeling healthier • Ability to deal with different emotions and cope with stress |
| Knowledge and skills | <ul style="list-style-type: none"> • Increased alcohol and other drug harm awareness • Understanding consequences of impaired driving • Understanding standard drink measures • Learning about strategies to avoid impaired driving • Learning useful tools, such as setting SMART goals • Understanding financial cost of alcohol and/or other drug use, and learning basic budgeting principles • Strengthened communication and interpersonal skills |

| | |
|-----------------------------------|--|
| | <ul style="list-style-type: none"> • Improved understanding of influence of alcohol and drugs on brain functioning and decision making • Taking up tertiary study (e.g. AOD counselling) |
| Cultural capability and belonging | <p>For Māori:</p> <ul style="list-style-type: none"> • Increased connection to culture, iwi, whenua • Sense of belonging • Strengthened sense of identity • Increased cultural knowledge • Increased participation in culture (e.g. desire to learn te reo Māori) |
| Work, care and volunteering | <ul style="list-style-type: none"> • Gained/re-gained/maintained employment • Regained professional registrations (e.g. nursing, teaching) • Working /volunteering for IDR programmes • Contributing to family business |
| Income, consumption and wealth | <ul style="list-style-type: none"> • Retaining/regaining driver licence (enabling employment) • Budgeting and saving money • Contributing to family costs |
| Leisure and play | <ul style="list-style-type: none"> • Taking up old hobbies • More physically active |
| Family and friends | <ul style="list-style-type: none"> • Putting more effort into family relationships • More positive relationships with partners and/or family members • Ability to take children to sports and school and visit family and friends after regaining driver licence • New social connections and a peer group through the IDR programmes |
| Safety | <ul style="list-style-type: none"> • Reduced or ceased driving under the influence • Creating and following safety plans • Relapse prevention planning • Implementing alternative strategies to driving under the influence |
| Subjective wellbeing | <ul style="list-style-type: none"> • More positive outlook on life • Feeling hopeful for the future • Improved self-efficacy • Getting a sense of purpose, value and direction |

Avoiding jail

In addition to the outcomes outlined in the table above, many participant interviewees spoke of avoiding going to jail as a result of the programme. The impacts of incarceration on life outcomes are profound, often leading to difficulties in finding stable employment, increased mental health challenges, and disrupted family connections. Research indicates that Māori (who are overrepresented in the IDR

programmes) and Pacific peoples, who are disproportionately represented in the prison population, experience compounded social and economic disadvantages post-incarceration.²⁶ Additionally, studies show that incarceration can hinder access to education and housing, perpetuating cycles of poverty and reoffending.²⁷

Building a body of knowledge for IDR programmes

Table 18: Building a body of knowledge evaluative judgement

| Vfl criteria | Sub-criteria | Judgement | Rationale |
|---|---|--------------------------|--|
| Learning supports programme development, is shared more broadly and contribute to evidence base | Learning supports programme development, is shared more broadly and contribute to evidence base | Not meeting expectations | The opportunity to build a knowledge base and community of practice of IDR programmes has not been realised. |

There is an opportunity to support the building of knowledge of IDR programmes

As mentioned elsewhere, providers indicated Health NZ/Ministry of Health have not been actively engaging with them, in terms of learning from them, supporting a community of practice, or building a knowledge base. One provider indicated that they have offered to facilitate connection and learning between providers, but this has not been taken up by Health NZ/Ministry of Health. There is clearly an opportunity for all parties to work more closely together in sharing practice and learning to benefit the knowledge base of impaired driving rehabilitation.

Nonetheless, some providers are actively contributing to a wider body of knowledge. One provider is doing their PhD on the subject and has written papers and presented at conferences. Providers who have commissioned evaluations have made these publicly available.

Economic analysis

Economic analysis of IDR programmes involves comparing the benefits of the programmes in monetary terms with the costs. Our findings are outlined below.

²⁶ Department of Corrections. (2019). *Māori and the Criminal Justice System: A Review of the Literature*.

²⁷ Fergusson, D M, Horwood L J, & Ridder EM. (2008). *Changes in the Life Circumstances of Young Adults and Their Effects on Recidivism: A New Zealand Study*.

Social benefits

The social benefits of IDR programmes that can potentially be quantified primarily come from avoiding harm associated with incidents of impaired driving. Most of this harm comes from road crashes where alcohol or drugs were a contributing factor. If IDR programmes can reduce the number of road journeys where the driver or rider is affected by alcohol or drugs compared to what would otherwise occur, it is expected that there will be fewer crashes. The avoided costs of those crashes are a social benefit that can be compared with the cost to provide the IDR programmes, to help determine if the benefits of the programmes are greater than their costs.

The cost of road crashes in New Zealand is high and links to impaired driving

The costs of road crashes in New Zealand are substantial. The total social cost of road crashes was estimated at \$11.6 billion for 2022.²⁸ This is an under-estimate of the true cost as crashes that did not result in death or serious injury are not always recorded. On average for 2022, social costs were around \$16.1 million per fatal crash, \$1.7 million per serious injury crash, and \$0.3 million per minor injury crash. These costs include the value of loss of life (currently valued at \$14.2 million per road crash fatality), permanent disability, lost productivity, medical treatment, court costs, and vehicle damage.

There is also a clear link between impaired driving and crashes. From 2020 to 2022, alcohol and/or drugs contributed to 45% of fatal crashes, 9% of serious crashes, and 12% of minor injury crashes. These harms affect more people than just the drivers. Between 2020 and 2022, for every 100 drivers who died in road crashes where they were under the influence of alcohol and/or drugs, 27 passengers and 12 other road users were also killed.²⁹

The IDR programmes would need to prevent one fatal crash every 22 years to justify its costs

From available data, the nine providers of IDR programmes being evaluated received funding of \$1.45m over a two-year contract from 1 July 2021 to 30 June 2023, or around \$726,000 per year. Given the average cost per fatal crash for 2022 of \$16.1 million, if this funding enabled the programmes to prevent one fatal crash per 22 years on average, the social benefits would justify the funding provided to the programmes.

Other potential benefits come from avoiding justice and corrections costs associated with impaired driving. Even if an incident of impaired driving does not lead to a crash, if the driver is caught there are costs associated with the resulting processes. IDR

²⁸ Ministry of Transport, *Social cost of road crashes and injuries*, 2023 update, available at <https://www.transport.govt.nz/area-of-interest/safety/social-cost-of-road-crashes-and-injuries>.

²⁹ Ministry of Transport Safety – Annual statistics; alcohol and drugs. Retrieved from: <https://www.transport.govt.nz/statistics-and-insights/safety-annual-statistics/alcohol-and-drugs/>

programmes may also contribute to improved employment outcomes for participants, and to improved physical and mental health if there is a change in alcohol consumption.

As illustrated throughout this report, there is some indicative evidence of improved road safety outcomes (e.g. reduced recidivism) in prior evaluations of some of the IDR programmes. In addition, self-reported experiences of programme participants, whānau and other stakeholders suggest positive impacts on behaviour at a personal level including reduced alcohol and drug use, reduced incidences of driving while impaired, pro-social attitudes and behaviour regarding impaired driving and high confidence levels of reduced likelihood of driving impaired again. These are the type of outcomes that the programme logic (Figure 1) posits will contribute to improved road safety outcomes.

