Reaching Employment through Active

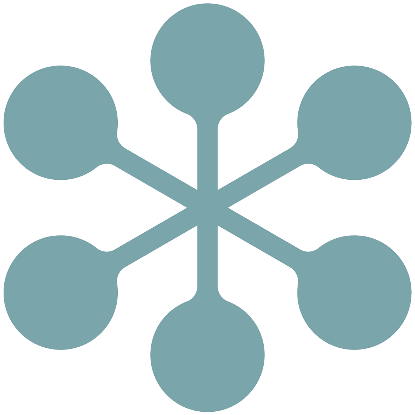
Co-ordinated Healthcare

The REACH Qualitative Evaluation Report

The report was prepared for:  
Ministry of Social Development

Te Manatū Whakahiato Ora

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# Executive summary

This report presents qualitative evaluation insights into the implementation of Reaching Employment through Active Co-ordinated Healthcare (REACH) services. REACH is part of a broader suite of services that make up the Oranga Mahi programme.

Overview of the REACH service

Since 2016, the Ministry of Social Development (MSD) and Waikato District Health Board (DHB) have co-designed and iterated the REACH service. In summary, REACH is a goal-orientated and personalised programme lasting up to 20 weeks. REACH targets working-aged MSD clients on a main benefit with a medical deferral from work obligations. MSD sets the programme aims as assisting a client to return to work and improve their wellbeing through the removal or reduction of psychosocial barriers which may have prevented a work-related outcome.

### A description of the REACH service delivery

An MSD case manager refers the client to the service. A key worker and living well coach (based in Waikato DHB) work with the enrolled client and their GP and MSD case manager. Between 2018 and 2019, an employment coach also supported the client.

The key worker and the client use the internationally developed Wellbeing Star tool to identify their goals against eight wellbeing domains. The insights from the Wellbeing Star tool are used to develop their client's action plan, and track progress. Each week, the key worker delivers interventions, including cognitive behavioural therapy (CBT) and acceptance and commitment therapy (ACT). Each week, the living well coach supports the client with daily living skills linked to their plan.

When health issues are addressed, the employment coach steps in to focus on work readiness activities. At the exit, clients are linked back to their GPs and MSD case managers.

The qualitative evaluation of REACH

This qualitative evaluation of REACH provides insights into the implementation and outcomes for clients using the service. The evaluation focuses on REACH’s implementation and service delivery between November 2019 and April 2021.

The findings are based on 30 interviews with clients and 27 face-to-face interviews with REACH staff, MSD staff, and GPs. The interviews were conducted in November 2020 and April 2021. All interviews followed an informed consent process.

The evaluation findings

### REACH’s design and implementation has strengthened over time

MSD and Waikato DHB used a co-design process to develop the REACH service. The co-design process was perceived by MSD and Waikato DHB stakeholders to strengthen REACH’s implementation throughout the trial from 2016 to 2021. Work with REACH clients and staff identified key areas for change, which were actioned in 2019. These changes included broadening the eligibility criteria, screening suitability at enrolment, hiring an employment coach and streamlining access to the programme fund. Waikato DHB also introduced an employment coach role between 2018 and 2019.

### Clients interviewed had a positive service experience

Feedback from clients interviewed in 2021 demonstrated a positive service experience across referral, enrolment, service delivery, and for some exit stages. Clients liked the relationship-based approach, which focused on their aspirations using the Wellbeing Star tool. Clients reported they gained helpful life strategies by having both clinical and daily living support through the key worker and living well coach. Clients interviewed who had exited REACH early did so due to unexpected health or family issues, or inability to sustain the required level of commitment. Clients appreciated being able to pause and recommence the service.

### REACH's implementation is consistent with the agreed delivery and can be strengthened

The implementation of REACH was consistent with the MSD's business process description and MSD and Waikato DHB's agreed service iterations.[[1]](#footnote-1)[[2]](#footnote-2) Feedback from client and key stakeholder interviews highlighted REACH's implementation can be strengthened by:

* reviewing the referral process to ensure appropriate people are referred and Māori can access the service
* strengthening whānau-centred approaches in REACH, Māori cultural references and te ao Māori, and having more Māori staff
* increasing understanding of the service, and the roles and responsibilities of MSD case managers and GPs, particularly when clients exit from REACH
* increasing client awareness and use of the employment coach role in supporting the transition to employment
* offering MSD case managers training to improve the consistency of responses to key worker requests relating to support or entitlements for clients
* enhancing awareness of the programme fund for REACH staff and improving the timeliness of funding decisions
* improving the transition to exit so clients feel supported to continue working on their goals.

### REACH is contributing to some positive outcomes for clients interviewed

The qualitative evaluation findings indicate REACH is creating pathways to positive living and work readiness within 12 to 20 weeks of the service. However, movement into employment on completion of the service is less evident. For clients interviewed, the wellbeing gains made were significant, given their starting points on entering REACH. Many lived with high levels of anxiety and depression, struggled to engage with others, and lacked confidence or purpose. While some clients interviewed had not entered employment, they had created a foundation that may, over time, lead to employment. For other clients, their underlying health or family circumstances may mean full-time employment is not a realistic long-term goal.

Clients and key stakeholders reported the following changes which are in line with the programme’s desired short-term outcomes:[[3]](#footnote-3)

* Many clients reported greater confidence and a sense of purpose and direction.
* Many clients said their lifestyle had improved, including diet, sleep, and exercise, and they had gained skills to self-manage their physical health and mental health.
* Many reported improved health, mental health, and wellbeing, particularly anxiety and depression.
* Some clients had strengthened their links to additional supports and services (e.g. GP, MSD) and were more confident engaging with services when needed. They also strengthened their links to their community by engaging in hobbies and sport.
* Some strengthened family relationships or learned to set boundaries when engaging with family.
* Some clients entered education or started voluntary work.
* A few had entered employment.

A few clients interviewed who did not complete REACH also made positive changes to their lifestyle. The few clients interviewed who exited very early had no changes they attributed to REACH.

Most clients interviewed who achieved positive outcomes said they would not have achieved them without REACH. Their response reflects that they are not aware of any other service like REACH to support them to identify and achieve their goals. A few clients felt they might have achieved the outcomes, but it would have been more challenging and taken longer.

# Overview of REACH

REACH is part of a broader suite of services that make up the Oranga Mahi programme.

Overview of the Oranga Mahi programme

The Oranga Mahi programme, funded by MSD, focuses on supporting people with disabilities and health conditions. Commencing in 2016, MSD has prototyped a range of services working in partnership with health sector agencies.

These cross-agency services trial new ways to help MSD clients and those at risk of coming on to a benefit. The trial services aim to improve MSD clients’ health and wellbeing and achieve sustainable employment outcomes. To date, the trial services are Here Toitū (including Responding Early in MidCentral region), Puāwaitanga, Whītiki Tauā, Rākau Rangatira, Individual Placement and Support which includes two youth adaptations (Take Charge/E Ara E [Rise Up!]), and REACH.

Description of the REACH service

### Below is an overview of the REACH service at April 2021

The REACH service is a partnership between MSD and Waikato DHB. REACH is a voluntary service delivered by a key worker and living well coach (based in Waikato DHB) who work with the client’s MSD case manager and GP.

In March 2021, REACH had 11 team members, including a team leader, five key workers and five living well coaches. REACH had around 60 active clients, with caseloads of about 15 clients per key worker and living well coach. The employment coach role, introduced in 2018, had been vacant since early 2020.

### REACH has broad eligibility criteria

Those eligible are MSD clients aged 18-64 years who receive a main benefit with a work capacity medical certificate and live in the Waikato DHB region. Clients are excluded if they are high-risk clients, pregnant, or have bipolar disorder or schizophrenia.

MSD case managers across the Waikato DHB region identify clients who may benefit from REACH. MSD case managers gain clients’ permission to forward their details to REACH using a standard template. The REACH referral process was streamlined when privacy issues about sharing information were resolved. REACH accepted internal referrals from Waikato DHB if they met the eligibility criteria. However, referrals from GPs, other agencies, or self-referrals were not accepted into the programme.

### On enrolment, clients are assigned a key worker and a living well coach

The enrolment process into REACH involves a face-to-face meeting with the REACH team. The client receives information about how the service works, including the requirement to meet their key worker and living well coach at least once a week. The client then has the option to enrol or not.

Once enrolled, the client is supported by the living well coach to establish healthy routines, their goals and action plans, developed through use of the Wellbeing Star tool described below. The client can contact their living well coach up to three times a day, with one contact being face-to-face. The living well coach is a listening ear and connects the client to other services, and as needed, their key worker, MSD case manager, and GP.

The key worker meets with the client weekly to build strategies to manage health and mental wellbeing issues, particularly anxiety. The tools used are based on the client’s action plans and emerging needs. The key workers use cognitive behavioural therapy (CBT) and acceptance and commitment therapy (ACT) with clients. The REACH team receive training on CBT and ACT from a Waikato DHB psychologist.

Between 2018 and 2019, Waikato DHB hired a temporary employment coach to work towards MSD’s employment outcomes for clients. The need for the role was identified during an iteration review of the REACH service in 2017. The coach supported the client to work towards employment once their health and wellbeing had stabilised. The employment coach worked with the client to look for, apply for, and gain employment (e.g. prepare a CV, connect with employers, and develop interview skills). They also followed up with the client after job placement and provided work-related support as needed.

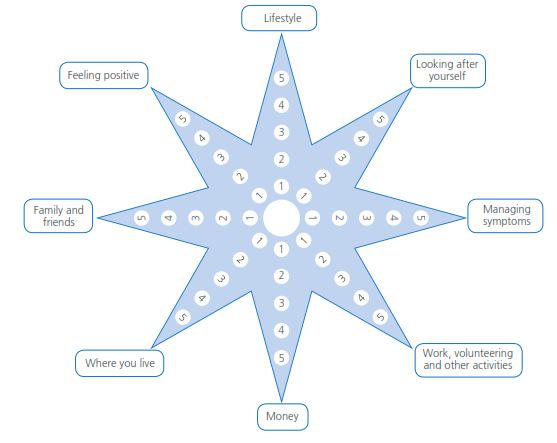
### The REACH team uses the Wellbeing Star tool to develop the client’s action plan

After enrolment, the client meets with the key worker and the living well coach meet to complete the Wellbeing Star tool (Figure 1). The key worker and client use the Wellbeing Star assessment to identify their goals and priorities. The scale used is based on 5 being ‘as good as it can be’, 4 is ‘getting there’, 3 is ‘making changes’, 2 is ‘finding out’, and 1 is ‘not thinking about it’. The key worker then uses the results to create the wellbeing plan and shares it with the client and the living well coach.

The Wellbeing Star tool identifies the client’s goals, develops their action plan, and tracks their progress. The tool is used to identify a client’s level of need. These levels are graded into green, amber, or red. The level of need determines the frequency of visits by the living well coach.

