Evaluation of the impact of Budget 2019 funding on the Harmful Sexual Behaviour Service for Non-mandated Adults

FINAL Evaluation Report

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Disclaimer

The views and interpretations in this report are those of the researchers and are not the official position of the Ministry of Social Development.

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Executive summary

Background and methodology

This evaluation sought to explore how frontline non-mandated harmful sexual behaviour (NM-HSB) service staff (including managers) and service users are experiencing the impacts of new funding provided through Budget 2019 (Budget-19). The Ministry of Social Development (MSD) funds four agencies to deliver NM-HSB adult services (18 years and older) in Aotearoa New Zealand, including one kaupapa Māori agency and three 'mainstream' agencies. The three mainstream agencies were the focus of the current evaluation. The three mainstream agencies are based in Christchurch, Wellington/Lower Hutt, and Auckland, and service large geographical areas from these main hubs.

Engagement with these services is voluntary (i.e. not mandated by the Court), allowing non-mandated clients to exit the service at any point without legal consequences. NM-HSB services at these agencies typically include assessment, psychoeducation, individual and group therapy, and sessions with whānau or support people, all delivered with the aim to prevent further harmful sexual behaviour (HSB). Additionally, since July 2019, these agencies have been funded to provide psychosocial support for service users, including assistance with daily issues such as food, petrol, employment, and budgeting.

A qualitative methodology was used for the evaluation, including:

- individual interviews with 14 NM-HSB service users
- interviews with three family or whānau members of service users (one of which was also conducted with the service user present)
- individual or group interviews with 21 NM-HSB service provider staff, including service managers, clinical leads, and clinicians.

These qualitative data were supplemented with quantitative data sourced from administrative reporting provided by service providers.

Budget-19 funding has supported significant expansion of NM-HSB services, although there are ongoing issues with levels of demand and waitlists

NM-HSB services have experienced significant expansion across Aotearoa New Zealand since the provision of Budget-19 funding, leading to the establishment of at least five new satellite sites beyond the main hubs in Christchurch, Wellington/Lower Hutt, and Auckland. This expansion, along with the removal of co-payment for the service and provision of financial support for transport, has increased accessibility for non-mandated service users in smaller or more remote areas, although consistent face-to-face service access remains limited outside main centres. Challenges also persist in sustaining staffing levels and recruiting qualified staff in these smaller or remote regions.

Although some service providers report keeping up with demand, the high level of demand for NM-HSB services, particularly from those with online HSB histories, has added pressure on NM-HSB providers, necessitating continued growth in services. While wait times have improved particularly over 2023-2024, they remain subjectively long for some users, who often experience high levels of psychological distress and ongoing issues managing their HSB while waiting for formal assessment and treatment to begin. Recent innovations, such as psychoeducational support groups for waitlisted service users, are being piloted to manage waitlists and service demand, although their effectiveness is still to be assessed.

NM-HSB services are contributing to reduced HSB and increased wellbeing, although there are opportunities to further develop cultural responsivity

Service users often entered NM-HSB services with limited expectations, primarily seeking help to stop their engagement in HSB. They also frequently struggled with severe mental health issues, including suicidal ideation, often exacerbated by feelings of shame and guilt about their behaviours and resulting social isolation. The respectful, non-judgmental approach of NM-HSB staff helped ease initial anxieties and facilitated deeper engagement with the programme. Despite initial hesitancy, group sessions were reported to be particularly beneficial, providing a sense of community and shared experience for group members. As a result of service engagement, service users reported that they had stopped engaging in HSB. They also reported substantial improvements in mental health, coping skills, and overall wellbeing, along with improved connections with friends and whānau. The development of practical strategies to desist from harmful behaviours was highlighted as a key benefit of the service. The Budget-19 funding has supported the establishment of bicultural advisor roles within all three provider agencies, contributing to growth in the bicultural responsiveness of the NM-HSB service. However, further training and development is needed to respond to clients with diverse cultural backgrounds and neurodiversity.

There has been an expansion in the diversity of supports provided, however key gaps remain in providing targeted maintenance and whānau supports

Since the Budget-19 funding, NM-HSB service providers have expanded treatment options, including developing a new group treatment framework, providing "top-up" sessions for ongoing support post-exit from the service, and providing psychosocial supports for service users. Despite these improvements, gaps in service provision remain, particularly in addressing ongoing trauma and mental health needs and providing comprehensive support for family and whānau members. Efforts are ongoing to improve consistency in service provision through enhanced supervision, training, and collaboration between NM-HSB service providers. However, variations in demand and resourcing mean that needed supports, including maintenance groups and whānau-specific supports, are not uniformly offered. Staff and service users identified key areas for further research and development, including specialised support for online HSB and neurodiverse service users, alongside increased online resources for non-mandated service users.

Staff report high job satisfaction, however large caseloads risk staff burnout, and there is a desire for more external training and structured onboarding

NM-HSB service staff report high job satisfaction and sense of purpose, driven by their meaningful roles and positive impact on community safety. Despite heavy caseloads and complex demands, staff are committed to delivering high-quality services, often working beyond their contracted hours. Recent funding increases have improved staff connectivity and workplace culture, although high caseloads and burnout remain key concerns for staff. Recruiting and retaining qualified staff is challenging, particularly due to competitive remuneration from other organisations and sectors. Supervision and training are areas of both progress and ongoing need, with calls for more external training opportunities, such as comprehensive training on HSB-specific skills and client interaction. Improved training and mentoring processes are needed to support new staff, particularly those without experience working with people who engage in HSB.

There is a high level of collaboration between NM-HSB service providers and government agencies, but a need for further local awareness and connection

There is a high level of alignment and collaboration between NM-HSB service providers, facilitated by increased staff capacity and new clinical leadership roles that have been partially enabled by the increase in NM-HSB service funding. This collaboration supports innovation and efficient funding use. Providers are well-connected with government stakeholders and local universities but need to strengthen local connections and partnerships, particularly with primary health organisations, to increase awareness and referrals. Service users generally have access to external referrals for additional support needs but often compartmentalise their HSB-related needs from broader life issues, indicating a need for better communication about available supports. Accessing mental health services remains challenging due to high waitlists and thresholds.

Conclusion and Recommendations

Following the provision of Budget-19 funding, there has been a significant expansion and improved accessibility of the NM-HSB service across Aotearoa New Zealand. Service users reported substantial improvements in wellbeing and reductions in harmful behaviours as a result of their engagement in the service, credited to the respectful, supportive approach of staff, engagement in group sessions, inclusion of whānau and other support people in treatment, and focus on the development of practical skills. Despite these positive impacts, service users still face challenges with consistent access to the service outside main centres, and increased demand has led to issues with wait times for services in many regions. Despite recent efforts to decrease waiting lists, these issues are likely to persist as awareness of the NM-HSB service grows in local communities. This highlights the ongoing need for secure funding in this space, as well as additional funding to address the high levels of demand and allow for further strategic development of the service.

NM-HSB staff report high job satisfaction and a sense of purpose, but face heavy caseloads and risk of burnout. They also report a desire for increased access to external training and more structured onboarding processes. Given the challenges identified with recruiting and retaining suitably qualified staff, addressing ongoing issues with caseloads, waitlists and service gaps through an increase in staff funding will require careful consideration and planning as to how to best attract the required staff members.

Below we provide a summary of the recommendations highlighted throughout this report that stemmed from the evaluation findings:

Recommendation	Who	Purpose
Service Development		
1. Explore additional resourcing and staffing requirements to further expand NM-HSB services into smaller and more remote regions, on a more consistent basis.	MSD and service providers	To increase accessibility of NM-HSB services
2. Consider increasing staff funding levels for the NM-HSB service, to support current and anticipated levels of demand, and to support ongoing improvements in service delivery and responsivity.	MSD	To address waitlist and caseload issues, and support further growth in service responsivity
3. Explore additional resourcing and staffing requirements to more consistently provide individualised support for whānau and other support people.	MSD and service providers	To improve service responsivity and impact

4. Explore additional resourcing and staffing requirements to more consistently provide maintenance groups and other supports for service users who have completed the core programme.	MSD and service providers	To improve service responsivity and impact
5. Explore the feasibility of providing further specialist trauma and mental health supports for service users, in addition to the core HSB programme.	MSD and service providers	To improve service responsivity and impact
6. Continue to grow connections and awareness of the NM-HSB service within local communities.	MSD and service providers	To improve sector integration and service responsivity
Policies and Procedures		
7. Review current strategies and procedures related to staff recruitment and retention, including a review of renumeration levels, to ensure they best support the recruitment of suitably qualified staff.	MSD and service providers	To support sustainable service expansion
8. Review client exit processes and other internal systems or procedures to ensure that active caseloads are efficiently managed.	Service providers	To address waitlist and caseload issues
9. Develop policies and procedures to support service users while they are on the waitlist, such as regular phone check-ins.	Service providers	To improve service responsivity
10. Develop policies and procedures to clearly communicate the availability of, and support access to, psychosocial supports for service users.	Service providers	To improve service responsivity and impact
Staff Training		
11. Establish policies and processes to support additional regular cultural and neurodiversity training and supervision for staff, as well as to support other areas of desired professional development for staff, including conducting internal research projects.	Service providers	To improve service responsivity and impact, and staff wellbeing
12. Review existing onboarding frameworks and procedures to ensure they are fit-for-purpose	Service providers	To improve service responsivity and staff wellbeing

1 Background

Budget 2019 (Budget-19) announced $90.3 million of funding over four years for the Ministry of Social Development (MSD) to invest in sexual violence services. A range of sexual violence services and initiatives received funding from Budget-19, including $11.3 million of new funding for the delivery of the Harmful Sexual Behaviour Service for non-mandated adults (NM-HSB Service).

A proportion of the Budget-19 funding was allocated for an associated research and evaluation work programme. The overarching research and evaluation work programme aims to:

- evaluate the impact of the Budget-19 investment in building the capability of specialist sexual violence services and in creating a more integrated, efficient, and responsive system for all those affected by sexual violence.
- increase MSD's and other stakeholders' understanding of how best to support people affected by sexual violence, with a focus on the needs of select priority groups.

In February 2023, MSD engaged an evaluation team lead out of the University of Canterbury to conduct an evaluation of the impact of the Budget-19 funding on NM-HSB Service provision in Aotearoa New Zealand, with a focus on how staff and service users have experienced these impacts. This document reports on the findings of this evaluation.

1.1 Non-mandated harmful sexual behaviour services

Harmful sexual behaviour (HSB) agencies offer specialist behaviour change and therapeutic services for people who have engaged in HSB, whether or not these behaviours have come to the attention of formal authorities. Harmful sexual behaviour is a term used to describe an array of sexual behaviours that involve elements of force, coercion and/or power by one person over another for sexual gratification and control.[1]

Harmful sexual behaviour providers deliver a broad range of services aimed at reducing the prevalence of HSB, including child and youth services, adapted and special needs groups, concerning ideation services for adults who experience sexual attraction to minors, and adult HSB services (18 years and older) for both mandated (referred through Ara Poutama [the Department of Corrections]) and non-mandated (NM) clients[2]. The current evaluation focused on the delivery of HSB services to non-mandated adult clients (NM-HSB services).

Referrals to the NM-HSB service can come from a client's family/whānau, other social service/health service providers, community professionals, government agencies (including the Department of Internal Affairs and Justice agencies), and more recently, via self-referral. MSD funds four agencies[3] to deliver NM-HSB services across Aotearoa New Zealand: three tauiwi agencies and one kaupapa Māori agency. Stop, the first of the tauiwi agencies, was established in the South Island in 1988, with

[1] This includes both 'non-contact' behaviour (such as voyeurism, online solicitation of minors, and viewing of child sexual exploitation material) and 'contact' behaviour (including non-consensual sexual contact, physical/verbal sexual harassment, and production of child sexual exploitation material).

[2] Throughout this report the terms 'client' and 'service user' are used interchangeably.

[3] The current evaluation focused on the delivery of the NM-HSB service by the three mainstream/tauiwi agencies – Safe Network, WellStop and Stop. The delivery of the NM-HSB service by the kaupapa Māori provider was excluded from the current evaluation..

WellStop in the lower North Island and Safe Network in the upper North Island both formally established in 1993.

Although the specific services offered by NM-HSB providers differ across agencies, all agencies deliver services in a community setting by clinicians trained and experienced in the assessment of, and intervention with, HSB. The purpose of treatment is to help clients resolve issues and understand their harmful behaviour, and to develop or enhance their skills to both prevent further HSB and to build positive, fulfilling lives. Services provided for NM-HSB clients include assessment, psychoeducation, individual and group therapy, and sessions with family, whānau or other support people. Due to treatment engagement being entirely voluntary and self-directed for non-mandated clients, these clients are able to exit the programme at any point without any legal consequences.

Group treatment programmes are structured on the same general framework across the three tauiwi providers. These programmes tend to be provided on a rolling basis, covering four main skill sets (emotional skills, relationship skills, sexual regulation skills, and self-management) over a 6-month period.[4] The groups tend to include a mix of mandated and non-mandated clients. Clients typically attend one group session a week, as well as periodic individual sessions before, during and potentially following completion of the group programme, depending on client need and risk level. These individual sessions include more targeted therapeutic work, systems reviews, and family/whānau support.

In addition to these core NM-HSB services, from 1 July 2019, these agencies were also contracted by MSD to deliver psychosocial support. These additional supports could include general assistance such as food or petrol vouchers, and assistance with employment or budgeting. However, these additional services are highly variable nationally and dependant on the resourcing of individual NM-HSB agencies.

2 Evaluation objectives

2.1 Evaluation Aims

The overarching aim of the evaluation was to explore **how frontline NM-HSB Service staff and service users are experiencing the impacts of the Budget-19 funding.** In particular, the evaluation aimed to capture:

- how the Budget-19 funding has impacted on the experiences of service users (e.g., access, responsiveness, outcomes)
- how the Budget-19 funding has impacted on the experiences of frontline staff (e.g., wellbeing and job satisfaction, capability, caseloads, access to training)
- other impacts of the funding, including impacts on the integration of the Safe to Talk service[5] with the NM-HSB Service
- successes and remaining challenges for the services and sector.

As highlighted by these aims, the focus of the evaluation was on the impacts of the Budget-19 funding on the **experiences** of these stakeholders. As such, a qualitative methodology was used for the evaluation. Quantitative information was also extracted from administrative reporting provided

[4] Clients may repeat the group programme if there is a need for further consolidation of knowledge and skills.
[5] Safe to Talk is a national sexual violence helpline that offers confidential information, support and referrals for both perpetrators and victims/survivors of sexual harm, and their family or whānau.

by NM-HSB service providers, to contextualise and supplement the insights drawn from the qualitative data.[6]

It is important to note that due to the retrospective nature of the evaluation, the relatively short timeframes since the additional funding was provided to organisations, and uncontrolled confounds such as external events (e.g., COVID-19) and the complexity of the HSB sector as a whole, there were limitations in a) the opportunity for measureable change to be made in service provision and b) the capacity of the evaluation to identify the Budget-19 funding as the cause of any changes observed. This was particularly difficult within the context of NM-HSB services given that:

- as previously mentioned, non-mandated clients are often mixed with mandated clients in the delivery of group programmes (a core component of NM-HSB services)
- mandated clients may switch to non-mandated status once their sentence or probationary period has been completed, thus technically changing the contract that they are funded through mid-engagement with the services
- there has been a relatively high level of staff turnover across NM-HSB providers, and so agency participants were often not able to comment on changes to NM-HSB services since 2019
- providers are often combining funding from multiple funders (e.g., Ministry of Justice, Ara Poutama [Department of Corrections], Ministry of Social Development) in order to fund their overall service provision, meaning it was difficult to disentagle or attibute X funding to Y service output.