While indicative of some positive road safety and personal outcomes, the available evidence outlined in this report is insufficient to quantify the benefits of the IDR programmes being evaluated. Key limitations are:

- The impact of participating in the IDR programmes being evaluated and the subsequent change in likelihood of being involved in a fatal or serious crash has not yet been investigated.
- Except for one study, outcomes for IDR programmes participants have not been compared to outcomes for people with similar characteristics who did not participate in IDR programmes.
- Personal outcomes such as employment and health have not been measured in a way that can be valued and compared to costs of the programmes.
- It is not clear whether existing analysis of outcomes has accounted for other interventions occurring at the same time as participation in an IDR programmes that may also directly affect impaired driving behaviour, such as court-mandated use of alcohol interlock devices.

Cost per participant

Based on the cost of \$726,000 per year, and activity data at hand (i.e. 765 people assessed for eight programmes, with 565 of those participating and 515 graduating), average funding provided under the two-year contract between July 2021 and June 2023 was estimated to be around \$2,000 per participant and around \$2,200 per graduate, across the nine providers included in the evaluation.³⁰ For providers where numbers of

³⁰ For providers where the number of participants and graduates were only available for part of the two-year funding period, these averages were calculated by pro-rating funding to match the period for which participant and graduate numbers were available. For example, if participant and graduate numbers were available for one year for a provider, half of that provider's funding was used in the calculation of average funding per participant and graduate. This assumes that providers continued to provide courses to a similar number of people in periods for which those numbers were not available.

participants were available for both years of the contract period, the average cost per participant ranged from around \$1,400 to around \$3,600. It was out of scope of this evaluation to compare these costs with similar programmes, but Health NZ may want to do so going forward.

Future data needs

To fully understand the return on investment of IDR programmes requires a more consistent approach to data gathering by all providers in future years, and a coordinated study of the impacts of these programmes on road safety outcomes. The types of data and analysis needed are detailed in Appendix 6.

10. What key insights might inform future programme development?

Based on the evaluation findings overall, and the ratings provided against individual VfI domains, we rate the IDR programmes as providing a ‘good’ value for investment. Findings indicate that the IDR programmes achieve equitable and economic resource management and equitable, efficient and effective programme delivery. They also suggest that the programmes generate social value, but the extent to which they do so is difficult to ascertain with the data at hand. This section outlines some key insights that might help inform future programme development.

National and regional level insights

Continued investment

The IDR programmes only need to prevent one fatal crash per 22 years, on average, for its social benefits to outweigh its costs. Additional benefits include avoiding justice and corrections costs associated with impaired driving and potentially improving employment outcomes for participants, as well as their physical and mental health. In this context, the outcomes of the programmes evidenced here appear valuable enough to continue the investment as a whole, at least until there is a better understanding of its and/or individual programme’s impact.

Understanding impact

There are clear signals coming through that the IDR programmes are delivering good outcomes from multiple delivery models. However, data collection is haphazard and inconsistent. To fully understand the IDR programmes’ effectiveness, impact and return on investment requires a more consistent approach to data gathering by all providers in future years, and a coordinated study of the impacts of these programmes on road safety outcomes. The types of data and analysis needed are detailed in Appendix 6.

Commissioning and funding approaches

The shift to regional commissioning models offers the potential for an integrated funding approach, but also the risk that delivery may get further fragmented through differing regional priorities. We note that continued funding should be within a framework that enables consistent funding prioritisation across regions and reporting on outcomes.

Flexibility in design and delivery is useful for supporting participation, engagement and completion and needs to be retained along with some common specifications to ensure consistency. The extent to which current contracts are fit for purpose in this flexible environment should be considered. Funding packages should consider the

realistic volumes and delivery components given the changing landscape and purchasing power since programmes were initiated over ten years ago and adjusted accordingly. Consideration should be made around contributing to costs associated with the provision of kai and transport as they are clearly key enablers to participation.

There is an opportunity for the relationship between Health NZ and providers to go beyond contract management. Health NZ and providers could work collectively to facilitate connection and engagement between providers and support shared learning and innovation. This could include other sector players such as dapaanz. A community of practice could potentially be led and sustained by providers themselves, but Health NZ should instigate the set up and support the process and ideally be involved to support the intersect between delivery and commissioning.

Changes to sentencing practice

The introduction of alcohol interlock devices and the reduction in Section 65 have impacted some of the IDR programmes by decreasing the number of referrals, and according to some, motivation to participate. With interlocks preventing individuals from driving under the influence, the immediate need for rehabilitation programmes may seem diminished. However, research indicates that these programmes remain essential for addressing the underlying behavioural issues related to impaired driving, as interlocks alone do not tackle the root causes of substance misuse and may only be a temporary fix. Continued support for rehabilitation is important to ensure long-term change and prevent recidivism, as interlocks do not replace the need for comprehensive education and support.³¹ Error! Bookmark not defined..³² There is an opportunity to explore the intersect between these practices and the IDR programmes.

IDR programmes in the wider AOD context

Providers emphasised that IDR programmes should be distinct from AOD treatment programmes, focusing specifically on behavioural and attitudinal changes related to driving under the influence, rather than addressing substance dependency. This aligns with the evidence; the separation ensures that individuals who need AOD treatment receive appropriate care before entering impaired driving programmes.³³ Nonetheless, due to the difference in focus, the impaired driving and AOD treatment programmes complement each other. Findings from the evaluation indicate that the IDR programmes have established referral pathways with AOD treatment providers and/or directly into their own internal AOD services. In fact, the IDR programmes were

³¹ New Zealand Transport Agency. (2021). *Review of the Alcohol Interlock Programme*. Retrieved from: <https://www.transport.govt.nz/assets/Uploads/TEBS-report-A-Reoffending-Evaluation-of-Alcohol-Ignition-Interlock-Sentences-from-2013-2017-in-New-Zealand-FINAL-WEB-VERSION.pdf>

³² Jonsson K. et al. (2020). The Effect of Ignition Interlocks on Recidivism and Subsequent Alcohol Use. *Journal of Studies on Alcohol and Drugs*, 81(3), 362-370.

³³ New Zealand Medical Journal. (2015). *Impaired Driving and Substance Use: Implications for Policy and Treatment*.

considered to work effectively as a 'point' of entry' to other support services more generally. There may be an opportunity to explore whether there could be a more considered approach to connecting the IDR programmes to other interventions.

Programme level insights

Some insights and considerations were also identified at the programme level. Some of these opportunities will likely require national and/or regional support.

In particular, there are some specific aspects of programme delivery that contribute to effective delivery and positive outcomes and should be considered across the programme as a whole. These include:

- Continued post-programme support to help facilitate sustained change over time.
- Tuakana teina/peer support approaches for enabling programmes to cater to different participant needs (e.g. literacy), supporting tuakana teina continued rehabilitation journey and providing another lived experience perspective.
- Lived experience, as it appears impactful and a key contributor to change.
- Involvement of family/whānau (or support people) in whanaungatanga and graduation as it appears useful for supporting participants on their rehabilitation journey and instils a sense of accountability.
- Post-programme follow-up, as it is an important factor for sustained change, and for understanding outcomes. It is not currently implemented across programmes. This practice should be re-instated and could be a useful tool in a coordinated data collection approach.