The key worker also identifies the appropriate interventions to support the plan (e.g., ACT, CBT). Each week, the client reviews the plan with the living well coach and looks at the steps to keep moving towards their goals in a safe and engaging way.

Figure 1: The Wellbeing Star tool[[4]](#footnote-4)



### MSD case managers support their clients to enact their action plans

The client’s MSD case manager receives a highlight report on their client’s progress from the key worker. Before the COVID-19 lockdown, the key worker met face to face with the MSD case manager to discuss their client’s progress and identify how to support the plan’s implementation. Following the COVID-19 lockdown, the highlight meetings moved to email and phone catch-ups. The highlight meetings ensure clients are receiving the correct entitlements or access to wider financial support. They also keep the MSD case manager informed and engaged in the client’s journey.

### GPs are informed and enable the client’s action plans

At the beginning of the service, the client visits their GP with the key worker to tell them about the service. The GP receives a copy of the Wellbeing Star assessment and the action plan. The GP reviews the action plan and the proposed work and work hours. They determine whether the proposed actions are appropriate for the client based on their health and wellbeing needs.

### A programme fund enables clients to access other support and services

A programme fund is used, as needed, to pay for health-related supports not covered by MSD funding. Access to the programme fund is dependent on the funds not being available or accessible in a timely manner through other sources (e.g., the disability allowance, DHB, or community funds).

### REACH has a phased transition out of the service

At around nine weeks, the client is reminded the service is for 12 weeks, and work commences to prepare for the transition to leave or the decision to extend to 20 weeks. As part of the transition, REACH staff work to link the client to other health and support services.

The REACH team can provide up to 12 weeks of post-service support, depending on the client’s needs.

The intended outcomes for REACH relate to health and employment

The intended outcomes, as detailed in the current REACH contract, are to:

* reduce physical and psychological barriers to work, to assist more clients in returning to work or increase their capacity to work
* build the capability of MSD case managers to work effectively with clients with a health condition, injury, or disability
* 80% of participants will exit the service with an improved health outcome
* 40% of participants will not be in receipt of a main benefit within 91 days of completing the service. Of which -
  + 60% of participants placed into full-time employment or exit from benefit due to employment will achieve 91 days in employment
  + of those clients who do not achieve a benefit exit as a result of employment, 30% of participants will exit the service with an increased work-readiness capacity.

REACH’s service design and implementation evolved over time

Since 2016, the MSD service design team worked with Waikato DHB to co-design and iterate the REACH service.

Between May and September 2016, REACH went live as a prototype in the Dinsdale service centre. Thirty MSD clients in work focused case management with a health condition or disability (WFCM-HCD) were included to test the operational processes of the prototype service.

In October 2016, based on the prototype’s success, REACH became a full trial located at Dinsdale, Hamilton East, Hamilton Central, and Glenview service centres. In March 2017, REACH was expanded to all MSD service centres within Waikato that offer the WFCM-HCD service.[[5]](#footnote-5)

The REACH team consulted with Waikato DHB’s Māori health unit, Te Puna Oranga, during the service design, implementation, and iteration. Māori representation on Waikato DHB’s directorates clinical governance group guided the REACH service. Waikato DHB’s Māori disability reference group, Te Roopu Tiaki Hunga Hauaa, were consulted on the design and supported the service’s implementation. A key frustration for the group was the inability for general practices to refer directly to REACH.

In 2019, the MSD service design team worked with REACH staff and clients to identify ways to strengthen the service. In November 2019, MSD and Waikato DHB actioned the following iterations[[6]](#footnote-6):

* The eligibility criteria was broadened to include anyone on a main benefit with a medical certificate deferring them from work for six to eight weeks.
* The duration of the service was extended from 12 to 20 weeks based on clients’ needs.
* The frequency of reviewing clients’ action plans by using the Wellbeing Star tool was increased to once every four weeks.
* The programme fund cap was increased from $300 to $500 to be consistent with other programme funds in the Oranga Mahi programme.
* The process to access the programme fund was streamlined.
* An educational REACH roadshow was held to increase referrals from MSD case managers, understanding of the different service roles, and awareness of the programme fund.

Some intended iterations did not progress due to the impact of COVID-19, including:

* introducing GP or self-referrals to the REACH service
* improving the cultural responsiveness of REACH for Māori and increasing access to the service by linking to Māori to Needs Assessment and Service Coordination services (NASC), through their eight locations at marae and NGOs.

This evaluation focuses on REACH’s implementation and service delivery between November 2019 and April 2021.

# Qualitative methods used to evaluate REACH

REACH’s evaluation is part of the Oranga Mahi evaluation

The Oranga Mahi evaluation aims to inform decisions about the programme. The overall evaluation will provide evidence of:

* the achievement in improving short-term to medium-term outcomes
* the strengths and weaknesses of the design and implementation
* the outcomes for Māori participants within a kaupapa Māori approach
* the achievements of similar programmes internationally to inform the programme.

The overarching Oranga Mahi evaluation has four main strands: the literature review, quantitative, qualitative, and kaupapa Māori evaluations. MSD will use the evidence across these strands to answer the evaluation questions. Appendix 1 has the Oranga Mahi 'live' intervention logic.

MSD’s ethics committee reviewed the Oranga Mahi evaluation plan. MSD also completed a privacy assessment.

Litmus was contracted to carry out the independent qualitative evaluation of REACH and Here Toitū components of Oranga Mahi.The MSD research and evaluation team conducted the literature review, quantitative and kaupapa Māori evaluation components.

REACH’s evaluation purpose

This evaluation offers qualitative insights into the implementation of REACH services and outcomes for clients using the services.

Key evaluation questions

The REACH qualitative evaluation answers the following four key evaluation questions. The sub-evaluation questions are in Appendix 2.

* How well has REACH been implemented to achieve the intended activities and immediate outcomes?
* How can the implementation of REACH be improved across the implementation domains above?
* How well have MSD and health agencies enabled and influenced the implementation of REACH?
* How is REACH supporting the achievement of the desired short-term and medium-term outcomes?

We used a qualitative evaluation approach

We used Patton’s utilisation-focussed evaluation approach.[[7]](#footnote-7) This approach argues evaluations should produce useful information to inform decision-making about a service. To increase usability, we engaged with MSD’s service design team, Waikato DHB, and MSD's Research and Evaluation team at critical evaluation stages, including design and planning, recruitment and engagement with participants, and analysis and reporting. These engagements enabled the ongoing refinement of the evaluation and offered early insights into the findings.

The evaluation is a qualitative process and outcome evaluation of REACH. The process evaluation focused on the intended and actual operations of REACH against the MSD business process description and MSD and Waikato DHB's agreed service iterations.[[8]](#footnote-8)[[9]](#footnote-9) This assessment framing recognised the co-design approach used by MSD and Waikato DHB.

The qualitative outcomes evaluation assessed client outcomes against the framing of the ‘live’ intervention logic for Oranga Mahi (Appendix 1), the eight Wellbeing Star domains[[10]](#footnote-10), and client reflections on the changes they related to REACH. The client outcomes were triangulated across these three frameworks to make informed judgements on the emerging outcomes. These findings were also assessed against feedback from key workers, living well coaches and GPs interviewed on their perceptions of client changes due to REACH.

Overview of qualitative data collection processes

The REACH evaluation was conducted over eight months and had two data collection rounds phased across the evaluation period. The data collection was phased to accommodate MSD’s information needs in December 2020.

1. Fieldwork in November 2020 focused on implementation and involved interviews with key stakeholders and service providers.
2. Fieldwork in April 2021 focused on ongoing implementation and qualitative outcomes and included interviews with clients and service providers.

### We did 27 interviews with stakeholders and 30 interviews with clients

Interviews were conducted face-to-face in a safe and comfortable place selected by clients (e.g. cafés, parks, community venues). The interviews lasted around 45 to 60 minutes. Clients received a koha of $50 (supermarket voucher). Appendix 3 contains the evaluation data collection tools, including provider and client information sheets, consent forms, and discussion guides.

Table 1 presents the sample profile for MSD staff and providers across the two fieldwork periods. Table 2 shows the sample profile of 30 clients interviewed in May 2021. Clients recruited had been enrolled since March 2020 and are at different stages in the service.

Table 1: Sample for REACH MSD staff and providers across the two fieldwork periods

|  |  |  |  |
| --- | --- | --- | --- |
| **Stakeholder type** | **Sub-groups** | **Fieldwork (a)**  **(implementation)**  **n=18** | **Fieldwork (b)**  **(outcomes)**  **n=9** |
| WDHB | Programme manager | 1 | - |
|  | Frontline manager\* | 1 | 1 |
|  | Key worker (clinical) | 3 | 2 |
|  | Living well coaches | 2 | 3 |
|  | General practitioner | 3 | 1 |
| MSD | National office\* | 4 | 1 |
|  | Health and disability coordinators | 1 | - |
|  | Programme coordinators | 1 | - |
|  | Case managers | 2 | 1 |

We interviewed two stakeholders twice in fieldwork (a) and (b). These interviews are marked with an asterisk\*.

Table 2: Sample profile of REACH clients interviewed in May 2021

| Domain | Profile | n=30 |
| --- | --- | --- |
| Stage | Midway through the service to nearing completion | 5 |
| Completed two to six months before May 2021 | 18 |
| Exited before completion two to six months before May 2021 | 7 |
| Gender | Male | 15 |
| Female | 14 |
| Gender diverse | 1 |
| Ethnicity | Māori | 9 |
| Other | 1 |
| European | 20 |
| Age | Under 30 | 16 |
| Over 30 | 14 |

We used an integrated data analysis approach

The analysis completed draws on Patton's utilization and qualitative analysis approach.[[11]](#footnote-11) As detailed in the evaluation plan, we transcribed and thematically coded in-depth interviews. We held an analysis workshop with the interviewers to develop code frames for the REACH sub-groups interviewed. The code frame was developed using the domains in the Oranga Mahi ‘live’ intervention logic and Wellbeing Star outcomes. Sub-themes were then developed as the transcripts were analysed. We analysed the findings by stakeholder type, whānau ethnicity, and stage in REACH. We explored commonalities in findings and outliers.

The qualitative evaluation plan to inform Oranga Mahi contains further details of the evaluation method[[12]](#footnote-12).

Limitations of the evaluation approach

The evaluation report draws on qualitative information. The evaluation team is confident that the evaluation findings presented accurately reflect the interviews completed to inform the report. Waikato DHB and MSD service design team reviewed the draft report for accuracy. The report has been peer-reviewed by MSD reviewers. The qualitative evaluation findings for REACH need to be considered together with the completed literature review and quantitative evaluation findings.