However, where possible, participants were asked to consider changes in HSB services for mandated adults delivered over this time as a baseline against which to evaluate the changes for the NM-HSB service. Comparison was also able to be made with findings from a baseline survey of service providers conducted by MSD in 2020[7].

These methods of data triangulation allow for some control of additional confounding factors. That said, the evaluation team was mindful of these limitations when analysing data and making evaluative judgements, and these limitations are clearly articulated in this final evaluation report. As a result of these limitations, we also refrain from making causal statements about the Budget-19 funding being responsible for changes or patterns that were noted in service provision over this time period.

2.2 Key Evaluation Questions

The evaluation was guided by the key evaluation questions provided below; further details on sub-questions and evaluation criteria are provided in Appendix A.

1. How has the funding impacted accessibility for NM-HSB service users?
2. How has the funding impacted the responsiveness of the NM-HSB service to service user needs?
3. How has the funding impacted the support NM-HSB service users receive?
4. What are the additional impacts of the funding for NM-HSB service users and frontline staff?

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[6] Data have thus far only been obtained from two of the three providers. We will aim to replace information with data drawn from all three providers, once available.

[7] Gregory, N., Momsen, K., Platts-Fowler, D., & Watterson, R. (2020). *Impact of Budget-19 on sexual violence services and the sector*. Ministry of Social Development.

5. To what extent has the funding impacted the workforce capacity of NM-HSB service providers?
6. To what extent has the funding impacted sector integration?
7. What improvements could be made to maximise the positive effects of the funding for NM-HSB service users and service staff?

3 Methodology

As mentioned above, the evaluation used a qualitative approach that was supplemented with insights drawn from quantitative administrative reporting. This approach was considered appropriate in light of the main evaluation aim of exploring the experiences of Budget-19 funding for both service users and frontline staff. These qualitative data provide rich and nuanced insight into how these impacts were realised among these key groups, and enable the centring of service user and staff voices in highlighting percieved flow-on effects on their lives more broadly. This approach therefore arguably provides a more holistic picture of the impacts of NM-HSB services following the increase in funding provided by Budget-19, that is also better able to identify any unanticipated outcomes than is possible through purely quantitative approach.

Further details on the evaluation methodology are provided in the sections below. This methodology was developed and finalised following an evaluation co-design session with representatives from NM-HSB service providers (Stop, WellStop and Safe Network), the evalution team, and the Ministry of Social Development, as well as peer review by an independent expert and the MSD Publications Committee. Ethics approval for the evaluation was granted by the University of Canterbury Human Research Ethics Committee (HREC 2023/71).

3.1 Key document review

The evaluation commenced with a review of key background documents that were provided to the evaluation team by MSD. These included Budget-19 documents, the baseline survey completed by MSD in 2020, and the NM-HSB intervention logic.

3.2 Initial site visits

Qualitative data collected for the evaluation were mostly collected through fieldwork conducted at three NM-HSB provider agency sites: Stop (Christchurch), WellStop (Wellington), and Safe Network (Auckland). Data were mostly collected in-person from Stop and WellStop, with data being collected entirely online from Safe Network. This was identified as the most effective approach due to the geographical spread of provider sites and key staff members at Safe Network.

Data collection at the sites was preceded by an initial site visit or team hui by at least one member of the interviewing team prior to data collection. The primary purpose of these initial site visits/hui was to build whakawhanaungatanga between evaluation team members and agency staff, and to discuss and agree the recruitment approach that made sense for local service users and other stakeholders.

3.3 Qualitative data collection

Qualitative data were collected through semi-structured individual and group interviews. The total number of individuals interviewed for the evaluation was distributed as follows:

Stakeholder	Number interviewed
NM-HSB service provider staff, including service managers, clinical leads, and clinicians	21
Service users (individual interviews)[8]	14
Whānau members of service users	3
Total	**38**

Although specific demographic details were not collected from participants (and in some cases were not known due to the participant choosing to stay anonymous, e.g., by turning off their camera during online interviews), across the sample participants were diverse in age, ethnic identity, gender identity, neurodiversity, and sexuality. Notably, however, we were not able to speak with any service users identifying as women. Interviewing a diverse range of stakeholder groups allowed for identification of broad themes across regions and groups impacted by the increased Budget-19 funding, as well as an assessment of variations in impacts across regions/sites. As the focus of the evaluation was on the impacts of the Budget-19 funding more broadly, and to protect the anonymity of participants, findings from the interviews are reported at an aggregated level rather than disaggregated by site. However, variations in findings are noted where relevant without specifying regions.

Interviews were mostly conducted face-to-face over a three-day period at each site, and were otherwise conducted online via Microsoft Teams/Zoom, or over the phone. With participant permission, interviews were audio recorded for later transcription.

3.3.1 Recruitment

Appropriate staff to be interviewed from each agency were initially identified by NM-HSB agency management, who were given an Information Sheet to pass on to potential participants. If they were willing to be involved, interviews were then arranged either directly by the evaluation team, or by agency management. Consent was then re-confirmed before interviews began. Interviews with NM-HSB provider staff generally lasted for an hour and were conducted as a mixture of individual (typically for management, including clinical leads) and group (typically for clinicians) interviews.

Similarly, service user and whānau participants were initially identified by NM-HSB agency staff (typically clinicians), who were provided with an Information Sheet to provide to potential participants to consider prior to confirming their interest to participate. NM-HSB agency staff were provided with a list of priority groups that the evaluation team was hoping to engage with from their agency, such as Māori or Pacific or neurodiverse service users, but staff ultimately made the decisions about the most appropriate people for the evaluation to engage with.

Interviews with service users and their whānau were mostly conducted on NM-HSB agency premises or over Teams/phone call, with timings arranged by NM-HSB agency staff. This allowed for oversight from NM-HSB agency staff as to the psychological safety of service users participating in the evaluation, both before and following interviews. It also meant that the evaluation team did not

[8] This included a mix of current and former clients.

learn any identifying details about service users unless they chose to share this information during the interview.

Interviews with service users and their whānau generally lasted from 30 to 60 minutes. Service users and their whānau who participated in an interview were provided with a koha of a $50 supermarket or petrol voucher.

Interview schedules used to guide interviews with each stakeholder group have been provided as Appendix B.

3.4 Review of administrative reporting

Qualitative data collected through the interviews outlined above was supplemented by a review of administrative quarterly reporting related to service access and provision for non-mandated service users. These documents included information on the number of non-mandated people referred to, and commencing, assessment, core treatment, and psychosocial supports on a quarterly basis from July 2018 to March 2024[9].

3.5 Analysis

Audio recordings of interviews were transcribed using Otter.ai transcription softwareas an initial step (with consent from participants), and then manually reviewed and amended by a member of the evaluation team. Transcripts were then analysed to identify recurring and divergent themes for each of the evaluation questions. The evaluation team worked collaboratively to draw together, interpret, and analyse the findings through the different evaluator perspectives. This process enabled the development of robust and culturally appropriate evaluation judgements through comparing data collected from the different sources. Themes were largely derived deductively, with the key evaluation questions used to guide the extraction of key themes. NVivo, a qualitative data analysis software programme,was used to organise transcripts and to identify and extract participant quotes.

Initial findings were then presented to key staff from NM-HSB service providers and MSD, at a ‘sense-making hui’. At this session, input was sought from these key stakeholders to interrogate the emerging findings against existing knowledge of the sector, and to provide additional context into the interpretation of what these findings meant for evaluative judgements. This feedback has been incorporated into the findings presented in the current report.

4 Limitations

Although the evaluation incorporated perspectives from multiple sources and utilised a qualitative approach to data collection and analysis that allowed for the development of rich, nuanced insights, there were also a number of limitations that should be considered when interpreting the findings.

Although qualitative data are uniquely suited to capture and communicate the experiences of those impacted by the increase in Budget-19 funding, qualitative data are not intended to be robustly generalisable to entire populations of interest. It is unclear the extent to which findings from the people we engaged with for this evaluation can be applied across service users and other key sector stakeholders. It is also difficult to measure the size of impacts realised by the increased Budget-19 funding through qualitative data alone. For this reason, any future evaluations of service or funding impacts should consider the use of quantitative approaches to measuring the size and scope of

[9] As at the time of drafting this report, these data had only been obtained from two of the three providers.

impacts made by NM-HSB services for service users and their whānau. We understand that there have been recent efforts to improve the database holding client data (which is standardised across the three tauiwi HSB providers), which should prove useful for future evaluations.

As previously mentioned, the complexity of the funding environment for HSB service providers and the relatively high turnover in clinical staff since 2019 created challenges for understanding the precise impacts of Budget-19 funding for service users and their whānau, and for provider staff. Many staff we spoke with had tenures of two years or less (with many hired within the past year), meaning that they had limited scope to understand the changes that had occurred in service provision. Further, clinical staff in particular were often unclear or vague on how exactly Budget-19 funding and other specific funding sources were used to support the variety of services provided by the agency. In addition, most clients engage with the service for a defined time period, meaning they are not able to speak to changes in how the programmes are delivered over time. As such, we are limited in our ability to attribute patterns or themes in our data to changes effected specifically by Budget-19 funding. As such, we speak more broadly to the experiences of staff and service users of the NM-HSB services post-2019 where there was limited evidence attributing these experiences to the increase in funding.

Due to the necessity of collaborating with NM-HSB agency staff to recruit service users and their whānau, the evaluation likely did not fully capture the perspectives of those whose experiences with the NM-HSB service were less positive or did not meet their needs. Although we did interview some individuals who were no longer engaged in treatment with NM-HSB agencies, it is likely that these participants skewed towards those with positive experiences and were therefore more willing to participate in the evaluation. Clinicians may also have been subconsciously influenced towards inviting participants they thought would respond positively to a request for an interview, which again would more likely be clients who had positive experiences with the service. Service user and staff reports may also have been influenced by a desire for agencies to retain or receive increased funding. Although challenging, future evaluations should explore ways to include the voices of service users who exited the programme before completing it, or who exited under less favourable circumstances (ideally including people who reached out to enquire about the NM-HSB service but did not end up engaging).This would enable evaluations to identify the reasons for these exits and barriers to realising the full potential of benefits afforded by increased funding for NM-HSB services. For example, it may be possible to identify these prior service users through probation officers or other community corrections services, for those who ended up being processed formally in the criminal justice system.

Relatedly, the evaluation team was unable to complete any interviews with national stakeholders and local sector partners, including agencies or individuals that commonly referred non-mandated service users (e.g., police, social workers, lawyers), as originally planned for the evaluation. This was for a variety of reasons, including people we reached out to either declining or not responding to the invitation, and some service providers not being able to identify relevant individuals or representatives to speak with. This was often because referrals did not regularly come from one individual or group of individuals, but rather through general self-referrals (though often encouraged by others such as lawyers or government agencies). This limited our ability to fully evaluate the impact of Budget-19 funding for referrals in and out of the NM-HSB service, particularly in terms of what the barriers might be for external stakeholders wanting to refer clients to the service. We were able to speak with service users and staff to gain a picture of the ease of referrals in and out from their perspectives, however. We also note that local awareness of the NM-HSB service was limited in several areas and has been identified as an area of potential opportunity for service providers. This

finding is supported by the apparent difficulty identifying appropriate referral agencies or other stakeholders that we could engage with for the evaluation.

Evaluation Findings

Findings from the evaluation are provided below, in sections structured according to the key evaluation questions and evaluation framework (see Appendix A). Quotes are used throughout to highlight key themes in the voice of NM-HSB service stakeholders.

5 Accessibility

KEQ 1: How has the Budget-19 funding impacted accessibility for NM-HSB service users?

Key insights

There has been a significant expansion of NM-HSB services across Aotearoa New Zealand since the provision of Budget-19 funding, with the establishment of new satellite sites beyond the main hubs in Christchurch, Wellington/Lower Hutt, and Auckland. This has increased accessibility for individuals in remote areas by allowing more regular in-person services, either through hiring permanent staff or deploying mobile staff from main hubs to satellite sites. The removal of co-payments for the NM-HSB service and provision of financial support for transport to provider sites were also highlighted as key facilitators of service access. However, despite these advancements, access to consistent services remains limited for people outside of main centres, with some service users only able to access services on specific days or by travelling large distances. Online and mobile options are being utilised, however rapport building and client comfort remains a challenge for online services, particularly in the initial stages of engagement. Challenges in sustaining high staffing levels and recruiting qualified staff in smaller or remote regions further complicates service provision in these areas.

The high level of non-mandated service user numbers, especially among those with online HSB histories, has added pressure on NM-HSB service providers to meet demand. While some providers have managed to meet this demand, others continue to struggle with insufficient funding to meet demand despite increased staffing and resources facilitated by the Budget-19 funding. The specialised nature of NM-HSB services means other mental health providers often cannot meet these needs, necessitating continued growth in services for non-mandated adults engaging in HSB. There may also be opportunities to review client exit processes to identify whether exit processes could be made more efficient, further supporting a reduction in wait times.

Despite wait times reportedly improving particularly over the past year due to an increase in staff and related ability to run significantly more treatment groups, wait times remain subjectively long for some service users. This wait time can be particularly challenging for NM-HSB service users, who often report high levels of psychological distress and ongoing issues managing their

5.1 Provider sites

The funding has allowed for the expansion of NM-HSB services across Aotearoa New Zealand

The Budget-19 funding has facilitated the expansion of NM-HSB services into new sites across the country. Each of the three tauiwi NM-HSB service agencies provide cover across relatively large

geographical areas, and the provision of additional funding has meant that in-person services have been able to be provided more regularly from at least five new satellite sites established outside of the main service hubs (historically Christchurch, Wellington and Lower Hutt, and Auckland). This allows people living outside the main centres greater access to face-to-face services without having to travel large distances to receive this support. Notably, however, these satellite sites are often only staffed one or two days a week, meaning that there is still limited access to services in these areas.

In some cases this additional coverage has been enabled through the hiring of permanent staff (either full time or part time) for these satellite sites, whereas in other cases mobile staff centred at the main service hubs have been travelling to these satellite sites to provide regular cover. For example, at one agency staff described how two of their clinicians travel to a rural town each Monday because several clients live there, enabling the agency to offer services more widely across the region and improve accessibility. For other satellite sites, a local medical or community space is hired once or twice a week so that local or travelling clinicians can provide regular face-to-face services at that location for service users.