Other insights at programme level include:

- There is a high need for impaired driving programmes in rural areas, but transport challenges mean they are not viable. Different delivery modalities, such as online and mobile programmes, could be explored.
- There is an opportunity for the evidence base for the IDR programmes to be updated. The Matua Raki Impaired Driver Treatment guidelines for addiction practitioners initially used for the design and implementation of the programme is from 2012.
- There is currently a fairly high attrition rate between assessment and programme start. We note that some providers have implemented approaches for managing waiting lists, which could be explored further by others.

Appendix 1: Value for Investment

The evaluation is underpinned by the Value for Investment (Vfi) approach. The Vfi approach is designed to answer evaluative questions about *how well resources are used, whether enough value is created, and how increased value could be created from the investment*.³⁴ Evaluative questions require a judgement to be made – based on evidence and using a transparent process of reasoning.

This approach combines theory and practice from economics and program evaluation, to support accountability and good resource allocation as well as reflection, learning and adaptation. The Vfi framework provides the basis for making and presenting judgements in a way that opens both the reasoning process and the evidence to scrutiny. The Vfi approach achieves these aims by:

- Using explicit criteria (dimensions of performance) and standards (levels of performance), co-defined and agreed with stakeholders, to provide a transparent basis for making sound judgements about the use of resources and the value created by the IDR programmes.
- Combining quantitative and qualitative forms of evidence to support a richer and more nuanced understanding than can be gained from the use of indicators alone.
- Accommodating economic evaluation (where feasible and appropriate) without limiting the analysis to economic methods and metrics alone.

This approach helps determine whether an investment is worthwhile on the basis of observable features of programme delivery, immediate outcomes, contribution to longer-term outcomes, and agreed definitions of what good performance and value would look like.

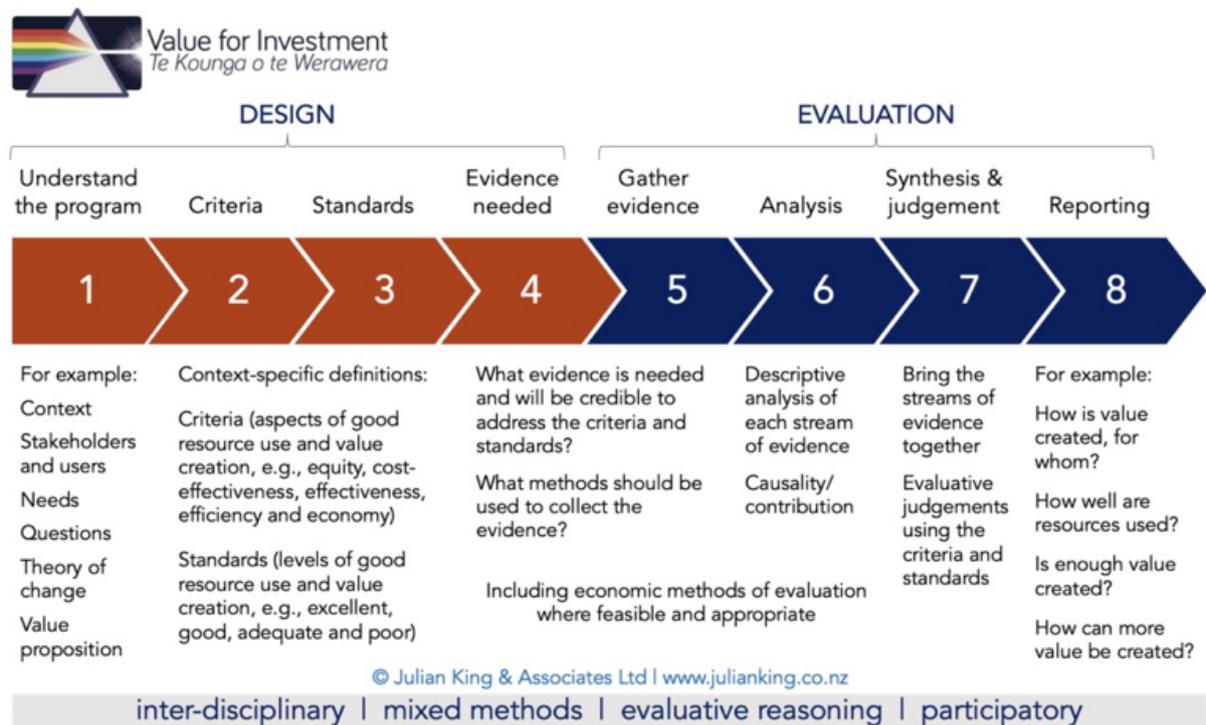
In Figure 15 below, we set out at a high level the steps in the Vfi approach, spanning evaluation design, criteria, and standards development, through to data collection, analysis, synthesis and reporting. This approach builds on established evaluative practice, by incorporating specific consideration of the value generated by the programme or service, as opposed to simply the delivery of intended outcomes. This consideration of value spanned all stages of the evaluation including:

- Defining how the IDR programmes create value, and for whom.
- Defining what good value would look like for the investment in the IDR programmes.

³⁴ King J. 2017. Using Economic Methods Evaluatively. *American Journal of Evaluation*, 38(1), 101–113.

- Determining what evidence is needed to determine the value of the IDR programmes.
- Gathering and organising evidence of performance and value.
- Interpreting the evidence on an agreed basis.
- Presenting a clear and robust performance story.

Figure 15: Value for Investment approach



Theory of change and theory of value creation

A theory of change provides an important reference point for understanding the intended process of change and outcomes.³⁵ It details how an intervention contributes to a chain of results and ultimately outcomes. The theory of change looks at how the resources or inputs into an organisation or a service such as the staff, the policies, knowledge, and guidance support the activities that then occur and the various outputs that may be delivered. These activities create outcomes and in turn, wider impacts for participants, communities, society, and government.

A theory of value creation (or value proposition) is a new and innovative addition to the field of programme theory, which extends a theory of change, and is drawn directly from the Vfl approach. This approach details the ways in which an intervention, programme

³⁵ Funnel SC, Rogers PJ. 2011. *Purposeful Program Theory: Effective use of theories of change and logic models*. Hoboken: Wiley.

or service is intended to use resources efficiently and effectively and create sufficient value to justify the resources used (i.e. value for money).^{36,37}

Explanation of the theory of change

Resources and Inputs

The theory of change acknowledges the resources that have been invested in the IDR programmes, both tangible and intangible (e.g. intellectual capital of service providers). Inputs are resources that are used to implement and deliver the programme. These include training for facilitators (although training is an activity, its role in the IDR programmes is an essential precursor to delivery, ensuring facilitators are ready to conduct programme activities), referral pathways, and guest speakers' expertise and time. Inputs may also include tangible resources provided directly, such as funding.

Activities

This describes what the programme does, and how it does it. As illustrated in the diagram, these include the delivery of workshops, assessment of participants, and connection to other agencies or community supports, such as for service referrals or other areas of personal/whānau support, where appropriate.