We acknowledge the following limitations to the qualitative evaluation:

* **Potential for selection bias**: MSD used a randomised sample selection and opt-out processes to ensure a diversity of clients were invited to take part in an interview. As agreed, we completed a mix of interviews based on age, gender, ethnicity, and stage in the REACH programme. Feedback from clients on their service experience and outcomes was fairly similar across client sub-groups. We have noted key differences in the report where they exist. In addition, feedback from providers and clients was consistent. However, we cannot guarantee that other REACH clients did not have different service experiences or outcomes.
* **Limitations of client sample**: We interviewed 30 clients (about 20% of the total users of the service). We have only limited feedback on those who exited REACH before the completion of the service. We interviewed only three people who had exited early. We also discussed the reasons for clients exiting REACH early with key workers and living well coaches. The clients interviewed who exited early spoke highly of the service and tools, including the Wellbeing Star. Their reasons for leaving early were health issues, family commitments, and inability to give the time required by the programme.
* **Limitations of provider sample**: We interviewed most providers involved in delivering the service and the MSD service design team. We achieved the agreed sub-sample size for GPs. However, given the number of GPs interviewed, other GPs involved with REACH may have differing perceptions of the value of the service for their patients.
* **Bias due to Covid-19 support**: REACH operated during COVID-19 lockdowns and restrictions. Some clients may have viewed the service more positively than they would have without COVID-19 support. The qualitative evaluation cannot explore a counterfactual apart from asking participants what would have happened without the service.
* **Recall bias**: We note some clients had difficulty recalling all their engagement with the REACH programme, particularly the duration of service received.
* **The Wellbeing Star tool is not a standardised research tool**: The Wellbeing Star tool was not designed as a standardised research tool to measure changes in wellbeing. The tool was developed for practitioners to use with clients to identify and assess progress towards their goals. We used client reflections on their Wellbeing Star ratings to identify domains where changes had occurred. We triangulated this information with the personal change stories they attributed to REACH. In this context, the results should be treated with some caution.

The report structure addresses the evaluation questions

The report reflects the themes arising from the analysis, and de-identified quotes support these. The term ‘clients’ refers to clients interviewed for the evaluation. We use the terms ‘many or most’, ‘some’, and ‘few’ in the report to indicate the frequency of the themes across interviews.

* ‘Many or most’ indicates the theme was noted by the majority of participants interviewed.
* ‘Some’ indicates the theme was noted by less than half of the participants interviewed.
* ‘Few’ indicates less than five participants noted the theme.

Clients interviewed appreciated the opportunity to share their experiences of REACH and what they gained from the service. Some clients noted that coming to the interview was a success marker as they would not have had the confidence to take part before REACH.

Findings



# How has REACH been implemented?

This section answers the following key evaluation question:

* How well has REACH been implemented to achieve the intended activities and immediate outcomes?

The findings presented focus on the implementation of REACH between November 2020 and April 2021. The section is structured to demonstrate service delivery from the client entering to exiting the REACH service.

COVID-19 affected the implementation of REACH

During the COVID-19 lockdown period, the REACH team shifted to supporting clients through phone check-ins and, if needed, dropping off supplies. The regular calls were important as some clients found that the lockdown period exacerbated their anxiety or depression. Time was spent on reassuring clients and educating them about COVID-19[[13]](#footnote-13).

**It** just **went on hold for them**. We still **did the welfare checks**. Discovered that we can function in that way. We were skeptical at first, but we did phone follow-up when needed. They knew we were still there. It was tough for some clients and not for others. As a team, we were fine. **Procedures from the DHB were good. We had plans and protocols**. (Key worker)

With MSD’s approval, Waikato DHB also deployed the REACH team to support other high-needs populations during the lockdown period.

Referral processes have strengthened

### MSD staff and clients describe the referral process as easy

MSD case managers interviewed describe the referral process to REACH as straightforward as it uses the standard provider template.

**We can just send the [standard provider template] through with the client's basic details**, which are the name, client number, phone, email address. Then there's a little bit that client meets the eligibility for the programme, and **we just fire it through to the REACH referrals**. (MSD case manager)

Most clients said they found out about REACH through their MSD case manager. A few were told about REACH through other services their MSD case manager had referred them to (e.g. Hauora, Explore). These clients connected with their MSD case manager to access the service. Most clients interviewed were open to trying REACH, having gained some insight into the service. Many clients had reached a stage where they wanted to make changes in their lives and needed support.

I like hadn’t done anything for three years**. But before I met with REACH I** got the ball rollingfor myself, and then it **just all fitted in perfectly**, **really. (Female, European, completed, under 30)**

### REACH referrals increased following the 2019 service iterations

Feedback from REACH staff suggests referrals to REACH were initially slow. The 2019 service iteration changes increased referrals by:

* increasing MSD case managers’ awareness of REACH through the 2019 educational roadshow. MSD case managers seeing positive results for their clients also increased their willingness to refer to REACH.
* broadening the eligibility criteria to increase the number of clients who can be referred.

In 2020, referrals to REACH declined and then increased post-lockdown. During the COVID-19 lockdown, MSD case managers’ workloads ramped up to ensure people were housed and had their entitlements. During this period, referrals to REACH declined. Post-COVID-19, referrals to REACH increased due to job losses and increased stress levels.

**Post-COVID**, we’ve been getting **a lot of clients** **coming** through our doors **with health issues and disabilities**, especially the ones who’ve **lost their jobs** and are now being diagnosed with **anxiety and depression** because of that. (MSD case manager)

### Feedback suggests few Māori clients are referred to REACH

REACH and MSD staff have mixed views on the extent to which whānau Māori are enrolled and remain engaged in REACH. Some MSD case managers said they had not referred many Māori or felt Māori disengaged after the first REACH meeting. The reasons for whānau Māori exiting early from REACH are not known. The lack of cultural processes, cultural icons, and references (signposts) may result in Māori clients disengaging at this stage.

### Some people referred are not appropriate for REACH

REACH staff interviewed noted inappropriate referrals to REACH (e.g., people with a traumatic brain injury or acute mental health issues who are not receiving services). REACH staff note the service does not have the capacity or capability to support people with acute mental health issues or traumatic brain injury.

Some of the **referrals we get are inappropriate.** I think they need to be triaged a little more robustly. I did an initial assessment with someone on Monday **who was still in [acute mental health centre]** and was moving out today into his own flat. It’s about defining what the remit of REACH is actually about**. Sometimes I feel we get treated as a primary health care mental health resource which we are not.** (Key worker)

REACH added a peer review process to screen referred clients for suitability. REACH’s peer review process involves an initial assessment and consent meeting with a key worker. Two key workers and a medical advisor review the assessment to determine the person’s suitability for the service. The medical advisor will review the person’s medical file and flag any risks or challenges to be mitigated if accepted to the service.

### Key workers support people not accepted into REACH into other services

Clients not accepted into REACH are connected by key workers to other more suitable services.[[14]](#footnote-14) Some MSD case managers see this as an example of health and MSD working to find solutions and services to best meet clients' needs. REACH’s ability to find alternative services strengthens the value of the service for MSD case managers.

If the service was **not exactly appropriate for my client at the time, they would always look at other agencies or referrals** **to help with whatever was going on with that client** at the time. Again, another reason why I used REACH quite a bit. They obviously could help me find an **appropriate support** network if REACH was not it. (MSD case manager)

The enrolment process builds client relationships

### Clients interviewed found the enrolment process reassuring

Key workers emphasised the importance of creating a welcoming and safe environment, and for clients to understand the programme is focused on their needs. Most clients said a staff member from REACH phoned them about a week or two after being told about the service by their MSD case manager. Many clients interviewed were anxious about enrolling in REACH. However, they found the process reassuring.

I remember we were by the lake when we met for the first time, and it was just one-on-one. She's nice. **The first time I was really nervous.** Now like my anxiety is quite different. I'm a bit nervous. But it's not like before when **my hands were shaking, and I was sweating**. I don't enjoy meeting people and stuff like that. (Male, completed, European, under 30)

### Some clients want to choose their key worker or living well coach

On enrolment to REACH, clients are assigned a key worker and living well coach. Initially, attempts were made to match clients to living well coaches, particularly by gender. However, as caseloads built up, clients are assigned to living well coaches based on geographical location and service capacity. Some clients want the opportunity to choose their key worker and living well coach based on gender or ethnicity.

Maybe people like me who feel more comfortable around women maybe have women with women instead of trying to get males because **I’m actually quite scared of males, assign women to women**. (Female, Māori, exited, over 30)

Clients like the relationship-building approach

Key workers and living well coaches focus on building a trusting relationship with clients. They work to get to know the client, their family and whānau, and their needs, values, and thinking styles.

Traditionally, they would come in, and there would be an informal agreement. Have an assessment and a GP appointment in the first two weeks. **We changed that, so the first month was a bit more semi-structured**. We developed things that were specific for the client… W**e look at things like thinking styles, values, and strengths, alongside the practical things**. (Key worker)

Clients like the relationship-building approach and having clear expectations of their contribution.

**REACH has expectations that are fair**, such as, "Okay, [Name D], we're going to go and do a walk when I see you on Thursday. Where do you want to go for a walk?" So if I was physically unable they would adjust to that but **they would still expect that I at least go for a walk**, because **they develop the relationship first so you want to be in their company**. (Female, completed, European, over 30)

### Clients like being able to pause and recommence the service

REACH staff note clients need a level of commitment and motivation to gain both wellbeing and employment benefits. However, they acknowledge not all clients in the service are at this stage in their journey. As a result, some clients accepted into the service exited early as they were not ready for the level of commitment. Other clients exited early due to health emergencies (e.g. severe burns) or unexpected family or life circumstances changes.

Clients appreciate the opportunity to stop and re-enter REACH. However, they prefer on return to work with their original key worker and living well coach. Due to capacity limits, this option may not be available, which means some clients do not re-engage.

Some people join and **they're not quite ready for the commitment**. They have to see the key worker once a week. They see us twice a week. When you've got health conditions and family dramas, suddenly it's, "**Oh, that's much harder than I thought it was going to be".** Then we'll usually say, "**How about you withdraw and then you come back 2 months down the track when things have settled down**". (Living well coach)

The Wellbeing Star tool helps define client goals

Key workers and living well coaches found the tool useful in enabling clients to understand where they are at, to identify goals and priorities, and the support needed to achieve their goals. REACH staff liked that the tool is visual and has a holistic, strengths-based, and empowering focus. Key workers are skilled at using the tool in a conversational way with clients.

### The Wellbeing Star tool is useful in setting goals and marking clients’ progress

All clients interviewed, both those who completed and exited REACH, completed their Wellbeing Star. Most clients interviewed said the Wellbeing Star tool gave useful insight into their strengths and enabled them to identify their priority goals. A few clients were initially hesitant about the tool as they disliked completing forms. However, with encouragement and support from the key worker, they were able to complete their Wellbeing Star.