Despite the expansion, gaps in service provision still exist, particularly outside main centres

Although the expansion of satellite sites and services has increased accessibility for people living outside of the main agency hubs, gaps still remain in consistent service provision across the country. In particular, access to frequent and consistent services is limited for people living outside the main centres. In some cases this means that service users may only be able to access services on the one day during the week that their local service site is staffed, but for large parts of the country there is still no access to any physical service sites without having to travel large distances. This is the case even for relatively large towns or cities; for example, it was reported that service users in Invercargill need to travel to Dunedin for face-to-face sessions.

Service providers are utilising online and other mobile options to help address the issue of geographical coverage, particularly after initial face-to-face assessment sessions have been completed. However, online engagement is not always a preferred or possible option for service users. In particular, some clinicians reported that it can be difficult to build rapport and have open conversations with service users online, especially where service users may not have access to safe or private spaces in which to engage in the highly sensitive discussions that are required as part of the treatment programme. This means that online options are unlikely to resolve all existing issues with service access.

> The funding has been used for things like developing therapy, policy, and training for staff on delivering services online … Some of those nuances can be a bit more difficult to manage, like how do we abide by codes of ethics and all of the things that are required for in-person practice while delivering online.

Service provider

It is unclear whether there is sufficient demand to sustain staffing levels in some areas, due to lack of active advertising in some regions

Although the availability of in-person services were reported as being beneficial for many service users, some NM-HSB service staff also reported uncertainty about whether there is sufficient demand in some regions to sustain permanent local staffing. Staff reported that numbers of service users in satellite regions tended to be lower than the rates seen in main centres, and at current levels may not be sufficient to justify permanent full-time (or even part-time) staffing.

However, staff also reported low levels of active advertising or proactive engagement with potential service users in these areas, due to an inability to meet surges in client demand if it were to eventuate. It was therefore unclear whether the lower demand in these areas is a reflection of true levels of need in the local community, or whether this is a consequence of lower levels of awareness or accessibility of services. Further exploration of the level of need and potential demand in these areas is therefore required before committing to new permanent staffing or service sites (and also to investigate whether pockets of unmet need remain in these communities).

Recruiting and retaining suitably qualified staff is also difficult for smaller or more remote regions

In addition to questions about the level of demand for NM-HSB services in some regions, permanently staffing services in these areas is made more challenging by the difficulty of recruiting and retaining appropriate staff. These satellite regions have smaller populations than the main centres, and it can therefore be difficult to identify people with the required specialist clinical skills to take on any roles that were able to be funded and advertised. In particular, the fact that satellite sites are often staffed by a sole clinician meant that the new recruits must have suitable experience and confidence to work somewhat independently (albeit with the regular levels of supervision required in these roles). This meant that many services are reporting difficulties in filling roles that were available in these more remote regions (and even sometimes in the main centres). This potentially highlights the need for greater training and education options to help support a steady supply of suitably qualified clinicians who can engage in the specialist work involved with the delivery of NM-HSB services.

> We have a clinician working [in a more remote region]. He's travelling long distances. He's aware that he's feeling a bit isolated at times from colleagues. Yeah, there's just some other challenges that happen when you service too wide for people.

Service provider

5.2 Demand

Non-mandated service user numbers have substantially increased in recent years, particularly those with online offending histories

Following Budget-19 funding, the numbers of non-mandated people referred for NM-HSB service assessment have substantially increased across providers. Although there was a slight drop in referrals over the 2020 and 2021 COVID-19 period, administrative data show that referrals have been consistently increasing since this period, and are now just under double the numbers reported in the 2018-2019 period[10]. Despite what might be assumed about the characteristics of non-mandated clients, staff reported that these clients are presenting across the risk spectrum, with a notable number of moderate- and high-risk clients self-referring for treatment. This highlights the ongoing need for a variety of specialist, and in some cases intensive, treatment options to address the individual needs of presenting non-mandated service users.

More specifically, provider staff reported that there has been a notable growth in clients with online[11]/child sexual exploitation material (CSEM)[12] offence histories among the non-mandated (and mandated) service user cohort, and that staff expected to see even more growth in this area. This was identified as an area of particular need in terms of further research and training addressing how to best intervene with these forms of harmful sexual behaviours, although staff also reported that the knowledge that did exist was being incorporated into existing service offerings where available.

> The other one is internet behaviours. We're getting so much more now where behaviours are online … So that's our next step in terms of service delivery and programme development, is staying on top of all of the ever-evolving stuff happening in the internet space and the best interventions on that.

Service provider

While some providers are keeping up with demand, others are unable to, as non-mandated clients continue to present with new types of need

Circumstances varied across providers regarding whether they were able to keep up with this increased demand for NM-HSB services. One provider noted that they had been able to keep up with demand to the point that they no longer have a waitlist; administrative data for this provider also confirmed that rates of referral for core HSB treatment were approximately matching levels of referral for assessment. However, other providers reported ongoing struggles to meet demand, stating that there is still insufficient funding to meet demand despite increases in staffing levels and resourcing facilitated by the Budget-19 funding. Some staff also reported some opportunities to

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[10] These numbers are based on administrative data from two providers.

[11] Online offending can include behaviours such as the online solicitation or grooming of children or young people for sexual purposes, and the sharing of digital CSEM or other abuse materials.

[12] Child sexual exploitation material refers to images or videos that depict the sexual abuse or sexual exploitation of children or young people. This is sometimes also referred to as child sexual abuse material (CSAM) or child pornogprahy.

improve client exit process, with current processes potentially contributing to the issues meeting demand (see further discussion of this below). Highlighting these issues, administrative data from one of these providers suggested that in recent years, only a quarter to a half of people referred for NM-HSB assessment were having assessments completed and referred for treatment within the quarter.

This was a key concern for these service providers, who noted the serious mental health needs and risk carried by people who were waiting to access services. Notably, staff from the provider that reported relatively low waitlist numbers also suggested that the low levels of current demand could be a consequence of the years of over-demand for the service. Prior to the increased funding, demand and waitlists were growing out of control, so the provider had stopped actively promoting the service. Now that waitlists were more manageable, active promotion had re-started, and it was anticipated that this would lead to commensurate growth in demand.

Places like [NM-HSB service provider] are very much needed and are very much in high demand.

Service provider

In addition, the aforementioned increase in demand from service users who had engaged in online HSB meant that new avenues of need were emerging, such as demand from distressed people reporting with online pornography addiction. Whereas previously providers had not had the capacity to accept referrals for forms of HSB that did not meet offence thresholds (referred to by service providers as "*borderline HSB*")[13], or for other problems that increase risk for HSB, the increase in non-mandated funding had meant that these referrals are now being accepted across many providers. This addresses a previous gap in HSB service provision, however it also further increases demand for NM-HSB services.

NM-HSB services are highly specialised, meaning that demand is often not able to be met by other mental health providers

Service providers noted that NM-HSB services are highly specialised, and that very few other community providers that are able to meet the needs that their service users are referred for. As such, staff highlighted the need to continue providing specific support to non-mandated adults engaging in HSB, given that non-mandated clients are often unable to receive appropriate support from other mental health service providers. Staff perceived that other mental health service providers may not be able or willing to offer this support due to the complexity presented by non-mandated adults with HSB, and perhaps not being sufficiently equipped to respond to the specificity of the HSB in relation to broader mental health needs (i.e. in the context of supporting people in their whole sense, rather than isolated conditions).

[13] This refers to behaviours that are problematic or potentially harmful, but that do not rise to the level of a criminal offence. This can include issues such as pornography addiction or engaging in frequent, excessive sexual fantasising.

Indeed, many service users we spoke with reported that they had been referred to NM-HSB service providers by other community therapists or psychologists who felt that they did not have the required expertise to address their needs. This was the case even for service users who had previously been convicted and imprisoned for HSB-related offending, who sometimes noted an ongoing unmet need for HSB-related support despite having already been through a formal criminal justice process. This level of specialisation naturally meant that demand for the providers' NM-HSB services would remain insofar as HSB remained an issue in communities.

> What I found horrifying was just the lack of support [my partner] got after he was released [from prison]. It was like his clinical psychologist inside [prison] had given all these recommendations and nothing was followed up, and there was no support really that was provided from probation or anything after.

Family/whānau member

Unclear processes around service user exit may be contributing to issues managing service demand

While high levels of demand remain an issue for many providers, some staff members noted that there could potentially be efficiencies made in terms of identifying the appropriate time for client exit. In particular, some staff noted that there are potentially unclear processes around the timing of client exit, with staff sometimes providing continued support to service users beyond what the client may require. While this may be explained by a tendency for some staff to 'hold onto' clients following programme completion with a view to continue supporting them through persisting life difficulties, others suggested that holding onto clients may serve to help staff manage the reporting that is required post-exit. In other words, where clinicians may not have sufficient capacity or opportunity to finalise client reporting for programme exit, they may be holding onto clients that could otherwise have already been released from their caseload. It is therefore recommended that NM-HSB service providers review their policies and procedures regarding the exiting of clients from the service, to identify whether there might be opportunities to streamline this process or identify ways in which clinicians can be supported to more efficiently manage client exits. More efficiently exiting service users would free up space for new clients, allowing for faster turnover of clients and reductions in time spent on waitlists.

5.3 Referrals and access

There has been an increase in referral pathway options for non-mandated service users, although pre-sentence pathways remain variable

Service users we spoke with described different pathways of being referred to the services, including via self-referral, family members, lawyers, social workers, local marae, and recommendations from other counsellors or psychologists in the community. Service provider staff also talked about police officers being more aware of the service and what they provide for clients, leading to more Police referrals. First contact with service providers was similarly made through various channels, including via agencies' online referral forms, walk-in, phone calls, and email communication. As we were

unable to engage with local referral partners for the evaluation, we were unable to triangulate this reported increase in referral ease and options with reports from other local stakeholder agencies.

> I brought [my partner's behaviours] up to my clinical psychologist, and she went, "*There is a place you can go called [service provider]*". And so [my partner] made a self-referral form, emailed them, and we were able to engage with them for about over six months.

Family/whānau member

Perhaps partially explaining the increase in non-mandated service user numbers, provider staff reported an increase in the variety of available referral pathways to access the NM-HSB service. In addition to the referral options that were in place prior to 2019, the Budget-19 funding enabled new access pathways for non-mandated clients, perhaps most significantly self-referrals, which are now permitted across NM-HSB service providers. Service providers noted that this increase in referral options has opened the NM-HSB service up to people with HSB-related difficulties that would not have been able to access the service previously, including individuals who had engaged in forms of HSB (or HSB-adjacent behaviours) but had not yet told anyone else about these behaviours. In this way, the new referral pathways afforded by the funding allowed for more preventative service provision, opening up the opportunity for NM-HSB service providers to work with clients who have not yet come to the attention of formal authorities.

> The [funding for service users] opened up and became more accessible, probably in the last four or five years. It became easier for people to access our services.

Service provider

Notably, differences remain between NM-HSB service providers as to whether they accept referrals from people who are facing pending charges for HSB-related offending and have not yet been sentenced. Although technically these people would fall under the scope of 'non-mandated' service access, some providers choose not to accept these referrals due to anticipated disruption to service provision should the person be imprisoned post-sentence. Some service provider staff also expressed concerns about motivation for treatment for these people, given that they may more so be accessing the service to present well in court and obtain a lighter sentence rather than to truly address their needs. That said, these providers stated that acceptance of these kinds of referrals is currently under review, and they may begin to accept such referrals in the near future. This would help to improve the consistency of service access across regions.

Financial support for service users has further increased accessibility of NM-HSB services

Since the Budget-19 funding was provided, service providers have also been able to support clients financially to access their services, further improving accessibility. Perhaps most significantly, co-payment for treatment has been removed across NM-HSB services, meaning that service users are able to access the service for free. Service users noted that this removed a significant barrier to service access, and also made the specialised service preferable to other forms of therapy or counselling through private clinicians, which was often not financially viable or sustainable.

> We were kind of hesitant because we didn't know where we were going to get the money from. But then when we heard that we don't have to and I think that's why we kind of jumped into it.

Family/whānau member

Service users also reported experiencing significant benefit from petrol vouchers or reimbursement provided for public transport in order for them to physically access the services. Provider staff highlighted the importance of offering dedicated support for service users who may travel some distance to access the site, as part of being responsive to their needs. Some providers noted, however, that there is currently a limited budget for this type of assistance and that there have been times when it has run out.

> Them offering the $20 voucher made it a lot easier and more accessible to get there.

Service user

There has been a decrease in wait times for service users across providers

Despite the increasing demand, NM-HSB provider staff reported an improvement in the timeliness of NM-HSB service access, particularly over 2023-2024. Staff and previous service users reported that clients had previously often had to wait months in order to begin regular engagement with a clinician, however this waiting time was reported to have reduced over approximately the past year. Overall, service users we spoke with were largely satisfied with wait times and described the sign-up process as both 'quick and easy'.

It was quite fast, considering most places you gotta wait months and months and months.

Service user

Staff described the significant benefit of the increase in both the number of funded non-mandated spaces and staff numbers on their ability to respond to the persistently high volume of demand, and to decrease wait times. This was a notable change given the constantly high caseloads they tended to manage in their day-to-day work. For example, for one NM-HSB service provider, an increase in funding for service user numbers (and therefore staffing levels) had meant that the number of concurrent treatment groups that could be run had increased from two to 14. This had a substantial impact on the length of time that service users were waiting to begin treatment.

To meet that demand, we need clinicians to deliver on the services. So being able to increase the number of clinicians that we employ, helps to manage people on that waitlist so that they're not just sitting there languishing waiting for a service … I think [the waitlist] got to about 70, which is phenomenal. And well above the contracted places that we have available … and I know now that it's no more than 15.

Service provider

Some service users still report long wait times, sometimes with little clarity about their status on the waitlist

Despite reports of overall decreases in waiting times to access NM-HSB services and general satisfaction with wait times, some recent service users still report a subjectively long wait time. For example, one service user reported waiting at least three months between referral and first contact from the service provider, and a further month before their first assessment session. Any length of wait could be problematic, as clients are often presenting to services with high levels of psychological distress. It is often these levels of distress that are prompting the reach-out to services in the first place. Service users also sometimes reported difficulties in managing ongoing engagement in HSB while they waited for formal services to begin, contributing to this distress. In addition, service provider staff spoke about the limited 'window of opportunity' to connect with some clients immediately following their initial contact with services. If these referrals are not picked up soon after they are made, potential service users may lose their motivation to continue engaging. It is unclear from the current evaluation how many potential service users disengaged from the NM-HSB service while waiting for assessment or treatment.

> We didn't hear back from [service provider] for over a year. It was quite frustrating even for my [whānau member] at the time, because he wanted a bit of help ... Before he was seen, by then he was a bit over it, you know. I just kept encouraging him, "please, just wait".