Intermediate outcomes

The proposed theory of change depicts a range of initial or 'intermediate' outcomes from the IDR programmes. For participants, these include initial engagement in the programme, established relationships with programme staff, and improved self-care.

With regard to impaired driving behaviour, the IDR programmes is expected to contribute to increased awareness amongst participants of the impact of their behaviour on others, the establishment of a plan to address this, and the development of strategies and skills to keep themselves and their whānau safe.

Longer-term outcomes

The theory of change depicts that there will be improved pro-social behaviour and a reduction in the level of impaired driving amongst participants. It is also envisioned that an increased awareness of the impact of their behaviour on whānau, and other factors will result in improved whānau relationships. Ultimately, an intended outcome is that participants will experience improved health and wellbeing.

Impact

The theory of change shows the potential for the IDR programmes to contribute to broader societal outcomes, which will have a positive impact on communities. A

³⁶ King J.2021. *Expanding theory-based evaluation: incorporating value creation in a theory of change. Evaluation and Program Planning.*

³⁷ For more information on theories of value creation, see: <https://www.julianking.co.nz/vfi/tovc/>

reduction in impaired driving is expected to contribute to improved road and community safety. As a result, there will be less burden on a range of public resources, including emergency services, Courts, Police, and health-related entities.

Explanation of theory of value creation

This section describes what would happen as a result of the IDR programmes operating in a way that aligned with the theory of value creation. It provides a logic for how resources may be transformed into significant social value. It posits that if the initiative looks after resources well (i.e. equitably, economically and efficiently), it will support participants to make positive changes in their lives that have flow on effects to their whānau and broader society. The reduction in both alcohol and other drug harm and societal and monetary costs of impaired driving will also contribute to improved community safety and wellbeing, improved family functioning, and the provision of economic benefits to Aotearoa. In the theory of value creation, the three overarching criteria are:

- Equitable and economic resource management
- Programme delivery that is equitable, efficient and effective
- The effective generation of social value for families, communities, and taxpayers.

These criteria are further defined through sub-criteria, discussed below.

Equitable and economic resource management

The VfI approach takes a broad view of resources beyond funding and acknowledges the range of resources that contribute to the IDR programmes. It posits that resources need to be well looked after to generate the desired value. For this programme it includes service design that values those with lived experience of addiction and/or driving impaired. It also values the existing infrastructure of providers, including the expertise and experience inherent in provider organisations (i.e. staff).

Programme delivery that is equitable, efficient, and effective

This level of the theory of value creation is primarily concerned with the delivery of the programme, ensuring that it is undertaken in an equitable, efficient, and effective way. The evaluation will explore the changes that are being achieved in the short- to medium-term that will indicate whether we are on track to create value in the longer term.

The valuing of te ao Māori and Kaupapa Māori approaches is fundamental to ensuring value; this includes, for example, sharing of karakia and kai during workshops, a whānau-centred approach, and the adoption of frameworks such as the Te Whare Tapa Whā model. Other contributions to achieving this value include a non-punitive approach; the utilisation of evidence-based interventions; ensuring that services are

delivered in a non-clinical manner and setting; and adapting the programme to meet the needs of participants, particularly where they face barriers in engaging.

Underpinning this dimension is the delivery of programmes that are adequately resource, and which meet intended outputs and outcomes; these will be explored across aspects of the theory of value creation, and specific further criteria may be developed as we review available expenditure and delivery data.

The effective generation of social value for families, communities, and taxpayers

This is the top level of the theory of value creation which is focused on what value is created, and for whom. Through working with participants, the IDR programmes can contribute to generating social value, such as fewer road crashes, trauma and deaths impacting communities, more efficient and equitable use of government resources, and a body of knowledge for future IDR programmes. Ultimately, there is the potential for participants to experience improved life outcomes.

Appendix 2: Detailed rubrics

Rubrics provide a transparent way of making evaluative judgements, by explicitly identifying how well the programme is expected to perform against key criteria (aspects of performance) and standards (levels of performance). Rubrics provide a way of presenting agreed definitions of quality and value at different levels of development. They make explicit the basis on which evaluative judgements will be made, and facilitate clarity of evaluation design, data collection, analysis and reporting.^{38,39}

Equitable and economic resource management

| Not meeting expectations | Adequate | Good | Excellent |
|---|--|---|--|
| Design and knowledge base draws on existing infrastructure and expertise of provider organisations | | | |
| <i>Performance is below the criterion for Adequate</i> | Provider expertise and infrastructure supports each programme's implementation | <i>Performance is more advanced than the criterion for Adequate but less than Excellent</i> | Local knowledge and infrastructure is utilised in project design and implementation, and Health NZ / Te Aka Whai Ora can draw on learning across different initiatives for future planning |
| Service design that values consumer voice/lived experience | | | |
| | Providers have access to lived experience knowledge/consumer voice to support programme development and delivery | | Lived experience/consumer voice is prioritised to meet the needs of tāngata whaiora |

Programme delivery that is equitable and efficient

| Not meeting expectations | Adequate | Good | Excellent |
|---|----------|------|-----------|
| Evolving and improving service delivery to overcome barriers to engagement/participation | | | |

³⁸ Davidson EJ. 2005. *Evaluation Methodology Basics – The Nuts and Bolts of Sound Evaluation*. Sage Publications, CA.

³⁹ King J, McKegg K, Oakden J, Wehipeihana N. 2013. Rubrics: A method for surfacing values and improving the credibility of evaluation. *Journal of MultiDisciplinary Evaluation*. Vol 9, No. 21.

| | | | |
|---|---|---|--|
| <i>Performance is below the criterion for Adequate</i> | Tāngata whaiora attend the majority of sessions and complete minimum requirements of programme | <i>Performance is more advanced than the criterion for Adequate but less than Excellent</i> | The vast majority of tāngata whaiora are fully engaged, attend all sessions, and exceed minimum requirements of programme |
| | Providers assess effectiveness of programme delivery and identify areas for improvement | | Providers actively adapt programme delivery to better meet needs of tāngata whaiora and assess impact of changes |
| Valuing of te ao Māori and Kaupapa Māori approaches | | | |
| | Providers are familiar with Te ao Māori and kaupapa Māori approaches which are evident in the delivery of some sessions | | Te ao Māori and kaupapa Māori approaches are highly valued and actively applied throughout all mahi undertaken by providers |
| Tailoring delivery to meet needs of tāngata whaiora | | | |
| | Facilitators have some knowledge of group dynamics and follow a programme outline | | Facilitators have in-depth experience and training in delivering group therapy, and are confident in adapting their approach as needed |
| A non-clinical and 'family' environment for tāngata whaiora | | | |
| | Sessions are delivered in suitable settings, with some refreshments provided | | Sessions are delivered in welcoming venues with plentiful food on offer |
| Adoption of accepted and well-evidenced psychological interventions | | | |
| | Providers are familiar with a range of psychological interventions and there is evidence of some uptake of these | | There is widespread uptake of well-evidenced psychological interventions, and improved knowledge of effective practice amongst providers |
| An overall health and wellbeing focus which is non-judgmental and non-punitive | | | |
| | Participants are comfortable sharing their | | Participants trust the process and feel empowered to make positive changes |

| | | | |
|--|--|---|--|
| | experiences in a group setting | | |
| TW develop or build on connections with whānau to support their behaviour change and personal development | | | |
| <i>Performance is below the criterion for Adequate</i> | Whānau are aware of the involvement of tāngata whaiora in IDR programmes | <i>Performance is more advanced than the criterion for Adequate but less than Excellent</i> | Whānau are in attendance and actively engaged in group/individual sessions alongside tāngata whaiora |
| | Tāngata whaiora maintain existing connections with supportive whānau throughout their involvement with the programme | | Existing connections with supportive whānau are further developed and strengthened both during and following completion of the programme |