**I think she's so clever at doing [Wellbeing Star].** We did it, it was somewhere in the middle of the coloured paper and the colour pens and the values cards and everything. **Every time a form gets put in front of me, I just freeze**. Everything shuts down. She watches that happening and changes it around. **She brings the answers out and she converts them into the form**. (Female, European, completed, under 30)

Clients interviewed who completed REACH found the final Wellbeing Star assessment useful in visually seeing and celebrating the progress they had made (discussed further in outcomes section). Clients also found the tool useful in determining their areas to work on when they leave REACH.

**The Wellbeing Star is how we set up my programme**. It was **really useful**. It really **made me look at my life and look at what I can achieve**. I relate really well to it. Yeah, it definitely helped a lot to have started my journey on the programme. It was easy to pick which one to go for and to work on. I really enjoyed it. The Wellbeing chart is really good, **totally recommend it to get people started**. (Female, European, completed, over 30)

### The Wellbeing Star tool is not based on mātauranga Māori

Some REACH staff like the holistic approach of the Wellbeing Star tool has some similarities to Te Whare Tapa Whā[[15]](#footnote-15).

I like **those areas, because they are similar to Te Whare Tapa Whā, which I love, and is important to me**. Without giving the concept of Te Whare Tapa Whā at the start, they're allowing themselves to see their world differently. So that Star, I like giving a copy to the clients so that they can see how they see their world because **when the Star is done at the end and there's been shifts out, amazing**. (Living well coach)

Māori clients interviewed commented on the usefulness of the Wellbeing Star in identifying their goals. One Māori client also noted the similarity of the Wellbeing Star tool with Te Wheke and Te Whare Tapa Whā and liked the tool for this reason. While positively received by Māori, the Wellbeing Star tool has no visible or written cultural references to te ao Māori and is not based on mātauranga Māori. An assessment of whether the tool is appropriate for Māori is not within the scope of this evaluation[[16]](#footnote-16).

It [Wellbeing Star tool] was quit**e useful because it was able to show me those areas where I was** in [for] want of a better term, **lacking** compared to the areas **where I had a strength** in. When I was doing it, I was thinking “yeah it might be this”, but I had thought of **Te Wheke model or Te Whare Tapa Whā** in my mind. (Male, Māori, under 30, completed)

### Clients are aware of and work to implement their wellbeing plan

All clients interviewed are aware of the goals they had set with their key worker using the insights from the Wellbeing Star tool. While some are aware of their plan, others are not. Most clients appreciated that the service was tailored to their needs and ability to enact change.

They [key worker and living well coach] will formulate a plan with the client. **The key worker will write the goals in the client’s language**. The plan is then allocated to the living well coach. **Each week the key worker and the living well coach will meet and write a plan for that week to help address those goals**. (Key worker)

### Clients have wide-ranging goals in their plans

Clients’ goals reflect their current health and wellbeing, interests, environment, and aspirations for education and employment. They appreciate the less pressurised approach of breaking down their goals into small and manageable steps.

**They don't push too hard**. They say even if i**t's a simple goal like going for a walk once a week or something**. He'd sit down, and we'd just figure out what we wanted to accomplish. Just really basic stuff like calling the doctor or going out to get a meal or something. **We'd update it throughout the weeks as well. If we figured out some more goals, we'd add on to it or take some away**. (Female, midway, European, under 30)

Goals mentioned by clients include:

* gaining new skills, including a driver’s licence to open up more employment opportunities
* improving organisational skills so their day is more structured
* connecting with others through improving family relations, being able to set boundaries with family, whanau, and others, and connecting within their community through hobbies and sport
* learning how to manage anxiety or anger
* connecting to their culture by learning te reo Māori
* starting or restarting educational study
* gaining employment or voluntary work.

Clients’ goals are refined throughout the service to reflect achievements gained or modified to accommodate new emerging challenges. Clients interviewed like this paced approach, which they feel is not overwhelming and enables them to acknowledge gains made.

**So the goals that they set are not set in concrete either.** Like they can change and **evolve** as well. Sometimes they might set too many or not enough, or they find that they're ploughing through the goals, and they've got to think of others. Yes, which is really cool; **they're quite flexible in that way as well. So it's completely at the client's pace.** (MSD case manager)

Clients like the different strengths of the two roles

### Clients have positive, trusting relationships with the REACH team

As intended, all clients interviewed said they meet with their key worker and living well coach most weeks. Clients look forward to the meetings and like that they are held at convenient and comfortable locations. The frequency of contact helps them focus on their goals.

Clients described their key workers and living well coach positively as relatable, good listeners, and knowledgeable.

They were **friendly and easy to talk to, easy to get along with**. If you had problems, you could talk to them. (Male, European, completed, under 30)

As appropriate, key workers and living well coaches engage with wider family and whānau. Some clients like this wider support. For a few, their partners and siblings were enrolled in the service. These clients appreciate working collectively.

### Clients find the daily living support from their living well coach useful

Clients find working with the living well coach decreases their isolation, increases the structure of their day, and builds their confidence and self-belief. Clients talked about the range of activities they do with their living well coach, including:

* going for walks
* getting their entitlements (e.g. for new glasses or clothes)
* joining gyms or fitness programmes
* finding volunteer work
* checking emails regularly
* working on their CV
* going for driving lessons
* connecting to Māori healer, counsellor, or support groups
* reconnecting with community activities or hobbies.

Small, small really, really small steps. But it put **everything out clearer for me on “What do I do from here?” instead of just seeing it as a huge picture**.... I’m pretty sure she gave me material to take away so that I can go back after. After I’ve **thought about things a little on my own, then I can go back and revisit it**. (Female, Māori, completed, over 30).

### Clients gain useful tools and strategies working weekly with their key worker

Most clients like the use of CBT and ACT as they identify their strengths and values and the steps needed to move towards their goals. Clients appreciate the tools are affirming and tailored to their lives.

[**Key worker] had seen that [stressful situation] and was able to draw me back into the world despite that going on**. So that was what took the time. She found creative ways to get the understanding that I needed. Like standing back, walking round, and **she'd bring me back and talk about mindfulness and get me back into my body when I was spinning out** on all that stuff, yeah. (Female, European, completed, over 30)

The key workers note CBT is beneficial when supporting clients to start the journey back to employment. Using CBT helps focus clients on their employment goals and the steps they need to achieve their goals.

Text, letter

Description automatically generatedSeveral clients mentioned the STOPP tool was helpful in calming their mind. A few clients carry the card in their wallets and refer to it when they get wound up.

[**STOPP] [key worker] gave it to me** before being let go at the end of the programme because it was **part of the CBT** stuff**. Useful.** It helps you to **reorganise your thoughts rather than just letting them build up**. Because of the problem with me, I **was always catastrophising** the little things. So rather than just let it go on, and on, and on, you, sort of, **stop and take a proper look at it.** (Male, Māori, completed, under 30)

### Few clients are aware of the employment coach

Only one client mentioned the employment coach, which may reflect that the role was vacant at the time of the interviews. The employment coach supported the client to update their CV and ensured they were aware of potential job opportunities.

**I had lots of homework to do with my CV and writing down my different certificates** and stuff that I did in my past, and then [the employment coach] would go in and work it into my CV. [The employment coach] **helped on the Seek**. She showed me how if an employer put a job on today or just now, it will show right now. So she made it **easier for me to see the recent ones** instead of seeing a whole lot of different days that people have put jobs down, so **that was really helpful**. (Female, nearing completion, European, over 30)

Provider feedback indicates the employment coach role was under-used. The lack of use may reflect a lack of awareness, or clients were not at the stage in their journey to look for part-time or full-time employment. In addition, many clients interviewed described health and mental health issues that could hinder a return to work.

**There should be more working with their employment coordinator**, getting CVs up to date, getting them employable. I think that's totally separate from building confidence and goal setting. (MSD case manager)

REACH can be strengthened for Māori clients

Māori clients have positive REACH service experience. However, as identified in the 2019 design iteration findings, more work is needed to strengthen access for Māori and for service design to align with te ao Māori.

### Māori clients have mainly positive experiences of REACH

The positive experiences of Māori clients reflect REACH’s holistic and person-centred approach, enabling them to grow. Māori clients appreciate that staff are encouraging, meet them face to face, make follow-up phone calls, provide options, and advocate small steps towards achieving their goals. Relationships are at the heart of this positive experience, with REACH staff building mutual respect and trust. For Māori clients, their positive experiences contrast with their other health and social service experiences.

A few Māori clients noted that staff changes and miscommunication caused frustration and uncertainty. These clients were demotivated by repeating their story and goals to multiple people. Māori preferred the process of whakawhanaungatanga which allows for the development of trust through establishing relationships, an understanding of who they are, the journey they have been on, connections and aspirations. Developing that relationship with one person reduced the need for constant repetition. Māori clients returning to the service, after a pause, want to reconnect with their original key worker and living well coach.

**Stick with the same people** from the beginning, **you’re having to repeat yourself, and then you’re going backward**s. (Female, Māori, completed, over 30)

### Māori clients value the use of te reo Māori by REACH staff

Clients reported that hearing te reo Māori makes them feel comfortable. They appreciate non-Māori using Māori words and phrases, even if they were struggling with the pronunciation.

**When I hear someone say “Kia ora” and things like that, I’m like, “Oh that’s wicked** that’s cool”. Even if they don’t pronounce it properly, that doesn’t matter because I know I pronounce some words differently. At least they’re trying, and then I tell them, “That was cool, eh”. (Male, Māori, completed, under 30)

Māori clients guide REACH staff on the use of te reo Māori. REACH staff appreciate Māori clients can be at different stages in connecting with te ao Māori.

If we had a **Māori person come into the service, we wouldn't immediately try and speak te reo to them.** We'd kind of let them guide where they **were at in terms of their immersion into te ao Māori** and for them to tell us their story and where they are at and **to kind of meet them where they were**. (Living well coach)

REACH staff supported several Māori clients to connect with te ao Māori. One REACH staff member supported a Māori client to learn weaving/raranga, and encouraged them to enrol in a te reo Māori class. Another helped an older Māori client to enrol in te reo classes. REACH staff are also referring clients to a Māori healer.

**We got her doing the weaving**. She was a grandmother, and she was really trying to connect. She was saying she wanted to work but I felt like from talking with her she was kind of taking the angle of keeping to herself. She signed up for a course at Te Rapa, the weaving course, and **another course in te reo**. She kind of went from there. (Key worker)

### REACH can strengthen the use of whānau-centred approaches

REACH, using the Wellbeing Star tool, mainly offers a person-centred service focused on working towards an individual’s goals. Occasionally, REACH staff will use a whānau-centred approach that places whānau Māori at the service centre. A whānau-centred approach tends to be adopted when REACH staff are aware of whānau dynamics impacting on the wellness of Māori clients. One example is when REACH staff facilitated a hui with whānau to bring closure by giving them a voice.