Family/whānau member

Some service users reported that while the wait was to be expected, what they struggled with most was the lack of contact from NM-HSB service staff while they were waiting. Many service users spoke about being at an absolute low point in their lives when reaching out to NM-HSB services for support, and so reaching out and then being 'left in the dark' in terms of when assessment and treatment might commence was difficult for them to manage. Service users reported being anxious to begin assessment and treatment, and finding it difficult to wait for engagement with the provider without any indication of how much longer they might need to wait. They also reported that they would have found it helpful for there to have been regular check-ins while they were waiting, to manage their ongoing distress and sense of isolation.

> I've always found that it takes a while for you to get accepted and to get started. Each time you're looking at about six to eight weeks from when you submit the paperwork to actually getting started ... I actually contacted them twice myself, just to see where things are at. Because I worry about these things. Have they got my appointment? When is that happening?

Service user

Some service users also spoke about subjectively long waiting periods in between assessment and treatment beginning. For example, one service user reported concern that they had a six-month wait between assessment and starting individual sessions. Another service user was dissatisfied with the perceived length and repetitiveness of their assessment process. This potentially indicated a need for greater communication with service users about the likely timeline of engagement once first contact is made, and what to expect from the assessment process.

> The assessment process was kind of annoying because it took so long. We basically had to have the same session three times in a row.

Service user

NM-HSB provider staff were aware of these ongoing issues with wait times, and attributed them to several factors, including the availability of appropriate clinicians to deliver services (such as staff who are capable and experienced in facilitating groupwork rather than individual sessions), capacity to take on more clients given current caseloads, and having sufficient client numbers to facilitate appropriate group work.

Additional staffing and resourcing have allowed for innovation in service delivery, helping to manage waitlists

The additional funding (and resulting increase in staffing levels) has created space and opportunity for providers to develop and recently implement innovative approaches to managing the previously mentioned issues with waitlists and service access. For example, one provider had started offering psychoeducational support groups for service users who were waiting for treatment to begin. Although this initiative was in its infancy when we spoke with staff at this provider, initial reports indicated that this could be an effective way to safely 'hold' clients while they were waiting for formal engagement to begin.

> The increase in funding allowed us to deliver support groups while somebody's assessment is being undertaken, so that they are still receiving some type of support. Because a lot of those people on that waitlist are people full of anxiety, and who have lost a whole lot of relationships, jobs, homes, those sorts of things. And they're probably having high levels of suicidal ideation and total despair. And no one to talk to.

Service provider

Another agency has developed and rolled out a new triage system to support more efficient client access to services. New service users are now typically triaged after first contact, and subsequent wait times are dependent on the urgency and complexity of the need presented. Staff report that the recently-implemented triage and referral process supports service users being contacted within four days of receiving the referral. The process includes a centralised referral inbox and targeted forms to gather all required information.

> [Referred clients] get a phone call pretty quickly, pretty much within four days of receiving the referral, just to get some background information and let them know that we're here.

Service provider

6 Responsiveness

KEQ 2: How has the funding impacted the responsiveness of the NM-HSB service to service user needs?

Key insights

Most service users entered NM-HSB services with limited expectations and were unsure about the types of support available to them beyond the specialist treatment for HSB. Their primary motivation for seeking help was to stop engaging in harmful behaviours. In addition, service users often struggled with severe mental health issues, including suicidal ideation, exacerbated by feelings of shame and guilt related to their behaviour. Social isolation and damaged relationships were common, with many service users hoping to rebuild connections with family and friends.

The respectful, non-judgmental approach of NM-HSB service staff was reported to help ease this initial hesitancy about the service, easing anxieties and facilitating deeper engagement in the programme. Initial hesitation about group work was common, but most service users found group sessions beneficial over time, providing a sense of community and shared experience. Service users noted substantial improvements in their mental health, coping skills, and overall wellbeing as a result of engaging with the NM-HSB service. Improved connections with friends and whānau were also reported by many service users, often facilitated by the NM-HSB service including joint sessions with service users and their support people. In particular, service users highlighted the development of practical strategies to desist from harmful behaviours and manage underlying factors contributing to these behaviours as a key takeaways from the service.

The Budget-19 funding has enabled the establishment of bicultural advisors across NM-HSB service providers, who have contributed to the growth in the cultural responsivity of the service. However, their ability to lead and implement further growth strategies is limited due to issues with capacity and split responsibilities. Staff also noted the need for further development in cultural responsiveness and training to respond to service users of diverse cultural backgrounds. Neurodiversity was also identified as a growing responsivity need by service providers, with staff reporting a desire for more training and research in this space.

6.1 Expectations and aspirations of service users

Most service users are unsure of what to expect or what is available from the NM-HSB service

Most service users reported that they did not have many expectations of the NM-HSB services prior to engagement and were largely unsure of what to expect. Many service users reported concerns about how they might be treated and some fear of being judged, particularly for those who had not previously interacted with any providers of HSB services, or had not disclosed their HSB-related issues to other professionals. However, they were universally driven by a desire to seek help for the HSB or HSB-adjacent behaviours that motivated the contact with service providers, hoping that engagement with the NM-HSB service would help them to stop engaging in these behaviours. This was reported as the primary motivation for engaging with the NM-HSB service by all service users we spoke with.

I didn't know [what to expect] because I haven't approached this sort of space. I just knew that I needed to speak to someone.

Service user

What I was hoping was just to learn really. It was basically knowledge ... And then it's just kind of getting to know the whole concept of things and how to prevent it and stuff like that.

Service user

This lack of expectation also meant that clients were generally not aware of what types of support were available to them through the NM-HSB service, and were therefore not aware of what they were able to ask for support with. This uncertainty about the support available to them appeared to persist even beyond completion of the NM-HSB treatment programme, with many service users we spoke with unclear about whether any ongoing needs they had were able to be supported by the NM-HSB providers. For example, many service users we spoke with had ongoing employment needs, as often legal consequences of their HSB made gaining employment difficult or impossible, particularly where there were ongoing community sentence conditions. However, most service users we spoke with expressed doubt about whether this was something that they could expect support with from the NM-HSB service. This highlights a potential opportunity for clearer communication to NM-HSB service users about the types of supports offered through the service, to ensure that they are accessing required supports where needed. While several clinicians noted that high workloads

had previously made it difficult for them to assess and address service users' psychosocial needs, this had been made easier with the hiring of dedicated staff to support the psychosocial aspect of the NM-HSB service; further information on this is provided under section *7.1 Types of support offered.*

Many service users are struggling with trauma and poor mental health, including suicidal ideation

Beyond a desire to address HSB, many of the service users we spoke with reported severe issues with mental health; although these mental health issues might not have been the primary reason for contacting NM-HSB services, it was often a need that service users were hoping the service could support them with. Often these mental health issues were related to intense feelings of shame, guilt and distress related to the HSB that they had engaged in, potentially exacerbated by legal or other formal procedures that had been initiated following discovery of these behaviours. These intense experiences of psychological distress were reaching the point of ongoing suicidal ideation or attempts for many of the service users we spoke with, who often referred to the period during which they first contacted the NM-HSB service as one of the lowest points of their life.

I thought death was guaranteed about a year ago before I started working with [service provider]. That's just where I thought my road would end, in early death ... And now I've come to see and realise that that doesn't have to be how it is. I can choose my own future and do what I want to do.

Service user

Many service users reported that these mental health issues may have also stemmed from unresolved childhood traumas, which made coping with the psychological impacts of their HSB and any subsequent formal consequences more difficult for them. Service users were often not consciously aware of the impacts of this trauma initially. They reported that engagement with the NM-HSB service helped them to become more cognisant of the need to address these historical traumas and how much it had been affecting their lives. Together, the strong and consistent theme of poor mental health and trauma backgrounds of NM-HSB service users highlights the ongoing need for these programmes to take a trauma-informed approach to service delivery, and to address mental health needs both as potential contributors to HSB as well as treatment needs in their own right.

Social isolation is also a primary need that service users are presenting with, and there is a strong desire to restore family and relationship dynamics

Related to these experiences of trauma and poor mental health, many service users also reported primary issues with social isolation and interpersonal issues. In many cases these were reported to directly result from their engaging in HSB, with social isolation being used as a strategy to avoid their "secrets" or behaviours being discovered by others. The sense of shame and guilt stemming from their behaviours also contributed to service users withdrawing from family or friends. Some service

users reported also losing friends or family relationships after choosing to disclose their HSB, or sexual interest in minors, to others and receiving a negative reaction to these disclosures.

> They're a very lonely group. At a very base level, they struggle with that kind of housing and friendships. So I think one of the things I'm surprised at is the amount of community that they get from just being part of this service.

Service provider

As such, both service users and NM-HSB service staff described how many service users present with the hopes of rebuilding relationships, particularly with partners and other family or whānau members, that have been damaged over time. This highlights an ongoing need for NM-HSB services to incorporate supports that help to restore these social connections.

> Quite often it's about restoring the whānau, wanting to get things back to the way they were, whether that's with their partner or their kids.

Service provider

Ideally this includes actively involving support people in the treatment programme where possible, both to provide education on how to best support their friend or family member through and beyond treatment, but also to identify needs that the support people might have in relation to their own reactions to the HSB that has been disclosed to them. Of course, the incorporation of family or whānau members in treatment needs to be done in a considered way, given that most HSB is perpetrated against family or whānau members, or other people known to the perpetrator.

> And I needed some support too, because I found it hard having to navigate my partner's past and what that could look like for my future. How his past was going to impact me as people found out.

Family/whānau member

Initially service users are very hesitant about group work, preferring to begin with individual sessions with clinicians

Service users described being initially most interested in individual sessions and very hesitant about group work. Specifically, service users commented on their apprehension to participate in group settings and share highly personal and private matters with others. Some attributed this to feeling anxious or uncomfortable, and worries about being judged and/or judgmental towards others. This led to many service users initially preferring to receive support through individual sessions.

> Specific to my personal needs, I felt more comfortable doing one-on-one [treatment].

Service user

However, most service users reported eventually warming to the idea of group treatment after a few individual sessions with their clinician, who helped to ease fears about the nature of the group and provide more information on what to expect. This was also helped by initial group sessions focussing on whakawhanaungatanga, or rapport-building between members. Service users reported that the group sessions eventually became one of the highlights of the NM-HSB service for them; this finding is expanded upon further below under *Section 6.2 Meeting expectations and aspirations of service users.*

6.2 Meeting expectations and aspirations of service users

Service users' expectations are often exceeded, particularly due to the approachable, non-judgmental, and respectful nature of staff

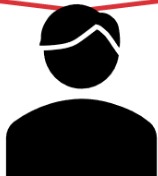
Across the board, service users noted how their experience with NM-HSB treatment exceeded their initial expectations. This was generally attributed to the 'comforting and welcoming' approach of clinicians and other NM-HSB service staff, who were reported to consistently approach service users in a respectful and non-judgmental manner. This helped ease the anxiety of service users when they first presented to the service, making them feel more comfortable about ongoing engagement.

> As you can imagine I was a bit nervous and didn't know what to expect or what was involved. But straight off the bat as soon as I walked in the door and introduced myself, I was made to feel welcome… They couldn't have made me feel any better.

Service user

Service users expressed gratitude for the way staff authentically built rapport, professionally conducted themselves and respectfully delivered support. A range of positive descriptors were used to articulate how friendly, kind, skilled and supportive staff were. This was raised as being central to their engagement with the service, providing a strong, safe foundation of trust within which they felt comfortable engaging in the sensitive conversations required as part of the programme.

> You can be honest without any feeling of judgment… There's shame about what you did but you feel like you can tell them anything.



Service user

Due to the strong connection that is built between service users and their clinician, a change in clinician due to changes between groups, staff leave or staff departure from the service was reported as being relatively disruptive to ongoing engagement in the programme. Service users that were required to change clinicians while engaged with the service reported not being able to get to quite the same level of comfort with subsequent clinicians, highlighting the importance of continuity of care. Service users at some provider sites mentioned that they were given a choice about whether they remained with the same clinician across assessment and treatment, which was seen as a positive aspect of the programme.

All of the service users that we spoke with identified either as men or non-binary, and there were mixed thoughts about engagement with female clinicians at the NM-HSB services. For some service users, women clinicians were welcomed as a needed 'maternal influence' in individual and group sessions, which is what clients reported they needed at that time. Other service users reported that it was difficult to discuss some of their needs and behaviours, particularly sexual needs and behaviours with women, and that they would have felt more comfortable with a man. NM-HSB service staff highlighted that learning to become comfortable engaging with women is a treatment need for many service users. While clinicians were not assigned to clients on this basis, it was noted that being required to engage with a woman clinician could therefore help to support treatment for some service users.

Service users reported that they were no longer engaging in HSB or other problematic behaviours after engaging in the NM-HSB service

Crucially, all service users that we spoke with reported that they were no longer engaging in the HSB and other problematic behaviours that prompted their referral, after engaging with the NM-HSB service. This was also corroborated by the family or whānau members that we spoke with.

> Looking at things from a different perspective gives you a bit more hope that you can stop making bad decisions, which I've done all my life.

Service user

Although the desire to desist from HSB was often present prior to engaging with the NM-HSB service, service users reported that the programme gave them the insight, practical skills and coping strategies required to actually stop these behaviours and address the underlying thinking, reacting and lifestyle factors that were maintaining the behaviours. In particular, many service users spoke about the value of developing specific plans that would help them identify situations or environments that might lead them back to HSB, and how they would manage these situations should they arise.[14]

> Just to have a plan of action, to have strategies to help with what I came in for. That was probably the biggest thing.

Service user

Although promising, it is important to note that any ongoing HSB that service users might actually have been engaging in was unlikely to be reported to evaluators. Participants were informed that any risk of ongoing harm to themselves or others around them would have to be reported to NM-HSB service staff by interviewers, and there likely would have been concerns about repercussions if they did reveal any ongoing HSB. In addition, clients who had completed the programme and engaged in subsequently discovered HSB would unlikely to have been available for interview. It is likely that a quantitative evaluation that includes assessment of reoffending data would provide more reliable evidence of the effectiveness of the NM-HSB service for reducing further engagement in HSB.

[14] This is often referred to in the literature as 'relapse prevention planning'.

Service users report now having improved wellbeing, new skills, and hope for the future

As a result of developing these skills and strategies required to address their HSB, service users described the profound, and sometimes transformative, impact of the NM-HSB service on their overall life and wellbeing. Many service users spoke to fundamental changes they had experienced with their personal development and ability to respond to life stressors, including being equipped with coping skills, communication skills, and strategies to sustainably improve their mental health and resilience. Many service users also reported being encouraged to engage in wellbeing practices, such as meditation, that they would not have previously given much credit or thought to. Some service users stated that they had been able to gain employment following engagement with the NM-HSB service, although this appeared to be mostly enabled by the improvement in their wellbeing and daily functioning rather than through specific employment support offered by the service.

> The work with [service provider] is very positive. It has had a very positive effect on my wellbeing. To be honest, I'm not sure how I would have done without it.

Service user

> Yeah, huge difference. I'm being who I want to be. I'm doing what I want to do. I'm working at a job that I enjoy. I'm doing hobbies that I didn't think I'd do. I'm more open, more happy. I feel like myself again, which hasn't been the case for about 12 years. So it's crazy the difference that has happened.