The effective generation of social value for families, communities, and taxpayers

| Not meeting expectations | Adequate | Good | Excellent |
|--|--|---|--|
| Fewer dangerous driving incidents and crashes affecting communities | | | |
| <i>Performance is below the criterion for Adequate</i> | There is emerging evidence of a reduction in rates of driving under the influence attributable to the IDR programmes | <i>Performance is more advanced than the criterion for Adequate but less than Excellent</i> | There is consistent evidence of a reduction in rates of driving under the influence attributable to the IDR programmes |
| Tāngata whaiora experience improved life outcomes | | | |
| | Tāngata whaiora can identify some positive changes across one or two life domains since completing the programme | | Tāngata whaiora can identify a range of positive changes across several and/or significant life domains since completing the programme |
| Building a body of knowledge for IDR programmes | | | |
| | Learning from individual providers supports the IDR programmes' ongoing development | | Learning from the IDR programmes is shared more broadly and contributes to the evidence base for the |

| | | | |
|--|--|--|--|
| | | | effective delivery of impaired driving rehabilitation programmes |
|--|--|--|--|

Appendix 3: Detailed data sources

Table 19: Spread of survey responses across providers

| Provider | Interviews (survey) | | | | |
|------------------------------------|---------------------|----------------------|---------------|----------|----------|
| | Staff | Current participants | Graduates | Others | Whānau |
| Harmony Pasifika | 2 | (26) | 4(4) | 3 | 1 |
| Manaaki Ora Trust | 2 | 4(6) | 1(1) | | |
| Odyssey House Trust | 2 | 4(12) | 2(2) | 1 | |
| Ngāti Kahu Hauora | 2 | (4) | 2 | | |
| Eduk8 Charitable Trust † | 1 | (1) | (1) | | |
| Health NZ Te Tai Tokerau | 7 | 4(6) | 3(3) | | |
| Downie Stewart Foundation | 3 | (3) | 8(7) | 1 | |
| Te Paepae Arahi Trust | 3 | (4) | 2(22) | | |
| Tūhoe Hauora Trust | 5 | (2) | 1 | | |
| Total per stakeholder group | 27 | 12(62) | 23(40) | 5 | 1 |
| Total overall | 68 (102) * | | | | |

* There were two additional responses against a provider that did not take part in this evaluation. These responses have still been used in our analysis as the respondents most likely ticked the wrong provider.

† The leadership of Eduk8 were overseas at the time we were undertaking interviews with programme participants, and as a result no courses were operating at the time, which prevented participant engagement. We were given extensive access to programme feedback forms, and previous analyses undertaken. Attempts were made to seek feedback through the programme graduate Facebook group, but few responses were received.

Table 20: Spread of other data sources across providers (where provided)

| Provider | Other data sources |
|------------------|--|
| Harmony Pasifika | <p>Thematic analysis of key themes from end -of-programme evaluation forms between 2014-2024</p> <p>Waters, G. (2019). <i>‘One For the Road - An Outcome Evaluation of a Drink Driver Rehabilitation Programme’</i>. RIDNZ. Unpublished</p> <p>One for the Road Group for Repeat Impaired Drivers Journal Article by Dawber A & Dawber T, dated 30.4.21</p> <p>Programme booklet, feedback form and screening tool templates</p> <p>OFTR Harmony Trust Conference Presentation Conf; 2021</p> <p>Contextual statistical data from 2014-2024 (n=2668)</p> |

| | |
|---------------------------|--|
| Manaaki Ora Trust | 2021-2024 participant end-of-programme evaluation forms (n=56) 2021-2024 facilitator de-brief/evaluation forms (n=51) |
| Odyssey House Trust | 2016-2017 (n=40) and 2018-2021 (n=36) reoffending statistics from NZ Police data base presented in PowerPoint from 2023 |
| Eduk8 Charitable Trust | 2023-2024 participant end-of-programme evaluation forms (n=112) 2023-2024 supporter end-of-programme evaluation forms (n=94) NZ Police. (2013). <i>Evaluation Report on “the Right Track – Te Ara Tutuki Pai”</i> . Programme 2011-2012 NZ Police. (2013). <i>The Right Track Waikato: An evaluation of graduate’s post-course offending</i> NZ Police. (2010). <i>Evaluation Report on the “Right Track” Programme</i> 2010 Police Evaluation Graphs |
| Health NZ Te Tai Tokerau | Database with 2013-2024 responses from: participant end-of-programme evaluations (n= 698); 3-month participant follow-ups (n=91) and whānau evaluations (n=72) Wood B. (2011). <i>Evaluation of Drive SOBA Programme – Mid and Far North Regions of Northland</i> . Written for Road Safety Trust Programme manual |
| Downie Stewart Foundation | 2022 participant end-of-programme evaluation forms (n=17) |
| Te Paepae Arahi Trust | 2023-2024 scanned end-of-programme evaluation forms (n=140) Narrative reporting for April 2021, July and September 2022 and May 2023 intakes |
| Tūhoe Hauora Trust | A master’s thesis: Waru NA. (2016). <i>An Evaluation of an Impaired Driver Treatment Programme Facilitated by Tūhoe Hauora</i> . |

Overview of provider reporting

Table 21 summarises the available reporting on activity from the nine providers included in this evaluation. There are some gaps in reporting, and in all years shown, activity reporting was not available from at least one provider. Due to lack of data, 2017/18 is excluded from further analysis. There were also some differences in the reporting from providers in terms of reporting categories and formats, and it is not clear if all providers have reported comparable data using the same standards and definitions.