**I’m not sure if we have implemented any whānau-centred approach within REACH**, and that is something **we need to work better on**. I do know there are instances where they have had diabetes or **health-related issues and they have spoken to the whole family and tried to make some lifestyle changes to help their health literacy**. But I don’t think it has happened as an intended of whānau-centred approach. It has just flowed on as part of their service. I think they need to focus more on how they can make it more whānau-centred moving forward. (MSD case manager)

### Māori cultural references and cultural pathways are absent in REACH

The tools used in REACH draw from western science and not mātauranga Māori. Having cultural references and symbols in the service would strengthen engagement with whānau Māori and create the opportunity, if wanted, for Māori clients to engage in te ao Māori.

**REACH has lacked a cultural lens Māori lens to the programme.** That’s been one of the things even in the staff presentation or in the practices and things as well. Just being informed about cultural practices and implementing that in terms of Māori and Pasifika clients hasn’t been witnessed, at least by me. (MSD case manager)

The REACH team has one Māori staff member. Efforts are made to link Māori clients to this staff member. However, the responsibility for cultural safety lies both in the service design and with all staff members. REACH staff have access to cultural advice from Waikato DHB kaumātua, and work closely with the Māori needs assessment service coordination.

Whether staff receive cultural training or cultural supervision is not known. REACH staff are seeking access to cultural training, the development of cultural competencies for their roles, and marae orientation. More Māori staff are needed at all levels of the service.

If we look at Waikato, at least 45 percent of our clients are Māori. First, **we need to have more Maōri representation in the team**. If that’s not possible, be more culturally informed and keep them more informed with the practices and how they can provide a more culturally informed service with a Māori lens. (MSD case manager)

MSD case managers’ engagement in REACH varies

### MSD case managers have positive relationships with REACH staff

MSD case managers interviewed value the REACH staff’s expertise and ability to support their clients in ways they could not. Over time, understanding of REACH has increased.

**I primarily used REACH because of who was running the programmes**. They had access and **the ability to go with my clients to doctors** or anything to do with addiction. They had networks available that I couldn't have done without them. Well, I could have, but it would have taken five or six months to even get to some points with some of my clients. **Having them there with the DHB helped a lot of my clients address some needs, and they wouldn’t have done it otherwise**. (MSD case manager)

### Engagement varies across MSD case managers

Feedback from REACH staff suggested there was variation in engagement with REACH across MSD case managers. They felt rural MSD case managers are more engaged with the service due to a closer relationship with their clients. Those in urban centres are less engaged, potentially reflecting more pressures on their time.

MSD case managers note the highlight meeting is important in understanding their clients' engagement and progress with REACH. However, they indicate the shift to virtual meetings post-COVID did not enable their involvement and support of REACH clients.

### Clients had mixed feedback on the role of the MSD Case Managers

Some clients went with their key workers to meet with their MSD case managers. For a few clients, the meeting was important as they did not have an established relationship with their MSD case manager. For others with a positive relationship with their case manager, the meeting was less critical. Some clients were positive about accessing additional support.

GPs interviewed want more information about REACH

### GPs interviewed have limited understanding of the REACH service

These GPs’ lack of knowledge reflects the small number of their clients enrolled in REACH and the busy nature of primary care. GPs interviewed want more information about the resources available through REACH and about how to refer to the service. GPs interviewed also want a clear agenda for the highlight meeting to maximise the interaction.

My understanding is that when I put people on the jobseekers benefit, **I don't even know who gets chosen to be on the programme.** It would be nice to clarify, and can I ask for that to be initiated in certain patients where I know it would make a difference. I don't know how frequent the input is, **I don't know much about it other than those two patients with those visits and documentation,** but I don't know a lot about it. (GP)

A few GPs interviewed are concerned about the appropriateness of the service for their clients, given their medical conditions. For example, one GP interviewed felt the REACH staff overstepped their role in claiming the client had not received appropriate medical support when they did not understand their medical condition. The key worker can seek advice from a medical advisor at the DHB before meeting with the GP to manage this potential tension. Occasionally, the medical advisor may call and discuss issues with the GP.

### For some clients, GP visits improve their use of primary care

Clients have mixed relationships with their GPs. Some are positive and others are not. Clients appreciate the joint visits to their GPs for a range of reasons. A few clients like the key worker explaining to the GP what they are doing on REACH and the changes gained. For these clients, their anxiety makes it difficult to express themselves.

**I had two doctor sessions that they paid for**. One is going into it, and one is coming out. Having them discuss with my doctor what was going on with me and how they felt I was doing was, I think, **useful. More accurately able to gauge where I was than if I'd gone myself**. I have low confidence, so I will shy away from things when I can and, as a result, it would tend to trigger stress that would also exacerbate my symptoms so with them able to identify that, "Yeah, when he's not stressed, he's pretty clear, pretty stable". (Male, European, under 30, completed)

A few clients have not seen their GP in a long time. REACH paying for the visits removed the cost barrier.

[**Visit to GP] that was good**. I didn't have to pay for it. It was good that they listened; **the doctor listened better**. (Female, European, completed, over 30)

A few clients also noted the key worker visit resulted in their GP listening to them more when they visited on their own. One client changed their GP to gain easier access and a more person-centred approach.

They also **helped me change to a different doctor** at the practice. Because the one that I was with, **I didn't click with. He literally would sit at the computer** and just go, "Oh, yeah, yeah, yeah". He didn't turn around and interact with the person. Moving to this new one, **she's a more people-orientated person**. (Male, Māori, completed, over 30)

The programme fund is useful but not accessible

Key workers and living well coaches enable their clients to access support and services to work towards the goals in their action plans. The types of services and supports accessed vary across clients and their goals. Common services mentioned are gym membership, driving lessons, physiotherapists, counsellors, Māori healers, and grants for glasses and clothes. Gaining access to these supports and services varies. Some are paid through Work and Income entitlements, and those not may be covered by the programme fund.

Feedback from REACH staff and MSD case managers highlights the importance of the programme fund to access support and services tailored to clients’ needs. However, some REACH staff have limited awareness of the programme fund, and access is slow. In a time-limited service, waiting two to three weeks for a funding decision can slow clients’ progress and adversely impact their motivation to keep moving towards their goals.

**It’s useful in theory, but how we access it can sometimes be confusing for us**. If MSD can’t do it, we have to look at all other areas and see if we can get funding, and if they don’t, we can use the discretionary fund, but that’s **not a quick process. That can go on for two or three weeks**. I’d like some more leniency around it. We’re trying to get to a wellbeing goal without two weeks of emails. (Key worker).

The option of 20 weeks increases client flexibility

REACH staff and MSD case managers were positive about clients having the option of extending the service from 12 to 20 weeks. The need for the extension is determined in collaboration with the client. REACH staff are mindful when working with clients to avoid creating dependency on the service, given the intensity of their provision.

Most clients interviewed did not recall the length of the service received from REACH. However, some wanted the service to be longer. The rest were mainly happy with the duration of the service, recognising REACH is a brief intervention.

The transition out of REACH can be strengthened

For a few clients, completing REACH is unsettling, and they miss the regular interactions with their living well coach and key worker. MSD case managers felt locating REACH in Waikato DHB created a smoother transition due to the potential to link clients to other health and wellbeing services. MSD case managers are aware clients may feel unsupported at this time. Unfortunately, MSD case managers cannot offer clients an intense level of support due to a lack of capacity. Some case managers suggested more involvement of GPs or other services could support clients during this transition period.

[After they exit REACH], then they get handed back to MSD. **With no dedicated case management approach, there can be quite a downfall**… They are sole flying from there, and that’s great, but **sometimes they might still need additional encouragement** and support. Unfortunately, **we don’t have the capacity to deliver that** and sometimes, people can fall through the cracks. (MSD case manager)

### REACH continues to support clients after service completion

The REACH team can provide up to 12 weeks of post-service support, depending on clients’ needs. Some clients who completed the service spoke of receiving follow-up from REACH through phone calls and in-person meetings. This ongoing support helped clients in continuing to work toward their goals. A few had not received any follow-up from REACH.

We're supposed to do it for 12 weeks, but they said if it was seen as important, like myself, **they could extend it to 20**, so they extended me to 20 weeks**. I didn’t want it to end, no**. And that's not because of anything more than **I still needed that validation, I still needed that interaction,** and I said to [Name A] at WINZ, **"I feel like now I've been lifted out of the well, but I've been abandoned"** because it just wasn't quite long enough. (Female, completed, European, under 30)

REACH staff interviewed like the opportunity to reconnect with clients who have completed the service. They encourage and motivate them to keep working on their plan and check on their progress. However, no pathway exists to reconnect clients to REACH or other services if clients face challenges or new emerging issues.

# How have MSD and health agencies enabled REACH’s implementation?

This section answers the following key evaluation question:

* How well have MSD and health agencies enabled and influenced the implementation?

REACH is a collaboration between health and employment services

REACH is based on Waikato DHB’s and MSD’s shared vision of strengthening clients’ health and wellbeing and enabling clients to achieve their aspirations. Both agencies brought their unique strengths to REACH. Waikato DHB offered their health and wellbeing expertise, and their links to primary care and mental health and wellbeing services. MSD brought their depth of expertise in entitlements and employment.

### REACH’s cross-agency way of working strengthened across time

Working collaboratively across agencies is not easy due to government and Crown agencies’ different vertical agency-focused accountabilities. Building an effective working relationship took time and commitment across the agencies.

Waikato DHB and the Oranga Mahi governance board met at a national level, supported by the MSD service design team, to discuss learnings and consider their implications for the service. Over time, relationships strengthened and appreciation of differing roles deepened. With the MSD service design team, REACH adopted an adaptive learning approach to strengthen the design and implementation through the trial.

Regionally, the REACH staff worked to build relationships with MSD case managers, primary care, and other health and support services. Implementing the service required REACH staff, GPs, and MSD case managers to understand their differing and complementary roles in the service. In addition, partners had to make time for the initiative and to support the service as intended. Having a programme coordinator was a key enabler for the service in addressing the tension points when working across agencies.

A key to the implementation of the service and why it worked, and why the relationship with the DHB was so good, was due to the **effort put in by the regional health advisor**. She played a **huge role in making this work** and her relationship with the REACH team, particularly with the team leader. This is one of the reasons why there was always good uptake of the service from MSD sites. (MSD)

Research highlights that having a shared vision, collective governance processes, a client-centred way of working based on adaptive learning, and a backbone function are necessary for effective cross-agency working methods.[[17]](#footnote-17) [[18]](#footnote-18)

**We need that whole integrated approach**. Yes, MSD can get the experts for employment, but we need a collaborative approach with someone who specialises with health conditions and disabilities and can help morph that aspect. We had to realise that. This whole multi-agency was DHBs sending their expertise in managing health conditions better. They were working towards employment, and working together to make it happen has been **one of the best things for our clients with health conditions and disabilities**. (MSD case manager)

### Data sharing and miscommunications were key cross-agency tension points

An initial challenge faced by REACH was the process of sharing client data and information across agencies. With client consent, sharing this data was intended to ensure client access to the appropriate support and services to step towards their goals.