Service user

Perhaps most significantly, most service users reported now having hope for what their future might hold. They often no longer experienced suicidal thoughts or urges, and expressed that it felt like a 'darkness' had been lifted from their lives. Many were excited to share the new activities or goals that they were focused on post-exit from the NM-HSB service, including fitness goals, new jobs, and plans to pursue further education. They reported that although they still had some way to go in terms of reaching what might be considered positive wellbeing, attending the NM-HSB service had equipped them with the skills they needed to continue improving themselves and their lives.

> Those dark feelings, I don't have them like I used to thanks to the help that I'm receiving.

Service user

Service users reported positive experiences with group sessions, deriving benefits not available through individual sessions alone

Despite many service users being initially very hesitant to participate in group work, all service users we spoke with reported group sessions being mostly a positive experience. Service users reported that group work helped them to understand others' perspectives, and most importantly, that they are not alone in their experiences. Many service users stated that it wasn't until attending group sessions that it had really dawned on them that other people were dealing with the same issues as them. As such, service users commented on the power of the group sessions to help alleviate feelings of loneliness, to share and listen to personal experiences, and even actively support others on their respective journeys.

> When I first came here, I felt like it was just me. Then I realised other people are struggling with the same issues.

Service user

This shared experience also enabled group members to gently challenge each other when they identified group members engaging in unhelpful thinking or behaviour patterns, and made them more receptive to the challenges they received themselves. For service users who had not yet engaged in what they considered to be more 'serious' forms of HSB, such as HSB involving direct contact with victims (as opposed to online HSB), hearing about the psychological, social and legal consequences for other group members who had engaged in these behaviours was reported to act as 'warnings' for them about what it would mean to 'head down the wrong pathway' and continue engaging in HSB. The group component of the service also enabled service users to build new friendships with group members, which helped to alleviate loneliness and feelings of isolation.

> The group turned out to be a very emotional and cathartic experience. I found it deeply valuable and useful, to the point where at the end of it I didn't want to leave. You get from it, but you give to it … I was more experienced in [group work] so I could sort of help the other people in the group who had never done it before.

Service user

Service users reported that these aforementioned benefits were unique to the group environment. Individual sessions were also seen as valuable, particularly for addressing specific personal issues, delving more deeply into sensitive areas such as sexual needs or behaviours, or more thoroughly exploring reactions to the content raised in group sessions. However, service users stated that they thought they got the most out of the NM-HSB service through a combination of group and individual sessions.

Although the perception of group sessions were mostly positive, some issues were identified relating to the intergroup dynamics between group members. These were particularly related to the rolling nature of groups, with some service users reporting issues with newer members joining the group after they had already spent time building trust and rapport between existing members. If not carefully vetted, newer group members could destabilise the group dynamic, leading to group members feeling uncomfortable or irritated by newer members. This was reported where, for example, new members might be of a different age profile to existing members, or held and shared beliefs that went against the established group kawa (group protocols/culture and behaviour). Although this did not lead to any service users we spoke with leaving the group, some reported a preference either for closing groups, or for more closely matching groups based on the demographic or needs profiles.

Service users are reconnecting with whānau and friends, often supported by sessions involving whānau or other support people

All service users spoke to the positive changes they have experienced in being able to better understand and manage their interpersonal relationships through improved communication, emotional regulation and social skills. Service users spoke about the powerful impacts of their experience and growth on their personal relationships, which had often been damaged as a result of their HSB or self-isolation, requiring the rebuilding of trust. Many service users that we spoke with reported that they were now reaching back out to repair these old relationships as a result of their engagement with the NM-HSB service.

To this purpose, many service users commented on the benefit of being able to include friends, whānau or other support people in NM-HSB service sessions; this was reported as being offered to service users across providers, with the increased staffing facilitated by Budget-19 funding supporting the capacity for these sessions to be offered. Service providers reported taking a broad conceptualisation of 'whānau' when offering these services, including providing support for friends or employers as well as family or whānau. Service users spoke to the value of the service recognising

that friends and whānau are an important source of support, and that they can benefit from better understanding what might be going on for their family member or friend. These sessions with support people allowed them to be 'brought up to speed' with what they had been working on in treatment, and provide guidance to support people about how they could be actively involved in helping support the client as they continued to make changes in their life.

> When the [post-treatment assessment and relapse prevention] reports came out, we were invited to that. We were able to ask questions. So there was very good whānau support ... The key thing was to make sure that we had a plan that was anchored and was followed. And they did a great job to take us all on a journey.

Family/whānau member

Whānau members we spoke with also described the value they derived from attending sessions with their family members. They reported challenges with finding information and resources online that would help them to understand how they can support their friend or family member, and that attending sessions with the service user helped to fill this gap. Whānau members also reported that attending sessions provided more certainty about what was happening for their family member, alleviating anxieties about what the future might hold for them and their whānau.

> I feel way less anxious. It did have a really positive impact on both of us ... I feel more safe.

Family/whānau member

Notably, several of the service users that we spoke with either did not have support people that they could bring into their sessions, or did not want their friends or whānau to know that they were accessing the service. This limited the opportunity to incorporate support people into the service for all clients.

6.3 Cultural responsiveness

Service users mostly reported that their cultural needs were being met

Service users mostly reported that their cultural needs were being met by the NM-HSB services, although many that we spoke with did not identify having any specific cultural needs. These clients stated that they had been asked about any cultural needs they might have had, however, and felt confident any needs of theirs would be met if requested.

Service users and whānau members who did report having cultural needs either stated that these were incorporated well by the NM-HSB service, or that they were seeking support for these needs

elsewhere. Some service users did not see the NM-HSB service providers as being the appropriate organisation to provide these forms of support, and preferred to address these needs through other activities and services that were more specifically focussed on building cultural connection and engagement.

> The fact that they recognised him as a person of colour was really big because he'd never experienced people acknowledging his cultural needs or his [developmental condition] needs either … Prior to his engaging with [service provider] there's been times where he has been discriminated against for that. He never felt that discrimination or anything here.

Family/whānau member

Some service users noted that they were not offered the opportunity to attend a culturally-specific group or LGBTQIA+-specific group, but that this is something that they would be interested in. One NM-HSB service provider was offering a Pacific support group and were planning to introduce a Tāne group, however NM-HSB service staff noted that opportunities to offer such groups across providers would be difficult due to insufficient service user numbers to support specialised treatment groups of these kinds.

The funding has allowed for the establishment of bicultural advisor roles, although these advisors often have limited capacity

Service provider staff across providers reported that the Budget-19 funding had allowed them to establish new bicultural advisor roles, and some providers also had Pacific advisors on staff. These advisors were able to help provide training and input across the organisations to ensure that the services were culturally safe and responsive. However, often these advisors were also managing their own caseloads, meaning that they had limited capacity to focus on the cultural responsivity components of their overall role. Some bicultural advisors we spoke with also reported having to cover a large scope of iwi engagement, which was often not manageable on top of this workload. There is therefore potentially scope to further increase targeted funding for bicultural supervision and leadership roles within NM-HSB services, to ensure that staff within these roles have capacity and space to continue to lead growth in this area.

Staff report improvements in the bicultural responsiveness of services, but would like further training and support for broader cultural responsivity

NM-HSB service staff reported that there have been recent improvements in the bicultural responsiveness of the service. Staff described how tikanga is increasingly incorporated into service delivery, including karakia, mihi whakatau and waiata, and that they were actively thinking more about the cultural needs of their clients and how they could be met. This was credited to the establishment of the bicultural advisors, who were able to lead staff in incorporating these changes into routine processes within organisations, and provide bespoke advice for individual clients.

> I will intentionally consider how comfortable they are with their cultural identity and things that I can do to recognise their wairua.

Service provider

That said, staff also noted a lack of specialist cultural supervision and training to inform their practice with service users from various other cultural backgrounds and communities, such as Pacific, South or South East Asian, and LGBTQIA+ people. They noted this as an area of development they would like to be able to invest time and effort into as part of their work, given that engaging with people from diverse backgrounds was inevitable given the lack of other providers providing the specialist support they did.

> Having cultural supervision would be a start.

Service provider

NM-HSB services are improving their responsiveness to neurodiverse service users

Staff at NM-HSB services that we spoke with also reported a perceived increased in neurodiverse clients presenting to the service[15]. Providers were adjusting their engagement, delivery style, and programme content to meet the individual needs of these service users, although they noted the limited resources and research available to help guide this work. This was particularly challenging in terms of understanding how to best address problematic beliefs or attitudes towards HSB with these service users, which is often a key treatment target for sexual offending. While a number of providers had internal neurodiversity expertise among staff, who were able to provide ad hoc advice and internal training, staff reported a desire for further external training and research to support their focus on increased responsivity for neurodiversity.

Several of the service users that we spoke with for the evaluation identified as neurodiverse, and all reported that their needs were being met through the NM-HSB service. One service provider also reported that they were currently exploring whether they could offer diagnostic assessments for service users with suspected neurodiversity in-house, which would address the significant challenges that many service users experienced in accessing assessment through other community or public mental health providers.

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[15] NM-HSB service providers have begun capturing data on neurodiversity in their administrative dataset in recent months, which will allow for a more systematic analysis of potential growth in this area.

7 Supports

KEQ 3: How has the funding impacted the support NM-HSB service users receive?

Key insights

Since the Budget-19 funding, NM-HSB service providers have significantly expanded the variety of treatment options for service users. For example, providers have introduced a new group treatment framework that accommodates different risk levels within the same group, enhancing the efficiency and inclusivity of group treatments. Increased staffing levels have also enabled the provision of "top-up" sessions, specialisation of treatment groups, and maintenance groups, which support former clients in maintaining progress and accountability post-treatment.

Despite these improvements, there are still gaps in service provision. Many service users reported ongoing mental health needs, such as depression and anxiety related to unresolved childhood trauma, which were not fully addressed by the NM-HSB service. There is also a need for more comprehensive, individual support for family and whānau members and other support people, who often experience significant psychological and social impacts following disclosures of HSB. Efforts are ongoing to improve consistency in service provision through enhanced supervision, training, and collaboration among providers, however variations in demand and resourcing across providers means that needed supports, including maintenance groups and whānau-specific supports, are not uniformly offered. Importantly, the workload and resourcing implications of an expansion of services would need to be considered before these are consistently rolled out.

Service users and NM-HSB service staff identified several areas for further research and development, including specialised support for online HSB and neurodiverse service users, alongside increased online resources to improve accessibility of supports for non-mandated service users.

7.1 Types of support offered

There has been an increase in the number and variety of HSB treatment options offered to service users

Since the Budget-19 funding was provided, NM-HSB providers have reported an increase in the number and variety of HSB treatment options offered to non-mandated service users. For example, there has been a recent innovation in the structure of group treatment being delivered across all three NM-HSB providers, through an initiative called *Focusing on a Positive Future*. In partnership with the Ministry of Social Development and Ara Poutama (the Department of Corrections), service providers have led the development of a new group treatment framework that allows for the delivery of treatment to groups comprising service users across different risk levels, while still matching treatment intensity with client risk.[16] This has meant that group treatment is a feasible option for a greater number of service users than was the case under the old non-mixed risk model, allowing for more efficient use of staff time, and enabling all service users to receive the benefits of

[16] Matching of treatment intensity to client risk is a fundamental principle of the Risk, Need, Responsivity (RNR) model of offender rehabilitation, which guides the development and delivery of most offending interventions internationally.

group treatment where this would be appropriate for them. The efficacy of this new group treatment framework is currently under separate evaluation.[17]

As a result of the increased staffing levels, all NM-HSB service providers are now also able to offer "top up" sessions for clients who have completed the formal programme, enabling more continuity of care for service users. This means that they are able to schedule in one-off sessions with clinicians when they might be feeling like they need a refresher of their skills or coping strategies, such as when they experience major life events, or when they feel like they might be heading back down a problematic pathway of behaviour. This enables a more proactive approach to potential relapses in behaviour, allowing previous service users to access supports without the need for any additional HSB to have occurred.

The ability to keep coming back when I need to and always have that support has helped.

Service user

Provision of longer-term support groups helps to maintain and embed progress made during core treatment, but is not always available across providers

As a result of increased staffing afforded by the Budget-19 funding, some NM-HSB providers have been able to provide 'maintenance groups' for service users who have completed the formal HSB programme, providing an ongoing source of support and sense of community that helps keep former clients accountable and on track towards their goals. This supplements the individual 'top-up' sessions on offer by providers, providing ongoing, regular support that offers the same benefits to group members as the core treatment group sessions. NM-HSB service staff noted that the maintenance group fills a current gap in the community for support groups for people who have engaged in HSB.

However, not all NM-HSB providers are able to offer these groups, due to limitations with staffing. Several service users we spoke to at these provider sites reported that they would be interested in attending such a group if it was available. Although contact with group members outside of group sessions is not permitted while engaged with the NM-HSB service[18], several previous service users at these sites reported that they continue to catch up with old group members for informal coffee support groups on a regular basis. Some previous service users also spoke about developing healthy habits, such as going to the gym, with previous group members. These post-service meet-ups were largely being organised by previous group members independently from NM-HSB service providers. It would therefore be beneficial to explore the additional resourcing and processes that would be required to enable maintenance groups to be consistently offered across NM-HSB service providers.

[17] This multi-year evaluation is being led by Dr Jacinta Cording and Dr Sarah Christofferson, University of Canterbury.

[18] This is mostly to manage potential risks of collusion or encouragement of ongoing HSB between group members, while they are still working on the causes of their prior HSB.

I think one of the things with my [whānau member] is, he wants to properly re-engage with the community. But obviously there's so much stigma and some of it is really fair enough. But you know, he's held himself accountable and he just wants to be better.

Family/whānau member

The variety of group work offered is limited by staffing and service user numbers

Although the increase in NM-HSB service funding has enabled innovation in group programme delivery and availability to clients, there are still limitations in the variety of group work offered to service users. In particular, providers are often not able to offer groups (or indeed individual sessions) in evenings or weekends, which can cause issues for service users who are trying to find regular employment while engaged with the service.

It's quite a long time for the group sessions ... Yeah, so it's just, it's hard for me. But it's hard for everyone. You just got to kind of fit around. I think the hours are probably not the best because it's not open on a Saturday or something like that.

Service user

In addition, while one provider reported being able to create more specialised groups, such as groups where members share similar HSB histories or demographics, this was not possible for the remaining two providers, who reported insufficient service user numbers to be able to tailor groups in this manner. This may limit the ability to reduce barriers relating to group dynamic and cohesion for service users engaging in group work. It also limits the ability to individualise the programme content for individual groups around specialised treatment or responsivity needs. That said, existing research is relatively limited in terms of understanding whether creating specialised groups in this manner helps to improve the effectiveness of HSB treatment.