Table 21: Summary of available provider reporting

| Financial year | Reports available | Number of people assessed | Number of participants | Number of graduates |
|----------------|-------------------|---------------------------|------------------------|---------------------|
| 2017/18 | 2 | 116 | 92 | 73 |
| 2018/19 | 8 | 754 | 514 | 445 |
| 2019/20 | 7 | 486 | 380 | 313 |
| 2020/21 | 8 | 540 | 403 | 329 |
| 2021/22 | *7 | 368 | 260 | 241 |
| 2022/23 | 8 | 397 | 305 | 274 |
| 2023/24 | 6 | 267 | 182 | 150 |
| Total | | 2,928 | 2,136 | 1,825 |

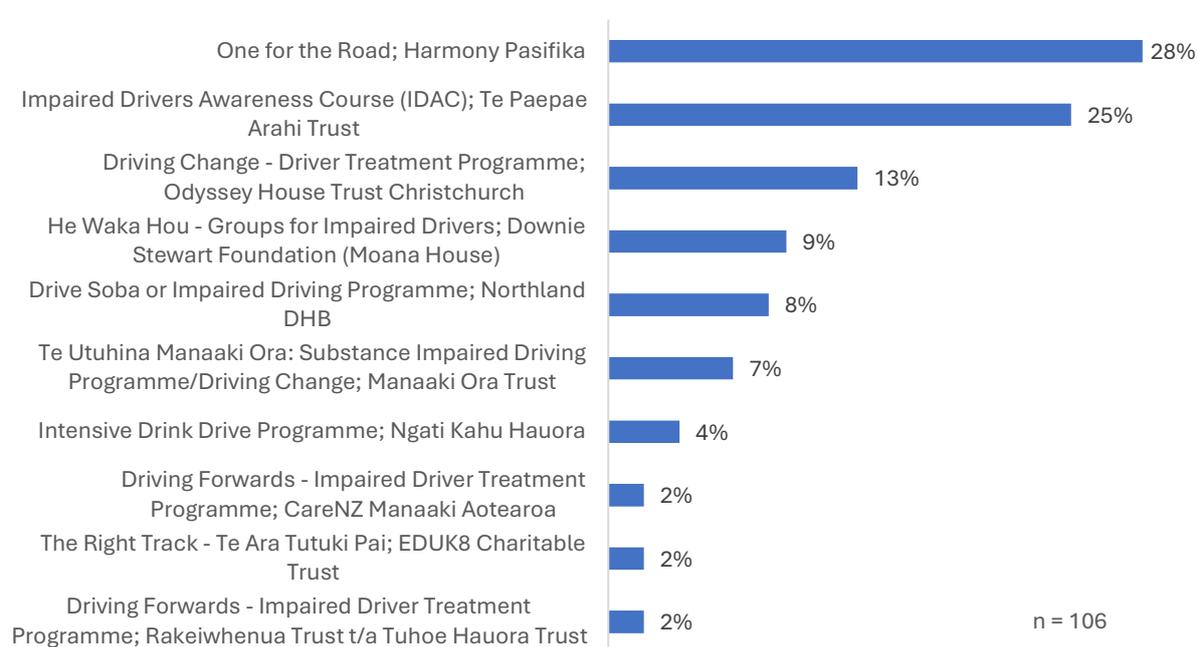
* In 2021/22, reports are available from all 9 providers, but one provider's courses were cancelled and activity levels reported by another are not internally consistent.

Appendix 4: Demographic profile of survey respondents

Programme providers are reflected unequally in response numbers

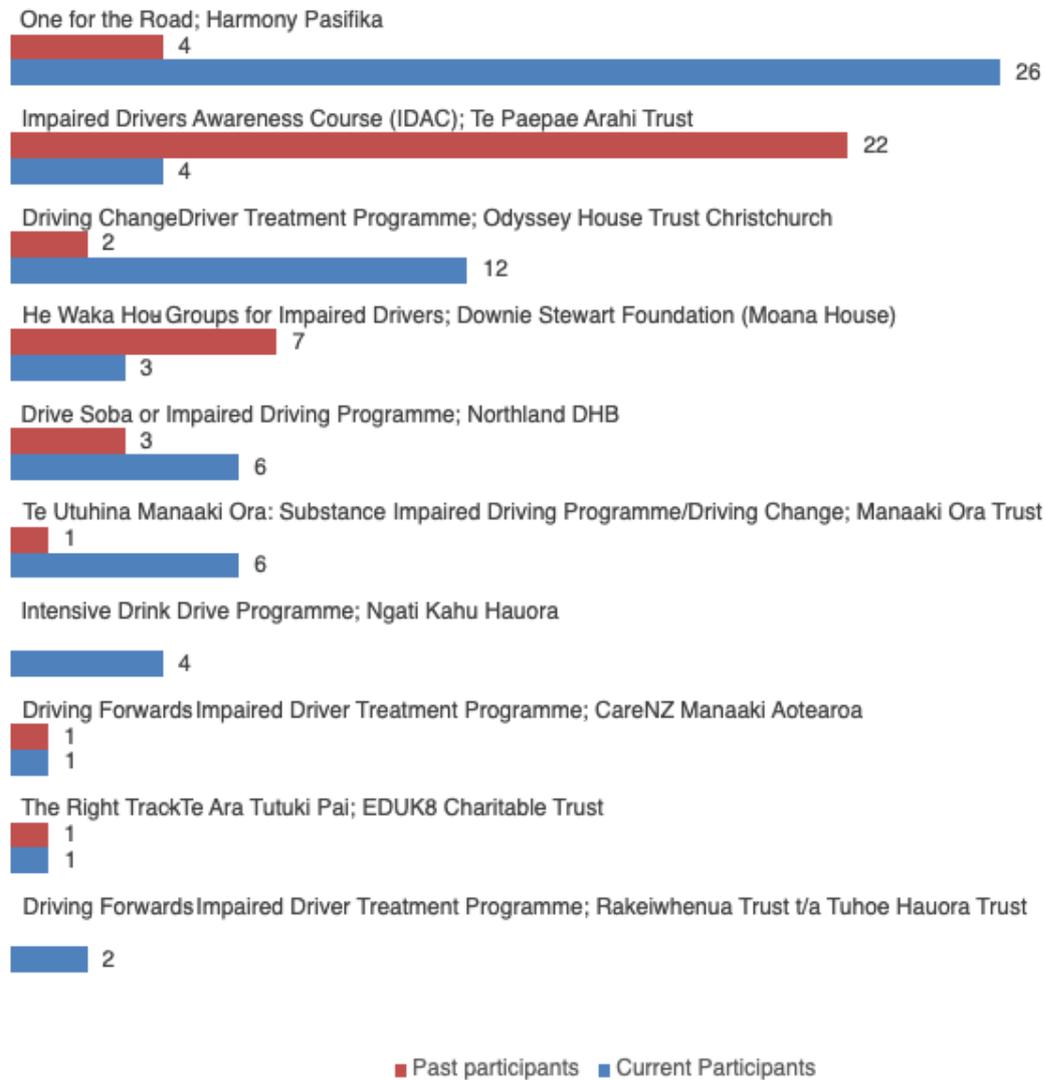
There was considerable variation in responses across the different service providers, as seen in Figure 16. Participants of One for the Road, delivered by Harmony Pasifika, formed the largest proportion of responses (28%). A following 25% attended or are attending the Impaired Drivers Awareness Course by Te Paepae Arahi. In contrast, participants of courses run by CareNZ, Eduk8, and Tūhoe Hauora formed a combined 6% of responses.

Figure 16: IDR programmes participation by service providers



The majority Harmony Pasifika respondents, who made up the largest proportion of the survey sample, were currently partaking in the One for the Road. In contrast, most of Te Paepae Arahi respondents were past participants (Figure 17).