**Sometimes the reluctance of agencies to share their understanding** **of that client**, even though that client will often be happy to agree to that. A lot of it was around the person creating this working week for themselves and filling it with meaningful activity. We liked the idea of the person being in control of it and inviting other parties to be a part of that, so they could see that working week. But that **became a really challenging conversation between DHB's legal, MSD's legal as to how you share those notes.** It became harder than it should be really, even though you've got that person's consent. (Key worker)

Changes in MSD case managers, particularly in urban centres, impeded the service. REACH staff also note the variation in responses from MSD case managers relating to requests to support clients or for entitlements. MSD case managers hold significant power to enable the service.

**I'll ask for specific funding for certain things**, and **they just reject it straight away**, and I'm like, "Why are you rejecting this?" "Because **we don't do it**", and I'm like, "Well, **you do because I've had it funded before from other WINZ offices** blah, blah, blah", and they're just no help and support, so to get the client help, **I've gone to different WINZ offices and requested their support to be able to get it.** (Key worker)

MSD processes for managing trials can be improved

Trials are both exciting and uncertain spaces with no assurance about ongoing funding. This uncertainty creates challenges for staff retention and management of client expectations. Feedback from Waikato DHB and MSD highlighted areas for future consideration in running trial services, specifically:

* reviewing the contract process used for a trial so it reflects the need for ongoing adaption within the trial
* setting up an evaluation from the outset, particularly quantitative data collection
* managing expectations and being transparent with providers of the trial’s ongoing funding
* ensuring senior regional MSD managers are informed about the trial’s progress and emerging outcomes
* ensuring sufficient time and appropriate processes to transition out if the trial does not become business as usual.

**We write our contracts like the trial services are an established business or service.** So we've got outcomes in there, we've got like, "For every person you get into employment for 30 days or 91 days, you'll get paid this much". Why do they do that? It's a trial. **We should be looking at numbers into work but also their connection to sustainable outcomes**. (MSD)

# How can REACH’s implementation be improved?

This section addresses the following key evaluation question:

* How can the implementation of REACH be improved?

This section highlights the enablers of REACH and then details the areas for ongoing improvement.

REACH is enabled by a holistic and relationship-based approach

Feedback from clients, REACH, and MSD staff identified a range of enablers for the service. This evaluation cannot assess the weighting of the enablers in achieving the gains from the service. The service is a holistic one, so it is likely the enablers will work collectively.

**I think the whole multi-disciplinary approach [works well]** because everyone is playing their part. But then **everyone is collaboratively working together** to help the plan move forward. (MSD case manager)

The enablers are:

* potential clients’ awareness of the commitment to meet regularly with their key workers and living well coach if accepted onto REACH
* a client-centred approach based on the holistic Wellbeing Star tool, which recognises the importance of addressing health, wellbeing, and other needs to progress clients to voluntary or paid employment or training outcomes
* a multi-disciplinary approach drawing on the expertise of the key worker, living well coach, employment coaches, GPs, and MSD case managers
* the frequency of the key worker and living well coach interactions with clients which enables momentum and gives time to build relationships and trust
* an accessible and flexible approach, including:
  + ensuring rural clients have access to REACH
  + offering clients the opportunity to pause and recommence the service if other issues impede them from taking part
  + having the option to extend the service to 20 weeks, if needed by clients
  + meeting clients in their preferred location (e.g., their homes, public spaces, the REACH office)
  + working at the pace set by the client
  + having a programme fund to tailor solutions and access support for clients to work towards their goals.

**We give the client the choice** **of whether they’d like to come in** or go to a **park or a café.** Sometimes with clinical interventions, you’d preferably go into their home or here. (Living well coach)

Improvements to REACH reflects service maturity

Clients interviewed had minimal feedback on potential improvements to the REACH service. Many were thankful for the service and the gains they had made. Some were concerned that criticising the service could jeopardise it.

Drawing across the client interviews and those with REACH staff and MSD staff, the following improvement areas were identified:

* reviewing the referral process to ensure appropriate people are referred and Māori can access the service
* strengthening whānau-centred approaches in REACH and Māori cultural references and te ao Māori, and having more Māori staff
* increasing understanding of the service and roles and responsibility, including:
  + MSD case managers having greater clarity on their roles in referrals and exits
  + GPs understanding the service and supporting clients on exit from the service
  + awareness and use of the employment coach role in supporting the transition to employment.
* offering MSD case managers training to improve the consistency of responses to key worker requests relating to support or entitlements for clients
* enhancing awareness of the programme fund and improving timeliness of funding decisions
* improving the transition to exit so clients feel supported to continue working on their goals
* more training for REACH staff on CBT and ACT and supporting people with significant mental health issues.
* improving MSD processes for managing trials around contracting and evaluating processes, trial promotion, and transition processes.

# How is REACH supporting short-term and medium-term outcomes?

This section answers the following key evaluation question:

* How is REACH supporting the achievement of the desired short-term and medium-term outcomes?

This section leads with the voice of clients and the changes they attribute to REACH. Feedback from REACH staff, MSD case managers and GPs on emerging outcomes are then presented.

REACH is enabling positive client change

Overall, the feedback below from both clients and key stakeholders demonstrates progress by REACH clients on achieving the agreed short-term outcomes ('live' logic model, Appendix 1). In summary, the short-term outcomes for clients are:

* progress against their goals
* better management of their health and wellbeing
* improved wellbeing
* improved work readiness
* strengthened links to additional support and services.

Less evidence was noted of progress against the medium-term outcomes of clients having:

* sustained health and wellbeing improvements
* secured meaningful part- or full-time employment
* gained qualifications or take part in meaningful training
* sustained links to additional support services and community.

Most clients interviewed noted positive health and self-confidence changes

Many clients interviewed explained they felt depressed or anxious before REACH and lacked the confidence and skills to engage with unknown people.

Out of the 30 clients interviewed, 27 clients noted positive changes they attributed to REACH. Changes highlighted by clients are multi-faceted and reflect their health status entering the service, home and community environment, and priority goals set using the Wellbeing Star tool.

### Many clients reported greater confidence and a sense of purpose

Unprompted, most clients spoke of feeling more confident and engaging more with people in their community. Working with the living well coach decreased clients’ isolation through engaging in sport, hobbies, and community activities. Clients also spoke of having more structure and purpose to their day and taking steps towards a better lifestyle (e.g. healthier diet, more exercise, stopping smoking).

### Many clients felt positive and could manage their health better

Many clients felt more positive about life than they had before entering REACH, and had strategies to deal with negative thoughts and mental health issues. Two clients said REACH saved their lives as they had previously had suicidal ideation.

### Some made steps towards education, volunteering, or employment

Clients were building up work readiness skills by gaining their driver licence, being in education, volunteering, doing work placements, and applying for work.

### Clients with no changes had early exits from the service

A few clients with no changes had exited early due to exacerbating health or family circumstances. Most clients who exited early spoke highly of the service and tools, including the Wellbeing Star. Some who did not complete REACH identified changes they attributed to the service, particularly changes to their lifestyle, looking after themselves, and managing their health symptoms.

They gave me **lots of options of type of work I could do** because I had to tell them I haven’t worked before and I didn’t know where to start. They said I could **start with volunteer work** because that might be something I could always put on my resume for future reference. So yeah, they **opened my eyes to a lot of stuff I could do**. (Male, exited, Māori, over 30)

Clients described holistic changes to their lives

Below are four examples, showing the holistic changes highlighted by clients:

1. Male Pacific client aged over 30 and who completed REACH. He spoke of gaining structure to his day and being able to manage his depression better. He has made several lifestyle changes relating to sleep and diet. His relationship with his family has improved. He was taking driving lessons and is confident to sit the test. He is also more confident engaging with Work and Income and feels positive about his job prospects.

**I think the biggest impact is having the daily structure part, yeah. Before, I never put any effort into maintaining a routine**. I mean I could have done it myself but it's getting over the hump that is depression, to do it. They definitely helped with that. They were the earthmoving company that turned the hump into a beautiful slope. Yeah, that's the biggest impact I think they had. Definitely to do with the routine. **Lot of it centred around having a shower, brushing my teeth, getting out of bed at a consistent time, going to bed at a consistent time, not using any devices before I go to bed because of the light that affects your eyes and disrupted sleep, that sort of stuff**.

1. Male, Māori, aged under 30, who completed REACH. REACH helped him lose weight and become fitter through a gym membership. REACH connected him back to sports and activities he enjoyed. He feels confident and able to have his voice heard. He is volunteering and working a few hours in a family business. He is interested in getting part-time work but does not want to push too hard and lose his gains.

I was **definitely apprehensive at first because at the time my anxiety levels were high**. **My stress levels were high**. Through the REACH programme, it managed to get me to where I am today where the **anxiety levels are kind of non-existent**. The stress is still there from time to time but mostly non-existent. Post-traumatic stress is still in the back of the mind, but it doesn't pop up as much as it used…**I'm kind of more outgoing than I was** beforehand, but that's the confidence side of things. I get my voice heard more often… **With doing the volunteering** and stuff like that, also with helping the parents with the shop from time to time. **I have started looking [for work], but all those part-time positions are saying that they want 20 hours plus**. The level that I'm on for medical deference at the moment, it's up to the 15 hours a week. I don't want to be pushing too hard. I know that maybe **in four to six months, I might be ready for the 20 hours a week** but currently just doing what I've been doing with the volunteering and stuff like that, **I feel that's a good balance that I've got at the moment.**

1. Female, European, aged under 30, and midway through REACH. The client has achieved her physical goals, learned relaxation techniques to manage her anxiety, and gained her driver licence. She is looking forward to completing REACH and her training so she can get off the benefit.

**Gave me more of a stronger sense of independence and self-worth and confidence.** I'm hoping to ride the rest of the programme out to see if I can do some last little bits of work around anxiety, and then **I'm essentially hoping by then I will finish my training, and I will be able to get off the benefit which will be a big relief**.

1. Female, European, aged over 30, and completed the service. REACH saved her life as she was actively contemplating suicide. The service helped her to manage her anxiety and depression and built her confidence and self-belief. She is now in education, working towards her employment goal, and has completed her CV.

**REACH just sees you as the person you are**. I mean I looked like something out of a cartoon character. **I couldn't look at people in the face; I was too scared to speak. I'd have panic attacks. I just wanted to be left alone, just had nothing**. I'm now sitting at the end of March, and I'm doing this course. I still struggle with depression, but it's not at the same level. Anxiety is still high, but it's not at the same level, and that's because people met me and **showed me that I was a likeable person and that I was not abnormal and freak** and that even though I thought I'm too old to do anything I'm doing it.