The increase in the number of funded non-mandated clients also increases the flexibility of length of engagement in the HSB programme

Many NM-HSB service staff reported that a key benefit of the increase in funded non-mandated client spaces was that service users who began the programme as a mandated service user were able to be transferred over to the non-mandated contract if they reached the end of their sentence mid-programme. Whereas previously these individuals would need to be exited at this point due to no longer being funded, this meant that service users were able to complete the programme, or

even repeat the programme for a second time if this was needed. Importantly, once transferred over to the non-mandated contract, service users were no longer under any legal obligation or requirement to remain engaged with the service. However, most service users chose to do so due to the benefit that they reported receiving from the programme.

The NM-HSB service funding has supported the provision of more diverse wrap-around supports for service users

The Budget-19 funding has enabled the expansion of psychosocial support across all NM-HSB service providers, with all establishing social work/psychosocial support roles (e.g., community navigators) to supplement the core HSB treatment programme. Notably, this has been a relatively recent development for a couple of NM-HSB providers (i.e. within the first half of 2024), and so the impacts of establishing these specific roles was not able to be fully explored in the current evaluation. Prior to establishing these roles, increased psychosocial supports were being provided by HSB programme clinicians, although this was reported as being somewhat limited due to capacity of clinicians to focus on these needs alongside their existing group and individual session work.

Beyond the establishment of these roles, the Budget-19 funding has enabled service providers to offer practical support with general day-to-day needs such as petrol and bus money, phone top-ups for communication purposes, and food for group sessions. The new staff in the psychosocial support roles were also able to help support service users into employment where this was possible, although this was a relatively new service offering and there was limited information about the effectiveness of this.

As mentioned above, service users were often unaware of these additional psychosocial supports available to them through the NM-HSB service, beyond the assistance with transport costs. This highlights a need for greater proactiveness around the communication of the variety of supports on offer to clients.

7.2 Support gaps

There is a need for specialist mental health and trauma support for service users

Although all service users that we spoke with reported increased wellbeing and daily functioning as a result of engaging with the NM-HSB service, many of the service users still reported ongoing mental health needs that they required support with post-engagement with the HSB programme. This included ongoing issues with depression and anxiety that were considered unrelated to their HSB, and were often attributed to unresolved childhood trauma that was not specifically addressed within the NM-HSB programme. They reported that they were not able to access these targeted mental health services through the NM-HSB service providers, instead either having to wait for public mental health services (including through ACC sensitive claims), or privately fund services themselves.

The provision of more targeted mental health supports is not a common feature of HSB treatment programmes internationally, given the lack of existing evidence linking mental health with HSB. However, a number of service users stated that if the support was available, they would have preferred to address these more specific mental health needs with their NM-HSB clinician, given that they had built strong rapport with them and it meant that they would not need to continue disclosing their stories and information to new people. As such, it could be beneficial to explore the feasibility, appropriateness and resourcing implications of providing these more holistic mental

health supports as a supplement to the core HSB treatment programme. Importantly, any such feasibility assessment would also have to consider whether there is the appropriate level of expertise among provider staff to address these mental health needs, given that not all NM-HSB service clinicians are registered psychologists, and may therefore have a more narrow scope of training and experience.

> I don't know if counselling is actually offered at [service provider]. But having that as an option would probably be helpful ... Because obviously, if I have been offered counselling, I would have taken it.

Service provider

There is a need for further support for family and whānau members of service users

Although all NM-HSB service providers were offering joint sessions with service users and their support people where appropriate, there is an ongoing need for targeted support for family and whānau members through their own separate sessions. While some service users were no longer connected with their family or whānau, others continued to maintain these relationships, although they had often been strained by the disclosure of the HSB. These family and whānau members expressed the heavy psychological toll that these disclosures had on them, and that they felt a sense of helplessness or loss about what the future might hold for them. There were also sometimes subjective feelings of guilt or shame about their ongoing relationships with their family or whānau member, and what this might mean for their own social reputation.

> I think I just needed some support, because when you're confronted with [your partner's HSB] history, it's quite hard to acknowledge. Especially because I can't fully tell people in my life about my partner's past. And obviously, if people did find out, there'd be lots of consequences and safety and all this other stuff, because people get quite reactive. And some of it's very fair, but it's complicated.

Family/whānau member

> I wanted some reassurance that I wasn't alone, like my situation wasn't unique. That there are people that are in relationships with people who are convicted of some pretty horrible stuff, and that they don't reoffend, you know? … So it was just [service provider's] reassurance that I'm not minimising someone else's pain because I'm with someone who perpetrated that. And sort of navigating how this is going to work.

Family/whānau member

Some NM-HSB service providers are able to support whānau in separate sessions, helping them to address these issues. Where this was available, family and whānau members reported a significant improvement in their wellbeing and hope for the future as a result of this support. This was also reported by service users whose family or whānau members had received this support.

> I'm starting to learn to concentrate on my own wellbeing to a certain extent … I can certainly help out my family because I'm feeling better about myself, both physically and mentally.

Family/whānau member

> I was asked if I'd like to get help for myself and I did. I had it for six weeks, and absolutely loved it.... It just made a lot of sense, you know, of what happened to my [family member] and to what he'd done and to where he is now … I can walk around with my head up high. Because I was so down. Even to this day because of that, I'm still walking with my head up high.

Family/whānau member

However, this separate support for whānau was not available across all NM-HSB service providers. Staff attributed this to a lack of available staff with the appropriate skillset to work with family, as well as a lack of capacity to provide these services as well as meeting demand from core service users. Ensuring consistency in the provision of this support is therefore crucial, given the lack of other services that provide support for family or whānau of HSB perpetrators. Additionally, none of the service providers were offering support groups for family or whānau of service users. This was

seen by service users, whānau members, and staff as being a key gap in current service offerings. It was expressed that a support group for whānau or other support people could offer not only acknowledgement and support specific to their own needs, but also a sense of community for support people given the social isolation that can also occur for them as a result of their whānau member's behaviours.

> What is missing is here is support for family and partners … A number of our supporting people would really benefit from a particular support group … We just don't have the capacity.

Service provider

There is a need for further development of specialist support for online HSB and neurodiverse service users

As reported above, NM-HSB service staff reported an increase in the presentation of service users with online HSB histories, and neurodiversity. Although service providers were incorporating more recent research into adapting their services where possible for these clients, there is an ongoing need for more research and training in this area. This was noted to be an international issue, rather than specific to NM-HSB services in Aotearoa New Zealand.

Staff across NM-HSB service providers reported good working relationships with local Universities and researchers, enabling some of this research to be supported. However, they also reported a desire for more capacity and funding to be more heavily involved in developing and conducting this research themselves, or in closer partnership with researchers. This would better enable the research to leverage from their rich clinical insights and ensure that the end products would be informative for ongoing service design and delivery.

> I would like more funding or space or resourcing around research. Because I think we could do a lot of that internally, if we don't think of research just as academic-level research, but just gaining insights.

Service provider

Offering information online, such as webinars, forums and online resources, could improve accessibility of support

Several service users reported a desire for more resources to be provided online, through modalities such as webinars, online forums, and online resources. It was felt that this would improve the

accessibility of supports on offer to help people stop engaging in HSB, particularly for non-mandated people who might be initially hesitant to physically make contact with HSB service providers.

Staff expressed fears that the increase in scope of services offered may mean that there is over-demand for services

Although the supports outlined above were identified as key gaps in service provision, some NM-HSB service staff expressed concerns that a significant increase in the scope of what they offered would cause flow-on effects in terms of inability to meet demand. As previously mentioned, some providers were already struggling to meet existing demand, and increasing the scope of supports offered could stretch this capacity even further, leading to unsafe caseloads and a concern that focus would be taken off the core function of providing specialist treatment for HSB. Any meaningful changes in the range or volume of supports offered would therefore require close consideration of resourcing and workload implications, ensuring that the core treatment provision would not be compromised by supplementary services.

7.3 Consistency of service provision

The core treatment is largely the same across services, with a high level of collaboration between providers

The quality and nature of the core HSB treatment provided is largely the same across service providers. This consistency in service provision is supported by a high level of collaboration between the three NM-HSB service providers we engaged with. This collaboration includes sharing ideas, treatment manuals and other resources, training, and planning materials across providers. As such, there is relatively equitable access to required HSB treatment regardless of service user location (aside from issues with actual service access depending on the geographical location of clients).

There are differences in the broader scope of what is offered nationally, often due to differences in demand and resourcing

As highlighted by various findings reported in the sections above, there are differences in the availability of additional supports provided by NM-HSB service providers beyond core HSB treatment, including the extent of psychosocial supports, supports offered to family or whānau members, flexibility in group options, and availability of maintenance supports. Both low and high demand can contribute to these inconsistencies.Low demand reduces the ability to assemble specialised or targeted groups, high levels of demand were stretching staff capacity, limiting their ability to deliver initiatives beyond the core HSB treatment service. Because of the differing levels of current demand for services across sites, this was therefore driving many of the inconsistencies identified across providers.

Staff are working to improve consistency of service provision through supervision and training

Staff across NM-HSB service providers commented on recent internal organisational developments to support consistency of service delivery. These included greater levels of clinical and peer supervision and the establishment of new clinical leadership positions, which also supported the alignment of services with best practice. Growing efforts were also reported to ensure adherence to standard approaches and processes through targeted training, such as using appropriate assessment measures, tools and reporting mechanisms in line with newly-developed templates. This was raised

particularly in the context of onboarding and training new staff, although all staff reported good levels of support in this respect.

> We're working to ensure that when new staff in particular come into the organisation, they're accessing the core training.

Service provider

8 Workforce capacity

KEQ 5: To what extent has the funding impacted the workforce capacity of NM-HSB service providers?

Key insights

NM-HSB service staff consistently report high job satisfaction and a sense of purpose, attributed to their meaningful roles and positive impact on community safety. Many staff, having transitioned from other social sector roles, find their work within NM-HSB services particularly fulfilling due to greater autonomy and the ability to respond flexibly to client needs. Despite heavy caseloads and complex demands, staff are committed to delivering high-quality services, driven by their dedication to client outcomes and the meaningful nature of their work.

Recent funding increases have improved staff connectivity and workplace culture, mitigating feelings of isolation and fostering collaboration within and across providers. However, high caseloads and the associated risk of burnout remain significant concerns, and are exacerbated by the challenging nature of the work and perceived increase in administrative burdens. Staff frequently work beyond their contractual hours, and NM-HSB service providers face difficulties in recruiting and retaining qualified staff, particularly in light of more competitive remuneration from other organisations and other sectors.

Supervision and training are areas of both progress and ongoing need. While staff report satisfaction with current supervision levels, including bicultural supervision, there is a call for more comprehensive training on HSB-specific skills and client interaction. Internal training opportunities have increased, but gaps remain in external training availability and targeted professional development. Onboarding new staff, particularly those without HSB experience, presents challenges, highlighting the need for improved training and mentoring processes to support new recruits in acquiring the necessary skills and knowledge for effective service delivery.

8.1 Staff wellbeing and workload

Staff report meaningful roles and a sense of contributing positively to the community

The NM-HSB staff that we spoke with consistently reported feeling a great sense of satisfaction and purpose in their role. Their very direct contribution to keeping communities safer made the work incredibly meaningful for staff, and they were proud of their ability to contribute positively to society. This was also noted by service users, who often stated a perception that their clinicians truly cared about them and helping them to change their behaviour.

> I have huge job satisfaction, because of the guys that I meet with, just the work that they put into bettering themselves. They really buy into it. At first they might not, but you know, they can buy into it.

Service provider

Many of the staff that we spoke with had previously worked in other government or non-governmental social sector roles, and they often commented on their current work within NM-HSB services being particularly meaningful and enjoyable. In particular, staff noted that they had more autonomy and scope within their current roles than they had experienced previously, allowing them to quickly and flexibly respond to individual client needs, and to develop skills in their specialist interest areas. This meant that although the work could often be complex and demanding, staff were committed to their roles and to their clients, enabling them to continue to deliver high-quality services despite often heavy caseloads.

There have been recent increases in staff connection and improvements in workplace culture

Despite this high sense of job satisfaction and meaning, many NM-HSB service staff also commented on this being a relatively isolating profession. There was often not a lot of collaboration with other mental health professionals outside of the HSB area, and staff were often not able to share their role or work with others, given the negative social reactions when they did disclose their work to others. Connections with colleagues were therefore key to addressing this isolation as well as sharing knowledge and skills, and staff across providers reported recent increases in opportunities to build these connections. Not only did the increase in funding increase the number of staff within providers, offering more chance for overlap and connection, but staff reported that it also created more space within workloads for team connection and collaboration to occur. This improved connectivity and connection was occurring both within and across providers.

We have an ability to get together as a team more, in-person and with other regions. This helps wellbeing because you're able to connect properly and share with your colleagues.

Service provider

As a result of this improved connectivity, staff also report recent improvements in workplace culture. It was felt that this more positive work environment would go some way to addressing the relatively high rates of staff turnover experienced by providers in recent years.

Staff are experiencing high caseloads and risk of burnout, partially related to the risk that they are managing within their work

As outlined in the preceding sections, staff report being able to take on more clients, but at the same time, demand and referrals continue to increase across most providers. Subsequently, NM-HSB service staff are carrying large caseloads, leading to long working hours and a sense of persistent demands on their time. Consequently, staff were reporting high levels of risk of burnout. This potential for burnout was exacerbated by the level of risk that they were managing daily given the clients that they were working with. Some areas also reported higher obligations related to data collection and administrative reporting, further placing demands on staff time.

It's not like there's any moments where it slows down and you can catch your breath.

Service provider

As a result of these high caseloads, many staff are working significantly more hours than are contractually required of them, especially for staff working in less than full time roles. They reported inevitably working more hours than required, particularly for tasks such as preparing for sessions and report writing, particularly given that this tended to compound and be required for several clients at once, once a group treatment programme ended. Staff running groupwork in the evenings also reported that the sessions tended to go overtime, and due to caseloads, it could be difficult for staff to take the time back.

> How much capacity there is to have staff wellbeing as the top priority … it all boils down to funding and high caseloads.

Service provider

There can be difficulties recruiting and retaining suitably qualified and experienced staff

Relatedly, staff reported difficulty attracting and retaining suitably qualified and experienced staff. It was acknowledged that this workforce capacity issue exists across the wider health sector, but that relatively low rates of renumeration made this particularly difficult for the NGO sector. This was especially the case for registered psychologists and other professions that could make significantly more money in private practice, or indeed in government organisations such as Te Whatu Ora (Health New Zealand). This difficulty attracting and retaining staff exacerbated issues with workload, both in terms of having fewer staff to carry the load, but also in the demands required from repeatedly needing to onboard and train new staff. In addition to competitive levels of renumeration, staff noted an ongoing need for increased training options and spaces offered by tertiary education providers, to provide an ongoing recruitment pool for providers.

> They're not going to come if they're not paid well, and they won't stay.