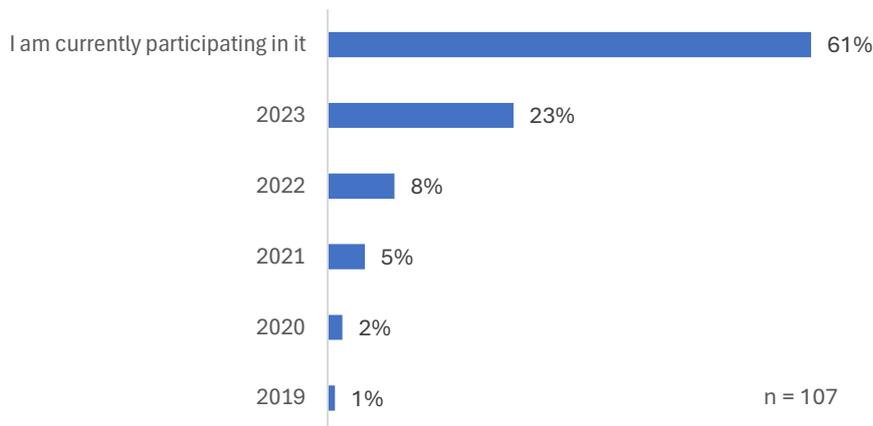
Figure 17: Past and current participants per provider



Current programme participants formed over half of survey responses

61% of respondents indicated that they were currently participating in an IDR programmes. Of the remaining 39%, 23% attended the programme in 2023 and 8% in 2022 (Figure 18).

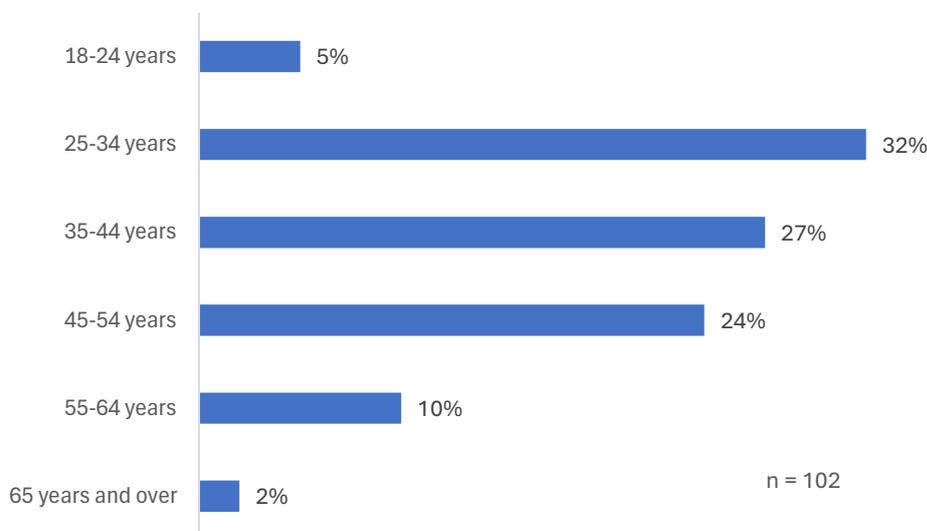
Figure 18: Distribution of current and past programme participants



Majority of survey respondents were aged between 25 and 44 years

The most common age group for respondents was 25-34 years (32%), followed by 35-44 years (27%) and 45-55 years (24%). 5% fell in the 18-24 age bracket, and only 2% were 65 years or older (Figure 19).

Figure 19: Respondents by age



A high proportion of respondents were male

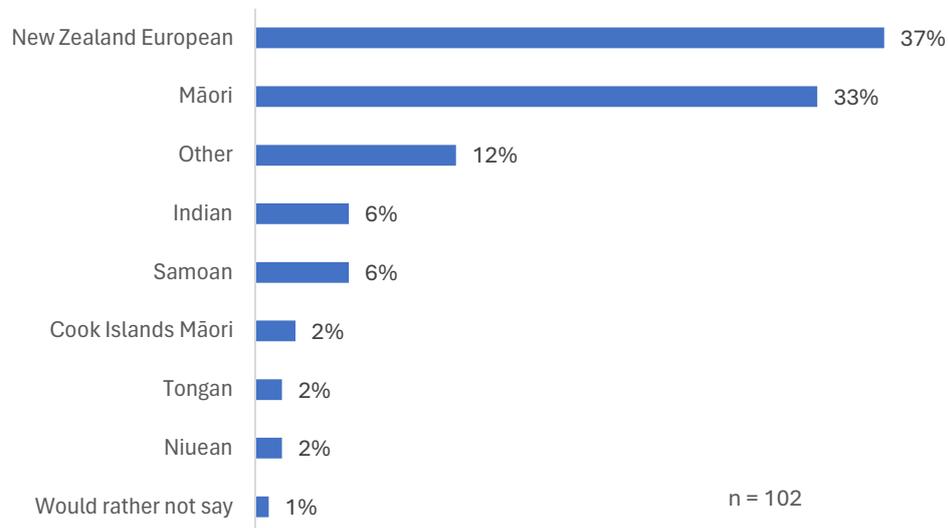
75% of survey respondents (n=101) identified as male and the remaining 25% identified as female. The male-dominant response pool aligns with gender trends across existing service providers' programme data. Respondents were also given the options of non-binary (0%) and gender not listed here (0%).

The survey captured responses from a wide range of ethnic identities

The respondent pool consisted of varied ethnic backgrounds, with 37% identifying as New Zealand European and 33% identifying as Māori. As the third most common

answer, Other (12%) encompassed identities such as Fijian, African, and Taiwanese. 19% of respondents selected more than one ethnic identity in their answer (Figure 20).

Figure 20: Respondents' ethnic identities



Note: Multiple responses were possible

Appendix 5: Brief overview of current programme models

| Provider | Programme length/duration | Key aspects of programme |
|------------------------------------|---|--|
| Harmony Pasifika: One for the Road | <p>22 hours over 9 weeks (Auckland)</p> <p>22 hours over 3-4 sessions (rural Waikato)</p> <p><i>Started as 10-hour programme⁴⁰</i></p> | <ul style="list-style-type: none"> • Draws on CBT, motivational interviewing, Gestalt, Transactional Analysis, relapse prevention techniques, stages of change and narrative theory. • Employs holistic approach that looks at participant’s lives across multiple dimensions. Draws on Māori and Pacific methods such as Te Whare Tapa Whā and Talanoa. • Includes victim statement. • Relational, non-clinical approach that explores family systems and whakawhanaungatanga. • Offers continued support group as part of wider services. • Whānau participation is encouraged. |
| Odyssey House: Driving Change | 22 hours over 10 weeks | <ul style="list-style-type: none"> • Based on education raising awareness and encouraging attitudinal and behavioural change. • Draws on motivational interviewing, CBT, SMART goals, Tripart brain theory, cycles of change and Te Whare Tapa Whā. • Includes presentation from paramedic guest speaker. • Holds separate men’s and women’s groups • Works 1:1 with repeat referrals so not to take up space from new participants. Also provides a 1-day programme for first time offenders. • Writes individual programme reports, provides individual session on programme completion and follow-up. • Whānau are welcome to attend graduation. |

⁴⁰ We note that the 10-hour programme was delivered prior to the 2013 IDR programme contract, which initially featured a 20-hour version.