### Clients note changes in the Wellbeing Star ratings on completing REACH

When prompted, clients could recall the changes in their Wellbeing Star ratings on completing REACH. Figure 1 shows the Wellbeing Star domains and the number of clients who mentioned a change in the domain (blue circle). The lifestyle and looking after yourself domains have been merged as clients did not differentiate them.

The findings are qualitative and are indicative and not representative of all clients using REACH. However, they reinforce the holistic nature of the changes.

Figure 1: Number of clients who mentioned changes relating to a domain in the Wellbeing Star tool

Diagram

Description automatically generated

Of the 27 clients interviewed who noted a positive change:

* Around two-thirds talked about changes in work, volunteering, and other activities.
  + Some clients have improved their work readiness, which includes gaining work experience, having the confidence to apply for and go to job interviews, and working on starting a business by building on a hobby area. For people who initially struggled with anxiety and engaging with people, this is a significant change.
  + Some clients work in voluntary positions for organisations like Habitat for Humanity, House of Science, conservation organisations, sporting codes, and educational organisations. These roles build clients’ confidence, help them make friends, and offer more structure to their day. Many spoke of using their voluntary experience to build up their CV.
  + Some clients were in education doing a range of courses geared towards their longer-term employment goals, e.g. welding, diploma in social work.

**It's exactly the right job for me right now because it's working for [organisation] and I'm doing sorting supervisor**. I'm working with clothing. I get to display things in the store. I also have almost like a supervisor role as well. That is the position that I was initially covering for so I supervise the volunteers and give them tasks. **Yeah, so it's definitely given me a purpose back and going from doing nothing for the last 3 years to this**. (Female, European, completed, under 30)

* Around half mentioned changes in feeling positive, their lifestyle and looking after themselves.
* Around half mentioned they are managing their health and mental health due to receiving health appointments, CBT, and other tools used by the key worker.
* Some mentioned changes in relationships with family and friends. Some mentioned reconnecting with their family. Others are now better at managing the boundaries with their family to maintain their mental wellbeing.

**Helping me to make boundaries with my [relative]**. I got so low I would get sick, so I made changes, removing myself from the [situation]. My [relative] was critical of how I was navigating a very difficult situation, **so I stopped trying to help so much, and that helped me get back into a position where I was able to, yeah, function better**. (Female, European, completed, over 30)

* Only a few clients mentioned improvement in money. Some had adopted strategies to improve their money management, while others struggled, or money was not a priority.
* Only a few clients interviewed mentioned changes in where they live. A few mentioned being conflicted between liking where they live but not getting on with family living there.

All stakeholders agreed clients they engage with are progressing towards their goals

Feedback from REACH staff, MSD case managers, and GPs reinforce the feedback from clients. All stakeholders interviewed gave examples of clients making progress towards their goals.

**I think a lot of it was just them coming up with a life plan and figuring out here are the steps**. And actually having some help making those first steps. Getting training lined up, getting into a course, those sorts of things. That’s where I have seen the improvements. I can think of three cases off the top of my head with ones that have had really positive responses to the REACH programme. And yes, I would say that is true with them. **They have been more articulate, definitely improvement with eye contact, and confidence is a good word for it**. (GP)

### Stakeholders said clients can better manage their health conditions

REACH staff, MSD case managers, and GPs support client feedback that REACH enables clients to improve their self-management of their health and mental health. REACH is achieving this through increasing clients’ health literacy to manage their health conditions.

The intention of the programme is to **give autonomy back to the clients to give them the power and knowledge of health literacy** and how they can help improve their conditions. So, it really **helps them take charge and make changes in their lives**. (MSD case manager)

Living well coaches enable clients to make healthy lifestyle choices relating to diet, exercise, and smoking. Living well coaches also role model these positive lifestyle choices (e.g. going swimming or walking with clients).

### Stakeholders said clients are linked to other supports and services

REACH staff worked to increase awareness of services and strengthened clients’ confidence to use services. The process of connecting to services builds clients’ skills to access services unaided after completing REACH. REACH staff also connected clients to digital health tools, like Healthline, to ensure access to free health advice after completing REACH.

**I like to look at the services, I like to see what's out there and I'll try to make a connection** because at the end of the day the programme is a programme and it has to come to an end. Sometimes we haven't addressed every issue, so I like to see what's out there and **see where we could possibly redirect people to get the support they need elsewhere** as well. (Living well coach)

### Stakeholders said clients’ wellbeing and mental health improved

REACH staff, MSD case managers, and GPs all identified clients for whom REACH contributed to an improvement in wellbeing. Examples include:

* REACH had built client confidence to engage with Work and Income, GPs, and other services.

Another young guy - he would come in with his mother and his brother, and **I'd talk to them, wouldn't talk to him**. We got him into REACH, and they would go out to where he lived and just do stuff. This young guy - **he came out with confidence**. The second to last visit I had with him, he walked in - just amazing. **He owned the place. He just walked in and greeted me, and sat down. Mum and brother were in the car**. (MSD case manager)

* REACH enabled clients to improve their health and hygiene.

I don't think I've met a client who hasn't improved. Seriously, honestly, I'm not just saying this. **Every client has improved, whether it be health and hygiene.** (Living well coach)

* REACH has strengthened relationships and increased happiness.

Boost confidence, **increase happiness, strengthen relationships, manage problems**, reduce stress, accomplish goals, build meaning and purpose, improve work, and improve their ability to engage in work. (Key worker)

Some stakeholders said clients’ work readiness improved

#### REACH is changing some clients’ employment beliefs and pathways

REACH staff and MSD case managers shared examples of how REACH is changing some client pathways. REACH is stopping some young clients from becoming long-term unemployed by changing their habits, improving their health and mental health, and supporting their goals.

**We are making a difference when you can see someone who is on the cusp of being a long-term beneficiary.** They're 19 years old, they're 20 years old, 21. They've **fallen into the stay-at-home game**, watch movies, drink caffeine, smoke, have headaches. **REACH stops them from becoming long-term beneficiaries**. They have a right to dignity; they have a right to a meaningful life. (Key worker)

**REACH is also supporting some clients who have been unemployed for over 10 years to identify their goals and create a new pathway forward.** As a few clients interviewed noted REACH shifted their long-held beliefs about not being able to work. (Key worker)

#### For some clients, becoming work-ready is a stepped process that takes time

REACH clients interviewed spoke of having significant health and mental health issues. REACH staff are aware their clients’ pathway to employment requires them to be well and have the capacity, capability, and confidence to seek paid work. This process takes time. REACH staff see voluntary work as a way to build confidence and work readiness.

**Clients referred to REACH are normally medium- to high-needs clients**. We cannot have a quick fix approach in REACH to get them into employment right away. As part of this programme, they have taken one or two steps to meeting their personal or health-related goals. **They are two steps ahead in that staircase approach**, **and eventually that will lead to employment**. In the majority of the cases, it does not happen as a result of the programme right away, **but they do get some employment outcomes**. (Key worker)

#### REACH and MSD staff shared examples of clients gaining employment

Below are five examples of clients returning to work and the challenges clients overcame to achieve their employment outcome.

Basically, I can think of a young guy who **I first met, and he was really shy**; he didn't want to say boo to a grasshopper or anything.... At first, he wasn't keen, **spent most of his time at home with his father,** and then he did agree to it and did really well... He went through an interview, but he got the job, and he's still there, and he is loving it. I **had reports from the employer, and my work broker has as well, about how great he is**. **He's off the benefit, has been for ages now and loving life.** (MSD case manager)

**He was in his 50s, saw him change**, totally disliking the way he lived, his mental health was poor, so many things, to now his environment is fine for him because his mental health is on the up. And he **got a full-time job with a car and he's in support work.** (Key worker)

So every week, the key worker would drive there and then more and more, the client would be driving. **Then he got a job in Hamilton, so he was quite happy to drive himself in there**. Isn't that amazing? Something like that, there's no way we could provide anything like that. (MSD case manager)

**The fact that one person was assigned to working with him, to actually listen to his specific needs** and be aware of that and then trying to work with him, being in contact with him regularly to try and find him maybe a place where he could work, and **he did actually find a job, someone told me that's part of the REACH programme**. **He's now employed, and he's in a relationship, and he's happy, which is great.** (GP)

**She does patrol now for security**. She couldn't work with her hands. Through the programme and getting the cognitive behaviour therapy and making sure **she was either on the right medication and or what to do if she had a panic attack**, she discovered, "Okay, life is not over because you can't do this type of work". Now she goes car patrolling where she doesn't have to use her hands all the time. (MSD case manager)

#### Some clients found employment after completing REACH

Some MSD case managers highlighted some REACH clients find work after completing the service – up to a year or more later. Their discussions with these clients indicate it is unlikely they would be employed without REACH.

With the team that is involved and their doctor on board and everything, it is a great place to start for some people. **The confidence they gain from that interaction sets them up. We often get exits into work eventually**. I generally find that within a year or 2, or less, those people are going to full-time work. (MSD case manager)

REACH staff also noted the work readiness process continues after completing the service.

**When I do my follow-up calls** I hear how well they're doing and where **they've gone in their life. From being sat in the house** and not being able to leave home because they've been suffering from chronic anxiety, and now being out doing their supermarket shopping and being able to go and visit family and friends. **When I do follow-up calls, for them to be able to consider thinking, "Now I'm getting ready. I'm ready to start looking for work now**”. (Living well coach)

#### One MSD case manager wants more emphasis on employment outcomes

Feedback from one MSD staff member suggests more emphasis on helping clients to become work ready. They are supportive of the positive holistic health changes. However, they want to see more clients going into paid employment.

**There's not a lot of getting into work**. It's very holistic, which is confidence building, goal setting, they're moving forward, which is fantastic, but the actual work outcomes…More of that needs to happen. Just getting our clients work ready. I don't see that. **They're not looking at the end goal of paid employment**. (MSD case manager)

#### Employment is a narrow marker of REACH’s success

REACH staff raised concerns that employment is used as the marker for the service’s success. This concern reflects the challenges of finding employment in rural areas and not recognising the wider health and life benefits clients gain from REACH.

Without REACH, most clients interviewed said they would not have achieved their outcomes

Most clients interviewed who achieved positive outcomes said they would not have achieved them without REACH. Their response reflects they are not aware of any other service like REACH that seeks to support them holistically to achieve their goals. Some clients acknowledged the positive role of their GP but noted they cannot afford to see their GP often.

It's **mainly because of the holistic approach** that REACH has, that made it **so easy to just grow and grow and grow.** (Male, Māori, completed under 30)

A few clients interviewed felt they might have achieved the outcomes independently, but it would have been challenging and taken longer. REACH staff, MSD staff, and GPs also agreed REACH fills an important gap in the health and social service system. REACH’s uniqueness is being a holistic and client- and goal-centred service.