Service provider

8.2 Staff training

Staff are satisfied with levels of supervision, including bicultural supervision

NM-HSB service staff reported that in recent years supervision policies have tightened and therefore clinical supervision is consistently being provided at appropriate levels, and often at higher levels than what is strictly required for professional registration. The increase in staffing levels and establishment of new clinical practice leadership roles across service providers has built internal capacity to access supervision from other highly experienced staff, both in terms of general case management, but also for consultation on specific treatment or responsivity needs.

As mentioned in *Section 6.3 Cultural responsiveness* above, although staff reported sufficient levels of bicultural supervision, they identified an ongoing need for increased access to supervision across broader service user cultures and backgrounds, including supervision specific to Pacific, South and South East Asian, and LGBQTIA+ populations.

There has been an increase in internal training provided, however there is a desire for more training on HSB-specific skills

Provider staff reported that there has been an increase in accessibility of, and participation in, training. This was particularly the case for internal training; as with internal supervision, the increased in staffing levels had allowed for a greater capacity and opportunity for sharing skills and knowledge within teams. However there are still gaps and a lack of availability for some desired training. In particular, staff reported that while they had good levels of training on the general policies and procedures relevant to NM-HSB service provision, there was less of a training focus on soft skills such as client interaction, as well as more targeted education about HSB and the characteristics of people who engage in HSB. Staff reported that they would like to be able to access more external training to support in these and other areas, to continue introducing new skills and ideas to the workplace, and so that individual interests of clinicians could be supported through targeted professional development.

> You get training on the systems and the policies, but you don't get the training in how to work with the people.

Service provider

Staff attributed this lack of available training to a lack of targeted funding for training. It was also noted that staff on shorter term contracts, or contracts with lower hours, found access to training more difficult, sometimes having to access training on days when they were not paid. Further, staff noted that it was difficult to access training in some of the areas they desired, such as particular risk assessment tools or emerging client groups including those engaging in online HSB, due to a lack of available training, or available research to inform this training.

Onboarding can be difficult, especially when recruiting staff with no HSB experience

Due to these aforementioned challenges with training, several staff reported that onboarding new staff could be an issue, especially when recruiting staff with no HSB experience. Due to the limited pool of suitable candidates from which to recruit, sometimes staff members were recruited who had experience working with clients in a psychosocial or mental health capacity, but did not have a background in HSB. Given the unique presentation and needs of HSB service users, this created a large gap in knowledge that peers had to help fill, all while also expecting the new staff members to pick up a caseload relatively quickly to assist with broader service demand. There were often no specific onboarding processes or trainings to help support new staff gain these HSB-required skills, further placing the burden on colleagues to try and proactively provide this support. Newer staff without HSB experience also found it difficult to preemptively ask for additional training and support, given that they may not realise what these needs would be prior to starting work with service users. It would therefore be beneficial to review onboarding processes across NM-HSB service providers, ensuring that appropriate training and mentoring processes are in place to support new staff with differing knowledge of, and experience with, HSB services and service users.

9 Sector integration

KEQ 6: To what extent has the funding impacted sector integration?

Key insights

There is a high level of alignment and collaboration among mainstream NM-HSB service providers, facilitated by increased staff capacity and new clinical leadership roles. This collaboration includes strategic initiatives, sharing resources, and developing a shared administrative database, enhancing the efficiency of funding use and supporting innovation. NM-HSB service providers are well-connected with government stakeholders and local universities, enabling joint research and training. However, connections at the local level are still developing, with recent efforts focusing on building partnerships and referral pathways through targeted outreach. In particular, there is a need to strengthen relationships with primary health organisations to increase awareness and referrals for NM-HSB services.

NM-HSB service users generally have access to external referrals for additional support needs, but often compartmentalise their HSB-related needs from broader life issues, indicating a need for better communication about available supports. Challenges remain in accessing mental health services, including ACC sensitive claims providers, due to high waitlists and thresholds.

9.1 Sector integration

There is a high level of alignment and collaboration across NM-HSB mainstream services

As reported above, there is a high level of collaboration and alignment across NM-HSB mainstream service providers, which staff reported has increased in recent years due to increased staff capacity for collaboration, and the establishment of new clinical practice leadership roles responsible for leading this collaboration. This includes collaboration on strategic initiatives, sharing of service manuals and resources, and the development of a shared administrative database (albeit with restricted access to client data within providers).

[The three mainstream service providers] are now working from the same manual. We're having a lot more meetings in terms of clinical practice and process than we ever did before. So it feels as though it's a "we" now, rather than a distant friends. Which is loads better.

Service provider

This high level of collaboration means that funding is able to be used more efficiently to support new innovations and service growth across the sector, leveraging off the specialist skills and knowledge held by staff across providers. Although the development of new initiatives is typically led within

individual providers, meaning that there are some differences in local processes and service user experiences while these are piloted, initiatives that prove to be worthwhile are generally then implemented across other provider sites, with adaptations as appropriate for the local context. This creates a safer environment within which to test new ideas, providing an opportunity to iron out unforeseen issues prior to broader rollout.

Service providers are generally well connected with government partners, however local connections are still being developed

NM-HSB service providers are generally very well connected with government stakeholders, including the Ministry of Social Development, Ara Poutama (Department of Corrections) and Oranga Tamariki (Ministry for Children). Staff also reported strong connections with local Universities, allowing for mutual support and benefit through joint research and training initiatives.

Conversely, service provider staff generally reported being less well connected at a local level, with staff often finding it difficult to identify key referrers and other local sector stakeholders that the evaluation team could engage with. Because local referrers were not engaged with for the evaluation, we are limited in our ability to understand the key drivers of the relatively low connectivity between NM-HSB service providers and local stakeholders. NM-HSB service staff generally attributed this lack of connection to being in 'survival' mode in recent years, and being reluctant to proactively build local connections and partnerships due to an inability to meet additional demand. Since the increase in NM-HSB service funding, however, there has been increased capacity to focus on developing local partnerships and connections through targeted outreach. These outreach efforts have generally focused on either upskilling staff at local organisations to improve their prevention and HSB response capabilities, or to build stronger referral pathways. Some providers have established specific community liaison roles to help support these efforts.

In terms of outreach for the purposes of educating and upskilling local workforces, it is hoped that these upskilling efforts will amplify the work done by NM-HSB staff, allowing for broader societal impacts than those realised by only working with individual perpetrators of HSB after the harm has been caused. For example, staff at one provider have been proactively engaging with local mental health residential staff to increase their confidence and ability to prevent and address lower-level HSB exhibited by residents. NM-HSB service staff have also been working to develop newer potential referral relationships with local organisations. For example, one service provider has been working with the New Zealand Red Cross to support and train Red Cross staff about HSB services and what sort of supports can be offered to their clients as they arrive and adjust in New Zealand.

> It's actually better and easier to work with the environment and get [residential staff] to really monitor and support behaviour. We almost get quite a bit bigger 'bang for our buck' working with the residential facilities, than we do talk therapy.

Service provider

There is a need to further develop relationships and integration with general practitioners and other primary health organisations

Areas of desired future growth in local service connection and integration were also identified by NM-HSB service provider staff, including a desire to increase connectivity with general practitioners, ACC sensitive claims providers, and other primary health organisations (PHOs). Growing relationships with PHOs was seen as important for 'spreading the word' about non-mandated services more broadly, and to support primary health providers to become more aware of HSB-related issues that people struggle with (e.g. pornography addiction), and when these may reach the point of requiring specialist referral for NM-HSB services. Given that PHOs are often the gateway into mental health services more broadly, this was seen as a key relationship that required more targeted development across providers.

There is limited connection to Safe to Talk, and limited awareness of Safe to Talk leading to referrals

NM-HSB service staff that we spoke with were familiar with Safe to Talk, but have little interaction with the service. Staff understand that they are often recommended to clients by Safe to Talk and are also receiving referrals from them, although they do not systematically collect information on how often this is happening. Staff reported that they do not have much contact themselves with Safe to Talk, and that they are not seen as a key referral partner.

9.2 Referrals out

Referrals to external supports are generally available if needed, although many clients compartmentalise their HSB-related needs

NM-HSB service users that we spoke to reported that they were offered referrals to external organisations where needed, including referrals to external employment supports and services providing mental health assessment and treatment, including autism and ADHD diagnoses. This also included referral to services that could provide support for broader family or whanau members, including relationship or marriage counselling.

> It was helpful because during the [NM-HSB service] process, [clinician] actually referred me on to a psychologist and I was diagnosed with Autism.

Service user

However, service users often also had difficulty recalling whether there were particular areas of need they discussed with their NM-HSB service clinician, or where they would have liked external referrals for support. Instead, service users appeared to often compartmentalise their HSB-related needs as being distinct from broader life issues, often not considering that they could, or should, be asking for support in these broader areas from their NM-HSB service clinician. There was also reluctance for referrals or 'warm handovers' from the service providers for some service users, who were concerned about how other providers might react if they knew they were a user of the NM-

HSB service. As noted above, this finding indicates a need for the broader issues that can be supported through NM-HSB services to be better communicated to service users, particularly with the recent increase in capacity to address clients' psychosocial needs.

There are challenges accessing mental health services, including ACC sensitive claims services, in some areas

Where additional needs are identified for NM-HSB service users, staff report some difficulties in referring clients to ACC sensitive claims and other mental health services. In particular, staff report large waitlists and difficulties with service users meeting the relatively high threshold now required to access public mental health services. Staff noted that this is an issue encountered across the health sector nationally, and they have limited ability to address this issue themselves. However, as noted above, several providers are exploring options to provide some of these mental health services in-house so that this more holistic care can be provided to service users.

10 Conclusion and recommendations

This evaluation of the Budget-19 funding for NM-HSB services has revealed a number of key insights into the experiences of NM-HSB service users and frontline staff following the increase in funding. There has been a significant expansion of NM-HSB services across Aotearoa New Zealand and a focus on increasing the flexibility of service delivery, which have together improved accessibility of the service. Collaboration among service providers is strong, supporting innovation and efficient funding use, though strengthening local connections, especially with primary health organisations, remains an important future focus for providers.

Despite this expansion of services and high level of collaboration between providers, consistent access to services for people living outside main centres remains a challenge, particularly where there are limited transportation options or people live a considerable distance away from their nearest physical provider site. As services have become more accessible, there have also been growing issues with demand and waitlists for service access. NM-HSB providers have more recently been implementing new initiatives to manage waitlists more effectively, however these issues are expected to persist under current funding levels for many providers, particularly as connections and awareness of the service within local communities grow.

Service users reported entering with limited expectations other than a key priority of addressing their HSB. As a result of their engagement with the NM-HSB service, service users reported substantial improvements in wellbeing and a reduction in HSB. Key enablers of these positive changes included the respectful and supportive approach of NM-HSB staff, the group sessions provided as part of core HSB treatment, the inclusion of whānau or other support people in treatment sessions, and the practical skills that they learned to help manage their behaviour. The establishment of bicultural advisors across all service providers has enhanced bicultural responsiveness of the NM-HSB services, however further development is necessary to address diverse cultural and neurodiversity needs.

Despite these advancements, gaps in service provision persist, particularly in addressing ongoing trauma and mental health needs, and providing comprehensive support for family and whānau members. There is also a need to better communicate the availability of psychosocial supports to service users. Efforts to improve consistency in service provision through enhanced supervision and training are ongoing, but variations in demand and resourcing impact the uniformity of these supports between regions. NM-HSB staff, while reporting high job satisfaction and a sense of

purpose, face challenges related to heavy caseloads and burnout. Staff also reported a desire for improved access to external training and formal onboarding processes. Given the challenges identified with recruiting and retaining suitably qualified staff, addressing ongoing issues with caseloads, waitlists and service gaps through an increase in staff funding will require careful consideration and planning as to how to best attract the required staff members.

It is important at this point to reiterate the limitations of this evaluation. The evaluation relied on comprehensive and rich qualitative data to inform evaluative judgements, however qualitative data are not generalisable to all service users and service provider staff. In particular, the evaluation was not able to include the voices of service users who chose not to engage with the NM-HSB service after initial contact, or who dropped out of the programme prior to completion. The reliance on qualitative insights and the complexity of the funding in this sector also prevented measurement of the exact size and scope of the funding's impact. This means that we cannot robustly attribute the experiences and outcomes found in the evaluation solely to the Budget-19 funding. Future evaluations of NM-HSB services should therefore consider using quantitative methods to address these limitations. Mixed methods evaluation approaches that incorporate quantitative data would allow for more specific and robust assessment of the impacts of NM-HSB services for service users and their family or whānau.

10.1 Recommendations

Below we provide a summary of the recommendations highlighted throughout this report that stemmed from the evaluation findings:

Recommendation	Who	Purpose
Service Development		
1. Explore additional resourcing and staffing requirements to further expand NM-HSB services into smaller and more remote regions, on a more consistent basis.	MSD and service providers	To increase accessibility of NM-HSB services
2. Consider increasing staff funding levels for the NM-HSB service, to support current and anticipated levels of demand, and to support ongoing improvements in service delivery and responsivity.	MSD	To address waitlist and caseload issues, and support further growth in service responsivity
3. Explore additional resourcing and staffing requirements to more consistently provide individualised support for whānau and other support people.	MSD and service providers	To improve service responsivity and impact
4. Explore additional resourcing and staffing requirements to more consistently provide maintenance groups and other supports for service users who have completed the core programme.	MSD and service providers	To improve service responsivity and impact
5. Explore the feasibility of providing further specialist trauma and mental health supports for service users, in addition to the core HSB programme.	MSD and service providers	To improve service responsivity and impact
6. Continue to grow connections and awareness of the NM-HSB service within local communities.	MSD and service providers	To improve sector integration and service responsivity

Policies and Procedures		
7. Review current strategies and procedures related to staff recruitment and retention, including a review of renumeration levels, to ensure they best support the recruitment of suitably qualified staff.	MSD and service providers	To support sustainable service expansion
8. Review client exit processes and other internal systems or procedures to ensure that active caseloads are efficiently managed.	Service providers	To address waitlist and caseload issues
9. Develop policies and procedures to support service users while they are on the waitlist, such as regular phone check-ins.	Service providers	To improve service responsivity
10. Develop policies and procedures to clearly communicate the availability of, and support access to, psychosocial supports for service users.	Service providers	To improve service responsivity and impact
Staff Training		
11. Establish policies and processes to support additional regular cultural and neurodiversity training and supervision for staff, as well as to support other areas of desired professional development for staff, including conducting internal research projects.	Service providers	To improve service responsivity and impact, and staff wellbeing
12. Review existing onboarding frameworks and procedures to ensure they are fit-for-purpose	Service providers	To improve service responsivity and staff wellbeing

Appendix A: Key evaluation questions and criteria

Table 1 below provides the key evaluation questions and sub-questions that guided the evaluation, as well as the performance indicators that were used to inform evaluative judgements about the impacts of the Budget-19 funding. Where these performance indicators reference "improvements" or "increases/decreases" in aspects of service delivery, these changes refer to a comparison of service delivery in 2017-2018 compared with the years from 2020 onwards.