| | | |
|--|---|---|
| Eduk8: (TRT/RID) | 43 hours in 9 sessions over a period of 5-8 weeks | <ul style="list-style-type: none"> • Approach focused on affecting the individual, using a multidimensional approach to all aspects of delivery to create opportunity for the content to resonate individually, dependent on previous learning and life experiences, enabling all learners to connect with essential messages. • Guest speakers from all walks of life including specialist NZ Police Teams, victims and offenders, past participants, Te Whatu Ora Trauma Specialists and many others create real life interaction to provide and enhance connectivity and learning. • Draws on CBT. • Specialist teams from NZ Police are involved in interactive aspects of the programme and are present throughout the programme, a feature which increases participants understanding of the role of NZ Police and gives NZ Police a unique insight into the rehabilitative opportunities that TRT provides. • Draws on Te Whare Tapa Whā. • Each participant is required to have support person with them for duration of programme. • Has graduate Facebook page for people to stay connected. |
| Health NZ Te Tai Tokerau: Impaired Driving Programme | 24 hours over 12 weeks <i>Locations other than Whangārei had different contact hours and programme lengths</i> | <ul style="list-style-type: none"> • Grounded in CBT and relapse prevention, focuses on six ‘criminogenic needs’ and employs motivational interviewing techniques. • Education centred on nature of addictions. • Pro-social behaviour is practiced through role play. • Session on victim empathy, through role play. • Each session and graduation end with feedback and review. • Whānau are invited to graduation. |
| Downie Stewart Foundation: He Waka Hou | 15 hours over six weeks <i>Started as 10-12 week programme</i> | <ul style="list-style-type: none"> • Delivered at Moana House in Matua Raki (separate to residential community), large group room with shower & kitchen facilities available to participants. • Residents of therapeutic community (residential and Aftercare) can refer into the programme. |

| | | |
|---|--|---|
| | | <ul style="list-style-type: none"> • Draws on psychotherapy approaches such as CBT, goal setting, stages of change, psycho-social education, impacts on relationships and whānau, risk-taking, and relapse prevention strategies. • Strong cultural underpinning throughout delivery and programme, including Te Whare Tapa Whā. • Relapse Prevention planning and Safety Plan. • Guest speaker from NZ Police and lived-experience perspective on the impacts of causing loss of life. Field trip activity for ‘impaired vision goggles’. • No whānau involvement. |
| Hauora Māori partners | | |
| <p>Manaaki Ora: Waka Ora</p> | <p>15-18 hours over six weeks</p> | <ul style="list-style-type: none"> • Part of a continuum of services for whānau who are impacted by addictions. • Kaupapa Māori and whānau centred approach – including Te Whare Tapa Whā, whakawātea/cleansing and connecting to whenua, whakataukī cards, Waka Ama. • Focuses on harm minimisation and good decision-making. • Draws on CBT and change process. • Emphasises small groups for non-threatening environment. Offers 1:1 option for those struggling in group setting, and as post-programme support. • No waitlist: instead, participants are allocated counsellor who work with them 1:1. • Care plans and safety planning. • Lived experience through facilitator. • Whānau invited to graduation. |
| <p>Ngāti Kahu Hauora: Intensive Drink Driving Programme</p> | <p>30 hours over 5 weeks <i>Started as 10-week programme</i></p> | <ul style="list-style-type: none"> • Uses Te Whare Tapa Whā. • Draws on CBT. • Incorporates guest speakers from Fire and Emergency Services and St John Ambulance. • Field trips to funeral home (to give tangible sense of dangers and consequences). • Participants explore their family histories and patterns of behaviour through genogram mapping. |

| | | |
|---------------------------------|---|--|
| | | <ul style="list-style-type: none"> • Impact statement via video. • Action and relapse prevention plans. • Participants are encouraged to bring support person to first and last session. |
| Te Paepae Arahi: (IDAC) | 16 hours over two concurrent days | <ul style="list-style-type: none"> • Use of tikanga and kaupapa Māori content, including Te Wheke and parts of Mahi Ātua programme. • Relapse prevention strategies. • Development of individual safety plans. • Lived experience. • Provides ongoing individual and/or group therapy to address any substance related issues. • Offers post programme follow-up support from their wider services. |
| Tūhoe Hauora: He Waka Oranga | Current programme 12 hours over 4 weeks but varies depending on location. Generally delivered over 4-7 weeks. | <ul style="list-style-type: none"> • Shifted to iwi-led approach. Iwi provides post-programme follow-up support. • Content grounded in a Kaupapa Māori wellbeing framework. Delivery is underpinned by the Mauri Ora imperatives of Mana, Mauri, Tapu, Tikanga, Wairua, Whānau and the ideology of helping participants transitioning from a state of kahupō ki te toiora. • The organisation's values are presented through a Te Ao Māori lens. • Covers Te Whare Tapa Whā. • Draws on CBT. • Waka Ama/Canoeing (subject to change). • NZ Police presentation. • First Aid. • Planning for safe driving, relapse prevention. |

Appendix 6: Data collection opportunities

Data collection to support future economic evaluation

To fully understand the return on investment of IDR programmes requires a more consistent approach to data gathering by all providers in future years. Data collection should be designed to enable a coordinated study of the impacts of these programmes on road safety and other relevant outcomes. This includes ensuring that all providers report activity and participant characteristics on a consistent basis.

The most robust way to quantify the social benefits of the programmes would be to compare outcomes such as subsequent involvement in crashes where alcohol or drugs were a factor for people who have completed an IDR programmes against people who have otherwise similar characteristics but who have not completed such a programme. This would enable the number and types of crashes, and the associated costs avoided by IDR programmes in the follow-up period to be estimated.

Doing such an analysis requires keeping track of individual drivers who have completed IDR programmes and monitoring their crash involvement and other relevant outcomes over a suitable follow-up period. To support a causal impact of IDR programmes participation on crash involvement and other outcomes, a comparison group of drivers who have not completed an IDR programme is also required. These drivers should have similar characteristics as those who did complete an IDR programme, for example in terms of age, gender, ethnicity, geographic location, years of driving experience, and history of impaired driving. Ideally, the comparison group should only include drivers that were not able to participate in an IDR programmes for reasons outside their control, to avoid potential bias from comparing people who chose to do a programme with those who chose not to. Such analysis would require access to centralised administrative data in addition to activity data collected by IDR providers.

To enable such analysis, key areas of future activity data collection by IDR programmes providers include records for individual participants of:

- Driver licence details
- Personal characteristics including age, gender, ethnicity, and area of residence
- Start and end dates of participation in the programme
- Outcome of the programme, i.e. whether it was completed successfully

As described above, this data collected by providers would need to be combined across providers and linked to administrative data on road crash involvement and potentially other outcomes of interest such as impaired driving convictions. It would also be necessary to consider the effects of court-mandated alcohol interlock devices

and any other interventions that may affect impaired driving behaviour when doing such analysis.

Costs, activity levels, and characteristics of the IDR programmes also need to be collected systematically. Costs should include all sources of funding plus the value of any “in-kind” contributions from the community. As noted above, basic activity data on the numbers of participants and graduates from each programme does not appear to be recorded consistently across providers and was not available in some cases. If some programmes are substantially different from others, these may need to be analysed separately. This may require classifying programmes according to characteristics such as the types of methods used, or population groups that are targeted.