It's **different from any other programme** because they have a specific person to work with their CBT and all that medical stuff. They have someone else who they can talk to. It's not, "You must do this, this and this". It's just an amazing programme for **clients just to be able to reach out and find that support that they just can't get from anywhere else**. (MSD case manager)

# Qualitative evaluation conclusions

### REACH is valued by clients, MSD case managers and GPs interviewed

The REACH service addresses service gaps for clients with mental health issues and creates positive pathways towards work. Both clients and key stakeholders are disappointed the service is being discontinued. However, neither MSD or Waikato DHB were able to secure further funding to deliver the service past June 2021.

### How well has REACH been implemented?

As intended, the service design and implementation of REACH iteratively evolved over the last four years to deliver desired client outcomes. Key changes supporting the outcomes were broadening the eligibility criteria and screening process, having an employment coach, and strengthening cross-agency relationships.

### How is REACH supporting the achievement of the desired outcomes?

Based on the qualitative evaluation findings, REACH delivers against three of the four intended outcomes in their contract. The qualitative evidence supports:

* REACH is reducing physical and psychological barriers to work to assist clients interviewed increase their capacity to work and potential to work.
* Most clients interviewed are exiting the service with improved health outcomes.
* Most clients have strengthened their work readiness. A few clients interviewed are entering employment, some are volunteering, and some are in education.

No evidence was found that REACH had increased the capability of MSD case managers to work effectively with clients with a health condition, injury, or disability. No REACH staff discussed working to improve MSD capability in this context.

### How well have MSD and health agencies enabled the implementation of REACH?

MSD and Waikato DHB worked in an effective cross-agency partnership to deliver REACH. Both agencies brought their unique strengths to REACH. Their achievements reflect a shared vision of strengthening clients’ health and wellbeing and enabling clients to achieve their aspirations. Time, commitment, and shared governance processes enabled the cross-agency way of working.

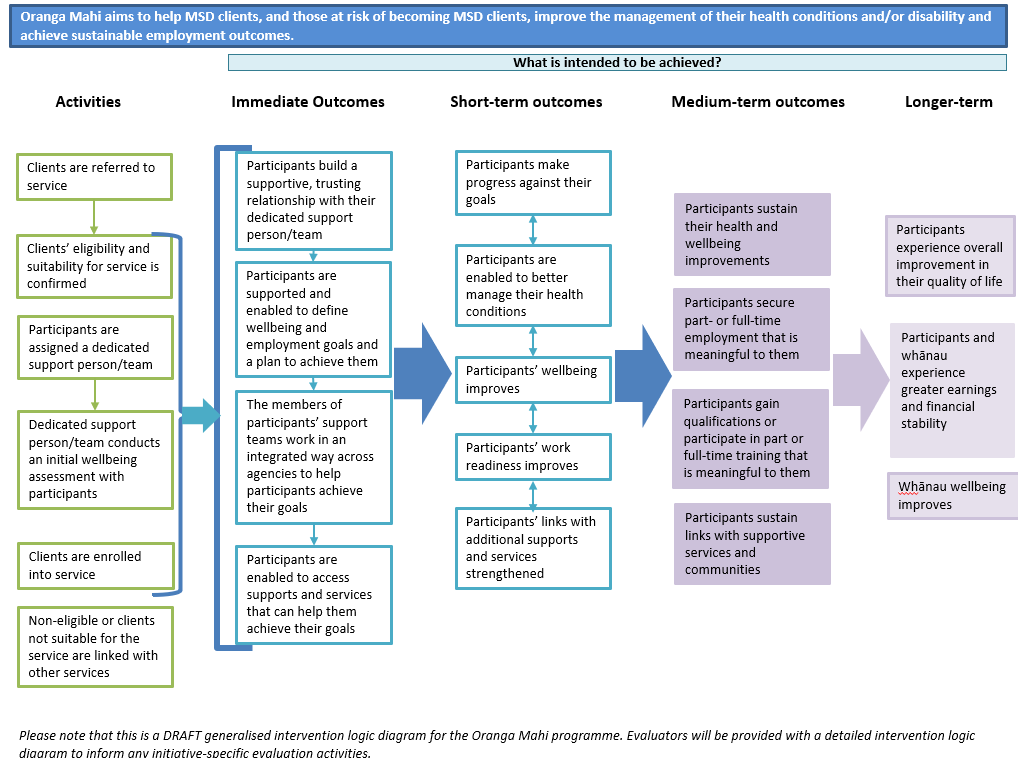
### How can the implementation of REACH be improved?

If the service continued, further work is needed to ensure access for Māori, strengthen cultural references and te ao Māori in the service, improve access to the programme fund, and refine the exit process so clients feel supported.

Appendices



Appendix 1: ‘Live’ intervention logic detailing the desired outcomes



Appendix 2: The key evaluation questions and sub-questions for REACH

| **Key evaluation questions** | **Sub-evaluation questions** | |
| --- | --- | --- |
| 1. **How well has REACH been implemented to achieve the intended activities and immediate outcomes?** | **Referral, enrolment, and retention**   * How well are the intended MSD client groups being referred to, enrolled in, and retained in REACH? * How have the changes to medical certification affected referrals, enrolment, and retentions in REACH? * Who and for what reasons are clients deemed ineligible or unsuitable for REACH? * To what extent are ineligible clients being linked to other support services? For what reasons are they not referred to other services?   **Engagement with the cross-agency support teams**   * To what extent have enrolled clients been (successfully) assigned their support team across MSD and health agencies? * How well are MSD and health agencies developing supportive and trusting relationships with their clients? * How well are the cross-agency teams working together?   How well does the cross-agency team meet the cultural and diverse needs of clients?  **Client plans and their use**   * How well have enrolled clients been enabled (by the dedicated support team/person) to define their wellbeing and employment goals and plans? * How and to what extent are the agreed plans being put into action? * How and how well are MSD and health agencies working in an integrated, culturally appropriate, and co-ordinated way across health and social services to implement plans and support clients? * To what extent can clients access support and services to achieve their goals? How well does the programme fund support this?   **Client-centred and flexible service delivery**   * To what extent are MSD and health agencies actively enabling clients to implement their plan and actively linking to services to achieve their goals? * How flexible is MSD and health agencies in supporting the implementation of client-centred wellbeing plans?   **Wellbeing Star Tool**   * How is the Wellbeing Star tool being used? * How useful is the Wellbeing Star tool in supporting clients to plan and monitor their goals? * How well does the tool support clients’ diverse needs? * How culturally appropriate is the tool? | |
| 1. **How can the implementation of REACH be improved across the implementation domains above?** | * How has the implementation of REACH changed over time? * How has COVID-19 affected the implementation of REACH? * What are the strengths of the REACH design and implementation? * What are the enablers and barriers of implementation across the domains? * How can the implementation of REACH be improved to meet the intended outcomes? | |
| 1. **How well have MSD and health agencies enabled and influenced the implementation of REACH?** | * How do the REACH services work within the context of the health sector and MSD? * How do the MSD regional influences and pressures change or support the intended implementation of REACH? * How does the DHB influence and pressure change or support the intended implementation of REACH? |
| 1. **How is REACH supporting the achievement of the desired short-term and medium-term outcomes?** | * How is integration of MSD, health, and social sector agencies working to support clients to achieve their goals? * How is REACH enabling whānau and clients to manage their disability or health conditions better? * What improvements are clients experiencing, from their involvement in REACH, including but not limited to their health and wellbeing goals? * How is REACH enabling clients to link to additional supports and services and sustain these links? * What improvements are clients experiencing in their work readiness, employment, or training (whether part-time or full-time) and are these being sustained over time? * How does the duration of REACH influence whānau and client experience and outcomes? | |

Appendix 3: Field tools

REACH Round 1a & b – MSD and provider interviews

|  |  |
| --- | --- |
| Information sheet | Consent form |

### Discussion guides

|  |  |  |
| --- | --- | --- |
| GP (short) | DHB managers | MSD Case manager |
| Key workers | MSD regional manager | MSD frontline |

MSD national office discussion guide Round 1a



REACH Round 1b – Client interviews

|  |  |  |
| --- | --- | --- |
| Information sheet | Consent form | Discussion guide |

Logo

Description automatically generated

1. MSD. (2019). *Service Delivery Client Experience and Service Design Realising Employment through Active Co-ordinated Healthcare (REACH) Trial. Business Process.* November 2019 [↑](#footnote-ref-1)
2. MSD. (2019). *REACH Iteration Response Plan*. [↑](#footnote-ref-2)
3. ‘Many’ or ‘most’ indicates the theme was noted by the majority of participants interviewed. ‘Some’ indicates the theme was noted by less than half of the participants interviewed. ‘Few’ indicates less than five participants noted the theme. [↑](#footnote-ref-3)
4. The Wellbeing Star tool was developed in the United Kingdom and has a solid evidential base: Outcomes Stars: a tool for measuring wellbeing - [What Works Wellbeing](https://whatworkswellbeing.org/blog/outcomes-stars-a-tool-for-measuring-wellbeing/) accessed 13 May 2021. [↑](#footnote-ref-4)
5. MSD. (2019). REACH Iteration Response Plan. [↑](#footnote-ref-5)
6. Ibid [↑](#footnote-ref-6)
7. Patton, M.Q. (2008). *Utilization-focused evaluation*. 4th edition. Thousand Oaks, CA: Sage. [↑](#footnote-ref-7)
8. MSD. (2019). *Service Delivery Client Experience and Service Design REACH Trial. Business Process*. November 2019. [↑](#footnote-ref-8)
9. MSD. (2019). *REACH Iteration Response Plan*. [↑](#footnote-ref-9)
10. Refer to the limitations section for the challenges in using the Wellbeing Star tool to assess clients' outcomes. [↑](#footnote-ref-10)
11. Patton, MQ. (2002). *Qualitative Research and Evaluation. (3rd ed.). Thousand Oaks, CA: Sage Publications.* [↑](#footnote-ref-11)
12. Litmus. 2020. *The Qualitative Evaluation Plan to inform Oranga Mahi* [↑](#footnote-ref-12)
13. We did not interview any REACH clients who received services from REACH during the lockdown period. [↑](#footnote-ref-13)
14. We did not interview anyone who was not accepted into REACH. [↑](#footnote-ref-14)
15. Te Whare Tapa Whā is a Māori health model that uses four pillars of wellbeing to provide a Māori perspective on health. [Māori health models – Te Whare Tapa Whā | Ministry of Health NZ](https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha) [↑](#footnote-ref-15)
16. The broader evalution of Oranga Mahi includes a kaupapa Māori evaluation which will explore how well the programme meets Māori needs. [↑](#footnote-ref-16)
17. Cabaj, M., Weaver, L. (2016). Collective impact 3.0: an evolving framework for community change. *Tamarack Institute Community Change Series*. [↑](#footnote-ref-17)
18. Kania, J., Kramer, M., Senge, P. (2018). *The Water of Systems Change*. [↑](#footnote-ref-18)