The performance indicators also reference a number of sources of information that were intended to be used to inform the evaluative judgements made. Briefly, intended sources included:

- Interviews with NM-HSB service users (current and previous), and their family or whānau members
- Interviews with NM-HSB service staff, including service managers, clinical leads, and clinicians
- Interviews with other local stakeholders, such as key referral agencies, national stakeholders, including MSD
- Review of administrative reporting by agencies to MSD.

Although planned, we were not able to interview any other local or national stakeholders for the current evaluation. Further details on the methods that were used for the current evaluation are provided above in the *Methodology* section (section 3, from page 10).

Table 1. Key Evaluation Questions, Sub-questions and Performance Indicators

KEQs	Sub-questions	Performance indicators[19]
1. How has the funding impacted accessibility for NM-HSB service users? **Criterion: Accessibility**	i. To what extent has the funding facilitated effective and responsive referral and access pathways to the services for service users, including from Safe to Talk?	• Service users report satisfaction with the ease and timeliness of the referral/access process • Staff report an improvement in the efficiency of the referral/access process • Referrers report an improvement in the ease and timeliness of referral pathways • External agencies report an improvement in awareness of referral pathways • Administrative data show an increase in referrals and enrolments across provider sites
	ii. To what extent has the funding facilitated access to service provider sites or supports by service users?	• Service users report satisfaction with the physical accessibility of provider sites and programmes • Staff report an improvement in the accessibility of provider sites and programmes for service users • External agencies (including MSD) report an improvement in accessibility of provider sites and programmes for service users • Administrative data show an increase in the number of locations where NM-HSB programmes are offered
	iii. To what extent has the funding affected the ability of services to reasonably meet service user demand?	• Service users report satisfaction with the timeliness of NM-HSB service access • Staff report an improvement in waitlist times for NM-HSB services • Referrers report an improvement in waitlist times and capacity to accept referrals for NM-HSB services

[19] "Service users" also includes the family and whānau of service users when referenced in the KEQs or performance indicators.

		• External agencies (including MSD) report an improvement in the ability to meet demand for NM-HSB services • Administrative data show a decrease in waitlist times for NM-HSB services • Administrative data show an increase in the number of NM-HSB programmes or services delivered
2. How has the funding impacted the responsiveness of the NM-HSB service to service user needs? **Criterion: Responsiveness**	i. What are the expectations or aspirations of service users when entering the service?	• *No performance indicators required*
	ii. To what extent has the funding affected the ability of services to meet the expectations or aspirations of service users?	• Service users report that the NM-HSB service meets their expectations and aspirations • Staff report an improvement in the ability to meet service user expectations and aspirations • External agencies (including MSD) report an increase in the ability of services to meet the expectations and aspirations of the non-mandated population
	iii. To what extent has the funding affected the delivery of culturally responsive services to service users?	• Service users report that the NM-HSB service meets their cultural needs • Staff report an increase in the ability to meet cultural needs through the NM-HSB service • Referrers report an increased confidence in the ability to refer clients with specific cultural needs to the NM-HSB service • External agencies (including MSD) report an increase in the ability of the NM-HSB service to meet the cultural needs of service users • Administrative reporting shows an increase in:

		○ Proportion of Māori and Pasifika clients referred/self-refer to NM-HSB services ○ Proportion of referred/self-referred Māori and Pasifika clients who enrol in the NM-HSB service ○ Proportion of enrolled Māori and Pasifika service users who successfully complete the NM-HSB programme
	iv. To what extent has the funding affected the responsivity of modes of service delivery for service users?	• Service users report that the NM-HSB service is delivered in a way that meets their responsivity needs • Service users report high quality relationships with their clinician • Staff report an improvement in the ways in which service delivery meets the responsivity needs of service users • External agencies (including MSD) report an improvement in the different modes of service delivery available to service users • Administrative data show an increase in the: ○ Proportion of referred/self-referred clients who enrol in the NM-HSB service ○ Proportion of enrolled service users who successfully complete the NM-HSB programme
3. How has the funding impacted the support NM-HSB service users receive?	i. To what extent has the funding affected the delivery of a consistent service for service users across agencies?	• Staff report an improvement in the ability to provide a consistent service for service users across locations

Criterion: Support		
		• External agencies report an improvement in the delivery of a consistent NM-HSB service for service users they are involved with • MSD report an improvement in the ability to provide a consistent service for service users nationally
	ii. To what extent has the funding affected the types of supports available for service users?	• Service users report satisfaction with the types of supports available to them through the NM-HSB service • Staff report an increase in the diversity of supports that are able to be offered to service users • Referrers report an increase in the diversity of supports that their clients are able to be referred to • External agencies (including MSD) report an increase in the diversity of supports able to be offered to service users • Administrative data show an increase in the types of supports that service users are engaging with
	iii. What, if any, are the remaining gaps in supports provided to meet the needs of service users?	• *Based on gaps identified in response to KEQ 3ii*
	iv. To what extent has the funding affected the delivery of the psychosocial support service?	• Service users report satisfaction with their ability to access required psychosocial supports • Staff report an improvement in the ability to deliver required psychosocial supports for service users • External agencies (including MSD) report an improvement in the ability of service providers to deliver psychosocial supports for service users

		• Administrative data shows an increase in the volume of psychosocial supports utilised by service users
4. What are the additional impacts of the funding for NM-HSB service users and frontline staff? **Criterion: Outcomes**	i. To what extent has the funding affected the ability of services to effect other intended outcomes of the service for service users?	• *Informed by data collected for KEQs 1-3*
	ii. What, if any, are the unintended outcomes of the funding for service users and/or frontline staff?	• *Informed by data collected for KEQs 1-3*
5. To what extent has the funding impacted the workforce capacity of NM-HSB service providers? **Criterion: Workforce capacity**	i. To what extent has the funding affected whether the services are appropriately resourced to successfully implement intended processes?	• Staff report an improvement in the ability to deliver services and implement processes as intended • MSD report an improvement the ability for service providers to deliver services and implement processes as intended
	ii. To what extent has the funding affected overall staff wellbeing and job satisfaction?	• Staff report an increase in wellbeing and job satisfaction
	iii. To what extent has the funding facilitated required training for frontline staff?	• Staff report an improvement in the accessibility of required and desired training • MSD report an improvement in service provider staff accessibility to required training
	iv. To what extent has the funding affected staff workload?	• Staff report an improvement in workload, including caseload and proportion of contact hours • Administrative data show an improvement in staff to active client ratios • Administrative data show an increase in clinician FTE per service provider, and a decrease in unfilled FTE
6. To what extent has the funding impacted sector integration?	i. To what extent has the funding facilitated collaboration between the services and sector partners, including Safe to Talk?	• Staff report an improvement in the connectivity with local and national sector partners, including Safe to Talk

Criterion: Sector integration		• Referrers and other external agencies (including Safe to Talk) report an improvement in connectivity with service providers • MSD report an improvement in connectivity between local/national sector partners and service providers
	ii. To what extent has the funding facilitated successful referrals from the services to other appropriate agencies?	• Service users report satisfaction with referral on to any additional external supports required • Staff report an improvement in their ability to refer service users to appropriate external supports • External agencies report an improvement in the functioning of referral pathways from services • MSD report an improvement in the functioning of referral pathways from services to external supports
7. What opportunities remain to maximise the positive effects of the funding for NM-HSB service users and service staff? **Criterion: Remaining opportunities**	i. What are the primary barriers and enablers of the funding effecting positive outcomes across the criteria of accessibility, responsiveness, outcomes, support, workforce capacity, and sector integration?	• *Informed by data collected for KEQS 1-6*
	ii. What opportunities exist to remove these barriers and enhance these enablers across services?	• *Informed by data collected for KEQS 1-6*

Appendix B: Interview schedules

1. Service users

Background

1. **Can you tell me a little bit about you and how long you have been working with XX service?**
   Prompt: What kind of services have you been accessing here? Have you been attending group sessions, or just individual sessions? Where do you attend the sessions? Have you always worked with the same clinician?

Access and referral to NMHSB service

2. **Can you tell me about the process you went through to start coming to this service?**
   Prompt: How did you find out about XX service? How did you first get in contact with XX service? What encouraged you to make the first contact? How easy was the sign-up process?

3. **How long did it take from first contact with XXX service to hearing from a clinician and going along to sessions?**
   Prompt: Were you happy with the length of time this took?

4. **Can you tell me about how easy or hard it is to travel here for your appointments?**
   Prompt: Do you have access to transportation? How long is your travel time? Is transport ever a barrier to accessing the service? If transport is difficult/unavailable, does the service ever help with this? Is your clinician aware of these transportation issues?

Service use and supports offered

5. **What kinds of help or support were you hoping to get when you first reached out to XXX service?**
   Prompt: Did you ever access, or want to access, group sessions? Was this available to you?

6. **When you actually got here, what was that experience like? Do you feel that you got the help and support you wanted?**
   Prompt: What did you find most helpful about the service? Are there things about the service that didn't work for you? Was there anything that you wanted help or support for that you didn't get help with?

7. **Can you tell me about the relationship you have with your clinician and any other staff you work with here at XXX service?**
   Prompt: Did you feel respected by the clinician and other service staff you engaged with? What worked for you, or didn't work for you, in terms of how they treated you?

8. **Was there anything that you needed help or support with outside of therapy?**
   Prompt: e.g., help with employment, housing, or financial issues? If so, did you receive the support you needed with this? Was your clinician helping you with this, or someone else?

9. **Can you tell me about whether the support you got here was personalised to meet any specific needs you had?**

Prompt: For example, how staff contacted you (email, text, phone), making the rooms more comfortable, how the session was run or content was delivered? If yes, please provide examples.

10. **Were there any specific cultural needs you requested XXX service include or acknowledge? What did these cultural needs look like? Did you feel that XXX service respected your cultural needs? How did XXX service include or acknowledge your specific cultural needs?**
    Prompt: In your family/culture, are there any specific beliefs/views/cultures/ways of doing things, such as opening with a prayer? If any, what did these look like and were these needs met? How were you feeling about the service meeting your cultural needs? Did you felt that you were treated culturally appropriate?

11. **Can you tell me about any other professional supports or services that XX service helped you to connect with?**
    Prompt: Were you aware that this referral had been made? Was it helpful? How did you find the handover or information shared? Did you feel in control of your information? Did you have to repeat your story to the new agency? Did you feel respected throughout the process?

12. **Did your family or whānau members access any supports through XX service?**
    Prompt: If yes, what was their experience like? If no, were there any supports that might have helped them? What stopped them from accessing these?

13. **Overall, can you tell me about any differences you have noticed in your life or wellbeing, or wellbeing of your family or whānau, after you started working with XXX service?**

14. **Have there been any unintended impacts of accessing the services here on your life or wellbeing, or the wellbeing of your family or whānau?**
    Prompt: e.g., impacts on employment or childcare?

Wrap-up

15. **If you were the one making decisions about how the services for clients like you were run in future, what is the one thing you would add or change that you think would make the biggest difference for clients who access these services?**

16. **Is there anything else you would like to tell us about XX service that we haven't asked about yet?**

2. Service providers

Background

1. **Can you tell me a little bit about you and your role at XX service? What is your involvement with the non-mandated clients?**
   Prompt: How long have you been working in this role?

Access and referral to NMHSB service

2. **Can you tell me about any changes you have noticed in how well the referral/access process works for non-mandated clients in recent years?**

Prompt: How can clients find out about the service? How are referrals/self-referrals made? Have you been receiving referrals from Safe to Talk? How easy is the sign-up process to navigate, for both clients and staff? How long does the process take from contact to clients seeing a clinician?

3. **Can you tell me about any changes you have noticed in how well XXX service has been able to keep up with demand from non-mandated clients in recent years?**
   Prompt: Have there been any changes in waitlist volumes and times? Have you noticed any changes in demand for the service from non-mandated clients?

Service use and supports offered

4. **Can you tell me about the common things that non-mandated clients are wanting support for when they engage with XXX service?**
   Prompt: Are these different or similar to the needs that mandated clients have?

5. **Can you tell me about any changes you have noticed in the ability of XXX service to meet these client needs or aspirations in recent years?**
   Prompt: What do clients seem to find most useful to support them? Are there things that work less well for the clients? Are there any common needs that you are not able to help support?

6. **Can you tell me about any changes you have noticed in the number of different types of supports that are able to be offered to non-mandated clients in recent years?**

7. **Can you tell me about any changes you have noticed in recent years in the ability for XX service to deliver psychosocial supports to non-mandated clients (e.g., support with financial barriers, employment, etc)?**
   Prompt: Who is delivering these psychosocial supports at XXX service? Have additional staff been hired (e.g., social workers), or is this additional support being provided by clinicians?

8. **Can you tell me about any changes you have noticed in the ability for the non-mandated service to be delivered in tailored ways or to meet responsivity needs for clients in recent years?**
   Prompt: For example, timing of groups, meeting the needs of disabled or neurodiverse clients.

9. **Can you tell me about any changes you have noticed in the ability of XXX service to meet the cultural needs of non-mandated clients in recent years?**
   Prompt: What are the common cultural needs of non-mandated clients? Are there any cultural needs that are not able to be met?

10. **Can you tell me about any changes you have noticed in how easy or hard it is for clients to travel to their treatment sessions and other appointments at XX service over recent years?**
    Prompt: Is transport ever a barrier to accessing the service? If transport is difficult/unavailable, does the service ever help with this? Have there been changes in these supports offered over time?

11. **Can you tell me about any changes you have noticed in the consistency of the non-mandated service offered across groups and locations in your service in recent years?**
    Prompt: Any changes in the consistency of quality and frequency? Any changes in the types of supports offered across locations?

12. **Can you tell me about any changes you have noticed in the ability to refer non-mandated clients to other needed supports, either within XX service or to external agencies, in recent years?**
    Prompt: What are the common additional needs that clients are referred on for? Have there been any changes in the ease of the handover process or information shared? Are you able to provide supports or referrals for family or whānau members?

13. **Overall, can you tell me about any differences you notice in the wellbeing of clients and their family or whānau after they have engaged in the peer support services you have spoken about?**

Workforce capacity

14. **Can you tell me about any changes you have noticed in your workload relating to non-mandated client services in recent years, including caseload and proportion of contact hours?**
    Prompt: Is your current workload manageable? Has the funding and any changes in service offering increased the demands on, or changed the nature of, your role?

15. **Can you tell me about any changes you have noticed in access to, and participation in, training or clinical supervision as part of your role related to the NMHSB service in recent years?**
    Prompt: Are you able to access the types of training you need or want for your role? Do you have regular clinical supervision?

16. **Can you tell me about any changes you have experienced in your wellbeing and satisfaction in your role at XX service in recent years?**

Sector integration

17. **Can you tell me about any changes you have noticed in the connections between XX service and other local or national sector partners in recent years?**

Prompt: Improved connections with referral sources? How well is XX service connected with Safe to Talk? What has been the outcome of any changes in sector connectivity?

Wrap-up

18. **If you were the one making decisions about how the non-mandated service was run in future, what is the one thing you would add or change that you think would make the biggest difference for clients who access this service?**

19. **Is there anything else you would like to tell us that we haven't asked about yet?**